BMC Health Services Research

Research article

Priority setting in the provincial health services authority: survey of key decision makers

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Published: 12 June 2007

BMC Health Services Research 2007, **7**:84 doi:10.1186/1472-6963-7-84

Received: 8 January 2007
Accepted: 12 June 2007

This article is available from: http://www.biomedcentral.com/1472-6963/7/84

Abstract

Background: In recent years, decision makers in Canada and elsewhere have expressed a desire for more explicit, evidence-based approaches to priority setting. To achieve this aim within health care organizations, knowledge of both the organizational context and stakeholder attitudes towards priority setting are required. The current work adds to a limited yet growing body of international literature describing priority setting practices in health organizations.

Methods: A qualitative study was conducted using in-depth, face-to-face interviews with 25 key decision makers of the Provincial Health Services Authority (PHSA) of British Columbia. Major themes and sub-themes were identified through content analysis.

Results: Priorities were described by decision makers as being set in an ad hoc manner, with resources generally allocated along historical lines. Participants identified the Strategic Plan and a strong research base as strengths of the organization. The main areas for improvement were a desire to have a more transparent process for priority setting, a need to develop a culture which supports explicit priority setting, and a focus on fairness in decision making. Barriers to an explicit allocation process included the challenge of providing specialized services for disparate patient groups, and a lack of formal training in priority setting amongst decision makers.

Conclusion: This study identified factors important to understanding organizational context and informed next steps for explicit priority setting for a provincial health authority. While the PHSA is unique in its organizational structure in Canada, lessons about priority setting should be transferable to other contexts.

Background

Due to limited resources, health care decision makers must make choices about what services to fund and what not to fund. This process of priority setting has traditionally been shaped by organizational cultures where norms and incentives have implicitly supported historically-based resource allocation processes [1]. That is, in most health care organizations, the process underlying decision making is based on the previous year's expenditure being rolled over to the current year, with some political and/or demographic adjustments. This can lead to 'allocation by stealth' and enables politics to directly enter into the fray [2]. The problem is, over the last decade, decision makers in various organizations across countries have expressed