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Implementing priority setting frameworks: Insights from leading researchers

Blake Angell[a,c,*], Jennie Pares[a], Gavin Mooney[b]

[a] NSW Agency for Clinical Innovation, Level 4, Sage Building, 67 Albert Avenue, Chatswood, NSW 2057, Australia
[b] Sydney School of Public Health, Edward Ford Building (A27), Fisher Road, University of Sydney, NSW 2006, Australia
[c] The George Institute for Global Health, Sydney Medical School, King George V Building 83 Missenden Road Camperdown 2050, Australia

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ABSTRACT

In spite of a substantial literature developing frameworks for policymakers to use in resource allocation decisions in healthcare, there remains limited published work reporting on the implementation or evaluation of such frameworks in practice. This paper presents findings of a targeted survey of 18 leading researchers around the implementation and evaluation of priority-setting exercises. Approximately one third of respondents knew of situations where recommendations of priority-setting exercises had been implemented, one third knew that recommendations had not been implemented and the final third responded that they did not know whether recommendations had been adopted. The lack of evidence linking the implementation of priority-setting recommendations to equity and efficiency outcomes was highlighted by all respondents. Features identified as facilitating successful implementation of priority-setting recommendations included having a climate ready to accept priority-setting, good leadership or a 'champion' for the priority-setting process and having a health economist to guide the process. Successful disinvestment was very uncommon in the experience of the researchers surveyed. Recommendations emerging from Program Budgeting and Marginal Analysis exercises appeared to be more widely implemented than those coming from alternative processes. Identifying if the process was repeated following the initial process was suggested as a means to measure success.

1. Introduction

Demand for services in health systems around the world will inevitably exceed the resources available to provide them. As such, decisions need to be made on which services and programs to fund and at what level [1]. Priority setting has been defined as 'decisions about the allocation of resources between the competing claims of different services, different patient groups or different elements of care' [3]. Substantial work has been devoted to the development of priority-setting frameworks to assist decision-makers balance these competing demands as public agencies are increasingly held accountable for the way in which resources are allocated [2,4–6,7]. A number of such frameworks exist, however, it has been highlighted that their effectiveness is likely constrained in practice, not by a lack of understanding on the part of policy-makers but by a lack of consideration for broader institutional and political characteristics of health systems in the frameworks [8]. As such an understanding of effective implementation and use of priority-setting frameworks is vital for decision-makers looking to implement such frameworks in health systems. This paper endeavours to shed more light on this issue through a survey of prominent researchers in the field

* Corresponding author.
E-mail address: bangell@georgeinstitute.org.au (B. Angell).

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to ascertain their views on facilitators and barriers to successful implementation of priority-setting frameworks and the evaluation of the use of such frameworks.

1.1. Existing evidence on the implementation of priority setting frameworks

A number of studies have investigated applying priority-setting frameworks in health systems around the world [7,10,11–21] and a small literature has developed investigating the facilitators and barriers to the implementation process. These have focused on a number of different priority-setting frameworks, though many have focused on Program Budgeting and Marginal Analysis (PBMA) frameworks. PBMA frameworks are based on the economic concepts of opportunity cost and the margin and seek to maximise the effectiveness of healthcare budgets by focusing on the marginal impacts of resource allocation decisions [22]. Mitton and Donaldson proposed a number of facilitators and barriers to implementing PBMA frameworks [23]. They highlighted a number of organisational and system level factors that act as both barriers (staffing issues, politics, too many administrative demands) and facilitators (strong leadership, designated resources to implement the framework, organisational culture, incentives and integrated budgets). The importance of organisational factors to the success of implementation was also highlighted by Cornelissen et al. in a community care context, who also emphasised the importance of adapting the priority setting framework (in this case PBMA) to ensure aligned with the ongoing business of the healthcare provider rather than being seen as a distinctly separate process [27]. Others have suggested that health researchers could improve the feasibility of priority-setting processes by working with decision-makers and 'embedding' themselves within organisations and promoting economic principles of opportunity cost and marginal analysis [24]. A number of other studies have looked at the views of policy-makers of the priority setting process both on the potential of implementing explicit frameworks (and desirable features of these) [12,15,25] as well as feedback on attempts to implement existing frameworks [13,14]. As a whole these studies have highlighted the importance of having clear processes, committed teams to implement the frameworks and a transparent process.

There have been few attempts at evaluating the effectiveness of implementation of these frameworks on either health or procedural outcomes. Tsourapas and Frew [26] attempted to review the success of a Program Budgeting and Marginal Analysis (PBMA) approach to priority-setting. They looked at all published PBMA studies and judged success in terms of 'whether participants gained a better understanding of the area under interest and therefore a change in the decision-making culture was achieved' [26]. In the wake of their review, they listed the ways that they encountered to evaluate PBMA:

1. To establish if a disinvestment list has been created.
2. To assess if resources have been successfully moved from the disinvestment list to the investment list.
3. To evaluate if the PBMA exercise has led to the improvement of participants' knowledge regarding the area under consideration.
4. To assess if PBMA has improved patient outcomes.
5. To observe if PBMA has influenced the organisational culture or way of thinking.
6. To assess if PBMA has been adopted for future use by the organisation.

Notably, improved efficiency and equity objectives, such as providing more health benefits for the same resource input or changing the distribution of benefits, are not listed here. The authors conclude that the success of implementing a PBMA framework depends largely on whether participants have considered the existing structures and priority-setting processes used in the area [26]. This paper investigates in closer detail the views of leading researchers of the implementation of priority-setting processes and what factors are identified as contributing the success or otherwise of this process.

2. Methodology

A targeted survey of leading authors in the priority-setting field was conducted to elicit their views on the implementation of priority-setting frameworks within health systems. The survey was conducted alongside a rapid review of the literature of the major priority-setting frameworks in the literature: PBMA, QALY league tables, needs-assessment methodologies, target setting, core health care, generalised cost-effectiveness analysis, accountability for reasonableness and the Swedish priority-setting system. These categories of priority-setting frameworks were selected by the authors as the most important to consider in the field. From this review, authors of key studies were selected and approached. This study was carried out to inform a health system within Australia and as such authors were purposively recruited based on their priority-setting research in either Australian jurisdictions or others comparable to the Australian situation. In total 18 authors of key studies were approached. Authors were approached via email in June 2012 by the senior author of this paper (GM) and were asked to respond within a two-week period. Participants were asked if they would address three questions related to their own experiences as researchers (either as a primary researcher in particular systems or based on their observations across the broader field):

1. To what extent have recommendations from priority setting exercises been implemented?
2. Where recommendations were implemented, what difference was made to efficiency and/or equity outcomes?
3. Where recommendations were implemented, what were the key reasons that allowed this or when recommendations were not implemented, why not?

These three questions were selected due to their practical importance for health systems looking to implement priority-setting frameworks and because these issues are little addressed in the academic literature. All researchers