

Do We Really Want to Know? The Potentially Negative Effect of Transparency in Decision Making on Perceived Legitimacy

Jenny de Fine Licht*

Building on the notion of transparency as a strong democratic value and theories of procedural justice, this article reports an explorative experimental test whether transparency in decision making may lead to increased perceived legitimacy in terms of decision acceptance and trust. This is done in a context of difficult decisions of high importance for citizens – namely priority setting in public health care. An experiment was designed in which ordinary citizens were presented with a description of a case of priority setting between two groups with different health care needs. One group was given no information at all on the decision-making procedure, as an example of non-transparent decision making, and six groups were presented with different descriptions of the decision-making procedure, as examples of transparency in decision making. The transparent procedures were derived from three basic forms of democratic decision making: representation, direct participation and expert decision making. A second manipulation framed the decision-making procedure alternatively in positive or negative terms in order to capture media framing effects as well. According to the findings of the study, transparent decision-making procedures tend to weaken rather than strengthen general trust in health care – a finding that might reveal obstacles to attempts to strengthen the legitimacy of health care by employing transparent procedures. The results also show that while the form of decision making had no significant impact on perceived legitimacy, positive or negative framing of a decision-making procedure influences public perceptions of both the procedure and the decision outcome.

Introduction

All societies must make difficult decisions on how to allocate scarce resources and necessary burdens (Elster 1992). In some way, explicitly or implicitly, they have to address the ever present questions of who gets what, when and how.

One policy area where this problem is extremely apparent today is publicly funded health care, where decisions regarding the allocation of large

* Jenny de Fine Licht, Department of Political Science, University of Gothenburg, Box 711, 405 30 Göteborg, Sweden. E-mail: Jenny.definelicht@pol.gu.se

but finite resources place the legitimacy of the political system under considerable strain. As a result of increased health care costs due to accelerating technological progress, aging populations and increased expectations about what medicine can and should do for us, everyone cannot get all the health care they want within the time they find reasonable (Daniels & Sabin 2008). For that reason, we must somehow set priorities among different needs. This pressing issue has led scholars and policy makers to argue that the decision-making procedures underlying priority setting should be more transparent in the sense that it should be explicitly reported who is responsible for the priority-setting decisions and why the limits are necessary (Daniels & Sabin 2008; Kenny & Joffres 2008; Landwehr 2009; Holm 1998). One of the main purposes behind this reasoning is to increase public acceptance of the priority-setting decisions and public trust in the health care institutions, which I will refer to as 'perceived legitimacy for health care management'.

The general idea of transparent decision making as a way to increase legitimacy and good governance is intuitively appealing and discussed in many different contexts (see, e.g., Hood & Heald 2006). From a normative point of view, most of us would probably prefer decision making that is open to the public view rather than decision making in private. However, there have thus far been surprisingly few empirical studies of the possible effects of transparent priority setting on public acceptance and trust in health care. Do transparent decision-making procedures truly have any impact on public acceptance of priority-setting decisions? And what should a legitimising decision-making procedure actually entail? In this article, I report on an explorative empirical study with the aim of testing the effect of transparency in decision making on perceived legitimacy in the context of priority setting in publicly funded health care. I address this question using an experiment in which respondents are presented with information about a case of priority setting between two groups with different health care needs.

In order to get an indication of the effect of transparency, I compare reactions to the decision in situations where it was explicitly reported how and by whom it was taken, with a situation where no information about the decision-making procedure was provided. In the literature on priority setting, the first situation is often referred to as '*explicit rationing*', while the second situation, when priority-setting decisions are made without insight, is referred to as '*implicit rationing*'. These terms will be used interchangeable with 'transparent' and 'non-transparent' decision making in priority setting.¹

In order to concretise what an explicit – that is, transparent – rationing procedure could look like, I also compare reactions to procedures with different forms of decision making: representation, direct participation and expert decision making. To control for media framing effects, each decision-making form is framed alternatively in positive or negative terms.

This article is structured as follows. First, I give a short introduction to the idea of transparency in terms of explicit rationing as a way to increase perceived legitimacy, and present some possible objections to the arguments. Thereafter I discuss some study details and report the empirical findings. The final section discusses the results.

Creating Legitimacy for Resource Management in Health Care

Fair allocation of care can never imply that everyone is given an equal amount of care; most people would probably say that this notion collapses under the weight of its own absurdity. Nor does saying that resources should be allocated according to need suffice since the needs that must be balanced are often very different and therefore difficult to compare. Someone has to decide what should be regarded as healthy versus sick, which methods and treatments should be available and how different needs should be ranked in relation to each other.

The traditional model for priority setting in public health care has been implicit rationing – that is, that doctors, once given a budget, have allocated health care resources according to what they believed would be most beneficial without public insight in the decision-making process (Daniels & Sabin 2008; Owen-Smith et al. 2009; Landwehr 2009). Usually this is regarded as rather uncontroversial at the patient level, when it is a question of deciding which patient is in most need of a given treatment, but more problematic when it comes to decisions regarding how to make priorities between different kinds of needs and different groups of patients.

However, that common resource is managed behind closed doors, with no actual oversight or means of demanding accountability, is not only discordant with democratic ideals, it is also thought unsustainable in an era of increasingly knowledgeable and demanding citizens. As the need for priority setting has become increasingly apparent, policy makers as well as researchers have come to fear that the public will become less inclined to accept rationing decisions, and that trust in the health care systems and institutions will decrease. Priority setting in public health care has thus become what Daniels and Sabin (2008), who have developed the most influential theory about transparent priority setting, ‘accountability for reasonableness’, call a ‘*legitimacy problem*’.

