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# Case study on priority setting in rural Southern Alberta: keeping the house from blowing in

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**Objective:** This case study describes the priority-setting process undertaken by health care providers in the Municipal District of Taber, Alta., to improve and integrate chronic disease services within a fixed budget.

**Methods:** Providers first reviewed the current chronic disease management system, then considered alternatives based on program priorities and costs and benefits of potential changes.

**Results:** Despite reaching consensus that a chronic disease clinic was the top priority for funding, providers were unable to redesign services accordingly. Redesign efforts were hampered by the groups' difficulty in identifying services that should receive fewer resources in order to fund priority areas, inexperience with priority-setting frameworks, group composition, the belief that many programs were already at "bare bone" funding levels, and perceptions of limited budget control. In the end, recommendations were made to use attrition to release resources, establish multi-disciplinary teams and group visits, where appropriate, and relocate providers to a centralized location. Upon review of study outcomes, Taber providers were granted more decision-making authority.

**Conclusion:** Overall, the use of a systematic priority-setting process, culminating in recommendations for action, has moved Taber providers closer to an integrated model of service delivery. It is recommended that formal priority-setting frameworks continue to be used in Taber for primary care renewal or at any level where consideration of existing evidence and projected costs is required.

**Objectif :** Cette étude de cas décrit le processus d'établissement des priorités que les prestataires de soins de santé du district municipal de Taber (Alb.) ont mis en place pour améliorer et intégrer les services de traitement des maladies chroniques dans le contexte d'un budget fixe.

**Méthodes :** Les prestataires ont commencé par analyser le système actuel de prise en charge de maladies chroniques et ont envisagé ensuite des solutions de rechange fondées sur les priorités du programme et les coûts et avantages de changements éventuels.

**Résultats :** Même s'il se sont entendus sur le fait que le financement d'une clinique de traitement des maladies chroniques constituait la grande priorité, les prestataires n'ont pu restructurer les services en conséquence. La difficulté que le groupe a eue à définir les services devant recevoir moins de ressources afin de financer les aspects prioritaires, l'inexpérience des cadres face à l'établissement de priorités, la composition du groupe, la perception de la situation — on croyait que beaucoup de programmes disposaient déjà d'un budget «réduit à l'os» et que le contrôle budgétaire était limité — a entravé les efforts de restructuration. On a finalement recommandé d'utiliser l'attrition pour dégager des ressources, d'établir des équipes multidisciplinaires et des visites collectives dans les cas appropriés, et de déménager des prestataires à un endroit centralisé. Lorsqu'on a analysé les résultats de l'étude, les prestataires de Taber ont obtenu plus de pouvoir décisionnel.

**Conclusion :** Dans l'ensemble, le recours à un processus d'établissement systématique

de priorités débouchant sur des recommandations d'interventions a rapproché davantage les prestataires de Taber d'un modèle intégré de prestation de services. On recommande de continuer d'utiliser des cadres structurés d'établissement de priorités à Taber pour renouveler les soins de santé primaires, ou à tout niveau où il faut tenir compte des données probantes existantes et des coûts projetés.

## INTRODUCTION

Taber is an agrarian-based rural community in Southern Alberta. Along with 8 other communities, it makes up the Chinook Health Region (CHR). The Municipal District of Taber has a population of about 15 000 in a geographically distinguishable area 55 km east of Lethbridge. Primary care health services available in Taber include a 25-bed hospital, a 70-bed long-term care facility, a health unit and an 8-physician group practice.

### *The rural reality*

It is well known that rural health care providers\* face a unique set of challenges. Not only must they practise their craft in an environment that is "under-serviced and underfunded," they are often perceived as second-class professionals when compared to their urban counterpart.<sup>1,2</sup> Similarly, residents in rural communities encounter fewer service delivery alternatives, have access to a limited array of support services and must travel further than those living in urban centres to receive specialty services.<sup>3</sup> The reality of resource scarcity, Taber's geographic distinctiveness, its array of health care services, and the desire of health care providers to integrate services made it an appropriate location in which to conduct a case study on priority setting.

Taber is involved in a 3-year primary care project, integrating physician clinic services with personal health services operated by the CHR and other key community programs.†

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\*The term provider encompasses both physicians and regional health care practitioners (nurses, rehab therapists and anyone providing frontline patient care) working in the Municipal District of Taber.

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†To facilitate this new model of care the information systems will be upgraded so care providers have access to current clinical practice guidelines and pertinent health record information; physicians will be paid through an alternative payment plan; and the management structure will be adapted to encourage teamwork and increase collaboration among providers.

