Priority-setting and hospital strategic planning: a qualitative case study

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Objectives: To describe and evaluate the priority-setting element of a hospital's strategic planning process.

Methods: Qualitative case study and evaluation against the conditions of 'accountability for reasonableness' of a strategic planning process at a large urban university-affiliated hospital.

Results: The hospital's strategic planning process met the conditions of 'accountability for reasonableness' in large part. Specifically: the hospital based its decisions on reasons (both information and criteria) that the participants felt were relevant to the hospital; the number and type of participants were very extensive; the process, decisions and reasons were well communicated throughout the organization, using multiple communication vehicles; and the process included an ethical framework linked to an effort to evaluate and improve the process. However, there were opportunities to improve the process, particularly by giving participants more time to absorb the information relevant to priority-setting decisions, more time to take difficult decisions and some means to appeal or revise decisions.

Conclusion: A case study linked to an evaluation using 'accountability for reasonableness' can serve to improve priority-setting in the context of hospital strategic planning.

Introduction

Hospitals account for a large proportion of health expenditures in every health system. For example, in 1999, 32% of Canadian health care spending went on hospitals.[1] Moreover, hospital boards and managers in every health system face the challenge of responding to changing demand patterns and providing quality care, while maintaining the 'bottom line'.[2] Many physicians practice some or most of the time in hospitals and are also involved in management, including setting priorities for the delivery of care. How hospitals set priorities is, therefore, a huge concern to physicians, board members, senior administrators and, of course, patients.

Although priority-setting occurs at all levels of the health system, most priority-setting research has focused on the macro (i.e. health system) or micro (i.e. bedside) policy-making levels. Although there is an emerging literature focused on priority-setting at the 'meso' level of policy-making, which includes hospitals,[3–8] no study has focused on priority-setting in the context of hospital strategic planning.

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Describing the process of strategic planning in a hospital is a necessary first step towards understanding and improving the process. As a second step, because what hospitals do may not be what they should do, it is necessary to go beyond description to evaluate the quality of the priority-setting process. 'Accountability for reasonableness' (AFR) has been recognized internationally as an appropriate ethical framework for evaluating priority-setting in health care institutions.[9–12] To date, it has not been used to evaluate priority-setting in the context of hospital strategic planning.

The purpose of this study was to describe priority-setting in the context of a hospital strategic planning initiative and to evaluate it against the conditions of AFR. The specific question addressed was: how well does this hospital's strategic planning initiative comply with the conditions of AFR?

Methods

Design

To describe priority-setting, we undertook a qualitative case study. A case study is 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context'.[13] The case study method is appropriate because priority-setting in hospitals is complex, context-dependent and involves social processes. To evaluate priority-setting, we compared the descriptive findings with the ethical framework of AFR described below.

Setting

Our study focused on a strategic planning initiative at Sunnybrook & Women's College Health Science Centre (S&W) in 2001. S&W is a tertiary-care teaching hospital, affiliated with the University of Toronto, and is the result of a recent amalgamation of three hospitals. It includes 612 acute-care beds, 543 long-term care beds, 74 nursery beds and 22 rehabilitation beds, with a total budget of CAN$455 million.

Sample

We included all key documents and meetings, and sampled key people using a combination of theoretical sampling (people who were involved in some significant aspect of the priority-setting initiative as identified by participants) and convenience sampling (people who were available).

Data collection

The dataset consisted of three sources: key documents (strategic planning documents); interviews with key informants (senior management); and observations of group deliberations (so-called 'decision days'). Key documents were obtained in electronic form when possible. Key informant interviews were audiotaped and transcribed. Observations of meetings were described in field notes taken by the researchers. An initial interview guide was developed based on the relevant literature and previous research. Participants were asked to describe the priority-setting process, their role and their reflections about the process (interview guide available upon request). The interview guide was revised during data collection and analysis to exploit emerging findings.[14] In addition, participants were asked to refine the recommendations for improvement to make them more relevant in their context.

We collected over 200 pages of documents, including: e-mails regarding the two decision days; written responses/comments; minutes of meetings of senior management, operations committee, medical advisory committee and board; a decision tree diagram; and the executive summary of the operating plan. We conducted ten individual and four focus group interviews with a total of 45 people, including board members, senior management, operational and clinical programme managers and medical chiefs/directors. We observed two decision days and one post hoc forum of senior management.

