Tools for priority setting: lessons from South Australia

Sandra G Leggat, Wendy Scheil, Helena Williams and Kate Kerin

Abstract

Background: This paper provides an overview of the process and tools used to develop and implement a priority setting framework for the Clinical Senate of South Australia. Established as a clinical advisory group to the Minister and Department of Health, the Clinical Senate recognised the need for an open priority setting process to fairly assign planning resources to the large number of clinical issues that needed to be addressed.

Discussion: Using a workbook, developed from the literature and evidence related to priority setting, agreement was reached on the use, components and structure of the priority setting process. The final products included a Gap Finder Tool and a Priority Setting Framework.

Summary: This paper describes the process used to develop the priority setting tools. Decision makers in other organisations can use similar processes and tools to develop or enhance their priority Setting processes.

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What is known about the topic?
Priority setting techniques are designed to guide decision-making when resources are constrained, through applying best available data and making otherwise implicit values and opinions explicit and testable.

What does this paper add?
This paper reports on the development of priority setting tools for use in constructing the work program of South Australia's Clinical Senate. The tools specify criteria for decision-making, and include a "gap analysis" tool designed to ensure inclusion of interventions across the continuum of health care.

What are the implications?
This approach has potential relevance for other policy-making bodies which must design a work program, or allocate health care resources, from among multiple competing health interventions. ◆

AS THE RESOURCES AVAILABLE for publicly-funded health care become increasingly constrained, government health departments throughout the world face challenges in effectively determining

Sandra G Leggat, BHSc, MHSc, MBA, PhD, Senior Lecturer
School of Public Health, La Trobe University, Melbourne, VIC.

Wendy Scheil, MB BS, FAFPHM, FRACGP, MAE, DTM&H, Principal Consultant (Medical)
Kate Kerin, BSSc, Project Officer
Metropolitan Division, South Australian Department of Health, Adelaide, SA.

Helena Williams, MB BS, FRACGP, Medical Director
Southern Division of General Practice, Adelaide, SA.

Correspondence: Dr Wendy Scheil, Metropolitan Division South Australian Department of Health, GPO Box 287 Rundle Mall, Adelaide, SA 5000.
wendy.scheil@health.sa.gov.au

funding priorities. When demand exceeds available resources, priorities must be set among competing opportunities. After a health system restructuring in South Australia, a Clinical Senate, comprising a multidisciplinary group of health professionals recognised as leaders in their fields, was established to provide advice to the Minister and Department of Health on clinical issues. The Senate members were looking for an effective method to agree on priorities for resource allocation (such as human and information resources for data collection and analysis) to the identification, planning and analysis of important clinical issues. A task group was established to identify or develop a priority setting framework for recommendation to the Clinical Senate.

Priority is defined in the dictionary as a preferential rating that allocates rights to goods and services usually in limited supply.[1] In practice, priority setting is a method of imposing people's values and judgements onto the available data to translate identified need to real

programs.[2] The literature suggested that in health the most common approach to priority setting and subsequent resource allocation was to continue to fund what had been previously funded — that is, implicit rationing.[3] Various jurisdictions have been considering better ways to define priorities that identify the greatest benefit for the available resources. The task group reviewed the literature and available priority setting models and could not find an existing framework that could be easily transferred to the South Australian context to meet their needs. The task group accepted the need to work through a process to develop a purpose built priority setting model.

Defining the priority setting framework

The literature describes priority setting in various health care contexts[4-8] and identifies a number of decision-making principles and approaches that could be used to set priorities.[3,9-15] Taking these into account, the considerations for priority setting were identified, as illustrated in Box 1.

A workbook (which can be accessed on <http://www.health.sa.gov.au/library/Portals/0/developing-a-clinical-priority setting-framework.pdf>) was developed to assist the task group and members of the Clinical Senate to design the priority setting framework. At a workshop, the task group used the workbook to explore, debate and decide on key organising principles for the framework. The first section of the workbook required the participants to define the components of the priority setting framework, while the second section focused on process. Each of the main considerations is discussed below.

Components of the priority setting framework

The purpose of the framework

The purposes of priority setting relate to resource allocation, such that the benefit is maximised and the costs (including opportunity costs) are mini-

mised. In the literature the following purposes were identified for priority setting processes:[14,16,17]

- setting priorities for investment, including prioritisation to assist in the allocation of time and energy to developmental proposals, as well as the ultimate selection among proposals;
- ranking the importance of identified needs (eg, determining who should receive health care, when there are insufficient resources to meet all needs);
- developing clinical guidelines;
- ranking identified health care solutions;
- decisions about whether to fund/purchase "expensive" treatments; and
- determining what should be excluded (eg, from the basic publicly-funded health care package) to reduce health care costs.