In this article I will use the term ‘perceived legitimacy’ to clarify that I refer to a Weberian kind of legitimacy: a public belief that the decision makers have the right to make those decisions, and that the public should accept them. This means that I will not evaluate whether transparency makes decision making more legitimate in a normative sense, but whether people *perceive* it as more legitimate in the sense that they are willing to

accept the decisions and trust the decision makers and their institutions. Legitimacy beliefs are important for citizens' feelings of belonging to a society since they can explain and make sense of a social system, but are also considered highly desirable from a decision maker's point of view since perceived legitimacy is related to voluntary compliance to laws and regulations, including tax regulations, which makes it easier and less costly to rule (Levi et al. 2009; Rothstein 2005; Tyler 2006).

Achieving lasting consensus within a democratic system as to the specifics of fair allocation is probably impossible. As more researchers have begun examining priority setting in health care, the notion of procedural justice (or fairness) as a potential solution to the problem of legitimacy has gained currency (Daniels & Sabin 2008; Dolan et al. 2007; Kipiriri et al. 2009; Wailoo & Anand 2005). The theory of procedural justice claims that people not only consider whether or not the outcome is in their favour when they judge the fairness of a decision but that they also judge the fairness of the procedure that leads to that decision (Thibaut & Walker 1975; Tyler et al. 1997; Tyler 2000, 2006; Ambrose 2002). Perceived fairness of decision-making procedures is thus claimed to be an important determinant of peoples' willingness to accept decisions and approve of institutions (Hibbing & Theiss-Morse 2001; Tyler & Rasinski 1991).

Even though focus on procedures entails risk of justifying outcomes that many people would think of as unfair (MacCoun 2005), procedural justice can thus give us a theoretical opportunity to achieve legitimacy for difficult decisions. According to Lind and Tyler, procedural justice can be especially important in policy areas such as priority setting in health care:

When life and death decisions are made, as is the case when scarce medical resources are being allocated, it is likely that procedural justice will be especially important to the legitimacy of medical institutions and the acceptability of their decisions. (Lind & Tyler 1988, 213)

The emphasis on procedures has led to calls for increased transparency in health care rationing. The reasoning goes that if it is explicitly stated by whom and on what grounds the priority-setting decision was made, citizens might understand why it is not possible for everyone to get all the care they want or need. They will not blame the decision makers, but instead recognise priority setting as a tool for allocating resources to the most beneficial areas and making room for new medical treatments. As a consequence, they will find the decisions more acceptable and put more trust in the management of public health care resources.

The notion of transparent decision-making procedures as a way to gain legitimacy for difficult decisions is appealing. Despite the lack of agreed upon definitions (Florini 2007), 'transparency' is a concept with clear positive connotations, at least in Western liberal democracies. The central idea that authoritative decisions should be open to public follows a long tradition

from Immanuel Kant's statement that all actions relating to the rights of other human beings are wrong if their maxim is incompatible with publicity, to nowadays calls for freedom of information laws, sunshine acts and fish-bowl governance (Gosseries 2005; Coglianese 2009).

However, this normative presumption in favour of transparency often leads to empirical assumptions of positive effects of transparency – for example, that transparency leads to increased trust. Daniels and Sabin (2008, 51) admit that their empirical claim of a positive correlation between transparency and trust is speculative, but argue that openness is the better strategy anyway:

But beyond our belief that greater openness, at worst, is no more likely than our current [implicit] approach to cause further erosion of trust and increased litigiousness, we see stronger reason for endorsing accountability for reasonableness.

Can we, however, really be sure that the biggest risk we run if we open up the procedures surrounding priority setting is that public acceptance and trust will not be affected at all? During the last years, a more critical approach to transparency and publicity has arisen (Etzioni 2010; Chambers 2004; Heald 2006). Although most researchers recognise transparency as a desirable democratic value and consider it an important component of representative democracy, more attention has been devoted to possible costs for other values we tend to hold strong, like efficiency, integrity or trust (Heald 2006; Tsoukas 1997; Strathern 2000; O'Neill 2002; Power 2003).

Findings from social psychology imply that there are potentially important restrictions to the theory of procedural justice, which might challenge the idea of a positive relationship between transparency and perceived legitimacy in certain situations (MacCoun 2006). For example, the effect of perceived fairness of the procedure tends to be weaker when people's outcome preferences represent strong moral convictions. In that kind of situation, outcome – and not procedural fairness – tends to be the major determinant of the perceived fairness of the decision (Bauman & Skitka 2009). Since trade-offs involving life and death on the basis of economic calculations are thought of as unpleasant, unthinkable or even taboo by many people (Calabresi & Bobbitt 1978; Fiske & Tetlock 1997), these findings suggest that it is not obvious that people will accept unfavourable priority-setting decisions even though they are taken by transparent and fair procedures.

Further, research has indicated that these negative feelings may not only be directed to the decisions in themselves, but also to the people that handle them (see forward Fiske & Tetlock 1997; Tetlock et al. 2000; Tetlock 2003). An authority openly engaging in allocation of scarce health care resources runs the risk of being perceived as suspect and immoral, and therefore it is possible to argue that increased openness risks undermining the legitimacy

of the public health care system. Some researchers therefore claim that priority setting in health care is always so context-dependent that decisions must in reality be taken by doctors through implicit rationing. Maintaining implicit rationing, ‘muddling through elegantly’, might thus be preferable to attempting to open decision-making procedures to public scrutiny (Hunter 1995; Mechanic 1997).

