



Blurred logics behind frontline staff decision-making for cancer control in Argentina

Natalia Luxardo & Hernán Manzelli

To cite this article: Natalia Luxardo & Hernán Manzelli (2017): Blurred logics behind frontline staff decision-making for cancer control in Argentina, Health Sociology Review

To link to this article: <http://dx.doi.org/10.1080/14461242.2017.1298973>



Published online: 17 Mar 2017.



Submit your article to this journal [↗](#)



View related articles [↗](#)



View Crossmark data [↗](#)



Blurred logics behind frontline staff decision-making for cancer control in Argentina

Natalia Luxardo^a and Hernán Manzelli^b

^aConsejo Nacional de Investigaciones Científicas y Técnicas (CONICET), Universidad de Buenos Aires (UBA), Buenos Aires, Argentina; ^bConsejo Nacional de Investigaciones Científicas y Técnicas (CONICET), Centro de Estudios de Población (CENEP), Universidad de Buenos Aires (UBA), Buenos Aires, Argentina

ABSTRACT

In this article we approach socioeconomic inequities in cancer by examining a particular dimension of health care: how health services attending patients with cancer set priorities for their daily activities. By using qualitative ethnographic data, we explore logics underlying how practitioners make priority-setting decisions regarding cancer prevention and care. We found four main types of accounts: accounts based on macro social inequalities, accounts based on patients' social and cultural features, accounts based on characteristics of health services, and accounts based on personal voluntarism. These blurred logics shape the everyday decisions which have an impact not only on the quality of health care in general but on the increasing socioeconomic inequities in cancer care attention.

ARTICLE HISTORY

Received 1 June 2016
Accepted 6 January 2017

KEYWORDS

Cancer; Latin America; priority setting; decision making; frontline practitioners; inequity

Introduction

Cancer is a leading cause of death and disability in low and middle income countries (Farmer et al., 2010). Differences in the incidence, prevalence, mortality, as well as the burden of cancer exist not only among developed and developing countries but also in specific population groups within countries. People from low income strata are generally diagnosed at later stages of the disease and tend to get less therapeutic care (World Health Organization [WHO], 2008). Epidemiological studies show that these disparities occur as a result of many different factors, such as unequal access to health care, socioeconomic factors, hazardous labour and environmental conditions, nutrition and differences in health behaviours (Marmot & Wilkinson, 2006; McMullin & Weiner, 2008). Moreover, certain issues keep people from seeking prevention and care at early stages of the disease, namely lack of awareness of the importance of screening and early detection, the stigma associated with cancer, and economic barriers (WHO, 2008).

There is a broad literature on determinants of health, as well as the social structures that generate them; although most determinants of health and illness are situated outside the health care sector (Black, 1980; Bouchard, Albertini, & Batista, 2012; Marmot, 2004), some are deeply implicated in the needs and access to health care (Angus et al., 2013; Broom &

Doron, 2011; King, Chen, Dagher, Holt, & Thomas, 2014). For example, the gap between the resources of health services and the needs and expectations of different population groups, as well as significant variations in how physicians carry out diagnostic and therapeutic decisions depending on their patients' gender, age, income -among other characteristics- may contribute to inequalities in health care (King et al., 2014; Peck & Denney, 2012).

This study is anchored within literature of equity that examines the linkage between socio-economic and health care inequalities, focusing on concrete mechanisms by which specific cancer disparities are generated (Gould, 2004; Sinding & Wiernikowski, 2009). This is well documented across the continuum of cancer control – understood as the strategy to 'attack' cancer globally that includes primary prevention, early diagnosis, treatment and palliative care- for different populations (King et al., 2014; Sinding, 2010).

There is a broad spectrum of possible perspectives which can be used to analyze the inner workings of the health care sector, one of them being connected to the process of decision-making. Taking decisions and establishing priorities is a daily activity in every health care system around the world and, consequently, there is a robust, interdisciplinary field of knowledge on the issue. As Hunink et al. (2014, p. 1) mentioned 'decisions in health care can be particularly awkward, involving a complex web of diagnostic and therapeutic uncertainties, patient preferences and values, and costs'. Decision makers are the ones who are designated to make choices on different alternatives. They are responsible for aligning available resources with institutional priorities, for managing the day-to-day activities in health services and, in some cases, for producing the official guidelines of how to proceed in different scenarios. However, as previous research has found, a great deal of everyday decision-making and priority-setting occurs on the front lines, carried out by bedside physicians, administrative clerks, and other health care professionals (Baltussen & Niessen, 2006; Martin, Abelson, & Singer, 2002). In addition to the medical and economic dimensions – as well as patients' preferences and values inscribed in diverse contexts- there is a far less analyzed dimension which is that of the socio-cultural and organisational aspects which may permeate important decisions and priority-setting by health system personnel.