### *GP-centred model (GPCM)*

Prior to the integrated primary care project, patients with chronic diseases were seen on a one-to-one basis at the physician clinic. Physicians were remunerated fee-for-service for each visit. Patients who were unable to successfully manage their disease were referred to specialists and/or the hospital. Taber physicians were supported in their provision of emergency department and inpatient care by CHR staff, which included those individuals employed by the region who provide front-line care, support and administrative services.

### *CHR program management model*

Under this model of care, GPs work autonomously but alongside CHR staff operating under a program management model (see Fig. 1). In the CHR, programs and services are organized around specific client groups (e.g., seniors, women and children). Each of these program areas is assigned to 1 of the 4 vice-presidents and managed by a program director. Based on previous work on priority setting in the CHR, it was found that<sup>4</sup>

"the process of setting priorities is one in which program and medical directors develop proposals that are then put forth for discussion at the Coordinating Council, which includes such directors and respective vice-presidents. Directors are also responsible for setting priorities for their own programs. The allocation of resources is a collaborative process between the vice-presidents and the [program and medical] directors at the Coordinating Council meetings."

Outcomes of this process are flavoured by historical trends, "whoever yells the loudest" and political pressures.

### *Motivations for change*

Following an integration pilot project on well-baby services, Taber providers realized that integrated primary care meant moving away from the GPCM. Taber health care providers selected chronic disease as the second service area to be integrated. Not only are the percentages of indi-

viduals with asthma, diabetes and hypertension higher in the CHR than they are for the province as a whole,<sup>5</sup> but the literature has shown that chronic diseases place tremendous physical and economic strain on afflicted individuals and on the health care system.

The total cost of asthma in Canada is estimated to be between \$504 million and \$648 million.<sup>6</sup> This translates to an average annual per capita cost of \$19.06. Similar concerns exist for individuals with diabetes and hypertension. Diabetes and its management are estimated<sup>7</sup> to “consume 1 in 7 health care dollars.” Although not as great a financial strain as asthma or diabetes, hypertension is a significant risk factor for cerebrovascular disease, coronary artery disease, congestive heart failure, renal failure and peripheral vascular disease.<sup>8</sup>

Taber health care providers wanted to redesign chronic disease services and move toward a more integrated and efficient model, one that reflects

their rural reality. Their goal was to improve the efficiency and quality of patient care by reducing service duplication through coordination of physician services with those offered by the region or other health organizations. It was further hoped that a more reasonable quality of work life for the overworked physicians in this rural community clinic would result. If services could be redesigned so that other health care providers spent more time helping patients manage their chronic diseases, then physicians’ quality of work life should improve.

### *A serendipitous encounter*

Early on in the Taber project, the CHR Chief Executive Officer and senior program directors were contacted by researchers from the University of Calgary who were interested in applying and evaluating an economic approach to priority-setting in real world Canadian health care set-

