Priority setting and resource allocation in health care

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Session outline

• Background to priority setting
• Economic/ ethics approach
• Implementation steps
• Outcomes and lessons learned
• Particular challenge of ‘disinvestment’
Global trends

• OECD countries range in total health expenditure from between 7-18% GDP

• After decades of growth over 4% per year, as of 2009 growth in public expenditure has declined in most OECD countries
  – Lower prices on medical products and drugs
  – Hospital budget constraints
  – Negotiations on wages
  – Cost shifting to private insurance or out of pocket

• Diminishing access for health prevention/promotion services; raises equity issues
Reform vs. management

- There is no health care system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. [OECD Economics Department Policy Notes, No. 2, 2010]

- Talk of crisis and calls for more funds obscure the fact that scarcity is a normal condition in publicly funded health care. Resources devoted to one service provided by a hospital or doctor are of necessity not available for other services. [Donaldson et al. 2002]
What is priority setting?

• Given that we can’t do everything, choices must be made about what to fund and what not to fund.

• Priority setting is about making these choices:
  - *Health authorities*
  - *Hospitals*
  - *Program areas*
  - *Individual services*

*Mitton and Donaldson CERA 2004*
What is typically done?

- Historical/political allocation: funding based on last year’s budget with some adjustments
  - Can become: ‘whoever yells the loudest’
  - Continual growth in budgets
  - Government mandates
  - Challenges with ‘one off’ requests even with a strong HTA-backed business case

- Surveys from across countries have indicated decision makers are uncertain about tools in the priority setting toolkit
### Historical vs. formal process

<table>
<thead>
<tr>
<th></th>
<th>Poor or very Poor</th>
<th>Fair</th>
<th>Good or very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Historical or Political Process</strong></td>
<td>18%</td>
<td>50%</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Formal/Rational Process</strong></td>
<td>2%</td>
<td>25%</td>
<td>73%</td>
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Those who stated their organization used a formal/rational process tended to be more satisfied with the priority setting process than those without.
Economics and ethics

• Literature on priority setting has economics and ethics contributions

• Useful to see these disciplines as complementary
  – Value for money
  – Fair process

• Develop and implement an approach to priority setting which incorporates both perspectives
Explicit trade-offs

Trade-offs have to be made, important to weigh out both costs and benefits and apply knowledge within broader framework.
Priority setting in health care

• Identify stakeholder values
• Use this to construct decision criteria
• Determine costs and ‘benefits’ of options
• Explicitly assess trade-offs
• Validate and communicate
• Accept winners and losers
"I think you should be more explicit here in step two."
Define aim and scope
Form “Advisory Panel”
Establish program budget
Develop decision criteria
Identify and rank options
Decisions and rationale
Decision review process
Evaluate and improve
PBMA/ A4R

Economics and ethics in practice

[Mitton and Donaldson 2004]
Key Concepts

• Shifting or re-allocating resources based on comparison against pre-defined criteria
• Incentives to encourage participation
• Clinicians and managers working together
• Ethical conditions built in
• Tool that supports decision making

Peacock et al. BMJ 2006
Criteria

- Operationalize organizational objectives
- Linked to strategic priorities
- Clearly defined at the outset
- Mutually exclusive
- Weight to reflect relative importance
- Involvement of relevant stakeholders
Expected Outcomes

• Primary benefits of explicit approach
  – Achieving real resource shifts consistent with strategic decision making objectives
  – Bending the cost curve and investing in areas where marginal gains are greatest
  – Clinical engagement and opportunity for public involvement
  – Greater transparency and accountability
International applications

- Wide range of program areas, majority at micro/ meso levels; more recently macro level applications

- 200+ exercises primarily in UK, NZ, Australia, Canada

- Distinct shift from focus on ‘efficiency’ to a management process aimed at meeting organizational objectives

- Majority of organizations that institute process tend to continue with it and see positive impact:
  - new way of thinking
  - re-allocation to better meet system objectives
Lessons learned

• Committed and supportive leadership
• External support and strong project management
• Explicit criteria and formal proposal scoring tool
• Importance of transparency of process and decisions
• Physician engagement in all aspects of the process
• Credible commitment takes time - organizational trust
• Recognition of political overlay
• Elements of high performance (process, structure, behavior)
Challenge of disinvestment

- Canadian experience: over 50 organizations with disinvestment ranging from $200K to $120M
  - Examples include investment which acts as an incentive
  - Not just about stopping ineffective services
  - Apply same rigorous methodology as for investments
  - Should be ongoing, not just to meet a deficit
Common Steps to Manage Resources

1. Generate revenue
2. Cost reduction activities
3. Outsource services
4. Re-engineering – LEAN, six sigma
5. Non-clinical integration, consolidation, standardization
6. Clinical integration, consolidation, standardization
7. Disinvestment

Common steps to meet fiscal constraints
- Removal of ineffective services
- Reduction of lower value services
Software tool

www.prioritizesoftware.com
Summary

- Substantial literature on implementation and evaluation of formal approaches (i.e., PBMA/A4R)
- Key success factor - strong leadership
- Process can be viewed as ‘vehicle’ for getting evidence in to decision making
- Software tool to support implementation – process efficiency and stakeholder engagement
- Doesn’t remove political overlay but provides legs to stand on in the face of government mandates
Case study: Vancouver Coastal Health

- One of six health authorities in BC
- Full spectrum of services, $3B annual operating budget and about 1.5 million people in catchment area
- Board of directors, senior executive team, 3 geographic health service delivery areas
Community Services

- Community services division
  - Services cover a continuum of care – from health promotion and prevention to primary care, secondary care, rehab and palliative
  - Total budget for 09/10: just over $600 million
  - Faced large budget deficit not resolved with ‘usual means’

