

**SUCCESSFUL PRIORITY SETTING:
A CONCEPTUAL FRAMEWORK
AND AN EVALUATION TOOL.**

by

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A thesis submitted in conformity with the requirements

for the degree of Ph.D

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ABSTRACT

Successful Priority Setting: A Conceptual Framework and an Evaluation Tool.

Doctor of Philosophy

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2008**

A growing demand for services and expensive innovative technologies is threatening the sustainability of healthcare systems worldwide. Decision makers in this environment struggle to set priorities appropriately, particularly because they lack consensus about which values should guide their decisions; this is because there is no agreement on best practices in priority setting. Decision makers (or ‘leaders’) who want to evaluate priority setting have little guidance to let them know if their efforts were successful. While approaches exist that are grounded in different disciplines, there is no way to know whether these approaches lead to successful priority setting. The purpose of this thesis is to present a conceptual framework and an evaluation tool for successful priority setting. The conceptual framework is the result of the synthesis of three empirical studies into a framework of ten separate but interconnected elements germane to successful priority setting: stakeholder understanding, shifted priorities/reallocation of resources, decision making quality, stakeholder acceptance and satisfaction, positive externalities, stakeholder engagement, use of explicit process, information management, consideration of values and context, and revision or appeals mechanism. The elements specify both

quantitative and qualitative dimensions of priority setting and relate to both process and outcome aspects. The evaluation tool is made up of three parts: a survey, interviews, and document analysis, and specifies both quantitative and qualitative dimensions and relates to both procedural and substantive dimensions of priority setting.

The framework and the tool were piloted in a meso-level urban hospital. The pilot test confirmed the usability of the tool as well as face and content validity (i.e., the tool measured relevant features of success identified in the conceptual framework). The tool can be used by leaders to evaluate and improve priority setting.

ACKNOWLEDGEMENTS

Thanks to Prof. Douglas K Martin who assisted me through my Masters and Ph.D, providing guidance, support, and funding.

The rest of my committee, Dr Peter A Singer and Dr Ross Upshur, I am grateful for your words of wisdom, advice, and encouragement over the past few years.

Raisa Deber, Jan Barnsley, Rhonda Cockerill and the rest of the faculty and support staff of HPME: thank you for challenging me to do my best and providing me with opportunities to learn and grow.

Jennifer Gibson, colleague, mentor, dear friend; thank-you for your keen advice, our heart-to-hearts, and your genuine inspiration.

To my ever-growing family: I am so thankful to have all of you in my life; every one of you has made me stronger and wiser in your own unique way. Having started this journey, I cannot imagine having crossed the finish line without the support of every one of you. My dear husband, you have taught me so much more than how to 'be a Ph.D'. To my beautiful children: my inspiration and favourite distraction, it was your smiles that made it all worth while.

Mom: you believed in me every step of the way. I cannot thank you enough for your cheer-leading, editing, and love.

The bottom line: I am incredible blessed for my support network, and I am done. Thank you.

Table of Contents

Chapter 1: Thesis Overview	xi
Introduction	1
Purpose and Objectives	3
Summary of the Chapters	5
Key Message	6
Chapter 2: Background and Significance	7
2.1 Overview of Priority Setting	8
A Definition of Priority Setting	8
The Context of Priority Setting: Canada	9
Macro-Level Priority Setting.....	9
<i>Provincial Budgets</i>	11
<i>Drug Priority Setting</i>	13
<i>Wait List Management</i>	15
<i>Summary</i>	17
Meso-Level Priority Setting.....	18
<i>Hospital Priority Setting</i>	18
<i>Regional Priority Setting</i>	20
<i>Disease-Specific Priority Setting</i>	21
<i>Summary</i>	22
Micro-Level Priority Setting.....	23
<i>Summary</i>	25
International Experience with Priority Setting	26
Summary: Canadian and International Macro-, Meso-, Micro- Priority Setting..	32
The Problems in Priority Setting	33
2.2 Success in Priority Setting	35
Discipline-specific Approaches	36
Evidence-Based Medicine	37
Health Economics	38
Legal Approaches	41
Political Science Approach	43
Philosophical Approaches.....	47
Interdisciplinary Approaches	48
Health Technology Assessment (HTA)	48
Interdisciplinary Approaches Specific to Developing Countries.....	51
Problems with Disciplinary-Specific Approaches	52
Successful Priority Setting	54
Summary: Success in Priority Setting.....	56
2.3 The Goals of Legitimacy and Fairness	59
What Is Legitimacy? What Is Fairness?	59
‘Accountability for Reasonableness’	60
Empirical Experience with Accountability for Reasonableness	62
Describe-Evaluate-Improve	64

Summary: Legitimacy & Fairness	65
2.4 Tools for Evaluating Success.....	66
2.5 Gaps in Knowledge	71
1) There is no comprehensive definition of successful priority setting	71
2) There is no tool for evaluating the achievement of success in priority setting	72
Chapter 3: Methodology.....	73
3.1 Methods for the Development of the Conceptual Framework	74
Methods Used in Conducting the Three Empirical Studies.....	74
Study #1: An International Delphi Consensus Panel.....	74
Study #2: One-on-One Interviews with Canadian Decision Makers.....	78
Study #3: National Patient and Decision Maker Focus Groups	82
Methods for the Synthesis of the Empirical Studies.....	87
3.2 Methods for the Development of Evaluation Tool.....	89
Sensibility Testing.....	90
3.3 Methods for the Real-World Application –The Pilot Test	94
Chapter 4: Results.....	102
Developing a Conceptual Framework.....	102
4.1 Results of Study #1: An International Delphi Consensus Building Exercise	103
Elements of Success.....	105
4.2 Results of Study #2: One-on-One Interviews with Canadian Decision Makers	109
4.3 Results of Study #3: National Patient and Decision Maker Focus Groups ...	116
4.4 Results of the Synthesis of the Three Studies – The Conceptual Framework	125
Chapter 5: Results.....	133
Developing and Testing the Evaluation Tool	133
5.1 Results of the Development of the Evaluation Tool.....	133
Validity Testing	137
5.2 Results of the Real-World Application - The Pilot Study	140
Background	140
Interpretation	141
Pilot Study Results	143
Pilot Study Interpretation	161
5.3 Usefulness of the Evaluation Tool	162
Pilot Test Debriefing.....	163
Researcher’s Experience	166
Refining the Conceptual Framework and Evaluation Tool.....	167
Transformation of the Conceptual Framework.....	167
Transformation of the Evaluation Tool.....	169
Chapter 6: Discussion	174
6.1 Synthesis of Findings	175
The Conceptual Framework for Successful Priority Setting.....	175
Fact-Value Distinction	179
The Tool for Evaluating Successful Priority Setting	180
Testing and Implementation of the Tool.....	184
6.2 Contribution to Knowledge.....	186

Relationship with Existing Literature on ‘Priority Setting Success’	186
Summary	195
Gaps in Knowledge	196
GAP #1: There is No Comprehensive Definition of Successful Priority Setting	196
GAP #2: There is no Tool for Evaluating Success of Priority Setting	198
6.3 Implications of this Research	200
Implications for Policy and Practice	200
1) Guidance for Decision Makers	200
2) A Useful Evaluation Tool	202
3) Education for Leaders and for Organizations	204
Implications for Other Countries, Cultures, and Health Systems	206
6.4 Limitations	207
Limitations of Individual Studies	207
Limitations of Study Overall	210
6.5 Conclusion	212
Future Research	212
1) Empirical Studies to evaluate the conceptual framework and the evaluation tool in different contexts	212
2) Quantitative Studies to Confirm Conceptual Framework and the Evaluation Tool	214
3) Create a forum to capture experiences and share lessons	216
4) Making the tool more user-friendly	217
Concluding Remarks	217

List of Tables

Table 2.1: Discipline Specific Approaches and Their Goals.....	53
Table 2.2: Summary of Studies.....	56
Table 2.3: The Four Conditions of Accountability for Reasonableness.....	61
Table 3.1: Delphi Participants	75
Table 3.2: Summary of Interview Participants	79
Table 3.4: Content Validity Participants	93
Table 3.5: Interview Participants	98
Table 4.1: Delphi Participants per Round	103
Table 4.2: Elements of Success – Results from 3 Studies	125
Table 4.3: Merged List.....	127
Table 4.4: Conceptual Framework	128
Table 5.1: Tool Development: Example of Assigning Question to Different Components (Revisions and Appeals Element).....	135
Table 5.2: Total Number of Questions from Each Component of the Evaluation Tool.....	136
Table 5.3: Survey Respondents	142
Table 5.4: Interview Participants	142
Table 5.5: Documents Analyzed	143
Table 5.6: Involvement in Process and Satisfaction with Involvement	144
Table 5.7: Cross Analysis of Job Title and Involvement in Budget Process.....	144
Table 5.8: Was there an explicit and predetermined timeline?	147
Table 5.9: Three outcome questions	159
Table 5.10: Comparison of 2 Questions on Satisfaction	160
Table 5.11: Changes/Revisions to Conceptual Framework	168
Table 5.12: New Conceptual Framework	169
Table 6.1: Conceptual Framework Compared to Accountability for Reasonableness.....	188
Table 6.2: Conceptual Framework Compared to Gibson et al.....	190

Table 6.3: Conceptual Framework Compared to Teng et al	191
Table 6.4: Conceptual Framework Compared to Mitton and Donaldson.....	192
Table 6.5: Conceptual Framework Compared to Mitton and Patten.....	193
Table 6.6: Comparison of Existing Definitions/Suggestion of Success in Priority Setting.....	195

List of Figures

Figure 2.1: Government Spending by Province in 2006.....	12
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List of Appendices

Appendix A: Interview Guide for One-On-One Interviews with Decision Makers across Canada.....	243
Appendix B: Focus Group Discussion Guides	244
Appendix C: Complete Version of Tool Implemented In Pilot Study	246
Appendix D: Letter of Support from Hospital	249
Appendix E: Hospital Report Generated From Pilot Test	250
Appendix F: Delphi Round One List of Items	273
Appendix G: First Version of Evaluation Tool	277
Appendix H: Changes to the Survey As A Result of the FCV Panel	280
Appendix I: Complete Results of the Survey	284
Appendix J: Tracked Changes to Interview Guide	290
Appendix K: Suggested Focus Group Discussion Guide	292
Appendix L: Evaluation Survey: Changes Made After Pilot Test of Tool	293
Appendix M: Document Analysis: Changes Made After Pilot Test of Tool	297
Appendix N: Complete Version of Tool (Post-Pilot Test Changes).....	298

Chapter 1: Thesis Overview

Introduction

The sustainability of the Canadian health care system is dependant on the ability of policy makers to make difficult priority setting decisions. The growing demand for services and expensive innovative technologies further threatens the sustainability of this system. Due to a lack of consensus regarding which values should guide their decisions, decision makers in this environment struggle to set priorities appropriately, or successfully. Decision makers, particularly in the Canadian publicly funded health system, are under growing pressure to improve their priority setting and to demonstrate the effectiveness of their decisions. Currently, decision makers do not have a common framework on which to base their priority setting decisions.

This is not a problem solely faced by Canadian decision makers. This problem is world-wide; it persists in both the developed and the developing world, and presents problems throughout various health care systems and numerous health care organizations. Priority setting is a global concern, which has made the determination of best practices within priority setting an international endeavour.

A comprehensive evidence-base to evaluate priority setting activities is needed, however this is lacking in the current priority setting literature. While there have been numerous attempts from around the globe to describe the activities associated with priority setting, evaluating the success of these activities has been difficult since there is no agreement on what achieving success in priority setting looks like. This lack of consensus on what should count as successful priority setting, coupled with both a lack of agreement on how to evaluate it and divergent views on

which values should dominate in priority setting, have left priority setting decision makers uncertain as to whether or not they have achieved success in their decisions.

One way to approach this problem is to determine how the relevant stakeholders understand successful priority setting. Greater insight into stakeholder's attitudes and perceptions of achieving success in priority setting could improve the way in which institutions and health care organizations set priorities.

There have been numerous empirical descriptions of priority setting in various contexts, as well as the application of different approaches to priority setting (cost-effectiveness assessment, health technology assessment (Battista & Hodge, 1996), program budgeting and marginal analysis). There have also been studies examining priority setting from the perspective of stakeholders. However, despite these endeavours, the subject of priority setting remains incomplete because no one has attempted to comprehensively define successful priority setting.

Although frameworks and tools exist to help Canadian decision makers with priority setting (such as 'accountability for reasonableness' or program budgeting and marginal analysis, described in Chapter 2), there are no frameworks that describe successful priority setting. Creating a framework to define success in priority setting is a step toward improving priority setting practices in health care organizations. In order to ground such a framework, one must begin by collecting and synthesizing the views of stakeholders, including decision makers, patients, and priority setting scholars.

These three groups of stakeholders are important for various reasons. Decision makers are responsible for priority setting decisions and are therefore a key stakeholder group in defining what it means to achieve success in priority setting. Patients are key stakeholders because the

health system exists for them and because their taxes, insurance premiums and out-of-pocket payments fund the system. Moreover, patients can contribute their experiences within the health system, as well as an intimate knowledge of the consequences of priority setting decisions. Priority setting scholars are another key stakeholder group because they can analyze and improve the theoretical grounding for decision making within health systems, and they may identify concepts that other stakeholder groups would not.

In order to improve something, one must be able to clearly define what they intend to improve. Ergo, defining what it means to be successful in priority setting is a necessary first step towards improving priority setting in general. The next step towards improving priority setting is to be able to evaluate it -- to know whether an organization is achieving success in their priority setting efforts. Currently, there is no framework for defining successful priority setting and no evaluation tool for measuring the achievement of success of priority setting.

Purpose and Objectives

The overall aim of this thesis is to address the research question: ‘How can we evaluate the achievement of success in priority setting?’. The specific objectives are:

1. Develop a conceptual framework to define successful priority setting; and
2. Develop a tool to evaluate the achievement of success in priority setting.

This study aims to address two major gaps in the existent literature on priority setting that align with real concerns of decision-makers. The first gap is that currently there is no conceptual framework for success in priority setting. The second gap is that there is no tool for evaluating the achievement of success in priority setting.

To achieve my first objective, I conducted three studies that used different methods of data collection, but similar methods of analysis. These three studies provided a diverse and rich knowledge base.

- o Study 1 was a modified Delphi consensus building initiative involving a panel of international scholars and decision makers.
- o Study 2 used one-on-one qualitative interviews with a wide variety of decision makers across the full range of the Canadian health care system.
- o Study 3 was qualitative and was based on multiple interconnected focus group interviews involving patients and policy makers from across Canada.

Subsequently, I synthesized the findings from these three studies into a coherent and comprehensive conceptual framework that describes successful priority setting. The conceptual framework has evolved and been refined throughout the research process. It includes ten elements of successful priority setting: stakeholder understanding, shifted priorities/reallocation of resources, decision making quality, stakeholder acceptance and satisfaction, positive externalities, stakeholder engagement, explicit process, clear and transparent information management, consideration of context and values, and revision or appeals mechanism. These elements outline both quantitative and qualitative dimensions of priority setting, and relate to both the procedural and substantive dimensions. The conceptual framework reflects ethical goals of priority setting and also practically-focused goals of decision makers; it is both normatively and empirically grounded.

To achieve my second objective, I developed an evaluation tool (or a “global index”, discussed in Chapter 3), grounded in the elements of the conceptual framework. Subsequently, the evaluation tool was refined and improved through a real-life test that was conducted in a mid-sized Ontario hospital. The tool can be used to evaluate the success of a health care institution’s priority setting.

It includes three components: a survey, interviews, and document analysis. These capture both the qualitative and quantitative dimensions of a priority setting process.

The following section provides a summary of the contents of each chapter of this thesis.

Summary of the Chapters

Chapter 2 contains the background and significance of the problems that are addressed by my research. First, I discuss the context of priority setting within the Canadian health care system, including descriptions of actual priority setting. Second, I describe the goal of success in priority setting and discuss the contributions that other fields and disciplines have made towards achieving this goal. Third, I define and discuss legitimacy and fairness as two ‘surrogate goals’ in priority setting. Fourth, I discuss evaluation and measurement tools that have been used in the achievement of success in various fields. Lastly, I present the two key gaps in the literature: there is no comprehensive definition of successful priority setting, and no tool for evaluating the achievement of success in priority setting.

Chapter 3 details the methods that were used in my research. Three empirical studies were conducted that provided the context for the primary data collection and subsequent creation of the conceptual framework. This chapter includes a description of the design, setting, sampling and participants, methods of data collection and analysis, and a description of the research ethics process for each study. I also describe the methods used in the development of the conceptual framework and the evaluation tool. Lastly, I describe three ways in which the evaluation tool is tested: the ways to test its face and content validity, the methods used for pilot testing, and the methods that can be used for its evaluation.

Chapter 4 focuses on the results of the primary data collection (three empirical studies) and the synthesis of these studies into the conceptual framework. In this chapter I present three lists of successful priority setting elements derived from each study. This chapter also presents the ten separate but interconnected elements of the conceptual framework that were derived from the synthesis of the three studies.

Chapter 5 focuses on the results of the development and testing of the evaluation tool. I describe the results of the face and content validity testing and the results of the pilot test. I also present analysis of the ‘ease of use’ of the tool and the subsequent refinements to the conceptual framework and the evaluation tool.

Chapter 6 is the discussion section of the thesis. In it, I describe how this research has contributed to the available knowledge of priority setting processes; in particular I describe how I fill the gaps in the knowledge that are described in Chapter 2. I also describe the implications that this research can have for policy and practice, and for future research. Lastly, I discuss the limitations of this research.

Key Message

Priority setting is complex and is becoming increasingly difficult as both the demand for services and the cost of care continue to grow. By providing decision makers with guidance regarding the achievement of successful priority setting, this thesis can begin to improve any priority setting process. The goal of this research is to improve priority setting practices in health care organizations across Canada; by defining successful priority setting through a conceptual framework, and by providing a tool to evaluate successful priority setting, we have gained significant progress toward this goal.

Chapter 2: Background and Significance

This chapter presents the intellectual setting in which this thesis is found. Priority setting is complex and this chapter aims to organize the relevant background knowledge to enhance clarity. It is divided into five sections.

In Section 2.1, I will provide an overview of priority setting by providing a definition of terms, explaining the context in which priority setting occurs, discussing the importance of priority setting in our current health care system, and examining the main problems faced by priority setting decision makers. In this section, I will report on the priority setting literature emerging from Canada that is relevant to this thesis, and touch on similar literature from other countries.

In Section 2.2, I will focus on the goal of success in priority setting and discuss the contributions that other fields/disciplines have made to this discussion. I will highlight the first major intellectual challenge that is fundamental to this research: there is no common understanding of successful priority setting.

In Section 2.3, I will define and discuss legitimacy and fairness as two ‘surrogate goals’ in priority setting. I will present ‘accountability of reasonableness’ as an ethical framework for legitimate and fair priority setting.

In Section 2.4, I will discuss measurements and tools that have been used to evaluate and measure success in various fields/disciplines. I will highlight the second major challenge that is fundamental to this research: there is no tool to evaluate the achievement of success in priority setting.

In Section 2.5, I will provide a chapter summary and present the gaps in knowledge that this research attempts to fill.

2.1 Overview of Priority Setting

In this section I will: (1) provide definitions of priority setting terms, (2) explain the context of priority setting (in Canada and internationally), and (3) end with discussion of the problems that decision makers face in priority setting.

A Definition of Priority Setting

Priority setting, also known as rationing or resource allocation, has been defined as the distribution of resources (e.g. money, time, beds, drugs) among competing interests (e.g. institutions, programs, people/patients, services, diseases)(McKneally, Dickens, Meslin, & Singer, 1997). Loughlin (1996) defined priority setting as the process by which decisions are made as to how to allocate health services resources ethically.

Priority setting is a complex and difficult problem faced by all decision makers at all levels of all health systems. Holm (1998) wrote: “Talking about priorities and, by implication, rationing of health care resources is difficult. It means accepting that some citizens will not get treatment that is potentially beneficial to them” (p.1002).

Daniels and Sabin (1997) have argued that there will always be moral disagreement in priority setting decisions. For example: balancing competing values (e.g., equity versus efficiency); the conflict between best outcomes and fair chance; and the ‘aggregation problem’ (when should small benefits for many outweigh large benefit for few?) (Daniels, 1994). A large problem that

priority setting decision makers face is: there is no clear understanding of successful priority setting.

In this thesis, I argue that in order to resolve any of the aforementioned moral disagreements, we need to establish a common understanding of what it means to achieve success in priority setting.

The Context of Priority Setting: Canada

Macro-Level Priority Setting

In Canada, there is relatively little interaction between decision makers at the macro, meso and micro levels in regards to setting priorities. Priority setting occurs in both governments (e.g. Local Health Integration Networks (LHINs), quasi-governmental organizations (e.g. Cancer Care Ontario), hospitals, and clinical programs and has been described as a series of unconnected experiments with no systematic mechanism for capturing the lessons or evaluating the strengths and weaknesses of each experiment (Martin & Singer, 2000).

Canada has been preoccupied with the public-private debate and defining ‘what is in the basket’ (i.e., what are the publicly covered core services) (Kirby, 2002; Romanow, 2002). Martin and Singer (2003b) reported that Canada has no central co-ordination and no central accountability for decision-making regarding health technologies. They maintain that Canada has no single, widely accepted procedural framework for priority setting, but instead various institutions use different procedures (technology assessment, institutional committees, and waiting-list management procedures) for their priority setting decisions.

The Architecture of the Canadian Health Care System

Canada is a federalist country. Federalism refers to an arrangement of political institutions and a philosophy of government (Burris, 2001) as well as an institutionalization of the notion of regional diversity (Doern & Phidd, 1983). Federal-provincial relations are complex and multifaceted networks of influence which have developed (Simeon, 2007), and are an important aspect in the way that health care is delivered in Canada.

Canada's health care system is organized into ten provincial and three territorial health plans. At the 'macro' level, Health Canada upholds Medicare through the Canada Health Act, giving individual plans an allocation of funding (through tax points and cash transfers) if they provide care according to the five conditions of the Act: comprehensiveness, universality, portability, accessibility and public administration. Currently (and since the inception of Medicare), all of the delivery of Canadian health care services occurs privately (by doctors, hospitals and other health care professionals) and 70% of health care is funded publicly (by the government). The remainder falls to private insurers, employers, and the public (Chodos & MacLeod, 2002; Deber, 2002). Publicly funded health care is financed through federal, provincial and territorial taxation. British Columbia, Alberta and Ontario also charge health care premiums, but non-payment of premiums does not preclude access to medically necessary services.

Medicare is a defining characteristic of Canada and is seen as a core Canadian value (Mendelsohn, 2002), and a defining attribute of our national identity (Axworthy & Spiegel, 2002). Health care is a key issue in influencing and shaping public debate and public policy (Doern & Phidd, 1983).

At the provincial/territorial level, decisions are made about what is included as a publicly covered core service – i.e., what will be considered medically necessary care, that is delivered in hospitals or by physicians and paid for by the provincial/territorial insurance plan. There is considerable provincial variation on this. At the meso level, most provinces have shifted to regions or districts (local health integration networks (LHINs) or regional health authorities (RHAs), etc.).

At the micro-level in Canada, patients enter the health care system through primary care (family doctor, nurse, nurse practitioner, physiotherapist, pharmacist, etc.), by way of physician clinics, or in a team setting (in Ontario, primary care restructuring is moving toward increasing 'family health teams' as well as Nurse Practitioner led clinics).

In Canada and around the world, health service resources are finite, and greater efficiency and/or more money will never prove sufficient to accommodate growing demand (Jones, Keresztes, Macdonald, Martin, Singer, & Walker, 2002). Concerns about system sustainability have increased emphasis on accountability between hospitals and funders.

In Ontario, new funding agreements called *hospital services accountability agreements* (H-SAA), between the Minister of Health & Long Term Care and the hospitals (through the LHINs) require hospitals to live strictly within their funding envelope. Annual budgeting processes are now faced with significant constraints and tight timelines. Health care organizations face the challenge of meeting community health needs within limited health care resources (Edgar, Salek, Shickle, & Cohen, 1998). Similar problems are experienced globally; Kovac (1998) reported on rationing in the hospital sector in Australia, discussing how government funding cuts have caused a rationing of services. He reported that cost shifting is happening at a rate detrimental to the system and it is clear that more accountable and consistent ways of making allocation decisions are required.

Provincial Budgets

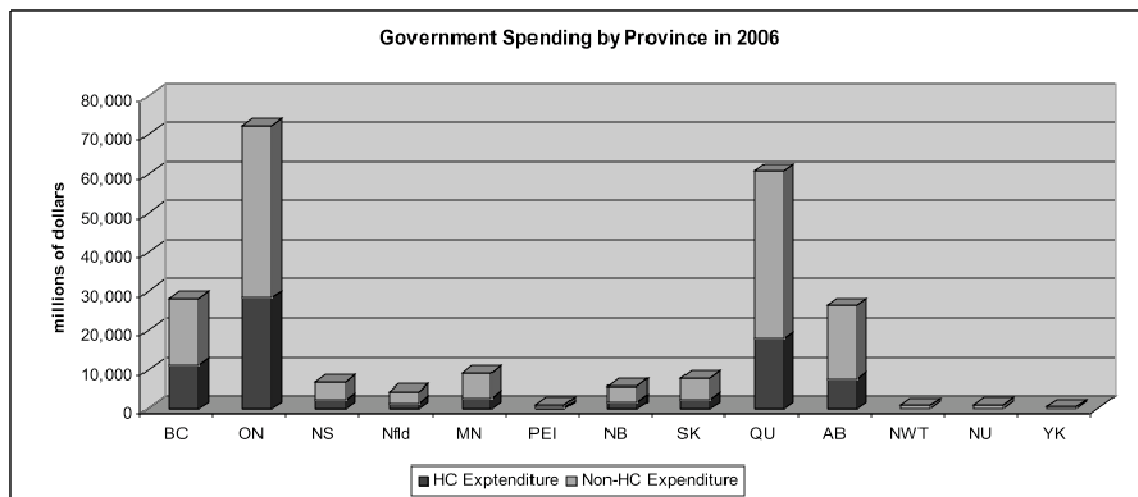
Approximately 70 per cent of total health care expenditures are covered by the ‘public purse’; funds that are generated through provincial and federal taxation. The other 30 per cent is considered ‘private’ funding and comes from employer-based insurance as well as personal funds paid directly by patients. Every province and territory sets its own budget that determines how much money is allocated to health care over other areas (education, roads, etc.) (Figure 2.1). While each province and territory can decide how to spend their revenues, most provincial budgets have been labeled ‘health care budgets’ (Simpson, 2008) due to their heavy focus on health care expenditures.

Health care is clearly a fundamental driver of our quality of life, but it's important to understand that other sectors of society also have a legitimate claim on the public purse. ((The Conference Board of Canada, 2001).

In most provinces, health care costs are rising faster than provincial revenues and than fiscal spending in other program areas (education, the environment).

A report published in 2000 estimated that public health expenditures would rise from 31 per cent in 2000 to 42 per cent in 2020 (The Conference Board of Canada, 2000). The 2008-2009 Ontario budget allocates 46 per cent of all spending (amounting to \$40.4 billion) to health care (Ontario Ministry of Finance, 2008).

Figure 2.1: Government Spending by Province in 2006



British Columbia has a unique regionalization approach, which utilizes both regional bodies and one province-wide authority: the Provincial Health Services Authority (PHSA). The PHSA is different from other meso-level authorities in that its mandate is province-wide and acts as an umbrella organization for eight provincial agencies (including cancer care, children's care, disease control, etc.) (Cranston & Powell, 2004). PHSA's primary role is to ensure that B.C. residents have access to a coordinated network of high-quality specialized health care services (Provincial Health Services Authority, 2008). This relatively new entity (created in 2002) has taken strides in priority setting efforts through adopting an explicit, transparent method (Mitton, MacKenzie, Cranston, & Teng, 2006). Using an adapted seven-step process (Mitton & Donaldson, 2004a), PHSA engaged in a transparent evidence-based priority setting activity.

Drug Priority Setting

The cost of drugs and technologies are escalating and demands for services are increasing, which is an international problem. Growing demand for health care services and the continual introduction of newer and more expensive drugs and technologies are threatening health system sustainability. In this environment, successful priority setting has become a necessity.

Ontario's Bill 102, the Transparent Drug System for Patients Act (2006), "aims to achieve savings in the Ontario Drug Benefit (ODB) program, which costs \$3.4 billion a year, by allowing more inter-changeability of generic drugs for brand-name drugs. It will make the system 'more efficient, more transparent, more accountable, more understandable,'" (Silversides, 2006). The ODB program provides drugs to senior citizens and social assistance recipients at no direct cost, other than a small co-payment. A recent commentary on the Bill spoke to the increased transparency of the ODB process since the introduction of the bill, stating that the public is now more aware of the pricing of generic drugs and the issuing of rebates to pharmacies worth up to 60% of a drug's price (Dhalla & Laupacis, 2008).

In an effort to standardize, inform, and improve drug reimbursement decisions, federal, provincial (with the exception of Quebec) and territorial governments created the Common Drug Review (CDR). CDR, in partnership with the Canadian Agency for Drugs and Technologies in Health (CADTH), critically assesses comparative clinical- and cost-effectiveness information of drugs. "The ultimate objective is to inform formulary listing decisions that both maximize health outcomes and achieve good 'value for money'" ((McMahon, Morgan, & Mitton, 2006)), p.200). The process was devised in consultation with the participating drug plans and the pharmaceutical industry, which submits drugs to the Canadian Expert Drug Advisory Committee (CEDAC). CEDAC considers three criteria for each new drug: 1) clinical studies (safety and/or efficacy and

effectiveness); 2) therapeutic advantages and disadvantages; and 3) cost-effectiveness. In a news release on a recent report by the Standing Committee on Health (Prescription Drugs - Part I The Common Drug Review: An F/P/T Process), CDR is described as:

...the single Federal/Provincial/Territorial (F/P/T) process that is used to review both the clinical efficacy and cost-effectiveness of new drugs and new indications for old drugs. This review process, which takes place after Health Canada has approved a drug for sale, leads to a recommendation regarding formulary listing under participating publicly-funded drug insurance plans. Publicly-funded plans include the provincial and territorial drug insurance plans, except that of Quebec, as well as six federal drug insurance plans. Committee members agree that the CDR is a good F/P/T process but that further improvements are necessary (House of Commons, 2007).

Key recommendations from the report included: improving openness and transparency and developing a separate process for the review of drugs for rare diseases, and for innovative drugs (Standing Committee on Health, 2007).

In response to this report, Dhalla and Laupacis (2008) discussed the need for more information to be given to the public in terms of pharmaceutical decisions. They added that since no country has full transparency in pharmaceutical policy-making, Canada has the opportunity to be an international leader.

McMahon et al. (2006) described CDR and compared it to the National Institute for Health and Clinical Excellence (NICE) in the UK. The CDR and the NICE systems function similarly on many levels, but are shaped by their own specific governmental priorities; funding, constraints and local politics. Both processes recognized transparent drug selection and opportunity costs in their allocation as important. They recommended additional resources to expand both the number and type of drugs CDR reviews (for both new and old treatment options), as well as to increase public participation in the process. The authors emphasized the importance of using the best current evidence to ensure legitimacy in decision making and highlighted three critical issues for

pharmaceutical priority setting: 1) drug selection, 2) centralized vs. decentralized decision-making, and 3) local receptor capacity.

Internationally, several countries including Australia and the Netherlands, have directly addressed drug priority setting with specific approaches. In Australia, Gallego (2007) reported that decisions were based on safety and effectiveness, budgeting both impact and cost on a per patient per year basis, and on number of patients likely to receive treatment. They reported that information on effectiveness was hard to find because of the new and innovative nature of high-cost medicines.

In the Netherlands, de Bont et al. (2006) documented the decisions of a national body responsible for prioritization decisions surrounding the reimbursement system in the treatment of growth hormone (the National Registry of Growth Hormone Treatment (LRG)). This study raised important considerations as to who should be involved in priority setting decisions; disagreement with how LRG policies are implemented at the front line proved that physicians should be engaged in the process to ensure commitment from stakeholders (often labelled 'buy-in').

'Value for money' (or efficiency) is the predominant goal in pharmaceutical priority setting; however the most notable finding from the above studies describing pharmaceutical priority setting is that there is a need for increased transparency and stakeholder engagement. The drug review experience has taught us that both transparency and stakeholder engagement are important to priority setting, and should therefore be included as key elements of successful priority setting.

Wait List Management

The Western Canada Waiting List Project (WCWL) was initiated in 1998 as a joint effort of the Canadian federal government and the western provincial governments (Saskatchewan, Alberta, and British Columbia). The intention was to set standards and criteria for priority areas with

existing wait times (i.e., to create standardized criteria to decide how to set priorities (Coster, McMillan, Brant, McGurran, Noseworthy, & Primary Care Panel of the Western Canada Waiting List Project, 2007)). The WCWL set out to influence the structure and management of waiting lists by developing practical tools for prioritizing patients on scheduled waiting lists (Noseworthy, McGurran, Hadorn, & Steering Committee of the Western Canada Waiting List Project, 2003). A review advocated that key terms (severity, urgency, need, and priority) needed to be defined in order to attain standardization (Hadorn & The Steering Committee of the Western Canada Waiting List, 2000). However, as Martin and Singer (2003b) reported, their efforts were largely lost due to lack of buy-in from front-line health care professionals.

In Ontario in 2000, the Joint Policy and Planning Committee (JPPC) launched the Ontario Wait List Project (OWL). OWL built on the work of WCWL to develop and evaluate priority setting tools for wait list management in Ontario (McKeen & MacKenzie, 2004). The OWL was taken over by the Ontario Wait Time Strategy in 2004.

The Ontario Wait Time Strategy (OWTS) increased efforts to improve access and reduce wait times in five areas (guided by a meeting of the first ministers (Health Council of Canada, 2006)): cancer surgery, cardiac revascularization procedures (coronary angiography, percutaneous coronary intervention, and coronary artery bypass graft surgery), cataract surgery, total joint hip and knee replacements, as well as Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) scans (Ministry of Health and Long-Term Care, 2007). Bruni et al. (2007) described priority setting of OWTS and concluded that, just as with the WCWL, there was room for improvement in public engagement (through shared decision making, focused outreach, and a feedback/appeals mechanism).

Manitoba also created a wait list program using a centralized database for cataracts, designed to act as a guide for surgery allocation, with the final decision remaining in the hands of individual ophthalmologists (Bellan & Mathen, 2001). Despite transitional problems (increased paper work, initial back logs), the authors felt that by providing objective and reliable measurements, the program has been shown to increase equity by introducing a uniform set of criteria. This paper (similar to other studies) showed the importance of keeping stakeholders involved throughout the entire process (especially those directly affected). The Manitoba program allows for long-term tracking, which can facilitate improvement over time.

Internationally, New Zealand created a booking system for prioritizing access to elective services and to provide consistency and fairness in allocating patients to surgery (Gauld & Derrett, 2000; Newdick & Derrett, 2006). The system provided referral guidelines and criteria for determining urgency of treatment, but authors have suggested it required greater clarity around the notion of rights to health care in priority setting decisions. Norway has adopted a legal approach to reduce wait times: The Norwegian Patients' Rights Act. This Act guarantees the population equal access to necessary specialized care (Kapuriri, Norheim, & Martin, 2007). However, Kapiriri et al. found that despite guidelines in place, lobby groups and public pressure often override them.

Summary

At the macro level in Canada, priority setting has varied considerably in composition and process, and there is little national coordination or consistency. Individual provinces have the freedom to make their own macro-level priority setting decisions, but most provinces are spending a considerable portion of their total budget on health care which is not sustainable in the current climate of rising health care costs and demands. Macro-initiatives like CDR and WCWL, OWTS, or the Manitoba Wait List Program show that it is possible to have a common process and to share information (and possibly lessons) across a health system, however, more work needs to be

done to improve buy-in from stakeholders. In recent years there has been a strong push toward transparency in priority setting, as is evident through pharmaceutical decision making where both legal and organization efforts are underway to improve transparency. It has been suggested that increased information in decision making along with standardizing decision making processes will aid in this effort. While a more informed and explicit process can act to improve transparency, there is no guarantee that these alone will lead to a better process. Wait list initiatives set out to make priority setting decisions transparent and standardized have fallen short in gaining buy-in from important stakeholders. Deciding which principles to use in wait list decision making is an important step, but alone it is insufficient in achieving a successful priority setting process.

Meso-Level Priority Setting

Much of the priority setting in a health system occurs at the ‘meso’ level of policy making. Meso-allocations occur in health care institutions such as hospitals, regional health authorities (RHAs) or local health integration networks (LHINs), and provincial disease-specific agencies (e.g. Cancer Care Ontario). At the meso level in Canada, most provinces have shifted resource allocation responsibilities to regions (RHAs, LHINs etc.), and priority setting within each region is carried out by senior administrators in these health care organizations as well as in hospitals.

Hospital Priority Setting

Recognizing that priority setting is an inherently ethical issue, Singer and Mapa (1998) examined the ethical dimensions of priority setting for health care executives and described five criteria specifically relevant to hospitals: mission, quality, efficiency, need and process. These five criteria provided a conceptual base, or common language, to discuss situations and identify sources of disagreement. The authors suggested that these five criteria often lead to different

options for expenditure, and call for the creation of an interdisciplinary, empirically grounded theory to help health care executives make difficult decisions.

Deber et al. (1994) surveyed 564 Canadian hospitals examining technology acquisition and found that decisions made in this regard were often ad hoc, lacking in input from technical experts, nurses and patients, and involved little regional planning. Committees comprised primarily of administrators, made most of the decisions based on medical request, manufacturer presentations and budgetary concerns, and impact was not a consideration.

Reeleder et al. (2008) examined Ontario's accountability agreements between hospitals and the Ministry of Health and Long Term Care (MOH). They reported on the conflict between achieving both quality and efficiency, and suggested several improvements in the fairness of government strategies. These included: efforts to increase transparency in processes by enhancing disclosure of reasons and supporting evidence for accountability agreements; better mechanisms for broad stakeholder engagement; and improvements to deliberation time. They concluded that government has the chance to improve the accountability and priority setting fairness of its hospitals through new local integration structures (i.e. LHINS), and in doing so "inspire trust and confidence among stakeholders" ((Reeleder D, Goel V, Singer PA et al., 2008), p. 171).

Bell et al. (2004) described hospital priority setting in response to SARS (severe acute respiratory syndrome). Their study showed that priority setting decisions were made at all levels of the institution. The primary criteria for decision making was patient and staff safety, but these criteria were accessible only to those directly involved in the decision making; communication beyond the core group of decision makers was incomplete. The study highlighted gaps between decisions that were made at a high level and the implementation of decisions at the front line.

Internationally, Bochner et al. (1994) described a priority setting scheme devised by an Australian hospital drug committee to rank drugs for inclusion on the hospital formulary. The method was based on six principles, focusing on the need to obtain the ‘greatest benefit for the most patients served’. While cost considerations were part of the process, they were not allowed to dominate the final result. A score was created by ranking drug treatments against the six principles; the score consisted of a numerator (the quality score) and a denominator (the cost score). The authors claimed they created a more equitable approach to priority setting; however, the approach is still expert-driven and does not include all stakeholders. The paper did however discuss the important (and sometimes unacknowledged) connection between meso and micro decisions and stakeholders, highlighting the conflict practitioners face between their responsibility to individual patients and their responsibility to society at large.

Regional Priority Setting

In a recent commentary on regional priority setting, Peacock et al. (2006) stated that while economic approaches can help, it is also important to “take into account the practical and ethical challenges faced by health care professionals” (p. 482). They commented on six stages of priority setting using Program Budgeting and Marginal Analysis (PBMA -- described below). They provided two checklists for consideration during priority setting: a checklist for pragmatic considerations (such as establishing organizational objectives and ensuring implementation) and a checklist for ethical considerations (such as publicity and appeals). In the end, they concluded that the process should be seen as fair through transparency and accountability. They concluded by stating that the most important challenge in priority setting is incorporating organizational context and ethics into economic approaches to priority setting.

Menon et al. (2007) described priority setting practices within Alberta RHAs and found that the organizations needed improvement in the area of public engagement. The decision makers

studied used both technical (such as clinical practice guidelines) and non-technical factors (such as alignment with goals in priority setting decision making), and the process proceeded in four steps: (1) identification of health care needs, (2) allocation of resources, (3) communication of decisions to stakeholders, and (4) management of feedback from them.

Internationally, Ham (1993) found that UK District Health Authorities (DHAs) avoided excluding services, and were instead focusing on guidelines for patient benefit. The public were involved via surveys, meetings, and community health councils; however, absence of information to guide priority setting (particularly cost-effectiveness information) was a major problem. Hope et al. (1998) examined the Oxfordshire RHA's "priorities forum" which focused on three key areas: evidence of effectiveness, equity, and patient choice. Key issues unaddressed by this forum were: relative funding for each area of health care, consistency in spending for treatments with broadly similar effects, and involving the public.

Disease-Specific Priority Setting

At the meso-level, priority setting in disease-specific health care agencies has been described in regards to two publicly funded health agencies for cancer and cardiac care in Ontario (Martin, Pater, & Singer, 2001; Singer, Martin, Giacomini, & Purdy, 2000). From the analysis, six interrelated priority setting themes emerged, all in relation to new technologies: institutions in which decisions are made; people who make the decisions; factors that people consider; reasons for the decisions made; process for the decision making; and appeals mechanisms for challenging the decisions. Martin et al. (2001) showed that these priority setting decisions were based on clusters of relevant factors, or values, and that clusters varied with each decision. Individual factors shaping the decisions of both committees included benefit, evidence, harm, cost, cost effectiveness, and pattern of death.

Internationally, Foy et al. (1999) described collaborations between a specialist cancer hospital and 6 RHAs in the UK with respect to funding new cancer drugs. Funding decisions were based on evidence thresholds determined by information on effectiveness, and influenced by the value placed on some clinical outcomes, political pressures, and financial constraints.

Internationally, Gallego et al. (2007) described an Australian example of priority setting practices for high-cost medicines (HCM) that operates through a hospital sub-committee called the High Cost Drugs Sub-Committee (HCD-SC). The HSD-SC makes decisions for the allocation of resources to high cost medicines. Decisions were based on safety and effectiveness, budgeting impact and cost on a per patient per year basis, and on the number of patients likely to receive treatment. It was reported that efficacy information was difficult to find because of the new and innovative nature of the HCM. Benefit and need were also important considerations for priority setting decisions. While difficult moral decisions were unavoidable in this situation, the authors felt an emphasis on procedural justice to ensure legitimacy in decision making should be used. The authors concluded that the results of this study support the need for strategies to improve decision making.

Summary

Meso-level organizations carry out a substantial proportion of health care priority setting decisions. Traditionally, priority setting in these organizations has been conducted on an ad hoc or historical manner, often excluding key stakeholders. There is a definite shift toward more inclusive processes, and decision makers want guidance on how best to execute priority setting. Priority setting decisions are becoming more principled and explicit; decisions are made using pre-determined criteria (safety, effectiveness, and evidence thresholds) and processes (four-steps,

PBMA, sub-committees). However, despite various efforts of hospitals and other meso-level health care organizations in Canada and around the world, there remains a lack of a system-wide approach to improve priority setting, and there is no common framework for identifying ‘best practices’. Organizations determine appropriate priority setting practices on their own, but there is often substantial room for improvement within individual practices. In order to improve priority setting, we need to understand what the current practices are, and what the stakeholders who are directly involved with priority setting think is important to achieving priority setting success.

Micro-Level Priority Setting

At the micro level, clinicians do a substantial amount of priority setting in their offices and at the bedside in hospitals. These decisions are made independently, but are affected by decisions made at other levels. For example, a macro level decision not to fund a specific drug will affect how care is allocated and delivered at the bedside.

At the micro-level, there are two significant problems that remain unresolved.

The first problem has focused on the role that the physician plays in priority setting decisions. The two sides of this argument are: (1) that the doctor should do everything possible for the individual patients, and (2) that the needs of the patient should be weighed against competing claims of society as a whole (Daniels, 1994; Sabin, 1998). In their traditional ‘care-giver’ role, physicians feel a sense of unease in declining a patient’s request (Carlsen & Norheim, 2005). Moreover, “physicians at the point of care are uniquely situated to observe the impact of priority setting decisions on patients in the form of scarcity, or less than equitable care” (Hurst, Forde, Reiter-Theil, Slowther, Perrier, Pegoraro et al., 2007).

In Canada, Meslin, Lemieux-Charles and Wortley (1997) developed a Management Ethics Framework to assist clinician managers (CMs) in reaching ethically justifiable resolutions to micro-level priority setting problems. They asked CMs if they were involved in any of ten resource allocation decisions, and, if so, how often they were involved, and how difficult the decision was for them. The authors also identified ten strategies for dealing with ethical issues; from their participants they found that the most frequent strategy was consultation, and more than 50 per cent said that their organization avoided the issue itself, or avoided involving stakeholders. The resulting framework consisted of three parts: a philosophical foundation (moral point of view and guiding principles), a template for working through ethical problems (identify problems, propose solutions, and evaluate the process), and a strategy to increase the effectiveness of the health care team (identify barriers and address different values/expectations).

Berry et al. (2007) interviewed medical oncologists in Ontario to determine the impact that Cancer Care Ontario's (CCO) new drug funding program (NDFP) has had on their practice. They found that many oncologists did not accept the limits (priority setting decisions) when the limits denied access to a drug they felt would be beneficial to their patient, and that overcoming those limits had a significant impact on oncologists practice. They concluded that policy makers should seriously consider the impact of limit decisions on the physician; efforts are required to increase the level of engagement that oncologists' have in decisions on funding policy.

The second problem has focused on whether micro-level decision making should be driven by the idiosyncrasies of individual physicians, or according to pre-determined standards. Walton et al. (2007) found that the Urgency Rating Score (URS, a standardized tool developed in Ontario) was only minimally helpful to clinicians in priority setting regarding cardiac surgery. Decisions in cardiac surgery were based on a mix of clinical and non-clinical criteria (for example, social factors including family support and environment), but the non-clinical reasons were not publicly

accessible. They concluded that priority setting in surgical programs should be unbiased, which would require greater publicity of the reasons behind specific decisions, and the enhancement of decision making that is based on the collective and not the individual.

Martin et al. (2003) described allocation of critical care beds for neurosurgery and showed that both medical (e.g. need) and non-medical (e.g. family wishes) factors affect decisions to admit patients and that non-medical factors were not widely known.

Rocker et al. (2003) described priority setting in relation to seasonal bed closures in a critical care unit, and concluded that increased stakeholder involvement, better data to inform decisions, and increased publicity of rationales for priority setting decisions were required. In regard to critical care admissions, Mielke et al. (2003) found that physicians' lack of knowledge of hospital admissions policies, or understanding of hospital priorities, resulted in their consideration of an ad hoc amalgam of medical and non-medical factors when making unit admission decisions, and Cooper et al (2005) concluded that formal guidelines for communication should be adopted to avoid 'parallel track' decision making (or, two separate routes for decisions to be made).

Summary

Studies of micro-level priority setting have shown that physicians have a key role in allocation decisions and are not always comfortable with that role. As a result, bedside rationing is often based on an ad hoc combination of medical and non-medical considerations, often lacks transparency, and is disconnected from meso-level priority setting (e.g. hospital policies). Efforts geared towards helping front-line decision makers have yielded little buy-in from stakeholders and have not led to improvements in allocation decisions. Numerous case studies of micro-level priority setting show that the lack of coordination and consistency felt at the macro and meso levels is also present in the micro level; decisions are based on a variety of inter-connected

reasons/factors, but guidance is lacking for these tough decisions. Micro-level decision makers lack the guidance and common language that could be beneficial in improving priority setting.

International Experience with Priority Setting

Every country struggles to make decisions about the allocation of resources; priority setting is pervasive in health care and is on the agendas of governments world-wide (Ham & McIver, 2000; Ham & Robert, 2003b). Although there has been much talk of macro priority setting strategies in Sweden, Norway, Netherlands, New Zealand and the U.K (Ham & Robert, 2003b), priority setting occurs at all levels of health care, and each level affects the others.

Early priority setting efforts focused on the idea that it is possible to devise a rational priority setting system to produce legitimate decisions and assumed that using the ‘right’ system would yield the ‘right’ results (Holm, 1998). Ham and Robert (2003b) brought together experts in the field of priority setting to summarize and analyze priority setting experiences in five countries: Norway, the Netherlands, New Zealand, Canada, and the United Kingdom. They found that the majority of countries used some sort of principles, a more explicit approach, to make priority setting decisions (Ham & Robert, 2003a).

Norway was the first country to attempt the principlist/values-based approach, which uses the severity of disease as its guiding principle of (Norheim, 2000). The Netherlands established four principles for priority setting: necessity, effectiveness, efficiency, and individual responsibility, to determine which non-essential services should be excluded from the national health services package (Berg M & van der Grinten, 2003). New Zealand used principles of effectiveness, efficiency, equity, and acceptability, in making decisions on health funding and purchasing.

The Experience of Norway

Norway was the first western country to develop national guidelines for priority setting in health care, beginning with the Lønning I commission's report, published in 1987. The report's driving characteristic was its concern for the worst off (the most severely ill). The commission identified five separate levels of priorities based on the guiding principle of severity of disease, and developed waiting list guarantees based on definitions of priority (emergency care for life-threatening diseases, treatment which prevents catastrophic or very serious long-term consequences (e.g. cancer), treatment which prevents less serious long-term consequences (e.g. hypertension), treatment with some beneficial effects (e.g. common cold) and treatment with no documented effects (Norheim, 2003). In 1996, the Lønning II commission revised the national guidelines of 1987 with the goal to involve clinicians' day-to-day experience with limit-setting decisions and to improve interaction between the political and clinical levels. The result was the recommendation that priority setting decisions should be made from the ground up, with clinicians making rationing decisions in their own field within four predefined priority groups: core or fundamental services, supplementary services, low priority services, and services with no priority. This second commission focused on the process and called for increased transparency in decision making (Calltorp, 1999; Daniels & Sabin, 2002; Norheim, 2003).