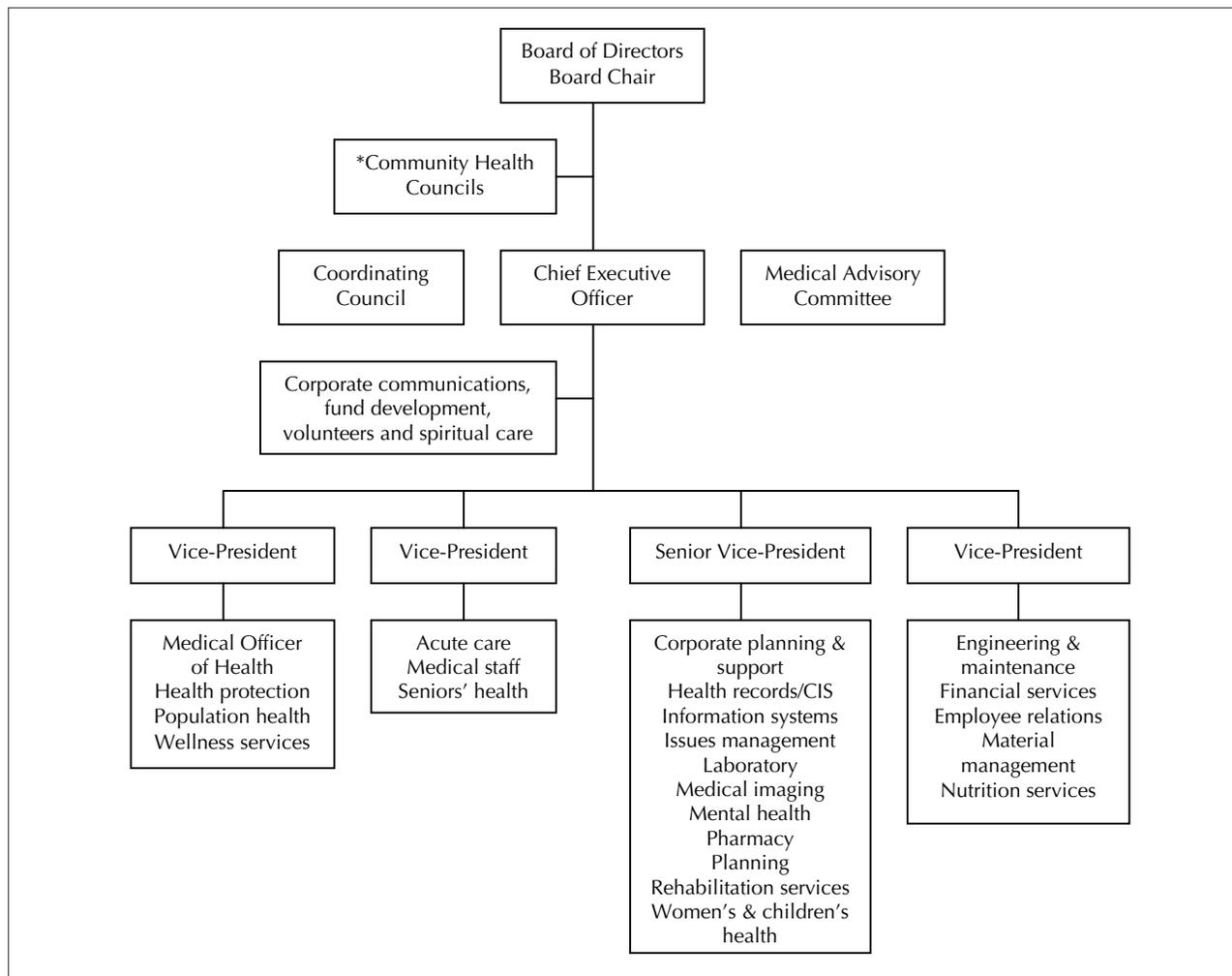


Fig. 1. Organizational chart/management model for the Chinook Health Region

tings. Taber providers were invited to participate in the priority-setting project, with the aim of improving integration and efficiency of chronic disease services.

Focusing on the priority-setting experiences of rural health care managers and providers makes the Taber case study unique. This paper describes the priority-setting process undertaken by Taber health care providers to improve the delivery of chronic disease services in their community.

## METHODS

The approach used in this project was program budgeting and marginal analysis (PBMA).<sup>9-12</sup> PBMA has been used widely in health care over the last 25 years, and can be made operational with 5 key questions, as outlined in Table 1.

The process involves identifying the current pattern of spending across services within a health board or within a specific program, in order to set priorities and make optimal decisions about service redesign. The questions outlined in Table 1 were followed by a decision-making advisory panel over a series of meetings, as depicted in Figure 2.

At the end of the process, panel members participated in a semi-structured follow-up survey on the strengths, weaknesses and overall merit of the PBMA. Eight of the panel members participated in the follow-up survey. Content analysis was performed on the interview notes. Information reported here focuses on the impediments to the priority-setting process. This information was combined with insights from the University of Calgary researchers, the research associate and the Case Costing Coordinator.

## RESULTS

### *Steps in the priority-setting process*

The priority-setting process began in March 2000 with an introductory session on PBMA. At the second meeting, alternatives to the GPCM were presented to the group (Table 2), based on practices found in the literature.<sup>13-18</sup> These alternatives were rated using a set of panel-generated criteria (Table 3). Panel members brainstormed attributes that they felt were key to achieving project goals and better management of chronic disease services. As such, the values of the panel itself were reflected in the decision-making process and contributed to the redesign plan.

The number and associated costs of inpatient visits at the Taber hospital, for the CHR and the province for 1998-1999 were presented at the third meeting of the panel (Table 4). After reviewing this data and considering the ranking criteria, the panel selected the Taber chronic disease clinic as their top priority for funding. A "wish list" for delivery of chronic disease services was then compiled. These items were individually costed and then ranked by the panel (Table 5). This identified the highest-priority items so that if only some of the resources required to fund the clinic were obtained, funding could be diverted to those items (e.g., the nurse educator). Originally, secretarial support was not identified as necessary; however, after discussion, it was deemed critical to clinic success.