However, even if we accept that a legitimate decision-making procedure should be transparent, the problem of practical implementation remains. For transparency to have an effect, there must be a procedure to make transparent. Although research has shown that the perception of whether a procedure was fair or not affects acceptance of a decision outcome, there is little research on how specific forms of decision making actually affect perceptions of a procedure as fair or unfair. In short: How should the transparent decision be made in practice for the public to accept and trust it? The research has generally not been particularly concrete on this point.

Representation, direct participation and expert decision making are three basic forms of decision making that can legitimise a democratic decision. Allowing decisions to be made by elected representatives who are held accountable through regular elections is perhaps the most common route (Manin 1997). Allowing elected representatives greater latitude to make value-based decisions, such as the elimination of certain treatments or prioritisation among different types of needs, could thus be a way to legitimise health care by procedural means. However, politicians are not always trusted by citizens and have little expert knowledge in many areas, and may thus choose to delegate decisions to experts.

Medical doctors are the obvious experts in health care, and have historically had significant control over it. Thus one possible form could be to have doctors making transparent priority-setting decisions – that is, to engage in a form of explicit professional rationing. Survey research has also indicated that most of the public thinks that priority-setting decisions should be taken by doctors (Litva et al. 2002). From the perspective of legitimacy, however, it is not obvious that doctors can or should make evaluative decisions about health care since they cannot be held democratically accountable and may have a considerable personal interest in how resources are allocated.

Allowing citizens to participate directly in decision making has long been a popular strategy for increasing legitimacy in health care (Contandriopoulos 2004; Litva et al. 2002; McKie et al. 2008; Davies et al. 2006; Fleck 2009). This has often been carried out by allowing the public to participate in various forms of citizens’ advisory panels. However, although there are studies showing that participating in deliberation can alter the participants’ attitudes and opinions to priority-setting issues (Abelson et al. 2003; Dolan et al. 1999), it has been poorly investigated whether citizen involvement increases the general public’s acceptance and trust in health care.

The specifics of a legitimising decision-making procedure are thus far from obvious. Although one form of decision making or another may be preferred based on various ideological premises and beliefs, the extent and manner in which various decision-making procedures actually affect public acceptance and trust in priority setting must be regarded as an empirical question.

Another aspect that further complicates the ambition to enhance the perceived legitimacy of priority setting in health care through procedures is that the information must somehow be communicated to the public. Information about how the decisions are made may come directly from the decision maker as a component of a communication strategy, although the most common route is that people find out about decisions and decision-making procedures through mass media coverage (Besley et al. 2008). Descriptions can never be entirely neutral, and certain aspects are always emphasised at the expense of others. This leads to a 'framing effect' (Chong & Druckman 2007), which has been shown to influence the perceived fairness of the procedure and the decision-making institution (Ramirez 2008; Baird & Gangl 2006). If reinforcing the legitimacy of health care is to be possible, it is thus necessary to take this potential effect into account.

As we have seen, there are several possible objections to transparency and procedural justice as a solution to the problem of perceived legitimacy in health care priority setting. Policy makers as well as researchers in this field have to some extent ignored the possible costs of transparency, and the question of process design is rarely concretised. Empirical research on how citizens actually react to openly reported priority-setting decisions is largely absent. Therefore, the aim of this study was to provide some explorative empirical insights into the question of how citizens react to explicit rationing in form of information about priority-setting decisions and decision-making procedures.

The Experiment

In order to explore the effect of transparent priority setting on public perceptions of legitimacy, this study was designed as an experiment in which subjects read a randomly distributed description of a priority-setting case. All subjects were presented with the same case, but information of how it had been made varied.

In the explicit conditions, descriptions varied as to whether the decision was taken mainly by politicians, doctors or through a citizens' advisory panel, and in whether the procedure was framed in a positive or negative way. In the implicit condition, the subjects were asked about their opinion of the same case, presented as an example of a priority-setting decision, but

without any description of how or by whom it had been taken. This proposal was meant to represent a baseline that should be close to how people, if at all, come in contact with the issue of priority setting; they hear about a decision that have been taken or could have been taken, and are perhaps asked about their opinion about it, but they are rarely provided with detailed information about the decision-making procedures.² The comparison between the implicit condition and the explicit conditions allows us to explore whether information about how a decision is taken affects acceptance and trust. The alternative – not asking any question at all about priority setting in the implicit condition – would not give us the same opportunity to explore the effect of procedural information. In total, this design gives us seven different conditions: one implicit and six explicit.

The subjects were 210 members of the public recruited at the central railway station in Gothenburg, the second-largest city in Sweden.³ The average age of subjects was 40, 57 percent were women and 48 percent stated that they had completed some higher education. Thus, there is a slight over-representation of women and higher levels of education in the sample, but it may be considered reasonably representative overall. The subjects were randomised to one of the seven various conditions after being asked if they wanted to participate in a study of ‘public opinions of Swedish health care and the allocation of health care resources’.

The priority-setting case referred to the elimination of public funding of in vitro fertilisation in favour of increasing adolescent psychiatric services. The criteria for selecting this case were that it must involve care and treatment that are relatively common and covered by the media, so that most people could understand the case without detailed technical information. Infertility is a condition that most people, both women and men, young and old, should be able to relate to, as a parent themselves, as a becoming parent or as a relative or friend to parents. It is also a growing problem in many countries as women tend to be older when they start building a family.⁴ Likewise, adolescent psychiatric illness is a problem that is quite well covered by media and considered a major problem in many countries. Both infertility treatment and adolescent psychiatric services therefore appeared to be pressing issues in most countries with publicly funded health care, and yet more open to discussion than, for example, restrictions in cancer care, which has already shown to provoke considerable public resistance in countries like the United Kingdom (Faden et al. 2009). The trade-off should therefore be considered as an important but not an extreme case. It also represents a case of prioritisation between two groups of patients for which there is no obvious measure of which is most important. The relative importance of infertility and psychiatry is not something that can be determined ‘on purely medical grounds’, but instead has to do with how people emphasise factors such as benefit, economic efficiency, quality of life and beliefs about

what is sick and what is not (Granberg 2004). It should be emphasised that the case is fictitious and has no immediate equivalent in reality.