Sweden placed human dignity as the highest value, followed by solidarity and then efficiency.

Denmark focused on equity, solidarity, security and autonomy to make health services priority setting decisions, and outlined no explicit methods for choosing between these goals, just the expectation that they would be balanced against one another (Sabik & Lie, 2008).

The Experience of New Zealand

In 1992 in New Zealand, the Core Services Committee was established to advise on which services should be funded under the national health care system. The Core Services Committee (CSC, now the National Health Committee, or NHC) used principles of effectiveness, efficiency, equity, and acceptability to make explicit recommendations. In making decisions on health funding and purchasing, New Zealand used a combination of a principles-based approach and PBMA. Starting with the existing (ad hoc) list of covered services, the CSC advised the Minister of Health on which services should be publicly funded by looking explicitly at unit cost and volume of treatment data and identified areas of improvement (a PBMA approach). Another key function of the CSC was to engage the public in the debate (Bloomfield, 2003). The NHC has made some major achievements, including agreement on prioritization principles, the creation of a booking system to replace wait lists, and the development of guidelines and clinical access criteria.

The Experience of Sweden

Sweden followed Norway in developing a national framework for priority setting through the Parliamentary Priorities Commission. This values-based framework placed human dignity as the highest value, followed by solidarity and then efficiency. Through this they defined five priority groups. This approach offered a way of thinking about priority setting that could assist in decision-making, but much of the substantive issues were left to the health authorities. They did not provide concrete recommendations for change (Ham & Coulter, 2000), nor did they include a role for the public (Sabik & Lie, 2008). In 2001, Sweden created a National Centre for Priority Setting in Health Care which acts as a countrywide resource with both national and international interfaces. They provide education, support, knowledge exchange and consultation services for the country's 20 county councils.

However, these countries soon discovered that priority setting principles were too abstract to be helpful in specific priority setting contexts. Subsequently, there was an increased recognition that priority setting should be considered an 'ethical' exercise (Goold, 1996; Singer & Mapa, 1998). In 2000, Martin and Singer (2000) suggested priority setting should enter a third phase, whereby allocation decisions should be based on sound techniques, relevant principles and fair processes.

Experiences from the USA (e.g. Oregon), the UK (e.g. NICE), and Israel showed a different approach to priority setting by attempting to define the services that should be included in a basket of services (a defining services approach). Services 'inside' the basket are funded by the health system, while services 'outside' of the basket are not covered.

Oregon used cost-effectiveness analysis (CEA) as the main tool for making recommendations, which was soon deemed unsuccessful and was abandoned in favour of public input and expert opinion (Bodenheimer, 1997). In the UK, the National Institute for Health and Clinical Excellence (NICE) is an independent organization responsible for providing national guidance on public health, health technologies and clinical practice. Israel also attempted to define practices

when they passed the National Health Insurance (NHI) law in 1995, ensuring the provision of a basic basket of services to citizens (Chinitz & Israeli, 1997; Chinitz, Shalev, Galai, & Israeli, 1998). While there was no explicit process to determine the basket, technology assessment is now being used to update the services covered, including a consideration for evidence based, epidemiological, and economic information (Shani, Siebzehner, Luxenberg, & Shemer, 2000).

The Experience of Oregon, USA

In the U.S. in the 1990s, the State of Oregon attempted to prioritize the health services covered by the state's Medicaid program (the publicly funded health program for people with low income). Oregon used cost-effectiveness analysis (CEA) as the main tool for making recommendations for expansions within Medicaid. The first results of the process led to the discrimination of disabled people. The final list of covered services was put into place in 1994 with 565 treatments covered and funded. CEA was deemed to have an ineffective system of priority setting on its own and was abandoned in favour of public input and expert opinion (Bodenheimer, 1997; Daniels & Sabin, 2002; Ham & Robert, 2003b). Currently in Oregon, there have been strides to make the health care system more transparent. For example, attempts have been made to make health care costs more "transparent, easily accessible and understandable to consumers" by comparing hospital cost data (average payments to Oregon hospitals) and quality data (risk-adjusted in-hospital death rates) (Oregon Government, 2007). Their website states: "By comparing information about hospitals with both cost and quality, consumers, providers, purchasers and the general public will be able to make more informed health care decisions".

The Experience of the U.K.

The UK's National Institute for Health and Clinical Excellence (NICE) is an independent organization responsible for providing national guidance on public health, health technologies and clinical practice. NICE makes priority setting recommendations in health technologies based on clinical evidence (how well the medicine or treatment works) and economic evidence (how well the medicine or treatment works in relation to how much it costs). NICE has been considered a significant priority setting initiative internationally (Ham & Coulter, 2000; Ham & Robert, 2003a). Although there has been a lack of adherence with NICE guidance (primarily due to cost) (Day, 2006; Mayor, 2006), a recently created 'Health care Commission' aims to ameliorate and improve this (Mayor, 2006). In a recent news report, Cole reported that the "House of Commons health select committee has called for a major shake-up in the way the National Institute for Health and Clinical Excellence (NICE) assesses new treatments" (Cole, 2008). The report says the current method of determining which drugs to fund has been considered unfair and time-consuming and stakeholders have questioned the quality of information on which the institute bases its decisions.

International experience with priority setting at the macro level in low and middle-income countries is an area of growing research, and there has been a recent increase of empirical studies describing priority setting in this context. For example, Mexico's recent health reforms have fuelled an intense analysis of the country's priority setting practices (Gonzalez-Pier E, 2006). In the Ashanti and Northern regions of Ghana, an evaluation of intra-regional resource allocation argued for more attention to equity within regions rather than between regions, and suggested several indices which were suggested to provide better mechanisms for assessing which districts require more resources (Asante AD, 2006).

The Experience of Mexico

The System of Social Protection in Health (SSPH) was created to improve financial influx into the health system. This was coupled with a health insurance component which gave rise to increased coverage for citizens who had previously had no access to health services. Three pillars provide the foundation for reform: ethical, technical, and political. Gonzalez-Pier et al. focused on Mexico's priority setting experiences during the reform (Gonzalez-Pier E, 2006). They argued that economic assessments as evidence for national health priority setting have two purposes: (1) to scan for missed opportunities of interventions that would provide good value for money but that are not currently included in the package and (2) to provide evidence to help counter political pressures. Standardized analytical approaches to decision making (e.g. CEA and burden of disease) along with other criteria (e.g. public expectation) were used to design three health intervention packages. They held that priority setting implies a trade-off between health system goals; therefore efforts should be made to ensure that societal goals are reflected. They concluded that building priority setting capacity in decision makers would be an important element of reform. (Frenk, Eduardo González-Pier, Octavio Gómez-Dantés, Miguel A Lezana, & Knaul., 2006).

Kapiriri et al. described priority setting in Uganda and found that Uganda has a significant component of public participation within priority setting:

Key stakeholders, including both technical and 'lay' participants, meet face to face to discuss the annual national priorities. In addition, Uganda also holds national health assemblies where the performance of the health sector is discussed with stakeholders, including members of the public ((Kapiriri, Norheim, & Martin, 2007), p. 92).

In a survey given to both national and district level decision makers, they found that personal experience, discussion with colleagues, and national policy and treatment guidelines were most influential when making decisions in health care and planning with the most often used sources of information being collegial discussions, doctor statements and text books (Kapiriri & Bondy, 2006). Further, they found that while Ugandan decision makers are committed to using evidence in priority setting, there is limited understanding of the available information (specifically, the burden of disease information) (Kapiriri, Norheim, & Heggenhougen, 2003).

The Experience of Tanzania

In Tanzania, a study on macro decision making of the essential health care intervention package found that a balanced scorecard approach is a possible method that could facilitate meaningful public involvement in priority setting (Makundi, Kapiriri, & Norheim, 2007). It can improve accountability through explicitness, transparency, and a commitment to scientific validity. They also found that many important decisions in priority setting (such as the assessment and interpretation of evidence) are so technical that direct participation from the public would not be feasible. The Tanzania Essential Health Interventions Project (TEHIP) is funded by the Canadian International Development Agency (CIDA) and executed by the International Development Research Centre (IDRC) and the Government of Tanzania's Ministry of Health. (Canadian International Development Agency, 2002) TEHIP has attempted to develop a priority setting approach premised on the idea that a person's health can be improved not only by spending more money, but also by spending money more wisely where the needs are greatest (The Economist, 2002a, 2002b). In two districts of Tanzania; Rufiji and Morogoro, health care professionals were trained to use scarce resources more effectively (overall package cost .80 cents per person per year) and thereby increase the well-being of the community. This led to a reduction in disease: infant deaths per 1,000 live births decreased from 100.1 to 46.6; and the death rate for children under the age of five went from 131.5 to 74.0 per 1,000 live births.

A uniquely international study by Kapiriri et al. (Kapiriri, Norheim, & Martin, 2007) compared Canadian, Norwegian and Ugandan priority setting at all three levels (macro, meso and micro). It was discovered that priority setting leadership was lacking in all three countries. Lessons were learned from each country: in Ontario they touted the JPPC (Joint Planning and Priorities Council) as an example of effective dispute resolution; the Norwegian Patients' Rights Act was

considered successful in enforcing financial sanctions for noncompliance with wait list legislation; and Ugandan participatory methods were commended in the creation of their Health Sector Strategic Plan. The authors argued for mechanisms to be built into the priority setting process to enhance communication within all levels and held that ‘health planners and practitioners at all levels desire systematic priority setting’ (p. 92).

Summary: Canadian and International Macro-, Meso-, Micro- Priority Setting

It has been argued that understanding the current decision making practices within health care organizations is an essential component to improving priority setting (Martin & Singer, 2003a; Mitton & Donaldson, 2004a). Efforts are underway globally to open ‘the black box’ of resource allocation, to improve priority setting, and to provide decision makers with adequate, up to date information. In Canada, Bill 102, the CDR, WCWL, and OWTS are examples of macro-level efforts. Internationally, the most important development may be NICE. This effort by the UK has resulted in a national and independent organization responsible for much of the country’s priority setting.

In Canada and internationally, each of the three levels of priority setting decisions affect the other, yet allocation decisions are often made in isolation of one another. Each level has its own challenges and lessons that provide insight into important elements in achieving successful priority setting can be drawn from each. All three levels lack coordination and consistency, and decision makers at every level want guidance in allocation decisions. Macro level transparency has been lacking in pharmaceutical priority setting, and wait list priority setting engagements and commitment from stakeholders (‘buy-in’) need improvement. These experiences show the importance of transparency and engagement in priority setting, but alone they are not enough, and more needs to be done to fully understand how to best operationalize them. Ad hoc processes at

the meso-level are being replaced with more formalized principlist approaches, but lack of buy-in from stakeholders has meant the processes have not produced successful results.

National and international descriptions of actual priority setting experiences are growing; more needs to be done to share lessons between countries. Lack of consistency and coordination are common at all three levels and traditional ad hoc priority setting will no longer suffice in the current environment of increased transparency and information. Moving forward, we know that we need to improve buy-in and engagement from stakeholders, and to improve transparency and the use of information. There is also a call for increased consistency (and even standardization) in order to provide an appropriate platform, or common ground, to work from. In order to move forward, we need not only to comprehend current practices, but also to have a clear understanding of what ‘best practices’ look like from the eyes of stakeholders.

The Problems in Priority Setting

One of the reasons why priority setting is so difficult is that there is reasonable disagreement about what the right decisions should be. According to Calabresi and Bobbit (1978), no matter how it is done, priority setting is a messy, conflict ridden, and ‘tragic’ social process.

Fundamentally, priority setting involves choices about values. However, values often conflict and people disagree about which values should dominate. For example, when should we allow an aggregation of modest benefits to a large number of people to outweigh more significant benefits to a few? And how much priority should be given to treatment of the sickest, most disabled patients? (Daniels, 1994).

This disagreement is normal, and is to be expected in a pluralistic democracy. Schattschneider may have had priority setting in mind when stating:

The involvement of the public in politics is a natural outgrowth of the kind of conflict that almost inevitably arises in a free society. The exploitation of this situation by responsible political leaders and organizations is the essence of democracy; the socialization of conflict is the essential democratic process” (Schattschneider, 1964) (p. 142).

In the absence of agreement about which values should ground priority setting decisions, there has been a shift in focus away from priorities and towards the process of priority setting (Daniels & Sabin, 2002; Goold, 1996; Martin & Singer, 2000). Ham (1993) argues, "Given that that there is no right answer in the priority setting debate, an important justification for the decisions that are made is that they have been arrived at as a result of due process” (p. 436).

Several discipline-specific approaches to priority setting have been suggested and are discussed below, however, there is no agreement on which is the best approach; there is no consensus on best practices.

Another problem is that leaders, who are responsible for priority setting, lack guidance for doing it well, and they are unaware of any priority setting tools available to them (Lomas, 1997; Mitton & Donaldson, 2002b). For example, Gibson et al. (Gibson, Martin, & Singer, 2004) found that “decision-makers seek pragmatic ways to set priorities fairly in strategic planning, but find limited guidance from the literature”. Mitton and Patten (Mitton & Patten, 2004) found decision makers were “frustrated with the lack of an explicit priority setting framework” and questioned “the credibility of resource allocation decision-making” (p. 1660).

Other studies have shown that decision makers want guidance in priority setting (Reeleder, Goel, Singer, & Martin, 2006). For example, Teng et al. (2007) found that decision makers desire “to adopt a formal approach to priority setting”. Decision makers in various health care contexts nationally and internationally have expressed dissatisfaction with the current priority setting

processes (Deber, Wiktorowicz, Leatt, & Champagne, 1995; Miller, 1997; Mitton & Donaldson, 2004b). In a study of hospital Chief Executives, Reeleder et al. (2005) reported that leaders themselves desired an explicit framework to guide priority setting and acknowledged leadership as a key area where improvement can make the most difference. An important conclusion of Reeleder's research was that leaders must monitor and evaluate decision making within their organization, but to do that well they need an evaluation tool.

Priority setting is an inevitable social process that currently has no universal standard for how decisions should be made. Further, leaders lack guidance in achieving successful priority setting. Scholars and decision makers have come to the realization that there is neither a principled, nor a technical solution to priority setting. Knowing what is meant by successful priority setting would provide guidance to leaders and would help them in designing their priority setting processes to achieve success.

2.2 Success in Priority Setting

In order to improve priority setting in health care institutions, such as hospitals and RHAs, it would be very helpful to know which institutions are currently successful in this area. However, the central problem in evaluating priority setting is that there exists no agreement about what achieving successful priority setting means. There is no accepted framework for evaluating decisions as right/wrong or good/bad. Decision makers want to know if their priority setting was successful (Canadian Priority Setting Research Network, 2005), but they cannot know until an appropriate measurement mechanism exists.

Ham (1993) suggested that we should focus on ensuring due process in priority setting. However, if we think of outcomes using satisfied stakeholders as an example, would there be wide-spread

agreement on the efficient use of resources and fair process? This is what this research is trying to do: determine a list of criteria (or elements) that can be agreed upon to define successful priority setting.

Other fields have tried to explicitly address the problem of success. However, these approaches are varied, and have no overarching definition. For example, in education, success has been measured using concepts such as creativity, fluency, originality, and elaboration (Burton, Horowitz, & Abeles, 1999). In business literature, books have detailed corporate success (Collins, 2001) and explained how to achieve success in this field (Mathur & Kenyon, 2001). Friesen and Johnson (1995) suggested defining success using “critical success factors”, or managerial factors, different for every organization and determined by decision makers. A key lesson here is that success must be defined within the context that it is being sought.

Studies on success from other fields show that an essential part of evaluating or measuring success is a firm understanding of what success means; that is, before we can evaluate success, we must first give it a definition. Currently there is no definition of successful priority setting. Discipline-specific approaches to priority setting can provide pieces to a definition, but do not provide a complete picture.

Discipline-specific Approaches

Various approaches to priority setting that are grounded in many disciplines have been suggested to aid in priority setting. Each approach presents an alternative idea of what a successful process should consider, and/or what a successful outcome would look like. While these approaches can be complementary, their underlying assumptions (i.e. underlying values) often conflict. By examining discipline-specific approaches, we can begin to understand portions of successful priority setting.

Some of the approaches discussed below have been previously discussed in this thesis, through the various descriptions of national and international priority setting. This section will attempt to more explicitly define and discuss approaches from evidence-based medicine, health economics, the law, political sciences, philosophy and interdisciplinary approaches. Each disciplinary approach provides a varied insight into how to define successful priority setting, and will be discussed in turn, along with its key assumptions and distinguishing characteristics.

Evidence-Based Medicine

**Evidence based medicine
focuses on the value of
*effectiveness***

Evidence-based medicine (EBM) is often used by health care professionals in priority setting. It is predominantly concerned with understanding the effectiveness of medical interventions; for example, random control trials are often thought of as the highest measurement of effectiveness.

Haynes et al (1996) defined EBM as “the conscientious and judicious use of current best medicine from clinical care research in the management of individual patients”. EBM helps to quantify, or categorize, benefits, harms and levels of evidence, so that providers and patients may choose an appropriately individualized treatment plan. It does not, however, balance effectiveness with other competing values, such as cost.

Sackett et al (1996) have warned against using EBM as a tool for cost cutting, even though EBM has significantly contributed to clinical guidelines, which have improved the effectiveness of care. Others share similar caution, stating that EBM gives clinical trials too much authority (Fienstein & Horwitz, 1997), uses a narrow definition of evidence (Cohen & Hersh, 2004), does

not include valuable information important to clinicians (Upshur, VanDenKerkhof, & Goel, 2001), and is not overly helpful in understanding the practice of clinical medicine (Upshur, 2005).

According to EBM, successful priority setting should maximize health and non-health benefits with available resources through trade-off costs and benefits decisions (Peacock, Ruta, Mitton et al., 2006). EBM does not, however, consider contextual factors and different values that play into, and are an essential part of, achieving successful priority setting.

Health Economics

Health economics focuses on the values of *efficiency*.

Health economics perspectives focus on ‘efficiency’. Health economics provides important information for priority setting decisions, such as the incremental cost-effectiveness of a new drug or treatment. An economic approach to priority setting looks at trade-offs based on the costs and benefits of health services or interventions to maximize health and non-health benefits (Peacock, Ruta, Mitton et al., 2006). Two methodologies that have come out of health economics are cost-effectiveness analysis (CEA) and program budgeting and marginal analysis (PBMA).

CEA is perhaps the most common form of economic analysis in priority setting. It involves estimating the number of dollars required to yield one unit of benefit, and compares that to the available alternatives. This requires converting all effects on both mortality and morbidity into one outcome measure (Quality Adjusted Life Year [QALY] or Disability Adjusted Life Year [DALY]). CEA is a practical tool for priority setting in many contexts, including hospitals (Mooney, 1987; Olsen, 1997). CEA involves the evaluation of two or more alternatives in which inputs are measured as economic costs, but at least some of the consequences are valued in non-

monetary terms. CEA is often applied from a the viewpoint of a societal, or national health care system, whereby the implied decision-maker is an agent for society with an objective to achieve the maximum possible health benefit with limited resources (Weinstein, 1990).

The Institute of Medicine Panel on Cost-Effectiveness argued that CEA should only be used as an aid to decision makers who must weigh the information in the context of other values (Russell, Gold, Siegel, Daniels, & Weinstein, 1996). Similarly, the U.S. Public Health Service Panel on Cost-Effectiveness stated: “other values of society, including considerations of distributive justice and fairness (e.g. giving priority at times to the sickest of individuals) require that CEA be viewed as an informer of decision making rather than as a decision maker per se” (Gold, Siegel, Russell, & Weinstein, 1996). Williams and Bryan draw on economic frameworks (Problem-Solving Model/Normative Economics/Interactive Model/Positive Economics) in an attempt to understand the use and applicability of cost effectiveness analysis in health policy decision making (Williams & Bryan, 2007). They highlight the accessibility and acceptability of data as two key barriers in the use of economic evaluations.

NICE, discussed above, has used CEA as a technique in deciding which drugs to fund. While this use of CEA has been debated (Cole, 2008; Dent & Sadler, 2002; Taylor, Drummond, Salkeld, & Sullivan, 2004), it has developed standards for the use of CEA in priority setting decision making.

WHO-CHOICE (discussed below) provides CEA information internationally to aid in priority setting decisions in developing countries. It has also released reports that detail steps to using CEA information (Hutubessy, Chisholm, Edejer, & WHOCHOICE, 2003; World Health Organization, 2003).

Program budgeting and marginal analysis (PBMA) is a “pragmatic, economic framework that identifies how resources are currently spent, before looking at potential changes in service provision, at the margin, to maximize benefit and minimize opportunity cost”(Mitton & Donaldson, 2002a). PBMA focuses on two fundamental economic principles; opportunity cost and marginal analysis, with a primary goal of maximizing the benefits and minimizing the opportunity costs of a given set of resources. PBMA attempts to answer five questions about resource use; the first three are in regards to program budgeting, and the last two are concerning marginal analysis:

- 1) What is the total amount of resources available?
- 2) How are these resources currently spent (and how does this pattern of spending fit with activity and objectives)?
- 3) What are the main candidates for more resources and what would be their effectiveness?
- 4) Would any services currently being funded be able to provide the same effectiveness with fewer resources; allowing some of the items from #3 to be implemented?
- 5) Are there services that should receive fewer resources, despite being effective, because an item in #3 provides more effectiveness per \$ spent?

Beyond focusing solely on questions of economic efficiency, PBMA claims to be useful in assessing how resource re-allocations influence both equity and efficiency (Ruta, Donaldson, & Gilray, 1996).

PBMA has been used to support ‘evidence-based’ decision making in primary care (Scott, Currie, & Donaldson, 1998), RHAs (Donaldson, 1995; Mitton & Donaldson, 2002a; Viney, Haas, & Mooney, 1995) and bedside rationing (Peacock, Ruta, Mitton et al., 2006) and is suggested for use in other program areas (for example, orthopaedics (Bate, Donaldson, & Ray, 2007)).

Studies evaluating the use of PBMA have shown that it can be an effective tool for aiding in priority setting decisions at the meso (Miller, 1997; Mitton & Patten, 2004) and micro level (Mitton, Donaldson, Shellian, & Pagenkopf, 2003). Mitton et al. (2005) described health care organizations' experiences with PBMA in Canada, UK, New Zealand, and Australia. The major challenges for PBMA are: the need to enhance evidence-based decision making; the importance of incentive structures to recognize and reward innovations and efficiencies; the need to involve physicians; the need to involve the public; and the importance of decision makers more explicitly incorporating values. In a study to determine the feasibility of applying PBMA in Canadian health regions, Mitton and Donaldson (Mitton & Donaldson, 2003) found that context is an integral part of PBMA application. A recent study holds that PBMA can be applied within health organizations at either micro-levels (i.e. within programmes of care) or higher (i.e. across broad service areas) (Mitton & Patten, 2004).

According to an economics approach, achieving successful priority setting would focus on efficiency as the key value in decision making. While it is important to consider value for money in achieving successful priority setting, using it as the only criterion is insufficient. Information efficiency is often easier to access and to understand, but this does not justify weighting it above other considerations.

Legal Approaches

Legal approaches focus on the *reasonableness* of allocation decisions within the framework of the law.

The law sets a minimum standard for the ethical practice of medicine. For example, the law holds that a physician's duty is to their patients, and physicians are expected to meet a reasonable standard of care. Similarly, hospitals or

regions must act in such a way that is considerate of the best interest of the community being served. McKneally et al. (1997) state: “it is understood in law that although there is no liability for making a decision that proves to be wrong, there may be liability for making a decision wrongly”.

In Ontario, accountability agreements are legally binding agreements between the Ministry of Health and Long-Term Care, the LHIN and the hospital for delivery of services within a set-budget (Reeleader D, Goel V, Singer PA et al., 2008). In Norway, The Norwegian Patients' Rights Act guarantees the population equal access to necessary specialized care (Kapuriri, Norheim, & Martin, 2007).

Martin and Singer (2000) identified three distinct legal issues that are relevant to priority setting. First, in Canada, the right to health care can be categorized as a social right, along with the right to education and freedom from discrimination. “Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth ” ((Romanow, 2002), p. xvi). The Canada Health Act (CHA) legislates medically necessary services as positive rights (an entitlement to have or receive something) and disallows discrimination in the delivery of hospital and physician care (Canada Health Act, 1985). Second, discrimination is prohibited by law through the Universal Declaration of Human Rights and various pieces of Provincial human rights legislation. These laws prohibit the denial of clinical services on the basis of factors unrelated to the patient’s clinical prognosis (e.g., age, sex, ethnicity, physical or mental disability, etc.). Third, there have been some resource allocation cases brought forward to the level of the courts, and their tendency is to favour the physician’s fiduciary responsibility to a patient. While the courts have remained relatively uninvolved in priority setting of health care services, a BC court ruled that a physicians’ responsibility to his/her patient should take precedence over his/her responsibility to Medicare

(Law Estate v. Simice (1994)). A Quebec court ruled in favour of individuals using their own resources to access the care they need (Chaoulli v Quebec ([2005] 1 S.C.R. 791).

Successful priority setting according to a legal approach would involve meeting minimum requirements as set by legislation within the jurisdiction that the priority setting is occurring. However, using solely legal approaches would not be helpful in achieving successful priority setting since it would only provide a minimum standard.

Political Science Approach

Political Science focuses on the political forces that interact to produce *negotiated* policy.

According to Klein, priority-setting is a political process that involves “pluralistic bargaining between different lobbies, modified by shifting political judgments made in the light of changing pressures”((Klein, 1993), p. 309).

Priority setting is a form of policy making; policies in health care ultimately affect front-line practices and priority setting decisions (Berry, Hubay, Soibelman et al., 2007).

Goddard et al. (2006) argued that the context of policy making and potential influences of normative theories of public policy making are relevant to understanding successful priority setting. He argues that doing so will provide greater benefit (for example: increased impact and understanding of decision making behaviour). They also held that there can be value in exploring and analyzing priority setting using political theory concepts.

Howlett and Ramesh (2003) described three widely used definitions of public policy:

1. Dye (1972) defined public policy most succinctly as ‘anything a government chooses to do or not to do’.
2. Jenkins (1978) defined public policy as ‘a set of interrelated decisions taken by a political actor or a group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve’. Jenkins moves beyond Dye by: a) stating public policy making is a process, not simply a choice, b) describing public policy as a set of decisions, c) acknowledging the government’s internal and external constraints on policy implementation, and d) introducing the idea of policy making as goal-oriented. This last idea provided a standard for the evaluation of public policy that included looking at the relevance of the goal, the congruence of goal and means, and the degree to which the means ultimately succeeds or fails to achieve the initial goal.
3. Anderson (1984) described a policy as ‘a purposive course of action followed by an actor or a set of actors dealing with a problem or matter of concern’.

These definitions agree on certain key aspects: public policies result from decisions made by governments, and decisions by governments to retain the status quo are just as much policy as are decisions to alter it (Howlett & Ramesh, 2003). They also all agree that stakeholders (or ‘actors’) are needed in order for decisions to be made.

Doern and Phidd (1983) describe a simple model of the stages of policy development: (i) identification of the problem (or ‘agenda setting’ as per Howlett and Ramesh 2003), (ii) shaping or defining the problem, (iii) searching for alternative ways to solve the problem, (iv) choosing the option (or the ‘decision making stage’), (v) implementation (involves both public officials and private citizens, therefore usually is the longest and most permanent state), and (vi) evaluation.

The ‘decision making stage’ is where resource allocation discussions are no longer theoretical, and a commitment to real resources is required. Brewer and DeLeon (1983) elaborate on the decision making stage of the public policy process describing it as “the choice among policy alternatives that have been generated and their likely effects on the problem estimated...it is the most overtly political stage in so far as the many potential solutions to a given problem must somehow be winnowed down and but one or a select few picked and readied for use” (Brewer & DeLeon, 1983).

In considering priority setting as a category within the policy making process, it is important to consider normative political theories that tell us how policy making (priority setting) ought to be done. These theories can also give insight into what is meant by successful priority setting.

For example, a rational approach dictates extensive evaluation of alternatives, and a maximization of utility in decision making. Rational choice theory describes human behaviour and laws of decision making; decisions determine behaviour and follow a set of general laws (optimizing certain opportunities over others, and individualism) (Coleman, 1990). Incrementalism emphasizes decision making through incremental, or small, steps/choices (Mintzberg, Raisinghani, & Theoret, 1976) and by exploring only some of the possible consequences of alternative actions. Incrementalism also holds that large changes occur as a combination of smaller decisions, or via ‘mixed scanning’ (combining a detailed (or rationalistic) examination of some sectors, with a truncated review of other sectors) (Etzioni, 1967). Either rationalistic or incremental, both agree on the importance of using available information in policy making processes.

‘Bounded rationality’ takes into account both knowledge and computational cognitive limitations of the decision maker (Lindblom, 1959) - - and holds that there are limits in formulating and

solving complex problems and in processing (receiving, storing, retrieving, transmitting) information (Simon, 1972). Instead of maximizing, decision makers use ‘satisficing’ - - attempting to achieve at least some minimum of utility.

Public choice holds that decision makers (politicians, bureaucrats, and voters) are guided by self-interest and rationality (Buchanan & Tollison, 1972) and political outcomes are a result of bargaining between governments (policy producers) and voters (policy consumers). In order to make an informed decision, all actors need to be at the table. This is emphasized in democratic political theories (Farrelly, 2004) and the ‘principle of participation’, where participation and equally weighted votes are necessary to achieving democratic legitimacy (Cohen, 1996).

According to a political science approach, achieving success in priority setting would focus heavily on process and aspects of each step within the process - - for example involving stakeholders who will be able to set the agenda and the scope of conflict correctly. For political science, successful priority setting would be defined by how the agenda and the scope were set. Together, these theories give insight into some of the historical influences on priority setting as a policy making process, and provide normative guidance to priority setting practices today. Information is a vital part of a policy process (and a priority setting process (Klein & Williams, 2000)), but we know that no matter how much information we have, we still need everyone at the table for the discussions. Policy making decisions, like priority setting decisions, are not easy, and we are left trying to achieve at least some minimum of utility.

Philosophical Approaches

Philosophical approaches focus on different conceptions of *justice*.

Different philosophical approaches to the problem of distributional justice cover a range of normative goals and guiding principles. These goals and principles help us to understand both the complexity of real-world priority

setting and shed light on the foundation on which value decisions are made. As discussed above, a core problem with priority setting is that it involves values which often conflict. Philosophical theories are explicitly value-oriented: they help us to understand potential underlying assumptions in decision making.

Philosophical theories (or approaches) to priority setting focus on meeting needs justly within resource constraints (Beauchamp & Childress, 1994). Disagreements occur because there is no consensus on what setting priorities ‘justly’ should mean. Different philosophical theories argue for different distributive principles for the allocation of health care resources. For example, utilitarian theories emphasize the greatest good for the greatest number (Mooney, 1987; Veatch, 2002), and egalitarian theories emphasize need and equality of opportunity (Daniels, 1985). Libertarian theories focus on individual choice and emphasize the process by which resource allocation decisions are made (Englehardt, 1996; Nozick, 1974).

Williams and Yeo documented a practical application of a philosophical approach and found that it was not helpful for decision making, but that it could be helpful for providing education to decision makers (Williams & Bryan, 2007; Williams, Yeo, & Hooper, 1996; Williams & Yeo, 2000). In their example, the Queens Region Board (P.E.I., Canada) RHA deemed ‘utility’ as the a priori guiding principles in decision making, with consideration also of community values. The decision making framework focused on producing as much good as possible with the resources available. Other principles such as access, self-reliance, and autonomy were incorporated into the

framework as constraints on utility. So, although this approach to priority setting was helpful in terms of education, very few practical changes occurred. The challenges brought about by implementing this type of principle based approach include a lack of agreement on guiding principles, lack of understanding or knowledge of community values, lack of key stakeholder buy-in, and lack of follow-up plans.

Different philosophical approaches emphasize different values and conclusions; there is no consensus about which one is right. Achieving successful priority setting using a philosophical approach would depend on which value or principle is invoked - - however, these approaches are most often too abstract to be applied in concrete decision making.

Interdisciplinary Approaches

Health Technology Assessment (HTA)

Traditionally, HTA is a combination of EBM and CEA, bolstered by attempts to incorporate ethics and other social values. HTA is a multidisciplinary field of health policy analysis that evaluates the properties and effects of health care technology. It studies the medical, social, ethical, and economic implications of development, diffusion, and use of health technology and provides information to support health care decisions at local, regional, national, and international levels. Battista and Hodge (Battista & Hodge, 1999) distinguish HTA from effectiveness and health outcomes research by four key features: (1) its focus is policy-making; (2) its content and processes are interdisciplinary; (3) it involves synthesizing existing data and, at times, generating new data; and (4) its findings are disseminated widely and dissemination strategies are tailored to target audiences. They have further suggested that HTA should be used within a framework of “responsible stewardship of resources,” (Battista & Hodge, 1996).

In Canada, decision makers have been encouraged to use HTA (Romanow, 2002). The Canadian Agency for Drugs and Technologies in Health (CADTH) is a primary source of HTA. As defined by CADTH, HTA is “an evaluation of the clinical effectiveness, cost-effectiveness, and broader impact of drugs, medical technologies, and health systems, both on patient health and the health care system. ... The findings from this process are then summarized in reports that translate scientific data into information that is relevant to decision making,” (Available at <http://www.cadth.ca/index.php/en/hta/faq>). According to CADTH, HTA provides “impartial, rigorous, evidence-based reviews of the clinical effectiveness, cost effectiveness, and broader impact of drugs, health technologies, and health systems.” CADTH has created many HTA reports for drugs, treatment regimes, diagnostic tools, and others. A typical report looks at patient group, regulatory status, current practice, evidence, cost, adverse effects, concurrent developments, implementation issues, and technology diffusion.

The Canadian Expert Drug Advisory Committee (CEDAC) of the CDR (Common Drug Review, discussed above) is housed within CADTH. As mentioned, CEDAC looks at three criteria for drug recommendations: 1) clinical studies, (safety and/or efficacy and effectiveness); 2) therapeutic advantages and disadvantages; and 3) cost-effectiveness. CDR has been criticized for being overly concerned with cost-effectiveness, however, the recent CDR report released by the Standing Committee on Health clarified that cost-effectiveness also included other costs to the health care system such as doctors’ visits and hospitalization (Standing Committee on Health, 2007). The report states:

The CDR process could be moved from one that has been technical, scientific and clinical to one that incorporates an analysis of competing human values within an ethical framework. However, it was also acknowledged that these human values and ethical considerations must be balanced with resource allocation challenges, pressures from the pharmaceutical industry to promote innovative medicines and the interests of patients.

In Ontario, the Ontario Health Technology Advisory Committee (OHTAC) acts as an arms length expert advisory committee to the Ontario health care system and the Ontario MOH to provide the best health technologies for Ontario. Similarly, Alberta has an arm's length HTA unit within the Alberta Heritage Foundation for Medical Research (AHFMR), and Quebec has AETMIS (L'Agence d'Évaluation Des Technologies et des Modes d'Intervention en Santé). In Saskatchewan, HTA was done primarily through The Health Services Utilization and Research Commission (HSURC), which ceased to exist in 2002. In summer 2002, the HSURC divided into two separate organizations; the Health Quality Council and the Saskatchewan Health Research Foundation (SHRF), the former of which does HTA for the province. In British Columbia, The British Columbia Office of Health Technology Assessment (BCOHTA) runs out of the University of British Columbia (Lehoux, Battista, & J.M., 2000).

Recently, Abelson et al. provided a thorough discussion of the role of the public in health technology assessment (HTA) decision-making (Abelson, Giacomini, Lehoux, & Gauvin, 2007). They provided a framework that maps the criteria of HTA onto opportunities for public involvement and looks at ways to combine the two. The framework distinguishes specific roles for the public and offers a selection of policy activities in which the public may engage.

According to HTA, successful priority setting would consider a variety of elements, most specifically a variety of information. HTA improves success by providing a substantive process built on information needs. However, HTA does not give emphasis to value considerations, individual needs, or specific context - - in other words, it is a generalized process that can help guide priority setting, but cannot guarantee that it is successful.

Interdisciplinary Approaches Specific to Developing Countries

Both WHO-CHOICE (World Health Organization CHOosing Interventions that are Cost Effective) and the Disease Control Priorities Project (DCPP) are interdisciplinary approaches to priority setting that combine evidence-based medicine (EBM) with cost-effectiveness analysis (CEA).

WHO-CHOICE started in 1998 with the development of standardized tools to develop regional databases on the costs, impact on population health and cost-effectiveness of key health interventions (see: <http://www.who.int/choice/en/>). It is intended to provide current, regularly updated information on the costs and effectiveness of a wide range of drugs and treatments. Since information is far-reaching, it allows for cross-comparison of data, which is helpful in making resource allocation decisions. It has been used by many countries in, for example, cataracts treatment (Baltussen, Sylla, & Mariotti, 2004), and psychiatry (Chisholm, 2005). Despite its intended usage as a supportive and functional tool, studies have shown that decision makers find the WHO-CHOICE approach to be too opaque, requiring unavailable expertise, and to be in conflict with local values (Kapiriri & Martin, 2006; Kapiriri & Norheim, 2004; Kapiriri, Norheim, & Heggenhougen, 2003).

The Disease Control Priorities Project

In the past decade, the Disease Control Priorities Project (DCPP) has become a source of important information for decision makers in developing countries in priority setting efforts. The DCPP continually assesses disease control priorities and produces evidence-based analysis and resource materials. DCPP has produced three technical resource publications to assist and inform health policymaking. The Disease Control Priorities in Developing Countries 2 (or DCP2) is an update of the original World Bank publication Disease Control Priorities in Developing Countries (or DCP1) (Jamison, Breman, Measham, Alleyne, Claeson, Evans et al., 2006b). DCP2 highlights cost-effective interventions, costs of disease burden, treatment, and prevention for a comprehensive range of diseases and conditions. From the DCPP website, the DCP2 is described as the following:

Combining insights from DCP2 and knowledge of their local situation, actors at many levels—from parliamentarians and health ministers to hospital administrators, health care workers, and concerned citizens—will be able to set priorities, select appropriate interventions, devise better means of delivery, improve management, and be more effective in mobilizing resources. In this manner, the benefits of technical progress in improving health can be extended and shared by all.

The DCPP's second major publication is a companion to DCP2, *Priorities in Health*. This summary and synthesis of DCP2 is meant to be a clearly worded reference guide for policy makers, and is available in seven languages (Jamison, Breman, Measham, Alleyne, Claeson, Evans et al., 2006a). Some of the information in the DCP2 draws on work from WHO-CHOICE (Chisholm & Evans, 2007). This significant and powerful publication cites statistics and stories from around the world, providing insight into global health concerns. The depth and breadth of this report speaks to the ever-growing need to set priorities for disease prevention.

... despite the high burden of disease in developing countries, success is possible and has been achieved even against great odds ...

Their third major publication was the *Global Burden of Disease and Risk Factors (GBD)*. The GBD focuses on health conditions in the 21st century and provides up-to-date data on the global burden of disease (Lopez, Mathers, Ezatti, Jamison, & Murray, 2006). This publication also describes the methodologies for cost-effectiveness calculations and conclusions presented in DCP2.

Problems with Disciplinary-Specific Approaches

Discipline specific approaches to priority setting have their own principles, processes, and goals

(Table 2.1). However, single criteria priority setting tools (e.g. cost-effectiveness, burden of

disease) are ineffective since priority setting processes involve many criteria and interventions (Baltussen & Niessen, 2006).

Table 2.1: Discipline-Specific Approaches and Their Goals	
Approach	Focus/Key Goals
Evidence-based Medicine	Effectiveness
Health Economics	Efficiency
Legal Approaches	Reasonableness
Political Sciences	Negotiation
Philosophical Approaches	Justice

The theories and approaches described above are relevant to priority setting because they help provide an understanding of underlying assumptions; on their own, however, they are insufficient. None of the approaches provide a comprehensive vision of successful priority setting, which is a multi-faceted (multi-element) concept.

There are two main problems with a discipline-specific approach. First, discipline specific theories are not often grounded in actual experiences of priority setting. Discipline specific theories often work outside of the process in a more abstract manner, disregarding many important components in decision making or providing only a narrow set of values in decision making (Martin, Pater, & Singer, 2001). By approaching priority setting decisions from an outside position, discipline specific theories ignore case-by-case differences vital in priority setting.

Second, there are few interconnections among the various discipline-specific theories (and even within each discipline – such as between different theories of justice). Since different theories

appeal to different values (efficiency, justice, etc.), it is difficult to argue that one is 'better'.

Discipline specific approaches are helpful in identifying the value components of decisions, or for educating decision makers, but insufficient in providing actual guidance for making concrete priority setting decisions.

Successful Priority Setting

Four studies have touched on the idea of improving priority setting by improving success factors (Table 2.2). However, these studies explored limited stakeholder groups and had a narrow focus.

First, through a series of workshops with board members and leadership at two RHAs and one hospital, Gibson et al. (2004) identified eight priority setting criteria (used to set clinical service priorities), ten key priority setting process elements and six parameters of success. From the perspective of these stakeholders, priority setting could be successful if it considered three outcome parameters (effect on organizational priorities and budgets, effect on staff, and effect on community), and three process parameters (efficiency of priority setting process, fairness, conformity with conditions of accountability for reasonableness (discussed below)).

Second, Teng et al. (2007) surveyed key decision makers at the 'macro-level' (the executive team in a provincial regional health authority) and identified factors important to understanding organizational context in priority setting. They found that an increase in the transparency of the priority setting process is needed in order to improve the decisions that are made. They also discussed the need for a culture supporting explicit priority setting, and a focus on fairness in priority setting. Participants in their study felt that strategic planning and a strong research base were organizational strengths, despite their ad hoc manner of setting priorities. A lack of formal training in priority setting and the challenge of providing specialized services for disparate groups were seen as two barriers to explicit priority setting. Participants from their study agreed that

goals, outcomes and benchmarks for success should be defined. They also agreed that key factors for success are a shared vision in priority setting, an explicit process for priority setting, and increased quality of information (demonstrated results and a data-driven culture).

Third, Mitton and Donaldson (2002a) completed a survey of senior executives and medical directors (priority setting decision makers) and found that while data drove the priority setting, decision making is done mainly in a historical matter. They felt that systematic evaluations are necessary to improve priority setting. They reported decision makers have a “desire for pragmatic assessment of benefit”; however Mitton and Donaldson also found that decision-makers were unaware of the priority setting tools available to them. They added that politics have a central, and at times superior, role in priority setting decisions, considered to be more important than ‘hard’ evidence. Decision makers in this survey desired more dialogue with the public and felt that PBMA would be a useful tool to aid in priority setting. In order to improve the success of priority setting, they suggested: (1) establish an actual (more systematic) process for developing priorities, (2) increase the communication between stakeholders, and (3) increase the quality of information/data used in priority setting.

Fourth, Mitton and Patten (2004) surveyed senior decision makers in Calgary health region before and after the decision making/priority setting tool ‘program budgeting marginal analysis’ (PBMA) was implemented. Their study showed that decision makers need important and clear information management beyond ‘higher-level’ information (such as randomized control trials). Decision makers also pointed to the need for greater dialogue in priority setting which can lead to an increased understanding in the overall priority setting process. Mitton and Patten focused on information in multiple forms, including better information on ‘capacity to benefit’, which was identified as being highly desired by decision makers. Along with the need for better information, their attempt to apply a novel framework for priority setting led to other factors to improve the

success of priority setting: (1) provide opportunities for re-allocation and re-investment, (2) the process needs to become part of routine planning, and (3) stakeholder (in this case, physician) involvement.

Table 2.2: Summary of Studies

Study	Success Factors
1 Gibson, J.L., Martin, D.K., & Singer, P.A. (2004). Setting priorities in health care organizations: criteria, processes, and parameters of success. BMC Health Serv Res, 4(1), 25.	<u>Outcome Parameters</u> - effect on organizational priorities and budgets - effect on staff - effect on community <u>Process Parameters</u> - efficiency of priority setting process - fairness - conformity with conditions of accountability for reasonableness
2 Teng, F., Mitton, C., & Mackenzie, J. (2007). Priority setting in the provincial health services authority: survey of key decision makers. BMC Health Serv Res, 7, 84.	- stakeholder engagement → shared vision in priority setting - an explicit process (like PBMA) - increased quality of information → priority setting culture
3 Mitton, C., & Donaldson, C. (2002). Setting priorities in Canadian regional health authorities: a survey of key decision makers. Health Policy, 60, 39-58.	(1) establish an actual (more systematic) process for developing priorities (2) increase communication between stakeholders, (3) increase quality of information/data used in priority setting.
4 Mitton, C., & Patten, S. (2004). Evidence-based priority-setting: what do the decision-makers think? J Health Serv Res Policy, 9(3), 146-152.	- better information through multiple forms - provide opportunities for re-allocation and re-investment - process needs to become part of routine planning - greater dialogue/stakeholder involvement.

Summary: Success in Priority Setting

Successful priority setting is a desirable goal for decision makers. However there is no agreed upon definition for successful priority setting, so there is no way of knowing if a particular set of priority setting decisions were successful. Priority setting is extremely complex - - choosing between competing values makes priority setting a fundamentally ethical issue (Singer & Mapa,

1998). Different disciplines offer their own perspective to how priority setting ‘ought’ to be done, defining ‘good’ (or successful) priority setting through values such as efficiency, equity, or justice. These normative approaches are necessary because they help identify important values and considerations for priority setting. However, alone they are insufficient and provide only a piece of a definition of successful priority setting. Decision makers/leaders can use these perspectives to guide priority setting efforts, but there is no guarantee that this will lead to achieving success in priority setting. There is a significant lack of guidance in discipline specific approaches; they outline which values to include, but they do not provide an indication of who should be involved and what a process should look like. Involving different stakeholders will bring these various values to the table, and while this is important and necessary, it further complicates priority setting decision making. The remaining problem is that there is no way to be certain which values are better, or which might lead to more successful priority setting. Values inherently conflict; we need to look beyond disciplinary (value-laden) approaches toward a more comprehensive approach and develop a common ground on which to evaluate the achievement of success.

Empirical studies are also important because they identify current priority setting practices. The studies mentioned above provide insight into defining successful priority setting. The problem with these studies is that they have a narrow focus (small range of stakeholders) and none of them have provided a practical solution to achieving successful priority setting. While we are more cognizant of important factors in successful priority setting, we still do not have a complete picture of it.

The literature has so far shown that while many authors and disciplines provide insight into defining successful priority setting, the definition remains fragmented. There is a need to define successful priority setting, to provide a common language, and to come to some agreement on a

conceptual basis for the concept. Normative approaches tell us what *ought* to be done, empirical studies tell us what *is being* done, yet there remains a lack of consensus on an appropriate approach to successful priority setting. This is because defining successful priority setting is a challenge and no framework exists to characterize it. In the midst of this lack of consensus, one ethical framework has surfaced as an important guide to achieving legitimate and fair priority setting. ‘Accountability for reasonableness’ (A4R), which focuses on the goals of legitimacy and fairness (Daniels & Sabin, 1997) is important to acknowledge because of its current international use and acceptance as a valid priority setting framework.

2.3 The Goals of Legitimacy and Fairness

Daniels (2005) and others (e.g. Ham (1993)) have argued that since we cannot agree on the correct approach to priority setting, and we cannot determine best priority setting outcomes, an appropriate approach to priority setting should focus on legitimacy and fairness. This next section describes the goals of legitimacy and fairness and the ethical framework developed to achieve them: ‘accountability for reasonableness’ (A4R). This is important for my thesis research because A4R has provided a preliminary foundation for building knowledge in one of the three empirical studies that I conducted.

What Is Legitimacy? What Is Fairness?

Legitimacy and fairness are inter-related moral concerns that can act as priority setting goals when other goals cannot be agreed upon. Scholars and decision makers have turned to legitimacy and fairness as surrogate goals for success particularly because there has been no comprehensive definition of successful priority setting; legitimacy and fairness are not substitutes for success, but they are considered to be the best goals available to date.

Legitimacy refers to the moral authority of institutional actors to make priority setting decisions. Legitimate decision makers may act fairly or unfairly (Daniels & Sabin, 2002; Rawls, 1999), but legitimacy can be achieved through a fair process (Daniels & Sabin, 2002; Rawls, 1999; Singer, Martin, Giacomini et al., 2000). Some have categorized legitimacy as two parallel processes, and a good priority setting process should appeal to both. First, a process should consider the internal concept (establishing confidence for the priorities within the health care delivery system itself). Second, a process should consider the external concept (assuring public confidence for health care priorities) (Garpenby, 2003).

Fairness refers to the moral acceptability of the priority setting process. That is, fair priority setting decisions are made through a process that is, and is perceived to be, morally acceptable, irrespective of outcome (Martin, 2007).

‘Accountability for Reasonableness’

Daniels and Sabin have created a framework that links fairness and legitimacy in priority setting called 'accountability for reasonableness' (A4R) (Daniels, 2000a; Daniels & Sabin, 1997, 1998).