Finally, the research associate met with each panel member to generate a list of potential "resource-release" areas (i.e., areas whose resources could be diverted, if necessary, to fund top priority items). The panel discussed the feasi-

1. What is the total amount of resources available? 2. How are these resources currently used?	Answering the first 2 questions provides information on how resources are currently used, and it encourages decision-makers to think about whether the current mix of services provided is aligned with program priorities.
3. What services are the main candidates for receiving more resources (and what are the costs and benefits of these expansions/ introductions)? 4. Can any services that currently receive funding be provided to the same level of effectiveness <b>but</b> with fewer resources (thus increasing technical efficiency), allowing some of the items from 3 to be implemented? 5. If improvements in technical efficiency are not possible, are there services that should receive fewer resources because they are less effective per dollar spent than something on the wish list?	Marginal analysis examines whether the mix of services could be changed to improve the benefit to the population overall. It involves identifying the costs and benefits of particular services or programs, and draws on evidence from the literature as well as local and out-of-region experts and reports.

bility of each suggestion before deciding which resource-release areas should fund the chronic disease clinic.

**Panel recommendations**

The panel agreed that any changes in the way

patients with chronic disease are serviced should be incremental, process-oriented and resource neutral. They made 4 recommendations.

1. Monies that become available through attrition will be put forth to fund items on the wish list where possible. New and current health care

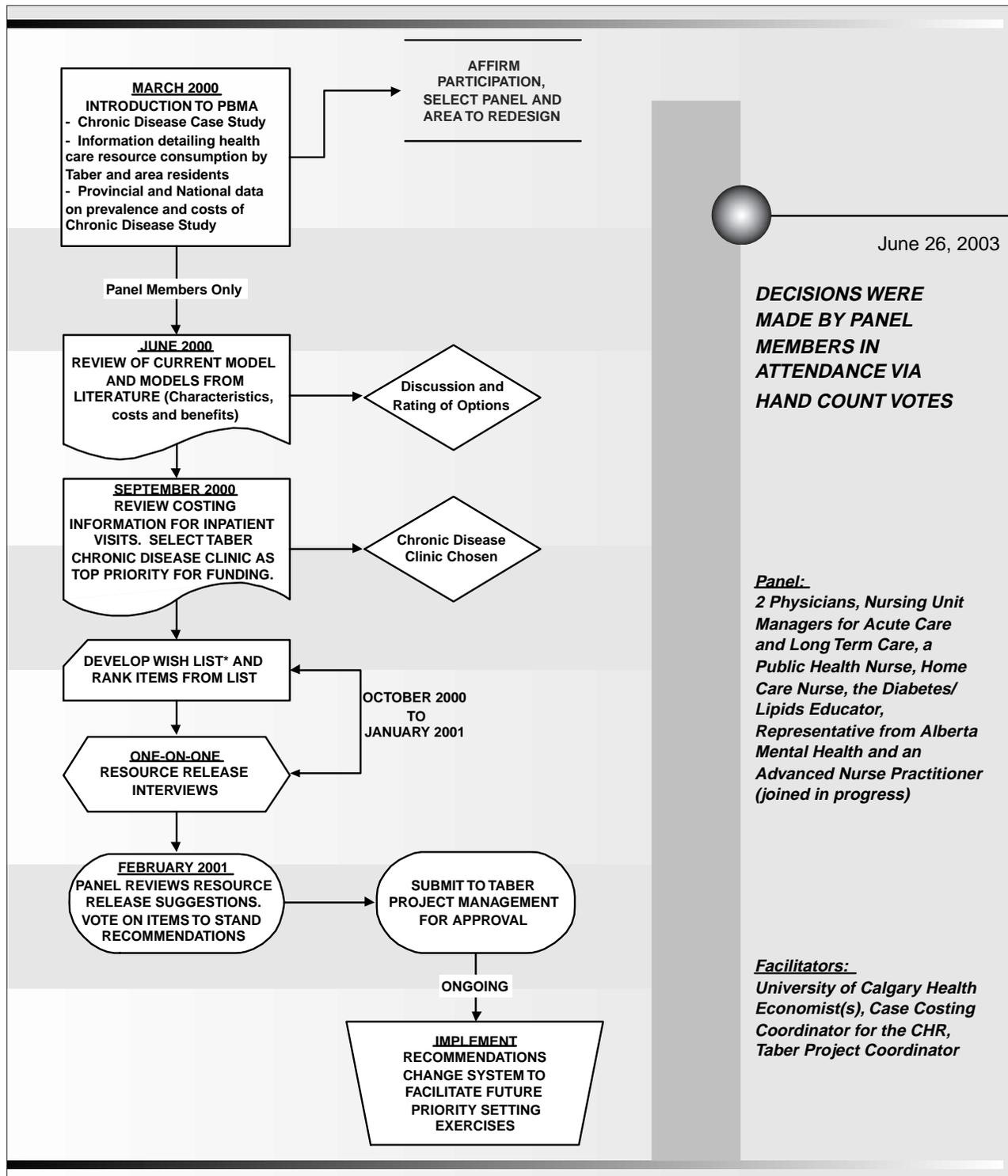


Fig. 2. The Taber priority-setting process. \*Wish list development began prior to September meeting and continued until mid-October 2000.

