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Commentary

Priority Setting Meets Multiple Streams: A Match to Be Further Examined?

Comment on "Introducing New Priority Setting and Resource Allocation Processes in a Canadian Healthcare Organization: A Case Study Analysis Informed by Multiple Streams Theory"

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Abstract

With demand for health services continuing to grow as populations age and new technologies emerge to meet health needs, healthcare policy-makers are under constant pressure to set priorities, ie, to make choices about the health services that can and cannot be funded within available resources. In a recent paper, Smith et al apply an influential policy studies framework – Kingdon's multiple streams approach (MSA) – to explore the factors that explain why one health service delivery organization adopted a formal priority setting framework (in the form of programme budgeting and marginal analysis [PBMA]) to assist it in making priority setting decisions. MSA is a theory of agenda-setting, ie, how it is that different issues do or do not reach a decision-making point. In this paper, I reflect on the use of the MSA framework to explore priority setting processes and how the framework might be applied to similar cases in future.

Keywords: Priority Setting, Resource Allocation, Programme Budgeting and Marginal Analysis (PBMA), Canada

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Introduction

With demand for health services continuing to grow as populations age and new technologies emerge to meet health needs, healthcare policy-makers are under constant pressure to set priorities, ie, to make choices about the health services that can and cannot be funded within available resources.[1] Programme budgeting and marginal analysis (PBMA) is a process that supports healthcare decision-makers in making such significant decisions. Its key stages are well described in the literature, as are the factors that support and provide barriers to success.[2-10] But very little has been written about why it is that formal processes such as PBMA come to be introduced in the first place.

An interesting approach has been taken by Smith et al[11] in their application of an influential policy studies framework – Kingdon's multiple streams approach (MSA)[12,13] – to explore the factors that explain why one health service delivery organization (IWK Health Centre, Halifax, NS, Canada) adopted a formal priority setting framework (in the form of PBMA) to assist it in making priority setting decisions at a time when its budget was being frozen. In this Commentary, I consider the use of MSA to examine the decision to use PBMA by IWK to assist in its decision-making, and what further research might be undertaken to further explore how and why organizations choose to formally and explicitly set priorities and why they choose certain frameworks to assist them in such decision-making.

The Work of Smith et al With Kingdon's Multiple Streams Approach

MSA is a theory of agenda-setting, ie, how it is that different issues do or do not reach a decision-making point. MSA posits that policy changes occur when a 'policy window' is opened, which in turn arises when multiple streams – a problem stream, a policy stream, and a politics stream – converge; often these are joined through a 'policy entrepreneur' who brings the three streams together and advocates for change.[12,13]

Smith et al[11] use the core concepts from Kingdon's MSA to help understand how it was possible to introduce a meaningful change to priority setting and resource allocation (PRSA) at the IWK. The background to the case study was that in 2011/2012 IWK's budget was frozen, and the Executive Leadership Team (ELT) at IWK took various measures to cut spending; however, the process was criticized internally, for its lack of engagement with key stakeholders and for not adopting an integrated view of IWK's health services delivery. With a further budget cut for 2012/2013, the ELT chose to use PBMA to make decisions about where to make cuts and PBMA was successfully implemented to support decision-making for the 2012/2013 year. Smith et al[11] find that the problem stream (lack of broad engagement in the 2011/2012 PSRA decision process); policy stream (PBMA is easy to understand; has been used elsewhere with success; and addressed the identified problems); and politics stream (the province of Nova Scotia allowed the IWK to pursue PBMA) joined to allow IWK to change the way in

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which it made resource allocation decisions for 2012/2013. Policy entrepreneurs were those aware of PBMA, who brought it to the attention of colleagues, and who trialled it at the senior management level. IWK was largely (but not entirely) successful at implementing the recommendations of the PBMA process as well.

Using Multiple Streams Approach to Explore Priority Setting

Smith et al[11] have shown that the MSA approach helps to explain why PBMA was able to be implemented at IWK in 2012/2013. Their analysis suggests that those wishing to bring about change in priority setting decision-making processes and/or promote PBMA would do well to consider whether a policy window has truly opened when they are asked to support agencies in undertaking a priority setting or PBMA exercise; the MSA provides a useful framework for thinking through such issues.

The work of Smith et al[11] raised several issues for me. First, is a framework aimed at illuminating public policy decisions relevant to PBMA? In my mind, yes, it is: public policy involves decision-making (both action and inaction) by a government or equivalent authority[13]; IWK is an authority funded to deliver health services to the general public through a provincial government. In addition, policy can involve the making of executive decisions,[14] clearly relevant in this case.