A4R is a conceptual framework that can be used to improve the legitimacy and fairness of priority setting processes in health care organizations (Daniels, 2000b). It is theoretically grounded in justice theories emphasizing democratic deliberation (Daniels & Sabin, 1997, 1998; Rawls, 1999). A4R is relevant to real-world priority setting processes (Daniels & Sabin, 1997) -- it was developed in the context of U.S. Health Maintenance Organizations and has been proven useful in other health care contexts, such as in hospitals.

A4R has been used nationally and internationally at all levels of the health system to evaluate the legitimacy and fairness of priority setting. It has traction among decision makers and is a preferred framework of priority setting researchers in Canada and internationally (Coster, McMillan, Brant et al., 2007; Gibson, Martin, & Singer, 2005b; Gibson, Martin, & Singer, 2004; Ham & McIver, 2000; Madden, Martin, Downey, & Singer, 2005; Martin, Hollenberg, MacRae, Madden, & Singer, 2003; Mielke, Martin, & Singer, 2003; Peacock, Ruta, Mitton et al., 2006; Walton, Martin, Peter et al., 2007). It can serve as a useful guide to develop and evaluate the legitimacy and fairness of priority setting processes.

A4R is an ethical decision-making framework that outlines four conditions of a legitimate and fair allocation process (Daniels & Sabin, 2002) (Table 2.3).

Table 2.3: The four conditions of ‘accountability for reasonableness’	
Relevance	Rationales for limit-setting decisions must rest on reasons (information and values) that fair-minded parties (managers, clinicians, patients, and affected others) can agree are relevant to meeting health care needs under resource constraints in the priority setting context.
Publicity	Limit-setting decisions and their rationales must be publicly accessible.
Revision	There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.
Enforcement	There is either voluntary or public regulation of the process to ensure that the first three conditions are met.

According to Daniels, ‘accountability for reasonableness’ provides a common language for discussing priority setting and so facilitates “improving [the public’s] grasp of the need for limits and the appropriate grounds and conditions for making decisions about them . . . The value of the Relevance and Publicity conditions is the ‘case law’ they establish regarding limit setting over time. A transparent and responsive process of revision and appeal similarly contributes to a grasp of the kinds of reasons that appropriately shape policy decisions” (Daniels & Sabin, 2002).

Since the creation of A4R, several studies have suggested changes, additions, or have combined A4R with new knowledge to advance new concepts for priority setting.

Combining information about how data is gathered with the concepts of A4R, Singer et al (Singer, Martin, Giacomini et al., 2000) proposed a ‘diamond model’ for priority setting comprising six elements: institutions, people, factors, reasons, process and appeals. They provided a model for priority setting in new technologies specific to cancer and cardiac care.

In another study, Gibson et al. (2005a) suggested adding empowerment as a fifth condition to the framework. The empowerment condition requires that steps should be taken to optimize effective

stakeholder participation and minimize the impact of power differences in the decision-making context. Gibson et al. highlighted that the four conditions of A4R were never meant to be exclusive and exhaustive; as such there is room for more conditions which provide guidance in achieving legitimate and fair priority setting.

Since Daniels and Sabin developed A4R in the context of US private managed care organizations, their fourth condition focused on public or voluntary regulation – that being the most obvious means of enforcement. However, Reeleder et al (Reeleder, Goel, Singer et al., 2006) conducted their research in a health system that was publicly funded and administered, and suggested that the term leadership more accurately portrays the task of enforcement, since leadership is an enabler of the other three conditions of A4R.

Empirical Experience with Accountability for Reasonableness

Priority setting has been described and evaluated using A4R as a conceptual framework to guide the research. These studies have shown that A4R can provide helpful guidance for priority setting leaders. Most of this research has been done in Canada, through the Canadian Priority Setting Research Network.

Martin et al. (2003) described and evaluated hospital strategic planning in the context of operational planning using A4R and found that the organization partially met all four conditions of A4R. In order to improve future priority setting iterations, they developed eight key recommendations for improvement, including allowing participants more time to process information, developing a coherent and comprehensive communication strategy, and developing an appeals (or revision) mechanism.

According to Martin et al. (2002) decision makers from the Cancer Care Ontario Policy Advisory Committee for the New Drug Funding Program and the Cardiac Care Network of Ontario Expert Panel on Intracoronary Stents and Abciximab felt there were two primary elements to fairness in priority setting: a fair process and recognition that fairness is relative (i.e., not all-or-nothing). They identified 11 elements of fair priority setting, which the authors related to the four conditions of 'accountability for reasonableness'.

Madden et al. (2005) described priority setting in the context of hospital clinical activities target setting with a focus on the appeals process. They determined that an appeals process improved priority setting by enhancing the quality of information used and, ultimately, the participants' perception of hospital fairness.

Gibson et al. (2006) described and evaluated priority setting in the Calgary health region and in doing so, evaluated the fairness of subscribing to PBMA. They held that PBMA is useful and can increase the fairness of priority setting and suggested four recommendations to improve the fairness of priority setting: 1) align the strategic direction of the organization with priority setting and engage a variety of stakeholders in this process; 2) outline obvious factors in priority setting to increase transparency; 3) allow time for the review of decisions and deliberation; and 4) have strong executive leadership to ensure conformity to a fair process. They added that there is potential to combine PBMA and A4R to provide stakeholders with a comprehensive approach using a fair process aimed at achieving optimal benefit with available resources.

Using A4R Mitton et al. (2006) empirically described and evaluated the fairness of centralized drug review processes in four countries (Canada, UK, Australia, New Zealand) and found that each country needed to improve the fairness of their processes and that stakeholder engagement should be a part of this. Participants felt that transparency was critical to the overall legitimacy

and fairness of priority setting. Mitton et al. concluded that it is essential that limit-setting decisions are publicized, proper mechanisms are established to ensure fair processes and formal mechanisms for appeals and revisions are upheld.

Reeleder et al. (2005) studied reports by the CEOs of Ontario hospitals on the fairness of priority setting within their own institutions. The study survey had CEOs (or their designates) evaluate their current priority setting activities against A4R. Overall, the relevance condition was met the best (75%) with the most room for improvement in the enforcement (or leadership) condition. Their most prominent finding was that improvements to the area of leadership would result in more of an impact than improvements to other areas.

Describe-Evaluate-Improve

A4R has been used by researchers as an evaluation framework to describe, evaluate and improve priority setting in real-world settings. This approach aids in capturing and sharing lessons for improving priority setting all over the world. Improving, in this sense, refers to making priority setting more legitimate and fair. This approach allows for collaborative work between stakeholders (scholars and policy makers) to gather and share systematic evidence as a basis for improving priority setting in various health care contexts (ministry of health, RHAs, hospitals, clinical programs, etc.).

This approach has been explained by Martin and Singer (2003a) as a constructive, practical, and accessible improvement strategy that is both research-based and normatively and empirically grounded. The research strategy involves combining case study research to describe priority setting, interdisciplinary research to evaluate the description using A4R, and action research to improve priority setting.

Martin (2007) highlighted the benefits of this approach stating that it 1) operationalizes the vague notion of evidence-based policy making; 2) opens the ‘black box’ of priority setting in a health system and reveals how decisions are made; and 3) creates an environment in which difficult priority setting decisions can be accepted by the public.

Summary: Legitimacy & Fairness

Since there is no agreement on the *right* priority setting outcomes, researchers in priority setting have instead focused on the process. Legitimacy and fairness are two desirable goals of a priority setting process. The ethical framework A4R can be used by decision makers and leaders in their organizations and it can also be used post-facto as an evaluation tool. Studies have shown the usefulness of A4R and there have been suggestions that A4R can be used as part of a strategy to improve priority setting efforts. A4R’s philosophical (and normative) grounding coupled with its empirical application make it an important contribution to current understanding of priority setting. What is more, the four conditions of A4R (along with legitimacy and fairness) are possible candidates for defining successful priority setting. It was for this reason that A4R was a starting point and theoretical grounding for one of the three empirical studies used in this thesis.

2.4 Tools for Evaluating Success

The primary objective of this thesis is to determine an appropriate definition of success, and once this task is complete the second objective will be addressed: how we can effectively evaluate the idea. In 2003, Martin and Singer argued that Canada would benefit from an emphasis on organizational development in relation to priority setting. In addition, they argued that it would be beneficial to develop a common evaluation tool against which experiences could be assessed, (Martin & Singer, 2003a). Currently, there is no tool to evaluate the success of priority setting; however, we can look to other fields to see how success has been evaluated and/or measured to gain insight into appropriate methods. The common theme in these studies was, that in order to evaluate success, it was first defined within the context.

Lockee et al. (2002) measured the success of distance education using both summative and formative evaluations, assessing curriculum design, professional impact, and increased enrolment. They suggested a method to determine the success of a distance education program that was based on the program's own stakeholders performing its evaluation. They concluded that in order to evaluate the success of distance education, 'success' needed to be defined.

In measuring the success of business start-ups, Reid and Smith (Reid & Smith, 2000) suggested quantitative statistical evaluations of employment growth, return on capital employed, and labour productivity.

The success of software development has been measured using alignment with business strategy, stakeholder buy-in, management and infrastructure support, and learning from stakeholder feedback (Zahran, 1998). Continuous Improvement and Total Quality Management have been used to evaluate and measure success in business (Lynch & Cross, 1995). Organizations exist

solely for the purpose of measuring the success and performance of organizations (for example, KPMG Enterprise is a global network of professional firms providing Audit, Tax, and Advisory services, operating in 145 countries and with more than 123,000 employees).

Business evaluation techniques have been applied to health care in the United States (Gish, 2002), and in Canada. For example, the balanced scorecard, which was first used in the business sector, has been used as a measure of performance and strategic management in health care environments (Kaplan & Norton, 1992). A balanced scorecard is a strategic management and measurement system that:

...translates an organization's mission and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system. The balanced scorecard retains an emphasis on achieving financial objectives but also includes the performance drivers of these financial objectives. The scorecard measures organizational performance across four balanced perspectives: financial, customers, internal business process, and learning and growth (Kaplan & Norton, 1996).

Balanced scorecards have been used in Canadian hospitals (Chow, Ganulin, Haddad, & Williamson, 1998; Pink, McKillop, Schraa, Preyra, Montgomery, & Baker, 2001). Zelman et al. (2003) concluded that the balanced scorecard: (1) is relevant to health care, but modification to reflect industry and organizational realities is necessary; (2) is used by a wide range of health care organizations; (3) has been extended to applications beyond that of strategic management; (4) has been modified to include perspectives, such as quality of care, outcomes, and access; (5) increases the need for valid, comprehensive, and timely information; and (6) has been used by two large-scale efforts across many health care organizations in a health care sector (hospital report and critical access in rural USA).

Indicators that are specific to health care have been used to determine the success of hospitals, regions, and both provincial and federal governments. Most of these indicators revolve around

health outcomes. For example, using self-reporting measures, patient outcomes (such as longer and healthier lives) have been used as an indicator of success of hospitals (Kind & Williams, 2004). Economic indicators are also often used in determining the success of new technologies (Phelps & Parente, 1990). Cockerill et al. (2006) developed a tool to measure the effectiveness of care networks specific to dementia patients. Their instrument used indicators such as physician knowledge, as well as quality and quantity of care to evaluate the experiences of both caregivers and care recipients.

The Hospital Standardized Mortality Ratio (HSMR) was developed to help hospitals evaluate mortality rates. This performance indicator helps hospitals measure patient safety and quality of care by comparing their rates to the national average (Canadian Institute for Health Information, 2007).

Report cards have also been used to measure quality and facilitate comparison of the quality of care across health care providers (Mcnamara, 2006; Mehrotra, Bodenheimer, & Dudley, 2003). Richard et al. (2005) developed an ethical framework to help guide the development and dissemination of cardiac report cards (CRCs). Their framework has ten principles: (1) improving quality of care, (2) informed understanding, (3) public accountability, (4) transparency, (5) equity, (6) access to information, (7) quality of information, (8) multi-stakeholder collaboration, (9) legitimacy, and (10) evaluation and continuous quality improvement.

Acceptance by consumers and providers were measured as indicators of success in evaluating the success of telehealth services, the technical acceptability of the system, cost/benefit/effectiveness, organizational support, satisfaction, recruitment and retention, and client outcomes such as quality of life (Hebert, 2001). Another telehealth evaluation study stated that ‘readiness to adopt a new technology’ was one factor that contributes to the success of a telehealth program (Hebert,

Paquin, & Iversen, 2002). Focus groups, home visits, and telephone and face-to-face interviews were used to collect data.

Australia developed a priority setting framework to assist the Clinical Senate of Australia (a clinical advisory group to the Minister and Department of Health) in priority setting decisions (Leggat, Scheil, Williams, & Kerin, 2006). They presented a workbook developed from the literature, which highlights the components and structure of a priority setting tool, in their efforts to recognize a need for an open priority setting process to fairly assign planning resources to a large number of clinical issues. Their final product is a largely clinical ‘Gap Finder Tool’ and a values-based ‘Priority Setting Framework’, meant to be used within a clear strategic plan. The framework has five criteria: health benefit, equity, benefit to public, cost-effectiveness, and capacity and sustainability. The Gap Finder Tool was created to identify deficiencies in health service interventions and examine key aspects of the health system to be addressed by the various clinical programs. Participants expressed concern in their ability to measure clinical impact given that limitations from the data elicited and stressed the importance of having a pre-determined strategic plan.

Several studies have evaluated the process and impact of NICE recommendations. Mayor reported that steps were in place to ameliorate this through the ‘Health Care Commission’ – a body created in 2004 to evaluate trusts in the NHS on a self-assessment of 44 standards, including conformance to NICE guidelines (Mayor, 2006). This standards-driven framework (called the annual health check) has seven domains (including safety, clinical effectiveness, and patient focus), designed to cover the full spectrum of health care, divided into core standards (existing requirements/minimum requirements) and developmental standards (directions for improvement)(Department of Health, 2004). The framework “ensures that the extra resources

being directed to the NHS are used to help measurably raise the level of performance year-on-year” ((Department of Health, 2004), Annex A, p.3).

Evaluating the success of health care (and other sectors) is possible through many of the aforementioned tools/processes, and different instruments may elicit different results (Peck, Asch, Goold, Roter, Ubel, McIntyre et al., 2001). However, evaluating success in priority setting is a new challenge that requires new tools/processes. Outcome measures, such as mortality rates, are helpful in evaluating the success of a health care organization, but they only provide a partial explanation of priority setting success. Further, it is very difficult to directly measure health outcomes due to the many possible confounding factors. It is most apparent through these studies that, in order for a tool to be helpful in evaluating success, it should be accompanied by an agreed upon standard (be it benchmarks, performance ratios, or definitions).

2.5 Gaps in Knowledge

The literature presented in this chapter has provided the backdrop for successful priority setting. Experiences from Canada and other countries at all three levels of health care have shown a lack of coherency and an agreed upon 'best' method for priority setting. Various disciplines provided an unstable foundation upon which to make recommendations to guide priority setting decisions, but provided no way of knowing which values should override or dominate. Countries around the world have tried to use principlist approaches to priority setting, but this proved to be too general and too unclear in practice (Holm, 1998). Priority setting scholars began to examine legitimacy and fairness as two goals of priority setting, but remain unsure that these goals would lead to success. The literature shows that decision makers lack guidance, and, more importantly, decision makers want guidance in their priority setting.

There is a call for improved stakeholder engagement, increased transparency, more explicit priority setting methods, and a method to determine if all of these efforts lead to successful priority setting. Each of these pieces of the puzzle need to be brought together to form one comprehensive definition of successful priority setting; next, the definition needs to be operationalized and turned into a tool to evaluate the achievement of success in priority setting.

There are two main gaps in knowledge that I am attempting to address in this thesis:

1) There is no comprehensive definition of successful priority setting

No single study has attempted to provide a broad overarching definition of successful priority setting. There is no consensus about how to define successful priority setting. While a few studies have reported on pieces of this problem, there has been no attempt to develop a comprehensive and integrated framework that combines all of the pieces. A4R provides a framework to evaluate

fairness in priority setting. This research attempts to fill this gap by providing a comprehensive definition of success.

2) There is no tool for evaluating the achievement of success in priority setting

Given that we lack consensus on the meaning of successful priority setting, we have no tool for evaluating priority setting decisions in an actual context. Outcome measures are helpful in evaluating the success of a health care organization, but they do not provide a complete picture of successful priority setting. A more comprehensive tool is needed. This research attempts to fill this gap by developing a tool to evaluate the achievement of success in priority setting.

Chapter 3: Methodology

In this chapter I will describe the methods used in my research.

The chapter is organized into three sections. Section 3.1 explains the methods that were used in the development of the conceptual framework. Three empirical studies were performed that formed the basis for the framework; these are presented in the first half of this section. Study 1 was a modified Delphi consensus study. This consensus building initiative involved a panel of international scholars and decision makers. Study 2 involved interviews with a wide variety of decision makers across the full range of the Canadian health care system. Study 3 combined patients and policy makers from across Canada into focus groups. This section examines multiple factors for each study, including: a description of design, setting, sampling and participants, methods of data collection and analysis, and a description of the research ethics process. The latter half of the section is dedicated to the methods used in the synthesis and refinement of the conceptual framework. This includes a description of the ways in which the empirical data that was collected from the three studies was combined and analyzed in aggregate to create the conceptual framework.

Section 3.2 focuses on the methods used in the development of the evaluation tool. In this section, I will describe the methods that I used to create the tool and the processes used in the sensibility testing and refinements of the tool.

Section 3.3 focuses on the pilot study and the methods used in its real-world application.

3.1 Methods for the Development of the Conceptual Framework

The conceptual framework was developed primarily based on the data collected through three empirical studies.

Methods Used in Conducting the Three Empirical Studies

The primary data collection phase revolved around three empirical studies which were used as input into the development of the conceptual framework. This section will describe the methodology used in this process.

Study #1: An International Delphi Consensus Panel

Design:

This study used a structured consensus building process known as the Delphi method (Adler & Ziglio, 1996). Delphi is a method for collecting and distilling information from a group of individuals. It allows for creative and structured data collection, while simultaneously fostering a learning opportunity for knowledge exchange between and amongst our Delphi panellists.

This study was initiated with a goal to develop a list of elements for successful priority setting that is agreed upon by international scholars and decision makers. For the purpose of this research, the Delphi process was modified to more accurately meet the goal of the study: Delphi provided a forum for the expression of international opinion, but was modified (described below) to provide our results with more integrity.

Sampling and Participants:

Our Delphi panel consisted of 12 scholars in the field of priority setting and health care decision makers (administrators) from five different health systems, chosen for their experience and interest in priority setting (Table 3.1).

Table 3.1: Delphi Participants		
Participant	Role	Country
Donna Larson	Decision Maker	Canada
Berit Bringedal	Decision Maker/Scholar	Norway
Terje Sletnes	Decision Maker	Norway
Andrew Dillon	Decision Maker	U.K.
Russell Teagarden	Decision Maker	U.S.A.
Craig Mitton	Scholar	Canada
Jennifer Gibson	Scholar	Canada
Douglas Martin	Scholar	Canada
Ole Frithjof Norheim	Scholar	Norway
Chris Ham	Scholar	U.K.
Norman Daniels	Scholar	U.S.A.
Lydia Kipiriri	Scholar	Uganda

Donna Larson is the Executive Advisor to the CEO at the Royal University Hospital, Saskatoon Health Region, in Saskatchewan.

Berit Bringedal is a Researcher and Assistant Professor at The University of Oslo, Department of Health Management and Health Economics and also works for The Research Institute of The Norwegian Medical Association.

Terje Sletnes is Head of Section at the Legeforeningen/Norwegian Medical Association.

Andrew Dillon is Chief Executive of the National Institute for Health and Clinical Excellence in the U.K.

Russell Teagarden is the Vice President of Clinical Practices and Therapeutics Medco Health Solutions, Inc., and holds academic appointments at Rutgers College of Pharmacy, Ohio Northern University College of Pharmacy, and Albany College of Pharmacy.

Craig Mitton is an Assistant Professor in Health Studies at the University of British Columbia. He also holds a Canada Research Chair in Health Care Priority Setting, and is a Research Scientist for both the Michael Smith Foundation for Health Research Scholar and the Centre for Health Care Innovation & Improvement.

Jennifer Gibson is an Assistant Professor in the Department of Health Policy Management and Evaluation at the University of Toronto. She is also the Director of Partnerships and Strategy at the Joint Centre for Bioethics at the University of Toronto.

Douglas Martin is an Associate Professor in the Department of Health Policy, Management and Evaluation, and the Joint Centre for Bioethics, University of Toronto.

Ole Frithjof Norheim is both a medical doctor and Professor at the University of Bergen in the Department of Public Health and Primary Health Care.

Chris Ham is a Health Policy Analyst and a Professor of Health Policy and Management at the University of Birmingham.

Norman Daniels is a Professor of both Population Ethics and Ethics and Population Health at Harvard University in the School of Public Health.

Lydia Kipiriri is a Research Associate with the Canadian Priority Setting Research Network.

Data Collection & Analysis:

Our study spanned three Delphi 'rounds'. Round 1 was conducted in May/June 2003 via email; and used the ethical framework 'accountability for reasonableness' (A4R) as the starting point for discussions (Daniels & Sabin, 1997). The panel members were presented with the open-ended research question: How can we measure the effectiveness of conformance with 'accountability for reasonableness?', and were asked to provide a response. I chose to use accountability for reasonableness (A4R) as a starting point for discussions because, at the time, it was the only empirically grounded and theoretically justified evaluation framework for priority setting. Also, as discussed in chapter 2, it has traction among decision makers and is a preferred framework for priority setting researchers internationally - it is therefore an appropriate starting place as well as a practical guide to develop, implement, and evaluate fair priority setting processes.

I analyzed the panellists' responses by identifying discreet elements and synthesizing similar elements under common conceptual labels. I generated a list of 54 items, organized into two categories: 1) elements of successful (or effective) priority setting (48 items); and 2) methods of evaluation (6 items).

Round 2 focused on the first category, which were the 48 elements of successful priority setting. It took place two months after Round 1 was completed. To enable direct consensus building, Round 2 was a face-to-face workshop that included all panel members. Round 2 was a broader discussion about effective (or successful) priority setting. All discussions were documented. The 48 elements of successful priority setting generated in Round 1 were the input into Round 2. All items were listed on large poster board and were posted throughout the room. During the workshop, panel members discussed and clarified each item. The 'dot' method was used to indicate the strength of preference for specific items: participants were each given 5 dots and were asked to place a dot beside the elements that they felt strongest about. A refined and

streamlined list of 14 items remained from the original 48. Refinements were also made to 6 evaluation methods at the end of the workshop.

Round 3 was conducted by email 4 months after Round 2. The list of 14 items from Round 2 was circulated and panellists were asked to make final suggestions and revisions to sharpen the list. The list was revised accordingly.

Research Ethics:

Ethics approval for this study was not necessary. The Delphi study consisted of discussions by various people regarding their views about priority setting. Participants did not discuss specific information about themselves or their organizations.

Study #2: One-on-One Interviews with Canadian Decision Makers

Design:

This study involved one-on-one, semi-structured qualitative interviews with decision makers within the Canadian health system. The goal of this study was to develop a list of elements for successful priority setting from the viewpoint of Canadian decision makers. These interviews allowed me to gain insight into the complexity of everyday priority setting from the viewpoint of decision-makers who work ‘in the trenches’.

Sampling and Participants:

Participants for this study were senior or executive level decision makers in health care organizations across Canada; for example, CEOs of hospitals and RHAs, Senior Administration of the Provincial Ministries of Health, and Senior Management of provincial health care organizations (e.g. Community Care Access Centres, District Health Units, etc.). Sample size was not formally calculated since our goal was to describe characteristics of successful priority setting

from the point of view of decision makers and not to generate conclusions that could easily be generalized.

Decision makers were sampled using a combination of two methods: (1) theoretical sampling, meaning people who were involved in a significant aspect of priority setting and (2) ‘snowball’ sampling, where participants were asked to identify others (colleagues) who might have knowledge or insight into priority setting and who should be interviewed. Some of the participants were originally identified through the attendee list of a national priority setting conference; others were identified through involvement with the Canadian Priority Setting Research Network (a national network dedicated to improving health care through improving priority setting). (A participant list is summarized in Table 3.2).

Table 3.2: Summary of Interview Participants

MACRO	Provincial Ministry of Health (British Columbia – 1; Alberta -1; Saskatchewan – 1; Ontario - 1, New Brunswick – 1; Nova Scotia - 2)	7
MESO	Hospital Senior Management (British Columbia -2; Alberta -1; Ontario - 12, Quebec – 2; Nova Scotia -1)	18
	Senior Management of Community Care Access Centres in Ontario	3
	Senior Management and Board Members of Regional Health Authorities (British Columbia -1; Alberta – 6; Saskatchewan - 3)	10
	Senior Management of Private Health Care Organizations (Alberta)	2
	Directors/Executive Directors of District Health Councils (3) and Public Health Units (2) (Ontario)	5
MICRO	Clinician Managers in hospitals (Alberta - 4, Saskatchewan -1; Ontario -1; Quebec -1; Nova Scotia -1)	8
	Other (policy analyst/consultants, ethics board members) (Alberta – 1; Ontario -1)	2
TOTAL		55

Participants were interviewed until conceptual saturation was reached, meaning that no new concepts were identified in successive interviews. Our sample included individuals from a wide range of different system levels and geographical areas.

Data Collection:

Data collection for this study involved one-on-one interviews. These were conducted in person or by telephone from July 2003 to May 2004. I conducted 55 interviews with decision makers from macro level health care (such as senior leaders from provincial ministries of health), meso level health care organizations (such as CEOs of hospitals and RHAs, senior management of public and district health units, as well as senior administrators of community care access centres (CCACs)), and micro level health care (such as senior clinical leaders and clinician managers in hospital programs). Participants came from 45 different organizations across Canada; the only provinces not represented were Newfoundland and PEI. Attempts were also made to ensure that there was representation within provinces; interviews did not focus solely on the capital regions of each province.

An interview guide that was developed based on previous research and relevant literature was used to conduct interviews with key informants. The interview guide was revised during the data collection and analysis period to explore emerging findings (See Appendix A for the two versions of the interview guide). The interview guide contained five main questions exploring views of priority setting: How do you set priorities in your organization? What are the organizational goals for priority setting? How do you know if you have met those goals? What would successful priority setting look like? How could priority setting be improved?

While participants' initial responses were probed to gain more in-depth views, no other guidance was given; participants gave responses based on their own understanding and definitions of

success and priority setting. While all questions contributed to the results of this study, the main focus was on “success in priority setting”. All interviews were audio taped and transcribed which generated over 800 pages of transcripts.

Data Analysis:

Data from the interviews was analyzed using a modified thematic analysis that proceeded in two steps: open and axial coding. First, in open coding, the data was read and then fractured by identifying chunks that related to a concept or idea (for example clinical volumes, balanced needs, frameworks, and communication). Second, in axial coding, similar ideas were organized into overarching themes by grouping similar codes. The overarching themes were elements of success in priority setting, and evaluating success of priority setting.

When analyzing the data, I was familiar with the elements of success from the previous study, but I attempted to ensure that the data was interpreted in isolation. The validity of the findings was addressed in three ways (Altheide & Johnson, 1994). First, two researchers coded the raw data to ensure accuracy and to guarantee that one person’s biases did not unduly skew the interpretation; differences were resolved through ongoing discussion. Second, all research activities were rigorously documented by the researcher to permit a critical appraisal of the methods (Mays & Pope, 1995). Third, to address potential interpretive bias in the researchers, a member check was used which allowed participants to verify the rationality of the findings. Fifteen participants were invited via email to read the results from the data analysis and consider two questions: 1) Is there anything you disagree with? and 2) Is there anything missing? Ten participants responded. Most felt that the results accurately captured the essence of the dilemma faced; some respondents suggested minor changes, which were incorporated.

Research Ethics:

Approval for this project was obtained from the Committee on the Use of Human Subjects of the University of Toronto. Written informed consent was obtained from each individual prior to

being interviewed. All data was protected as confidential and was available only to the research team. No individuals have been identified in reports without their explicit agreement.

Study #3: National Patient and Decision Maker Focus Groups

Design:

This study used a distinctive focus group design called a “circle within a circle” approach. As far as I am aware, this technique has only been used in one other study (Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003). A total of five focus groups took place. First, two independent focus groups were held, one with patients and one with policy makers. Second, two additional focus groups were held using the “circle within a circle” approach: the first had the patients in an inner circle and the decision makers in an outer circle, the second had the opposite (decision makers in the inner circle). The final focus group had both groups participating, sitting side-by-side in a large circle.

This “circle within a circle” approach is innovative and flexible, and holds several advantages over traditional focus groups. First, by having two separate stakeholder focus groups, many group-specific issues can be explored in depth, which may not have been possible in front of the other groups (i.e., separate groups gave a safe space, particularly for traditionally disempowered groups, to discuss undisclosed issues). Next, having one group listen while the other group spoke provided an invaluable opportunity for knowledge exchange, making each group privy to information they might not have elucidated in one large group. Finally, by allowing the two stakeholder groups to discuss as one large group, ideas and concerns were clarified, occasionally challenged, and ultimately refined and strengthened through dialogue.

Setting:

This research was set around an existing event; an Alberta-based Provincial Health Ethics Network (PHEN) conference on the topic of ethics in resources allocation (April 10, 11 and 12, 2003). The study utilized this conference as a unique opportunity to bring together patients and policy makers in one location. All study participants participated in the PHEN conference.

This study was done in partnership with the Charles E. Frosst Foundation (FF) for Health Care. The FF was an educational organization that worked to engage members of the public in health policy decision making; it was a distinct entity that operated at arm's length from the drug manufacturer, Merck Frosst. The original intent of the study during data collection was to demonstrate the value of educational/deliberative dialogues. However, since the FF ceased to exist shortly after our event - - we assumed sole stewardship of the data, and brought the study to completion.

Sampling and Participants:

The FF sponsored a delegation of 13 patients and 13 decision makers to participate, including at least one of each from every province and territory. For ease of reading, the term 'patient' has been used to describe the group who participated in this study since the majority were health system patients; a more accurate descriptor could be 'health system user' since all participants labelled 'patient' were familiar with and frequently used the health system, either as a patient or with a loved one.

Patients were individual citizens rather than health organization or advocacy group delegates. They were comprised of both sexes and of various age groups and they had different health challenges and experiences as users of the system. Although the majority of participants were patients, care providers also attended and participated in discussions. The group was eclectic and

diverse in medical history and prognosis. For example, a husband and son of a recently deceased patient attended; the patient had been asked to attend the conference and passed away after being invited. Another participant brought her mother; the participant was an 18 year old patient who had been using the system her whole life.

Patients were identified and approached through various health networks, organizations and associations. A wide demographic range of participants was sought, not only regionally, but also of various age groups, types of diseases or illnesses, etc. FF sponsored each participant, which included coverage of their travel and hospitality costs.

In addition, 13 health policy makers were recruited by FF. There was at least one policy maker from each province. Participants represented different levels of government and different health care contexts (Table 3.3).

Sample size was not formally calculated here because we were not looking to make generalizations.

Table 3.3: Summary of Focus Group Participants: Policy Makers

MACRO	National level (Canadian Medical Foundation, Canadian Nurses Association, Health Canada, Western Canada Waiting List Project)	4
	Provincial Level (Provincial Ministry of Health, Provincial Government (other than MOH))	3
MESO	Senior Management of Regional Health Authorities (P.E.I, Manitoba, Alberta)	5
	Senior Management Hospitals	1
TOTAL		13

Data Collection:

Data collection involved multiple focus group discussions that were organized into the following three sections:

1. Two independent parallel focus groups: one with patients and one with policy makers
2. Two “circle within a circle” focus groups: one that had the patients in an inner circle discussing while the policy makers listened from an outer circle ; the second was done in reverse (patients outside, policy makers inside)
3. One common focus group where both patients and decision makers discussed together

All focus groups were led using discussion guides (see Appendix B for discussion guides). All discussions were video taped and transcribed.

In the first section of the day, each group (patients/policy makers) participated in separate, parallel focus groups, in order to discuss ideas and concerns related to health care priority setting. The patient-only and the policy maker-only focus group were run in the same manner; each was given an hour and a half for discussion which was moderated by a facilitator. I led the patient-only focus group and my supervisor DKM led the policy maker-only focus group. The focus group discussion began with a brief introduction to the topic of priority setting; this discussion was lengthier for the policy-maker only focus group than the patient only focus group.

In the second section of the day, the “circle-within-a-circle” focus groups were held; one group spoke while the other listened, beginning with the patients in an inner circle discussing and the policy makers listening from an outer circle. The patients spoke with one another about priority setting; much of the discussion from the first patients’ only focus group was re-visited with some additions and clarifications. Policy makers then moved into the inner circle and had a discussion

similar to their first focus group discussion; patients were in an outer circle listening. Policy makers began by commenting on the patients' discussion, but then changed focus to their own thoughts and opinions.

During each parallel focus group, the moderator took notes using large flip chart paper. These flip charts served two purposes: they provided discussion points for the focus groups and a hard copy of data points for future analysis. During the "circle within a circle" focus groups, the moderator made use of the flip chart notes from the first focus group discussion and added to them. The other moderator was observing and making detailed notes on the discussion as well as other non-verbal observations (body language, tone of voice, and pace of conversation).

The final section of the day had one common focus group with all participants, patients and policy makers, in one large circle. This interaction between the two groups was fruitful in illuminating new issues that had not previously been discussed, as well as in bringing other issues to consensus.

Data Analysis:

The data analysis proceeded into two steps: open and axial coding (Strauss & Corbin, 1998). In open coding, the data was read and then fractured by identifying chunks of data that related to a concept or idea (for example, education). In axial coding, similar ideas and concepts were organized into overarching thematic categories (for example, communication and process). I then further developed these themes using illustrative verbatim quotes and illuminative case studies (Patton, 2002). The overarching themes were influenced by previous literature and by previous studies. Element labels were created by the research team to reflect the results (the comments and thoughts of participants). Although the research team had knowledge of the results from studies #1 and #2, results from study #3 were analyzed independent of the previous results. The analysis

was facilitated by, and culminated with writing, which served as an important tool in formalizing elements and making explicit assumptions that influence data interpretation (Richardson, 1994).

The primary goal of the analysis was to develop a description of the discussions that would help in evaluating the achievement of success in priority setting. A second goal was to determine the usefulness of this approach to patient/policy maker engagement, but this thesis will focus only on the first objective.

Research Ethics:

At first, ethics approval for the data collection was received by Ethica Ethics Committee, an independent, non-institutional research ethics board based in Montreal, Quebec. It was chosen because the initial sponsor for this study was the Frosst Foundation, which was not affiliated with any institution that had its own research ethics process. After FF ceased to exist, research ethics approval in regard to the ongoing data analysis for this project was obtained from the Committee on the use of Human Subjects of the University of Toronto. Written informed consent was obtained from each individual before the start of the first focus group. The videotapes, transcripts and observations are protected as confidential, and available only to the research team. No individuals have been identified without their explicit agreement.

Methods for the Synthesis of the Empirical Studies

The first step in developing the conceptual framework involved synthesizing the three empirical studies described above. Developing the conceptual framework involved comparison and analysis between the raw data and the coding lists that were developed during data analysis. The end results of coding from the raw data were three lists of elements of successful priority setting. These coding lists acted as thematic codes when moving forward to create the conceptual framework.

A list of elements of successful priority setting emerged from each study, resulting in a total of three lists. First, I compared the lists from each study, and amalgamated them into one all-inclusive list. Next, any similar items within the large list were merged. When there was disagreement or uncertainty about merging items (i.e. can they legitimately be combined, or should they remain separate), I went back to the original data and re-analyzed the individual and specific meaning of the element and how it originally emerged in the data.

Elements that were only discussed in one study were re-analyzed as well. To do this, all of the studies were re-visited using that specific element as a thematic code. The data was examined again, but this time with a specific goal of finding information to support the element. Elements that were not supported in the other empirical studies were eliminated, while elements that were supported remained in the list.

In the end the similar items merged to create a list of 10 comprehensive elements. Finally, the 10 elements were split into 5 process and 5 outcome elements according to their focus.

Validity

The validity of this analysis was confirmed in two ways. First, I used email to circulate the conceptual framework to a selection of participants from the three studies and to a group of interdisciplinary scholars for their comments and refinements. Fifteen study participants and eight scholars were invited to comment. Seven of the participants and all eight scholars replied via email with comments and questions for clarification. Revisions were made accordingly.

Second, to increase credibility of the framework, the draft was presented to scholars at four national conferences and workshops. In order to refine the framework, participants' comments

and criticisms were incorporated, resulting in the current framework that contains the ten existing items.

3.2 Methods for the Development of Evaluation Tool

When considering the development of a scale (or an index, or tool) to evaluate a phenomenon, it is important to determine if another scale exists that can be used. In the case of success in priority setting, no such scale exists; therefore a new scale was required. The three empirical studies and the conceptual framework were used as input into scale development. Since success in priority setting is a complex concept, I developed a global scale (Text Box 3.1).

The creation of the evaluation tool was a multi-step process. The first step in its development was to pose questions that attempted to operationalize each element of the conceptual framework. In this step, I tried to be over-inclusive of questions. This first step involved proposing indicators for the tool derived from the conceptual framework. The indicators mapped onto the ethical and practical goals of priority setting, specified both quantitative and qualitative dimensions of priority setting, and related to both the procedural and substantive dimensions of priority setting.

The next step was to choose the format of the tool according to the questions in order to determine which would be best for each. Three components were chosen: a survey, interviews, and document analysis. Each question from step one was assigned to the appropriate format.

The third step was to revise each of the questions within their format. The draft tool was subjected to a cyclical process of proposing evaluation indicators and refining them based on the feedback received from stakeholders.

The final evaluation tool was revised twice more throughout the research: first through face and content validity testing, and second after the actual empirical application ('ease of use' through the pilot test). The next section discusses the sensibility testing.

Text Box 3.1: Scale Development - A Global Index

(The following information is taken from 'Clinimetrics' by Alvan Feinstein (Feinstein, 1987))

Feinstein uses the term 'global' to refer to content which is a broad overview of a complex phenomenon. (p. 92)

"When we form a composite index or a global scale for a complex phenomenon, the scientific goal is to get an overall appraisal of the total phenomenon, not to preserve the identity of each component. If we want to know about each component, we would use or review separate indexes for the component." (p.100)

The main disadvantage of a global index is that the results are often not replicable by other observers (inter-rater reliability; reproducible consistency). However, global indexes are valuable in denoting changes of state – that is, individual ratings using the same scale will be reasonably well standardized (internal validity).

Global indices can have a high intra-rater consistency (when the same person applies it more than once, there will be standardization) but often a low inter-rater consistency (when applied by separate researchers). Since global indices permit measuring states of change, comparable results can be achieved. Further, it is possible to acquire validity in measuring since measuring change or transition ratings often yields consistency because raters are likely to use similar criteria when measuring, for example: "better, no change, worse".

Feinstein argues that "a collection of transition ratings may be reasonably well standardized within and among the individual members of the group" (p. 97). That is, if the evaluation tool created in this thesis were used to evaluate the achievement of success in priority setting in one organization, it would be possible to evaluate states of change, or to evaluate improvement.

Sensibility Testing

There are several important psychometric properties (or attributes) that should be considered when developing a new measurement scale. Traditionally defined, 'psychometrics' refers to

validity (or ‘consistency’) and reliability properties of a measurement (Streiner & Norman, 2003). Feinstein adds sensibility as a third attribute (Feinstein, 1987).

An instrument can be considered reliable if measurements obtained under different circumstances yield similar results. Reliability looks at both the internal consistency (items within the measurement measure the same thing) and stability of a measure (inter-observer, intra-observer, or test-retest). Validity is concerned with the ability to reproduce the tool (convergent validity, criterion validity, and concurrent validity, or construct validity where no measure exists).

I did not do traditional psychometric testing; instead I chose to look at the sensibility of the tool (Text Box 3.2) for the scope of this thesis.

Design:

To establish the ‘sensibility’ of the candidate indicators, the tool was critically appraised by key informants (researchers and decision makers).

The sensibility testing of the tool proceeded in two phases. First, the entire tool was mapped onto the conceptual framework and sent to a group of seven interdisciplinary researchers for comments and feedback. Each person replied with their own perspective and revisions were made to the tool accordingly.

Second, the tool was sent to a larger sample of both interdisciplinary researchers and priority setting decision makers for more specific comments and feedback surrounding the face and content validity. The remainder of this section is dedicated to this second phase: the face and content validity panel.

Text Box 3.2: Sensibility

(The following information is taken from ‘Clinimetrics’ by Alvan Feinstein (Feinstein, 1987)).

In the instance where there is no existing scale to evaluate a construct, and a new scale is to be developed, there are important properties (or attributes) that should be considered. Reliability (or ‘consistency’) and validity are the most common, and Feinstein adds a third attribute, sensibility.

Feinstein holds that sensibility ought to be used to evaluate any index. This evaluation takes place in 5 steps: (1) understanding the purpose or framework of the index (what is it supposed to do?); (2) checking the overt format, or, is the index comprehensive and suitable for what it is measuring; (3) judging face validity (coherency, interpersonal exchange, focus of data); (4) judging the content validity (check for omissions of important variables, or inclusion of inappropriate ones, as well as suitability of scale and quality of data); and (5) ease of usage.

Face validity is a minimum prerequisite to overall validity. It is a subjective judgment about the overall tool: “on the surface does it appear to measure the stated construct”. Content validity applies to the scale as a whole and looks at whether the scale has enough items and ‘adequately covers the domain under investigation’. Content validity can be measured through expert opinion both formally (using a content validity index, or CVI) or informally (yes/no).

Feinstein concludes that features of sensibility “are often the most important things that determine the clinical success or failure of an index” (p165).

Sampling and Participants:

In total, 16 people were asked to comment on the face and content validity of the survey. The 16 people included seven priority setting scholars and nine decision makers involved in priority setting decisions. Four out of the seven priority setting scholars were also clinicians involved in priority setting decisions. This group represented both ‘experts’ and ‘users’. Out of the 16 panellists who were invited, 12 responded (Table 3.4).

Panellists that were invited to participate via email. Panellists, who were decision makers, were selected based on previous participation in this research, or participation in previous Canadian Priority Setting Research Network events. Panellists, who were scholars, were selected based on

membership or participation in the Canadian Priority Setting Research Network events and the International Society of Priority Setting Research.

Table 3.4: Content Validity Participants

	Category	Name	Reply
1	Ps scholar	Jennifer Gibson	1
2	Ps scholar	Lydia Kaporiri	2
3	Ps scholar	Jens Mielke	3
4	Ps scholar	Norm Daniels	4
5	Ps scholar	Ole Norheim	
6	Ps scholar	Solly Benatar	
7	Policy Maker	David Reeleder	5
8	Decision Maker	Laura Freeman	6
9	Decision Maker	Lorraine Sederquest	7
10	Decision Maker	Scott Berry	8
11	Decision Maker	Jean Graham	9
12	Decision Maker	Bob Bell	10
13	Decision Maker	Susanne Babic	11
14	Decision Maker	Murray Martin (Hamilton HSC)	12
15	Decision Maker	Chris Powers (QEII)	
16	Decision Maker	Reuben Devlin (Humber River)	

An initial email was sent out on April 25, 2007 inviting the various people to participate.

Panellists were provided with the conceptual framework (the ten elements) and a worksheet with all of the questions divided into their format (surveys, interviews, document analysis). Panellists used email and the worksheet to comment on the questions. On May 6, 2007 a reminder email was sent to those who had not replied.

Data Collection and Analysis:

Data collection for the face and content validity panel took place from April to May 2007.

Participants were asked to send their comments on the face and content validity of the tool via email. Each comment submitted by the panellists was read and analyzed independently.

Comments were then analyzed in aggregate to find consensus amongst the panellists. The data gathered was next used to refine the tool.

Research Ethics:

This research did not require research ethics approval since it is a quality assurance study; ethics approval is not required to question colleagues and experts about the face validity of a tool.

3.3 Methods for the Real-World Application –The Pilot Study

In order to test the real-world applicability and usability of the evaluation tool, a pilot study was conducted in an organization that had recently completed a priority setting process.

Design:

The pilot study consisted of two main parts:

Part I: Implementation of the evaluation tool;

Part II: Debriefing of findings from Part I and evaluation of the tool.

The purpose of Part I was to perform an actual empirical application of the evaluation tool to test its feasibility and usability. (See Appendix C for a complete version of tool used in the pilot study).

The purpose of Part II was to determine if the outcome of the tool (a report on the findings from Part I) was useful to an organization.

The project started in May 2007; data analysis was finished by July 2007. The debriefing occurred in October 2007. The following section describes the methods for both Part I and Part II.

Setting

A mid-sized urban hospital in Ontario was chosen as the setting for this research due to their current interest in priority setting activities and their willingness to support bioethics research. They are a fast growing organization that provided a living laboratory setting suitable for testing this evaluation tool. The hospital's Senior Management was keen to support this research. (See letter of support in Appendix D). The hospital presently has just fewer than 300 beds, and approximately 200 physicians and 1800 staff members. The hospital provides complex continuing care, critical care, mental health, obstetrics, and paediatric care. At the time of the pilot study, the hospital had recently completed a substantial budget allocation process, which provided a good opportunity for a retrospective evaluation.

Sampling and Participants

Participants were employees of the hospital and included those who were involved in the 2007-2008 budgeting process both directly (Senior Management, administration, program managers and directors) and indirectly (for e.g., front line nurses and physicians, ancillary staff etc.).

In order to sample for key documents and people, a convenience sampling (documents/people that were available) was performed. Next, a combination of theoretical sampling (people who were involved in a significant aspect of the priority setting initiative) and snowball sampling (asking those who we interviewed to refer others who would be appropriate to interview) were used.

Sample size for surveys and individual interviews was not formally calculated. The goal of this pilot study was to describe the experiences of individuals within this hospital in regards to the priority setting process, as well as to gain a deeper understanding of the functionality of the tool in a real-world setting.

Survey participants were recruited through an internal email. Over 5000 hospital employees received the email. It is difficult to know exactly how many received the invitation to participate because some of those who possess an internal email account do not actually use it. In total, 105 participants completed the survey.

Participants for the interviews were selected based on their position in the hospital. Senior leaders and program managers were selected, as well as hospital corporate management. Nine one-on-one interviews were completed in total. The goal of these interviews was to obtain a sample of individuals who had participated in the 2007-2008 budgeting process; the goal was not to reach conceptual saturation (i.e. until no new concepts arose in successive interviews) or to make generalizations.

Data Collection – Part I

Data collection consisted of three overlapping steps: an on-line survey, one-on-one interviews, and document analysis.

Survey

The invitation to complete the survey was sent out via email to the organization's internal listserv on a Monday morning. The survey was hosted by an on-line survey tool called Survey Monkey.

The survey was intended to capture

- Hospital staff: nurses, doctors, allied health professionals, other health care providers
- Senior managers
- Board of Directors
- Clinical and Administrative Managers

The original intent was to send the survey to a small selection (50-60) of hospital staff; however, due to a communication error, over 3000 hospital staff and employees received the survey,

including senior management, front line staff, allied health professionals, and support staff. Any hospital employee who had an organizational email account was eligible to receive the survey.

Respondents were given two weeks to complete the survey; at the end of the first week 88 had done so. One week into the survey a reminder email was sent to the Senior Leadership Team and the Leadership Group. 105 participants completed the survey in total. Since it was difficult to determine how many people received the survey, it is not possible to calculate an accurate response rate.

Interviews

Key informant interviews were used to validate survey information and to gather information that required more depth or explanation. Interviews lasted no longer than 30 minutes.

Participants were invited to be interviewed through internal email communication. First, in the email that invited staff to complete the survey, respondents were asked if they were interested in being interviewed. Second, an additional email was sent directly to the hospital senior management team inviting them to volunteer as interviewees.

Interviews started soon after the survey began. The goal was to have ten one-on-one interviews.

In total nine interviews were completed between May 2007 and June 2007 (Table 3.5).

Participants were chosen based on their involvement in the priority setting process. All were directly involved in the 2007-2008 budgeting process with the exception of one participant who was working within the budget that was created for her by her predecessor.

Interviews were semi-structured and followed an interview guide. The interview guide was modified and revised throughout data collection to exploit emerging findings (Altheide & Johnson, 1994).

Table 3.5: Interview Participants	
Position	
Program Directors	4
Senior Leadership Team	1
Program Managers	3
Other	1
TOTAL	9

Document Analysis

Document analysis was conducted throughout the survey and the interviews provided quantitative data as well as insight into the budgeting process and outcomes. Documents were helpful in highlighting discrepancies between survey results and interviews and what was recorded in the interviews. The majority of documents were collected by internal decision support services (the Decisions Support Department). Others were public documents that were obtained through the hospital's website. Document analysis helped to determine who should be involved in the interviews.

In total, ten documents were collected from decision support, four from the website, two documents through email communications with Senior Leadership, and a few others were obtained directly from the Senior Leadership Team.

The Report

All of the information listed above (surveys, interviews, document analysis) were analyzed (described below) and brought together in a report for hospital Senior Management. The report had three sections. Section One discussed the background to the report, introduced the conceptual

framework and evaluation tool, and summarized demographics of the study participants. Section Two presented the results from the evaluation tool in ten sub-sections (one section per element of the conceptual framework). The last section provided eight recommendations for improvement.

Data Collection – PART II

The results from Part I (see Appendix E for report) were used as the input for Part II. Data collection involved a second round of one-on-one interviews to determine the usefulness and accuracy of the results from the evaluation tool.

Specifically, I asked:

1. Were the results from the report useful to you and/or your organization?
2. Was there anything missing from the report that would help your organization in improving priority setting?
3. To what extent did the tool capture elements of success in priority setting?
4. Is there anything unhelpful in the report that could have been omitted?
5. How will you use the results of the report?