The workshop participants agreed on a vision to define the purpose of the priority setting framework for the Clinical Senate:

> The Clinical Senate's Priority Setting Framework will enable the Senate to provide advice to the Department of Health (and others, such as the Regions) in relation to health priorities, with the expectation that these priorities will form the basis for the State agenda on health. This advice will be developed using a fair, transparent process.

The level of application

Priority setting for health can be applied at a range of levels including "whole of government", health system (region or state), institution, treatment or patient levels. At whole of government level, it is applied to decisions about resources allocated to health services or health improvement relative to other sectors of the economy. At region or state level, it is applied to the broad distribution of resources among geographical areas, populations/communities, and health services, and may be extended to choices between centralising or decentralising services. At this level, priority setting among health services can be horizontal (that is, setting priorities between clinical areas, such as determining the relative resource allocation to orthopaedic versus oncol-

ogy services) or vertical (that is, setting priorities within specific clinical areas, such as allocation among prevention/promotion through smoking cessation programs or treatment options for patients with cardiovascular disease).

At the institutional level, priority setting applies to the allocation of resources to various programs and services within a provider institution or identified grouping of institutions. The vertical and horizontal considerations are also applicable at this level. For example, a hospital needs to allocate among the various clinical departments and services (horizontal) as well as among levels, of care with a clinical stream, such as prevention, community services, acute inpatient, and sub-acute services (vertical). At the treatment level, priority setting applies to the more specific allocation of resources to particular forms of treatment or health gain programs and, at the patient level, to the choice of which patient should receive treatment as well as how much should be spent on individual patients.

In line with the Clinical Senate's state-wide mandate, it was decided that the Priority Setting Framework should be designed for use at the state level, to set priorities for the Senate's work program, with both horizontal (among clinical areas) and vertical (among modalities within clinical areas) application.

The underlying values

The workshop participants then considered the values that would underpin the framework. This discussion included the definition of "health" and "health service" and consideration of the criteria to be used in priority setting. The debate around the criteria included:

- *What type of criteria would be used?* The group debated the use of substantive criteria, including medical, ethical, political and economic, as well as process criteria.
- *How many criteria were required?* A recent study of priority setting among 11 NHS Authorities found the number of criteria ranged between 3 and 14 (average 7.7 criteria).[18] It was also noted that in many cases where there was a relatively small number of criteria (eg, 3 to 5

criteria), each criterion contained a number of elements.[18,19]

- *Would the criteria be weighted?* The group discussed the relative advantages and disadvantages of weighting.
- *Whose values and what process would be used to inform the priority setting criteria?* While the literature suggested that expert opinion does not necessarily reflect the views of non-expert members of society, using expert opinion can allow the methodology to be applied consistently.[20] Similarly, it was suggested that community participants may actually represent professional (dominant), managerial or repressed (marginalised) interests and not fully reflect "community" interests.[21] Overall, there has been substantial debate about whether it is possible to find truly reflective community views, and a study of the priority setting processes in the United Kingdom found that lay people were more often involved in the scoring or rating of the options against the criteria and not in the selection or weighting of the criteria.[18]

In our case, the Clinical Senate was charged with the task of advising on clinical issues from the perspective of clinicians. The group defined five criteria incorporating their values as clinicians and recognised that there were times when the Clinical Senate might advise the Minister that additional input would be required from the community and consumers.

The criteria chosen were:

- *Health benefit:* Is there evidence that the intervention or service has a health benefit?
- *Equity:* Does the intervention or service contribute to equity of access and outcomes, considering: the needs of culturally and linguistically diverse (CALD) communities, gender, geography, education levels, Aboriginal and Torres Strait Islander health needs and socio-economic status.
- *Benefit to the public:* Does the intervention provide maximum gain for maximum time, with impact on the maximum number of people, with consideration of the timelines for achievement of the outcomes?