- Aim to address the deficit and consider potential for re-allocation
Scope and timeline

• Specific programs were targeted by the process (about $250 million of the total program budget)
• Programs were excluded for valid reasons: mandated programs, joint programs...
  – Budget challenge: $4.65 million
  – Training began Jan. 6, recommendations approved March 23
Process structure

- Senior Executive Team
- Advisory Panel
- Working Group - included clinical leaders
<table>
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<tr>
<th>DOMAIN</th>
<th>Domain Weights</th>
<th>CRITERIA</th>
<th>DEFINITION</th>
<th>Criteria Weight</th>
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</table>
| Strategic alignment     | 30             | Alignment to Mandate                   | 1) The service is directly related to health care or preventative health  
2) The service is not provided by another organization outside VCH  
3) The service is not the responsibility of an organization outside VCH                                                                 | 15              |
|                         |                | Efficiency, Effectiveness and Appropriateness | 1) Optimal use of resources to yield maximum benefits and results,  
2) Care that is known to achieve intended outcomes  
3) Care provided is evidence based and specific to individual clinical needs  
4) Promote wellness & prevention initiatives,  
5) Support clients at home/returning home or self management                                                                 | 5               |
|                         |                | Access                                 | Impact on timely access to appropriate health care services for defined population(s). **Note:** the 'defined populations' are those using the services affected by the proposed changes. | 5               |
|                         |                | Flow/ Integration                      | Impact on the coordination of health care services among programs to ensure flow and continuity of care from the patient's perspective (improve flow transitions) | 5               |
| Health Impact           | 45             | Numbers affected                       | Number of individuals affected by the proposed change                                                                                                                                                | 8               |
|                         |                | Equity                                 | Impact on the health status of recognized groups where there is a known health status gap.                                                                                                             | 10              |
|                         |                | Significance of impact                 | Impact on clinical outcomes for the patient/client, including risk of adverse events, as compared to current practice/service.                                                                           | 11              |
|                         |                | Health promotion and disease prevention | Impact on illness and/or injury prevention, well-being and harm reduction as measured by projected longer term improvements in health                                                                   | 8               |
|                         |                | Client experience                       | Impact on safety, effectiveness, and client experience of health service(s) provided.                                                                                                                    | 8               |
| Organizational Impact   | 25             | Workplace environment                  | Impact on workplace environment including morale, tools and equipment, personal and professional growth and teamwork                                                                                     | 5               |
|                         |                | Innovation and knowledge transfer       | Impact on the generation and/or application of new knowledge/practice.                                                                                                                                 | 5               |
|                         |                | Implementation                          | Challenges to the implementation of proposed initiative (or reversal)                                                                                                                                 | 5               |
|                         |                | Downstream impact on service utilization | Impact of the proposed change on future use of health care services                                                                                                                                   | 10              |
Proposals

- Two phase proposal development process:
  1) Disinvestments
  2) Investments

- Business case template, targets, explicit submission process
Disinvestment proposals

- 55 proposals with a value of approximately $5.4 million
- Included efficiency gains and service changes (efficiency gains about $650,000)
- In the end, 44 options recommended with a total value of $4.9M
Project evaluation

• Successful in outlining a plan to meet financial obligations
• All participants said decisions were stronger/ more defensible then with no process
• Re-allocation did occur and gap was met using a ‘rational’ criteria-based process
• Strong support for process from CFO and well received by senior executive and Board
Case Study
Eastern Health

Eastern Health Region

- BUDGET 1.3 Billion
- PHYSICIANS 1,200
- VOLUNTEERS 700
- FOUNDATIONS 7
- POPULATION 306,000
- EMPLOYEES 13,000

Provincial Programs
- Cardiac Care
- Mental Health
- Cancer Care
- Diagnostic Imaging
- Women/Child Health
- Laboratory Services
- Rehabilitation Services

28 Health Care Facilities
- Acute care (925 inpatient beds)
- Community health centres
- Long-term care facilities
- Provincial cancer/rehab

30 communities

Eastern Health slides courtesy of Ms. Sharon Lehr
Expectations—more please...
Common Solutions
Eastern Health

- Recurring budget deficit – $20M
- Unique Population – aging demographic/urban-rural
- Increased demand in emergency departments
- Capacity challenges in medical/surgical beds with ALC issues
- Capital investment requirements
- Efficiency versus Transformation
Eastern Health Process

- A New Participative Approach
- Executive/Board support
- Senior management/clinical leader participation
- All clinical, corporate and support services
- Business cases developed for investment & disinvestment options (weighted criteria)
EH–PBMA Approach

- Operating Budget planning
- Capital planning
EH PBMA Outcomes

- Team engagement and empowerment
- Innovative ideas
- “Team” selection of operating and capital priorities
- Bottom Up versus Top Down
- $40M prioritized list of potential disinvestments
- $ Ranked capital priorities
Evaluation

• Excellent engagement overall
  – Long time clinician: “This is the best management process I have ever seen in this organization.”

• Staying the course, using the process for deficit reduction and ongoing re-allocation

• Strong support from leadership team and Board of Directors – mitigating political interference
Practical application

- Identify need for refining existing processes
- Obtain leadership commitment to proceed
- Determine aim and scope of activity
- Decide on project structure
- Develop decision criteria
- Generate proposals using standard template
- Provide recommendations for action
- Validation and communication
- Evaluation and project tracking

4-6 month process, building internal capacity and stakeholder engagement -- leading to resource re-allocation to better achieve organizational objectives
Future research

• Further developing methods for measuring benefit and assessing relative value
• Pushing envelope on practice of patient/public input in actual priority setting exercises
• Better understanding change management/organizational behaviour --- why is this so hard?!!
Discussion

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