Data Analysis

For the surveys, data was analyzed using simple descriptive statistics for close-ended questions and modified thematic analysis for the open-ended survey questions. Similar thematic analysis was used to analyze the interviews and the documents collected in document analysis.

Thematic analysis was used for the debriefing and the second round of interviews.

Thematic analysis was guided by the ten elements in the conceptual framework. Data was first analyzed using open-coding in order to be broad and inclusive. Data were fractured by identifying

chunks that relate to a concept or idea. Next, axial coding was used to identify similar ideas and over-arching themes.

Once the surveys, interviews and documents were analyzed separately, data was then synthesized and re-analyzed. All data was re-read both ‘within’ and ‘between’ material (surveys, interview transcripts and documents); the conceptual framework acted as a guide to data analysis.

Gap analysis was performed to look at mismatches between the indicators and the conceptual framework. Here we compared the actual performance of the tool with the expected performance.

The validity of the findings was addressed in three ways (Altheide & Johnson, 1994). First, data was presented to a group of interdisciplinary researchers several times throughout analysis to ensure accuracy and lack of personal bias. Any differences were resolved through ongoing discussion. Second, all research activities were rigorously documented by the researcher to permit a critical appraisal of the methods (Mays & Pope, 1995). Third, the debriefing acted to verify the reasonableness of the findings in a type of “member check”.

Research Ethics

Research ethics was obtained through both the University of Toronto Ethics Review Office and the Hospital Ethics Board.

The first page of the survey was the consent form. The consent form ended with: “by starting this survey you are agreeing to the terms of this consent form.” Consent was implied by participation in the survey.

Written informed consent was obtained from each participant prior to their being interviewed. In the case of telephone interviews, interviewees were sent an e-copy of the consent form prior to the interview and consent was obtained verbally.

There were no direct risks or harms to any individual or institution, and there were also no direct benefits to any individual. Participants were not compensated for their involvement in this study. All raw data was (and is) protected as confidential and is available only to the research team. No individuals were identified in dissemination without explicit agreement.

Chapter 4: Results

Developing a Conceptual Framework

This chapter focuses on the results of the primary data collection studies (the three empirical studies) and the synthesis of these studies into the conceptual framework. This chapter provides three lists of elements of successful priority setting that were derived from each study, as well as the ten separate but interconnected elements of the conceptual framework.

This chapter is organized into four sections. In Section 4.1, I will describe the results from Study 1; the modified Delphi consensus study. In Section 4.2, I will describe the results from Study 2; the one-on-one decision maker interviews. In Section 4.3, I will describe the results from Study 3; the focus group study. In Section 4.4, I will describe results of the synthesis of the three studies and the resulting conceptual framework for successful priority setting.

4.1 Results of Study #1: An International Delphi Consensus Building Exercise

The purpose of this study was to gain consensus on the benefits of using an ethical framework to guide priority setting. The ethical framework ‘accountability for reasonableness’ (A4R) was used as a guiding framework and input into Round 1 of the study. However, the Delphi panellist identified elements of successful priority setting that are too easy to generalize and go beyond A4R.

Our study spanned three Delphi ‘rounds’. The first and third were done via email, and the second was done in person (Table 4.1).

Table 4.1: Delphi Participants per Round

Participant	Role	Country	Round		
			1	2	3
Donna Larson	Decision Maker	Canada	✓	✓	✓
Berit Bringedal	Decision Maker/Scholar	Norway	✓	✓	✓
Terje Sletnes	Decision Maker	Norway	✓	✓	✓
Andrew Dillon	Decision Maker	U.K.	✓	✓	
Russell Teagarden	Decision Maker	U.S.A.	✓	✓	✓
Chris Ham	Decision Maker	U.K.	✓	✓	
Craig Mitton	Scholar	Canada	✓	✓	✓
Jennifer Gibson	Scholar	Canada	✓	✓	✓
Douglas Martin	Scholar	Canada	✓	✓	✓
Ole Frithjof Norheim	Scholar	Norway	✓	✓	✓
Norman Daniels	Scholar	U.S.A.	✓	✓	✓
Lydia Kapingiri	Scholar	Uganda	✓	✓	✓

In Round 1, panel members were asked to answer the question: How can we measure the effectiveness of conformance with of ‘accountability for reasonableness?’ Twelve panellists were invited to respond, and all twelve responded electronically. I generated a list of 45 items from Round 1, which I then organized into two broad categories: 1) elements of successful (or effective) priority setting (39 items); and 2) methods of evaluation (6 items). The first category was subdivided into (a) items directly related to A4R (organized by relevance, publicity, appeals,

enforcement and other) and (b) indirectly related to A4R, but relevant to effectiveness/success. For example, ‘wide professional consultation’ is an item directly related to A4R and the relevance condition; another item directly related to A4R and the relevance condition is that ‘representatives of different stakeholder groups are represented and meaningfully participate in the allocation decision-making processes’. Two examples of items indirectly related to A4R are ‘maximization of benefits and minimization of opportunity costs’ and ‘commitment to implementation’ (see Appendix F for a complete list of items).

Round Two was the face-to-face workshop. Here, we discussed the 39 elements of successful priority setting identified by participants in Round One. Element labels came directly from participants in Round One; Round Two provided an opportunity for panellists to refine the elements and their labels. The ‘dot’ method was used to indicate the strength of people’s preference for certain elements: participants were each given five dots and placed a dot beside the elements they felt strongest about. The end result of Round Two was a refined list of 14 elements including ‘the degree to which main ideas become embedded in culture’ and ‘reduced number of complaints’.

In Round Three, we electronically circulated a report that included a summary of the workshop and the 14 elements. Participants were asked to comment on the report. Out of the 12 participants, 10 replied with very positive feedback. All of the comments were collected and assembled into one document which was organized under the original 14 elements. A number of comments focused on increasing the clarity of each item:

Elements could use some elaboration, ...to make them more fully comprehensible, but also to make better distinctions amongst them than their designations suggest.
Improved decision making is a too vague and broad notion, it must be sharpened.
Consistency is one aspect, end-result is another.

Other comments from the panel encouraged more description and classification of stakeholders:

Some specification on who decision makers are is necessary.

The public could be considered a stakeholder in some ways, especially in single-payer systems. Should this be rolled up under stakeholder acceptance?

From the comments, the elements of success were refined and others were combined. The end-result was a list of six elements of successful priority setting, which are presented in descending order according to the participants' strength of preference (Text Box 4.1).

Elements of Success

(1) Improved Stakeholder Understanding

All participants agreed that an improvement in stakeholder understanding of priority setting decisions and rationales would be an indicator of successful priority setting. Understanding has to do with recognizing that limits are inevitable, as well as a clearer specification of the alternatives open to decision-makers. It also enables people who are affected by the outcomes of priority setting to be aware of (articulate or recognize) the priority setting decisions that were made (or at least what is and what is not available in a general sense).

Participants used the word 'stakeholder' to refer to patients, providers, payers, and decision makers (e.g. administrators, legislators/regulators); decision makers were those individuals who had a direct role in the priority setting decisions.

(2) Acknowledgement of Appeals

Panellists agreed that adhering to an open and transparent appeals process could contribute to its overall success by reducing the gravity or number of appeals. According to participants, appeals (or complaints) may be indicators of lack of trust or lack of fairness, but they may also be an indicator of increased awareness of the priority setting process. For this reason, the positive

effects of an appeals process might not immediately be observable, instead increased publicity might cause an increase in appeals based on the premise that when more people are aware of the process they are better able to complain.

Participants felt that as priority setting becomes more formalized and successful, appeals may originate from a better understanding of decisions, or correspond to increased stakeholder participation. Therefore appeals may increase, remain constant, or even decrease. For this reason, it would be important to assess the number of appeals received as well as their qualitative nature. All participants agreed that a long-term reduction in appeals would be indicative of successful priority setting.

(3) Increased Stakeholder Acceptance and Satisfaction

All panellists agreed that increased stakeholder acceptance of the priority setting process and outcomes would be a good evaluate of success. Acceptance can refer to both the decision making process itself and the quality of the decision being made. Panellists felt that this could be manifested through enhanced buy-in with the process, or through improved public awareness around the process and outcomes. Panellists discussed the idea that stakeholder acceptance is somewhat dependant on stakeholder understanding, (the first element discussed); however understanding does not necessarily lead to acceptance.

Participants felt that increased stakeholder satisfaction would be another important indicator of success. Panellists described satisfaction as one step further than acceptance, implying a degree of contentment with the process.

Panellists discussed the public's acceptance and satisfaction as a separate stakeholder group, and it was agreed that public satisfaction was not a required element of success for priority setting.

(4) Improved Decision Making & Social Learning

All participants felt that an improvement in organizational decision making would be a characteristic of successful priority setting. Improved decision making was defined as a broad notion which represented a number of smaller ideas that could be made evident by tracking decision making over time. For example, improved decision making would discourage ‘bad behaviour’ (such as discriminatory reasoning, ‘back room’ dealing, and manipulation or distortion of the decision-making process) and encourage transparency and due process (‘good behaviour’).

Panellists also discussed ‘social learning’ as a benefit of a successful priority setting process. Social learning, for panellists, was indicated by the degree to which reasoning improves or becomes more consistent over time. It is related to the degree of institutionalization of, or compliance with, the priority setting process. For panellists, institutionalization meant that improved decision making, or the goal of improving decision making, becomes embedded within the organization as an established part of organizational culture.

(5) Shift in Resource Distribution

Shifts in resources, between or within programs, were seen by participants to be an important element of successful priority setting. Panellists cautioned that while shifting resources is one potential outcome of a priority setting process, it is not a definitive one, and does not always have to occur to denote a successful process.

(6) External Factors

Most of the participants agreed that successful priority setting should still be evident even outside the organization in some respect. Four ideas were proposed and endorsed by participants as ideas for evaluating successful priority setting external to the organization. They are, in no particular order:

1. An increase in positive media exposure
2. Changes in federal and local legislation
3. Peer 'emulation' ('admiration')- - other organizations learn from and follow the priority setting process used
4. Enhancement of market perception - - providers promote themselves through successful priority setting

Text Box 4.1: Elements of Success - - Views of International Scholars and Decision Makers

- (1) Improved Stakeholder Understanding
- (2) Acknowledgement of Appeals
- (3) Increased Stakeholder Acceptance and Satisfaction
- (4) Improved Decision Making & Social Learning
- (5) Shift in Resource Distribution
- (6) External Factors

4.2 Results of Study #2: One-on-One Interviews with Canadian Decision Makers

The purpose of this study was to gather the views of stakeholders who are directly involved in priority setting. In the interviews, I asked decision makers about their experience with priority setting (how they currently set priorities, setting and meeting goals, and defining successful priority setting). The results presented here are derived from interviews with 55 decision makers across multiple levels of the Canadian health care system. Interviews were analyzed and coded identifying chunks of data that related to a concept or idea; similar ideas were organized into overarching themes, or elements of success in priority setting. According to those interviewed, success in priority setting is characterized by seven elements (Text Box 4.2).

The seven elements are presented below in no particular order; decision makers were not asked about the relative importance or weighting of the elements. The element headings were created by the researcher (myself) in consultation with the research team, and they reflect the comments of interviewees. Verbatim quotes from participants are provided to illustrate key points.

(1) Explicit Process

Participants agreed that in order for priority setting to be successful, decision-makers should follow an explicit process that has been pre-determined (as opposed to ad hoc or historically determined) and agreed upon by decision makers.

The goal of priority setting here is to, first of all, have a decision-making tool around how we determine how we invest in our clinical programs, how we decide in a budgeting process, you know, what gets X amount of resources and what gets less. So, goal 1 is a decision-making tool.

Participants stressed that beyond general procedural structure, specific objectives and criteria for priority setting should be decided early in the process and there should be buy-in from those involved in the decision making process.

If you can get a large enough people-- or large enough number of people to agree on some goals and objectives that they all feel are important and are doable, put them in that

order, one they've got to be important and two they've got to be something that people feel can be done, then at least as a beginning you've got that base of people who are committed to doing what they can to advance things.

It is worth noting that while the majority of participants felt that an explicit process would be helpful in guiding their organization's priority setting, very few participants knew of a concrete process or applicable framework, with the exception of a small number who were familiar with the A4R framework. Other tools to aid in priority setting process, such as cost-effectiveness (CEA), were mentioned, but participants saw the need for information beyond what these tools could give.

According to participants, a fixed timeline is an important component of successful priority setting since it would ensure priority setting is finished in an efficient manner. Participants felt that a priority setting process that was time consuming and lengthy was a detriment to buy-in and the overall success of the process. However, participants expressed a need for a balance between doing it "well" and doing it quickly. One participant said:

In health care there are incredibly convoluted processes that take extensive amounts of time and resources... When it really comes down to it, it's a decision that's going to be made in 10 minutes... I see this as very inefficient and a waste of people's time.

(2) Context Consideration

All participants stated that successful priority setting involves a substantial amount of information, and one of the most important aspects of this information was context. For most participants, context included the type of health care organization (community or academic), its location (which city; urban or rural), and the demographics of the population served. Analyzing the organizational context also meant reviewing previous strategic plans and resource allocation decisions.

And the goals in terms of priority setting, tend to be-- if we sit around the table, ..., we have usually a lot of participants representing different organizations, different regions, different care providers. So that a lot of different contextual pieces usually at our table

which bring different priorities. And that's a good thing, because then ultimately you have-- well, broader input, but broader buy-in.

There was a dichotomy in the interviewees' views regarding a framework to guide successful priority setting. Half felt that while context was an important consideration, a framework for a successful priority setting process should be generalized. The other half felt that the framework for a successful priority setting process should be context specific and reflect the specific type of organization (population served, location, etc). They also expressed that a framework should be flexible for contextual considerations.

The content would vary depending on the environment, I mean what would be a criteria that would be important to an academic teaching facility is not as important to a local community hospital but the process of clarifying the values and the criteria and linking them to be able to rate different initiatives, to come up with priorities, the process could be the same.

Other participants felt that a priority setting framework should be less context-specific and more generalized to allow broad application.

Interviewees felt that a framework for successful priority setting should include predetermined external set of criteria that are specific to organizational context.

Having consistent markers are very important, that people measure the same things throughout the country... We need more consistency.

With the introduction of the standardized tool, there would be at the very least a common assessment that would give a baseline that is valid, reliable.

Participants stated current budget reports, community needs assessments, policy reports (e.g., Romanow, Kirby, Health Aare Accord), various evidence based reports (including cost-effectiveness data and health technology assessments) and health system information (e.g., regional budgets) were all pieces of contextual information.

We need information on what is happening from a planning perspective in the regions that I need to strengthen my original planning capacity.

(3) Consideration of Values

All participants felt that the mission, vision and values of an organization would be a good starting point for priority setting. This was especially true for participants from large hospitals and macro level institutions (such as Provincial Ministries of Health).

Creating a new vision for the organization and refining a mission and developing what we call 'key success factors' that are sort of sign posts on the way to achieving 'vision' helped us organize a lot of our priorities.

Participants recognized the need to incorporate values of the health care organization with those of the government, requiring a balance between "the political and the right decisions for health care". Values of the organization, (e.g., service delivery goals, clinical volumes) were seen as important considerations in successful priority setting.

The outcome goal is that we have a better distribution of clinical services that more reflects our mandate that fits within what we currently have in terms of resources and what we currently predict we are going to have in terms of resources.

(4) Inclusive Process

The majority of participants agreed that inclusivity is important for success in priority setting, not only to ensure representation in the process, but also to ensure that diverse reasoning styles are considered. Participants felt that priority setting would be successful if it involved the 'right' people, meaning not only those who are directly implicated in the priority setting process, but also those affected by the outcome. Determining who stakeholders are should be a separate and thorough step in the priority setting initiative.

I think part of the process has to be a real clear stakeholder analysis around who are the people that are going to be most affected, who are the people that are going to be least affected and who are these professional stakeholders back there who they need to know about.

Participants argued for the importance of balanced involvement in priority setting, with no over-representation of any one group.

Some kind of balance between people who are responsible for putting the ideas in place, that allocate the resources or that make the decisions along with the people who would benefit from it.

Many participants stressed the importance of including the public in priority setting. Participants felt that involving community members would ensure an increase in positive community perception as well as an increase in the general understanding of priority setting itself. Participants, however, did not know of a method that would adequately assess this.

Participants also felt that increased inclusivity in the priority setting process comes with increased satisfaction, as well as changes in employee morale. Surveys (patient, community, and employee) were described by participants as a way of evaluating this.

People don't like stuff being done to them. And I think-- if you take the time to explain, ...-- you minimize some of the resistance to change... -- (The opposite) part of it would be reflected in bad morale. People emailing you and saying, we can't believe such and such a decision was made, and I wasn't involved.

Some participants discussed the value of having someone external to the organization involved in the priority setting, such as “an independent auditor-type” or an “external review body”.

Participants felt that this would demonstrate openness and accountability as well as a commitment to the larger health care context and strategic goals.

(5) Effective Communication

All participants felt that effective communication was an important element of successful priority setting.

Communication is really critical...the need for something that is as open as is possible and as accepted as is possible and communicated as effectively as is possible.

Many described communication as multi-directional between decision-makers, the public, the staff and other stakeholders. Many participants from large health care organizations discussed the struggle to effectively relay priorities to all stakeholders and the difficulty of ensuring that communications are well understood.

There is never enough communication. So even if you think you're inundating people with information, they can choose to read or not read. And that's up to them. ... So

that's-- again that's part of process. In the end if people don't have the accurate information, they won't-- they can't make the right decision... I think communication was our biggest struggle.

Participants also noted that there is a lack of communication of priorities and strategic directions between organizations:

Part of the issues around the budget process and making decisions around it, was the lack of communication where the-- what seemed to be-- well, they claim it was unclear communication from us. And we claim that they never responded to our request. So it was a matter of determining a pro- a better process.

(6) Comply with External Guidance and/or Directives

Participants from smaller health care organizations (CCACs, District Health Units, etc.), and smaller regional health authorities said that external directives (e.g., those from provincial ministry of health) were important driving factors in successful priority setting. Similarly, participants from smaller provinces were more likely to consider federal health care directives in their priority setting. These participants stated that many of their priority setting goals came from government-set priorities.

If the Ministry has asked us to do it, and we pretty well need a good reason not to.

Not all participants agreed - - some felt the exact opposite was true:

The (provincial) government has little or no impact on (our strategic directions), which I find odd.

Still, participants from all levels of organizations said that matching up organizational priorities with the priorities or funding from external sources would be an indicator of successful priority setting. An example of this would be aligning program funding with provincial Ministry of Health priorities

We've had a palliative care focus for about four years now. We are putting more dollars into that now. We are developing more expertise; we are looking more closely because we know that's where presumably at some point the province having said we'll come together and say that palliative care is what's needed.

(7) Support a Learning Organization

Participants focused on two specific areas of learning within an organization: the people, and the organization itself. Participants felt that successful priority setting would provide learning among staff (for example, capacity building and improved understanding) as well as promote lasting changes within an organization (for example, shifts in culture, or mission, vision, values).

Successful priority setting would set criteria for future decision making and engrain elements of success in their organization.

Although learning from past priority setting experiences was a key issue discussed by participants, they were uncertain how to transform these experiences into lessons. Some participants suggested qualitative methods to evaluate a long-term organizational change such as a shift in an organization's culture, mission, vision, and/or value statement.

The outcome of any priority setting exercise has to be some sort of an action, a shift in vision or a shift in growth or validation of what's currently happening.

(We're) trying to change the culture of the organization to one of a greater sense of pride and ownership and respect and energy and excitement about doing what we do.

Text Box 4.2: Elements of Success - - Views of Canadian Decision Makers

- (1) Explicit Process
- (2) Context Consideration
- (3) Consideration of Values
- (4) Inclusive Process
- (5) Effective Communication
- (6) External Guidance and/or Directives
- (7) Support a Learning Organization

4.3 Results of Study #3: National Patient and Decision Maker Focus Groups

This study was designed to gather patients' and decision makers' views on successful priority setting. Separate focus groups were held with both groups, to gather opinions unique to each, and then together, to reach consensus on issues and potentially discover new ideas. Specifically, we asked focus groups to discuss problems of priority setting and possible solutions. Through analysis of the focus group discussions, eight elements of success in priority setting were identified (Text Box 4.3). These elements are presented in no particular order, with the exception of the last element which was discussed by the decision makers only. In the final focus group (both groups together), it was evident that both decision makers and patients agreed on the importance of the first seven elements.

Verbatim quotes and case studies from participants are provided to illustrate key points.

(1) Integrated Process

Patients and decision makers agreed that a vital component of successful priority setting is integration both within and between health care organizations, the provinces and the government. Integration consists of two main components: coordination and consistency. Coordination refers to harmonious functioning of the different levels and areas of the health system, whereas consistency infers a degree of similarity in priority setting practices/processes.

Integration in priority setting was discussed for three areas or levels: within a health care organization, between health care organizations, and between the different levels of government (federal and provincial).

In the decision maker focus group, participants focused heavily on the lack of coordination within their own health care organization.

They say that every regional health authority has two business plans, one for the government and one for the region, what should be done with this?

This lack of coordination was reflected in an absence of structure or process within the organization, meaning that many are left not knowing who is making what decisions and what decisions have been made.

There are a lot of levels and ego and there is no contact between the different levels, you have the doctor... the nurse...the administrator, and between everything there is no management or contact.

We tend to deal with this as silos - - this is health, and health is all-important... but once the dollars implications came out, we had the federal government saying we don't have the money, so we'd already made a macro allocation decision before we'd even considered the evidence.

Decision makers also highlighted the difficulty in setting focused priorities for patient care caused by a lack of coordination between health care organizations (for example between a hospital and a long-term care facility). This is demonstrated by the troubles experienced in continuity of care amongst health care organizations.

There's a lack of coordination ... so hospitals are looking to put out patients earlier, that only works if ... all those programs are there to catch those people... that doesn't seem to be occurring effectively.

Patients agreed that superior coordination between health care organizations would improve priority setting and better meet their needs. One example given by a patient illustrates this point (Case A).

Both groups agreed that successful priority setting requires coordination between the different levels of government. For example, among the ten provinces and three territories, there are

thirteen different systems across Canada, “If we could do a lot more sharing then I am sure we would save some costs as well.”

Case A

Patient C died of breast cancer at a young age, leaving her husband and their small child. She was being treated for cancer in British Columbia even though she lived in the Yukon. Where she lived, there were no acceptable facilities for her chemotherapy, so every two weeks she flew, alone, to a hospital in BC and was given her treatment. The provincial government would pay for her and one caregiver to fly to BC, however, the government would not pay for their son to fly and therefore patient C had to fly alone. Patient C spent many painful hours receiving treatment in BC. After her death, patient C’s husband made a large financial donation to finance a chemotherapy treatment room in their local hospital in the Yukon.

Successful priority setting also requires coordination between different levels of government (federal and provincial).

The problem is the dysfunctionality between the relationship between the two ‘cause they can’t get together and figure out how to respect the priority setting... That’s as much of a provincial indictment as it is a federal one.

(2) Inclusive Process

Patients and decision makers unanimously agreed that having the right people involved in priority setting is of utmost importance. Decision makers highlighted the importance of the right mix of stakeholders at the table:

It’s more than just talking to the patient who thinks he might need, but you also need that professional component to it, and you have to achieve that balance.

Decision makers felt that involving the public in priority setting can be laborious and difficult. They expressed dissatisfaction with their past experiences in public engagement. One decision maker claimed:

It is an inefficient use of time to poll public when their views aren't ever really used.

That creates so much frustration in the system of caregivers and they've spent all this time and this is what the decision is going to be anyway - - I just, I see this as a very inefficient and a waste of people's time.

While decision makers see value in engaging the public, there is difficulty defining who the public is: "Are they users of the system or (an)other (grouping) ... and how do you ensure representation?"

Citizen engagement ... is a very difficult exercise... If it's a uniformed exercise, you basically get what they saw on TV and read in the newspapers, or the big issues. So that's why the voice of the patient is an interesting area, because you're getting people who've been in the system recently and in a major way, who have some authority and expertise.

Some decision makers expressed frustration about their experience and involvement in priority setting. There was disappointment that priority setting processes were often more of a political exercise rather than one that generates a "real, significant policy shift".

Similarly, patients also expressed their concerns about how their opinions were used, expressing a general feeling that decisions makers are too far removed from the bedside and the view of the patient is sometimes lost.

It is a very difficult situation and very easy to loose track of the patient, loose that compassion when you are dealing on such an abstract level... I am not saying it is wrong, but a lot of them are dealing with the patient in a very abstract way.

(3) Effective Communication

Both patients and decision makers discussed lack of effective communication as a current barrier to successful priority setting. They described lack of communication as a lack of open channels of communication or multiple vehicles of communication. Communication of the priority setting process was felt to be important and essential to the overall success of the process.

We understand that the system is stressed, but one of the problems we are having is that the reason it is stressed is that somehow communication has to be there.

Decision makers focused most on the external communication of priority setting outcomes and the internal communication of the priority setting structure.

[H]ard to identify the point of decision-making – at what level the decision has been made. Often we are just drifting into things and we never know when it has been set as a priority.

Decision makers felt that the issue of communication was already on the political agenda, but that there was no immediate solution.

Those are decisions and discussions that have been had in this country over and over again, so why is the political chasm not being bridged?

Patients also focused a substantial amount of their discussions on communication between individuals within the health care system such as administrators and clinicians. For patients, lack of communication translates into a lack of knowledge and understanding, which can manifest as a fear of the unknown. Not understanding the priority setting process and potential outcomes left some patients afraid; for example, some are afraid that rationing will lead to reductions in care and services provided.

They are rationing things because of the money problems, and if something happens and you need it, I don't know if it will be there.

Patients felt that lack of communication was not only an issue between patients and providers, but also between groups of health care providers.

So communication is really lacking here and it's not just communication with the patients, its communication between the doctors, the nurses, the RHAs, it's a real bad problem throughout the whole medical community.

Patients saw communication in successful priority setting as a two way process which providers should initiate. Patients in this focus group felt that they were lacking information about priority setting decisions. Some patients experienced situations where the lack of communication affected their personal care or health care treatment (Case B).

Case B

Patient X was diagnosed with multiple sclerosis at a very young age. As a young child she was forced to use bulky and heavy wheelchairs. When she became a teenager, she and her mother decided it was time to get a sleek wheelchair that would allow her to get around better. The wheelchair they picked out was small, lightweight and purple. When they put forward the application to get the wheelchair covered by the provincial health insurance, their claim was denied. Instead, the provincial insurance would pay for a larger, bulkier automatic (motored) wheel chair as prescribed by the insurance plan. Both the mother and daughter were quite upset by this outcome. After further analysis by the mother, it turned out that the wheelchair she wanted for her daughter cost less than the one the government would pay for. There was no attempt by the ministry to involve the patient and her family in this decision making process, nor was there any communication to them regarding the decision making process. The decision was attributed to a policy that had been made years before.

(4) Education

Decision makers spoke of the need to educate clinicians, the public, and the patients about the inevitability of priority setting. An increase in the education of stakeholders would increase the success of the priority setting.

So how do we take a clinician and a client and educate them as to the big picture? Because every individual is part of a community, and every community is made up of individuals. So how do you let them make those larger decisions at their micro-level?

Decision makers also saw the importance of educating other stakeholders regarding the context of priority setting within the larger health care system. Patients talked more than the decision makers about educating policy makers and clinicians. As one patient said: “We need to educate the policy makers about chronic pain, about taking pills, about depression”. Patients felt that a key factor in priority setting decisions should be consideration of patient experiences; decision makers and policy makers need to gain a better understanding of what it means to be a patient.

Patients also saw the value in gaining education about health care costs, especially costs pertaining to their own medical treatments.

Give us [patients] the information: how much it costs. There ought to be access to that information on how we can look after ourselves... If you know how much one doctor visit is going to cost, maybe you won't go that day to ask him about something irrelevant.

Patients felt they are denied control over their own medical treatment and are often given prescriptions or treatments without an explanation, as a “do as you are told” mentality. Patients wanted more knowledge about the priority setting process and the reasons behind the decisions: in the current situation, “they (doctors) don't empower the patient to help themselves”.

Patients discussed the idea of ‘partnership’ in the first focus group. In the large focus group that combined patients with decision makers, the patients further clarified partnership as a way of empowering patients and allowing flexibility. Patients felt that they have been denied control over their own medical treatment. Decision makers furthered this idea in their parallel focus group by discussing the need for education for patients and the public.

(5) Transparency of Process and Information

Although both groups felt that transparency was a key element of successful priority setting, and that there is currently a lack of transparency in Canadian priority setting, the issue was discussed more in depth by the decision makers.

For decision makers, transparency dealt directly with the priority setting process; what the process looked like, what criteria were being used, what the timeline was, etc. Another key issue in transparency surrounded the information being used to make priority setting decisions. Participants felt that there was insufficient information available to make legitimate decisions, and that more effort should be made to ensure that adequate information is available.

Decision makers felt that a transparent process includes elements of both information and communication. Specific to the priority setting process, increased transparency would improve consistency and legitimacy of priority setting across health care organizations.

One common feature regardless of the level – that it lacks generally, transparency. I don't think that it's just an issue of communication. In the end, could you go back and arrive at the same decision again if you started at that point; and often you can't, either conceptually or otherwise, because there is no transparency and there is no consistency, and some of that has to do with communication. I think that's true whether it's macro-level decision making or its micro-level decision making.

(6) Consideration of Context

Both patients and decision makers agreed that a successful priority setting process needs to consider the context of the priority setting. One decision maker pointed to “data, client need, needs assessment, values of the Board, and values of the organization...” as important elements to priority setting, along with clinical evidence and cost-effectiveness data. Others felt that context also included current literature and evidence in successful priority setting (for example, Canadian Institute Health Information reports, Health Care Accord, Romanow and Kirby reports, good practices of other organizations).

Decision makers felt that current and regularly updated information was an important part of the priority setting context. Some participants thought that such information was lacking, whereas others felt that it is not the amount of information, but rather that the interpretation and use of the available information was lacking.

I think we have lots of information – more than we can use... The challenge us to analyze the data, interpret it in some kind of meaningful way and provide it to those who need to know.

(7) Consideration of Values

Decision makers and patients all stated that they recognized the need to include values in successful priority setting. Decision makers focused on the values of the organization (such as the mission, vision, and values) as well as the values of individuals within the organization. Decision makers also discussed political values as an influence on priority setting, but had mixed feelings about whether this was a positive or negative influence to the process.

I can only come back to three possible ways of thinking about this: it's gotta be based on the values, the evidence, and the interests. And we often make priority setting decisions in public policy and do it without explicit recognition of what values we're trying to achieve or appeal to.

Decision makers all agreed that the starting point of priority setting needs to be the mission, vision and values of the organization.

In any sort of organization or government or strategic planning, there's an overarching shared vision that you start from. You don't start at priorities – you start way up.

Patients focused more on patient and public values, but saw the inherent need to consider organizational goals and values. Patients felt that political values should not play a role in priority setting.

(8) Recognized Shift/Change in Resources

Decision makers felt that in order for priority setting to be successful, actual changes or shifts in resources would be an inevitable result or outcome. This idea was not discussed by patients in their separate focus groups, and it was not brought up for discussion in the large (all-together) focus group.

Decision makers were frustrated with the amount of time and energy that they invest in priority setting initiatives that have no tangible results.

We have all of these exercises, yet I wonder how the voice is actually converted into real, significant policy shift...you see so little of what you've really articulated being internalized.

Text Box 4.3: Elements of Success - - Views of Canadian Patients and Decision Makers

- (1) Integrated Process
- (2) Inclusive Process
- (3) Effective Communication
- (4) Education
- (5) Transparency of Process and Information
- (6) Consideration of Context
- (7) Consideration of Values
- (8) Recognized Shift/Change in Resources

4.4 Results of the Synthesis of the Three Studies – The Conceptual Framework

The three studies presented above provide insight into key elements necessary for successful priority setting. When looking at the data in aggregate, it is possible to create a list of key success elements. The three studies provided 21 elements of success (Table 4.2).

Table 4.2: Elements of Success - - Results from 3 Studies

Views of International Scholars and Decision Makers (Delphi)	Views of Canadian Decision Makers (1on1)	Views of Canadian Patients and Decision Makers (Focus Groups)
(1) Improved Stakeholder Understanding (2) Acknowledgement of Appeals (3) Increased Stakeholder Acceptance and Satisfaction (4) Improved Decision Making & Social Learning (5) Shift in Resource Distribution (6) External Factors	(1) Explicit Process (2) Context Consideration (3) Consideration of Values (4) Inclusive Process (5) Effective Communication (6) External Guidance and/or Directives (7) Support a Learning Organization	(1) Integrated Process (2) Inclusive Process (3) Effective Communication (4) Education (5) Transparency of Process and Information (6) Consideration of Context (7) Consideration of Values (8) Recognized Shift/Change in Resources

In order to make one comprehensive list of elements of successful priority setting, similar items from the three separate lists were merged. To do this, I re-read and re-analyzed raw data to look

for similarities. This involved a lot of comparison and evaluation between the raw data and the coding lists of all three studies to ensure that the merged list reflected and captured the original description and meaning.

First, I compared the lists from each study and amalgamated the three to make one all-inclusive list. Next, similar items within the large list were merged.

Making a comprehensive list also involved merging similar items within lists; for example, context consideration and consideration for values were merged within views of Canadian decision makers. Similarly, in the focus group list, consideration of context and consideration of values were merged. These four elements were then merged together to create ‘consideration of context and values’. Merging also occurred when improved stakeholder understanding (from Delphi) and education (from the focus groups) were combined to create the element ‘Improved Stakeholder Understanding’.

In the end, a list of ten items was created (Table 4.3). The element labels (left column) were created by the research team based on the results of the three studies; where possible, we used labels that were verbatim from either the original raw data (i.e. participants themselves used the words) or from the three separate lists of successful priority setting from the individual studies (i.e. labels that the research team had previously used to reflect study results).

When there was disagreement or uncertainty about merging items, I went back to the original data and re-analyzed the individual and specific meaning of the element and how it originally emerged in the data. There were few inconsistencies between the elements of success derived from each of the three studies. There were some contradictions between the two focus groups in study #2, (patients/health system users versus decision/policy makers), mainly regarding procedural

elements of priority setting. For example, patients were less concerned with procedural efficiency, but more focused on partnership in public consultation and education. Decision makers saw the importance of public consultation, but spent more time discussing the priority setting process, highlighting (among other things) the importance of efficiency.

Table 4.3: Merged List			
ELEMENTS	Delphi	1-on-1	Focus Grps
1. Stakeholder Engagement		•	•
2. Explicit Process		•	•
3. Information Management			•
4. Consideration of Context & Values		•	•
5. Revision or Appeals Mechanism	•		
6. Stakeholder understanding	•	•	•
7. Shifted priorities /Reallocation of resources	•		•
8. Improved Decision Making Quality	•	•	
9. Stakeholder Acceptance & Satisfaction	•		
10. Positive Externalities	•	•	

Elements that were only discussed in one study were re-analyzed as well. To do this, all of the studies were re-analyzed using the specific element as a thematic code. To do this, I re-read the data specifically looking for information to support the element. Elements that were not supported in the other empirical studies were eliminated, while elements that were supported remained in the list. Both ‘Information Management’ and ‘Revision or Appeals Mechanism’ remained on the final list as elements of successful priority setting because evidence was found in the raw data to support each of these elements. For example, ‘Information Management’ was explicitly discussed, but only by decision makers in the focus groups, however, when I reanalyzed all of the data in aggregate (all three studies), lack of information and desire for more information was a common theme.

Next, using electronic communications, I circulated the conceptual framework along with an explanation of the elements to a selection of participants from the three studies, as well as a group of interdisciplinary scholars, for their comments and refinements. Fifteen participants from the various studies were invited to comment on the framework, in addition to eight scholars. Seven of the participants and all eight scholars replied via email with comments and questions of clarification. Most of the comments pertained to the wording of the elements. For example ‘information management’ was clarified and further qualified as ‘clear and transparent information management’, and ‘improved’ was added to ‘stakeholder understanding’ to reflect the idea of change over time. Revisions were made accordingly. Several of the participants asked to comment encouraged more organization within the list; as a result, the elements were organized into two sections: 1) five process elements, and 2) five outcome elements according to their focus.

Each element is important individually but is also related to the others, thus forming a robust and comprehensive framework (Table 4.4). Each of the ten elements is described below.

Table 4.4: Conceptual Framework	
	Elements
PROCESS	Stakeholder Engagement
	Use of Explicit Process
	Clear and Transparent Information Management
	Consideration of Context & Values
	Revision or Appeals Mechanism
OUTCOMES	Improved Stakeholder Understanding
	Shifted priorities /Reallocation of Resources
	Improved Decision Making Quality
	Stakeholder Acceptance & Satisfaction
	Positive Externalities

PROCESS CONCEPTS

1. Stakeholder Engagement

Stakeholder engagement refers to an organization's efforts to identify the relevant internal and external stakeholders and to involve those stakeholders effectively in the decision-making process. This should include, at a minimum, administrators, clinicians, members of the public and patients. To ensure adequate engagement, identifying and engaging stakeholders should involve multiple techniques, such as round tables, open forums, departmental meetings. There should be a genuine commitment from the organization to engage stakeholders effectively through partnership and empowerment. Stakeholder engagement is also concerned with stakeholder satisfaction regarding the level of their involvement in the decision-making process.

2. Use of Explicit Process

An explicit process is one that is transparent, not only to decision makers, but also to other stakeholders. Adhering to a predetermined process can enhance trust and confidence in the process. Transparency means knowing who is making the decision as well as how and why the decision will be made. Communication needs to be well coordinated, systematic and well-planned. All stakeholders (internal and external) should be probed for information relevant to the priority setting decisions, and information should be communicated effectively using multiple vehicles (town-hall, departmental meetings, memos, emails, etc.)

3. Information Management

Information management refers first to the information made available to decision makers during the priority setting process. This includes what was used and what was perceived to be lacking. Second, information management considers how the information was managed, including how it was collected and collated. Relevant information includes, but is not restricted to: health

outcomes data, economic data (such as cost effectiveness analyses), community needs assessment, current policies or policy reports, and the experiences of both clinicians and patients.

4. Consideration of Values and Context

Values and context are important considerations in any priority setting process, including the values of the organization, the values of staff within that organization, and the values of other stakeholders (such as patients, policy makers, politicians, and members of the community). The mission, vision and values of the organization should guide priority setting. Priority setting decisions should be based on reasons that are grounded in clear value choices, and those reasons should be made explicit. This also involves not only looking within the organization at previous priority setting decisions, but also studying what other health care organizations are doing. This would involve looking at organizations in the local community, at other health care organizations with similar mandates, as well as looking at the other levels of health care provision. Context is distinct from values and considers the organization's goals in the health care environment, as articulated in its strategic directions.

5. Revision or Appeal Mechanism

A revision process is a formal mechanism for the review of decisions, and for addressing disagreements constructively. Such a mechanism is important to ensure the priority setting process rules and requirements are communicated clearly ahead of time. The dual purposes of a revision process are to: 1) improve the quality of decisions by providing opportunities for new information to be brought forward, errors to be corrected, and failures in due process to be remedied; and 2) to operationalize the key ethical concept of responsiveness.

OUTCOME CONCEPTS

1. Improved Stakeholder Understanding

Stakeholder understanding implies more than basic knowledge of the process. It assumes stakeholders have gained insight into the priority setting process (e.g., its goals, rationale and rationale for its decisions) and/or the organization (e.g., mission, vision, values, and strategic plan). As stakeholder understanding increases, stakeholder acceptance and confidence should also increase.

2. Shifted Priorities and/or Reallocated Resources

A successful priority setting process results in the allocation of budgets across portfolios, changes in utilization of physical resources (e.g., operating theatre schedules, bed allocations) or possibly changes in strategic directions. Effort that does not result in change may encourage the perception among stakeholders that the process is an inefficient use of time or is done for the outward appearance ('window-dressing') of pre-determined outcomes. A reaffirmation of previous resource allocation decisions (e.g. the previous year's budget) may, in some circumstances, be seen as a success.

3. Improved Decision Making Quality

Decision making quality relates to appropriate use of available evidence, consistency of reasoning, institutionalization of the priority setting process, alignment with the goals of the process, and compliance with the prescribed process. It also captures the extent to which the institution is learning from its experience in order to facilitate ongoing improvement. This component is most visible as subsequent iterations of priority setting are evaluated; where consistency and building on previous priority setting would be indicative of a successful process. Institutional learning, increased institutionalization of priorities, more efficient decision making, more consistent decision making, and increased compliance with decisions (i.e. 'buy-in') are all

valuable outcomes of successful priority setting that are difficult to achieve. Institutional learning from experience facilitates ongoing institutional improvement, which is made more visible as subsequent iterations of priority setting are evaluated.

4. Stakeholder Acceptance and Satisfaction

It is important to consider the satisfaction of all stakeholder groups, both internal and external to the hospital (community groups/public and governmental health agencies/ministries of health).

Successful priority setting leads to increased satisfaction over multiple decision cycles.

Stakeholder acceptance is indicated by continued willingness to participate in the process (i.e. ‘buy-in’) as well as the degree of contentment with the process. Stakeholders may be able to accept priority setting decisions, even if they may not always agree with the outcomes.

5. Positive Externalities

Positive externalities can act as a sort of check and balance, ensuring information is made transparent to stakeholders through various avenues, and/or establishing good practices for budgeting in other health care organizations. As an indicator of success, externalities may include positive media coverage (which can contribute to public dialogue, social learning, and improved decision making in subsequent iterations of priority setting), peer-emulation or health sector recognition (e.g. by other health care organizations, CCHSA, etc), changes in policies, and, potentially, changes to legislations or practice.

Chapter 5: Results

Developing and Testing the Evaluation Tool

This chapter focuses on the results of the development and testing of the evaluation tool. In this chapter, I will discuss how the tool was developed, how it was applied in a real-world setting, and how both the framework and the tool evolved throughout the process.

This chapter is organized into three sections. In Section 5.1, I will describe the development of the evaluation tool, operationalizing the ten elements described in Chapter 4. In this section, I will also describe the results of assessing the face and content validity of the tool. In Section 5.2, I will report the results of the real-world application of the evaluation tool, which is referred to as the pilot study, and I will present the results of the survey, interviews, and documents analysis in aggregate. I will also briefly describe the recommendations derived from the application and interpretation of the evaluation tool results. In Section 5.3, I will discuss the perceived usefulness of the evaluation tool, first from the point of view of pilot study participants, and second from the point of view of the researcher. I will also discuss the refinements to the conceptual framework and the evaluation tool as a result of the pilot study.

5.1 Results of the Development of the Evaluation Tool

The evaluation tool was designed to operationalize the notion of successful priority setting and to help health care organizations identify strengths and opportunities for improvement in their priority setting activities. It was developed using the ten elements of the conceptual framework (described in Chapter 4). I developed the evaluation tool through an iterative process of proposing indicators (questions) and then refining the indicators through feedback from stakeholders and

scholars. The questions reflected both quantitative and qualitative dimensions of the conceptual framework.

The first step in developing the evaluation tool was to propose questions attempting to operationalize each element of the conceptual framework. In this step, I tried to be over-inclusive with questions. The indicators mapped onto the ethical and practical goals of priority setting, specified both quantitative and qualitative dimensions of priority setting, and related to both the procedural and substantive dimensions of priority setting. Questions were created to relate to the elements of the conceptual framework; however, since each element is multi-faceted, more than one question was created to capture the various aspects of each element. For example, to capture the ‘revisions or appeals’ element, I created six questions (Text Box 5.1). 56 questions were developed in total.

Text Box 5.1: Tool Development: Example Questions for Revisions and Appeals Element

1. Was there a revision or appeals process present in the priority setting process?
2. What happened if people did not agree with the decision that was made, or the process by which the decision was made?
3. How would you grade the quality and thoroughness of this revision or appeals process?
4. Are there any documents surrounding the use of an appeal process?
5. What did the revision or appeals process look like?
6. What communication devices were used for the revision or appeals process?

The next step was to choose the format for the tool that would be most suitable for eliciting responses for questions, as well as be appropriate for the purpose of evaluating the achievement of success within a health care organization. I decided to use three components (or formats): a survey, one-on-one interviews, and document analysis. Surveys can be anonymous (to deal with sensitive questions) and allow for more breadth of questions in a short amount of time (through

simple yes/no or Likert scale). Through surveys, it is also possible to engage more stakeholders in less time. Interviews allow more depth and, being face-to-face, provide the opportunity to clarify ideas and discover new themes. Document analysis provides the opportunity, firstly to harmonize information from surveys and interviews with actual records, and secondly, to more objectively gain understanding about the background and process. I chose these three methods of assessment because they could provide a comprehensive and complete evaluation of the priority setting process. Further, participants from Study #2 (the decision makers; Sections 3.1 and 4.2) suggested that a survey was an appropriate method for gathering data about successful priority setting.

Once I had determined the format (surveys, interviews, document analysis), I took all 56 questions and assigned them to the most appropriate component (Table 5.1). Table 5.2 shows the total number of questions from each component of the evaluation tool (survey (S), interviews (I) and document analysis (D)) as well as the total questions for each domain.

Table 5.1: Tool Development: Example of Assigning Questions to Different Components (Revisions and Appeals Element)		
Survey	Interviews	Document Analysis
Was there a revision or appeals process present in the priority setting process?	What happened if people did not agree with the decision that was made, or the process by which the decision was made? How would you score the quality and thoroughness of this process?	Are there any documents surrounding the use of an appeal process? What did the process look like? What communication devices were used?

The end-result was a survey comprised of 26 questions (see Appendix G for the first draft of the evaluation tool). Questions were formatted as yes/no, simple Likert scales, check box, and open-ended questions (please list or please explain). In order to make the survey less complicated and more logical, questions were organized into seven sections reflecting a logical sequence of a

priority setting process, as opposed to according to the ten elements (i.e. process questions came before outcome questions).

Table 5.2: Total Number of Questions from Each Component of the Evaluation Tool

Outcome	Stakeholder Understanding	4	S	3
			I	1
			D	0
	Shifted Resources	2	S	0
			I	1
			D	1
	Improved Decision Making	7	S	3
			I	2
			D	2
	Stakeholder Acceptance	6	S	5
			I	1
			D	0
	Positive Externalities	2	S	0
			I	0
			D	2
Process	Stakeholder Engagement	8	S	6
			I	1
			D	1
	Explicit Process	8	S	5
			I	1
			D	2
	Information Management	11	S	7
			I	0
			D	4
	Values & Context	3	S	1
			I	1
			D	1
	Revisions Process	5	S	3
			I	1
			D	1

Interview questions were also refined to ensure clarity and avoid jargon. Questions were consolidated and organized with probes, which decreased the number of questions from 18 to five. Interview questions were also organized according to the sequence of a priority setting process.

Document analysis questions were revised to ensure both straightforwardness and that each question related to only one element of the conceptual framework. Document analysis questions remained organized according to the conceptual framework; there were 14 questions in total.

Validity Testing

Once the draft tool was finalized, the next step was to test and validate it. As discussed in Chapter 3, I chose to focus on two aspects of validity: face and content. Since face and content validity pertains to perceptions of the tool, it is therefore important to test the tool with individuals similar to the group that will be using the tool, or ‘users’. Testing face and content validity involved giving the items to a group of users and/or a group of experts to determine if any items should be added to fill any gaps in relation to the conceptual framework being used. While it is possible to test content validity using statistical analysis of each question (explored further Chapter 6), I decided to test the content validity of the survey via email with a group of users and experts in the field of priority setting. In order to assess the face and content validity, I assembled a panel of both experts and users, which I have called the Face/Content Validity Panel (FCV Panel).

All three components of the draft tool were disseminated to an interdisciplinary group of researchers to assess readability, clarity, and how well the questions captured or reflected the ten elements of the conceptual framework. In total, 12 expert panellists participated in the FCV Panel (See Section 3.2 for a list of panel participants). Panellists were provided with the conceptual framework (the ten elements) and a worksheet with all of the questions divided into their format (surveys, interviews, document analysis). Panellists made comments on the worksheet and also sent comments electronically (email).

Panellists suggested very few conceptual changes and most changes concerned wording (deleting confusing words and consistency of wording). Problem questions were re-worded. For example the question: “Were the decisions that were made in the priority setting process reflected in other areas? If yes, where?” was changed to: “To what degree are the following items reflected in the 2007/08 budget? (followed by a list of seven specific items including mission, vision, values, and staff, patient and community values).

Overall, the panel members believed the survey to be valid, with some minor revisions. Three of the participants felt that the flow of questions should be revised. Two participants felt that the subject headings in the survey should better reflect the elements of the conceptual framework. As a result, two headings were added (‘More on Process’ and ‘Stakeholder Engagement’) and the existing five headings were re-worded to be more explicit and simplistic (e.g.: ‘Communication of Process’ was changed to ‘Communication’). Another participant thought that clarification could also be greater if some sections included a brief introduction preceding questions. Four participants felt that there was some confusion of terms in the survey, such as using words interchangeably that should not be used that way (for example: ‘components’ and ‘items’).

Almost all participants suggested questions that they felt should be added to the survey. Most of the add-ons were open-ended to allow survey respondents to explain yes/no answers (“please explain”). Five panellists agreed that the survey should include a question aimed at capturing the level of respondent involvement in priority setting (e.g. “How involved were you with the priority setting process?”). Another panellist felt that a question regarding job title (demographics) should be included.

One panellist cautioned that the survey might need to have context-specific questions, depending on the priority setting process being evaluated. Another panellist furthered this statement by

saying that the survey seemed to be geared toward larger acute health care organizations and would have to be contextualized.