- providers working with chronic disease patients may have their job descriptions written or modified to formalize their involvement in the clinic.
2. The Heterogeneous Chronic Diseases Group Visit model<sup>15</sup> will be followed, or modified where appropriate. This will involve volunteer-led education sessions of 10 to 15 participants on various aspects of living with chronic disease (e.g., nutrition, exercise).
  3. Teams of health care providers will be built around the care needs of individuals with chronic diseases, and the care provided will be guided by clinical practice guidelines. Actual team members may include the following: nurse educator, physician, dietitian, respiratory therapist, occupational therapist, physical therapist, and/or pharmacist.
  4. Where appropriate, health care providers (e.g., diabetes and lipids education educator and home care) will be relocated from the health unit (about 5–10 minutes away) to the empty Taber hospital wing to increase the opportunities for contact with physicians and other health care providers.
- These recommendations were sent to the Taber Project Management Team‡ (Taber providers and senior administration from the CHR) for approval.

‡The Taber Project Management Team was established to foster communication and awareness between CHR administrators and health care providers. It also serves as a forum for fast tracking funding, staffing, program and practice requests arising from the Taber project.

Option	Description
1. Lethbridge Regional Hospital Chronic Disease Management Clinic	Increase referrals to existing clinics in Lethbridge where possible.
2. Taber Chronic Disease Management Clinic	The chronic disease clinic would educate and conduct follow-up visits with patients who have chronic diseases. Initially this would involve individuals who have asthma, diabetes or hypertension. The clinic would operate on an open referral system whereby clients register with the clinic, make appointments with educators and dietitian and/or register to attend various group sessions offered by the clinic. These sessions could be staff or client led, depending on the needs of the client. Given that asthma is often an environmentally triggered disease, the asthma educator may need to educate his or her clients somewhat differently (e.g., home visits may be required). Nurse educators will require specialized training particular to each/all of the chronic diseases they will encounter.
3. Home visits	Nurse clinicians are advanced professional staff involved in direct and indirect patient care. The primary emphasis is the independent management of direct and indirect care across practice or program areas to meet the needs of a complex patient population. They may act as a consultant to staff within or outside the facility, using their expertise regarding the specific patient population. In addition to the management of direct patient care, they are responsible for planning, developing, implementing and evaluating care programs and protocols. They often develop programs for staff, patient or family education across practice or program areas, including the incorporation of new directions, recent research results or innovative techniques. Depending on where they work and the training received, a nurse clinician may or may not diagnose and prescribe medication to clients. <u>Note:</u> for the purposes of this option, a nurse clinician is an individual who visits clients in their home to discuss treatment plans, concerns, medications, etc.
4. Peer support	Volunteer lay instructors receive training. (In the initial study, lay leaders were trained by the researchers to educate group members about how to make management choices and reach self-selected dietary, exercise and medication goals.) All of the lay leaders had chronic diseases themselves. They educated group members with various chronic diseases (e.g., heart disease, lung ailments, stroke, arthritis) in disease self-management. The groups were made up of 10–15 people of mixed ages and diagnoses and met at a community site in 7 weekly 2.5-hour sessions. Rather than prescribing specific behaviour changes, the Chronic Disease Self-Management Program leaders helped participants make management choices and reach self-selected dietary, exercise and medication goals. Participants also helped each other solve disease-related problems and discussed how to manage symptoms such as pain or fatigue.
5. Clinical practice guidelines (CPGs)	Involves issuing reminders about the CPGs, agreeing to and engaging in peer audits regarding CPG compliance, directing feedback to specific providers to modify practice (toward the CPG). Step 1. Identify areas (practices, procedures) to target. Step 2. Develop criteria for assessing compliance/application. Step 3. Audit records. Step 4. Provide feedback to peers.

\*These options do not necessarily have to be mutually independent.

Shortly thereafter, Taber health care providers began implementing the recommendations. For example, multidisciplinary care teams have been formed around chronic diseases.

### *Barriers affecting change*

Through the follow-up surveys, barriers to conducting the process were identified. Despite the changes made,

health care providers were unsuccessful in realizing their top priority, a chronic disease clinic. These barriers are classified as “barriers affecting change” (getting it done), “barriers to the priority-setting process” (getting it right) and “panel diversity” (Table 6).