The case descriptions were written to resemble journalistic descriptions since that is how most ordinary citizens come into contact with the issue of priority setting. The positively framed decision made by politicians emphasised the opportunity to demand democratic accountability. In the negative version, politicians were depicted as 'weathervanes', changing position with the winds of temporary opinion and lacking any medical knowledge. In the expert version, the scientific expertise of doctors was weighed against the lack of oversight and risk of self-interest. The citizen's advisory panel was positively framed by emphasising that the experiences of ordinary people were given credence in the decision-making procedure. In order to negatively frame the civil dialogue, the public was instead depicted as a kind of hostage for unpopular decisions for which politicians wished to disclaim responsibility.

After reading the case description, the subjects answered a survey. The dependent variables chosen to capture perceived legitimacy were *procedure acceptance* and *decision acceptance* for the specific prioritisation case and *general trust in the public health care system*.

In the explicit groups, decision acceptance was measured using an index that was structured based on three survey questions: *What do you think of the decision to eliminate public funding of in vitro fertilisation in order to fund increased adolescent psychiatric services?*, *How fair do you think the decision is?* and *How willing are you to accept the decision?* (Cronbach's α 0.907). Procedure acceptance was measured using an index structured from three items: *What do you think of how the decision was made?*, *How fairly do you think the decision was made?* and *How fairly do you think you as a citizen were treated when the decision was made?* (Cronbach's α 0.857). Procedure acceptance and decision acceptance are positively correlated (0.80) insofar as that the more positively people perceived the procedure to be, the more positively they perceived the decision to be.

Subjects in the implicit condition did not get any questions about the procedure since they received no description of how the decision had been taken. Although the implicit condition certainly implies that there was an underlying procedure that the subjects are not being told about – since there was a decision taken – the natural answer to questions about the procedure would probably have been 'I do not know' and such questions were therefore avoided. Subjects were, however, presented with the concrete decision outcome and asked to give their opinion about it as an indication of decision acceptance: *Priorities are often set in health care that may entail limitations for certain groups. For example, this might involve eliminating public funding of in vitro fertilisation to make funding available for increased adolescent psychiatric services. How would you feel about a proposal like that?* This

question was included to be able to explore whether information about how a particular decision was taken makes people more willing to accept it, as opposed to a situation where they simply are asked to report their opinion about a theoretical proposal.

Trust in the public health care and allocation of health care resources in general was measured using three separate questions that were the same in both the explicit groups and the implicit group: *If you think about how health care resources are currently allocated among various groups with health care needs, how fair do you think the allocation is?*, *If you think about how health care resources are currently allocated among various groups with health care needs, how fair do you think the allocation is?* and *How much do you trust the public health care system in Sweden?* The comparison between the implicit condition and the explicit conditions allows us to explore whether information about how a particular decision was taken influences peoples' opinions about health care at a general level.

All responses were given on a scale of 1–7, where 7 represents very high acceptance/trust. ANOVA was used to control the randomisation with regard to sex, education, age, personal experience of health care and initial opinion about how well health care works. The question *How much opportunity did you feel you had as a citizen to influence the decision?* was used as a stimulus control. As expected, those who had read the case involving a civic dialogue felt they had the greatest opportunity to have an influence (3.5 on average), and those who had been given an expert decision felt they had the least opportunity to have an influence (2.1 on average).

Results

The first stage of analysis will evaluate effects within the group of explicit procedures – that is, effects of the form of decision making (politicians, doctors or a citizens' advisory panel) and framing (positive or negative) on acceptance of a specific priority-setting decision. The implicit group was excluded from this analysis. Tables 1 and 2 shows the mean values for procedure acceptance and decision acceptance in the specific prioritisation case; eliminating public funding of in vitro fertilisation to enable funding of an increase in adolescent psychiatric services.

A two-way ANOVA yielded no significant main effect of the form of decision making for either procedure acceptance ($F_{2,160} = 0.500$, $p = 0.607$, $\eta_p^2 = 0.01$) or decision acceptance ($F_{2,168} = 0.502$, $p = 0.606$, $\eta_p^2 = 0.00$). Thus, it seems to make no difference to citizens whether priority-setting decisions are made mainly by politicians, professionals or through a procedure in which citizens are directly involved. The form of decision making affects neither the subjects' acceptance of the procedure, nor the decision itself. It is noteworthy that a decision made by professionals does not seem to lead

Table 1. Mean Values for Procedure Acceptance in the Specific Priority Setting Case (1–7).
Explicit Rationing

Decision made by:	Positive framing	Negative framing	Total	Effect, η^2
Politicians	4.1 (29)	3.3 (24)	3.7 (53)	
Doctors	3.7 (29)	3.1 (28)	3.4 (57)	
Citizens' panel	3.9 (26)	3.2 (30)	3.5 (56)	
Total	3.9 (84)	3.2 (82)	3.5 (166)	0.06***
Effect, η^2			0.01	

Notes: Mean values on a scale of 1 (low acceptance) to 7 (high acceptance). Rounded off to the nearest tenth. Implicit group excluded. N for each group in parentheses. *** $p < 0.01$; ** $p < 0.05$.