The survey was revised accord to panellist's comments. By addressing issues of flow (which questions should come first, etc.), I was able to eliminate similar questions. I also changed two of the subject headings and added a brief explanation before the questions in order to clarify. The wording of certain questions was also altered to ensure consistency.

As a result of the FCV Panel, eleven questions were added and three questions were deleted.

Other questions were combined or their format was altered. The original survey had 26 questions; the revised survey had 34 questions, and a 35th question to gather demographic data (see Appendix H for a table detailing the tracked changes to the survey as a result of the FCV Panel).

5.2 Results of the Real-World Application - The Pilot Study

This section describes the results of the implementation of the tool, or Part I of the pilot study.

The overall aim of this pilot study was to test the real-world applicability of the evaluation tool by applying it to the 2007/08 budgeting process at the hospital. The first objective of the pilot study was to use the tool to evaluate a priority setting activity at the hospital, specifically the 2007/08 budgeting cycle. The second objective was to evaluate the usefulness of the tool. This section deals with the first objective; the second objective will be dealt with in the next section (5.3).

The pilot test (methods described in Chapter 3) began in May 2007 and was completed by July 2007. It was led by Shannon Sibbald (SS) in collaboration with the Vice President, Corporate Services & Chief Financial Officer and the Organizational Development Leader/Ombudsperson of the hospital, with academic oversight from Dr. Douglas Martin (DKM, supervisor) and Dr. Jennifer Gibson (JG, Assistant Professor, Department of Health Policy, Management & Evaluation and Director, Partnerships & Strategy University of Toronto Joint Centre for Bioethics).

Participants were recruited to participate in both the survey and the interviews via email invitation. In total, 114 hospital employees participated in this study.

Background

This study evaluated the hospital's 2007/08 budgetary process, which was conducted between June and September 2006. The context for the hospital's budgeting process included: recent change in the hospital's Senior Leadership, the creation of Local Health Integration Networks (LHINs) in Ontario, and the new Ministry of Health and Long Term Care (MOH) Hospital

Accountability Agreements (HAPS). The first challenge of the 2007/08 budget process was to achieve a balanced budget within the context of the resources available as well as a predicted salary increase of 3%. Second, managers were expected to create their own budget for the first time, using a new computer-based budgeting tool; this marked a significant departure from past practice where accountability for budgeting rested primarily with the senior team.

Program managers and directors were asked to complete the budget tool over a 4-week period in the summer of 2006. A meeting to present the proposed budgets was held soon after budget submission. Budgets were analyzed by senior management and areas of concern were identified; managers and directors were asked to implement changes if required. From there, the budget was presented to the Board and submitted to the MOH (as part of the HAPS report).

Interpretation

A link to the survey was sent through internal email; anyone with an organization email address received a survey link. The response rate of the entire survey could not be determined because it is difficult to know how many people actually received the email: there are over 5000 employees at the hospital, and while most have an organization account, not all have activated, or used, their accounts (a number of employees use personal accounts instead of hospital email). Response rate on a question by question basis started off high (100% of the people responded to the first question), and decreased as respondents did the survey (41% responded to the last question, #34).

In total, 105 hospital employees responded to the online survey; however, 27 surveys were not analyzed because they were incomplete. The results of 78 surveys were analyzed (Table 5.3). Thirty-one were front line staff, 13 were program directors (PD), 8 were program managers (PM), one was from the senior leadership team (SLT), 8 indicated 'other' under job title and 17 did not indicate a title. Although there was an option for 'Board Members', no respondents selected this

as the Board of Directors did not receive the survey. ‘Front line’ was used to define health care professionals who work at the bedside and have direct contact with patients (nurses, allied health, and physicians). ‘Other’ captured hospital employees such as clerical and engineering staff.

Table 5.3: Survey Respondents

Job Title	
Front Line Staff	31
Program Directors	13
Program Managers	8
Senior Leadership Team	1
Other	8
Unknown/did not say	17
TOTAL	78

Nine hospital management level staff participated in one-on-one interviews (Table 5.4).

Individuals were interviewed based on their involvement in the priority setting process: eight were directly involved in the 2007/08 budgeting process and one participant started her management position immediately following the process, but had to work within the budget that was created for her by her predecessor.

Table 5.4: Interview Participants

Position	
Program Directors	4
Senior Leadership Team	1
Program Managers	3
Other	1
TOTAL	9

Eighteen documents were analyzed (Table 5.5):

Table 5.5: Documents Analyzed	
Documents	
Decision Support Documents	10
Website Information	4
Email communications	2
Meeting Information	2
TOTAL	18

Pilot Study Results

The results from the survey, the interviews and the document analysis are presented in aggregate in this section, according to the ten elements of the conceptual framework. (See Appendix I for complete results of the survey).

Stakeholder Engagement

RECALL: Stakeholder engagement refers to an organization's efforts to identify the relevant internal and external stakeholders and to involve these stakeholders effectively in the decision-making process. Stakeholder engagement is also concerned with stakeholder satisfaction regarding the level of their involvement in the decision-making process.

The survey had seven questions specific to stakeholder engagement. Fifty-nine per cent of respondents stated they were 'not at all involved' in the budgeting process, 21.8% were 'very involved' and 19.2% were 'somewhat involved'. This question was followed by a question on the satisfaction of involvement: 37.3% were not satisfied with their involvement, 26.7% were satisfied, and the remainder (36%) were not sure (Table 5.6). Respondents had a chance to explain their answer in an open-ended question. Twenty respondents commented that there was not enough involvement or input from front line staff. This was followed by comments expressing desire to be involved, but not knowing how, not being invited or not being informed. Many participants (both in interviews and the survey) pointed to tight timelines as a primary reason why broader consultation was not achieved. Respondents were asked: "Was everyone

involved in the 2007/08 budget who should have been?” While 62.3% (n=48) answered ‘I don’t know’, 11.7% (n=9) said yes. 26% (n=20) answered no, and were prompted to specify who should have been involved; eight respondents said more front-line, four respondents advocated specifically for more involvement from nursing staff, and others suggested increased engagement from unions and allied health professionals.

Table 5.6: Involvement in Process and Satisfaction with Involvement

	Very	Somewhat	Not at all	Not Sure
How Involved	21.8% (17)	19.2% (15)	59% (46)	
Satisfied with Involvement	26.7% (20)		37.3% (28)	36% (27)

These results can be cross-analyzed according to job title. A key strength of the 2007/08 budgeting process was the involvement of the program director and managers, which was a significant departure from past budgeting exercises that were largely driven by senior management decision-making alone. Managers (including senior leadership team (SLT), program directors, and program managers) were the group most involved in the budgeting process: 90.9% of managers who completed the survey reported being somewhat or very involved in the budgeting process. The results suggest that this group was generally satisfied with their level of involvement. By contrast, front line staff was least involved in the budgeting process: 87.5% of front line staff who completed the survey reported not being involved in the budgeting process at all (Table 5.7). The results suggest that this group had little understanding of what the process entailed, and was therefore generally unsatisfied with the budgeting process.

Table 5.7: Cross Analysis of Job Title and Involvement in Budget Process

Job Title	Not at all involved	Somewhat/ Very involved	TOTAL
Front Line	35 (87.5%)	5 (12.5%)	40
Management	2 (9.1%)	20 (90.9%)	22
TOTAL	37	25	62

Interview participants all agreed that front line staff should have been more involved, and that increased consultation and engagement of external stakeholders, such as community groups, the public, and other health care providers, was required.

They didn't seem to get their groups (front line) involved. The other thing I think was a struggle was getting the programs talking to each other and some of the clinical areas engaged as to where the pushing factors were in the organization and what decisions were made and how they might impact on the other areas.

Interviewees expressed an interest in greater internal collaboration on budgets to capture significant cross-departmental interdependencies.

In a question about methods of engaging stakeholders, 68% (n=53) of survey respondents did not know if there were multiple methods of stakeholder engagement; while 16.7% (n=13) said there were not multiple methods; 15.4% (n=12) said that there were. Respondents were asked if the methods of engagement were effective: the majority (72.5%; n=50) did not know. The next question asked respondents to explain their response; 18 respondents gave open-ended replies, commenting on the limited timeline of the budget, the inaccessibility of budgeting meetings to front line staff (due to bad timing/shift workers, inadequate communication, and the assumption that front line opinion wouldn't be considered). Three respondents said that there needed to be more opportunities for inter-departmental discussion. This was loudly echoed in interviews, where almost all interviewees (who were closely involved in the process) said that better engagement strategies were needed.

Shortly before budget submission, a large meeting was held to allow program directors and program managers to present proposed budgets. This meeting helped inform and engage decision makers; however, some interviewees felt that there needed to be more standardization in budget presentations to decrease confusion. Interview participants felt that there could have been more

communication throughout the process, especially in the form of inter-departmental meetings where there seemed to be a lack of information sharing. Records of meetings about the '2007/08 budget (such as minutes) were limited as departmental budgetary discussions were mostly informal and records were unavailable or did not exist.

Explicit Process

RECALL: An explicit process is one that is transparent not only to decision makers, but also to other stakeholders. Adhering to a predetermined process can enhance trust and confidence in the process. Transparency means knowing who is making the decision, how the decision will be made, and why decisions were made.

The first question of the survey asked if respondents were aware of the process and the steps involved in the 2007/08 budgeting. 59.1% (n=62) were not aware of the process and steps involved; 36.2% (n=38) of respondents were aware and 4.8% (n=5) answered that they did not know. When asked if they thought that the process was fair, the majority (69.5%; n=73) said they did not know, 20% (n=21) said yes, and 10.5% (n=11) said no. 54.8% (n=57) of respondents said that they did not understand the purpose and goals of the process, while 45.2% (n=47) did understand.

Through interviews and document analysis, it was apparent that an explicit and pre-determined timeline existed. In the survey, 42.3% were aware of an explicit and pre-determined timeline, while 3.9% were not. The majority, 53.9%, answered 'I don't know' to this question. However, interview participants felt that the time of year and the short time frame that was allotted to complete the tool were limitations to a fully explicit and transparent process. Decision makers felt rushed to complete the budget tool and did not feel that they had adequate time to collect or analyze data. Participants from both interviews and surveys suggested that allowing more time for data collection and analysis would improve the process. When this question is analyzed against those who were involved versus those who were not, we see that 78% of those somewhat or very

involved were aware of the timeline, whereas 76% of those not involved were unaware (answered: “Don’t know”) (Table 5.8).

Table 5.8: Was there an explicit and predetermined timeline?			
	Yes	No	I don’t know
Survey Result	42.3%(44)	3.9% (4)	53.9%(56)
Participants Somewhat Involved	76.47% (26)	8.82% (3)	14.71% (5)
Participants Not Involved	21.74% (10)	2.17% (1)	76.09% (35)

When asked about how decisions for the 2007/08 budget were made, 50% (n=39) said they did not know, 33.3% (n=26) were not sure, and 16.7% (n=13) reported that they did know how decisions were made. 55% (n=12) of program managers and program directors involved in the survey reported knowing how decisions were made and 97% (n=45) of those survey respondents who were ‘not directly involved’ in the process were uncertain of how decisions were made.

When asked if respondents knew who was making decisions, 37.2% (n=29) said yes, 34.6% (n=27) didn’t know, and 28.2% (n=22) said no. Respondents who answered yes were asked to specify who the decision makers were: 29 respondents offered a reply, most agreed that SLT had the decision making power, some thought that the board also had a hand in the decision making, and others felt that the decision making lay solely in the hands of the CFO. Interviewees were also uncertain as to who was accountable for the final budget decisions: the various options were the senior management team, the chief financial officer, and the MOH.

Managers are maybe confused about whether they’re making a decision within their own budgets or whether their director is or whether the senior team is ... the process is very iterative, it goes back and forth between levels.

Information Management

RECALL: Information management refers first to the information made available to decision makers during the priority setting process, including what was used and what was perceived to be lacking. Information can take a number of forms, specifically documents or data used in the decision making. Second, information management considers how the information was managed, including how it was collected and collated.

Decision makers were provided with various documents and data during the hospital's 2007/08 budget process. The computer-based tool was pre-populated with data and information that came from previous year's budgets as well as existing funding structures. Staffing information and calculations (number of staff, vacation days, sick days, etc.) were also included in the tool along with calculations for the mandatory pay increase. Program directors and managers were asked to benchmark their decisions against the hospital's peer organizations. Information about total expense per patient activity was provided from nine peer hospitals. If decision-makers felt that their department was not accurately represented by one of the nine, they were encouraged to find another hospital that was a better fit. Program managers and program directors also had access to three decision making frameworks to guide their local budgeting decisions:

1. The Ministry of Health and Long Term Care's Prioritization Framework (a.k.a. 'Six Steps'), which outlined the government's directions around hospital allocation of resources and steps toward achieving a balanced operating position.
2. An ethical decision making framework, adapted from Gibson et al, 'Evidence, Economics and Ethics: Resource Allocation in Health Services Organizations' (2006), which provided guidance on how decisions should be made from the standpoint of fairness.
3. An activity analysis tool developed at the hospital, which provided six questions to help program directors and managers identify budgetary options, including possible disinvestments.

The results showed that the decision-making frameworks provided were rarely used. Only one interviewee mentioned drawing on the 'six steps' framework and it was never mentioned in

surveys. Moreover, program directors and managers felt that the information available was often insufficient to make decisions, causing many to draw on additional information sources.

The most common input program managers and program directors used to inform budgeting decisions was capital need (e.g. equipment needs and/or updating existing materials). Next, participants mentioned interdependency, or consideration for impact on other departments within the hospital (intra-hospital) as well as inter-hospital impact. Strategic directions (including the hospital's mission, vision and values) were additional considerations in decision making, although these were not built explicitly into the computer-based decision making tool. Trust fund availability (or the ability to apply for more money from sources other than the capital budget), and revenue sources (alternative ways of bringing money in to a department) were used by several participants to make budget decisions.

Financial information (such as historical budgeting, staffing and salary information) also played a role in decision making for the 2007/08 budget, but the availability of such information was felt to be insufficient. A few interview participants felt poorly informed or unprepared to make budget decisions and thought that more information would be helpful in this process. Some suggestions included: budget forecasts, staff satisfaction evaluates, and patient care information.

Trying to develop the operating budget which was a total frustration because there was no history ... or at least no accurate history as to how the previous budgets were developed.

Length of time working within a department was captured informally through interviews, meaning that it was not a formal question, but often came up in conversation. Length of time in a management role and within the organization as a whole seemed to have an impact on what inputs were used in decision-making. Participants who had been with the hospital long term tended to rely on their "own forecasting" and "personal knowledge" for decision making. Long term employees also had information made available to them that newer participants struggled to

gather, such as information acquired through working relationships with colleagues both internal and external to the hospital. Newer employees or those newly promoted to their positions felt at a disadvantage in terms of making budgeting decisions.

Information was managed largely through the computer-based budgeting tool. Efforts were made to help program directors and managers use the tool including: a training session, a Decision Support Services personnel dedicated to their department, and electronic communications with the Decision Support Services team.

There were major hurdles because the template, the tool, was brand new and it had horrible hitches in it, bugs that should have been worked out, and the managers wasted a lot of time which was a crime and there was a lot of rework because it was brand new and it was done probably way too quickly. So they suffered ...that was a huge problem.

The computer-based tool seemed to increase the overall transparency of the budget process from the viewpoint of tool users. The tool standardized the budget process. As a result, program directors and managers knew what was expected of them and of their colleagues, and they also gained a better understanding of the overall budgeting process.

Program managers and directors were able to submit feedback and questions to Decision Support electronically through a shared folder on the hospital's internal computer network that they all could access. An electronic bulletin board called "Budget Issues" compiled frequently asked questions including how to retrieve information, what to do if work was lost, how to incorporate MOH directives/funding, and how to include information that did not fit in the pre-populated areas. Questions and answers were continuously updated throughout the budget process. Decision Support Services compiled feedback from program managers and program directors into an intra-web document, "Feedback Regarding Budget Process & Template". All interviewees expressed gratitude for the accessibility and expertise of the Decision Support Services department throughout the process.

Three survey questions focused explicitly on the communication of different components of the budgeting. These included the purpose and goals, the methods, the outcomes, and the revision/appeals process. Respondents were asked if the different components were communicated to them; the majority of respondents (51.5%) felt that the purpose and goals as well as the methods were communicated; 41.4% indicated that the outcomes were communicated. Regarding the revisions/appeals, 62% said that they were not communicated. When asked ‘how well’ the components were communicated, 50.4% felt that the purpose and goals were communicated ‘adequately’, ‘well’ or ‘very well’. The remaining components (the methods, the outcomes, and the revisions/appeals) were seen by majority to be poorly communicated (50.7%, 54.5%, and 71.6% respectively).

Both the surveys and the interviews confirmed the most prevalent form of communication to be email (58.3%; n=28 surveyed cited email). Interviewees highlighted that email communication was done largely between Decision Support Services and the Program Managers/Directors, but not front-line staff. Despite attempts, I did not find any emails to analyze. Departmental meetings (54.2%; n=26) and peer-to-peer informal (43.8%; n=21) were also used. Eleven open-ended responses highlighted ‘other methods of communication’ including: staff meetings, training sessions, local media, informal supervisor to staff discussions, and Q&A from shared folders (computer based).

Next, respondents were asked how communication could be improved. Thirty-one respondents provided ideas on how to enhance communication including: increased electronic communication (use of hospital-wide emails and desktop background information), more meetings (departmental, open-forums, or town-hall meetings), more information (on how to get involved, on the steps

within the process), more training and more direct communication between managers and staff (fewer large group meetings).

Values and Context

RECALL: Values and context are important considerations in any priority setting process, including the values of the organization, the values of staff within that organization, and the values of other stakeholders (such as patients, policy makers, politicians, and members of the community). Context is distinct from values and considers the organization's goals in the health care environment articulated in its strategic directions.

The hospital had recently gone through a review of its strategic directions. Although the mission, vision, and values were not explicit criteria in budgetary decision making, they were an implicit part of the budget process, as indicated in both the survey and the interviews. In the survey, the majority of respondents felt that the mission, vision and values of the hospital were considered in the 2007/08 budget (60%; n=42); all interviewees felt that the budget followed the strategic directions, and saw at least some reflection of organizational values in the budget.

They were always reviewed – the mission, vision, values – were always reviewed at every budget session and the strategic directions, every budget had to be supported by the strategic directions.

The majority of respondents felt that the strategic plan was considered in the budgeting (65.7%, n=46). 51.4% (n=35) felt that culture was considered, 53% (n=36) thought community values were considered, and 50% (n=34) thought patient values were considered.

Interviewees and survey respondents felt that staff values were not considered as much as they should have been; evident mostly through the survey where many respondents (39.7%, n=27) felt their values were not considered (in contrast, 33.8%, n=23 thought they were). In interviews, participants related this to the emerging culture of shared accountability at the hospital.

I think it was a huge cultural shift for hospitals to start to be accountable and to start to be responsible for multi-year planning...And it's a whole paradigm shift.

Several interviewees described how the new budgeting method and the resulting increased accountability would take time to adapt to and make happen. Most were very positive that this shift would occur in upcoming budgetary cycles as the tool is improved and as stakeholders become comfortable with it and the accompanying accountability.

Context played a role in the hospital's 2007/08 budget. Survey results indicated that the majority of respondents felt that contextual factors were considered in the budget (57.4%, n=39); interviews echoed this. Several interviewees mentioned that their city is a high growth area which has exacerbated the pressure on the hospital's budget to meet the increased demand for health care services. The impact of emerging LHIN context was discussed by interviewees as important considerations for budgeting, although it was not yet clear to interviewees what the implications would be.

(Impact) is becoming more of an issue as the LHINs structure becomes a reality for upcoming budgets.

Program managers and program directors also considered information from peer hospitals to situate the hospital in the larger health care context and make priority setting decisions.

78.3% (n=65) of respondents did not know if there was integration of the hospital's 2007/08 budget with other health care organizations. Through document analysis, it was apparent that PDs and PMs had access to information about their 'peer hospitals' (the 25th percentile of hospitals in Ontario with similar services and budgets). It would be the decision of PMs and PDs to use that data in their decision making for budget setting. Interviewees discussed the shift towards the hospital budget aligning with LHINs, but interviewees were uncertain of the end-result of this shift or how it might affect the program's bottom line. Some interview participants pointed to poor communication of data available regarding the LHINs.

Respondents were asked if other items should have been considered in the 2007/08 budgeting process. 61% (n=36) thought that there should be other things considered in the budgeting process, the most common item being ‘staffing levels,’ followed by population growth, under funded areas, HAPS submission, clinical priorities, and external factors (such as home care and family support set up).

Respondents were asked if there were items that were considered in the budget that should not have been. The majority of respondents (81%, n=42) answered no. Three respondents said yes, and provided open-ended responses including: ‘individual units should not have been considered’, and ‘the focus was too much on the 3% decrease in the budget’.

Respondents were asked about seven values and context items (mission, vision and values; strategic plan; context; culture; community values; patient values; and staff values) and their reflection in the outcome of the budget. The majority of respondents said that all elements were ‘somewhat’ or ‘appropriately’ reflected in the budget.

Revision Process

RECALL: A revision process is a formal mechanism for decisions to be reviewed and for addressing disagreements constructively. The purpose of a revision process is to improve the quality of decisions by providing opportunities for new information to be brought forward, errors to be corrected, and failures in due process to be remedied.

The 2007/08 hospital budget procedure did not have a formal revision process. In the survey, 70% (n=58) of respondents made this clear when they responded that they were unsure of avenues for revisions or appeals. Document analysis and interviews communicated that there was no formal revision or appeals process, and most interviewees didn’t know what they would do if

they wanted to contest a decision. Some interviewees stated that if they disagreed they would bring issues to their superior, but beyond making a concern known, they were not aware of the process which followed.

Interviewees talked about the ‘back and forth’ that went on between different levels of management; however, these were seen largely as one-way discussions. Interviewees felt that a two-way dialogue to allow changes to final budget decisions was lacking; instead interviewees felt the final budget was more reflective of the needs of senior management.

In the absence of that I felt very frustrated that there really wasn’t a second round. ... a culture there where indeed that I could have a consultation where I had more of a chance to talk to a senior group.

Despite this, most interview participants indicated that they were sufficiently satisfied with the decision outcomes and that they would probably not access a revision process if one were available. However, some interview participants felt that a ‘second round’ of discussion should have been available.

Outcomes Components

Stakeholder Understanding

RECALL: Stakeholder understanding implies more than basic knowledge of the process. It assumes stakeholders have gained insight into the priority setting (e.g. goals of the process, rationale for priority setting and rationale for priority setting decisions) and/or the organization (e.g. mission, vision, values, and strategic plan). Stakeholder understanding is a key element of fairness in a priority setting process.

According to interview participants, the new budget process provided an opportunity for innovation in thinking. Program directors and program managers had to learn the tool as well as the intricacies of budgeting. Interviewees felt that the priority setting process improved their understanding of the budget process, of spending in other areas of the hospital, and of the

accountability required in the budget. Interview participants regarded the learning that occurred through the budget process as a very positive experience.

the biggest outcome was that the managers learned what was in their budget, ...it was a huge learning curve it was a huge accountability piece too - - accountable for something that they built and they understood. ...and that's a new experience

62.3% (n=43) of respondents understood the outcome of the 2007/08 budget (either completely or somewhat), whereas 37.7% (n=25) did not understand. In order to get a sense of the learning that occurred during the 2007/08 budgeting process, respondents were asked to rank their familiarity with several items that may or may not have been considered during the budget: (1) mission, vision and values, (2) strategic plan; (3) context; (4) culture; (5) community values; (6) patient values; and (7) staff values; each of which were mentioned earlier in the survey surrounding information used in decision making. The majority of respondents did not become more familiar with any of the items.

Shifted Resources

RECALL: A successful priority setting process results in the allocation of budgets across portfolios, changes in utilization of physical resources (e.g. operating theatre schedules, bed allocations) or possibly changes in strategic directions. A reallocation in resources from the previous year's budget is not necessary for successful priority setting, however, in some circumstances this may be one indicator of success.

When asked whether the 2007/08 budget process was consistent with previous budgets, the majority (73.8% n=76) answered "I don't know". 9.7% (n=10) felt it was consistent with previous budgets, and 16.5% (n=17) said it was not. While most program directors and program managers welcomed the accountability and the flexibility to shift money within a department, some interviewees did not understand where surplus money went or how funds were being used at an organizational level. This lack of transparency in reallocations was the cause of several participants' dissatisfaction with the overall process. Three survey participants said that they were not satisfied with the priority setting process due to small identifiable changes in the actual

budget, stating it felt more like a “status-quo exercise”. Although the complexity of budgeting material made it difficult to evaluate actual shifts or changes in resources on a hospital level, it became apparent through interviews that budgeting had led to resource shifts both within their own departments and between departments.

Decision Making Quality

RECALL: Decision making quality relates to appropriate use of available evidence, consistency of reasoning, institutionalization of the priority setting process, alignment with the goals of the process and compliance with the prescribed process. It also captures the extent to which the institution is learning from its experience to facilitate ongoing improvement. This component is most obvious as subsequent iterations of priority setting are evaluated; where consistency and building on previous priority setting would be indicative of a successful process.

According to those most involved in the budgeting process, the new approach to budgeting was an improvement in the quality of decision making. Since budgets from previous years had been set centrally by the finance department, many decision makers valued the increase in accountability. Interviewees felt that the changes increased their overall awareness of the organizational budget.

What’s always useful.. is to have the boundaries set ... don’t ask me to get creative if I don’t know how far I can go – I need to know how far I can go with this... I can’t be real creative if I’m being cautious about money.

Senior Management encouraged decision makers to approach budget decision making not just from a mechanical stand-point, but also from a more “creative lens” (i.e. coming up with innovative solutions and not sticking to historical decisions). While some interviewees welcomed this approach, others were hesitant due to inadequate information and training/education. Participants felt that training before the budgeting process began could help to implement a creative approach to decision making and budgeting and would make them more comfortable in making priority setting decisions.

The interviews and surveys contained some complaints regarding the lack of standardization in the budget process. Specifically, some interviewees discussed room for improvement in the budget presentations at the Leadership Forum (e.g. every department should bring forward the same information). There were also complaints around the lack of communication in making both inter-departmental budgeting decisions (e.g. how one department's decisions would effect the other) and inter-organizational decision making (e.g. how decisions made at other organizations would effect the hospital and vice versa).

Stakeholder Acceptance

RECALL: Stakeholders may be able to accept priority setting decisions, even if they may not always agree with the outcomes. Stakeholder acceptance is indicated by continued willingness to participate in the process (i.e. buy-in) as well as the degree of contentment with the process. This element is difficult to evaluate after one priority setting iteration. However, it is possible to gain insight into stakeholder acceptance by asking stakeholders about satisfaction with the process and outcomes. It is important to consider all stakeholder groups, both internal to the hospital and external to the hospital (community groups/public and the MOH).

Stakeholders internal to the hospital generally accepted the budget. The survey explicitly asked respondents if they accepted and were satisfied with budget outcomes. 95.4% (n=21) of managers/directors and 32.5% (n=13) of front line either completely or somewhat accepted the outcomes of the budget. Some respondents were dissatisfied with the outcomes because they felt that they were unaware or uninformed. The majority of survey respondents (54.3%, n=38) accepted the outcomes. Some interviewees were unhappy with inter-departmental resource shifts, but overall accepted the process and the reasons behind the budget decisions.

Participants were asked how satisfied they were with the process behind the budget and were asked to explain their answer. Twenty-six respondents provided open-ended responses including: they were not satisfied because they did not know about the process, they were not involved in the process, or they were not engaged in the budget. Four respondents listed lack of, or poor,

communication as a reason for decreased satisfaction. Those who were involved in the process stated the computer-based budget tool was a source of frustration; others saw the new tool as an increase in accountability and as a “work in progress (that will) improve over time”.

54.3% of respondents accepted the outcomes of the 2007/08 budget (either completely or somewhat), 41.4% were unsure, and 4.3% did not accept the outcomes. 38.5% of respondents were satisfied with the outcome of the 2007/08 budget (either completely or somewhat), 38.6% did not know, and 22.9% were not satisfied with the outcome. 62.3% of respondents understood the outcome of the 2007/08 budget (either completely or somewhat), whereas 37.7% did not understand. (It is important to note that if the outcomes were not well communicated, it would be difficult to understand, accept, or be satisfied with them; recall that 41.4% said the outcomes were communicated, 41.4% said they were not, and 17.2% either did not know or did not answer.) When asked how well the outcomes were communicated, 54.5% said they were not well communicated, or were communicated very poorly. The response trend of decreasing percentage from understanding to satisfied might be explained by the fact that the outcomes were not well communicated to respondents (Table 5.9).

Table 5.9: Three Outcomes Questions			
	Yes (completely or somewhat)	No	I don't know
Q1: Accept Outcomes	54.3% (38)	4.3% (3)	41.4% (29)
Q2: Satisfied with Outcomes	38.5% (27)	22.9% (16)	38.6% (27)
Q3: Understand Outcomes	62.3% (43)	37.7% (25)	0

Respondents were also asked: how satisfied are you with the outcomes of the budget, which is similar to the previously asked question: “are you satisfied with the outcomes of the 2007/08 budget?” The main difference between these two questions was the response options. For the question “are you satisfied”, respondents could choose completely, somewhat, not at all, or I

don't know. For the question "how satisfied are you", respondents could choose neutral or somewhat satisfied (64.1% chose this), not at all satisfied (25%), and satisfied or very satisfied (11%) (Table 5.10). Participants were asked to explain their answer in each circumstance. Twenty-one respondents provided a reply. Eight respondents repeated what they had stated for the previous open-ended question on satisfaction of process; "unable to comment because I am not aware of the outcomes". Other respondents commented that the lack of communication was a problem, sending "mixed messages" about the outcomes.

Table 5.10: Comparison of 2 Questions on Satisfaction

Question	Not Satisfied	Middle Category (somewhat, neutral, satisfied)	Completely or Very Satisfied	I don't know
Are you satisfied with the outcomes?	22.9% (16)	31.4% (22)	7.1% (5)	38.6% (27)
How satisfied are you with the outcomes?	25% (16)	64.1% (41)	11 % (7)	

When participants were asked the open-ended question of how they would improve, or what changes they would make to the 2007/08 budgeting process, 28 offered a reply. The two main ideas were to increase communication, and develop a better tool. Other respondents discussed the need for a better timeline (not in the summer), an explicit appeals process, more transparency, and increased involvement (front line staff and external stakeholders).

External to the hospital, it was less clear whether there was acceptance and/or satisfaction with the budget process or outcomes. Once the budget was complete, it went back and forth to the MOH several times before agreement on its terms was reached. This was done at the upper management level and included little discussion with other stakeholders. Neither the public nor

any community groups were directly involved in the budget process, making it difficult to get a sense of their acceptance and/or satisfaction.

Positive Externalities

RECALL: As an indicator of success, externalities may include positive media coverage (which can contribute to public dialogue, social learning, and improved decision making in subsequent iterations of priority setting), peer-emulation or health sector recognition (e.g. by other health care organizations, CCHSA (accreditation), etc.), changes in policies, and potentially changes to legislations or practice.

There was no evidence of positive externalities (e.g. for media reports, peer commentaries, or health sector responses) to suggest that others perceived the hospital's budgeting process to be successful. There were no survey questions reflecting positive externalities, and further, there was no pertinent information available in document analysis or one-on-one interviews. Interviewees were probed regarding peer emulation and policy changes but were unaware of any relevant information.

Pilot Study Interpretation

Validity for the pilot study was addressed in three ways. First, the data was triangulated from three different sources (documents, interviews, and observations) to maximize comprehensiveness and diversity (Mays & Pope, 1995). Second, the results of the pilot study were analyzed and interpreted by three researchers (SS, DKM, and JLG). Third, although I primarily collected the data, members of an interdisciplinary research team enhanced the "reflexivity" in the analysis by becoming familiar with the data and participating in the data analysis (Rosenfield, 1992). This was done through two interim analysis meetings where the data was presented to a team of researchers and the findings were discussed in detail.

The analysis culminated in an 8-page report which was disseminated to hospital Senior Management (See Appendix E).

The report was organized according to the ten elements (five process elements and five outcome elements) of the conceptual framework. Each section discussed findings from the tool, and two provided evidence and concrete data from the study. From the analysis and the interpretation, we also identified eight recommendations (or opportunities) for improvement which were presented and described in the report (text box 5.2).

Text Box 5.2: Recommendations for Improvement

1. Increase consultation with stakeholders (internal and external)
2. Develop an explicit and formalized communication plan
3. Revisit data and information needs
4. Include a revision or appeals process
5. Improve the computer-based budget tool
6. Address key timing concerns
7. Provide training for decision makers
8. Build on lessons learned

5.3 Usefulness of the Evaluation Tool

This section focuses on the perceived usefulness of the tool; recall that the second objective of the pilot study was to evaluate the usefulness of the tool. This pilot study demonstrated that it is feasible to use the tool in a health care organization. However it is important to determine if the tool is sensible (specifically; is it useful and appropriate?). The pilot test provided an exceptional opportunity to test this and to answer this question.

First, I will discuss the results from debriefing hospital senior management. These results focus on the user's perception of the usefulness of the information gleaned from the tool. The debriefing addressed the questions: How appropriate was the tool for evaluating success? Could

the results be used in a real-world setting? What (if anything) has been done with the recommendations? Second, I will explain my experiences as a researcher with tool implementation (part of Feinstein's 'ease of use' criterion for a sensible tool).

This section also explains refinements and changes made to the tool as a result of the pilot study.

Pilot Test Debriefing

A report was generated from the pilot test that was circulated to the hospital senior management (See Appendix E for report). Once they had reviewed the report, we discussed the usefulness of the information, their thoughts on their participation in the study, and the results of the pilot test. Three one-on-one phone interviews/debriefing sessions were held; one with the CEO, one with the VP of Finance (CFO) and one with the Leader of Organizational Development and Ombudsperson. The main purpose of the discussions was to determine the usefulness of information generated from the evaluation tool.

The specific questions asked were:

1. Were the results from the report useful to you and or your organization?
2. Was there anything missing from the report that would be important in evaluating or improving success in priority setting in your organization?
3. To what extent did the tool capture elements of success in priority setting?
4. Is there anything unhelpful in the report that could have been omitted?
5. How will you use the results of the report?

All three participants felt that the report generated useful information that could be translated to positive changes in organizational priority setting. Participants felt that the report captured the essence of the process and that it spoke to the underlying cultural shift that was occurring in the organization. They were grateful for the insight that the report provided and valued the perspective of an external researcher.

The timing of report dissemination came just after the completion of the 2008/09 annual budget setting process, which used a similar process to the one that was evaluated previously in the study (2007/08). One interviewee felt that the report could have improved the 2008/09 budgeting since it had similar areas needing improvement.

If we'd done these (recommendations), would it have made a difference? Yeah

Specifically, the interviewee pointed to the computer-based budgeting tool and a continued lack of external consultation in areas still requiring improvement. Another participant focused on the organization's continuing struggle to get decision makers engaged in the process and hoped that this report would improve that.

While the report covered general and broad spectrum recommendations, interviewees felt that it would have been more useful if it provided more specific details on implementing recommendations and potentially providing details on the practices of other health care organizations; what works and what does not.

What managers want: ... tell me what it is, and I'll do it.

It would be helpful to have more about other organizations, feedback about some things we have never tried, best practices... success in other organizations.

The report was distributed to Leadership Forum (over 50 program directors and managers) for further discussion and brainstorming on how to implement the recommendations for the 2009-2010 budget process.

This is the first stage, to get feedback and put it all together. Next, we need action steps. This is the data collection phase, now we have to improve this.

No one felt the report contained any information that was unhelpful or that needed to be omitted. One interviewee stressed the importance of doing this kind of evaluation regularly and qualified this by saying:

It is essential to have buy-in from Senior Management from the beginning.

Through these interviews, it became evident that the information obtained from the evaluation tool was useful to key stakeholders.

Senior Management's willingness to adopt the recommendations for improvement is further evidence of the usefulness of the tool. The report has resulted in four major changes within the organization since it was disseminated. These are:

- a. Change to Timing: As per recommendation #6 (address key timing concerns), the hospital has ensured that budgeting does not occur in the summer months. The 2009/10 budget process began in the Fall of 2007, and commitments have been made to finish it by Spring 2008.
- b. Development of Global Objectives and Goals: All program directors and managers were asked to create 'global objectives and goals' separate from the budgeting process, in order to have a long-term plan in mind when making priority setting decisions. This change in practice stemmed from both the recommendation to increase information for decision makers (#3) and the call for increased training of decision makers (#7).
- c. Adoption of Information Database: The hospital has recently started using a new information database. This "leading edge, Rubik's cube of information" provides decision makers with up-to-date and accurate information for decision making and is a direct response to recommendation #3 (re-visit data and information needs).

d. Focus Group Consultations: In order to learn more about the strengths and weaknesses of the budgeting process, hospital senior management has held focus groups with employees. These groups focused discussions with newer employees. This directly touches on two recommendations from the report #1 (increased consultation) and #7 (increased training, especially for newer employees).

Researcher's Experience

The pilot test of the evaluation tool provided an opportunity to see how the tool performed in a real-world setting. Through this experience, I was able to gain a better understanding of how the tool functioned and its applicability in the health care context.

Being an external researcher had both advantages and disadvantages. One advantage was that I was not seen as an 'investigator', which allowed me to form a trusting relationship with interviewees with decreased the possibility of 'social desirability' bias (responding in a way that is favourable to the research question, or, saying what they think they should say). Another advantage was the expertise that I brought to the organization, which was appreciated and led to increased cooperation in executing the research. Survey respondents valued the opportunity to express their concerns to a removed third party to speak with.

A disadvantage was that I lacked 'internal' organizational knowledge. Perhaps the most salient example of this is the culture shift that accompanied the 2007/08 budgeting process. I was told by many interviewees, and hinted at the fact through surveys and document analysis, that this budget process represented more than just number crunching; this budget meant a new mode of operating in the organization. As an external researcher, I was unable to capture the depth of this transformation. Another example of my lack of internal knowledge came when I tried to evaluate

externalities of the budgeting process. Since the process was finished there was no information (that I could find) that captured an external reaction or perspective (if any) on the process.

The tool was limited in the area of ease of analyzing the budget. The Ministry of Health and Long Term Care has very specific accounting and reporting regulations that health care organizations must follow. These regulations can (and do) change from year to year, which made it difficult to track organizational changes or shifts; many resource shifts happened as a result of Ministry directives to change protocol for financial records. Regulations across organizations can be advantageous in future iterations of the tool, allowing the comparison of results both within and between organizations.

Refining the Conceptual Framework and Evaluation Tool

The pilot test provided an opportunity to re-evaluate the conceptual framework and the tool, providing ideas for further refinement. As a result, both the conceptual framework and the evaluation tool were revised in several ways. Refinements were made based on researcher experience with the tool, feedback from pilot study participants, and further collaborative conceptual thinking (i.e. writing the report with the other researchers (JLG, DKM) provided a chance to re-think and fine-tune the framework and tool).

The following section presents the changes that were made to the conceptual framework and the evaluation tool (the survey, the interview guide, and the document analysis guide) as a result of the real-world application.

Transformation of the Conceptual Framework

The pilot test provided the opportunity to re-think the conceptual framework as well as its elements and their descriptions; some of the titles and descriptions of the elements were changed

or refined as a result. To do this, I went back to the primary data (the three studies, detailed in Chapter 4) to ensure the element captured the original meaning that was intended. (Table 5.11)

While this tool could be used to evaluate change over time, its main use is to evaluate priority setting. Words like ‘improved’ imply a shift over time, so elements with that descriptor were refined. For example, ‘Improved Decision Making Quality’ was re-titled: ‘Quality Decision Making’ to more accurately capture the institutionalization of the priority setting decisions, social learning within the organization, and increased transparency and consistency of the process. Similarly, ‘Improved Stakeholder Understanding’ was changed to ‘Stakeholder Understanding’. Again, ‘improved’ was eliminated because it implies progression or a lapse in time, and while this tool can evaluate improvement or change over time, it’s the original purpose was for one-time use.

Table 5.11: Changes/Refinements to Conceptual Framework

	Elements	Change
Outcomes	Improved Stakeholder Understanding	Removed ‘improved’ - - implies a time lapse
	Shifted Priorities /Reallocation Of Resources	Removed words to simplify
	Improved Decision Making Quality	Removed ‘improved’ - - implies a time lapse
	Stakeholder Acceptance & Satisfaction	no change
	Positive Externalities	no change
Process	Stakeholder Engagement	no change
	Use Of Explicit Process	Removed words to simplify
	Clear And Transparent Information Management	no change
	Consideration Of Values and Context	no change
	Revision Or Appeals Mechanism	no change

In the pilot study and debriefing, individuals referred to elements in brief or truncated forms. For this reason, it made sense to try and simplify the element labels. A more stream-lined element label decreases excessive jargon and simplifies the framework for use within an organization. In

order to simplify the conceptual framework, the element ‘Shifted Priorities/Reallocation of Resources’ was altered, and words were deleted from the original label and shortened to ‘Shifted Resources’. Similarly, ‘Use of Explicit Process’ became ‘Explicit Process’. The core meaning of the element remains the same.

The new conceptual framework is more stream-lined, remaining comprehensive without being verbose (Table 5.12).

Table 5.12: New Conceptual Framework	
OUTCOMES	Stakeholder Understanding
	Shifted Resources
	Decision Making Quality
	Stakeholder Acceptance & Satisfaction
	Positive Externalities
PROCESS	Stakeholder Engagement
	Explicit Process
	Clear & Transparent Information Management
	Consideration of Values & Context
	Revision Or Appeals Mechanism

Transformation of the Evaluation Tool

The pilot test provided the opportunity to re-think certain aspects of the evaluation tool including ease of use, how questions were worded, duplication of information, etc. Changes were made as a result of the following factors: (1) experiences of SS in implementation/data collection; (2) direct comments from interviewees (in both Part I and II); (3) experiences/results of SS in data analysis; or (4) a combination of the aforementioned.

Interview Guide:

The interview guide was changed once during data collection (see Appendix J for tracked changes). Five probes were deleted because they were found to be repetitive (a similar question was better answered in another component of the evaluation tool) or redundant (the interviewee

naturally answered them). Issues of repetition became evident during interviews when probing questions such as “Was anyone involved that shouldn’t be?” were asked, and the interviewee would respond something to the effect of: “I answered that in the survey already”. Any repetitive questions were omitted.

Analysis of the survey results illuminated that two areas of the conceptual framework were not being adequately addressed. For this reason, in the interview guide, one probe was made into a question to ensure that appeals/revisions were directly addressed, and one question was added to capture stakeholder learning. Additionally, one probe was moved to a new question where it was better suited.

The original interview guide had five questions and ten probes, the new guide had seven questions and four probes.

While the time commitment for a one-on-one interview was more demanding than that of the survey, all interviewees agreed that the interview was a more valuable method of discussing opinions and feelings. Interviews facilitated rich data collection that was not as accessible through the survey or document analysis.

Focus groups are one possible avenue to simplify tool implementation. A focus group could also act as a method of stakeholder engagement. One interviewee during the pilot test suggested that a group debriefing would be helpful for understanding the outcome of the budget. A focus group could provide two-way communication for stakeholders to become more fully engaged in the priority setting process. (See Appendix K for suggested focus group discussion guide)

The Survey:

As mentioned previously, the question by question response rate in the pilot test started off high (100% of the people responded to the first question), and decreased as respondents completed the survey (the last question, #34, had only 41% response rate). Out of the 105 surveys collected, 27 did not complete the survey in its entirety (25.7% non-response rate). One possible reason for the low completion rate was the length of the survey. The average length of time it took to complete the survey was difficult to ascertain since respondents could start the survey, leave it open, and complete it at a later time. Further, there was no time limit or suggested time of completion. Ideally, the survey should take 20 minutes to complete; in order to facilitate a faster completion time, some survey questions were omitted. In discussing the survey with interview participants, almost all reported that the survey was an acceptable length and that they would be fine with completing the survey again for future priority setting. However, this group is not representative of majority of people filling out the survey (recall interviewees were ‘more involved’ in the budgeting process, whereas survey respondents largely fell within the ‘not at all’ involved to ‘very’ involved categories).

The total number of questions was reduced from 35 to 26. Nine questions were omitted, including five open-ended questions. Some were eliminated to decrease repetitiveness (for example, the question: “How satisfied are you with the outcomes of the budget?” was similar to a previous question: “Are you satisfied with the outcomes of the 2007/08 budget?” and was therefore deleted). Other questions were eliminated because they were too complicated (poorly designed ranking lists for example). Open-ended questions that did not generate useful or novel information (discovered by SS during data analysis) were also eliminated (for example: List other methods of communication (used in the priority setting process)).

Two questions were added to the survey. First: “Were you aware that [the health care organization] had a priority setting process?” (yes/no) was added. Many of the open-ended

answers from respondents stated that they were unaware of the process; by adding this question correlations with other questions can be made, and can help create a stronger analysis. Second, in the demographic section, a question was added asking the respondent the length of their employment with the organization. During interviews, it became obvious that the length of time working in the organization had a direct effect on priority setting decisions due to the information they had available and the contacts they had made in their employment. “Physician” was also added as a category choice for the demographic ‘job title’ question, which is helpful in survey analysis. (See Appendix L for changes made to the survey)

Document Analysis:

The most significant change to the document analysis portion of the tool was in the way that questions were organized. Headers were created to indicate the types of documents to analyze (e.g. a header ‘Analyze Meeting Minutes’ was added), followed by questions to analyze the documents with (e.g. is there a record of who was involved?). Most changes to the document analysis guide were driven by the experiences of SS during data collection and analysis.

Some questions were separated to ensure that one issue was considered during each question. For example, the question: “Is there a record of the process by which decisions were made and the people involved?” was made into two questions: “Is there a record of the process by which decision were made?” and “Is there a record of the people involved?”

The original document analysis guide contained 13 questions in no particular order or category. The new guide had 12 questions in five categories. One question on communication was omitted because it was better captured in the survey and interviews, thus it was repetitive and not as accurate in the document analysis guide. (See Appendix M for changes made to document analysis guide).

Certain questions in the document analysis were difficult for an external researcher to answer; specifically, questions pertaining to the fiscal budget (e.g. ‘Does the budget reflect a change in resources or priorities given to programs?’). These questions required extensive knowledge, not only of the organization’s budget, but also of Ministry of Health and Long Term Care’s accounting and budgeting guidelines. For example, a change in the budget from year to year might occur not because of a priority setting decision to shift resources internally, but because of a change in MOH guidelines for hospital accounting. If the organization implements the tool (especially the document analysis section) with a researcher/individual internal to the organization, this should be less of a problem.

Similarly, the question: ‘Were any media reports generated from this process?’ would be easier to answer for someone internal to the organization, most notably public relations staff. It was difficult and time consuming to collect this information from an external perspective.

The final conceptual framework and tool (survey, interview guide, and document analysis questions) is presented in the appendix in its entirety (Appendix N).

Chapter 6: Discussion

In this chapter, I will provide a discussion and concluding remarks for this thesis. I will also examine its limitations, and steps for further research.

The chapter is organized into five sections. In Section 6.1, I will recap and synthesize the main findings of this research. In Section 6.2, I will discuss the way in which this research contributes to knowledge by examining the relationship between its findings and the literature. I will review the gaps in knowledge described in Chapter 2 and how I filled these gaps. In Section 6.3, I will describe the implications for policy and practice that result from this research. In Section 6.4, I will describe the limitations of this research. In Section 6.5, I will discuss future research possibilities and will provide a conclusion to the thesis.

6.1 Synthesis of Findings

The first intention of this research was to develop a conceptual framework for successful priority setting. The second purpose was to develop a tool to evaluate the achievement of successful priority setting in real-world allocation decisions.

The conceptual framework and evaluation tool presented here can guide the development, implementation, and evaluation of priority setting activities in health care organizations across Canada; more research is required to determine if they are internationally applicable. The framework and tool can provide guidance for decision makers in their priority setting, and may also help them to avoid difficult issues or problems that can arise in organizational priority setting.

The Conceptual Framework for Successful Priority Setting

In Chapter 4, I presented the findings from three studies, that described various stakeholders' views regarding successful priority setting. The three studies were 1) a Delphi consensus panel involving decision makers and scholars from five countries, 2) interviews with decision-makers from across the Canadian health system, and 3) multiple focus groups with Canadian policy makers and patients. From these findings I created a conceptual framework that can guide decision makers (and other stakeholders) in better understanding successful priority setting. The conceptual framework serves as a foundation for a strategic and practical approach to developing priority setting practices.

The conceptual framework contains ten elements of successful priority setting. It is advancement in knowledge because it is the first attempt to comprehensively describe components of successful priority setting. It provides a way of thinking about successful priority setting and the considerations, or elements, essential to its achievement. It also offers a common language for

decision makers and stakeholders to discuss successful priority setting and share learning, both within and between institutions.

The ten elements identified in this framework are interconnected and interdependent. While each of them represents a unique element that can add to the overall success of priority setting, it is difficult to use these elements in isolation. For example, communication has a role in many of the other elements; it is vital to stakeholder involvement to ensure open and consistent communication.