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1 Considerations in the design of a priority setting framework
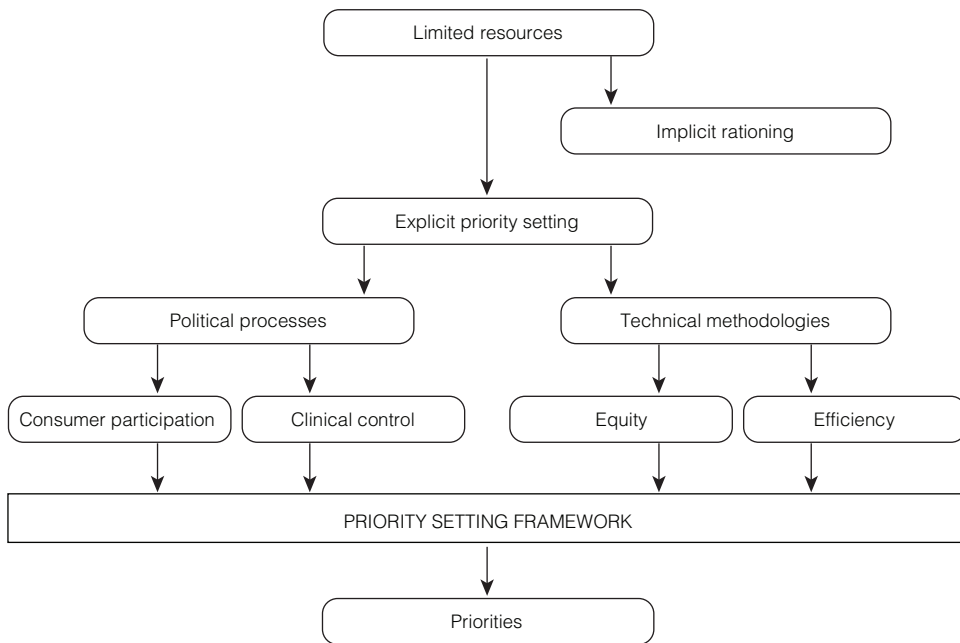
Adapted from Eagar[16] (p. 199)

- *Cost-effectiveness:* Does the intervention provide the greatest value for the resources invested?
- *Capacity and sustainability:* Can the intervention deliver, maintain and ensure continuing quality of the service, including workforce, capital, etc?

The criteria were weighted the same except for equity, where the Aboriginal and Torres Strait Islander component was given an individual weighting equivalent to the other criteria in recognition of the importance of the Aboriginal and Torres Strait Islander aspects in the framework.

Procedural and technical considerations

As illustrated in Box 1, the priority setting literature stressed the importance of attention to the procedure, especially the "politics" of involvement, as well as the technical discourse. Any priority setting exercise should ensure that due

process has been followed in using the technical evidence to make the decisions.[22] Correct priority setting process is characterised by transparency and accountability[23] and is explicit.[24] Experts have advised that it is important to ensure priority setting is not so technical in nature that the relevance is lost, while also ensuring that the methodologies are not too general, thereby preventing real decisions from being made.[5] The procedural considerations included discussion of the processes and participants who would define and evaluate the potential priorities using the framework.

The task group identified the need for the Clinical Senate to identify perceived deficiencies in clinical health service interventions throughout the health care continuum. This resulted in the development of a Gap Finder Tool (Box 2), for which the members agreed on column headings for key aspects of the health system to be

addressed in clinical service planning, and representative clinical areas in the rows. The Clinical Senate used this tool to ensure that a range of intervention options within a clinical area were considered, as well as considering the priorities among the large range of clinical services.

Once target clinical domains and areas were identified using the Gap Finder Tool, the intervention options could then be evaluated with the chosen criteria. Using a simple Excel spreadsheet the Clinical Senate members individually ranked each of the interventions, providing a 0 to 4 rating, with 4 indicating maximum ability to meet the criterion and 0 indicating no ability to meet the criterion. The individual rankings were presented at a meeting, with discussion and debate about the strength of the evidence. The participants were then given an opportunity to make revisions to their individual rankings. Following confirmation of the individual rankings, the weightings were applied and totalled to provide an indication of the overall priority assigned by the Clinical Senate.

Technical considerations primarily relate to the availability and quality of background or supporting information for the priority setting process. Many of the priority setting processes reported in the literature were hampered by the lack of comparable data on cost-effectiveness. There is no consistent approach to the research, with completion of studies at different times, in different contexts, for different purposes, providing different perspectives, such that it is difficult to use the results in comparative methodologies.[20] To overcome this issue it was recommended that those involved in priority setting recognise that priorities must be changed if further evidence of public preference as well as medical technology and experience becomes apparent.[25] Consistent with this advice, the task group recognised they would only be able to draw upon the best available evidence; that they may need to recommend commissioning of research to extend the evidence; and that they would need to regularly revisit priorities in the light of new evidence. The participants discussed the fact that there may not always be sufficient data (eg, health economic analysis, evidence of effectiveness, etc.) available to the priority setting process and indicated that the Clinical Senate would identify important areas for analysis, but would recognise that priorities may have to be set using the best available information at the time.