Table 2. Mean Values for Decision Acceptance in the Specific Priority Setting Case (1–7).
Explicit Rationing

Decision made by:	Positive framing	Negative framing	Total	Effect, η^2
Politicians	4.6 (30)	3.9 (29)	4.3 (59)	
Doctors	4.3 (29)	3.9 (30)	4.1 (59)	
Citizens' panel	4.8 (26)	4.0 (30)	4.4 (56)	
Total	4.5 (85)	4.0 (89)	4.2 (174)	0.03**
Effect, η^2			0.00	

Notes: Mean values on a scale of 1 (low acceptance) to 7 (high acceptance). Rounded off to the nearest tenth. Implicit group excluded. N for each group in parentheses. *** $p < 0.01$; ** $p < 0.05$.

to higher acceptance for the procedure nor for the actual decision, which contradicts much of the accepted understanding of legitimacy in health care contexts. In addition, the much emphasised strategy of letting the citizens take part in the decision-making procedure does not get support either. If it really is the case that people do not seem to care about who is taking a priority-setting decision, it would certainly be valuable knowledge both for research and policy making. However, a failure to reject the null hypothesis does not prove that there is no effect, and therefore this result must be interpreted with caution until further replications have been carried out.

Conversely, the main effect of framing was significant for both procedure acceptance ($F_{1,160} = 10.193$, $p = 0.002$, $\eta_p^2 = 0.06$) and decision acceptance ($F_{1,168} = 5.84$, $p = 0.017$, $\eta_p^2 = 0.03$). The framing effect goes in the expected direction; those who were given a positive description of the decision-making procedure have significantly higher acceptance for both the procedure and the decision than those who were given a negative description. Reading a positively framed description of a procedure thus strengthens the perceived legitimacy of the decision, regardless of form of decision making. The results suggest that it is, to a certain extent, possible to manipulate

people to perceive both a decision and a form of decision making as more legitimate by accentuating the positive aspects of that specific form of decision making, while negative framing may weaken all forms of decision making in terms of perceived legitimacy. However, it is important to observe that while the effect of framing is significant, the explanatory value is very low. Accordingly, one must be cautious about drawing too far-reaching conclusions. There was nothing to indicate any interaction effect between framing and form of decision making for procedure acceptance ($F_{2,160} = 0.058$, $p = 0.944$) or decision acceptance ($F_{2,168} = 0.337$, $p = 0.714$).

When it comes to effects on trust in health care on the general level, essentially no significant effects of form of decision making or framing were demonstrated. The only significant effect shown was the effect of framing on trust in how priorities are set, and then only at the 10 percent level ($F_{1,169} = 3.581$, $p = 0.06$, $\eta_p^2 = 0.02$). Thus it does not seem as if the public draws conclusions about health care and the allocation of health care resources based on information about how a specific priority setting was done.

We now turn to the effect of transparency in decision making, which means that we now bring the implicit group into the analysis. In order to get an indication of the effect of explicit rationing on decision acceptance in the specific case, a comparison was made between the answer to the question *What do you think of the decision to eliminate public funding of in vitro fertilisation to make funding available for increased adolescent psychiatric services?* by the explicit (transparent) groups and the answer to the question *Priorities are often set in health care that may entail limitations for certain groups. For example, this might involve eliminating public funding of in vitro fertilisation to make funding available for increased adolescent psychiatric services. How would you feel about a proposal like that?* by the implicit group. The explicit groups answered 4.5 on average, while the implicit group answered 4.7 on average, on a seven-point scale where 7 indicates higher degree of acceptance. The difference was insignificant ($F_{1,203} = 0.322$, $p = 0.571$, $\eta_p^2 = 0.00$), which means there is nothing to indicate that the public would be more likely to accept a specific priority-setting decision if the underlying procedure and reasons for the decision were reported openly. As emphasised earlier, the questions were not expressed in the same words. The result for decision acceptance should therefore be interpreted with caution as it could be the result of the implicit group answering to a theoretical proposal and the explicit groups answering to a more concrete question after having read about the decision-making procedure.

At the general level, however, where the questions were expressed in exactly the same words, the comparison between the implicit and the explicit groups showed a slightly *negative* effect of explicit rationing. Table 3 shows mean values for the dependent variables that measure general trust in health care for the implicit rationing group and the explicit rationing

Table 3. Mean Values for General Trust in the Public Health Care System (1–7). Explicit and implicit rationing

	Trust in Swedish public health care	Perceived fairness of the allocation of public health care resources	Trust in how priorities are set in public health care
Explicit rationing	4.7 (177)	4.1 (174)	3.9 (175)
Implicit rationing	5.4 (30)	4.6 (29)	4.5 (30)
Effect, η^2	0.03***	0.01*	0.03**

Notes: Mean values on a scale of 1 (low acceptance/trust) to 7 (high acceptance/trust). Rounded off to the nearest tenth. N for each group in parentheses. *** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.

