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Changing priority setting practice: The role of implementation in practice change

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ABSTRACT

Background: Programme budgeting and marginal analysis (PBMA) is a priority setting approach that assists decision makers in choosing among resource demands. This paper describes and evaluates the process of implementing PBMA in a Canadian regional health authority, and draws out key lessons learned from this experience.
Methods: Qualitative data were collected through semi-structured participant interviews (twelve post year-1; nine post year-2), meeting attendance, and document review. Interview transcripts were analyzed using a constant comparison technique. Other data were analyzed to evaluate PBMA implementation.
Results: Desire for more clarity and for PBMA adaptations emerged as overarching themes. Participants desired greater clarity of their roles and how PBMA should be used to achieve PBMA's potential benefits. They argued that each PBMA stage should be useful independent of the others so that implementation could be adapted. To help improve clarity and ensure that resources were available to support PBMA, participants requested an organizational readiness and capacity assessment.
Conclusion: We suggest tactics by which PBMA may be more closely aligned with real-world priority setting practice. Our results also contribute to the literature on PBMA use in various healthcare settings. Highlighting implementation issues and potential responses to these should be of interest to decision makers implementing PBMA and other evidence-informed practices.

1. Introduction

Allocating scarce healthcare resources to meet growing population needs in an evolving healthcare context is a challenging task. Competing and increasing demands for service, shifting care models, and demographic change complicate efforts to decide how best to meet population needs with limited resources. In most Canadian provinces, responsibility for allocating resources falls to regional health authorities [1] where decision makers are

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often constrained by institutional practices and legislated requirements which may interfere with setting priorities based on local population need or maximizing benefit from services provided. It has also been shown that in some instances decision makers lack knowledge, skills and awareness of available tools that could assist with priority setting [2]. In such situations, services are often funded based on historical patterns [3], meaning that funding for a given year is determined largely by what was funded in previous years. Even if this historical allocation is adjusted to accommodate current organizational and population demands, it is not necessarily designed to maximize benefits from limited resources – something to which decision makers think a priority setting process should aspire [4].

A number of priority setting tools are available to help decision makers. One is an evidence-informed and systematic process known as programme budgeting and marginal analysis (PBMA), described in Table 1. PBMA implementation has evolved with repeated use in different contexts. The seven-step implementation approach used in this study [5,6] is designed to contextualize PBMA and the economic principles upon which it is based. As with many innovations, the manner in which PBMA is implemented affects its acceptance and use by decision maker end-users.

The purpose of this paper is to describe and evaluate the process of, and describe the experience and lessons learned from, introducing PBMA into a Canadian regional health authority community care portfolio. PBMA requires a change in usual priority setting practice, which, as with any change, can be difficult to achieve [7,8]. Highlighting potential implementation issues and responses to these should be of interest to decision makers who wish to more effectively employ PBMA and other evidence-informed practices.

1.1. Programme budgeting and marginal analysis (PBMA)

PBMA is a framework designed to assist decision makers in making choices around limited resources. It does so through operationalizing the economic principles of opportunity cost and the margin.[1] PBMA has been used in the healthcare field since the 1970s and is currently being used in health authorities in several Canadian provinces. PBMA's seven stages are outlined in Table 1. Programme budgeting, addressed in the first two stages, requires an in-depth look at current services and fund distribution to provide a map of activities and expenditures [3]. Marginal analysis, represented in the remaining stages, is the evaluative component of PBMA. It explores options to shift resources by focusing on both benefits and costs of incremental changes in resource allocation [3].

PBMA has been successfully used many times [e.g., 9, 10–12]; however, questions about how best to implement PBMA still exist. Implementation-relevant issues identified in the literature include difficulty obtaining adequate information for the programme budget [13,14], difficulty with disinvestment [15], limited monetary impact [16], difficult-to-measure outcomes [11], organizational barriers to adoption [11], and questions of long term sustainability [17].

[1] Opportunity cost can be defined as the lost benefit from the next best use of resources. The margin refers to the benefit gained (or lost) from adding (or subtracting) the next unit of resources to a programme [3].

2. Methods

2.1. Context

This study was conducted from 2006 to 2009 with community care decision makers from the Central Okanagan Local Health Area (LHA) in British Columbia's Interior Health Authority (IH). At the time of this study, the Central Okanagan LHA served a population of 176,130 of which 18.6% were 65 years of age or older [18]. The annual operating budget of the Central Okanagan community care portfolio was approximately CAD $25.5 million, which covered the following services: home support, community nursing, rehabilitation, case-management, adult day programmes, some chronic disease management and specialized residential programmes, and community-based social work, respiratory, and dietitian care.

2.2. PBMA implementation and evaluation

Researchers supported decision makers in implementing PBMA to set priorities to inform resource allocation in the 2007/08 and 2008/09 budget cycles. PBMA implementation was undertaken as described in the literature and outlined in Table 1. Organizational buy-in was promoted with support from an internal champion with previous PBMA experience and assistance from an IH project coordinator. The researchers also led a utilization focused evaluation [19] of the PBMA initiative.

The goals of the evaluation were first, to adjust the implementation approach according to participants' needs at the time, and second, to collect data on barriers/facilitators experienced and effective strategies to address these in this context. As such, our evaluation was formative [20], focused on adapting and refining PBMA and its implementation with the participants rather than retrospectively assessing its effectiveness. PBMA implementation evaluation was conducted by the researchers through iterative plan-act-observe-reflect action research cycles [21].

2.3. Data collection

Using a multi-method design [22], qualitative data were collected through semi-structured individual participant interviews post year-1 and year-2 of PBMA, meeting attendance by researcher(s) throughout the two-year implementation, regular conversations with participants and the IH project coordinator during and after the meetings, and document review. Gathering data over the duration of the implementation enabled capture of data about actual behaviour and real-time perspectives rather than relying on participant recall [23]. This study involved data triangulation (e.g., meeting attendance and ongoing discussions with participants), investigator triangulation