### *Getting it done*

The biggest roadblock identified by participants and

**Table 3. Taber panel-generated criteria for ranking the 5 alternatives, as described in Table 2, and their rank of each option**

Criteria or rank	Alternative / Options				
	Lethbridge Regional Hospital CDM* clinic	Taber CDM clinic	Home visits	Peer support	Clinical practice guidelines
<b>Patient impact (patient outcomes, e.g., control)</b>	Geographical distance may limit effectiveness	Positive impact on patient outcomes	Positive impact on patient outcomes	Positive impact on patient outcomes	Positive impact on patient outcomes
<b>Provider impact (communication)</b>	Limited impact on Taber providers	Increases the opportunities for and channels of communication because all the providers are in one location	Limited impacts on communication; may require role clarification and redesign.	No impact for Taber providers	
<b>Resource impact</b>	Taber resources not required	Resource intensive (i.e., requires tens of thousands of dollars)	Few additional resources required.	Minimal impact, as will be held in existing community facilities during their regular operating hours.	Depends on individual physicians and practice patterns. May either increase or decrease resource consumption (e.g., for some doctors adherence may mean more lab tests being ordered; for others this could mean fewer visits).
<b>Taber group's rank of each option</b>	Poor match	Best match	Fits well	Fits well	Fits well

CDM = chronic disease management

**Table 4. Micro program budget of chronic disease inpatient cases and expenses in Taber, in the Chinook Health Region (CHR) and in the province of Alberta for 1998–1999**

Location	Total no. of patients	No. of chronic disease inpatient cases (and % of total in each location)			
		Diabetes	Asthma	Hypertension	Total
Taber	1 327	131 (9.87)	80 (6.03)	205 (15.45)	416 (31.35)
CHR (excluding Taber)	19 718	1 738 (8.81)	853 (4.33)	2 257 (11.45)	4 848 (24.59)
Province of Alberta (excluding CHR)	321 486	23 442 (7.29)	12 201 (3.80)	36 596 (11.38)	72 239 (22.47)
Location	Total expenses, \$	Expenses (\$) for chronic disease inpatient care (and % of total in each location)			
		Diabetes	Asthma	Hypertension	Total
Taber*	3 658 911	535 116 (14.62)	194 536 (5.32)	747 528 (20.43)	1 477 180 (40.37)
CHR (excluding Taber)	68 499 281	8 619 171 (12.58)	2 949 880 (4.31)	11 731 894 (17.13)	23 300 945 (34.02)
Province of Alberta (excluding CHR)	1 260 482 924	136 155 837 (10.80)	46 827 764 (3.72)	221 802 793 (17.60)	404 786 394 (32.11)

\*Expenses were calculated using the regions' costing database.

researchers was the panel's inability to release resources. This barrier was born out of a series of different, yet related, circumstances. For example, panel members have frequent contact in and out of the work setting with other health care providers working in Taber. It is believed that this familiarity served to curtail suggestions by members of what resources to release.

Of approximately 30 suggestions by panel members, only 4 carried any potential (e.g., reduce x-ray department hours at the hospital, close the satellite clinic in Vauxhall). It may be that panel members hesitated to make suggestions that would have a negative impact on their colleagues.

Further to this, several panel members were unable to generate resource-release suggestions because their programs were funded at skeletal levels. Most managers/members did not feel they knew enough about other programs to identify any resource releases beyond their own program areas. In those rare instances where suggestions involved the scaling back of existing services, other panel members did not let the items stand. It is held that the inability of Taber health care providers to release resources was due more to their living and working in a tight-knit community than to a systematic inability of health care decision-makers to reallocate resources to maximize benefits.

The fact that this exercise was undertaken as part of a pilot project on health care reform may have served to curtail the resource investments and risk-taking behaviours of those managers/program directors directly involved in this exercise. It is more effi-

Rank, staff position	Full-time-equivalent (FTE) desired	Salary, \$
1. Nurse educator	0.6*	26 700
2. Home visit / care nurse educator	1.0	44 500
3. Dietitian	0.8	35 200
4. Physician †	As needed	(Different pool)
5. Respiratory therapist	0.5	22 000
6. Counsellor	0.5	25 000
7. Occupational therapist	0.4	24 000
‡ Secretarial support	1.0	21 500
<b>Total</b>		<b>198 900</b>

\*Taber clinic already has a 0.4 FTE nurse educator from Diabetes and Lipids Education.  
 †Physicians were deemed an integral part of the clinic but not included in the calculations because they are paid separately from the Chinook Health Region budget.  
 ‡Unranked, but deemed necessary after the fact.

cient and prudent for managers to minimize resource and human investments in a project that has an uncertain future and maximize investments in projects that are guaranteed to be around for many years. Hence, some managers and program directors may have maintained the status quo with respect to allocation of resources to avoid having to undergo the staff and program changes required to return to the GPCM in the future.