In a previous ethnographic study which explored some relevant features of the social treatment of cancer in Argentina's health services (Luxardo & Manzelli, 2015) we observed subtle, implicit and repeated narratives from health professionals on making decisions and establishing priority-settings in oncology services which go far beyond the guidelines included in their official programs and protocols. Routine activities in a health service require taking decisions that are not deemed 'important enough' to be included in the official guidelines or to merit seeking instructions from authorities. These were small, everyday decisions. We observed that this kind of ad-hoc decision-making and priority-setting would sometimes shape or reproduce some aspects of the social and economic inequities among patients with cancer. In general, these actions had a more negative impact on health interventions given to patients from a lower economic stratum, with a lower level of education or from specific ethnic groups (e.g. indigenous peoples). These initial findings drove us to explore in more depth the underlying logics of the daily establishment of priorities or decision-making.

What decisions were taken on a daily basis and how they were experienced by professionals in oncology health services? How were these decisions taken? Which accounts by health services' staff explained them? Were decisions consensual or, on the contrary,

were they a source of friction among staff? These new, inductively derived findings directed our attention towards theoretical concepts such as decision-making and priority-setting, but as they actually take place in health services every day, rather than as they are formally depicted in official documents and programs.

In this article we distance ourselves from the classical economic models of decision-making theory usually developed in Administration, which deem decision-making to mean the rational, deliberate and purposeful actions that occur in every organisation (Tarter & Hoy, 1998). Furthermore, we avoid delving into conceptual discussions on what decision-making, priority setting or resource allocation mean for various theories and only briefly define them from the single perspective taken in this study, simply in order to specify the terms' theoretical implications.

We support a flexible, broad definition of decision-making which responds to research interests. In other words, we need to understand what happens from the point of view of our informants. The issue of how professionals participate in priority-setting is usually presented in connection with micro-level priority-setting performed by physicians at bedside, but we extend it to the rest of staff, given that they also make daily decisions on cancer care and prevention (Martin et al., 2002).

In Argentina, cancer is the second leading cause of death (Abriata, Roques, Macías, & Loria, 2012). The IARC Report (WHO, 2008) states that the region of Latin America is experiencing the greatest cancer burden, and identifies the following as the main problems in public health when dealing with cancer: having to diagnose at advanced stages of the disease, poor access and quality of cancer treatments, limited access to affordable cancer drugs, poorly trained health personnel, weak epidemiological surveillance and low priority and resources for cancer in the public health agenda.

The country has a mixed health system with three sectors: public, social security and private; they have different population coverage, services and funding. Penckaszadeh, Leone, and Rovere (2010) state that it has been an increased fragmentation, inequity and inefficacy, as health care is increasingly prey to economic interests of private corporations, trade union bureaucracies and the medical professional establishments. All provinces and the City of Buenos Aires are autonomous in implementing public health policies. The public system is underfinanced and deteriorated, with access barriers and low quality of care and one-third of the patients that receive care in the public sector have some type of social security coverage (Penckaszadeh et al., 2010).

In this article, we aim to advance our understanding of the socioeconomic inequities in cancer. A particular dimension of healthcare is examined: the process of decision-making and priority setting in daily activities in health services. More specifically, the general aim of this article is to explore and describe how health services' staffs establish priority-setting decisions on cancer prevention and cancer care interventions and the accountability or the thinking behind the staffs' decisions or priorities. To this end, we used qualitative perspectives using data proceeding from ethnographic fieldwork conducted in oncology health services in Argentina in 2012 and 2013.

Methods

This article presents the specific results of a larger project which was carried out in oncology health services throughout Argentina during the years 2012 and 2013, and was

supported by the National Cancer Institute (INC). The purpose of the study was to describe the most relevant features in the social treatment of cancer, specifically in connection with the provision of health care to patients with this disease. Using an ethnographic approach, we analyzed the views of stakeholders, staff members, patients as well as their family caregivers on the different dimensions of health care provision.

The type of analysis that we follow in this article is embedded in a qualitative research tradition known as reanalysis, which is still being defined and debated (Wasterfors, Akerstrom, & Jacobson, 2014.)

Reanalysis can be described as a type of secondary analysis that relies on primary sources. It includes any second look at previously collected data picked from any source, such as archives or interviews. We also carried out a supplementary analysis based on data generated by the same research team, exploring some aspects that had previously gone unnoticed and were unexplored in the theory.

Data was taken from interviews conducted during the Primary Study (PS) period (2012–2013) with staffs of sixteen hospitals and fourteen health centres attending patients with cancer. The facilities varied in size, region and type. At least two hospitals and two health centres were included from each region of Argentina -Northwest, Northeast, *Cuyo*, Center, Patagonia and the Buenos Aires metropolitan area.

The study subjects totalled 40 health professionals (physicians, nurses, social workers and psychologists). This sample was selected purposively: professionals who (1) were currently working in any area of cancer prevention and/or cancer care; (2) belonged to different positions within the broad umbrella of roles and disciplines that are in charge of cancer control. Only professionals from the public sector were included. Thirty were interviewed by NL: seventeen physicians (specialising in Oncology, Gynecology and Clinical Medicine), eight nurses, three psychologists and two social workers. In order to obtain the same type of data from all of Argentina, we included interviews conducted by other members of the research team that also carried out the PS (Fernández, Bengochea, Durand, & Hong, 2015).