Data analysis

Analysis of the data consisted of a modified thematic analysis organized into two phases: open and axial coding.[15] In open coding, the data were read and then fractured by identifying chunks of data that related to an idea (decisions, participants, agreement mechanism, objectives, timing, information). In axial coding, similar ideas were organized into overarching themes, which were the four conditions of AFR.

We addressed the validity of our findings in six ways.[16] First, we triangulated data from three different sources (documents, interviews and observations) to maximize comprehensiveness and diversity.[17] Second, two primary researchers coded the raw data. Third, along with the primary researchers, a third researcher participated in the development of the coding framework. Fourth, members of an independent interdisciplinary research group, consisting of a philosopher, nurse, hospital administrator and bioethicist, enhanced the 'reflexivity' in the analysis by becoming familiar with the data and participating in the data analysis. Thus, the role of prior assumptions and experience, which can influence any inquiry, were acknowledged and examined. Fifth, all research activities were rigorously documented to permit a critical appraisal of the methods.[18] Sixth, a draft report was distributed throughout the organization and comments were invited. The participants verified the accuracy of the report and the reasonableness of the findings. Furthermore, at a subsequent strategic planning meeting involving the top managers in the organization, the participants were asked whether the case study description adequately captured the 2000–2001 priority-setting initiative. Forty voted 'yes', one voted 'no'.

Conceptual framework

To evaluate the case study description we used the AFR framework developed by Daniels and Sabin.[19–21] According to AFR, an institution's priority-setting decisions may be considered fair if they satisfy four conditions: relevance; publicity; appeals; and enforcement (described in the Table).

Research ethics

The board and senior management of S&W agreed to participate in the project and approval was obtained from the University of Toronto Human Subjects Review Committee. Written informed consent was obtained from each individual before they were interviewed. All raw data were protected as confidential and available only to the research team. No individuals have been identified in dissemination without their explicit agreement.

Table   The four conditions of 'accountability for reasonableness'

Condition	Description
Relevance	Priority-setting decisions must rest on reasons (including information and principles) that fair-minded parties can agree are relevant to meeting context-specific needs under resource constraints. Fair-minded parties are stakeholders who are predisposed to decision-making according to rules of mutual cooperation.
Publicity	Priority-setting decisions and their rationales must be publicly accessible.
Appeals	The priority-setting process must include a mechanism for challenge and dispute resolution regarding priority-setting decisions.
Enforcement	There must be voluntary or public regulation to ensure that the first three conditions are met.

Results

Description of the strategic planning process

In 2001, in the wake of the amalgamation of three organizations, the senior management of S&W launched an innovative priority-setting exercise to guide future decision-making. In the background were three issues: the organization and management structure was still perceived as fragmented; the hospital had a major budget deficit ($30M); and there was pressure from the board for the organization to become more focused by deciding what its core activities should be.

The cornerstones of the priority-setting initiative were two 'decision days', six weeks apart. Decision day 1 involved members of senior management, clinical operations, programme administrative and medical leaders, nurses, other clinicians and other corporate managers. For decision day 2, the list of participants grew to include medical chiefs and heads not necessarily involved in senior management activities. Most participants were invited by senior management and some were recommended by programme leaders.

In preparation for the first decision day, an extensive information-gathering exercise assembled statistics for each clinical management grouping, including patient data. The information was distributed to all participants between one and five days before decision day 1. E-mail correspondence was sent 24 hours before decision day 1 with the agenda and expectations for the day. A decision tree was created by members of the senior management team to facilitate decisions about clinical service priorities (CSP).

Decision day 1 focused on a major reorganization of hospital programmes. The primary task was to select, from nine existing programmes, five priority programmes or CSPs that would get preferential treatment in subsequent allocation of resources. The five programmes selected were cardiac care, musculoskeletal care, perinatal and gynaecological care, trauma care and cancer care; these accounted for approximately one-half of the total hospital services. During decision day 1, decision-makers were to vote openly (show of hands) with no abstentions. Participants agreed that the next steps involved developing a plan to implement the CSPs and finalizing the 2001/2002 operating budget.