Finally, some members of the panel had unrealistic expectations about what PBMA could provide them. § Three panel members expected the framework to present them with a "new-and-ready to implement chronic disease services model." However, this is not what PBMA provides. The new program model must be developed by the panel (i.e., the decision-makers) and not the framework. Further, redesigned services must be described in sufficient detail to permit accurate costing. The purpose of the exercise should be reinforced frequently to prevent panel members from holding unrealistic expectations about what the framework can accomplish.

### *Getting it right*

Although the diverse make-up of the expert panel

Barriers	Comments
Getting it Done	<p>Participants and researchers identified 5 circumstances that contributed to the panel's inability to release resources, including:</p> <ul style="list-style-type: none"> <li>• Taber's small town atmosphere made participants reluctant to reallocate resources if they would negatively impact colleagues.</li> <li>• Participants believed funding was already at bare bones level for many programs</li> <li>• Unrealistic expectations regarding PBMA</li> </ul>
Getting it Right	<p>Not all panel members were managers. This exercise was undertaken as part of a pilot project, making managers and directors more reluctant to shift human or financial resources.</p>
Panel Diversity with respect to skill sets, work experiences, expectations	<p>It was difficult to gauge how much time should be spent covering items (e.g., program budget). Spend more time at the beginning, to clarify what PBMA framework can or cannot do.</p>
PBMA = program budgeting and marginal analysis	

§This barrier became apparent to the researchers only after the exercise was well under way.

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did serve to fuel much discussion and consideration of service redesign alternatives, not all panel members were managers, and those who were, were constrained in reallocating resources by the existing management model in place at the CHR. This was identified as a problem by 4 of the panel members and by the research team. At the time of this exercise, overall authority of the various service area budgets resided with CHR senior program managers and directors in Lethbridge, and, as such, all budget requests needed to be funnelled through these individuals.

To illustrate what this meant for Taber managers, the Nursing Unit Manager of Acute Care in the Taber Hospital might have to pass a budgetary request along the chain of command 2 or 3 times before having her request reviewed. Given the different responsibilities and priorities of the individuals involved in this management model it was not unusual to encounter a significant time lag between the time of request and senior administration response time. Most of the panel members interviewed in follow-up believed that limited control over department budgets and associated wait times to process budget requests frustrated the resource reallocation efforts undertaken by panel members.

### *Panel diversity*

The different skills and work experience of panel members may have impeded the process. When presenting information, it required a significant amount of education for the panel members and effort on the part of facilitators (in planning and preparation) in order to achieve a common understanding. This was especially true when the program budget was presented. Although some panel members asked questions about the program budget, only in the follow-up survey was it discovered that 3 panel members did not understand the budget. In the words of one respondent, "stats are not my strong suit." This is perhaps not a weakness of the expert panel but of the researchers' inability to fully grasp the level of understanding of the panel. Future exercises should spend more time reviewing the program budget data shared with panel members.

The composition of the expert panel is important. These panels are an invaluable component of the priority-setting process.<sup>19</sup> In the absence of evidence from the literature, panel members can provide estimates of costs and benefits for changes to the programs or services under study, and aid in defining

those costs and benefits. Alternatively, the panel can decide if the evidence in the literature is locally applicable. For example, in the Taber exercise, literature was presented regarding the benefits of volunteer-led peer support groups. The panel rejected this option on the grounds that Taber has often experienced low numbers of volunteers in relation to health care problems.

## **DISCUSSION**

### *Judging success*

Despite reaching a consensus that a chronic disease clinic was the top priority, providers were prevented from re-designing services accordingly. Nonetheless, the panel was able to move away from a GPCM of chronic disease care and closer to a more integrated model. This outcome begs 2 questions: 1) overall, what is the effectiveness of the framework? and 2) what measures can be taken to remove or minimize the priority setting and resource-release barriers encountered in Taber?

Traditionally, the gold standard used to measure success in PBMA studies has been the level of resource reallocation.<sup>20</sup> The most successful exercises were those where the greatest number of dollars were reallocated. However, recent work suggests that this definition of success is too narrow.<sup>20,21</sup> What has been advocated instead is redefining success in priority-setting exercises to include its influence on the way of thinking in an organization.