It is noticed that the main criterion for selecting the interviews for this article was the presence of the codes under our new analysis. The structure of the final theoretical sample, with 40 cases is balanced in terms of the characteristics of the interviewees (gender, position, region). The potential bias in the limitations of the study refers to those interviewees that do not accept to answer the questions, the response bias, this is a common bias for this type of study.

We utilised a semi-structured questionnaire with open questions which discussed different phases in cancer control specifically geared towards interviewees' different positions and disciplines. Most interviews were audio taped but for certain topics some respondents felt uneasy and chose not to be taped.

Different strategies for conducting interviews were implemented *in vivo* according to the context. The characteristics of the settings where we developed our fieldwork demanded being alert and sensitive to institutional contingencies that occurred during the information-gathering process.

The PS was approved by local Ethics Committees and approved by the INC. All interviews were confidential. Also, in order to prevent the possibility of interviewees being identified we did not identify provinces but rather the country's six main regions. Consent was obtained by explaining to the participating subjects our main objective

and scope of the research project. We made clear that the use of collected data would not be restricted to a final report but would be shared and discussed with health services' teams and policy makers. The main goal of obtaining this data was to become better acquainted with current conditions, guiding an informed transformation of everyday activities in health services treating patients with cancer. Considering that the purpose of this reanalysis of primary data is closely related to the aims and the scope of the PS, it is understood that this query is covered by the terms under which consent was originally obtained.

In order to process and analyze the qualitative data, we followed an interpretative tradition which seeks to understand in detail the multiple, diverse positions to which social actors adhere, and locates these positions within a broader range of underlying beliefs, perspectives and/or agendas (Charmaz, 2005). This perspective takes an in-depth exploratory approach to data collection, aimed at documenting the subjective and complex experiences of the respondents.

Findings

Frontline practitioners accounts for establishing priorities

The process of setting priorities in giving care to patients with cancer is shaped mostly by the day-to-day activities at the health services frontlines. Official guidelines and program protocols play an important role in taking such decisions, but restricting these processes to written documents obscures a great part of what is going on at health services. There is an indispensable, interpretative action behind the understanding of those guidelines.

This interpretive action of understanding and implementing program guidelines and protocols is permeated by skepticism that some health workers feel about these tools (Luxardo & Manzelli, 2015). A critical distance from these tools generates a window of opportunity for individual considerations on priority-setting processes in daily activities in health services. In a heuristic effort to analyze some of the accounts on establishing priorities, we found reasoning that may have resulted in decisions that shaped some aspects of the social and economic inequities among patients with cancer.

'Better something than nothing' versus 'Better nothing than fabrications': accounts based on macro social inequalities

A key reasoning that guides health personnel when having to establish priorities is considering the structural vulnerability prevalent in the communities where each health service is located. Specifically, their target population finds itself in a vulnerable situation within society and this is something with which health services have to deal. Thus, priority-setting at the frontline is rooted in one of two logics: either a pragmatic logic that deals with what is possible given limited resources; or the gold standard logic, closer to what is clinically recommended. This is a position of context versus content: both include making decisions about types and spaces for treatment, ways of disclosing diagnoses, and referrals.

Often, the task of setting priorities is based on what resources are available, without taking into consideration other issues that fall outside the scope of the intervention. Oncologists have to decide on treatments whose supply is restricted or rather rely on obsolete therapies which are no longer recommended. This may lead them to decide to refer

patients to private practices, where they can get the right kind of treatment. As one physician explained:

We have good oncologists, good centres, professionals with excellent training, our team is first rate ... yet we are failing at specific treatments. Oncology drugs are usually covered in the Province's programs -and delivered on time- but we lack high complexity equipment for specific treatments. Radiotherapy (...) we had a cobalt bomb which is not working right now. Thus, all those type of treatments have to be paid out of pocket. (Male doctor, hospital from Central Region in Fernández et al., 2015, pp. 122–123.)

This perspective relies on an external objective reality that health services are unable to change, and this social impossibility of change is extended to health care activities, leading to a cycle of decline in already poor interventions. In this regard, the quality of practices for cancer prevention may be questionable, given the oft-repeated axiom: 'What are you going to do? At least this is better than nothing.' They suggest that, as doctors working for the public service and vulnerable populations, they must take decisions that help people gain access to 'at least' some type of care, affected by factors that constrains the quality of treatment in those settings: labour strikes, shortage of professionals, equipment for tests, treatments that do not work, waiting times for appointments running up to months, having to stand in line for hours, among others. Some professionals take into consideration contextual factors in their daily practices.