Table 4. Mean Value Differences between the Explicit Rationing Groups and the Implicit Rationing Group (Difference = $\text{mean}_{\text{exp}} - \text{mean}_{\text{imp}}$)

	Trust in Swedish health care	Perceived fairness of the allocation of health care resources	Trust in how priorities are set
Explicit rationing procedures			
Politicians, positive framing	−0.80** (30)	−0.70 (30)	−0.60* (30)
Politicians, negative framing	−0.80** (29)	−0.50 (28)	−0.90*** (29)
Doctors, positive framing	−0.80** (30)	−0.40 (30)	−0.40 (30)
Doctors, negative framing	−0.60* (29)	−0.60 (28)	−0.80** (28)
Citizens' panel, positive framing	−0.20 (29)	−0.40 (28)	−0.30 (28)
Citizens' panel, negative framing	−1.1*** (30)	−0.70* (30)	−0.70** (30)

Notes: N for the implicit group is 30 (trust in Swedish health care), 29 (Perceived fairness of allocation) and 30 (trust in how priorities are set). N for the explicit groups in parentheses. Mean values given on a scale of 1 (low acceptance/trust) to 7 (high acceptance/trust). Rounded off to the nearest tenth. Two tailed test. *** $p < 0.01$; ** $p < 0.05$; * $p < 0.10$.

groups. As we see in the table, mean values for the implicit group are higher than mean values for the explicit rationing groups for all dependent variables. The effect is significant for trust in Swedish health care ($F_{1,205} = 7.482$, $p = 0.007$, $\eta_p^2 = 0.03$), fairness of allocation of public health care resources, albeit only at the 10 percent level ($F_{1,201} = 2.834$, $p = 0.094$, $\eta_p^2 = 0.01$), and for trust in how priorities are set in public health care ($F_{1,203} = 5.812$, $p = 0.017$, $\eta_p^2 = 0.03$).

Table 4 shows the mean value for the various explicit rationing groups in relation to the mean value for the implicit group. A negative sign indicates that the mean value for the explicit group is lower than the mean value for the implicit group. Although the earlier analysis showed no significant effects of the form of decision making and framing, we see here that all explicit rationing groups have lower mean values for the variables that

measure general trust in health care than the implicit group, although not all differences are significant.

As a whole, the result thus implies that explicit rationing – that is, transparency about how priorities are set in health care – does not necessarily leads to increased general trust in health care. If anything, the effect seems to be the opposite. Information about how a priority-setting decision is taken tends to weaken general trust in health care. Although we should avoid too far-reaching conclusions based on one explorative experiment, this shows that the common assumption of a positive relationship between transparency and perceived legitimacy does not get empirical support.

Discussion

Transparency is a strong democratic value that most of us embrace. However, the findings from this empirical study indicate that the relationship between transparency, in the form of explicit rationing, and perceived legitimacy might be more complicated than often assumed. The analysis showed that levels of trust in the health care system were actually higher among the group given no information about the procedures than it was among the groups made privy to the procedure underlying a priority-setting decision. Although we should keep in mind that this is an explorative study, and that further replications are necessary to validate the results, this implies that transparency could actually lead to weakened, rather than strengthened perceived legitimacy.

A potential explanation for this could be that many people, as long as they and their relatives are healthy, are not familiar with the allocation of common health care resources. Information about how a priority-setting decision was taken might therefore make people more aware of the fact that there are decisions being made that are potentially harmful for them. Another closely related explanation is that health care might be of special emotional importance for people, and that information about how trade-offs between different needs are done therefore triggers feelings of discomfort and anxiety. Perhaps these are things that we simply do not want to know too much about. Together these effects might lead to the fact that at least the first reaction is to distrust the authorities and the institutions making those decisions. Potential mechanisms for how people process and react to information of this kind should be explored further.

Another finding is that perceived legitimacy seemed to be unaffected by who took the decisions – doctors, politicians or the participating public. The different forms of decision making seemed to have no effect on decision acceptance, procedure acceptance or general trust in health care. If this result can prove to be stable in further studies, this is rather surprising. Although doctors generally receive stronger public support and trust than,

for example, politicians, people did not seem to accept priority-setting decisions to a larger extent if made by doctors. This could perhaps be an effect of people becoming more disappointed when they do not like a decision taken by doctors than if they do not like a decision taken by politicians. Likewise, citizens' involvement did not have any effect on the general public's perceptions of legitimacy, even though increased public participation in one of the most articulated strategies for increasing legitimacy in health care management. Actually taking part in deliberation on priority-setting issues might lead to increased acceptance and trust, but simply being informed that other citizens had that opportunity to do so did not seem to have any effect. Taken together, this implies that people in general might not care that much about the procedure when judging the decision in the case of priority setting in health care. The turn from a focus on principles to a focus on procedures when it comes to priority-setting strategies can thus be even more problematic to implement than previous research has suggested.

The study does show that different framing of forms of decision making can have an effect on public perceptions of priority-setting decisions. If the good reasons for a particular form of decision making are accentuated, people tend to be more likely to accept not only the procedure, but also the actual decision. Thus, the media has a potentially big influence over how prioritisations are perceived by the public. Since it is often stated that the duty of the media is not to support, but rather to monitor, the decision makers, negative publicity is probably a risk that should be taken into account. If decision makers do not take charge, the perceived legitimacy of public health care priority setting could to a large extent be in the hands of the media.

In sum, this study suggests that we cannot simply assume that a transparent and objectively legitimate procedure will automatically lead to greater public acceptance and trust. At least on a short term, the effect may even be the opposite, especially if the media present critical reports. At the same time, it has been claimed that it is probably not possible to maintain implicit rationing in the future, and therefore it is important to explore further how to generate perceived legitimacy for these difficult, and yet necessary, decisions. For example, we should test if the effect of transparency is different in a higher stake scenario, or whether information about the whole decision-making process, including decision makers' deliberation, affects perceived legitimacy differently. We should also explore effects over time and compare different decision-making procedures.

Finally, it should be emphasised that these empirical findings do not add up to a normative case against transparency. Even if we found a negative effect of transparency in further replications, there might be good reasons from a normative point of view to increase transparency in decision making, such as respect for citizens' right to know how common resources are allocated.