Between decision days, a CSP workbook was created to assist individual programmes to prioritize their work according to the five CSPs, and to address the deficit problem. Programme consultation meetings were held over a one-week period to review the CSP workbooks and generate feasible solutions for reducing the deficit. At the end of the consultations, 78 CSP workbooks were completed and a budget strategy was developed.

Decision day 2 focused on the development of the 2001/2002 operating budget. Seventy decisions were made: 47 initiatives for expense reductions (e.g. eliminate 100 hours per year of cystoscopy time); operational efficiency (e.g. consolidation of laboratories, clinics and inpatient units) and increased focus (e.g. potential transfer of adolescent psychiatry to another institution); 14 initiatives that would not proceed without additional funding; and nine initiatives that would be targeted for investment within the 2001/2002 budget. The voting mechanism was the same as on decision day 1. The next steps included a communication strategy to present the decisions.

Evaluation of the strategic planning process using AFR

Relevance condition

An enormous volume of information was captured and shared within the institution in a limited time. However, most participants felt that, in order to improve decision-making, additional information was needed. For example, information that may have relevance to decision-making but was not part of the process included: information about community initiatives; Ministry of Health funding calculations; and educational priorities originating at the university that might influence prioritization of the hospital's clinical programmes. One participant said: 'A fair minded person would have trouble voting on items with less than full information'.

Senior management made an effort to include many of the organization's people in the decision-making. Sixty-eight participants were invited to be decision-makers during the decision days. However, participants expressed concerns about finding the right balance between inclusivity and getting the 'right' people making decisions. For example, some participants were not sure why they had been invited to participate when others were not, and why they were made to vote on areas outside their specialty.

The voting process was clear, simple and open. However, most felt that it caused pressure to vote on a superficial level without adequate time to consider all relevant information or review the potential consequences of each decision. Many participants recommended a closed, or secret, voting process that permitted abstentions.

The goal of the priority-setting exercise was 'to operationalize the strategic directions within the fiscal realities of the organization'. However, some participants remained unclear about whether the exercise was focused on strategic (i.e. hospital's strengths) or operational goals (i.e. budget pressures).

Participants felt pressured to make decisions for the April 2001 operating plan submission. Consequently, many felt that they were given insufficient time to review the volumes of information and consider the consequences of their decisions.

Publicity condition

The process of priority-setting was clearly communicated to all decision-makers. Everyone had a clear understanding of what was required to meet board pressures, though most were uncertain about the 'why' or 'how'. However, the

process for identifying individual decisions taken during the decision days was not transparent. Communications to decision-makers arrived anywhere from five days to 24 hours prior to decision day. Participants commented that this was insufficient to absorb all the information relevant to taking tough decisions.

Multiple modes of communication were used, including: broadcast e-mail; intranet posting of presentations; internal newsletter; and special meetings with board committees. Post-decision day information was delivered hospital-wide within 48 hours. The explicit message focused on what was required to operationalize the strategic goals; the implicit message was that some programmes/people might be cut. Informal communication arrived to staff by 'word of mouth'. Some front-line staff felt that they did not have adequate information to assess the likely impact of the decisions on their livelihoods, and that this uncertainty damaged morale.

There was relatively little communication with external partners and affiliates (Ministry of Health and Long-term Care, the university, other hospitals, community links) or the general public. Patients were made aware of the initiative through internal newsletters.

Appeals condition

The exercise did not include a formal appeals mechanism and some challenges were made regarding the fairness of the voting mechanism and the information that was perceived to be missing. In one instance, clinicians in a programme, dissatisfied with the process, used the media to publicize their concerns. Many participants argued in favour of an appeals or revisions process.

Enforcement condition

The inclusion of an ethical framework (AFR) to evaluate the priority-setting process was strongly supported by senior management and other participants.

Our findings were distributed in the form of a draft report throughout the organization, and another decision day was held to consider the report and subsequent recommendations for improvement. This was a vital step towards meeting the enforcement condition. The participants voted to accept the recommendations and they provided refinements that would help operationalize the recommendations. They conducted a closed (secret ballot) vote to determine the process they would follow for the upcoming budget cycle in response to the following question: Do you agree that the process of priority-setting for the upcoming budget cycle will be what we did last year *plus* the recommendations in the report *plus* refinements provided by today's discussion, and that we should repeat the case study and evaluation leading to further research-based revisions? Participants agreed 52 to four.