In extreme situations, and in the worst settings, cancer is just the tip of the iceberg for an entire situation of exclusion. If this tip emerges by blowing up to the surface, all other problems, whether associated or not with the disease, would require support and responses that an already frail institution could not afford. Like Pandora's Box, it is best kept closed. As one clinical doctor put it:

Being diagnosed with cancer is the least serious thing they could have in their life. Alcoholism, unemployment, drugs, malnutrition, domestic violence, sexual abuse ... what can our institution do with all of that? (...) We choose just to leave things as they are now; let the person go back to his hovel with the problem that brought them here solved. Is this the best practice? No. It's the practice that we can afford. (Female clinical doctor from hospital in Northwest region)

In contrast, there is another perspective which sustains that health workers cannot reduce the thresholds of medical attention in the name of benefiting the poor. Thus among professionals conflicts arise that are rooted in these two confronted visions of how to make proper decisions: to consider what is clinically recommended or to consider the context and what is possible for that particular reality (the lesser of two evils).

An interesting example provided by our interviewees is about a specific program for genital and breast cancer. Gynecologists resisted the proposal, supported by many clinic and generalist practitioners at the first level (where people in rural areas go for first attention), of 'opening' certain practices, typically considered as belonging to their own specialty (e.g. taking PAP samples) to the scope of other specialists, such as clinicians or generalists. This proposal is defended by the latter as a strategy to give women the opportunity of early detection as soon as they contact the institution, considering that this may turn out to be the only chance that they have at early detection. These professionals maintain that even when certain diagnoses practices (e.g. colposcopy) should not be transferred, others -also useful for cancer prevention- very well can be.

Some professionals resist becoming an accomplice to the subtle ‘vacating’ of the health system, instead of demanding what are considered the best practices in clinical care. Two gynecologists referred to this situation as the proposal of ‘poor medicine for the poor’ and mentioned the pressures they face in this regard, considering that epidemiological surveillance relies on numbers rather than quality, so what is important is that procedures be done (no matter how). One weighty argument for this side is the huge number of mistaken diagnoses oncologists have found in the disease trajectories of people at advanced stages of cancer.

What is at stake here is to what extent quality standards must be followed -or sacrificed- in order to have, at the very least, something realistic to implement. Oncologists have their international clinical practices for treatments, however, due to the lack of resources and other factors, they sometimes decide to lower thresholds depending on what is possible. Another example of how these two perspectives influence priority-settings processes appears in the case of breast cancer. Most surgeons believe that plastic surgery should be practiced on the same day as the mastectomy. However, this is often unfeasible because of difficulties in raising the money for breast prostheses.

I’d like to implant the breast prosthesis at the same time as the mastectomy, even when there are indications against doing so. I talked to several people and they asked ‘where will you get the money for the breast prosthesis?’ and so on ... they only throw a spanner in the works ... it’s a general deterioration of the hospital ... The less we do, the better.. (Male doctor, hospital from City of Buenos Aires in Fernández et al., 2015, p. 108)

As a consequence, priority-setting in treatments lays out minimum and maximum quality standards. As this oncologist doctor points out:

First, access to brachytherapy ... Do we have it? It’s a good start. Second, we need to optimize the time between treatments, and try to avoid delays. If we have no brachytherapy, external beam plus boost is better than nothing. And if there is no boost, we’ll only do external beam.. (Medical doctor, peri-urban Buenos Aires in Bengochea, 2015, p. 168)

The opposite situation is mentioned by oncologists who believe that the quality in medical service will determine the patient’s chances to live or die. Thus, for radiotherapy, they prioritise quality over comfort so, whenever possible, they choose to refer patients to radiotherapy centres that are further from their residences but which they know to be appropriate.

These dilemmas were also mentioned with rural patients. Travel to treatment cancer services -available in urban areas- was pointed out as a subtle pressure when deciding referrals and types of treatment. Patients diagnosed with cancer living in rural areas many times insist on the need to rush to be out of home in the shortest period possible, even when they could not find neither treatment facilities nor biomedical oncological expertise at home. So, medical doctors have to deal with this when deciding.

‘Taking care of themselves is just not in them’: accounts based on social and cultural characteristics of the patients

Another important line of reasoning when establishing priorities is related with the social and cultural characteristics of the target population. Health service staffs have vast experience and knowledge about the population they are working with. The fact that guidelines and program protocols generally ignore this knowledge was one of the sources of the

skepticism that health workers have about them. This lack of attention to cultural specificities in the guidelines leaves room for individual and personal decisions.

In interviews held in the countryside, doctors expressed that they lack interlocutors to implement preventive programs so it is nearly impossible to get one off the ground. Community referents such as nurses, teachers, administrative staff, are also immersed in very unfavourable contexts.

This reasoning acquires tangible complexity in fundamental decisions such as the diagnostic disclosure. Some medical doctors expressed that they often doubt whether to disclose cancer to their patients. They stated that all the problems associated with this disclosure would generate a worse reality, because, at any rate, patients would be unable to take action in initiating their care.