Second, this raises a further question: IWK was allowed by the province of Nova Scotia (which funds IWK) to use PBMA as its priority setting approach in 2012/2013. This is a further layer of decision-making where an analysis using the MSA might be useful: what were the factors that supported this agreement?

Third, not all the recommendations from the PBMA exercise were accepted by the province. An analysis of the characteristics of the rejected decisions, using the MSA, might also be useful to guide future resource allocation and PBMA exercises. Perhaps each option needed its own problem, policy, and politics stream to converge, with policy entrepreneurs to back them? The logical conclusion from this analysis might be that some options for cutting services are excluded early on in a PBMA process on the grounds that they will not be accepted by the politics stream. However, it would be concerning if such options are systematically excluded: the potential for bias in decision-making (ie, support of services that do not do well on the decision criteria) is too great. Interestingly, however, Kingdon's MSA tells us that if we have a set of policy options available, it may just be a matter of waiting for a future policy window to open so that previously rejected options become real considerations for change, given different problem and politics contexts. Smith et al[11] note the "*…government hear[d] about PBMA and stepp[ed] in, saying 'Can you give us a list of your quick wins'? Which we said, no, we're going to follow the process the whole way through.*" This further supports the application of the MSA in this context: an existing list would have proven a highly important, readily available policy option (solution) to a difficult problem (the need to cut spending). To what extent, then, has the PBMA process undertaken by IWK provided a solution to future policy problems of the same type? This to me has always been a key reason why regular, formalised priority setting processes are crucial: they provide important information that might assist in solving future allocation problems (both those where there is new money available and those where budgets may need to be cut to remain within budget).

This links with a fourth issue: the time available to make decisions. A usual criticism of PBMA is that it takes time – in my own experience, quite a considerable period of time for key decision-makers to understand the approach, agree on its value, run the process, and reach decisions. IWK seems to have front-footed this for its 2012/2013 budget process – so was a key factor in the success of changing to PBMA that IWK had the time, resources, and information to run the process well? Where might this fit within the MSA framework?

Fifth, key to the success in changing the priority setting approach to PBMA was the extensive work that has been done by the research team and others in Canada in promoting, trialling, researching, and writing up, various PBMA exercises.[15-20] This shows how important it is to have available evidence to hand when the problem and politics stream converge to demand a policy response. Building such an evidence base takes considerable time and resource. The MSA suggests that the policy solutions arising from evidence also need a problem and an appropriate political context with which to join for the research to taken up, an important issue for those working to improve the take-up of research findings and implement the findings from research.[21]

Sixth, the analysis of the IWK case also suggests that PBMA made it harder for people to advocate for their own area. It is not clear in the article why this was the case, but it likely required good leadership and a commitment by all decision-makers to the fair and systematic weighing up of alternatives. I personally have seen PBMA processes undermined by a strong senior manager suggesting changes to decision criteria or the weight they are accorded, or to the scores or value assigned to health services, that result in 'pet' projects trumping all others. Further analyses of why it was in the IWK case that it became harder for those involved to advocate for their own area would be useful.

Finally, it would be useful to know if PBMA is continuing to be used by IWK beyond the 2012/2013 budget year, and if not, why not?

Smith et al[11] have opened up an interesting area for further research, one that could assist in the development of frameworks to support the use of PBMA in decision-making in healthcare. It would be useful to bring together the existing literature on PBMA and frame it within the MSA to assess what we do and do not know about why formal priority setting or PBMA approaches are and are not successfully introduced and their decisions acted upon. Smith et al[11] used the core concepts of MSA in their analyses, but there are deeper levels of the framework that warrant further exploration.[13] This in turn is likely to open up further areas of enquiry, to assist in the further development of the literature to support more systematic decision-making in healthcare in future.

Moreover, further analyses using MSA provide an opportunity to compare and contrast the advantages and disadvantages of MSA with alternative approaches, such as Rogers's[22] and Greenhalgh et al approach to the diffusion of innovations,[23] and Sabatier's work on implementation research.[24] Such analyses may result in the generation of a framework that would allow more in-depth analyses of decision-making on

whether or not to engage in explicit priority setting decision-making processes, the choice of process, and whether or not such formal decision-making is sustained over time.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

JMC is the single author of the paper.

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