While each element of the framework is important in and of itself, the framework is held together by the connections between elements, and these connections provide insight into the complexities of priority setting:

1. Stakeholder engagement, both internally and externally, is a vital component of successful priority setting. It was evident through this study that all stakeholders surveyed wanted to be involved in priority setting and felt that they should be involved, and that their involvement in the process is directly related to each other's satisfaction/acceptance. Stakeholder engagement is also directly linked to stakeholder understanding, which is in turn linked to stakeholder satisfaction. These three pillars of stakeholder 'inclusion' are also related to almost every other element of the framework. While stakeholder engagement has been resisted in the public sector (Daniels & Sabin, 2002), it is an important element of success in priority setting despite potential challenges.
2. Stakeholder inclusion is vital to ensuring the right values are considered, and to determining information needs (information management). Stakeholder inclusion ensures that relevant information is included in the process. Information management ensures that the right people have the right information to make the right decisions; part of this is

including the right values, elicited from stakeholders. Revision/appeals mechanisms allow new information or arguments to be considered. To this end, information management, consideration of values (and context), and revision/appeals process are connected to each other and to the improvement of decision quality throughout the process.

3. Communication links stakeholder engagement and explicit process. Using multiple methods to communicate also allows for broader engagement of potential stakeholders. Ultimately, the transparency this entails will improve stakeholder satisfaction and acceptance of the process.
4. Revisions and appeals are an important part of any priority setting process and help to further engage stakeholders and strengthen information management by allowing a second look at the decisions made and the information used. Information thought to be lacking and new information can be used in a revision/appeals process. Improving the responsiveness of decision makers in using a revision process can directly improve decision making quality.
5. Stakeholder understanding directly effects stakeholder satisfaction and acceptance, therefore increasing confidence and buy-in for the process. By increasing opportunities for institutional learning, future iterations of priority setting processes will be more robust and grounded in organizational values, that is, they will have improved the quality of decision making. Increased understanding of an organization's mission, vision, values and strategic directions directly affects buy-in and overall satisfaction and acceptance of the process.

6. Improving the decision making quality can be an end in itself of a priority setting process, however, as the quality improves, so too will other elements of successful priority setting such as a more explicit process, and better information management.
7. While shifting priorities can be important in order for a priority setting process to be successful, they are not necessary and do not directly relate to any other element.
8. Similarly, positive externalities have little to do with other elements with one exception: taking a priority setting process beyond the organization can be a method of broadening communication to stakeholders.

Elements identified in this research were neither ranked nor weighted since there was no empirical evidence to suggest that one element was more important than another. However, it is important to note that in data collection (the three empirical studies), we did not ask any questions on weighting or ranking; it is possible that adding weights or ranking would be appropriate and more research would have to be done to confirm this. For example, we could take the conceptual framework to a new group of stakeholders (including the public) and ask them (quantitatively) to rank the elements. Economic approaches strongly advocate weighting criteria (Mitton & Donaldson, 2004b). As the conceptual framework and tool are implemented and used in similar contexts as well as others, it is a possibility that a natural weighting (or ranking) of the elements will occur (i.e. without quantitative studies). For example, if organizations that use the tool are consistently asking for more information or focus on ‘stakeholder engagement’, this might be an indication to weight ‘stakeholder engagement’ heavier than other elements. Similarly, if decision makers and leaders feel that there is a gap between the information that the tool produces and what is needed to make changes to improve their priority setting, it would be important to

investigate the difference (gap analysis) and determine which area of the tool and framework need more weight.

Fact-Value Distinction

Although the ten elements are not directly derived from moral theory, they hold normative relevance for two reasons.

First, they are derived from overlapping consensus of empirical observations involving the participants' reported values. Many of the participants were actual priority setting decision makers who are motivated to improve priority setting because they are directly involved in it. It is important to distinguish here between facts and values. The 'fact/value distinction' differentiates statements about *what is the case* from statements about *what ought to be the case*. Facts are descriptive, telling us what was done; values are prescriptive, telling us what should be done. The value-relevance of this study comes from the participants' values, such as their normative reasoning, and not from the data analysis. In this research, I have 'described' participants' views; the participants have provided what they thought 'should be' included.

Second, individual elements are connected with concepts grounded in normative theories about public policy making in a pluralistic democracy. To help provide a way in which to decide between competing theories, Rawls discusses 'Wide Reflective Equilibrium' (WRE) (Rawls, 1971). In WRE ". . . one is to be presented with all possible descriptions to which one might plausibly conform one's judgments together with all relevant philosophical arguments for them." (p. 49). This form of deliberation aids in moral decision making. WRE holds that agreement can be achieved when we look at all of the possible theories and how they interact with moral principles to come up with the "correct" (moral) decision. Daniels expanded on the concept of WRE and holds that WRE attempts to produce coherence in individuals' personal beliefs,

including his/her moral judgments, moral principles, and relevant background theories (Daniels, 1979).

Through the process of public discussion with a plurality of differently opinioned and situated others, people often gain new information, learn of different experiences of their collective problems, or find that their own initial opinions are founded on prejudice or ignorance, or that they have misunderstood the relation of their own interests to others (Young, 2000).

For example, stakeholder engagement promotes involvement beyond the decision makers, which is closely related to theories in deliberative democracy (Rawls, 1993), which consider political equality through a commitment to ‘equal concern’ for the interests of all (Moon, 2004) and the ‘principle of participation’ (Cohen, 1996). Theorists hold participation needs to be meaningful, and so, stakeholders should be actively engaged in discussion.

In Dahl’s (1989) thinking, democratic deliberation included ‘enlightened understanding’ or equal opportunity for discovering and validating a decision. In my conceptual framework, ‘Stakeholder Understanding’ encourages learning or ‘enlightenment’ beyond mere participation.

Another example is the element that supports consideration for context (both internal and external environment), which is part of rational choice theory, where consideration of external environment is important in evaluating decisions. “Pairwise exchanges in social life do not take place in a vacuum. They take place in a setting in which there is competition for the resources held by each actor” (Coleman, 1990)(p. 131).

The Tool for Evaluating Successful Priority Setting

The evaluation tool was based on the ten elements from the conceptual framework. The purpose of the evaluation tool was to provide a simple, practical way for an organization to evaluate what it means to achieve success in its priority setting activities and identify areas for improvement.

The creation of the evaluation tool was an iterative process that included proposing evaluation indicators and refining them based on the feedback received from stakeholders and the actual empirical application (the hospital pilot test). Indicators were derived from the conceptual framework and mapped on to the ethical and practical goals of priority setting.

Traditionally, outcome measures that are used in relation to health policy analyses refer to health outcomes in a selected population (e.g. morbidity and mortality). However, my framework identifies priority setting outcomes rather than health outcomes. Health outcomes may be influenced by priority setting decisions, but are also influenced by a myriad of other factors such as quality of care. It is difficult to directly assess the achievement of priority setting success by measuring or evaluating health outcomes. Measuring priority setting success is possible by evaluating direct priority setting outcomes such as improved stakeholder understanding, shifted priorities, improved decision making, stakeholder acceptance, and positive externalities.

The tool is made up of three parts: a survey, interviews, and document analysis. The tool specifies both quantitative and qualitative dimensions of priority setting and relates both to its procedural and substantive dimensions. As the tool is applied in more health care organizations, it may become more streamlined. Future research is required to determine the best combination of the components; for example, the need for one-on-one interviews could decrease and the use of surveys could increase, since surveys are easier and more cost effective to implement, and do not require a trained interviewer. However, these are trade-offs that would need to be assessed.

Two issues that are specific to the tool and remain unanswered by this thesis, are timing of tool implementation and, what priority setting process this tool is best suited for (operational versus strategic planning). Further research is needed in order to determine an appropriate time to implement as well as the suitable priority process to evaluate.

The ideal timing for implementation of the evaluation tool is not known. There are several options, each with advantages and disadvantages. First, decision makers/leaders could implement the tool soon after a priority setting process is complete. Disadvantages to implementing too soon include: (1) actual shifts or changes from the process (or lack thereof) will not be known and (2) possibility of response bias (people will over identify the process as good because they feel good about the process). Second, the tool could be implemented six months after the priority setting process in order to allow stakeholders time to see actual changes. Disadvantages to this implementation option are: (1) stakeholders might forget details of the process (history bias), and/or (2) long-term changes will still not be captured. Ideally, the tool will be implemented each time an organization goes through the specific priority setting process and the problem of capturing actual changes will be ameliorated. The results of the evaluation tool can then be used to improve future priority setting iterations.

Both operational and strategic planning are priority setting processes; the major differences are that the former is short term and has a financial focus, and the latter is more often long-term, conceptual and should have a guiding role in operational planning. Strategic planning defines the direction of the hospital and its priorities, whereas operational planning looks at budgetary decisions (for example, to cut or reduce a clinical program or to eliminate nursing staff positions).

The pilot study in this thesis looked at operational planning, and discovered that the tool was successfully implemented, meaning that we now know that the tool (and framework) can be used in operational planning. The primary advantage of using this tool for operational planning is firstly budgetary, but it is also important to note that operational decisions directly impact frontline staff more than strategic decisions; therefore they might be better suited to answer questions. Second, since operational planning is a regular process, it could be easier for

participants to review previous year's decision making and more easily compare the processes. However, disadvantages of using it for operational planning include the several weaknesses found during implementation such as the large percentage of 'I don't know' responses (discussed below) and the issue with response rate calculation.

The framework and tool might be better suited to be used in strategic planning where, by its nature, more stakeholders are involved and the process is more multi-faceted. One advantage of using this framework and tool in strategic planning is that having more stakeholders involved in the process would mean that the number of people aware of the process would be larger (than if used only in operational planning). Having more people involved would translate into an increase in information available for the process. Also, senior leadership may prefer to dedicate resources to implement the tool for strategic planning which is more elaborate and happens once every five years, rather than operational planning which happens more frequently. Implementing the tool during strategic planning would also work to benefit (or improve) decision making at the operational level. The conceptual framework explains how a successful priority setting process increases decision making quality at every level. A disadvantage of using the tool for strategic planning is the increased workload that stakeholders would incur from doing a lengthy priority setting process followed by a potentially lengthy evaluation (this has been discussed by Peacock (1998)). Another disadvantage is that strategic direction decisions have less of a direct impact on frontline staff, and staff might therefore lack the knowledge to answer some questions.

The tool is not intended to be a blueprint for priority setting practices. It is expected that the tool may need adjustment according to each organization's context (add or remove questions). While the framework presents unifying ideas that underlie successful priority setting, modification to contextualize the tool is anticipated. (This is discussed below in reference to future research).

Testing and Implementation of the Tool

To determine the ‘sensibility’ of the tool to priority setting, it was critically appraised and pilot tested. First, key informants (researchers and decision makers) assessed the overt format, and the face and content validity of the tool. Second, the ease of use was assessed in the pilot test that was preformed in a mid-size hospital in Ontario. The appraisal and the pilot test confirmed that the tool could effectively evaluate the relevant features of success identified in the conceptual framework. The pilot test further confirmed the ease of use of the tool.

The analysis of the results from tool implementation provided an excellent opportunity to assess the usefulness of the data collected and the ability of the tool to adequately capture the characteristics of each element. One of the biggest problems that came from this analysis was from the survey component and the large percentage of unsure responses (‘I don’t know’ and/or ‘Not sure’). This overwhelming trend of unsure responses could have arisen for a number of reasons. First, it could be poor wording of the question or the response options; it may have been better not to offer ‘I don’t know’ as an option, or to rephrase questions into statements to elicit agreement or disagreement (for example: “Do you think the process was fair?” yes/no/I don’t know, would become “the process was fair” agree/ disagree).

A second possibility is that the words themselves, or the meaning of the words, were unclear to respondents. For example, in the question, ‘In comparison to previous decision making or priority setting at [the hospital], is there consistency in reasoning between previous and the 2007/08 budgeting process?’, the term ‘consistency in reasoning’ is complex and can mean different things to different readers. Similarly, the question, ‘Do you think the process was fair?’, where 69.5% of respondents said ‘I don’t know’, it is possible that respondents did not feel that ‘fair’ was an appropriate term to use, or that they were more unsure of the meaning of the term ‘fair’

than they were about the fairness of the process in question. Similarly, it is possible that some questions were too abstract to relate to their daily practice and experience.

Third, it is possibly inappropriate for front-line stakeholders to complete the survey for this particular type of priority setting exercise (annual budgeting/operational planning); that is, it is possible that respondents truly didn't know the answers to the questions.

The trend in the pilot results was that the percentage of 'I don't knows' decreased as the survey progressed (this is an opposite effect than what we would expect in a lengthy survey where the percentage of 'I don't knows' increases through survey progression, sometimes called 'respondents fatigue'). Therefore, a fourth possibility for why 'I don't knows' were so high early on in the survey is that respondents were not confident in their responses, and that this confidence grew as the survey progressed.

Discussions with pilot test participants that followed the assessment demonstrated the usefulness of the outcomes of the tool. More research needs to be done to determine the validity and consistency of the tool in other health care organizations and levels of the health system.

6.2 Contribution to Knowledge

Relationship with Existing Literature on ‘Priority Setting Success’

Evaluating the achievement of success in priority setting is difficult to do when ‘success’ has not been defined. Other fields unrelated to health care priority setting (such as education, business) have suggested how to define and evaluate success (discussed in Section 2.4); within the priority setting literature, a few studies and disciplinary-specific approaches have examined pieces of successful priority setting (discussed in section 2.2). However, this research provides a more coherent and comprehensive definition of success than any previously existing tools or attempts.

Some of the ten elements in this framework have been described in other research. For example: use of an explicit process (Martin & Singer, 2000), consideration for stakeholders’ needs (Stone, 1997), the use of a revision or appeals mechanism (Madden, Martin, Downey et al., 2005), and a thorough communication plan (Bell, Hyland, DePellegrin et al., 2004). Other elements have not. This research brought the elements all together for the first time into a comprehensive conceptual framework.

In this section I will compare what my conceptual framework offers as a comprehensive definition of successful priority setting with what authors within the priority setting field have identified as partial definitions of success in priority setting.

Compared to Accountability for Reasonableness (Daniels and Sabin)

‘Accountability for reasonableness’ (A4R) was discussed early in section 2.3 as a framework for evaluating fair priority setting (Daniels & Sabin, 2002). I argued that fairness and legitimacy have been used as two surrogate goals to achieving success in priority setting. The four conditions of A4R are reflected because they were embedded in the Delphi study (Study #1) and because many

of my interview participants (Study #3) explicitly referred to them (See table 6.1). A4R is an acceptable normative framework that has been used both internationally and in Canada; it has real-world applicability and traction among decision makers.

The first condition of A4R, relevance, is similar to two elements from my framework: stakeholder engagement and consideration of values and context. The relevance condition and stakeholder engagement are both concerned with involving stakeholders to ensure that the right reasons are brought to the decision making table. Like the relevance condition, consideration of values and context, speaks to the importance of the best available information as part of priority setting decision making.

‘Use of Explicit Process’ is very similar to the second condition of A4R, publicity, since both incorporate a core focus of making the process (and its outcomes) accessible to all stakeholders. Use of explicit process takes the condition a step further by highlighting the importance of having a process planned out from the start, including a communication plan.

Lastly, the third condition of A4R, revisions/appeals, is comparable to the revision or appeals element of my conceptual framework. Both stipulate the need for a mechanism for challenge, including an opportunity for revising decisions in light of considerations that stakeholders may raise.

The fourth condition in A4R, enforcement, is not directly reflected to elements of my framework, but it did influence the logic of creating the framework and tool, that is, enforcement refers to the importance of regulation (voluntary or public) of the process, and is an area that requires improvement (Reeleder, Goel, Singer et al., 2006). This framework and tool fit into the goal of improving (or meeting) the enforcement condition by improving leadership.

Table 6.1: Conceptual Framework compared to ‘Accountability for Reasonableness’

	Elements	Daniels and Sabin: ‘A4R’
PROCESS	Stakeholder Engagement	Relevance Condition
	Use of Explicit Process	Publicity Condition
	Clear and Transparent Information Management	
	Consideration of Values and Context	Relevance Condition
	Revision or Appeals Mechanism	Revision/Appeals Condition
OUTCOMES	Stakeholder understanding	
	Shifted priorities /Reallocation of resources	
	Decision Making Quality	
	Stakeholder Acceptance & Satisfaction	
	Positive Externalities	

My conceptual framework is complementary and advances ‘accountability for reasonableness’ by considering the outcomes of a priority setting process, whereas A4R focuses mainly on the process of priority setting. Further, my framework adds information management as a key procedural element for successful priority setting; placing an emphasis on the importance of not only communicating information, but of effectively managing it through each step of the priority setting process.

Compared to Gibson et al.

Gibson et al. (2004) identified six parameters of success from the perspective of health care administrators (three outcome elements and three process elements). Effect on organizational priorities and budget is very similar to the outcome element ‘Shifted priorities /Reallocation of resources,’ as both are concerned with actual changes in resources allocation. Effect on staff is most similar to ‘stakeholder acceptance and satisfaction’ as both focus on the broad impact of priority setting (satisfaction, morale, organizational recruitment and retention initiatives) and are also similar to ‘stakeholder understanding’. Their third outcome parameter, effect on community, is related to two elements from my conceptual framework: ‘stakeholder acceptance and

satisfaction’, and ‘positive externalities’. Gibson’s parameter and my elements capture a number of variables: neutral or positive public media recognition, improved public acceptance or community support, improved public perception of institutional accountability, health care integration through increased partnerships, enhanced education/research peer recognition, and emulation by other organizations.

Gibson et al. also identified three process parameters. Efficiency of priority setting process has to do with capacity and ease in decision making - - ‘use of explicit process’ also deals with these issues as well as concerns about transparency and publicity of the process. Gibson talked about “conformity with the conditions of ‘accountability for reasonableness’”, which, in my framework can be compared to the ‘revisions or appeals mechanism’ element. The last process parameter is ‘fairness’, which included: considerations for stakeholders’ understanding, stakeholders’ engagement, justified and reasonable decisions, consistent and fair process, and Winners/losers issues well-managed. Again, this parameter directly relates to two elements: “stakeholder engagement” and “use of explicit process”. In Table 6.2, I map out the comparison between my conceptual framework and the parameters identified by Gibson et al.

My framework is complementary and advances Gibson et al by widening the scope of stakeholder involvement in data collection. Data was collected in Gibson et al through a series of workshops with board members and senior leaders at two RHAs and one hospital, whereas data collection for my study was done with over 200 participants ranging from the patient level to Senior Administration, allowing for a more complete (or representative) representation of successful priority setting.

Table 6.2: Conceptual Framework compared to Gibson et al

	Key Element	Gibson et al. “Parameter of Success”
PROCESS	Stakeholder Engagement	Fairness
	Use of Explicit Process	Efficiency of Priority Setting Process & Fairness
	Clear and Transparent Information Management	
	Consideration of Values and Context	
	Revision or Appeals Mechanism	Conformity with the Conditions of ‘Accountability For Reasonableness’
OUTCOMES	Stakeholder understanding	Effect on staff
	Shifted priorities /Reallocation of resources	Effect on Organizational Priorities And Budget
	Decision Making Quality	
	Stakeholder Acceptance & Satisfaction	Effect on Staff & (Effect on Community)
	Positive Externalities	Effect on Community

Compared to Teng et al.

Teng et al. (2007) presented “essential elements to improve priority setting”. This study found that decision makers desired a more explicit framework or process for priority setting, which is comparable to the ‘use of explicit process’ in my framework. Both have the desire for explicit priority setting that is well communicated and considerate of all stakeholders at their core. Teng’s ‘stakeholder involvement’ is similar to ‘stakeholder engagement’ in that both highlight the importance of stakeholder opinion and participation. Teng highlights that increased engagement can lead to shared vision in priority setting, an important piece in priority setting culture. Teng’s ‘priority setting culture’ is captured in my conceptual framework through ‘decision making quality’ where a key indicator is to make priority setting a part of organizational culture. (Table 6.3)

The essential elements brought forward by Teng et al represent an important piece of successful priority setting; however, their elements do not provide a complete illustration of success in priority setting. My framework is complementary and provides a more comprehensive

representation of the elements of successful priority setting. Teng et al. also indicate that lack of tools for priority setting is a barrier to improvement in priority setting- - the conceptual framework (and evaluation tool) developed in this thesis fill this gap by providing a priority setting tool.

Table 6.3: Conceptual Framework compared to Teng et al.

	Elements	Teng et al. “Elements to Improve priority setting”
PROCESS	Stakeholder Engagement	Stakeholder Involvement
	Use of Explicit Process	Explicit Priority Setting Process
	Clear and Transparent Information Management	Increased quality of information
	Consideration of Values and Context	
	Revision or Appeals Mechanism	
OUTCOMES	Stakeholder understanding	
	Shifted priorities /Reallocation of resources	
	Decision Making Quality	Priority Setting Culture (shared priority setting vision)
	Stakeholder Acceptance & Satisfaction	
	Positive Externalities	

Compared to Mitton and Donaldson

Mitton and Donaldson (2002) surveyed priority setting decision makers and reported that they have a “desire for pragmatic assessment of benefit”. Decision-makers felt that there was no clear process for setting priorities and were unaware of the priority setting tools available. They also found that politics have a central, and often superior role over ‘hard’ evidence in priority setting decisions; more of a balance was desired. ‘Clear and transparent information management’ aims to address the issue of imbalanced information. Decision makers in the survey desired more dialogue with key stakeholders including physicians and the public, which is similar to ‘stakeholder engagement’ where dialogue with both internal and external stakeholders is recommended as a key element of successful priority setting. Decision makers felt that an explicit priority setting process would be useful; this is captured by my framework through ‘use of

explicit process’ which outlines the importance that the process is clear, transparent and understood by decision makers and other stakeholders (Table 6.4).

Table 6.4: Conceptual Framework compared to Mitton and Donaldson		
	Elements	Mitton and Donaldson ‘what decision makers want in a priority setting process’
PROCESS	Stakeholder Engagement	Increase communication/dialogue between stakeholders
	Use of Explicit Process	Establish an actual (more systematic) process for developing priorities (e.g. PBMA)
	Clear and Transparent Information Management	Increase quality of information/data used
	Consideration of Values and Context	
	Revision or Appeals Mechanism	
OUTCOMES	Stakeholder understanding	
	Shifted priorities /Reallocation of resources	
	Decision Making Quality	
	Stakeholder Acceptance & Satisfaction	
	Positive Externalities	

Mitton and Donaldson found that decision makers desire an explicit framework and that there remains a role for academics in presenting options and providing guidance. My framework is complementary and advances this thinking by providing a framework that is functional for both decision makers and stakeholders. Mitton and Donaldson also pointed out that there is a lack of meaningful measures to compare diverse health care activities and inform policy decisions. My framework and evaluation tool addresses and builds on this, providing a common language for evaluation and comparison. In addition, my study went one step further by using a broader sample than that of Mitton and Donaldson, who focused on decision makers in one province (Alberta).

Compared to Mitton and Patten

Mitton and Patten (2004) surveyed decision makers in Calgary health region pre and post PBMA implementation. Their study highlighted the need for important and clear information management, which is supported by my research. Decision makers in their study pointed to the need for more information and greater dialogue in priority setting, the latter of which can be compared to ‘stakeholder engagement’ in my framework. They also held that opportunities for re-allocation and re-investment are needed, which is similar to shifted priorities /reallocation of resources, but different in that Mitton and Patten see it more as a process component, whereas in my framework it is an outcome element. My research supports Mitton and Patten’s argument that in order to make priority setting part of a learning organization (decision making quality in my framework), a priority setting process needs to become part of routine planning. They conclude that greater dialogue (increased communication) can lead to greater understanding in the overall priority setting process (an outcome element of my framework) (Table 6.5).

Table 6.5: Conceptual Framework compared to Mitton and Patten		
	Elements	Mitton and Patten
PROCESS	Stakeholder Engagement	Greater dialogue/stakeholder involvement.
	Use of Explicit Process	
	Clear and Transparent Information Management	Better information through multiple forms
	Consideration of Values and Context	
	Revision or Appeals Mechanism	
OUTCOMES	Stakeholder understanding	
	Shifted priorities /Reallocation of resources	Provide opportunities for re-allocation and re-investment
	Decision Making Quality	The process needs to become part of routine planning
	Stakeholder Acceptance & Satisfaction	
	Positive Externalities	

Again, my framework is complementary to the survey by Mitton and Patten. I also build on their work by spending time looking equally at processes and outcomes. Mitton and Patten focused on

types of information the decision makers wanted which was not originally covered by my research. However, an important finding that has been added to the 'information management' element to boost the comprehensiveness is that decision makers want information in multiple forms, including better information on 'capacity to benefit'. In Mitton and Patten's study, participants talked about 'hard' and 'soft' information (e.g. anecdotal stories and expert opinion).

Summary

To summarize, my research is complementary to previous studies that identified pieces of successful priority setting, and it builds and expands upon these previous works by describing a broad range of stakeholders' views about successful priority setting and synthesizes them into one conceptual framework that can be used by decision makers to improve priority setting. Table 6.6 shows that each element in my framework has been discussed by at least one author.

Table 6.6: Comparison of Existing Definitions/Suggestions of Success in Priority Setting

	Elements	A4R	Gibson	Teng	Mitt/Don	Mitt/Patt
Process	Stakeholder Engagement	•	•	•	•	•
	Use of Explicit Process	•	•	•	•	
	Clear and Transparent Information Management			•	•	•
	Consideration of Values and Context	•				
	Revision or Appeals Mechanism	•	•			
Outcomes	Stakeholder Understanding		•			
	Shifted Priorities /Reallocation of Resources		•			•
	Decision Making Quality			•		•
	Stakeholder Acceptance & Satisfaction		•			
	Positive Externalities		•			

My framework provides a comprehensive image of successful priority setting, which supports and is supported by the existing literature. My framework also re-introduces elements that had not been as prevalent in the literature (e.g. stakeholder understanding), but are equally important in striving for success in priority setting. Prior to this thesis, the dominant literature was focused on

process elements; this framework is unique in that it adds outcome elements to the comprehensive view of successful priority setting.

Gaps in Knowledge

In Chapter 2 (Section 2.5), I identified two gaps in knowledge. In this section I will describe how I answered the questions that had been left open by these knowledge gaps.

GAP #1: There is No Comprehensive Definition of Successful Priority Setting

No single study has attempted to provide a broad overarching definition of successful priority setting. There is no consensus about how to define successful priority setting. While a few studies have reported on pieces of this problem, there has been no attempt to develop a comprehensive and integrated framework that combines all of the pieces. A4R provides a framework to evaluate fairness in priority setting. This research attempts to fill this gap by providing a comprehensive definition of success.

This study has allowed us to identify and illuminate ten elements germane to successful priority setting from the perspectives of decision makers and patients from Canada, and priority setting scholars from around the world. A few studies have described decision-makers' views of priority setting, but this study advances the priority setting knowledge through use of a broad range of participants in our three studies (i.e. decision makers from over 50 institutions across macro-, meso- and micro- policy levels, patients, and international priority setting scholars), and the richness and specificity of the ten elements we identified.

The creation of a comprehensive conceptual framework is an important step forward in priority setting literature. The framework was developed through the lens of priority setting decision makers and stakeholders, and fills a gap in knowledge by providing guidance for decision makers.

In other words, it was created by stakeholders, for stakeholders. The conceptual framework provides an overview of successful priority setting by listing ten elements to achieve success (stakeholder understanding, shifted resources, decision making quality, stakeholder acceptance and satisfaction, positive externalities, stakeholder engagements, explicit process, clear and transparent information management, consideration of values and context, and revision or appeals mechanism). Other studies have described some of the elements of success, which this research illuminates, however most research has only focused on a piece of the problem while this research provides a comprehensive view.

This research is the first comprehensive description of success in priority setting across stakeholder groups. This work provides meaning and a definition to the abstract concept of successful priority setting and provides concrete terms to help facilitate discussion around successful priority setting. Further, organizations now have an identifiable target. Through the development of the conceptual framework and the evaluation tool, organizations and priority setting scholars have access to a common language. By defining the concept of successful priority setting, it can be discussed more frequently and more purposefully. As research continues, this can work to benefit priority setting in many ways.

The conceptual framework is a broad description of the necessary elements of successful priority setting. Decision makers and stakeholders still have to evaluate their organization in order to contextualize the framework. In other words, this framework isn't 'one size fits all'. The framework attempts to describe ten elements that are important for achieving successful priority setting, however, it assumes that the organization is coming from a stable environment with existing mission, vision, and values statements, and is also an organization that is open to change. In order to effectively use the framework, an organization should have several facilitators in place (such as a culture to learn, leadership, resources, and others (Mitton & Donaldson, 2003)).

Facilitators for achieving success in priority setting process have been defined in the literature. Examples include: leadership and/or process champion (Reeleder, Goel, Singer et al., 2006), learning culture, resources, (Mitton & Donaldson, 2003) and commitment to process (Teng, Mitton, & Mackenzie, 2007). For this reason, an organization lacking any of the aforementioned elements might not find the framework very helpful in its current construction. In this case, an organization could use the framework as a tool for developing organizational direction.

GAP #2: There is No Tool for Evaluating the Achievement of Success in Priority Setting

Given that we lack consensus on the meaning of successful priority setting, we have no tool for evaluating priority setting decisions in an actual context. Outcome measures are helpful in evaluating the success of a health care organization, but they do not provide a complete picture of successful priority setting. A more comprehensive tool is needed. This research attempts to fill this gap by developing a tool to evaluate the achievement of success in priority setting.

Based on the conceptual framework, I developed an evaluation tool which is intended to help health care organizations identify strengths and opportunities for improvement in their priority setting and resource allocation activities. The evaluation tool has three components: a survey, one-on-one interviews, and documents analysis. The evaluation tool is intended to be used by health care decision makers involved in priority setting activities.

This is the first attempt to create a tool to evaluate the achievement of success in priority setting in health care organizations. The combination of the conceptual framework and the evaluation tool provide a definition to the previously vague notion of successful priority setting.

Further research is needed in order to determine the best implementation method for this tool. Currently, this study shows that it is possible for an individual external to the organization to

come in and implement this tool; however, in this study, the external researcher (SS) had knowledge and expertise in the field of priority setting. This may not be the case in every situation.

This evaluation tool is an important contribution to the priority setting field since it is the first of its kind. Currently, there is no comprehensive way to evaluate an organization's priority setting activities. Priority setting has been evaluated using the ethical framework 'accountability for reasonableness', but those evaluations focused on fairness, which is only one aspect of priority setting. This tool takes the evaluation beyond fairness to evaluating the achievement of successful priority setting. Fairness is a component of successful priority setting, but it is not the only indicator.

Economic evaluations have also been used to evaluate priority setting, but there is no consistent set of indicators or methods to be used to assess them. This research filled a gap in knowledge by presenting an original tool which can be used by decision makers who are involved in priority setting activities daily. The main strength of this tool is that it provides an organization the opportunity to evaluate their priority setting and see good practices as well as areas of needed improvement. The tool does not provide 'best practices' or solutions to areas of needed improvement - - this could be an add-on, but not directly part of the tool. It could enhance its usefulness to health care organizations; however it would require constant updating and therefore would not be as comprehensive a tool. Again, this is a possibility for the tool, but not one that was pursued during this research.

6.3 Implications of this Research

Implications for Policy and Practice

The conceptual framework and evaluation tool that were created from this research can guide the development, implementation, and evaluation of priority setting activities in health care organizations across Canada. The framework and tool can provide guidance for decision makers in their priority setting. Further, by considering the ten elements of the framework and implementing the evaluation tool, leaders can make steps to improving priority setting in health care organizations.

1) Guidance for Decision Makers

The conceptual framework, the evaluation tool, and the lessons learned through this study provide practical guidance to decision makers across the country. More than that, the tool and the framework provided will assist in improving health care leadership. Studies have shown that leaders want guidance; Reeleder et al. identified leadership as the aspect of priority setting most in need of improvement (Reeleder, Goel, Singer et al., 2006). It is the goal that the conceptual framework and tool from this research will provide a strategic and practical improvement tool for leaders, along with a common language and the opportunity to increase priority setting capacity within organizations (an important finding from Frenk et al. (2006))

The conceptual framework and evaluation tool provide decision makers with a means to create successful priority setting within their organization without the need for expertise or special knowledge of existing priority setting tools. This will ultimately improve the quality of decision making in health care organizations.

Decision makers can use the conceptual framework in their daily activities as a guide to ensuring that successful priority setting is achieved. Regular administrative activities (such as budgeting, strategic planning) and even unexpected priority setting decision making (such as a natural disaster) can be improved by using the ten elements of this framework as a starting point for process planning. The evaluation tool can also work to improve any decision making process by evaluating the outcome of a process, and by promoting organizational learning and stakeholder satisfaction. Both the conceptual framework and the evaluation tool are easy to understand and easy to use. The conceptual framework can be used immediately by decision makers and priority setting scholars nation-wide. Although further research is needed to determine the applicability of the tool in various health system levels (i.e. meso vs. macro vs. micro), decision makers can still make use of the tool in its current format.

Further research in other organizations and in different health care contexts would allow for the comparison of lessons between hospitals and could provide an understanding of the problems faced in various hospital contexts. It is helpful to have an idea of the level of priority setting success that is currently achieved by health care institutions. By applying the evaluation tool in numerous health care organizations (at the macro and meso levels), we could:

1. capture lessons from priority setting experiences that could be used to improve future priority setting processes;
2. bring that learning into academic literature, in which hospital priority setting is under described, and in particular to provide leadership in the form of ‘good’ practices that can be shared with other health care organizations; and
3. cultivate learning organizations.

The conceptual framework can also be used when planning a priority setting exercise. By considering the ten elements important for success in priority setting, decision makers can work toward achieving success (or improving priority setting) from the planning stages of priority

setting. When planning a priority setting process, planners should focus more on the process elements of the conceptual framework. Once the process is planned out and is in the implementation stage, priority setting planners should focus on the outcome elements of the conceptual framework and attempt to maximize success by achieving the five outcome elements. The conceptual framework and evaluation tool are not just to be used in major decision-making processes; they can ultimately foster a learning organization for all staff allowing them to learn good practices and opportunities for improvement, strategies for good decision-making and organizational involvement throughout the process.

2) A Useful Evaluation Tool

The evaluation tool developed in this research provides a guide for decision makers to improve the quality of their priority setting. The tool is intended to be used by senior leadership (CEOs, CFOs, executive directors, etc) in health care organizations across the country. Since the pilot test was performed in a meso-level organization, the tool is currently best suited for meso-level organizations (though further research is suggested to make the tool useable in other contexts at all levels of health care).

Through this tool, health care decision makers can be asked to rate themselves on their organization's ability to promote a successful priority setting process. This tool could be used to advance priority setting practices in health care organizations nation-wide. Through its use, an organization will be able to identify areas of good practice as well as areas needing improvement. Areas of improvement could be included in performance agreements (for e.g. Ontario's Accountability Agreements (Reeleder D, Goel V, Singer PA et al., 2008)).

The evaluation tool can help facilitate and establish good priority setting practices within health care regions; for example, the new Ontario Local Health Integration Networks (LHINs). LHINs

could use the evaluation tool in their regions and create incentives for sharing successful priority setting practices.

This evaluation tool provides the opportunity for health care organizations to build capacity in priority setting decision making. Any priority setting or decision-making processes should be fair and rigorous with an explanation of the reasons behind decisions (Daniels & Sabin, 1997). Use of this evaluation tool could facilitate a greater capability to incorporate relevant information for decision making with the potential for greater learning and innovation. The evaluation tool can provide explanation and further rationale to stakeholders on priority setting decisions and reasons. This, in turn, can be a learning experience, not only for the health care organization itself, but also for other organizations and decision makers.

The results of the pilot study may help to improve organizational priority setting within that hospital, and can also provide guidance for other hospitals nation-wide. My experience with the tool shows that by working toward achieving success in any decision making process, organizational learning can improve, capacity for decision making could increase, and ultimately the priority setting process could become more successful with each iteration. This tool can help increase transparency and inclusivity in decision-making; further research is required to verify this. If the results are shared broadly with other health care organizations, the lessons learnt from one organization's priority setting can be used to help improve priority setting across a health care region or system.

More research is required to contextualize the tool (to suit different organizations) before it can be used by decision makers and leaders in any health care context. This includes determining the best time to implement (how long post-process), making the tool more user-friendly (stream-line components), and determining the most appropriate usage for the tool (strategic planning versus

operational planning versus other priority setting exercises). All of these issues are discussed throughout this chapter.

Second, the alignment between the conceptual framework and the tool needs to be improved and simplified to allow individuals (internal to the organization) straightforward implementation and analysis. As it currently stands, a researcher needs to have intimate knowledge of the conceptual framework, the tool, and their relationship to one another in order to analyze the results of the tool. This limitation should be minimized with future iterations and pilot tests.

Third, the appropriate role of the public in the evaluation tool needs to be determined. In the pilot study, the public was not involved in surveys (or interviews), so it is difficult to know if this tool can be used by the public in its current form. Before we can determine the appropriate role of the public, it is important to define what is meant by the term public. The meaning of public might also change depending on what priority setting process the evaluation is used for (strategic versus operational). In general, hospitals are publicly accountable for the use of funds generated through taxation; this would be one meaning of public. The general public should have a role at the strategic level. Another meaning of public is those who are most affected by the decisions; democratic justice requires that those affected by a decision (particularly the most vulnerable and least powerful) should have the opportunity to influence it. At the operational level, specific patient and staff population views and perspectives are relevant since they will be most directly affected.

3) Education for Leaders and for Organizations

Improved priority setting can, ideally, lead to stronger and more cohesive organizations. As stakeholder engagement increases, so will stakeholder satisfaction, which could help in facilitating a culture that is aware of the need for priority setting and the best way to meet that

need. Specifically, by following the ten elements for successful priority setting, organizations will start to form better habits in priority setting. The ten elements of successful priority setting can be thought of as ‘Ten Habits of Successful Priority Setting’ in health care organizations. By committing to evaluate priority setting, a successful learning organization is created, and, in turn, can work to create a more successful health system through the sharing of lessons learned.

Currently, lack of quality leadership is a significant barrier in every health system. As Reeleder et al. (Reeleder, Goel, Singer et al., 2006) pointed out, effective leadership is required for fair and legitimate priority setting. They also found that the enforcement, or leadership condition of ‘accountability for reasonableness’ was the condition that left the most room for improvement. It is important to note that leadership is a requirement for implementing the conceptual framework and evaluation tool from my research. Once a champion or a leader commits to using the framework and tool within an organization, capacity in decision making can only be bettered and priority setting improved.

Martin and Singer (Martin & Singer, 2003a) presented a framework for improving priority setting: describe-evaluate-improve. This strategy, described in Chapter 2, involves combining case study research to describe priority setting, interdisciplinary research to evaluate, and action research to improve priority setting. This strategy is an important part of leadership, and can build capacity for leaders - - this strategy can be directly applied to my research.

1. Decision makers (leaders) need to describe their organization’s priority setting activities, made possible through the use of the evaluation tool.
2. Next, decision makers need to evaluate the priority setting by comparing the results from the evaluation tool with the ten elements of the conceptual framework; what are the areas of good fit, what areas need improvement?

3. Lastly, decision makers can work towards improving priority setting by tackling areas needing improvement.

Implications for Other Countries, Cultures, and Health Systems

The framework and the evaluation tool were created in the context of the Canadian health system, and although this limits international applicability, it may be that both the framework and the tool can be used to enlighten priority setting practices internationally. Further research is needed to determine the exact use of the framework and tool in other countries, cultures, and health systems (discussed below); however, by becoming aware of elements of successful priority setting in the Canadian context, other countries can begin to evaluate or compare elements of success in their own organizations. Lessons learned through the application of the tool can be shared with other countries, and hopefully decision makers will be able to see elements of their own priority setting in some of the results.

As mentioned above, the lack of effective priority setting leadership is a significant barrier in every health system. If the conceptual framework and evaluation tool can be the starting point for conversations about success in priority setting, it will be a positive endeavour. Kipiriri and Martin (Kipiriri & Martin, 2007) advocated for the need to improve priority setting in developing countries since current priority setting processes are political and value-laden. They argued that the information and tools available to decision makers in these countries are insufficient and suggest an approach to improving priority setting in developing countries that includes three strategic foci: (i) capturing current priority setting practices, (ii) improving the legitimacy and capacity of institutions that set priorities, and (iii) developing fair priority setting processes. Martin and Singer (Martin & Singer, 2003a) speak to the first focus by providing methodology to describe, evaluate and improve priority setting. This research can speak to the second and third

foci by providing a means to enhance awareness of elements of successful priority setting and, in doing so, to build capacity.

6.4 Limitations

Limitations of Individual Studies

The three studies undertaken in this research have limitations. All three revolved around gathering the views of stakeholders regarding successful priority setting, but from different perspectives. While each study had a similar methodology for data analysis, each used different strategies of data collection. While the limitations are similar, there are some differences.

Each study was limited by its participants; the views and results from each study are not generalizable to other stakeholders. Generalizability has been defined as the degree to which the findings can be generalized from the study sample to the entire population (Polit & Hungler, 1991) p. 645). However, the rich description this study has presented still provides a valuable contribution to the knowledge base of successful priority setting. Studying more stakeholders in other contexts would provide an ever richer description and is a potential for future research and refinement of the elements of success presented in this research.

It is possible that the views provided by participants in the three empirical studies were shaped by social desirability bias, and responses given in the interviews might not correspond to what the various organizations actually do in terms of priority setting. However, we found no glaring inconsistencies between the interview data and the documentary support in data collection, suggesting that what participants were saying was in line with what was actually happening in the organization. It is also possible that because my participant pool contained a majority of decision makers and leaders and not toward the public (including patients and community), that the conceptual framework (and evaluation tool) was skewed toward one stakeholder group. Had I

included more public perspective in the empirical data collection phase, there might have been more emphasis on stakeholder involvement and ensuring that patients/public were included as a key stakeholder group. Since the general public do not make decisions at the level that hospital administrators do, their input is the most they might expect to contribute. The existing 'stakeholder engagement' element could be broken down into types of stakeholders to ensure that a successful priority setting process included the opinions of public stakeholders as well as internal staff. Furthermore, more emphasis on the publicity aspect of both the process and the outcomes could allow for the public to be involved by first being informed. More public involvement might dictate a strong education process element. As it is now, education is captured in the outcome 'stakeholder understanding', whereas if there was more public involvement this might become a process element. In general, I am confident that the participant pool in the three empirical studies, along with the member checks, ensured that the public voice was heard and included in the conceptual framework and evaluation tool.

The use of 'accountability for reasonableness' as a guiding framework leading off Round #1 was a limitation specific to Study #1 (the Delphi consensus panel). I deliberately chose to use the existing ethical framework 'accountability for reasonableness' as a starting point for discussions because, as discussed in Chapter 2, it has traction among decision makers and is a preferred framework of priority setting researchers internationally; it is a useful tool and a practical guide to develop, implement, and evaluate fair priority setting processes. Despite this deliberate choice to use 'accountability for reasonableness' as a guiding framework, the possibility remains that the conceptual framework (and therefore the evaluation tool) is biased to the four conditions of 'accountability for reasonableness'.

The main limitation for Study #2, the one-on-one interviews, was its focus on Canadian decision makers. The sample of decision makers was broad and far reaching; however, some areas were

clearly under-represented, such as mental health. The views expressed in this thesis may not accurately represent the exact environment priority setting decision makers are facing today, especially in provinces such as Ontario where regionalization through LHINs is causing changes to many health care policies, including priority setting practices.

Study #3, the focus groups, used an innovative technique called circle-within-circle. This novel technique might be considered to be less robust than using traditional focus group techniques. While we could have used a traditional focus group approach, the circle-within-circle technique provided a unique opportunity to have a discussion with both patients and decision-makers. It is my belief that the final focus group (where both the decision makers and the patients discussed priority setting together) would not have been as fruitful had there not been the earlier focus group discussions allowing the patients to discuss priority setting without the decision makers present (causing potential power relations).

In amalgamating the three lists of successful priority setting from the three empirical studies, I made the decision to eliminate ideas/elements that were only discussed in one study. This decision was made after analyzing the data in aggregate and discovering the similarities between the three studies and the lack of consistency; that is, with the exception of two, most items were discussed in all three studies. First, in the one-on-one interviews, ‘external guidance and/or directives’ was discussed, but not elsewhere; it was therefore not included in the final list. Second, ‘education’ was discussed in the focus groups (more so by the patients); this was also not included in the final conceptual framework. It is important to note that before these two elements were omitted, I re-analyzed all the data using ‘external guidance and/or directives’ and ‘education’ as thematic codes: I searched through all the transcripts to see if anything was said that would fit into these codes.

It was impossible to calculate the survey response rate for the hospital pilot test, due to complications in administration. Recall from the results (section 5.2) that the survey went out to the entire hospital instead of a select (and controlled) group. Using demographic information from the survey, I know that the majority of respondents were front line staff with little to no experience with the hospital budgeting (priority setting) process. It is possible that the front line staff who responded did so because they were discouraged or angry with not being involved in the priority setting process. It is also possible that there were front line staff who were involved, but who did not respond to the survey. However, there was no evidence to suggest that this was the case, and to be sure, data was analyzed using a filter for involvement in the process. Another limitation to understanding front line staff perspective is that one-on-one interviews with front line staff were not performed. Future pilot tests should complete one-on-one interviews with a sample of all stakeholders, including community and patient groups.

Limitations of Study Overall

Overall, the primary limitation of this research is its generalizability. The results reflect the views of a wide range of key stakeholders, but most are from the Canadian health system, and they may not represent the views of stakeholders in other countries or cultures. The sampling technique was designed to probe a robust range of perspectives. Further research is required to determine the wider applicability of the elements described here. However, the goal of qualitative research is not generalizability. Rather, it is to provide a rich description of context-specific phenomena that have an independent, valuable, and significant meaning.

Priority setting is about putting forward recommendations or making changes to allow more benefit to come from the available resources. In order to determine if priority setting was successful it is important to know if those recommendations were implemented, and if they caused success (greater benefit of the resources), as opposed to if they had not been implemented.

This research does not make the distinction between a priority setting exercise and implementing the recommendations from the priority setting exercise.

If I were to perform this study again, I would design the three studies to feed into one another. For example, I would present the results of one study to participants from the next study for comments and feedback. While member checks were done for all three studies, allowing for cross referencing of the results may have built more rigour into the conceptual framework and evaluation tool. It would also be interesting to add more public stakeholders to the discussion to ensure that the elements were truly based on a wide stakeholder perspective. It is possible to take the existing conceptual framework and tool and present them to a public audience to gather feedback and potentially revise them. Doing this would increase the legitimacy of my framework and tool and increase their acceptance by all stakeholders.

I would also be more careful of leading questions, especially in Study #1, the Delphi, where participants were guided by the ethical framework 'accountability for reasonableness'. While I feel strongly about the merit and international practical applicability of A4R, its explicit use caused some questions surrounding the key elements derived from the research.

6.5 Conclusion

Future Research

1) Empirical Studies to evaluate the conceptual framework and the evaluation tool in different contexts

The evaluation tool will need to be adjusted for each health care organization context. While the framework presents unifying ideas that underlie successful priority setting, modification to contextualize the tool is anticipated.

a. Within the Canadian System

In order to refine the evaluation tool, a pilot study was conducted at a mid-size urban hospital in Ontario. This pilot study was extremely useful in determining areas of needed improvement for the evaluation tool, as well as sorting out issues of semantics and of comprehension. In order to make the evaluation tool useful for health care organizations across Canada, more pilot testing is required.

Recall that during the face and content validity testing of the evaluation tool, one respondent said that the tool would need to be contextualized to suit her organization; ideally, after several iterations the tool will have contextual modifications to meet these needs. By piloting the tool in other organizations of various sizes and levels, it will become a more substantial and influential instrument for health care decision makers.

Piloting should be done in a variety of health care organizations across the country. Ideally, pilots would be performed in different hospital locales (rural vs. urban), different hospital types (community vs. teaching), and different levels of hospitals (tertiary, quaternary). Pilots would

need to be conducted in health care organizations other than hospitals in order to make this tool accessible to organizations such as long-term care facilities and mental health organizations.

As more pilots are achieved, the reliability and validity of the tool will become stronger. Recall that in this research, I tested for ‘sensibility’ of the tool (face and content validity and ease of usage). The more validity the tool can accrue through subsequent tests, the stronger and the more reliable of an evaluation tool it will become.

b. In other Countries and Cultures

To take this tool another step further would be to open it up internationally. Again, in order to ensure that the tool would effectively capture other demographics, pilots would need to be conducted in other countries. The conceptual framework and evaluation tool from my research can be used to improve priority setting in developing countries by providing a common language and an easy to use tool, which is somewhat answering Kipiriri & Martin’s call for improved priority setting in developing countries (Kipiriri & Martin, 2007).

It is also important to test the tool and framework internationally to determine applicability and context. For example, Mshana et al (Mshana, Shemilu, Ndawi, Momburi, Olsen, Byskov et al., 2007) illustrated the appeal of ‘accountability for reasonableness’ with Tanzanian decision makers. They focused on improving priority setting through capacity building with district planning teams and showed that it is possible to implement A4R, however, it is not clear as to whether actual improvements in priority setting were gained. The conceptual framework and evaluation tool from my research can be used to evaluate their process.

Another potential location for application is Mexico, where the government is undergoing a large health system restructuring (discussed in Chapter 2). This would not only test the framework and tool in an international context, but it would also test it at the macro level.

c. With the Public

In order to determine the best place for the public to participate in the tool (when, if at all), more pilot tests need to be carried out with the public. Above I discussed two possible definitions of the public: the general public and the affected public. 'Involving the public' may take a variety of forms and there may be some evaluation questions where public involvement is more relevant and some engagement modalities which are more suitable to address these questions to the public. Research will need to be done to determine appropriate questions, appropriate format, and appropriate timing for public involvement.