During the fieldwork we found that prejudices and stereotypes on the target population have influence on the inequality of care. These stereotypes may possibly activate a self-fulfilling prophecy, such as shorter time for consultation because they 'won't follow any medical prescription anyway'; untrustworthy relationship in the clinical encounter since 'they [patients] only come for emergencies', condescendence 'I don't lose my time giving explanations. Medical language it's hard to understand for them' and others.

Health workers will insist on and dedicate efforts to proposals that they consider fruitful in advance or, on the contrary, they will rapidly give up on projects they consider pointless. For example, in the countryside, the staff stated that the lack of education of rural workers is liable to render proper measures for cancer control futile.

The Province's Health Ministry wanted a strategy of primary care attention that would enable rural workers to do their job while being protected against chemicals which are responsible for many types of cancer. You know, such as wearing masks when fumigating crops, the appropriate boots, so that all their clothes wouldn't be full of chemicals ... but we gave up. Taking care of themselves is just not in them. They wear the boots one day and the next day ... barefoot again. (Male nurse, hospital from Northeast region)

'The health services that we have': accounts based on characteristics of the health services

Four main aspects emerged in the intrinsic limitations of the health system: bureaucratic rules, negligence, labour conditions and political influence.

Bureaucratic mechanisms in social insurance for the poor were named as responsible for reducing physicians' potential to choose between treatments. As stated by an oncologist: 'our hands are tied' with regards to best practices, since following international guidelines is almost impossible due to insurance requisites. Access to medication or medical tests is denied. The lack of drugs in countryside institutions has been noted: 'Not even basic drugs, not to mention monoclonal antibody therapy'.

Another example of these bureaucratic obstacles is related with radiology services. Doctors said that they must complete a radiotherapy treatment in order to be authorised to schedule new appointments for the second phase of treatment. But this requisite causes delays that work against optimal timing:

I'm not allowed to schedule a brachytherapy appointment until the patient has completed radiotherapy, which is insane ... if there are any administrative obstacles, as there usually

are, the patient might have to wait for two months ... the quality of that kind of radiotherapy is the worst because the timing is wrong. (Male doctor from Central region, Bengochea, 2015, p. 169.)

The geographic location of patients is considered a central issue for therapeutic success because many treatments fail due to the times between radiology sessions. ‘We ask the patient to lie and leave some information blank when filling forms on health insurance’. Having certain types of health insurance or living in certain locations may mean that patients are denied treatments, medications, or practices. In the treatment of cervical cancer, each day of delay between external radiotherapy and localised therapy reduces the chances of five-year survival. As a result, referring to a specific specialist is frequently a medical option, not a protocol to be followed.

The way health systems organise their logistics is also considered an obstacle. Taking the prevention of cervical cancer again as an example, doctors mentioned complications brought about by delays in obtaining biopsies. Extractions are taken in one place, analyzed in another and later must return to the first place of attention. The problem is with the most vulnerable population: if people never return to pick up results of their biopsies, there are no institutional mechanisms to follow up on these unclaimed tests. Patients’ circumstances are outside of the scope of the institution.

Priority-setting for cancer control also includes ‘partial’ or even the ‘absence of making decisions. Negligence in different areas of the health system has become naturalised by some health workers. Several interviewees mentioned that issues of logistics are underestimated, which sometimes causes a loss of previous efforts made by prevention programs. For instance, staff involved in cervical cancer programs talked about the problems of biological samples obtained with PAP tests. These professionals stated that quite often samples become useless because after extraction, they were never delivered to the proper place in time to be analyzed. These interviewees recalled not uncommon episodes in which half of the glassware containing cervix samples were broken in transport. They also discussed samples that were not in proper conditions: no spray, in bad hygienic conditions and later contaminated, among others.

One important decision that frontline oncologists must take is whether to disclose to patients that have been wrongly diagnosed that their disease is at advanced stages because of inefficient attention. Blaming colleagues is not an option: most of the time these errors are obscured by blurred explanations to patients and family about why they are now in such advanced situation. Many examples were mentioned: gynecologists who do not do medical transfers on time, dentists that dismiss sore spots in the mouth, throat specialists that keep patients on antibiotic treatment after long-lasting sore throats.

Physicians dealing with high complexity believe that their colleagues of the first level of attention should not be blamed for erring diagnoses and/or treatments. As one specialist interviewed stated:

I think professionals do their best, everything they can do, but they don’t have enough training. It’s a matter of expertise, of specific training. Everything now is within a protocol; there are norms, guides of clinical practices. (Male oncologist from city of Buenos Aires, Fernández et al., 2015, p. 127.)

Some interviewees listed labour conditions in the public health system among the factors that affect the priority-setting process. Low salaries and poor working conditions

(e.g. part-time or temporary work) result in health workers taking on multiple jobs, double shifts, private practices, outpatient care. With the pretext of their low salaries, some health centre professionals work fewer hours than scheduled, which in turn causes the health service to be particularly saturated because of the reduced consultation hours.