ACKNOWLEDGEMENT

I would like to thank the National Centre for Priority Setting in Health Care in Sweden, and especially Peter Garpenby, for valuable comments and financial support, and Peter Esaiasson for valuable comments on earlier drafts.

NOTES

1. According to Mansbridge (2009, 386), a distinction can be made between transparency in rational (e.g., that decision makers declare the reasons on which the decisions were based) and transparency in process (e.g., that the public has the possibility to follow and monitor the process). Following this distinction, explicit rationing is in this article understood more as transparency in rational than transparency in process.
2. It should be noted that subjects in the implicit condition were only implicitly denied information about the procedure; they were not explicitly told that they would not get procedural information. To be explicitly denied information would probably result in stronger reactions (see, e.g., Van den Bos (1999) about the effect of being explicitly denied the opportunity of 'voice' in decision-making situations).
3. A total of 30 questionnaires were collected for each condition – in total 210 – but due to some participants' non-response to separate questions, the N-values are not always 30 in all groups.
4. In Sweden, the availability of publicly funded in vitro fertilisation is also determined regionally and thus varies across the country. As a result, it is not an unrealistic scenario that restrictions could be imposed.

Appendix. Wording of Questions

Procedure Acceptance (Explicit Groups Only)

What do you think of how the decision was made?

How fairly do you think the decision was made?

How fairly do you think you as a citizen were treated when the decision was made?

An index was constructed from these questions, Cronbach's α 0.857.

Decision Acceptance

Implicit group:

Priorities are often set in health care that may entail limitations for certain groups. For example, this might involve eliminating public funding of in vitro fertilisation to make funding available for increased adolescent psychiatric services. How would you feel about a proposal like that?

Explicit groups:

What do you think of the decision to eliminate public funding of in vitro fertilisation in order to fund increased adolescent psychiatric services?

How fair do you think the decision is?

How willing are you to accept the decision?

An index was constructed from these questions, Cronbach's α .907

Trust in Health Care at a General Level (Implicit and Explicit Groups)

If you think about how health care resources are currently allocated among various groups with health care needs, how fair do you think the allocation is?
If you think about how health care resources are currently allocated among various groups with health care needs, how fair do you think the allocation is?
How much do you trust the public health care system in Sweden?

REFERENCES

- Abelson, J. et al. 2003. 'Does Deliberation Make a Difference? Results from a Citizens Panel Study of Health Goals Priority Setting', *Health Policy*, 66, 95–106.
- Ambrose, M. L. 2002. 'Contemporary Justice Research: A New Look at Familiar Questions', *Organizational Behavior and Human Decision Processes*, 89, 803–12.
- Baird, V. & Gangl, A. 2006. 'Shattering the Myth of Legality: The Impact of the Media's Framing of Supreme Court Procedures on Perceptions of Fairness', *Political Psychology*, 27(4), 597–614.
- Bauman, C. & Skitka, L. 2009. 'Moral Disagreement and Procedural Justice: Moral Mandates as Constraints to Voice Effects', *Australian Journal of Psychology*, 61(1), 40–9.
- Besley, J. C. et al. 2008. 'Local Newspaper Coverage of Health Authority Fairness during Cancer Cluster Investigations', *Science Communication*, 29, 498–521.
- Calabresi, G. & Bobbitt, P. 1978. *Tragic Choices*. New York: Norton & Co.
- Chambers, S. 2004. 'Behind Closed Doors: Publicity, Secrecy and the Quality of Deliberation', *Journal of Political Philosophy*, 12(4), 389–410.
- Chong, D. & Druckman, J. N. 2007. 'Framing Theory', *Annual Review of Political Science*, 10, 103–26.
- Coglianese, C. 2009. 'The Transparency President? The Obama Administration and Open Government', *Governance*, 22(4), 529–44.
- Contandriopoulos, D. 2004. 'A Sociological Perspective on Public Participation in Health Care', *Social Science & Medicine*, 58, 321–30.
- Daniels, N. & Sabin, J. 2008. *Setting Limits Fairly: Learning to Share Resources for Health*. New York: Oxford University Press.
- Davies, C. et al. 2006. *Citizens at the Centre: Deliberative Participation in Health care Decisions*. Bristol: Policy Press.
- Dolan, A. et al. 1999. 'Effect of Discussion and Deliberation on the Public's Views of Priority Setting in Health Care: Focus Group Study'. *British Medical Journal*, 318, 916–9.
- Dolan, A. et al. 2007. 'It Ain't What You Do, It's the Way That You Do It: Characteristics of Procedural Justice and Their Importance in Social Decision-making', *Journal of Economic Behavior & Organization*, 64, 157–70.
- Elster, J. 1992. *Local Justice: How Institutions Allocate Scarce Goods and Necessary Burdens*. Cambridge: Cambridge University Press.
- Etzioni, A. 2010. 'Is Transparency the Best Disinfectant?' *Journal of Political Philosophy*, 18, 389–404.
- Faden, R. R. et al. 2009. 'Expensive Cancer Drugs: A Comparison between the United States and the United Kingdom', *Milbank Quarterly*, 87, 789–819.
- Fiske, A. & Tetlock, P. E. 1997. 'Taboo Trade-offs: Reactions to Transactions That Transgress Spheres of Justice', *Political Psychology*, 2, 255–97.
- Fleck, L. 2009. *Just Caring: Health Care Rationing and Democratic Deliberation*, Oxford, Oxford University Press.
- Florini, A. M. 2007. 'The Battle Over Transparency', in Florini, A., ed., *The Right to Know: Transparency for an Open World*. New York: Columbia University Press.

