



Determining and broadening the definition of impact from implementing a rational priority setting approach in a healthcare organization



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ABSTRACT

Techniques to manage scarce healthcare resources continue to evolve in response to changing, growing and competing demands. Yet there is no standard definition in the priority setting literature of what might constitute the desired impact or success of resource management activities.

In this 2006–09 study, using action research methodology, we determined the impact of implementing a formal priority setting model, Program Budgeting and Marginal Analysis (PBMA), in a Canadian health authority. Qualitative data were collected through post year-1 ($n = 12$) and year-2 ($n = 9$) participant interviews, meeting observation and document review. Interviews were analyzed using a constant comparison technique to identify major themes.

Impact can be defined as effects at three levels: system, group, and individual. System-level impact can be seen in the actual selection of priorities and resource re-allocation. In this case, participants prioritized a list of \$760,000 worth of investment proposals and \$38,000 of disinvestment proposals; however, there was no clear evidence as to whether financial resources were reallocated as a result. Group and individual impacts, less frequently reported in the literature, included changes in priority setting knowledge, attitudes and practice. PBMA impacts at these three levels were found to be interrelated.

This work argues in favor of attempts to expand the definition of priority setting success by including both desired system-level outcomes like resource re-allocation and individual or group level impacts like changes to priority setting knowledge, attitudes and practice. These latter impacts are worth pursuing as they appear to be intrinsic to successful system-wide priority setting. A broader definition of PBMA impact may also suggest conceptualizing PBMA as both a priority setting approach and as a tool to develop individual and group priority setting knowledge and practice. These results should be of interest to researchers and decision makers using or considering a formal priority setting approach to manage scarce healthcare resources.

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Approaches to manage scarce healthcare resources continue to evolve in response to changing, growing and competing demands. Yet there is no standard definition in the priority setting literature of what might constitute the desired impact or success of resource management activities. Actual resource reallocation is the typically used measure for the impact of using a formal priority setting approach: this is system-level impact, i.e., impact across a set of interrelated units, like an organization, that share a common goal (Rogers, 2003). Yet some studies have suggested other possible

Table 1
Stages in a PBMA priority setting exercise (Mitton and Donaldson, 2004a, 2004b; Peacock et al., 2006).

Stage	Description of stage
1 Determine the aim and scope of the priority setting exercise	Determine whether PBMA will be used to examine changes in services within a given program (micro/within program design) or between programs (macro/between program study design).
2 Compile a “program budget”	The resources and costs of programs may need to be identified and quantified, which, when combined with activity information, is the program budget.
3 Form a “marginal analysis” advisory panel	Made up of key stakeholders (managers, clinicians, consumers, etc.) in the priority setting process
4 Determine locally relevant decision-making criteria	To be elicited from the advisory panel (e.g., maximizing benefits, improving access and equity, reducing waiting times, etc.), with reference to national, regional and local objectives, and specified objectives of the health system and community.
5 Identify options for (a) service growth (b) resource release from gains in operational efficiency (c) resource release from scaling back or ceasing some services	The program budget, along with information on decision-making objectives, evidence on benefits from service, changes in local health care needs, and policy guidance, are used to highlight options for investment and disinvestment.
6 Evaluate investments & disinvestments	Evaluate, in terms of costs and benefits; make recommendations for funding growth areas with new resources and/or moving resources from 5 (b) and 5 (c) to 5 (a) above.
7 Validate results & reallocate resources	Re-examine and validate evidence and judgments used in the process and reallocate resources according to cost-benefit ratios and other decision-making criteria.

measures or indicators of successful implementation of a priority setting approach. For instance, Sibbald et al. (2009) expand on the definition of successful priority setting by identifying additional outcomes such as stakeholder understanding and engagement, decision making quality, stakeholder acceptance and satisfaction, and positive externalities.

To investigate the impact of a formal priority setting approach, we studied the implementation of ‘Program Budgeting and Marginal Analysis (PBMA)’ in one Canadian regional health authority community care context. While several factors contributed to early PBMA discontinuation, participants indicated that PBMA still had a positive impact in this setting. The objective of this paper is to describe that impact qualitatively, based on participants’ perspectives.

Our work contributes to the definition of success, as one component of impact, by broadening the definition of impact to include not only system-level outcomes like resource re-allocation but also individual and group levels of impact identified in this study. In this way these findings address an important gap in the literature, which will be of interest to researchers and decision makers using or considering a formal priority setting approach to manage scarce healthcare resources. It is imperative that healthcare resources are managed well, and it is also vital that we have a good understanding of the processes for resource management. This study sought to explore the nuances in this challenging and important field of healthcare priority setting.

1. PBMA

PBMA is a framework designed to assist decision makers with making choices to allocate healthcare resources. It is often categorized as an economic approach to priority setting because it merges two distinct but often linked economic activities: Program Budgeting and Marginal Analysis. Program budgeting, which is sometimes viewed as a planning framework, describes the distribution of resources across different programs; it does so by providing a map of expenditures and sometimes activities for the various programs (Jefferson et al., 2000; Mitton and Donaldson, 2004a, 2004b). Marginal analysis is the examination of the costs and benefits of small changes in the existing pattern of expenditure in a particular portfolio (Jefferson et al., 2000; Mitton and Donaldson, 2004a, 2004b). PBMA (Table 1) has been used in a variety of healthcare settings since the 1970s (Mitton and Donaldson, 2001; Tsourapas and Frew, 2011). Various studies have determined that it effectively incorporates economic (Mitton and Donaldson,

2004a, 2004b) and ethical principles (Gibson et al., 2006), and multiple surveys have shown that decision makers prefer it over historical and political approaches to priority setting (Dionne et al., 2008; Mitton and Donaldson, 2002; Teng et al., 2007). A 2001 systematic review evaluated PBMA impact using the system-level criteria of resources reallocated or priorities set (Mitton and Donaldson, 2001). Using these criteria, the authors found that PBMA had a positive impact in 59% of the cases. A more recent literature review evaluated PBMA success using various definitions of success and found that the success rate was highest (65%) when success was defined as ‘implementation of some/all of the advisory panel’s recommendations’ and lowest (22%) when success was defined as ‘adopting the framework for future use’ (Tsourapas and Frew, 2011).

The differing definitions of positive impact or success used above make it difficult to compare studies with one another. Also, in some PBMA cases, authors have indicated limited impact on specific outcomes – e.g., limited effectiveness (Bohmer et al., 2001), limited monetary impact from resource reallocation (Urquhart et al., 2008), limited evaluation and/or difficult-to-measure outcomes (Mitton and Donaldson, 2003). Yet, even in these examples, participants often indicated that PBMA was “worthwhile and valuable” (Bohmer et al., 2001, 47) and that it had a positive impact. If the ultimate goal of using PBMA is to reallocate resources to redesign services to better meet organizational objectives (Peacock et al., 2010), determining success by this outcome makes evaluative sense (Patton, 1997). However, our research fits with the emerging stream of literature which contends that resource re-allocation by itself is insufficient as a measure of the full impact of priority setting processes such as PBMA. Our research expands the definition of impact to include effects at the system, group, and individual levels.

2. Methods

2.1. Context

With the aim of implementing PBMA to inform resource allocation decisions for two consecutive budget cycles, this 2006–2009 study was conducted in British Columbia’s Interior Health Authority (IH) Central Okanagan Local Health Area (LHA) community care portfolio. At this time, the LHA population was 176,130 with 18.6% 65-years of age and older (Interior Health, 2007). With an annual operating budget of approximately CAD \$25.5 million, the Central Okanagan community care portfolio included the following services: case-management, adult day programs, home support,

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