They [staff] complain about labor conditions and make an ‘ad hoc’ act of justice for themselves by working fewer hours ... but in the end, when you check the overall picture, well ... it’s not a bad salary for just two hours of work! (Male doctor from a health centre in the Central region.)

There is no political decision to demand that these professionals do what they are expected to do because it would mean a discussion on raising salaries. At the same time, nor is there the political will to improve job conditions. In this way, the reduction of working hours becomes naturalised as a way of maximising low salaries.

Another element influencing priority-setting processes is that of political influence. Economic and human resources are distributed among programs according to local political mileage. In this sense, cancer is a political matter. For example, some interviewees expressed that cancers affecting the blood system are disdained by hospital managers. They cannot capitalise success in these treatments because they require high investment combined with poor visibility or social recognition. Hematologists reported that at local health care practices, patients with cancer in the blood system tend to be rejected due to the complexity of these cases. Dismissing patients with this type of cancer is an unspoken policy among hospital administrators: ‘[this type of patient] is a problem that no one wants to deal with’.

At the other extreme, certain practices with great visibility and good reputations drain the scarce resources, mostly guided by the logic of ‘showing off’. Oncologists at high complexity hospitals in the North-East region complained to us about their institutional websites sometimes offering certain medical residencies which exceed their real capacity, posted without checking with the hospital first. Programs focused on children and women receive more funding. Moreover, funds spent on visible investments and building infrastructure are lacking in other less obvious areas, such as chemotherapy chairs.

Political influence is also an important factor determining who can really take decisions. Priority setting does not always depend on a hospital’s formal organisation chart. As one director mentioned, a mayor’s influence may be decisive in priority-setting, depending on what happens to be on the political agenda and consequently more politically profitable. In some hospitals, the decisive pressure is exercised by labour unions, which have the power of discarding or fomenting specific proposals.

‘Just with your own effort’: accounts based on personal voluntarism

The last identified logic underlying the processes of establishing priorities is a special one because it shows health workers’ individual efforts to improve the quality of care for patients with cancer. Many doctors try to resolve problems with their own resources that are usually insufficient to meet the many needs.

During fieldwork we registered that some health services staff take great pains to help patients, and take an active role in obtaining what is needed. They turn to personal contacts that are key to getting attention, drugs, certain type of tests, and referrals. However, the patient’s case depends on the diligence of the staff member, and ultimately, on the

empathy between the patient and the health service staff member. What is underlying here is a logic of doing a patient a favour which falls beyond the actual responsibilities of the job. They may, for example, help get a difficult to obtain appointment for a lab test, the proper medication for completing treatment or an authorisation from the health insurance for a referral.

Throughout all the focused ethnographies and interviews we held, we identified traits of personal logic behind institutions that impinge particular characteristics which depend on human factors, in addition to structural conditions. There are staffs that counterbalance the tight constraints in cancer care through their good will and extra efforts, as one male nurse said sarcastically: ‘Whenever it works, it’s because you put your heart – and I would add your blood, sweat and tears also- into it’. Reversely, as was already mentioned, there are also those who only make things worse through their negligence and lack of commitment but also their resignation, an attribute we noted in more than a few health providers’ narratives, justified in the adverse context where they belong:

You learn to be in automatic pilot ... You choose to be a clinical doctor in a rural health center because your ideals to change reality are strong. But when month after month, the only answers you get to your requests are excuses made by corrupt politicians ... and you see all your efforts go to waste, hierarchies based on political contacts and no training, well ... let me put it this way: you just throw in the towel. (Male doctor, health centre from Northwest Region)

Thus, we observed that many times referrals to specialists are made outside of protocol, based on associations between the personnel of different services, and on the level of commitment and the initiative of the staff. One social worker remarked:

When nobody can find a way to make an appointment for a certain test in time, we go to Ana, the administrator, and beg her to change the doctor’s schedule. She always finds a spot. (Female social worker, hospital from the city of Buenos Aires)

Many social workers, nurses and psychologists we interviewed mentioned that some doctors make referrals to specialists ‘hanging in the air’, in other words without taking into consideration the context and the feasibility of the orders requested. This omission may lead to the intervention eventually failing. This was illustrated by one nurse:

‘The oncologist sent a patient to have radiation therapy in one place that, due to cost-cutting measures, had few professionals to do the sessions’.

Often, the desire to help patients also goes beyond their expertise. It may lead to incorrect diagnoses, and subsequently, futile treatments that only delay proper care. Clinicians at the first level try to solve health problems with what they have at their disposal. The ability to care for patients along a continuum of response or clinical outcome includes clinicians’ deciding when to refer patients to other health care professionals. Doctors say their colleagues are reluctant to refer patients because it may look as if they lack the resources or technical competence to provide a response. Some doctors also indicated that health insurance institutions pressure them into not making medical referrals or requesting complex lab tests.

Finally, two main issues were found as positive within this context. One, the rewards of doing their job with dignity despite circumstances, the sense of feeling good by helping others and receiving gratitude from them and their families. The other positive side

staff mentioned was the teamwork, the feeling of 'belonging' and cooperation among them was also found rewarding.