2) Quantitative Studies to Confirm Conceptual Framework and the Evaluation Tool

As I have already noted, the tool which I have created satisfies criteria for sensibility. However, further statistical validation is a requirement of any newly developed tool. The main ways to validate a tool is through tests of reliability (or as Feinstein calls it, 'consistency' (Feinstein, 1987)) and validity (primarily criterion and construct validity).

Consistency can be evaluated both internally and externally. External consistency can be tested by reapplying the test to the same entity. If it yields similar results when tested by the same person, it demonstrates intra-observer reliability. If it yields similar results when tested by another person, it demonstrates inter-observer reliability. Due to the impact of time (and potential testing bias), testing this tool by the same person might not yield any fruitful results. It may be helpful to perform another pilot test with two separate researchers to implement the tool; if the two researchers came out with similar results, we could assume some sense of external consistency.

Internally, the consistency of this tool is less relevant since it does not use a sum of scores within the measure to determine success. However, in an effort to streamline the tool, it would be valuable to measure its performance consistency and internal homogeneity to reduce the duplication of questions. While these two attributes can be tested using statistical methods (split-half or Cronbach's alpha), doing so was beyond the scope of this thesis.

In the absence of a definitive standard of priority setting, there was nothing against which to test our tool in order to gain validity. To combat this, Feinstein suggests 'consensual validation' (Feinstein, 1987), which involves experts (or "appropriate authorities") discussing and agreeing on the correct standard against which the tool is then tested. This, in effect, was done for the conceptual framework in Study #1 of this research, the Delphi Consensus Panel. This could be done again using the tool and broadening the group of "appropriate authorities".

Suggestion 1: create a survey asking how important each element in the conceptual framework is and send to a large number of decision makers locally, nationally, and internationally

Suggestion 2: create a survey asking how well each decision maker's (or organization's) current practice scores on each element

Studies using approaches similar to the suggestions above have been performed in other areas of research. For example Reeleder et al. surveyed Ontario CEOs and asked them to rate their organization's priority setting efforts on meeting the four conditions of 'accountability for reasonableness' (Reeleder, Martin, Keresztes et al., 2005).

Validity can also be proven (or gained) with subsequent iterations of the tool. Feinstein calls this 'validation by application', whereby we determine what happens as the tool is implemented, noting its ability to predict, identify, and/or instruct on our construct (successful priority setting) (Feinstein, 1987).

3) Create a forum to capture experiences and share lessons

An important step in further research is to ensure that the experiences of organizations that use the conceptual framework or apply the evaluation tool are captured. Allowing lessons learned to be captured and shared will work to strengthen health care regions and health care systems nationwide and internationally.

To facilitate this, health care organizations who are committed to using the framework and the tool should also commit to reporting their findings and sharing them with other health care organizations in their region, and other health care organizations in similar situations. For example, a hospital in Ontario could implement the tool, evaluate the results and share them with the other hospitals in their LHIN.

Sharing lessons was a suggestion from the one-on-one interviews with Canadian decision makers. Decision makers want to be aware of good practices of other organizations and determine how best to apply them to their own organizations. Interviewees from the debriefing of the pilot test (implementation of the evaluation tool) echoed this, saying that knowing what works well in other organizations would be a helpful add-on to the pilot test report and make it more useful to implement.

Similarly, lessons should be shared with other countries. Sharing good practices and learning what works well in various health care contexts would benefit any health care organization, locally, nationally or internationally.

As mentioned above (Section 6.3), comparing lessons between hospitals would help us to understand the problems faced in different hospital contexts and to gauge the current level of success enjoyed by health care institutions.

4) Making the tool more user-friendly

With further research and pilot tests, this tool will become marketable, and will be usable by health care decision makers. As discussed above, further research is required to determine the best combination of the evaluation tool components (survey versus interviews versus document analysis). Ideally the need for one-on-one interviews would decrease and the use of surveys increase; surveys are easier to implement and are more cost-effective, and survey implementation does not require a trained researcher (interviews do).

In addition, further research should be done to determine the best way to implement the tool. The pilot at the hospital proved that an external researcher can effectively implement the tool. Ideally, the tool will be implemented by someone internal to the organization, again for cost-effectiveness and ease of implementation. The advantage of having an individual internal to the organization implementing the tool is that he/she will have ‘insider knowledge’ of the organizational culture and values, and ideally the priority setting process as well. This can ultimately save time in tool implementation and produce more comprehensive results. In the end, this can only help to improve priority setting activities in the organization.

Concluding Remarks

The conceptual framework and evaluation tool created through this research provide a platform to discuss, evaluate, and improve current priority setting practices. Having a definition of success (the conceptual framework) will help decision makers in discussing and planning priority setting; having an evaluation tool will help decision makers in monitoring and evaluating priority setting

efforts. While the framework and the tool are in their infancy, it is possible for them to provide guidance and open up potentially muddled priority setting processes. It is my hope that at the very least, the framework and tool will foster meaningful discussions and enlighten stakeholders as they move forward in priority setting activities. I have not created a solution to priority setting, but have provided guidance in a comprehensive, reasonable, and usable manner. I hope that those ‘in the trenches’ of priority setting will find this contribution helpful.

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APPENDIX A:

INTERVIEW GUIDE FOR ONE-ON-ONE INTERVIEWS WITH DECISION MAKERS ACROSS CANADA

Priority Setting Interview Guide

May 1, 2003

Thank you for agreeing to be interviewed. The purpose of this interview is to describe the views of decisions makers about effective priority setting interventions.

You are being interviewed along with many other decision makers from different organizations in order to capture diverse viewpoints regarding priority setting. Priority setting is one of the most important and thorny problems facing the Canadian healthcare system -- indeed any health system. It is complex and difficult, and there is no agreement about the goals of priority setting. Consequently, it is unclear how we can know that interventions intended to improve priority setting in healthcare institutions actually provide improvement.

In this interview you will be asked to describe your views on the needs and goals of priority setting. Before we begin, do you have any questions?

Questions:

1. What goals do you or your organization have for priority setting?
2. How do you know if you have met those goals?
3. What would a successful priority setting process look like?
4. How could your priority setting be improved?

*** All responses will be probed for clarity and comprehensiveness.

Priority Setting Interview Guide

May 8, 2004

Thank you for agreeing to be interviewed. The purpose of this interview is to describe the views of decisions makers about effective and successful priority setting interventions.

You are being interviewed along with many other decision makers from different organizations in order to capture diverse viewpoints regarding priority setting. Priority setting is one of the most important and thorny problems facing the Canadian healthcare system -- indeed any health system. It is complex and difficult, and there is no agreement about the goals of priority setting. Consequently, it is unclear how we can know that interventions intended to improve priority setting in healthcare institutions actually provide improvement.

In this interview you will be asked to describe your views on the needs and goals of priority setting. Before we begin, do you have any questions?

Questions:

1. How do you set priorities in your organization?
2. What goals do you or your organization have for priority setting?
3. How do you know if you have met those goals?
4. What would a successful priority setting process look like?
5. How could your priority setting be improved?

*** All responses will be probed for clarity and comprehensiveness.

APPENDIX B:

FOCUS GROUP DISCUSSION GUIDES

Patient Focus Group

Over the past 3 days you have heard and read a lot about health care priority setting.

1. What are the most important things you have learned?
2. What concerns you most?
3. If you could have a few minutes with Canada's health policy makers – the people who have the responsibility for making priority setting decisions:
 - a. What would you like to ask them?
 - b. What would you like to tell them?

Policy Makers Focus Group

Priority setting in health care is a difficult and complex problem. It occurs at all levels of the health care system, and it is different at each level and in each health care context. Each of you has experience with health care priority setting that is unique and, to date, undescribed.

1. What do you find the most difficult part of priority setting?
2. What do you think would help with the difficult problem of priority setting?
3. If you could have a few minutes with patients – the people who are the most affected by priority setting decisions:
 - a. What would you like to ask them?
 - b. What would you like to tell them?

Circle-within-a-circle

Good Afternoon. We are at the stage in the day where we want everybody to talk together. We appreciate you all being here.

To make sure that we have a valuable discussion, I would like to set some ground rules:

1. We have two perspectives represented- be respectful of the other points of view here today. Please let the other group members talk.
2. There will be times in the discussion where just patients or policy makers speak. If you are listening, please respect the people talking and do not talk during that time. You will have a chance to comment.

I will be the group moderator, which means that we will be asking questions, listening, and moving the conversation along. There are no right or wrong answers to anything I am asking today – and all opinions are valuable to the discussion.

So, let's discuss some basic information about how this focus group will go.

- 75 minutes per segment
- location of bathrooms

- what they should do if they need to leave for any reason
- cell phones and pagers

Is everyone ready? We are going to start by having the patients come to the center of the room to talk while the policy makers listen. Later, the policy makers will come into the center of the room. In the final segment, we have a joint discussion with everybody involved.

Segment 1 - Patients In

With regard to health care priority setting:

1. What concerns you most?
2. What would you most like to tell the policy makers around you?
3. What concrete action steps would you like to see taken next?

Segment 2 - Policy Makers In

With regard to health care priority setting:

1. What is the most difficult part of health care priority setting?
2. What would you most like to tell the patients around you?
3. What concrete action steps would you like to see taken next?

Segment 3 - Open Forum – Both Groups

1. What questions do you have that remain unanswered?
2. Open discussion: Where do we go from here?

APPENDIX C:

COMPLETE VERSION OF TOOL IMPLEMENTED IN PILOT STUDY

Royal Victoria Hospital 2007-2008 Budgeting Process Evaluation Tool

PART 1: Survey

General Process

The following survey is in reference to the 2007/08 operating budget completed over the summer of 2006 and concluded in September with the HAPS submission.

The first set of questions is about the budgeting process (not the budgeting outcomes).

1. Were you aware of the process and steps involved in the 2007-2008 budgeting? (yes/no/I don't know)
2. Do you think the process was fair? (yes/no/I don't know)
3. Did you understand the purpose and goals of the 2007-2008 budgeting process? (yes/no)
4. Was there an explicit and predetermined timeline for the 2007-2008 budgeting process? (yes/no/I don't know)
5. In comparison to previous decision making or priority setting at [the hospital], is there consistency in reasoning between previous and the 2007-2008 budgeting process? (yes/no/I don't know)

More on Process

6. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)? (yes/no/I don't know)
7. Was there integration of [the hospital]'s 2007-2008 budgeting process with other healthcare organizations? (yes/no/I don't know)
8. During the 2007-2008 budgeting process, the following were considered: (rank strongly agree, agree, disagree, strongly disagree or N/A)

a. [the hospital] Mission, vision, values	e. Community Values
b. [the hospital] Strategic plan	f. Patient Values
c. [the hospital] Context	g. Staff Values
d. [the hospital] Culture	
9. Are there other items that should have been considered in the 2007-2008 budgeting process? (yes/no and please specify)
10. Are there items that were considered in the 2007-2008 budgeting process that should NOT have been? (yes/no and please specify)

Stakeholder Engagement

11. Were there multiple methods of engaging stakeholders/decision makers? (yes/no/I don't know)
12. Were these methods effective? (yes/no/I don't know)
13. Please explain (open-ended)
14. Was everyone involved in the 2007-2008 budgeting process who should have been involved? (yes/no/I don't know... if no please specify who should have been involved)
15. How involved were you in the 2007-2008 budget?
16. Were you satisfied with your involvement in the 2007-2008 budgeting process? (yes/no/not sure)
17. Please explain. (open-ended)

Decision Makers

18. Do you know how the decisions for the 2007-2008 budgeting process were made? (yes/no/I don't know)
19. Do you know who was making the decisions for the 2007-2008 budgeting process? (yes/no/I don't know and please state who)

Communication

20. For the following elements of the 2007-2008 budgeting process, please indicate if they were communicated to you. (yes/no/I don't know)
- | | |
|--------------------|----------------------|
| a. Purpose & Goals | c. Outcomes |
| b. Methods | d. Revisions/Appeals |
21. For the following elements of the 2007-2008 budgeting process, please indicate how well they were communicated to you. (rank: they were not, very poorly, adequately, well, very well, and N/A)
- | | |
|--------------------|----------------------|
| a. Purpose & Goals | c. Outcomes |
| b. Methods | d. Revisions/Appeals |
22. How were the above items communicated to you? (select all that apply)
- | | |
|-------------------------|---------------------------|
| a. Via email | e. Meeting: Departmental |
| b. Paystub | f. Meeting: Hospital-wide |
| c. Hospital newsletter | g. Peer-to-peer Informal |
| d. Announcement posting | h. Peer-to-peer Formal |
23. Other methods of communication (list)
24. How could the communication be improved? (open ended)

Outputs and Outcomes

25. Do you understand the outcome of the 2007-2008 budget
26. Do you accept the outcomes of the 2007-2008 budget
27. Are you satisfied with the outcomes of the 2007-2008 budget
28. Now that the 2007-2008 budgeting process is finished, please indicate if you are more familiar with the following items yes, more familiar; no, not more familiar; same now as before; I don't know)
- | | |
|---|---------------------|
| a. [the hospital] Mission, vision, values | e. Community Values |
| b. [the hospital] Strategic plan | f. Patient Values |
| c. [the hospital] Context | g. Staff Values |
| d. [the hospital] Culture | |
29. To what degree are the following items reflected in the 2007-2008 budget? (rank: not reflected, somewhat reflected, appropriate amount, very reflected, overly reflected)
- | | |
|---|---------------------|
| a. [the hospital] Mission, vision, values | e. Community Values |
| b. [the hospital] Strategic plan | f. Patient Values |
| c. [the hospital] Context | g. Staff Values |
| d. [the hospital] Culture | |

Overall View of the Process

30. How satisfied were you with the process behind the 2007-2008 budget? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)
31. Please explain. (open-ended)
32. How satisfied were you with the outcomes of the 2007-2008 budget? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)
33. Please explain. (open-ended)
34. How would you improve/what changes would you make to the 2007-2008 budgeting process? (open-ended)

PART 2: Interview Guide

1. Please talk to me about the people who were involved in the 2007-2008 budget process.
- What was your role?
 - Was anyone not involved that should have been?
2. Tell me about the 2007-2008 budgeting process?
- Was there an explicit process that you were aware of? // Was the process transparent and clear?
 - What were the major considerations?
 - What information/data was used?
 - What role did values play? (organizational values [mission, vision, values]; staff values; community values etc.)
 - Did you know who was making the decisions?

- f. Did you know how decisions were made? // Were there explicit and predetermined criteria and timeline? // What happened if people did not agree with the decisions or the process?
3. What was the outcome of the 2007-2008 budgeting process?
 - a. How are things different from before this 2007-2008 budget process?
 - b. How were the decisions reflected elsewhere in the organization?
4. What did you learn from the 2007-2008 budget process?
 - a. Improved knowledge or understanding of the organization? (mission, vision and values?)
5. How satisfied were you with the 2007-2008 budget process overall?
6. How would you improve the 2007-2008 budgeting process?

PART 3: Document Analysis

1. Is there a record of who was involved during each phase of the 2007-2008 budget process? Are the records consistent?
2. Is there a description of the 2007-2008 budget process in documents?
3. Is there a record of the process by which decisions were made and the people involved?
4. What information/data was used to inform the 2007-2008 budget process?
5. What forms of communication were used? (memos, meeting minutes, website, etc)
6. Was information tailored to the various stakeholders allowing access and comprehension at a number of levels?
7. Was there a clear communication plan?
8. Review mission, vision and values statements and other related documents; were the mission, vision and values considered during the process or changed/revised after the process?
9. Are there any documents surrounding the use of an appeal process? What did the process look like? What communication devices were used?
10. Does the budget reflect a change in resources or priorities given to programs?
11. Does the budget have similar or different goals/priorities than other organizational documents (e.g. strategic plan, other departmental/program budgets)?
12. Were any media reports generated from the 2007-2008 budget process? (before, during or after?) (Internally or externally driven?)
13. Have there been any legislation or policy changes as a result of this 2007-2008 budget process?

APPENDIX D:
LETTER OF SUPPORT FROM HOSPITAL

February 19, 2007

Ms. Shannon Madden
University of Toronto Joint Centre for Bioethics
88 College Street
Toronto Ontario
M5G 1L4

Dear Ms. Madden

Re: Study of Tool for Priority Setting in Hospitals

It is with enthusiasm that I write to support your research surrounding the evaluation of priority setting in our organization. I understand that through your previous research, you have developed a tool to evaluate priority setting in hospitals and I am pleased to offer you support from [REDACTED] Hospital [REDACTED].

I understand that [REDACTED] will be the first to use this tool. I also understand that you and your research team will be solely responsible for data collection and data analysis. I will be available to assist and advise in the study's dissemination and knowledge translation.

In hospitals, very little research has been done to evaluate the success of priority setting, and it is very much needed. Lack of information leads to a lack of consistency and quality decision making. Your research protocol to evaluate a recent priority setting process at [REDACTED] is both commendable and desirable.

I look forward to collaborating with you on this project.

Sincerely,
The [REDACTED] Hospital

[REDACTED]
Vice President Corporate Services & CFO

People
Care

APPENDIX E:
HOSPITAL REPORT GENERATED FROM PILOT TEST

Evaluating Success in Priority Setting at the [*the hospital*]

Report on Findings

DRAFT for DISCUSSION

September 17, 2007

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EXECUTIVE SUMMARY

Growing demand for healthcare services and the continual introduction of newer and more expensive technologies are threatening health system sustainability. In this environment, effective priority setting is fundamental. In Ontario, a new funding agreement between the Minister of Health & Long Term Care and hospitals requires them to live strictly within their funding envelope. Annual budgeting processes are now faced with significant constraints on tight timelines. There is a challenge of meeting community health needs within limited health care resources. Concerns about system sustainability have increased emphasis on accountability between hospitals and funders.

In "May of 2006" [*the hospital*] began their new budget process for the 2007-2008 fiscal year. For the first time, a computer-based budgeting tool, "budget sys" was used. Also novel to the process, program managers and program directors were involved in a new and more accountable role - - setting their own budgets.

Overall, the '07-'08 budget process featured many positive elements. The new process made great strides in broadening stakeholder engagement. In an attempt to ensure a well informed budget, leaders tried to provide adequate information to decision makers. [*the hospital*] provided further support to decision makers throughout the process as well as a mechanism for questions and feedback. Those who were involved in the '07-'08 budget were satisfied with the process and accepted its outcomes. Many of this group's complaints surrounded the computer-based tool (e.g., losing data, incomplete information)

Stakeholders who were not involved in the budget process (e.g. many front line staff) were not satisfied with it and had very limited understanding of the process or its outcomes. The lack of understanding is due in part to a lack of communication throughout the process. In hind sight, the '07-'08 budget process would have been more successful if decision makers were provided with more complete information, and a specific process for appeal or budget revisions.

In order to improve the future budgeting processes this report offers eight recommendations:

1. Increase consultation with stakeholders (internal and external)
2. Develop an explicit and formalized communication plan
3. Revisit data and information needs
4. Include a Revision or Appeals Process
5. Improve the computer-based budget tool
6. Address Key Timing Concerns
7. Provide Training for Decision Makers
8. Build on lessons learned

1. OVERVIEW

1.1 – Purpose of this document

The purpose of this document is to report preliminary findings, including recommendations, from a pilot study to evaluate *[the hospital]*'s 2007-2008 budget setting process using a new evaluation tool. This report is the result of a research collaboration between *[the hospital]* and S Madden. The evaluation tool was developed by S Madden as part of PhD research in the Department of Health Policy Management and Evaluation and the Joint Centre for Bioethics at the University of Toronto. The authors are grateful to *[the hospital]* for having agreed to collaborate with us in testing the evaluative framework.

There are three main parts to this document: 1) a background & overview, 2) summary of key findings, and 3) draft recommendations for improvement to inform future budgeting or priority setting processes at *[the hospital]*.

1.2 – Background

1.2.1 – Challenges of Priority Setting in Health Care

Priority setting is complex and difficult; it is done at every level of the healthcare system, but there is no agreement on how to do it well or what doing it means to do it well.

Priority setting, also known as rationing or resource allocation, is a complex and difficult problem faced by all decision makers at all levels of all health systems, including macro (e.g. governments), meso (e.g. regional health authorities (RHAs), hospitals), and micro (e.g. clinical programs) levels. As there is relatively little interaction between decision makers at the three levels, or among institutions, regarding the setting of priorities, priority setting may be described as a series of unconnected experiments with no systematic mechanism for capturing the lessons, or evaluating the strengths and weaknesses, of each experiment. (Martin & Singer, 2000).

Hospital administrators, constrained by budget restrictions and confronted by increasing demand, find it a particularly difficult challenge to maintain services and quality, while controlling costs. In recent years, there have been several empirical descriptions of priority setting in various hospital contexts (Coulter & Ham, 2000; Foy, So, Rous, & Scarffe, 1999; Hope, Hicks, Reynolds, Crisp, & Griffiths, 1998) and studies evaluating hospital priority setting against an ethical framework (Bell, Hyland, DePellegrin, Upshur, Bernstein, & Martin, 2004; Mielke, Martin, & Singer, 2003).

However, there has not been a common framework to measure success of priority setting, and the strengths and weaknesses of different approaches.

One of the reasons why priority setting is so difficult is that there is reasonable disagreement about what the right decisions should be. Priority setting decisions involve value choices and well-intentioned intelligent people often disagree about which values should dominate -- for example, When should we fund an expensive intervention that provides a small benefit? or Who should be the first to receive vaccines in a pandemic influenza crisis? Given that we lack consensus on these and many other thorny priority setting decisions, we have no 'gold-standard' for evaluating decisions. However, the framework we describe here is a new development in evaluating priority setting and providing guidance to decision makers and scholars interested in successful priority setting.

The conceptual framework specifies the elements of a successful priority setting process.

1.2.2 - Conceptual Framework and Evaluation Tool

The conceptual framework (see Appendix A) consists of five process and five outcome elements of successful priority, which were identified through 1) expert stakeholder consultation (a Delphi panel with decision makers and scholars), 2) public consultation (focus groups with policy makers and patients), and 3) decision-maker interviews (across Canada in all levels of healthcare); these elements were augmented by validation from the literature (Bell, Hyland, DePellegrin et al., 2004; Gibson, Martin, & Singer, 2005b; Madden, Martin, Downey, & Singer, 2005; Martin & Singer, 2000; Peacock, Ruta, Mitton, Donaldson, Bate, & Murtagh, 2006; Stone, 1997). Based on the conceptual framework, we developed an evaluation tool, which is intended to help healthcare organizations identify strengths and opportunities for improvement in their priority setting and resource allocation activities.

The evaluation tool operationalizes the framework to measure successful priority setting.

1.2.3 – Overview of [the hospital] Budgeting Process

The context for the [the hospital] budgeting process included: recent change in the hospital's Senior Leadership, the creation of Local Health Integration Networks (LHINs) in the province, and the new Ministry of Health and Long Term Care Hospital Accountability Agreements. The '07-'08 budget process was conducted between June and September 2006. The first challenge of the 2007-2008 budget process was to achieve a balanced budget within available resources and a predicted salary increase of 3%. Second, managers were expected for the first time to create their own budget, using a new computer-based budgeting tool; this

marked a significant departure from past practice where accountability for budgeting rested primarily with the senior team.

Program managers and directors were asked to complete the budget tool over a 4-week period in the summer of 2006. A meeting to present the proposed budgets was held soon after budget submission. Budgets were analyzed by senior management and areas of concern were identified; managers and directors were asked to implement changes if required. From there, the budget was presented to the Board and submitted to the MoHLTC (the HAPS form).

1.3 – Overview of the study

Two objectives:

- 1) Evaluate RVH '07-'08 budget process
- 2) Evaluate the effectiveness of the tool

The overall aim of this pilot study was to test the real-world applicability of the evaluation tool by applying it to the '07/08 budgeting process at *[the hospital]*. This pilot study had two objectives:

- 1) to use the tool to evaluate a priority setting initiative at the *[the hospital]*, specifically the most recent budgeting cycle; and
- 2) to assess the effectiveness of the tool.

This pilot study was led by Shannon Madden (PhD Candidate) in collaboration with ** (Vice President, Corporate Services & Chief Financial Officer) and ** (Organizational Development Leader/Ombudsperson) of *[the hospital]*, with academic oversight from Dr. Douglas Martin and Dr. Jennifer Gibson at the University of Toronto Joint Centre for Bioethics. The pilot study was conducted in May-June 2007. In total 120 *[the hospital]* employees participated in this study. Research ethics was acquired through both the University of Toronto Ethics Review Office and the *[the hospital]* Research Ethics Board.

The evaluation tool consisted of three parts: an online survey, one-on-one interviews, and document analysis. Participants were recruited to participate in both the survey and the interviews via email invitation. Data analysis proceeded in four steps: 1) analysis of the survey, 2) analysis of the interviews, 3) analysis of documents, and 4) a synthesis of the three parts.

105 *[the hospital]* employees responded to the online survey (table 1):

Table 1: Survey Respondents

Job Title	
Front Line (or other)	40
Program Directors	13
Program Managers	8
Senior Leadership Team	1
Unknown	43
TOTAL	105

9 [the hospital] management level staff participated in one-on-one interviews (table 2):

Table 2: Interview Participants

Position	
Program Directors	4
Senior Leadership Team	1
Program Managers	3
Other	1
TOTAL	9

18 documents were analyzed (table 3; Appendix B):

Table 3: Documents Analyzed

Documents	
Decision Support Documents	10
Website Information	4
Email communications	2
Meeting Information	2
TOTAL	18

1.5 – Use of this document

This is a draft report of the study findings. The next step is to learn from RVH how valuable and useful the information in this report is and how it might be improved.

The findings from this study will be used primarily in the doctoral thesis of the primary researcher of this study (S Madden). The next step of this research is to learn from [the hospital] how helpful the information

contained in this report is. This document describes preliminary findings of the study and is for the information of Senior Management. This report may be disseminated by [*the hospital*] Senior Management at their discretion. Anyone who has comments about the evaluation, please send comments to Shannon Madden (shannon.madden@utoronto.ca).

2.0 FINDINGS

The study findings are organized according to the 10 components (5 process and 5 outcome) of the conceptual framework. Each section will: 1) describe the component, 2) discuss findings from the tool, and 3) provide evidence and concrete data from the study. At the end of the report of the findings, we will identify opportunities for improvement.

Overall, while this evaluation identified opportunities for improvement, the '07-08 [the hospital] budget process exhibited a number of good practices consistent with successful priority setting. The evaluation of the budget process using the evaluation tool showed that while the budgeting process did not meet all of the 10 components of successful priority setting, the process still had several key strengths.

2.1 – Process Components

2.1.1 Stakeholder Engagement

A strength of the '07-08 budgeting process was its broader engagement of internal stakeholders compared to previous processes.

Stakeholder engagement refers to an organization's efforts to identify the relevant internal and external stakeholders and to involve these stakeholders effectively in the decision-making process. Stakeholder engagement is also concerned with stakeholder satisfaction regarding the level of their involvement in the decision-making process.

Managers (including senior management, program directors, and program managers) were most involved in the budgeting process: 90.9% of managers who completed the survey reported being somewhat or very involved in the budgeting process (table 4). Our findings suggest that this group was generally satisfied with their level of involvement, including their shared accountability for program budgets, which they saw as an improvement over previous top-down budgeting approaches. By contrast, front line staff was least involved in the budgeting process: 87.5% of front line staff who completed the survey reported being not at all involved in the budgeting process (table 4). Our findings suggest that this group was generally not satisfied with the budgeting process and had very little understanding of what the process entailed. This group expressed an interest in being more involved and better informed with the budget process.

Table 4 – Cross Analysis of Job Title and Involvement in Budget Process

Job Title	Not at all involved	Somewhat/ Very involved	TOTAL
Front Line	35 (87.5%)	5 (12.5%)	40
Management	2 (9.1%)	20 (90.9%)	22
TOTAL	37	25	62

“they didn’t seem to get their groups (front line) involved. The other thing I think was a struggle was getting the programs talking to each other and some of the clinical areas engaged as to where the pushing factors were in the organization and what decisions were made and how they might impact on the other areas”

Transparency throughout the budget was not ideal leading to confusion among decision-makers and misunderstanding among staff.

“Managers are maybe confused about whether they’re making a decision within their own budgets or whether their director is or whether the senior team is ... the process is very iterative, it goes back and forth between levels.”

“There needs to be transparency at the CEO level but there wasn’t transparency at the staff level or even there were some managers who weren’t aware of what was on the out list”

A key strength of the 2007-2008 budgeting process was its involvement of program director and managers in the budgeting process, which was a significant departure from past budgeting exercises that were largely driven by senior management decision-making alone. However, the findings suggest that there are some opportunities to strengthen stakeholder involvement in future budgeting exercises. Interview participants all agreed that there should have been more involvement of front line staff as well as increased consultation and engagement of external stakeholders such as community groups, the public, and other healthcare providers). Many participants (both in interviews and the survey) pointed to tight timelines as a chief reason why broader consultation was not facilitated. The management group also expressed an interest in greater internal collaboration on budgets to capture significant cross-departmental interdependencies.

2.1.2 Explicit Process

An explicit process is one that is transparent not only to decision makers, but also to other stakeholders. Adhering to a predetermined process can enhance trust and confidence in the process. Transparency means knowing who is making the decision, how the decision will be made, and why decisions were made.

Knowing who the decision makers in a priority setting process are is a key aspect transparency. 86% of survey respondents not involved in the budget process did not know who the decision-makers were compared to 72% of survey respondents involved in the process who did. However, it was evident from interviews that even among those who were involved directly in the process, there remained uncertainty as to who was accountable for making the final budget decisions (e.g., SLT versus CFO versus MOHLTC). Another key aspect of transparency is openness about how decisions are made. Among managers, only 55% reported knowing how decisions were being made (i.e., 45% did not know or were unsure). 97% of those survey respondents who were not involved in the process were uncertain of how decisions were made. 76% of those who were not involved in budget decision making reported not knowing if there was a timeline for budget decisions compared to 78% of those involved knew the timeline. Most survey respondents were satisfied with the outcomes of the budget (75%). Those who were not attributed their dissatisfaction to being unaware or uninformed of the rationale for budgetary decisions.

Communication is a key strategy for enhancing transparency. According to survey respondents, information about the budgeting process was

communicated through a number of vehicles: email (58.3%), departmental meetings (54.2%), and peer-to-peer informal communication (43.8%). Email communication was done largely between Decision Support Services and the Program Managers/Directors, but not to front-line staff. Close to budget submission a large meeting was held for program directors and program managers to present proposed budgets. This meeting helped inform and engage decision makers; some interviewees felt to decrease confusion there needed to be more standardization in budget presentations. Interview participants felt there could have been more communication throughout the process especially in the form of inter-departmental meetings where there seemed to be a lack of information sharing. Records of meetings about the '07-'08 budget (such as minutes) were limited. Discussions at the departmental level surrounding the budget were mostly informal and records were unavailable or did not exist.

Interview participants felt the time of year and the short time frame allotted to complete the tool was a limitation to a fully explicit and transparent process. Decision makers felt rushed to complete the budget tool and did not feel they had adequate time to collect or analyze data. Participants from both interviews and surveys suggested allowing more time for data collection and analysis would improve the process.

The information provided to the decision makers was high-quality, but was used infrequently. Decision makers want more RVH-specific 'hard data' to work with.

2.1.3 Information Management

Information management refers first to the information made available to decision makers during the priority setting process, including what was used and what was perceived to be lacking. Information can take a number of forms, specifically documents or data used in the decision making. Second, information management considers how the information was managed, including how it was collected and collated.

Decision makers were provided with various documents and data during the [*the hospital*] '07-'08 budget process. The computer-based tool was pre-populated with data and information that came from previous year's budgets as well as existing funding structures. Staffing information and calculations (number of staff, vacation days, sick days, etc.) were also included in the tool along with calculations for the mandatory pay increase. Program directors and managers were asked to benchmark their decisions against [*the hospital*]'s peer hospitals. Information about total expense per patient activity were provided from nine peer hospitals and their total expense per patient activity. If decision-makers felt their department was not accurately represented by one of the nine, they were encouraged to find another hospital that was a better fit. Program managers and program directors also had access to three decision making frameworks to guide their local budgeting decisions:

1. The Ministry of Health and Long Term Care's Prioritization Framework (a.k.a. 'Six Steps'), which outlined the government's directions around hospital allocation of resources and steps toward achieving a balanced operating position.

2. An ethical decision making framework, adapted from Gibson et al, 'Evidence, Economics and Ethics: Resource Allocation in Health Services Organizations' (2006), which provided guidance on how should be made from the standpoint of fairness.
3. An activity analysis tool developed at [the hospital], which provided six questions to help program directors and managers identify budgetary options, including possible disinvestments.

"The question is how much of that [information] is relevant to what you're doing, how much of it should you have access to, and how do you use it once you do."

However, we found that the decision-making frameworks provided were rarely used (e.g., only one person mentioned drawing on the 'six steps' framework). Moreover, program directors and managers felt that the available information was often not sufficient to make decisions and many drew on additional information sources. The most common input program managers and program directors used to inform budgeting decisions was capital need (e.g., equipment needs and/or updating existing materials). Next, participants talked about interdependency, or consideration for impact on other departments within [the hospital] (intra-hospital) as well as inter-hospital impact. Strategic directions (including [the hospital]'s mission, vision and values) were additional considerations in decision making, although not built explicitly into the computer-based decision tool. Other information that was used by a few participants to make budget decisions was trust fund availability (the ability to apply for more money from sources other than the capital budget) and revenue sources (alternative ways of bringing in money to a department). Financial information (such as historical budgeting, staffing and salaries information) also played a role in decision making for the '07-'08 budget, but the availability of such information was felt to be insufficient. A few interview participants felt poorly informed or unprepared to make budget decisions and thought that more information would be helpful in making budget decisions. Some suggestions included: budget forecasts, staff satisfaction measures, and patient care information.

"trying to develop the operating budget which was a total frustration because there was no history ... or at least no accurate history as to how the previous budgets were developed..."

Length of time working within a department, in a management role, and at [the hospital] seemed also to have an impact on what inputs were used in decision-making. Participants who had been with [the hospital] for a while tended to rely on their "own forecasting" and "personal knowledge" for decision making. Interview participants who had been in their position for a while had information available to them that newer participants struggled to gather. Interview participants cited information they had by virtue of working relationships with colleagues internal and external to the hospital. Some staff who were newer employees or newly promoted to their positions felt at a disadvantage in terms of making budgeting decisions.

Information was managed largely through the use of the computer-based budgeting tool. As mentioned, [the hospital] developed a new computer-based budgeting tool to facilitate budgeting. Efforts were made to help program directors and managers use the tool, including a training session, dedicated Decision Support Services personnel, and electronic communications with the Decision Support Services team. Program

"There were major hurdles because the template, the tool was brand new and it had horrible hitches in it, bugs that should have been worked out, and the managers wasted a lot of time which was a crime and there was a lot of rework because it was brand new and it was done probably way too quickly. So they suffered ..that was a huge problem."

managers and directors were able to submit feedback and questions to Decision Support electronically through a 'shared folder' (an internal hospital driver). An electronic bulletin board called "Budget Issues" compiled frequently asked questions including how to retrieve information, what to do if work was lost, how to incorporate MOH directives/funding, and how to include information that did not fit in the pre-populated areas. Questions and answers were continuously updated throughout the budget process. Decision Support Services compiled feedback from program managers and program directors into an intra-web document, "Feedback Regarding Budget Process & Template". All interviewees expressed gratitude for the accessibility and expertise the Decision Support Services department throughout the process.

The computer-based tool seemed to increase the overall transparency of the budget process from the viewpoint of tool users. The tool standardized the budget process. As a result, program directors and managers knew what was expected of them and of their colleagues, and also gained a better understanding of the overall budgeting process.

Consideration of RVH values and context was implicit, not explicit.

2.1.4 Values and Context

Values and context are important considerations in any priority setting process, including the values of the organization, the values of staff within that organization, and the values of other stakeholders (such as patients, policy makers, politicians, and members of the community). Context is distinct from values and considers the organization's goals in the health care environment articulated in its strategic directions.

"They were always reviewed – the mission, vision, values – were always reviewed at every budget session and the strategic directions, every budget had to be supported by the strategic directions."

"But I think it was a huge cultural shift for hospitals to start to be accountable and to start to be responsible for multi-year planning...And it's a whole paradigm shift."

upcoming budgets."

[the hospital] had recently gone through a review of its strategic directions. In the survey, the majority of respondents felt the mission, vision and values of [the hospital] were considered; all interviewees felt the budget followed the strategic directions and saw at least some reflection of organizational values in the budget. Although the mission, vision and values were not explicit criteria in budget decision making, they were implicitly a part of the budget process as indicated in both the survey and the interviews. There was also an attempt to determine other values that were considered in the budget process. Interviewees and survey respondents felt that staff values were not considered as much as they should have been. This was evident mostly through the survey where many respondents (40%) felt their values were not considered. There was a weaker sense of agreement on the consideration of community and patient values. Related to this discussion, interview participants talked about an emerging culture of shared accountability at [the hospital]. Several participants described how the new way of budgeting and the increased accountability would take time to adapt to and make happen. Most were very positive that this shift would occur in upcoming budget cycles as the tool is bettered and as stakeholders become more comfortable with the tool and the accompanying accountability.

[the hospital]'s context played a role in the 2007-2008 budget, particularly in considerations of the emerging LHIN context and in the use of peer hospital information to situate [the hospital] in the larger healthcare

context. Survey results indicated that the majority felt contextual factors were considered in the budget (57.4%); interviews echoed this. Several participants mentioned that Barrie is a high growth area which has exacerbated the pressure on *[the hospital]*'s budget to meet the increased demand for healthcare services.

There was no formal process for decisions to be reviewed or for stakeholders to bring forward new information or raise questions about controversial decisions.

"in the absence of that I felt very frustrated that there really wasn't a second round. ... a culture there where indeed that I could have a consultation where I had more of a chance to talk to a senior group"

Those who were involved in the budget process had an improved understanding and awareness of budgeting both departmentally and organizationally compared to those who were not involved.

"the biggest outcome was that the managers learned what was in their budget, ...it was a huge learning curve it was a huge accountability piece too - - accountable for something that they built and they understood. ...and that's a new experience"

2.1.5 Revision Process

A revision process is a formal mechanism for decisions to be reviewed and for addressing disagreements constructively. The purpose of a revision process is to improve the quality of decisions by providing opportunities for new information to be brought forward, errors to be corrected, and failures in due process to be remedied.

The 2007-2008 *[the hospital]* budget process did not have a formal revision process. In the survey, this was clear where 62% were unsure of any avenues for revisions or appeals. Interviewees talked about the 'back and forth' that went on between different levels of management. These discussions were largely seen as one-way discussions whereby the budget needed to meet the demand of the more senior manager and not a two-way dialogue whereby any changes could be made to final decisions. Most interview participants said they were sufficiently satisfied with the decision outcomes that they probably not have accessed the revision process if one were available. However, other interview participants felt that a 'second round' of discussion was lacking and should have been available.

2.2 – Outcomes Components

2.2.1 Stakeholder Understanding

Stakeholder understanding implies more than basic knowledge of the process. It assumes stakeholders have gained insight into the priority setting (e.g., goals of the process, rationale for priority setting and rationale for priority setting decisions) and/or the organization (e.g., mission, vision, values, and strategic plan). Stakeholder understanding is a key element of fairness in a priority setting process.

There were two distinct cohorts in this study: those who were involved in the budgeting process and those who were not. For the '07-'08 *[the hospital]* budget process, there was an increase in stakeholder understanding by those who were most involved in the process. By cross-analyzing survey data, it is evident that those who were most directly involved in the '07-'08 budget believed they had an understanding of the process, while those who were not involved did not. Those who were not involved were also less satisfied with the process. Interview participants

discussed the learning that occurred through the budget process as a very positive experience.

A new budget process, including the new tool, stimulated innovation in thinking. Program directors and program managers had to learn the tool as well as the intricacies of budgeting. In the end, through the interviews, it was clear that decision makers came out of the process with an improved understanding of the budget process, of spending in other areas of the hospital, and of the accountability required in the budget.

Shifts in resources were difficult to track and lefts some decision makers confused with the outcome.

2.2.2 Shifted Resources

A successful priority setting process results in the allocation of budgets across portfolios, changes in utilization of physical resources (e.g., operating theatre schedules, bed allocations) or possibly changes in strategic directions. A reallocation in resources from the previous year's budget is not necessary for successful priority setting, however, in some circumstances this may be one indicator of success.

Program directors and program managers welcomed the accountability and the flexibility to shift money within a department and that ensued with the new budget process. However, some interviewees did not understand where surplus money went or how funds were being used at an organizational level. This lack of transparency in reallocations was the cause of dissatisfaction for several participants with the overall process. Moreover, a number of survey participants said that they were not satisfied with the priority setting process due to small identifiable changes in the actual budget, stating it felt more like a "status-quo exercise". Although it was difficult to measure and evaluate actual shifts or changes in resources on a hospital level given the complexity of budgeting material, it was apparent in interview discussions that the budgeting exercise had led to shifts in resources both within their own departments and between departments.

The 2007-2008 budgeting process was seen as an improvement over past budgeting exercises.

2.2.3 Decision Making Quality

Decision making quality relates to appropriate use of available evidence, consistency of reasoning, institutionalization of the priority setting process, alignment with the goals of the process and compliance with the prescribed process. It also captures the extent to which the institution is learning from its experience to facilitate ongoing improvement. This component is most obvious as subsequent iterations of priority setting are evaluated; where consistency and building on previous priority setting would be indicative of a successful process.

According to those most involved in the budgeting process, *[the hospital]*'s new approach to budgeting is an improvement in decision making quality. As previous year's budgets had been centrally set by the finance department, many decision makers valued the increase in accountability. Interviewees felt it increased their overall awareness of the overall budget of the organization. Senior Management encouraged decision makers to

"What's always useful.. is to have the boundaries set ... don't ask me to get creative if I don't know how far I can go – I need to know how far I can go with this... I can't be real creative if I'm being cautious about money."

approach budget decision making not just from a mechanical stand-point, but also from a more creative lens. While a few interviewees welcomed this approach, others were hesitant to take on this new approach due to inadequate information and training/education. Participants felt that training up-front would help to implement a creative approach to decision making and budgeting.

There were some complaints around the lack of standardization in the budget process. Specifically, some participants talked about the budget presentations at the Leadership Forum indicating that there was room for improvement (e.g. every department should bring forward the same information). There were also complaints around the lack of information available in making both inter-departmental budgeting decisions (e.g. how one department's decisions would effect the other) and inter-organizational decision making (e.g. how decisions made at other organizations would effect [the hospital] and vice versa).

Stakeholder acceptance depended on whether or not the stakeholder was involved directly involved in the budgeting process.

2.2.4 Stakeholder Acceptance

Stakeholders may be able to accept priority setting decisions, even if they may not always agree with the outcomes. Stakeholder acceptance is indicated by continued willingness to participate in the process (i.e., buy-in) as well as the degree of contentment with the process. This concept is difficult to measure after one priority setting iteration. However, it is possible to gain insight into stakeholder acceptance by asking stakeholders about satisfaction with the process and outcomes. It is important to consider all stakeholder groups, both internal to the hospital and external to the hospital (community groups/public and the MoHLTC).

Internal to the hospital, generally the budget was accepted by stakeholders. The survey explicitly asked respondents if they accepted the outcomes of the budget and if they were satisfied with the outcomes. 95% of managers/directors and 32% of front line either completely or somewhat accepted the outcomes of the budget. Those who were dissatisfied with the outcomes said being unaware or uninformed as were the main reasons. The majority of survey respondents (70.3%) also accepted the outcomes. Some program directors and program managers interviewed were unhappy with inter-departmental resource shifts, but overall they accepted the process and the reasons.

External to the hospital, it is less clear whether there was acceptance and/or satisfaction with the budget process or outcomes. Once the budget was complete, it went back and forth to the MoHLTC several times before reaching agreement on its terms. This was done at the upper management level with little discussion with other stakeholders. Neither the public nor any community groups were directly involved in the budget process. It is therefore difficult to get a sense of their acceptance and/or satisfaction.

2.2.5 Positive Externalities

There was limited evidence to evaluate RVH on this component.

As an indicator of success, externalities may include positive media coverage (which can contribute to public dialogue, social learning, and improved decision making in subsequent iterations of priority setting), peer-emulation or health sector recognition (e.g. by other health care organizations, CCHSA, etc), changes in policies, and potentially changes to legislations or practice.

We could not find any evidence of positive externalities, such as media reports concerning the budgeting process, peer commentaries, or health sector responses, to suggest that *[the hospital]*'s budgeting process was perceived to be successful by others. However it is still important for *[the hospital]* to consider the implications positive externalities can have on successful priority setting. Positive externalities can act as a sort of check and balance, ensuring information is made transparent to stakeholders through various avenues, and/or establishing good practices for budgeting in other healthcare organizations.

"It's not something that is going to change over night because we had a very centralized budgeting model...."

3.0 – Recommendations for Improvement

Evaluating the process against the conceptual framework for successful priority setting, it is apparent that while *[the hospital]*'s process has areas for improvement, there are also areas of strength. The 2007-2008 *[the hospital]* budget process improved stakeholder engagement compared to previous year's budget process. *[the hospital]*'s innovative approach to the budgeting process, including the new tool, was a positive advance toward making the budgeting process more explicit, rigorous, and consistent across program areas. Moreover, *[the hospital]* Executive's willingness to collaborate on the research and the active participation of staff, managers, and senior managers in the evaluation process are evidence of *[the hospital]*'s interest as an organization in learning from and building on their experience.

Based on the evaluation findings, we identified eight opportunities for improvement and offer the following recommendations to inform the development of future budgeting or other priority setting processes at *[the hospital]*.

1. Increase consultation with stakeholders (internal and external)
2. Develop an explicit and formalized communication plan
3. Revisit data and information needs
4. Include a Revision or Appeals Process
5. Improve the computer-based budget tool
6. Address key timing concerns
7. Provide Training for Decision Makers
8. Build on lessons learned

1. Increase Stakeholder Consultation

Involving a broad range of internal and external stakeholders in the process facilitates buy-in across a range of stakeholder interests, enhances the evidence-base of decisions, and strengthens alignment of decisions with relevant stakeholder values. Increasing engagement of staff, community and other health care providers affected by budgeting decisions (e.g., CCAC), is particularly relevant in the emerging LHIN context where health care providers will need to coordinate their efforts to meet community health needs.

Strategies used by other institutions include: engaging staff and community representatives around the development of priority setting criteria in advance of budgeting exercises, requiring managers to account for the stakeholders they have consulted in developing business plans, and involving community and other stakeholders in assessing the impact of proposed budgetary decisions.

Recommendation #1. [the hospital] should engage a broader range of internal and external stakeholders in the budgeting process, including front line staff, other healthcare providers, and the public. For example, research has shown that broader stakeholder involvement in defining the criteria for priority setting can contribute to greater acceptance of priority setting decisions. (Abelson, Lomas, Eyles, Bitch, & Veenstra, 1995; Gibson, Martin, & Singer, 2005a)

2. Develop an Explicit and Formalized Communication Plan

Transparency is important in any resource allocation process because it allows all stakeholders to have access to information used in decision making. This in turns allows stakeholders and decision makers to meaningfully participate in priority setting.

In any process, it is important that the key messages are communicated consistently and clearly to affected stakeholders. Iterative communication facilitates iterative learning, provides opportunities for iterative input, and demonstrates the organization's willingness to engage with its stakeholders.

"the tough decisions (i.e. the program cuts) were not communicated to everyone... that was a conscious decision... rumors got out and caused some embarrassment."

There are three important considerations in developing a formal communication plan: 1) the plan should include iterative opportunities for engaging affected communities throughout the budgeting process, 2) communication materials should describe the budgeting goals (including contextual factors and scope of the exercise), criteria, process, and possible outcomes (Gibson, Martin, & Singer, 2005a), and 3) multiple communications methods should be used to optimize outreach to both internal and external stakeholders.

Recommendation #2: [the hospital] should ensure a communication plan is developed before the budget process begins. The plan should involve multiple vehicles of communication and should include relevant information on the budgeting process from start to finish. For example, some institutions have held town hall meetings with staff to provide updates on budget pressures and emerging

strategies, developed communications materials for managers to facilitate effective engagement with front line staff, and published regular updates for staff in hospital-wide communications (newsletters, email),

"My targets are not clear to me at this point and they should be because we're starting to work on it... Financial targets and the assumptions behind it. I think that needs to be clarified. We need Finance to prepare a document for us that tells us all that stuff."

3. Revisit Data and Information Needs

The quality and quantity of information used in a priority setting process is an on-going issue for any organization. It is important, however, to ensure that during a priority setting process, decision makers are provided with an adequate amount of up-to-date information to inform decisions. It is also a good idea to revisit data and information needs throughout the priority setting process, adding any information that might be new or not originally included. In order to enhance the information base for a budget process, decision makers should be provided with, or have access to, an information data base.

Recommendation #3: [the hospital] should ensure that all decision makers have access to adequate information and decision support. [the hospital] should engage program directors/managers in identifying gaps in data and in developing strategies for collecting appropriate data to inform subsequent budgeting exercises.

4. Develop a Revision or Appeals Process

A revision process allows decisions to improve the quality of decisions in light of new information or corrections, to engage stakeholders openly and constructively around the data and values informing budget decision, and to resolve disputes. Revisions and appeals provides the opportunity for new, potentially fundamental, information to be included in the decision making process. A revisions or appeals process is a constructive way for stakeholders to raise concerns about decisions and to propose reasonable alternatives to improve the quality of decisions.