Discussion

How well did this hospital's strategic planning initiative comply with the conditions of AFR? The hospital's

processes went a long way towards meeting the conditions of AFR. Specifically, the hospital based its decisions on reasons (both information and criteria) that the participants felt were relevant to the hospital; the number and type of participants were very extensive; the process, decisions and reasons were well communicated throughout the organization, using multiple communication vehicles; and the process included an ethical framework linked to an effort to evaluate and improve the process. These elements that comply with AFR can be considered examples of 'good' practice in regard to hospital priority-setting.

In addition to identifying 'good' practices, we have also identified opportunities for improving the fairness of this hospital's priority-setting process that flow from the analysis. In particular, we have identified eight recommendations for improvement (see the Box).

We recognize that the primary limitation of this analysis is its generalizability. Our results from a large urban university-affiliated hospital may not be generalizable to other teaching hospitals, general hospitals (either urban or rural), or specialty (e.g. children's) hospitals. However, generalizability is seldom an all-or-none phenomenon. Fairness is a common goal for priority-setting and every hospital engages in strategic planning. It is likely that other hospitals will 'see themselves' in our findings and that at least some of our lessons will be helpful to them.[22] Thus this study will be of general interest to all physicians who work in hospitals and are involved in strategic planning, as well as hospital administrators. In addition, although each hospital will have different clinical and financial goals for its priority-setting, the key outcome in the context of this paper is not the particular details of what is achieved, but whether the process improves. Fairness is a relative concept, lying along a spectrum. Even if a particular institution appears to undertake priority-setting well (i.e. fairly), its processes may still be improved (i.e. made more fair). Our ultimate aim is to improve priority-setting, not achieve predetermined standards.

An additional limitation of this study is that we have not examined the consequences of the recommended changes. This study is a first step in a process of evaluation and improvement in priority-setting at this hospital. It will be important to continue the case study through subsequent budget cycles to evaluate the effect of these recommendations on priority-setting at the hospital.

This research is innovative in two ways. To our knowledge, this is the first description of hospital priority-setting focusing on the entire range of priority-setting decisions and with evaluation using AFR. Previously, AFR has been used to evaluate priority-setting at the level of health systems, not provider institutions. For example, Ham examined 'contested decisions' in the UK National Health Service;[9,23] Norheim analysed priority-setting at the health system level in Norway;[11] and Martin and Singer examined priority-setting for health technologies in Canada.[12]

> **Box** Eight recommendations to improve priority-setting in the hospital
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> 1. Ensure that all relevant information is included (e.g. information about academic and community impact). An analysis of the impact of decisions on community needs must be conducted.
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> 2. Reconsider certain critical elements of the decision-making process (e.g. group size, meeting frequency) to permit a thorough discussion of the reasons for priority-setting decisions.
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> 3. Reconsider the mechanism for reaching agreement. Use a 'closed vote' (secret ballot) agreement system with abstentions.
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> 4. In communications, clarify basic aspects of decision-making, such as the relationship between operational and strategic planning, how the strategic directions were derived, what the designation of a 'clinical service priority' implies, and develop a method to communicate progress on the decisions and their impact.
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> 5. Start the priority-setting process early so the timing can be more relaxed and the relevant information can be reviewed by participants well in advance of each meeting.
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> 6. Develop a formal communication plan to support the strategic planning process. The focus of this communication plan should be on the consistency of messages to the hospital staff and on reaching out to the hospital's broader community to ensure it is aware of the process, the decisions and the reasons for the decisions.
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> 7. Develop a formal appeals process. Designate the conditions under which appeals may be made (e.g. new evidence or arguments) and the person to whom appeals should be addressed.
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> 8. Repeat the case study during the next budget cycle to assess the effectiveness of these recommendations and provide further evidence-based recommendations for improvement.

The second innovation in this research is moving beyond merely studying to improving. We used the ethical framework of AFR to evaluate the strategic planning process, and developed a small number of clear, practical, focused and easy-to-implement recommendations for improvement. These recommendations were overwhelmingly supported by the participants, who also provided refinements that made the recommendations more practicable; at the time of writing, the organization has implemented seven of the eight recommendations. We propose that this research process – a case study linked to an evaluation using AFR – can serve as a model for improving priority-setting in hospital strategic planning.

Acknowledgements

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