Lessons

Many of the lessons from this initiative are consistent with the findings of other studies, and strengthen our learning about effective approaches to priority setting. Following the workbook steps provided a uniform starting and information platform for Clinical Senate members to contribute towards setting the priorities for the group. Each of the members was chosen as a leader in their specific area of health, and the priority setting framework provided a structured way to discuss the varying interest areas and impact on the health of the community. Senate members wanted the priority setting tool to provide a transparent process to identify agreed health areas and felt this process may in itself broaden the scope of the Senate's agenda.

Nonetheless, consistent with other studies, the participants expressed concern about their ability to measure clinical impact given the limitations of the data, the studies and the decision support capabilities.[14] However, they felt that identifying the information needs would, at a minimum, raise the issues for greater consideration. The use of the framework promoted the evaluation of health interventions against desired outcomes and the participants felt that this may lead to a redistribution of resources away from areas supported by implicit rationing models and towards more equitable allocation.

An important lesson was the need to use the Priority Setting Framework within a clear strategic plan. In this process the participants were clear about the definition of health to be used, as it directly flowed from the targets and goals set by the Department of Health following the 2003 Generational Health Review. However, there was considerable debate among Clinical Senate members as to the level of application of priority

2 South Australian clinical senate gap finder tool

Clinical domain \ Clinical areas	Progression of strategic plans	Improve state-wide co-ordination - includes metropolitan and rural	Workforce: rural and urban; recruitment and retention; role redesign	Advancing research into action	Linkages - operational and to support research	Aboriginal and Torres Strait Islander	Primary care	Redesigning care	Hospital avoidance	After hours	Data collection	Medication	Equitable access and funding	Safety and quality
Clinical areas in general														
Mental health														
Cardiac														
Cancer														
Musculoskeletal														
Chronic disease														
Obstetric														
Peripheral vascular disease														
Oral health														
Anaesthetic														
ICU														
Primary care														
Paediatric														
Aged care														
Support systems														
Information management														
Evidence based care														
Funding models														

setting. Some considered the tool vital to determine the broad areas within health that required further action, while others wished to use it to determine annual priorities for the Senate, and others considered it a useful tool to distinguish the order for action among the varied and numerous issues the Senate was asked to consider. These discussions highlighted the need for the specific responsibilities of the various players in the system in relation to the priority setting process to be explicit. The recent reform of the governance of the health system in South Australia led to vigorous debate regarding the roles of the Department of Health and the Boards of the newly appointed health regions in relation to priority setting. The participants stressed the need for a communication strategy outlining the priorities of the Clinical Senate and how they had been established.

It was suggested that this communications strategy would enable broad communication of the goals and approach that the Clinical Senate would use to begin to define the necessary roles and responsibilities. Members reinforced the iterative nature of this work, requesting input and feedback on at least an annual basis. Other research has suggested that the purpose of the communication strategy

> … should be to ensure that stakeholders know and understand the scope and necessity of priority setting decision making, the degrees of freedom within which priority

setting would take place (including explicit identification of any "sacred cows" that would be immune from priority setting), and the particularities of the priority setting process (who will do what, how the process will work, and why)[14] (p. 9).

The Clinical Senate members considered that explicitly stating the criteria and weighting processes used for priority setting would improve the fairness of the priority setting process. They suggested that the use of similar tools and frameworks across the state would allow different groups to compare the way in which different health interventions were assessed. To further this process, the generic workbook has been published on the South Australian Department of Health website.

Conclusions

The process and lessons we report here make a contribution to extending our knowledge of how to define, design and implement priority setting in the health care sector. The information and processes contained in the workbook provide a generic basis through which members of health groups can discuss differing viewpoints about priorities in a structured way. It provides an alternate way to view implicit rationing and opportunity to consider redistribution of current resources. Recommendations regarding the implementation of more innovative and potentially more efficient health practices can be linked to iterative priority setting processes.

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Competing interests

The authors declare that they have no competing interests.

Authorship

Helena Williams chaired the task group, which commissioned Sandra Leggat to facilitate this piece of work. Wendy Scheil, as a member of the group, and Kate Kerin, as Executive Assistant, assisted with writing this article.

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