Recommendation #4: [the hospital] should plan and execute a revisions process for the next iteration of budget setting. Experience shows that a revisions or appeals process should be explicit, allowing for concerns to be address on new information, errors in information, or failures of due process. (Madden, Martin, Downey et al., 2005)

5. Refine the Computer-Based Budget Tool

A well organized and user-friendly tool will eliminate some of the frustration that decision-makers experienced and will hopefully lead to more satisfaction and acceptance with the overall process. An improved tool could offer more evidence-based decisions, more confidence in the quality of decisions, and a greater ease in making decisions.

Changes have already been made to improve the computer-based budget tool for the 2008-2009 budget process. It is important that stakeholders

"It would have been nice to involve the people in the tool itself. It was not a bad tool, it was a good tool, it was just that I think that it could have been maybe designed a little more efficiently but none of us ... I don't believe any of us were involved in the development of the tool."

are aware that their feedback has been taken into consideration as the tool is being improved. One participant of the interviews recommended including program managers and directors (tool-users) in refining and piloting the budget tool before implementation.

Recommendation #5: *[the hospital]* should continue to update and improve the computer-based budgeting tool addressing issues brought about during the 2007-2008 process. *[the hospital]* should revise the tool based on people's feedback in this evaluation and pilot a revised tool in advance of the budget cycle to addresses any outstanding concerns

6. Address Key Timing Concerns

It is important to consider both the time of year and the length of time to complete any priority setting process. The budgeting process could be implemented during a time frame that would enable a) more effective stakeholder engagement, and b) more effective information collection, communication and analysis.

A fair process allows stakeholders enough time to review all information provided, and to gather other information. A successful priority setting process requires adequate time to allow for full stakeholder engagement and ensure a fully transparent process. Addressing timing concerns would not only allow for a more explicit decision making process, but could also help create conditions for more effective stakeholder engagement.

Recommendation #6: *[the hospital]* should reconsider the timing of their budgeting decisions to optimize as much as possible the opportunities for effective stakeholder engagement, collection of relevant data, and deliberation locally and institutionally on budget decisions.

"I think there are a lot of positive things that came out of the process. I think people should be responsible for their budgets, I don't have a problem with that, but I think that in order to get people there ... there isn't enough education and training for middle managers around budgeting kind of stuff, you know, and innovative and creative ways of doing things."

7. Provide Training for Decision Makers

Training needs emerged as an area requiring attention from Senior Management. Training for stakeholders should be specific to their needs - for e.g. innovative approaches to budgeting. This finding concurs with other research done on power relations, where adequate skill development was important for effective participation and preparedness in priority setting. By providing decision makers with tools to make informed decisions, the overall success of the process could improve along with increased satisfaction, and enhanced buy-in (institutionalization) of the budget.

Recommendation #7: *[the hospital]* should attempt to increase the budgeting skill set of decision makers by providing specific and tailored training.

8. Build on Lessons Learned

"it was the first time we were actually doing this so, you know, it was a double whammy because it's the first time you're actually learning to go through the budget process yourself"

Building on lessons learned here can improve future budgeting exercises. The lessons learned are the above recommendations (#1-7). This will also help to build capacity with decision makers and work toward enhanced institutionalization of the priority setting process. This includes, but is not limited to, improvements in participant's skill set or effectiveness, enhanced alignment with the goals of the process, and increased compliance with the prescribed process. This can ultimately lead to greater satisfaction with and understanding of both the need for priority setting and the process itself.

Recommendation #8: *[the hospital]* should develop improvement strategies based on these recommendations and re-evaluate their budgeting process every year, capturing new lessons and improvements with each iteration. In particular, *[the hospital]* should share these lessons with stakeholders in the organization and work with them to identify improvement strategies to inform next year's budget cycle.

REPORT APPENDIX A

Conceptual Framework

Key Concept	
PROCESS	1. Stakeholder Engagement
	2. Use of Explicit Process
	3. Clear & Transparent Information Management
	4. Consideration of Values
	5. Revision or Appeals Mechanism
OUTCOMES	1. Improved SH understanding
	2. Shifted priorities /Reallocation of resources
	3. Improved Decision Making Quality
	4. SH Acceptance & Satisfaction
	5. Positive Externalities

REPORT APPENDIX B

Documents Analyzed

1. Peer-Hospital Functional Centre Comparison
2. Three Decision Making Frameworks:
 - a. Ministry of Health and Long Term Care Prioritization Framework
 - b. Ethical Decision Making Framework
 - c. Activity Tool Analysis
3. 2007/08 Hospital Annual Planning Process Timeline
4. Budget Issues – Frequently Asked Questions (from shared folders)
5. Feedback Regarding Budget Process & Template (from shared folders)
6. 2007/08 Budget Process PowerPoint Presentation to Leadership Forum
7. [the hospital] Budget Training & Support Sign-up Sheet for Training
8. 2007/08 & 2008/09 Operating Budget 'How To' Document
9. Meeting Notes (Senior Leadership Team)
10. [the hospital] Organizational Chart (email)
11. [the hospital] Mission, Vision and Values Statements (website)
12. About [the hospital] (website)
13. [the hospital] Fast Facts and History (website)
14. Wait Times at [the hospital] (website)

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APPENDIX F:

DELPHI ROUND ONE LIST OF ITEMS

DIRECTLY RELATED TO A4R

Relevance

- 1) Assessments of the health needs or other interests of the affected populations have been determined and documented. Other interests could take into account concessions on health needs for other gains or advantages (job security, education) as result from collective bargaining or political processes.
- 2) Representatives of different stakeholders groups are represented and meaningfully participate in the allocation decision-making process.
- 3) Data or generally accepted opinion exist that support specific allocation policies and management practices.
- 4) No policies or management practices (e.g., requirements for patients or providers) are in place that can frustrate access to the allocated health care services either purposely or inadvertently.
- 5) A systematic search and evaluation of evidence
 - Conformance with evidence would require expert judgment
 - The quality of decisions should be higher because rationales are required, there is less scope for decisions to be based on considerations other than the available evidence e.g. lobbying and political pressure, though lobbying will still occur.
- 6) Wide professional consultations

Publicity

- 7) Communication materials and mechanisms made available by policy makers, and by surveys of stakeholders and direct observation approaches.
- 8) Decisions are public and accessible
- 9) Reasons are given in non-technical language

Appeals

- 10) Policies, rationales, and requirements can be revised as made necessary by changes in objectives to providing allocations or new information or arguments that have a bearing on allocation decisions.
- 11) Policies and procedures in place addressing surveillance needs to determine when changes are necessary to general allocation policies and to adjudicate individual requests from stakeholders for revisions in general policies or individual decisions.

- 12) Documentation exists showing responses to new information or stakeholder requests for changes in policies or practices

Enforcement

- 13) Mechanisms exist that ensure the processes are available and function properly
- 14) Governmental regulatory requirements for compliance to processes.
- 15) Internal policies and procedures (including auditing functions) to ensure compliance.
- 16) Voluntary arrangements with independent third-parties exist to assess compliance with processes and/or to adjudicate stakeholder requests for changes in policies or for appeals of individual decisions.

Other forms of outcome indicators

Available through interested observers such as governmental agencies, courts, news media, and cultural apparatus; could include, but not be limited to the following:

- 17) Qualitative and quantitative measures of federal and local legislation and regulation targeting problems meant to be addressed by the main ideas of accountability for reasonableness
- 18) Qualitative and quantitative measures of complaints and grievances about health care service allocation policies and management practices brought by stakeholders in the process
- 19) Number of appeals submitted for unavailable health care services that can be tied to insufficient conformance to the main ideas of accountability for reasonableness
- 20) The number of lawsuits filed and the size of awards provided for problems that correspond to the main ideas of accountability for reasonableness
- 21) The number and nature of news media accounts of problems with health care service allocation policies and management practices
- 22) The frequency and nature of content in common cultural media (plays, movies, books)
- 23) Principles or criteria are explainable and justifiable to lay audiences need to have at their core the overriding responsibility to make decisions consistent with the public's health needs as well as available resources -- both present and future.
- 24) Evaluation that has structure and is somewhat generic
 - An evaluation framework for measuring effectiveness of the given priority setting process that provides structure for evaluation but is also generic enough to be adapted in the local context
 - Tool provides guidance but is at the same time not overly prescriptive
- 25) Resource inequalities are compensated\

- Re-allocation of resources; improved patient outcomes
- 26) Relevant Stakeholders: consideration of the differing roles of governing bodies, executive management, operational management, and (in some situations) physicians and other health care professionals -- but also alignment with the decision-making structure of the affected organization (who gets to decide what?).
 - 27) The organization must be inclusive enough for the participation of key stakeholders, to be accepted by all parties; The organization must be exclusive enough to reach a limit-setting decision within reasonable time and resources; All key stakeholders have equal access and voice.
 - 28) Stakeholder understanding: greater knowledge of why decisions have been made
 - 29) Impact on stakeholder understanding of limits and their rationales
 - Measured in surveys in natural experiments
 - Measured in use of web pages or other devices for explaining limits, eg: of pharmacy benefits
 - 30) Satisfaction of the participants: self-rated usefulness by participants; important to draw on the judgments of decision makers themselves and of key stakeholders; whether decisions 'felt fair' - as assessed by decision makers and stakeholders, and in the context of what has been achieved in other settings.
 - 31) Policies and mechanisms in place to make affected populations aware of
 - Objectives to providing covered health care services
 - Health services available and specific conditions/requirements
 - Mechanisms available that facilitate access to covered health services, including appeals processes
 - Rationales for allocations, conditions, and requirements
 - 32) Degree to which main ideas become embedded in culture: improvement could be measured by the nature and number of enhancements to the original process
 - 33) Enhancement of market perception: of provider in situations where some providers promote themselves as abiding by A4R
 - 34) High degree of stakeholder acceptance
 - 35) High degree of reasonable public acceptance

Indirectly Related to A4R (but relevant to effectiveness)

- 36) There needs to be clear objectives/purpose: decision makers need to have clear objectives upon which they agree.
- 37) Commitment to implementation: without a commitment to implementation / follow-through based on the results, the process is incomplete and its credibility may be undermined for any subsequent use.
- 38) Maximization of benefits and minimization of opportunity costs
- 39) Effectiveness measured by efficiency:
 - An efficiently timed process that provides for meaningful involvement without demanding excessive time or effort.
 - a lengthy time for stakeholder involvement, etc., crucial energy and sustained knowledge/understanding and commitment can be compromised.

Methods of Evaluation

Direct Methods

- 40) Survey or observational research. Enough variability exists among different public and private programs that it may be possible to detect differences among important outcome variables according to the degree to which A4R ideas are used.
- 41) Public or private programs ready to implement approaches drawing from accountability for reasonableness concepts could provide the substrate for pre-post measurements of effectiveness.

Indirect Methods

- 42) Less direct methods could be used to triangulate or substitute for direct survey measurements. Different types of organizations that make decisions on health care service allocations of various types are set up to collect data that could be useful in determining the effectiveness of ideas derived from accountability for reasonableness.
- 43) Apply it more than once
- 44) Effectiveness measured by the number of completed processes
- 45) Comparisons within a single system and/or between different systems

APPENDIX G

FIRST VERSION OF EVALUATION TOOL

Priority Setting Process Evaluation Survey

General Process

1. Did you understand the purpose and goals of the priority setting process? (yes/no)
2. In comparison to previous decision making or priority setting at ORGANIZATION'S, is there consistency in reasoning between those and the priority setting process? (yes/no/I don't know)
3. During the priority setting process, the following were considered: (rank not at all, not enough, appropriately, excessively or N/A)
 - a) Organization's Mission, Vision, Values
 - b) Organization's Strategic Plan
 - c) Organization's Context
 - d) Organization's Culture
 - e) Community Values
 - f) Patient Values
 - g) Staff Values
4. Are there other items that should have been considered in the priority setting process? (yes/no and please list)
5. Are there items that were considered in the priority setting process that should NOT have been? (yes/no and please list)
6. Now that the priority setting process is finished, are you more familiar with the Organization's mission, vision, and values? (yes/no/I don't know)
7. Were there multiple methods of engaging stakeholders/decision makers? (yes/no/I don't know)
8. Were you aware of process and steps involved in the priority setting process? (yes/no/I don't know)
9. Was there an explicit and predetermined timeline for the priority setting process? (yes/no/I don't know)
10. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)? (yes/no/I don't know)

Decision Makers

11. Was everyone involved in the priority setting process who should have been involved? (yes/no/I don't know)
12. Who was not involved in the process that should have been? (List)
13. Do you know how the decisions for the priority setting process were made? (yes/no/I don't know)
14. Do you know who was making the decisions for the priority setting process? (yes/no/I don't know and List)
15. Was there integration of Organization's priority setting process with other healthcare organizations? (yes/no/I don't know)

Communication of Process

16. For the following elements of the priority setting process, please indicate how well they were communicated to you. (rank: they were not, very poorly,

adequately, well, very well, and N/A)

- a) Purpose & Goals
- b) Methods
- c) Outcomes
- d) Revision/Appeals

17. How were the above items communicated to you? (select all that apply)

- a) Via email
- b) Paystub
- c) Hospital newsletter
- d) Announcement posting
- e) Meeting: Departmental
- f) Meeting: Hospital-wide
- g) Peer-to-peer Informal
- h) Peer-to-peer Formal

18. Other methods of communication (list)

Outcomes of the Process

- 19. Please describe the outcome of the priority setting process as you understand it. (open-ended)
- 20. To what degree were the following items present in the outcome of the priority setting process? (rank: not present, somewhat present, appropriate amount, very present, heavily present)
 - a) Organization's Mission, vision, values
 - b) Organization's Strategic plan
 - c) Organization's Context
 - d) Organization's Culture
 - e) Community Values
 - f) Patient Values
 - g) Staff Values
- 21. Are you familiar with Organization's organizational priorities? (yes/no)
- 22. Did the outcome of the priority setting process address or identify organizational priorities? (yes/no/not sure)

Overall View of the Process

- 23. Were you satisfied with your involvement in the priority setting process? (yes/no/not sure)
- 24. How satisfied were you with the priority setting process? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)
- 25. What was the most satisfying for you with the priority setting process? (open-ended)
- 26. How would you improve/what changes would you make to the priority setting process? (open-ended)

- 1. Please explain the priority setting process.
 - Was this a good process?
 - Did you learn anything from this process? (directly to the priorities/priority setting process, and indirectly to the organization itself).
- 2. Please talk to me about the people who were involved in the priority setting process?
 - Was anyone missing?

- Was anyone there that shouldn't have been?
 - What about the people who were affected by the priority setting process?
 - Talk to me about acceptance and satisfaction of the process? (buy-in)
3. What was your role in the process?
 - Perceptions on the inclusiveness?
 - Quality of engagement? Partnership or empowerment?
 - Issues of power and authority?
 4. How was information gathered? How was information disseminated?
 - Good? Bad? Improved?
 - Consideration of values: staff, organization?
 5. What happened if people didn't like the decision that was made, or the process by which the decision was made?
 - Quality and thoroughness of the revision/appeals mechanism.
 6. How would you improve the process?

1. Does the budget reflect a change in resources or priorities given to programs?
2. Were any changes made to strategic documents?
3. Do any documents exist that reflect the process and/or decisions made during the priority setting?
4. Were any media reports generated from this priority setting process? (before, during or after?) (Internally or externally driven?)
5. Has there been any legislation or policy changes as a result of this priority setting process?
6. Is there a record of who was involved during each phase of the priority setting process?
7. Is there a description of the priority setting process in documents?
8. Is there a record of the process by which decision were made and the people involved?
9. What forms of communication were used? (memos, meeting minutes, website, etc)
10. Was information tailored to the various stakeholders allowing access and comprehension at a number of levels?
11. Was there a clear communication plan?
12. Review mission, vision and values statements and other related documents; Were the mission, vision and values considered during the process or changed/revised after the process?
13. Are there any documents surrounding the use of an appeal process? What did the process look like? What communication devices were used?

APPENDIX H:

CHANGES TO THE SURVEY AS A RESULT OF THE FCV PANEL

Original Survey Tool	Changes Made
General Process	
The following survey is in reference to the 2007/08 operating budget completed over the summer of 2006 and concluded in September with the HAPS submission.	<i>Added text</i>
The first set of questions is about the budgeting process (not the budgeting outcomes).	<i>Added text</i>
1. Were you aware of the process and steps involved in the 2007-2008 budgeting? (yes/no/I don't know)	<i>Previously Q#10</i>
2. Do you think the process was fair? (yes/no/I don't know)	<i>Added question</i>
3. Did you understand the purpose and goals of the 2007-2008 budgeting process? (yes/no)	<i>Previously Q#1</i>
4. Was there an explicit and predetermined timeline for the 2007-2008 budgeting process? (yes/no/I don't know)	<i>Previously Q#11</i>
5. In comparison to previous decision making or priority setting at RVH, is there consistency in reasoning between previous and the 2007-2008 budgeting process? (yes/no/I don't know)	<i>Previously Q#2</i>
More on Process	
6. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)? (yes/no/I don't know)	<i>Previously Q#12</i>
7. Was there integration of RVH's 2007-2008 budgeting process with other healthcare organizations? (yes/no/I don't know)	<i>Previously Q#18</i>
8. During the 2007-2008 budgeting process, the following were considered: (rank strongly agree, agree, disagree, strongly disagree or N/A) a) RVH Mission, vision, values b) RVH Strategic plan c) RVH Context d) RVH Culture e) Community Values f) Patient Values g) Staff Values	<i>Previously Q#3 Changed wording of ranking from: not at all – excessively</i>
9. Are there other items that should have been considered in the 2007-2008 budgeting process? (yes/no and please specify)	<i>Previously Q#4 Combined with Q#5 Please list</i>
10. Are there items that were considered in the 2007-2008 budgeting process that should NOT have been? (yes/no and please specify)	<i>Previously Q#6 Combined with Q#7 Please list</i>
Stakeholder Engagement	
11. Were there multiple methods of engaging	<i>Previously Q#9</i>

stakeholders/decision makers? (yes/no/I don't know)	
12. Were these methods effective? (yes/no/I don't know)	<i>Added question</i>
13. Please explain (open-ended)	<i>Added question</i>
14. Was everyone involved in the 2007-2008 budgeting process who should have been involved? (yes/no/I don't know... if no please specify who should have been involved)	<i>Previously Q#13 Combined with Q #14 – Who was not involved that should have been?</i>
15. How involved were you in the 2007-2008 budget? (very involved, somewhat involved, not at all involved)	<i>Added question</i>
16. Were you satisfied with your involvement in the 2007-2008 budgeting process? (yes/no/not sure)	<i>Previously Q#26</i>
17. Please explain. (open-ended)	
<u>Decision Makers</u>	
18. Do you know how the decisions for the 2007-2008 budgeting process were made? (yes/no/I don't know)	<i>Previously Q#15</i>
19. Do you know who was making the decisions for the 2007-2008 budgeting process? (yes/no/I don't know and please state who)	<i>Previously Q#16 Combined with Q#17 Please list</i>
<u>Communication</u>	<i>Changed header name from Communication of Process</i>
20. For the following elements of the 2007-2008 budgeting process, please if they were communicated to you. (yes/no/I don't know)	<i>Added Question</i>
a) Purpose & Goals b) Methods c) Outcomes d) Revision/Appeals	
21. For the following elements of the 2007-2008 budgeting process, please indicate how well they were communicated to you. (rank: they were not, very poorly, adequately, well, very well, and N/A) a) Purpose & Goals b) Methods c) Outcomes d) Revision/Appeals	<i>Previously Q#19</i>
22. How were the above items communicated to you? (select all that apply) a) Via email b) Pay stub c) Hospital newsletter d) Announcement posting	<i>Previously Q#20</i>

e) Meeting: Departmental f) Meeting: Hospital-wide g) Peer-to-peer Informal h) Peer-to-peer Formal	
23. Other methods of communication (list)	<i>Previously Q#21</i>
24. How could the communication be improved? (open ended)	<i>Added question</i>
<u>Outputs and Outcomes</u>	<i>Changed header name; previously Outputs of the Process</i>
25. Do you understand the outcome of the 2007-2008 budget	<i>Added Question</i>
26. Do you accept the outcomes of the 2007-2008 budget	<i>Added Question</i>
27. Are you satisfied with the outcomes of the 2007-2008 budget	<i>Added Question</i>
28. Now that the 2007-2008 budgeting process is finished, please indicate if you are more familiar with the following items (yes/no/I don't know) a) RVH Mission, vision, values b) RVH Strategic plan c) RVH Context d) RVH Culture e) Community Values f) Patient Values g) Staff Values	<i>Previously Q#8</i>
29. To what degree are the following items reflected in the 2007-2008 budget? (rank: not reflected, somewhat reflected, appropriate amount, very reflected, overly reflected) a) RVH Mission, vision, values b) RVH Strategic plan	<i>Previously Q#23</i> 1. <i>Changed wording; previously: To what degree were the following items reflected in the outcome of the 2007-2008 budgeting process;</i> 2. <i>Changed scale from: not present, somewhat present, appropriate amount, very present, heavily present</i>

c) RVH Context d) RVH Culture e) Community Values f) Patient Values g) Staff Values	
Overall View of the Process	
30. How satisfied were you with the process behind the 2007-2008 budget? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)	<i>Previously Q#27; separated into Q#30 and Q#32</i>
31. Please explain. (open-ended)	<i>Added question</i>
32. How satisfied were you with the outcomes of the 2007-2008 budget? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)	<i>Previously Q#27; separated into Q#30 and Q#32</i>
33. Please explain. (open-ended)	<i>Added question</i>
34. How would you improve/what changes would you make to the 2007-2008 budgeting process? (open-ended)	<i>Previously Q#29 (always last question)</i>
Demographic Information	
Thank you for your time in completing this survey. Your input and feedback are very valuable. The following information is being gathered for demographic purposes only. This information will not be tied to the answers you have given in your survey. Once you leave this page, your browser will close.	<i>Added section</i>
Job Title	
a) Senior Leadership Team	
b) Board Member	
c) Program Director	
d) Program Manager	
e) Front Line Staff	
f) Other (please specify)	

DELETED QUESTIONS

Please describe the outcome of the 2007-2008 budgeting process as you understand it. (open-ended)	<i>Question #22 DELETED – unclear</i>
Are you familiar with RVH's organizational priorities? (yes/no)	<i>Question #24 DELETED – repetitive</i>
Did the outcome of the 2007-2008 budgeting process address or identify organizational priorities? (yes/no/not sure)	<i>Question #25 DELETED – repetitive with Q#29</i>

APPENDIX I

COMPLETE RESULTS OF THE SURVEY

Q1. Were you aware of process and steps involved in the 2007-2008 budgeting?

<i>Answer Options</i>	n	%
Yes	38	36.20%
No	62	59.10%
I don't know	5	4.80%
<i>Total</i>	105	
<i>(skipped)</i>	0	

Q2. Do you think the process was fair?

<i>Answer Options</i>	n	%
Yes	21	20.00%
No	11	10.50%
I don't know	73	69.50%
<i>Total</i>	105	
<i>(skipped)</i>	0	

Q3. Did you understand the purpose and goals of the 2007-2008 budgeting process?

<i>Answer Options</i>	n	%
Yes	47	45.20%
No	57	54.80%
<i>Total</i>	104	
<i>(skipped)</i>	1	

Q4. Was there an explicit and predetermined timeline for the 2007-2008 budgeting process?

<i>Answer Options</i>	n	%
Yes	44	42.30%
No	4	3.90%
I don't know	56	53.90%
<i>Total</i>	104	
<i>(skipped)</i>	1	

Q5. In comparison to previous decision making or priority setting at [the hospital], is there consistency in reasoning between previous and the 2007-2008 budgeting process?

<i>Answer Options</i>	n	%
Yes	10	9.70%
No	17	16.50%
I don't know	76	73.80%
<i>Total</i>	103	
<i>(skipped)</i>	2	

Q6. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)?

<i>Answer Options</i>	n	%
Yes	8	9.60%
No	17	20.50%
I don't know	58	69.90%
<i>Total</i>	83	
<i>(skipped)</i>	22	

Q7. Was there integration of [the hospital]'s 2007-2008 budgeting process with other healthcare organizations?

<i>Answer Options</i>	n	%
Yes	8	9.60%
No	10	12.10%
I don't know	65	78.30%
<i>Total</i>	83	
<i>(skipped)</i>	22	

Q8. During the 2007-2008 budgeting process, the following were considered:

<i>Answer Options</i>	n	strongAgree	agree	disagree	strongDisagree	N/A
[the hospital]'s Mission, Vision, and Values	70	8	34	12	2	14
[the hospital] Strategic Plan	70	8	38	9	1	14
[the hospital] Context	68	7	32	6	2	21
[the hospital] Culture	68	5	30	10	4	19
Community Values	68	3	33	13	3	16
Patient Values	68	5	29	17	2	15
Staff Values	68	4	19	21	6	18
<i>Total</i>	70					
<i>(skipped)</i>	35					

Q9. Are there other items that should have been considered in the 2007-2008 budgeting process?

<i>Answer Options</i>	n	%
No	23	39.00%
Yes; please specify	36	61.00%
<i>Total</i>	59	
<i>(skipped)</i>	46	

Q10. Are there items that were considered in the 2007-2008 budgeting process that should NOT have been?

<i>Answer Options</i>	n	%
No	42	80.80%
Yes; please specify	10	19.20%
<i>Total</i>	52	
<i>(skipped)</i>	53	

Q11. Were there multiple methods of engaging stakeholders/decision makers?

<i>Answer Options</i>	n	%
Yes	12	15.40%
No	13	16.70%
I don't know	53	68.00%

<i>Total</i>	78
<i>(skipped)</i>	27

Q12. Were these methods effective?

<i>Answer Options</i>	n	%
Yes	5	7.30%
No	14	20.30%
I don't know	50	72.50%
<i>Total</i>	69	
<i>(skipped)</i>	36	

Q13. Please explain.(Open-Ended)

<i>Total</i>	18
<i>(skipped)</i>	87

Q14. Was everyone involved in the 2007-2008 budget who should have been?

<i>Answer Options</i>	n	%
Yes	9	11.70%
I don't know	48	62.30%
No	20	26.00%
<i>Total</i>	77	<i>answered</i>
<i>(skipped)</i>	28	<i>skipped</i>

Q15. How involved in the 2007-2008 budget were you?

<i>Answer Options</i>	n	%
Very involved	17	21.80%
Somewhat involved	15	19.20%
Not at all involved	46	59.00%
<i>Total</i>	78	
<i>(skipped)</i>	27	

Q16. Were you satisfied with your involvement in the 2007-2008 budget?

<i>Answer Options</i>	n	%
Yes	20	26.70%
No	28	37.30%
Not Sure	27	36.00%
<i>Total</i>	75	
<i>(skipped)</i>	30	

Q17. Please explain. (Open-Ended)

<i>answered</i>	21
<i>skipped</i>	84

Q18. Do you know how the decisions for the 2007-2008 budget were made?

<i>Answer Options</i>	n	%
Yes	13	16.70%
No	39	50.00%

Not Sure	26	33.30%
<i>Total</i>	78	
<i>(skipped)</i>	27	

Q19. Do you know who was making the decisions for the 2007-2008 budget?

<i>Answer Options</i>	n	%
No	22	28.20%
I don't know	27	34.60%
Yes; Please state who	29	37.20%
<i>Total</i>	78	
<i>(skipped)</i>	27	

Q20. For the following elements of the 2007-2008 budget, please if they were communicated to you.

<i>Answer Options</i>	n	yes	no	I don't know	N/A
Purpose & Goals of Process	71	35	24	9	3
Methods	70	29	27	11	3
Outcomes	71	29	29	10	3
Revision/Appeals Process	71	8	44	16	3
<i>Total</i>	71				
<i>(skipped)</i>	34				

Q21. For the following elements, please indicate how well they were communicated to you.

<i>Answer Options</i>	n	were not	very poorly	adequately	well	very well	N/A
Purpose & Goals	67	20	9	26	6	2	4
Methods	67	23	11	19	6	1	7
Outcomes	66	21	15	17	6	1	6
Revision/Appeals Process	67	37	11	7	3	1	8
<i>Total</i>	68						
<i>(skipped)</i>	37						

Q22. How were the above items communicated to you? (check all that apply)

<i>Answer Options</i>	n
E-mail	28
Paystub	0
Hospital Newsletter	2
Announcement Posting	4
Meeting: Departmental	26
Meeting: Hospital-Wide	18
Peer-to-Peer Informal	21
Peer-to-Peer Formal	16
<i>Total</i>	48
<i>(skipped)</i>	57

Q23. Other methods of communication. (Open-Ended)

<i>answered</i>	11
<i>skipped</i>	94

Q24. How could communication be improved? (Open-Ended)

<i>answered</i>	31
<i>skipped</i>	74

Q25. Do you understand the outcome of the 2007-2008 budget?

<i>Answer Options</i>	n	%
Yes, completely understand	11	15.90%
Somewhat understand	32	46.40%
No, don't understand	26	37.70%
<i>Total</i>	69	
<i>(skipped)</i>	36	

Q26. Do you accept the outcomes of the 2007-2008 budget?

<i>Answer Options</i>	n	%
Yes, completely accept	9	12.90%
Somewhat accept	29	41.40%
No, don't at all accept	3	4.30%
I don't know	29	41.40%
<i>Total</i>	70	
<i>(skipped)</i>	35	

Q27. Are you satisfied with the outcomes of the 2007-2008 budget?

<i>Answer Options</i>	n	%
Yes, completely satisfied	5	7.10%
Somewhat satisfied	22	31.40%
No, not satisfied	16	22.90%
I don't know	27	38.60%
<i>Total</i>	70	
<i>(skipped)</i>	35	

Q28. Now that the 2007-2008 budgeting process is finished, please indicate if you are more familiar with the following items

<i>Answer Options</i>	n	more	no, not more	same as before	I don't know
[the hospital] Mission, vision, values	61	5	14	37	5
[the hospital] Strategic plan	62	8	16	32	6
[the hospital] Context	56	1	19	28	8
[the hospital] Culture	55	2	16	30	7
Community Values	55	4	18	28	5
Patient Values	55	3	18	29	5
Staff Values	58	5	18	30	5
<i>Total</i>	67				
<i>(skipped)</i>	38				

Q29. To what degree are the following items reflected in the 2007-2008 budget?

<i>Answer Options</i>	n	not	somewhat	appropriately	very	overly
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[the hospital] Mission, Vision,& Values	42	4	14	22	2	0
[the hospital] Strategic Plan	41	1	15	21	4	0
[the hospital] Context	39	5	15	16	3	0
[the hospital] Culture	39	8	15	15	1	0
Community Values	40	10	15	15	0	0
Patient Values	38	9	14	14	1	0
Staff Values	39	13	13	12	1	0
<i>Total</i>	42					
<i>(skipped)</i>	63					

Q30. How satisfied were you with the process behind the 2007-2008 budget?

<i>Answer Options</i>	n	%
Not at all satisfied	18	28.10%
Somewhat satisfied	13	20.30%
Neutral	27	42.20%
Satisfied	5	7.80%
Very satisfied	1	1.60%
<i>Total</i>	64	
<i>(skipped)</i>	41	

Q31. Please explain. (Open-Ended)

<i>answered</i>	26
<i>skipped</i>	79

Q32. How satisfied were you with the outcomes of the 2007-2008 budget?

<i>Answer Options</i>	n	%
Not at all satisfied	16	25.00%
Somewhat satisfied	12	18.80%
Neutral	29	45.30%
Satisfied	6	9.40%
Very satisfied	1	1.60%
<i>Total</i>	64	
<i>(skipped)</i>	41	

Q33. Please explain.(Open-Ended)

<i>answered</i>	21
<i>skipped</i>	84

Q34. How would you improve/what changes would you make to the 2007-2008 budgeting process? (Open-Ended)

<i>answered</i>	28
<i>skipped</i>	77

APPENDIX J

TRACKED CHANGES TO INTERVIEW GUIDE

[Hospital] 2007-2008 Budgeting Process	No Change	[Hospital] 2007-2008 Budgeting Process
Interview Guide		Interview Guide
March 4, 2007	Date Change	June 7, 2007
Thank you for agreeing to be interviewed. The purpose of this research is to use a tool to evaluate the recent '07-'08 budgeting process in your organization. This is a newly developed tool that your organization has agreed to pilot test. You are being interviewed along with others from different parts of the organization in order to capture diverse viewpoints regarding the budgeting process. In this interview you will be asked to describe the recently completed budgeting process at [the hospital]. Before we begin, do you have any questions?	No Change	Thank you for agreeing to be interviewed. The purpose of this research is to use a tool to evaluate the recent '07-'08 budgeting process in your organization. This is a newly developed tool that your organization has agreed to pilot test. You are being interviewed along with others from different parts of the organization in order to capture diverse viewpoints regarding the budgeting process. In this interview you will be asked to describe the recently completed budgeting process at [the hospital]. Before we begin, do you have any questions?
7. Please talk to me about the people who were involved in the priority setting process.	Expanded	1. Please talk to me about who was involved in the priority setting process and how they were involved.
• What was your role?	Omitted – Repetitive	
• Was anyone not involved that should have been?	Omitted – Repetitive	
2. Tell me about the 2007-2008 budgeting process.	No Change	2. Tell me about the 2007-2008 budgeting process
• Was there an explicit process that you were aware of? // Was the process transparent and clear?	Streamlined/ Combined	• Explicit & transparent process?
• What were the major considerations?		• What were the major considerations? (values, culture, context)
• What information/data was used?		
• What role did values play? (organizational values [mission, vision, values]; staff values; community values etc.)		
• Did you know who was making the decisions?	Omitted – Repetitive	3. What happened if people did not agree with the decisions or the
• Did you know how decisions were made? // Were there explicit and	Made into question	

predetermined criteria and timeline? //		process?
3. What was the outcome of the 2007-2008 budgeting process?	Omitted – Repetitive	
How are things different from before this priority setting process?	Made into question	4. How are things different from before this priority setting process?
How were the decisions reflected elsewhere in the organization?	No Change	How were the decisions reflected elsewhere in the organization?
4. How satisfied were you with the priority setting process overall?	No Change (moved to #7)	7. How satisfied were you with the priority setting process overall?
5. How would you improve the 2007-2008 budgeting process?	No Change (moved to #6)	6 How would you improve the 2007-2008 budgeting process?
	Question Added	5. What did you learn from the priority setting process?
	Probe Added	Improved knowledge or understanding of the organization? (e.g. strategic plan; mission, vision and values; staff/community values)

APPENDIX K
SUGGESTED FOCUS GROUP DISCUSSION GUIDE

1. Let's talk about stakeholder involvement in the priority setting process. Who was involved? Who should have been involved? In what capacity?
2. What did the process look like?
 - i. Was there an explicit & transparent process?
 - ii. What were the major considerations? (values, culture, context)
 - iii. What happened if people did not agree with the decisions or the process?
3. What was learnt from the priority setting process? Personally? Organization-wide?
 - i. Improved knowledge or understanding of the organization? (e.g. strategic plan; mission, vision and values; staff/community values)
4. What could be done to improve the priority setting process?

APPENDIX L

EVALUATION SURVEY

CHANGES MADE AFTER PILOT TEST OF TOOL

New Survey Tool	Changes Made
<u>General Process</u>	<i>This title does not reflect what is now included in the survey.</i>
The following survey is in reference to the 2007/08 operating budget completed over the summer of 2006 and concluded in September with the HAPS submission.	
There are 26 questions in total in this survey	<i>This was added to better inform respondents of what to expect for this survey.</i>
The first set of questions is about the budgeting process (not the budgeting outcomes).	<i>With the rearrangement of the survey questions, the first set of questions is no longer solely pertaining to the process.</i>
1. Were you aware of that [the hospital] had a 2007-2008 budgeting process in the summer of 2006? (yes/no)	<i>Added question. Throughout analysis it was apparent that not everyone knew the budgeting had taken place – this will be a helpful question that will give insight in the way respondents answer the remainder of the survey.</i>
2. How involved were you in the 2007-2008 budget? (very involved, somewhat involved, not at all involved)	<i>This question was added from the content validity panel and was originally #15. By moving this question to earlier in the survey, it will provide essential information for analyzing the rest of the survey. As well, if question by question response rate decreases as respondents progress through the survey, having this question earlier in the survey will ensure a higher response rate for this essential question.</i>
3. Were you satisfied with your involvement in the 2007-2008 budgeting process? (yes/no/not sure)	<i>This used to have options for yes/no/not sure and is now just an open-ended question. This decreases the overall number of questions in the survey and also will hopefully generate more rich open-ended replies. Previously question #16, combined with question #17 (question 17 omitted)</i>
<u>Information and Communication</u>	<i>This subtitle was added to reflect the questions that are now in this section</i>
4. For the following elements of the 2007-2008 budgeting process, please if they were communicated to you. (yes/no/I don't know) a. Purpose & Goals b. Methods c. Outcomes d. Revision/Appeals	<i>This question, previously #20, was moved earlier to provide important information about responses that will be given later in the survey. Recall that for the [the hospital] budget, there was not a revisions/appeals process, however there were questions in the survey that assumed there way. If respondents answered NO to any of the elements, it would be possible to omit questions later in the survey that deal directly with that element.</i>
5. For the following elements of the 2007-2008 budgeting process, please indicate how well they were communicated to you. (rank: they were not, very poorly, adequately, well, very well, and N/A) a. Purpose & Goals b. Methods	<i>Previously question #21.</i>

c. Outcomes d. Revision/Appeals	
6. Did you understand the purpose and goals of the 2007-2008 budgeting process? (yes/no)	<i>Previously question #3</i>
7. How could the communication be improved? (open-ended)	<i>Previously question #24</i>
Process	<i>Changed from More on Process</i>
8. Was there an explicit and predetermined timeline for the 2007-2008 budgeting process? (yes/no/I don't know)	<i>Previously question #4</i>
9. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)? (yes/no/I don't know)	<i>Previously question #6</i>
10. During the budgeting process, the following items were considered: (not considered and that is ok, not considered but should have been, considered the appropriate amount, considered but should be considered more, considered too much) a. [the hospital] Mission, vision, values b. [the hospital] Strategic plan c. [the hospital] Context d. [the hospital] Culture e. Community Values f. Patient Values g. Staff Values	<i>Ranking options changed from: strongly agree, agree, disagree, strongly disagree or N/A. This will hopefully provide more insight into respondent's feelings on the consideration of the listed elements. Previously question #8</i>
11. Are there other items that should have been considered in the 2007-2008 budgeting process? (yes/no and please specify)	<i>Previously question #9</i>
Stakeholder Engagement	
12. Were there multiple methods of engaging stakeholders/decision makers? (yes/no/I don't know)	<i>Previously question #11</i>
13. SKIP PATTERN Were these methods successful? (yes/no/I don't know)	<i>This question was added through the content validity panel. A skip pattern was added such that if respondents answered 'no' to the previous question, this question will now be skipped. The word 'effective' was also changed to avoid confusion of the definition in answering the question. Previously question #12</i>
14. Do you know how the decisions for the 2007-2008 budgeting process were made? (yes/no/I don't know)	<i>Previously question #18</i>
15. Do you know who was making the decisions for the 2007-2008 budgeting process? (yes/no/I don't know and please state who)	<i>Previously question #19</i>
16. Who should have been involved in the 2007-2008 budgeting process that was not? (skip question or open-ended)	<i>This question was reworded from: "Was everyone involved in the 2007-2008 budgeting process who should have been involved? (yes/no/I don't know... if no please specify who should have been involved)". This new, more simplistic form of the question should capture the same responses and allow quicker completion rate if respondents do not want to answer it. Previously question #14</i>
Outcomes	<i>Changed from Outputs and Outcomes</i>
17. Do you understand the outcome of the 2007-2008 budget? (yes, completely understand; somewhat understand; no, don't understand)	<i>previously question #25</i>

18. Do you accept the outcomes of the 2007-2008 budget? (yes, completely accept; somewhat accept; no, don't accept)	<i>previously question #26</i>
19. Are you satisfied with the outcomes of the 2007-2008 budget? (yes, completely satisfied; somewhat satisfied; no, not satisfied)	<i>previously question #27</i>
20. To what degree are the following items reflected in the budget? (not reflected and that is ok, not reflected but should have been, reflected the appropriate amount, reflected but should be considered more, reflected too much) a. [the hospital] Mission, vision, values b. [the hospital] Strategic plan c. [the hospital] Context d. [the hospital] Culture e. Community Values f. Patient Values g. Staff Values	<i>Previously question #29 this question was moved to follow the previous question to generate more consistent results. Ranking was changed from (rank: not reflected, somewhat reflected, appropriate amount, very reflected, overly reflected)</i>
21. In comparison to previous decision making or priority setting at [the hospital], is there consistency in reasoning between previous and the 2007-2008 budgeting process? (yes/no/I don't know)	<i>Previously question #5</i>
22. Was there integration of [the hospital]'s 2007-2008 budgeting process with other healthcare organizations? (yes/no/I don't know)	<i>Previously question #7</i>
Overall View of the Process – there are the last three formal questions of the survey.	<i>Added text</i>
23. Do you think the process was fair? (yes/no/I don't know)	<i>Previously question #3 This was an added question through the content validity panel and despite all participants answering it, the majority of respondents answered 'I don't know'. By moving this question to later in the survey, participants have a chance to see how other survey questions might contribute to their conception of 'fairness'. This will hopefully generate a stronger response in yes or no options.</i>
24. How satisfied were you with the process behind the 2007-2008 budget? (Completely satisfied, somewhat satisfied, not at all satisfied)	<i>Ranking was changed from not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied. previously question #30</i>
25. How would you improve/what changes would you make to the 2007-2008 budgeting process? (open-ended)	<i>By omitting the previous two open ended questions, the hope is that this question will capture what came out of the above questions and any other final comments participants have. previously question #34</i>
Demographic Information	
Thank you for your time in completing this survey. Your input and feedback are very valuable.	
The following information is being gathered for demographic purposes only. This information will not be tied to the answers you have given in your survey.	
Once you leave this page, your browser will close.	
26. Job Title a. Senior Leadership Team b. Board Member c. Program Director d. Program Manager e. Physician	<i>Previously question #35</i>
	<i>Added category</i>

- f. Front Line Staff
g. Other (please specify)

DELETED QUESTIONS

Were you aware of the process and steps involved in the 2007-2008 budgeting? (yes/no/I don't know)	<i>Since a new question #1 was added and the questions on communication were moved to earlier in the survey, this question (previously #1) becomes redundant. The idea that if the process was communicated to the respondent, it can be assumed that they were 'aware' of the process.</i>
Are there items that were considered in the 2007-2008 budgeting process that should NOT have been? (yes/no and please specify)	<i>This question (previously question #10) did not generate rich or innovative information. The majority of respondents (81%) answered 'no' to this question and 53 respondents skipped this question.</i>
Now that the 2007-2008 budgeting process is finished, please indicate if you are more familiar with the following items yes, more familiar; no, not more familiar; same now as before; I don't know) a. [the hospital] Mission, vision, values b. [the hospital] Strategic plan c. [the hospital] Context d. [the hospital] Culture e. Community Values f. Patient Values g. Staff Values	<i>This question's ranking options were poorly designed and did not generate the data intended. This question aimed to capture 'stakeholder learning' and did not. (previously question #28)</i>
Please explain (open-ended) question for "how satisfied are you with the process" (now question #26)	<i>This did not generate any rich data. Since it was open-ended, it added to the length of time it takes to complete the survey. The hope is the information that would have been collected here will now be captured in the last open-ended question on the survey (question #27)</i>
How satisfied were you with the outcomes of the 2007-2008 budget? (rank: not at all satisfied, somewhat satisfied, neutral, satisfied, very satisfied)	<i>This question: "how satisfied are you with the outcomes of the budget?" is very similar to a previously asked question: "are you satisfied with the outcomes of the 2007-2008 budget?". (Previously question #32). The 'please explain' open-ended question that went along with this question was also omitted (previously question #33)</i>
How were the above items communicated to you? (select all that apply) a. Via email b. Pay stub c. Hospital newsletter d. Announcement posting e. Meeting: Departmental f. Meeting: Hospital-wide g. Peer-to-peer Informal h. Peer-to-peer Formal	<i>Previously question #22 – deleted because it did not generate any new data that could not be collected in document analysis. This question also did not contribute in a significant way to measuring the concept of communication</i>
Other methods of communication (list/open-ended)	<i>Previously question #23 – Deleted for the same reason as above.</i>

DOCUMENT ANALYSIS

CHANGES MADE AFTER PILOT TEST OF TOOL

[illegible]

APPENDIX N

COMPLETE VERSION OF TOOL (POST-PILOT TEST CHANGES)

SURVEY

1. Were you aware of that [THE HEALTHCARE ORGANIZATION] had a priority setting process? (yes/no)
2. How involved were you in the priority setting? (very involved, somewhat involved, not at all involved)
3. Were you satisfied with your involvement in the priority setting process? (yes/no/not sure)

Information and Communication

4. For the following elements of the priority setting process, please if they were communicated to you. (yes/no/I don't know)
 - a. Purpose & Goals
 - b. Methods
 - c. Outcomes
 - d. Revision/Appeals
5. For the following elements of the priority setting process, please indicate how well they were communicated to you. (rank: they were not, very poorly, adequately, well, very well, and N/A)
 - a. Purpose & Goals
 - b. Methods
 - c. Outcomes
 - d. Revision/Appeals
6. Did you understand the purpose and goals of the priority setting process? (yes/no)
7. How could the communication be improved? (open-ended)

Process

8. Was there an explicit and predetermined timeline for the priority setting process? (yes/no/I don't know)
9. Was there a revision or appeals process available (whereby a decision could be contested or reviewed)? (yes/no/I don't know)
10. During the priority setting process, the following items were considered: (not considered and that is ok, not considered but should have been, considered the appropriate amount, considered but should be considered more, considered too much)
 - a. [THE HEALTHCARE ORGANIZATION] Mission, vision, values
 - b. [THE HEALTHCARE ORGANIZATION] Strategic plan
 - c. [THE HEALTHCARE ORGANIZATION] Context

- d. [THE HEALTHCARE ORGANIZATION] Culture
- e. Community Values
- f. Patient Values
- g. Staff Values

11. Are there other items that should have been considered in the priority setting process? (yes/no and please specify)

Stakeholder Engagement

- 12.** Were there multiple methods of engaging stakeholders/decision makers? (yes/no/I don't know)
- 13.** Were these methods successful? (yes/no/I don't know)
- 14.** Do you know how the decisions for the priority setting process were made? (yes/no/I don't know)
- 15.** Do you know who was making the decisions for the priority setting process? (yes/no/I don't know and please state who)
- 16.** Who should have been involved in the priority setting process that was not? (skip question or open-ended)

Outcomes

- 17.** Do you understand the outcome of the priority setting? (yes, completely understand; somewhat understand; no, don't understand)
- 18.** Do you accept the outcomes of the priority setting? (yes, completely accept; somewhat accept; no, don't accept)
- 19.** Are you satisfied with the outcomes of the priority setting? (yes, completely satisfied; somewhat satisfied; no, not satisfied)
- 20.** To what degree are the following items reflected in the priority setting? (not reflected and that is ok, not reflected but should have been, reflected the appropriate amount, reflected but should be considered more, reflected too much)
- a. [THE HEALTHCARE ORGANIZATION] Mission, vision, values
 - b. [THE HEALTHCARE ORGANIZATION] Strategic plan
 - c. [THE HEALTHCARE ORGANIZATION] Context
 - d. [THE HEALTHCARE ORGANIZATION] Culture
 - e. Community Values
 - f. Patient Values
 - g. Staff Values
- 21.** In comparison to previous decision making or priority setting at [THE HEALTHCARE ORGANIZATION], is there consistency in reasoning between previous and the priority setting process? (yes/no/I don't know)
- 22.** Was there integration of [THE HEALTHCARE ORGANIZATION]'s priority setting process with other healthcare organizations? (yes/no/I don't know)

Overall View of the Process – these are the last three formal questions of the survey.

- 23.** Do you think the process was fair? (yes/no/I don't know)

- 24.**How satisfied were you with the process behind the priority setting? (Completely satisfied, somewhat satisfied, not at all satisfied)
- 25.**How would you improve/what changes would you make to the priority setting process? (open-ended)

INTERVIEW GUIDE

1. Please talk to me about who was involved in the priority setting process and how they were involved.
2. Tell me about the priority setting process.
 - i. Was there an explicit & transparent process?
 - ii. What were the major considerations? (values, culture, context)
3. What happened if people did not agree with the decisions or the process?
4. How are things different from before this priority setting process?
 - i. How were the decisions reflected elsewhere in the organization?
5. What did you learn from the priority setting process?
 - i. Improved knowledge or understanding of the organization? (e.g. strategic plan; mission, vision and values; staff/community values)
6. How would you improve the priority setting process?
7. How satisfied were you with the priority setting process overall?

DOCUMENT ANALYSIS

Analyze Communication Documents: (meeting minutes, emails, memos, website, etc)

1. Is there a record of who was involved during each phase of the priority setting process? Are the records consistent?
2. Is there a record of the process by which decisions were made and the people involved?
3. What forms of communication were used?
4. Was there a clear communication plan?
5. Are there any documents surrounding the use of an appeal process? What did the process look like?

Analyze Information/Handouts:

6. Is there a description of the priority setting process in documents?
7. What information/data was used to inform the priority setting process?

Analyze Mission/Vision/Values & Strategic Plan:

8. Were the mission, vision and values considered during the process or changed/revised after the process?

Analyze Budget:

9. Does the budget reflect a change in resources or priorities given to programs?
10. Does the budget have similar or different goals/priorities than other organizational documents (e.g. strategic plan, other departmental/program budgets)?

Analyze External Documents:

11. Were any media reports generated from this priority setting process? (before, during or after?) (Internally or externally driven?)
12. Has there been any legislation or policy changes as a result of this priority setting process?