It seems reasonable in this case study to measure success not only according to allocation amounts but, as well, the extent to which management of chronic disease services has moved away from the GPCM. Examination of the recommendations put forth by the expert panel under this broader definition suggests that the activity was at least partially successful (e.g., multidisciplinary teams have been established).¶

Process-oriented changes resulting from the exercise are not as extensive as the full-blown chronic disease clinic option nor are they completely unexpected. It has been noted<sup>22</sup> that in many PBMA studies "... suggestions deal more with the operational efficiency of services rather than allocative

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¶Other recommendations that have been put into practice include electronic co-charting, relocation of community staff into the hospital and the development of clinical practice guideline reminder sheets.

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issues about where to shift resources.”\*\* This was clearly the case in Taber, where improvements in technical efficiency were outlined (i.e., question 4 in Table 1), but little was put forth in actually scaling back or stopping current services (i.e., question 5 in Table 1). The development of a chronic disease clinic in Taber would have meant taking resources from elsewhere in the community because additional resources were not forthcoming from the CHR. In this way, responses to the easier questions of technical efficiency were put forth, and the group failed to address the much more difficult questions of efficiency in allocating resources.

### *Ways forward*

In an attempt to remove impediments to proactive priority setting, Taber health care providers and CHR administration examined the existing management structure to see what changes could be made. The Taber Integrated Primary Care Project Coordinator then presented a proposal to the CHR Regional Executive Council and Taber Project Management Team asking that the existing management structure be modified to further empower Taber health care providers and managers making resource allocation decisions.

In response to this request a number of system changes were approved and are in the process of being implemented. First, the Project Coordinator is now able to access Taber-specific information, including aggregated clinical data, financial reports and program budgets, personnel information (e.g., overtime, workload measures) and other administrative data as required for strategic planning. Second, resource reallocation can now be negotiated directly with CHR program directors. Third, CHR administration will support pre-defined coverage for Taber health care providers to participate in planning (including research), development and implementation of new initiatives. There is some concern that these changes may not have gone far enough to enable Taber managers to reallocate resources. Taber health care providers are still part of a regional structure that values regional program standards and because of this are still required to negotiate with program directors in Lethbridge.

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\*\*Technical or operational efficiency looks at the best way of achieving an objective, while efficiency in allocating resources involves objectives and allocation of resources competing with each other.

### *Reality of scarcity and generalizability*

Underfunding as a starting point for application of the PBMA framework is not unique to Taber.<sup>4,12</sup> What managers must do is look at ways of maximizing the benefits that can be accrued through optimal allocation of these resources, not become immobilized by finite or reduced resources. Indeed, in periods of stagnant or declining funding, organizations have an even greater need for a sensitive, well-grounded allocation model. Education is recommended as the vehicle of choice to drive the paradigm shift from “I can’t do that, I have no money” to “If we move \$10 000 currently allocated to Program C and reinvest it into Program B then we can improve overall benefit to the population being serviced.” Only after this way of thinking is internalized will decision-makers be able to expand their focus from the impacts of service contractions to the opportunity costs and benefits of service contractions and resultant service expansions.

Health care decision-makers who work in rural settings characterized by a small service mix, resource scarcity and limited autonomy in resource reallocation may find the information contained herein on the barriers to priority setting relevant for 2 reasons. First, the barriers to priority setting in Taber have been described in length. It is not unrealistic to expect that some of these barriers will be encountered in other rural communities. Thus, this knowledge may aid these communities in avoiding or reducing the impact of these barriers. Second, the suggestions for moving forward (e.g., new management structures) in the face of barriers to explicit priority setting may also be relevant elsewhere, as rural communities are challenged with making localized decisions while often being a part of a larger, regional decision-making body.

As with any case study, the degree to which the findings can be generalized is always in question. The fact that not all members of the expert panel participated in the follow-up interviews is another study limitation that must be considered when interpreting study findings. Nonetheless it is both plausible and probable that many of the system barriers encountered in Taber exist in other rural settings. Similarly suggestions for moving forward may also be transferable to different settings in rural Canada.

### **CONCLUSION**

Perhaps the most important lesson learned from this case study is that health care decision-makers not

only require frameworks to set priorities for health care services but they need support in overcoming built-in system barriers. For decision-makers residing in rural communities this may require an additional step: revamping the organizational reporting structure and allocation processes to reduce time lags in the process and to incorporate evidence and local expertise. If increasing demand and existing regional management structures are the "big bad wolves" facing rural decision-makers, then perhaps PBMA is the brick house that will allow managers to set, support and implement their priorities and keep the house from blowing in. Based on this case study it is recommended that the PBMA framework be used in similar endeavours in the future in both Taber and at a regional level.

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