- Gosseries, A. 2005. 'Publicity', in *Stanford Encyclopedia of Philosophy*. Available online at: <http://plato.stanford.edu/entries/publicity/>.
- Granberg, M. 2004. *Economic Aspects of Infertility Treatment*. Göteborg: Sahlgrenska University Hospital.
- Heald, D. 2006. 'Transparency as an Instrumental Value', in Hood, C. & Heald, D., eds, *Transparency: The Key to Better Governance*. Oxford: Oxford University Press.
- Hibbing, J. R. & Theiss-Morse, E. 2001. 'Process Preferences and American Politics: What the People Want Government to Be', *American Political Science Review*, 95, 145–53.
- Holm, S. 1998. 'Goodbye to the Simple Solutions: The Second Phase of Priority Setting in Health Care', *British Medical Journal*, 317, 1000–2.
- Hood, C. & Heald, H., eds. 2006. *Transparency: The Key to Better Governance*. Oxford: Oxford University Press.
- Hunter, D. J. 1995. 'Rationing Health Care: The Political Perspective'. *British Medical Bulletin*, 51, 876–84.
- Kapiriri, L. et al. 2009. 'Fairness and Accountability for Reasonableness: Do the Views of Priority Setting Decision Makers Differ Across Health Systems and Levels of Decision Making?' *Social Science & Medicine*, 68, 766–73.
- Kenny, N. & Joffres, C. 2008. 'An Ethical Analysis of International Health Priority-setting', *Health Care Analysis*, 16, 145–60.
- Landwehr, C. 2009. 'Deciding How to Decide: The Case of Health Care Rationing', *Public Administration*, 87, 586–603.
- Levi, M. et al. 2009. 'Conceptualizing Legitimacy, Measuring Legitimizing Beliefs', *American Behavioral Scientist*, 53, 354–75.
- Lind, E. A. & Tyler, T. R. 1988. *The Social Psychology of Procedural Justice*. New York: Plenum.
- Litva, A. et al. 2002. 'The Public is too Subjective: Public Involvement at Different Levels of Health-care Decision Making', *Social Science & Medicine*, 54, 1825–37.
- MacCoun, R. J. 2005. 'Voice, Control and Belonging: The Double-edged Sword of Procedural Fairness', *Annual Review of Law and Social Science*, 1, 171–201.
- MacCoun, R. J. 2006. 'Psychological Constraints on Transparency in Legal and Government Decision Making', *Swiss Political Science Review*, 12(3), 112–21.
- Manin, B. 1997. *The Principles of Representative Government*. Cambridge: Cambridge University Press.
- Mansbridge, J. 2009. 'A "Selection Model" of Political Representation', *Journal of Political Philosophy*, 17(4), 369–98.
- McKie, J. et al. 2008. 'Who Should be Involved in Health Care Decision Making? A Qualitative Study', *Health Care Analysis*, 16, 114–26.
- Mechanic, D. 1997. 'Muddling Through Elegantly: Finding the Proper Balance in Rationing', *Health Affairs*, 16, 83–92.
- O'Neill, O. 2002. *A Question of Trust*. Cambridge: Cambridge University Press.
- Owen-Smith, A. et al. 2009. 'I Can See Where They're Coming From, but When You're On the End of It . . . You Just Want to Get the Money and the Drug: Explaining Reactions to Explicit Health care Rationing', *Social Science & Medicine*, 68, 1935–42.
- Power, M. 2003. 'Evaluating the Audit Explosion', *Law and Policy*, 25(3), 185–202.
- Ramirez, M. D. 2008. 'Procedural Perceptions and Support for the US Supreme Court', *Political Psychology*, 29, 675–98.
- Rothstein, B. 2005. *Social Traps and the Problem of Trust*. Cambridge: Cambridge University Press.
- Strathern, M. 2000. 'The Tyranny of Transparency', *British Educational Research Journal*, 26(3), 309–21.
- Tetlock, P. et al. 2000. 'The Psychology of the Unthinkable: Taboo Trade-offs, Forbidden Base Rates and Heretical Counterfactuals', *Journal of Personality and Social Psychology*, 78(5), 853–70.
- Tetlock, P. 2003. 'Thinking the Unthinkable: Sacred Values and Taboo Cognitions'. *Trends in Cognitive Sciences*, 7(7), 320–4.
- Thibaut, J. & Walker, L. 1975. *Procedural Justice: A Psychological Analysis*. Hillsdale, NJ: Erlbaum.

- Tsoukas, H. 1997. 'The Tyranny of Light: The Temptations and the Paradoxes of the Information Society', *Futures*, 29(9), 827–43.
- Tyler, T. R. 2000. 'Social Justice: Outcome and Procedure', *International Journal of Psychology*, 35, 117–25.
- Tyler, T. R. 2006. 'Psychological Perspectives on Legitimacy and Legitimation', *Annual Review of Psychology*, 57, 375–400.
- Tyler, T. & Rasinski, K. 1991. 'Procedural Justice, Institutional Legitimacy and the Acceptance of Unpopular US Supreme Court Decisions: A Reply to Gibson', *Law & Society Review*, 25, 621–30.
- Tyler, T. R. et al. 1997. *Social Justice in a Diverse Society*. Boulder, CO: Westview Press.
- Wailoo, A. & Anand, P. 2005. 'The Nature of Procedural Preferences for Health-care Rationing Decisions', *Social Science & Medicine*, 60, 223–6.
- Van den Bos, K. 1999. 'What are We Talking about When We Talk about No-voice Procedures? On the Psychology of the Fair Outcome Effect', *Journal of Experimental Social Psychology*, 35, 560–77.