Discussion

In this article we explored the logics of health service staffs which shape priority-setting processes. We were particularly interested in narratives that would result in small, daily actions of social inequality in the attention of patients with cancer. The accounts for priority-setting were not only rationales but also contingencies for applying them, pragmatic decisions staff must make on a daily basis, and finally, the absence or uncertain decisions made or not made with no more reasons than emotional and intuitive excuses.

We identified some logics underlying the priority-setting process by describing four main types of accounts: accounts based on macro social inequalities, accounts based on the social and cultural characteristics of the patients, accounts based on the characteristics of health services, and accounts based on personal voluntarism. The findings of this article illustrate how health workers' priority-setting processes have an impact not only on the quality of health care in general but on the increasing socioeconomic inequities in health care of patients with cancer in particular by practices adopted to fit in such adverse context/population. The impact of this sort of adaptive intervention, according to the context, many times implies a deterioration of the quality of the medicine, which means in the end, getting poor medicine for the poor. Broom and Doron (2011) have studied in India how this sort of bad quality intervention reproduces inequity in cancer care. Also McMullin and Weiner (2008) speak out against these types of 'discarded care'. In the study of Sinding and Wiernikowski (2009), they quoted an oncologist who speaks about offering more conservative treatment to older people with fewer social supports.

We share the arguments of Angus et al. (2013), supporting the idea that health services and procedures can reinforce and complicate patients' economic vulnerabilities, considering that barriers, constraints, deterrents were systemic features of the health care and delivery system. For example, through obstacles for doing referrals, making appointments on time, lack of agreement with the considered unfair eligibility for coverage, constant service cutbacks, hospitals directors' reduction of the budget for not 'political profitable' interventions, the arbitrary use of public resources according to what can be much more visible, among others.

As other authors state, inequitable conditions of life, such as poverty, unemployment, class' relations, insurance status among others interact to form health inequalities at the individual-level chronic disease like cancer (Angus et al., 2013). This article shed a tiny light on how health workers' priority-setting processes have an impact not only in the quality of health care in general but in increasing the socioeconomic inequities in cancer care attention.

These findings also reveal some possible directions for policy making. Excessive reliance on official guidelines and program protocols conducts to a comfort zone for everybody involved except the patients: policy makers are doing their job by elaborating guidelines and health workers are doing their job by applying the guidelines but 'adapted' to real conditions. As Jones and colleagues remarked

The dynamics of change -generated by resource scarcity and community demands – are faster than can be accommodated by traditional strategic planning processes, which are seldom sufficiently responsive to rapidly changing environmental and operating conditions. Long-term plans are routinely pre-empted by immediate pressures and contingencies (Jones et al., 2002, p. 2).

Even when it is clear that official guidelines and program protocols are fundamental for taking decisions and establishing priorities, they need to be complemented by other mechanisms which leave room for health workers to actively participate in adapting these guidelines to real everyday situations in health services. Disregarding these interpretative actions that tend to take place when applying official guidelines leaves the door open for personal and arbitrary interpretations of the guidelines which, as we have observed, impact on socioeconomic inequities in health care for patients with cancer.

Although there have been attempts to increase the quality of care in oncology services across the country in Argentina -for example through the creation of the National Cancer Institute in 2010 and the development of specific programs for cervix, breast and colon cancer- most are still in their early stages. We think that it is a good opportunity for creating mechanisms that intensify and guide the involvement of frontline health workers through active participation and that would include the perspectives of patients and their families.

Conclusions

This research also presents some limitations. The most salient is the possible presence of a bias in the sample because some health workers refused to be interviewed. Moreover, the relatively small number of staff selected for a study at the national level may limit the scope of the results. A study with a larger sample would provide more evidence on the ways that health workers interact with patients with cancer. Another limitation is the lack of a theoretical background with which to discuss and propose models of priority-setting on the day-to-day basis. It presents issues that should be analyzed in greater depth in future research. The concept of priority-setting at health services' frontlines allow to rethink some of the daily decisions taken by health workers more critically. Another interesting topic for future analysis is go deeper in explaining how these small, daily decisions perpetuate greater socioeconomic inequality in patients with cancer.

We aim to contribute with concrete insights, operative indicators and evidence that might lead to better understanding of how decisions are taken in health services attending patients with cancer in a middle income country.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

Abriata, G., Roques, L. F., Macías, G., & Loria, D. (2012). *Atlas de Mortalidad por Cáncer. Argentina 2007–2011*. Buenos Aires: Instituto Nacional del Cáncer, Ministerio de Salud.

- Angus, J. E., Lombardo, A., Lowndes, R. H., Cechetto, N., Ahmad, F., & Bierman, A. S. (2013). Beyond barriers in studying disparities in women's access to health services in Ontario, Canada: A qualitative metasynthesis. *Qualitative Health Research*, 23(4), 476–494.
- Baltussen, R., & Niessen, L. (2006). Priority setting of health interventions: The need for multi-criteria decision analysis. *Cost Effectiveness and Resource Allocation*, 4, 14.
- Bengochea, L. (2015). Escuchando a los radioterapeutas para identificar a los desafíos venideros. In N. Luxardo & L. Bengochea (Eds.), *Cancer and society. Multiple standpoints, perspectives, focuses* (pp. 157–171). Buenos Aires: Editorial Biblos.
- Black, S. D. (1980). *Inequalities in health: Report of a research working group*. Londres: Department of Health and Social Security.
- Bouchard, L., Albertini, M., & Batista, R. (2012). Bibliometric study of research on health inequalities. Second ISA forum of Sociology. Distributed paper.
- Broom, A., & Doron, A. (2011). The rise of cancer in urban India: Cultural understandings, structural inequalities and the emergence of the clinic. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 16(3), 250–266.
- Charmaz, K. (2005). Grounded theory in the 21st Century. Applications for advancing social justice studies. In N. Denzin & I. Lincoln (Eds.), *The sage handbook of qualitative research* (pp. 507–536). Thousands Oaks, London and New Delhi: SAGE Publications.
- Farmer, P., Frenk, J., Knaul, F. M., Shulman, L. N., Alleyne, G., Armstrong, L., ... Seffrin, J. R. (2010). Expansion of cancer care and control in countries of low and middle income: A call to action. *The Lancet*, 376, 1186–1193.
- Fernández, S., Bengochea, L., Durand, A., & Hong, I. W. (2015). La perspectiva de decisores e integrantes de los equipo de salud sobre prevención y atención. In N. Luxardo & L. Bengochea (Eds.), *Cancer and society. Multiple standpoints, perspectives, focuses* (pp. 107–156). Buenos Aires: Editorial Biblos.
- Gould, J. (2004). Lower-income women with breast cancer: Interacting with cancer treatment and income security systems. *Canadian Woman Studies*, 24(1), 31–36.
- Hunink, M., Weinstein, M., Wittenberg, E., Drummond, M., Pliskin, J., Wong, J., & Glasziou, P. (2014). *Decision making in health and medicine integrating evidence and values* (2nd ed.). Cambridge: Cambridge University Press.
- Jones, C., Keresztes, C., Macdonald, K., Martin, D., Singer, P., & Walker, H. (2002). *Priority-setting in Ontario's hospitals: Management report*. Canada: Queen's Center for Health Services and Policy Research. The Joint Center for Bioethics, University of Toronto, The Change Foundation.
- King, C. J., Chen, J., Dagher, R. K., Holt, C. L., & Thomas, S. B. (2014). Decomposing differences in medical care access among cancer survivors by race and ethnicity. *American Journal of Medical Quality*, 30, 1–11.
- Luxardo, N., & Manzelli, H. (2015). Clinical narratives: Cancer attention from providers and patients. In N. Luxardo & L. Bengochea (Eds.), *Cancer and Society. Multiple standpoints, perspectives, focuses* (pp. 319–386). Buenos Aires: Editorial Biblos.
- Marmot, M. (2004). *Status syndrome*. Londres: BlumSBury.
- Marmot, M., & Wilkinson, R. (Eds.). (2006). *Social determinants of health* (2nd ed.). Oxford: Oxford University Press.
- Martin, D., Abelson, J., & Singer, P. (2002). Participation in health care priority-setting through the eyes of the participants. *Journal of Health Services Research & Policy*, 7(4), 222–229.
- McMullin, J., & Weiner, D. (2008). Introduction: An anthropology of cancer. In J. McMullin & D. Weiner (Eds.), *Confronting cancer: Metaphors, advocacy and anthropology* (pp. 30–27). Santa Fe: School of Advanced Research Press.
- Peck, M., & Denney, M. (2012). Disparities in the conduct of the medical encounter: The effects of physician and patient race and gender. *SAGE Open*, 2, 1–14.
- Penckaszadeh, V. B., Leone, F., & Rovere, M. (2010). The health system in Argentina: An unequal struggle between equity and the market. *Italian Journal of Public Health*, 7(4), 350–358.
- Sinding, C. (2010). Using institutional ethnography to understand the production of health care disparities. *Qualitative Health Research*, 20(12), 1656–1663.

- Sinding, C., & Wiernikowski, J. (2009). Treatment decision making and its discontents. *Social Work in Health Care*, 48(6), 614–634.
- Tarter, C. J., & Hoy, W. K. (1998). Toward a contingency theory of decision making. *Journal of Educational Administration*, 36(3), 212–228.
- Wasterfors, D., Akerstrom, M., & Jacobson, K. (2014). Reanalysis of qualitative data. In F. Uwe (Ed.), *the sage handbook of qualitative data analysis* (pp. 467–480). Los Angeles and London: Sage.
- World Health Organization. (2008). *World cancer report 2008*. Edited by P. Boyle and B. Lewin. Lyon: International Agency for Research on Cancer/WHO.