The Best Use of Available Resources
An approach to prioritisation
Foreword

This resource is the product of a joint District Health Boards and Ministry of Health initiative. It provides for a common approach to the prioritisation of health and disability services.

District Health Boards and the Ministry of Health are required to carry out principles-based prioritisation processes in order to meet the objectives of the New Zealand Public Health and Disability (NZPHD) Act 2000. In order to recognise and respect the principles of the Treaty of Waitangi, and with the view to improving health outcomes for Māori, the NZPHD Act provides for mechanisms to enable Māori to contribute to decision-making and to participate in the delivery of health and disability services. District Health Boards are required to take He Korowai Oranga, the Māori Health Strategy, into account in meeting their statutory objectives and functions for Māori health. The process set out in this document aims to assist funders of health and disability services with the requirement to undertake prioritisation. It also provides a means by which the objectives and kaupapa of He Korowai Oranga can be incorporated into their prioritisation activities.

In developing this resource the working group has built on what has gone before. It has made extensive use of the work of the former Health Funding Authority, the National Health Committee and other relevant New Zealand and international work.

This previous work has shown that prioritisation decisions must be guided by the principles or values that are important to the society in which the decisions are made. Over time a number of principles have consistently emerged as appropriate in guiding decision-making about publicly funded health care in New Zealand (Health Funding Authority 2000). These are:

- **Effectiveness**: Publicly funded health and disability services should be effective. Effective services are those that produce more of the outcomes we desire, such as reductions in pain, the maintenance of daily activities, greater independence and the prevention of premature death.
• **Equity:** Services that reduce significant inequalities in the health and independence of New Zealanders are given a higher priority.

• **Value for money:** New Zealanders should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.

Previous work has also consistently identified the need to improve Māori health outcomes.¹ The working group has adopted the concept of whānau ora from He Korowai Oranga to ensure that Māori health is taken into account.

Whānau ora means considering effectiveness, value for money and equity for Māori from a Māori perspective. It also recognises that prioritisation processes should enable Māori to participate in and contribute to strategies for Māori health improvement, and foster the development of Māori capacity to participate in the health and disability sector.

This resource provides a framework for funders of health and disability services to gather and assess evidence about how services contribute to the principles of effectiveness, value for money and equity, and the achievement of whānau ora.

It provides a process that allows decision-makers to make informed judgements about what services to fund, in a transparent and consistent way. Funding decisions that are consistent and transparent will help maintain and increase the trust of New Zealanders in the public health and disability sector.

The working group’s process is not mandatory. It is offered to funders of health and disability services as a way forward in achieving the best use of available resources and increasing the consistency and coherence of funding decisions. Ultimately we all want to see the greatest benefit arising from health and disability funding, resulting in increased health status and independence for all New Zealanders, and reduced inequalities.

¹ As a population group, Māori continue to have the poorest health status of any ethnic group in New Zealand (Ministry of Health 2003).
How to Use This Resource

This resource has been developed so that it is accessible to different audiences. For example, Board members will require an overview of the framework while District Health Board and Ministry analysts will require more detailed guidance on how to undertake a prioritisation analysis.

The booklet provides the overview. More detailed information and guidance is available on the accompanying CD.

On the CD you will find both the information contained in the booklet and links to more detailed information. The resource has been designed to allow readers to ‘drill down’ to increasingly detailed information as their needs and interests require.
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What is Prioritisation?

‘Prioritisation is concerned with how we make decisions about what health and disability services or interventions to fund, for the benefit of New Zealanders, within the resources available’ (Health Funding Authority 2000).

Prioritisation is about managing existing services effectively as well as making decisions about what new services to fund.

Why Prioritise?

Prioritisation provides an opportunity to allocate or reallocate funding, on the basis of evidence, to services that are more effective in improving health and independence and reducing inequalities.

The necessity to prioritise is often linked to resourcing levels – the more constrained the resources the more prioritisation is needed. But the need to prioritise is not only driven by constrained resources. Even in an environment of plenty, decision-makers need to be aware of the 'opportunity cost' of funding decisions, that is, what the value of the chosen service is compared to alternative uses of the funds.

The health sector operates in a continually changing environment. Many past funding decisions have led to a growth in expenditure that was neither envisaged nor desired. If a funder allows expenditure on a particular service to grow in an uncontrolled way at the expense of other services, then a decision not to intervene is, in effect, a prioritisation decision. The risk for the funder is that major prioritisation decisions will be made this way rather than through a considered prioritisation process.
Over time changes will occur that may affect whether some services should continue to be funded. Changes may occur in the community’s needs or there may be significant changes in medical technology or accepted clinical practice. Services that were funded with high hopes of providing significant health gain or contributing to reducing inequalities might not be as effective as originally supposed. An important part of managing services effectively is giving consideration to whether they should continue to be funded.

Ensuring that services are both accessible and appropriate for the population groups they are intended for is recognised as being fundamental to achieving health gain. Prioritisation provides an opportunity to shift funding towards services that are more accessible and appropriate for Māori and other groups where there is high need.

In the past, funders of health and disability services have had few tools or processes for evaluating demands to extend existing services, fund new services or adopt new technology. The prioritisation process is a way of managing these demands, although this does not imply that funders of health and disability services should be bound to process any or all demands from outside sources for additional funding.

The prioritisation process outlined in this document is a way forward in achieving the best use of the resources available for health and disability services. It provides a means by which decision-makers can make informed prioritisation decisions in a transparent and systematic way.

The Context for Prioritisation

Prioritisation occurs at all levels of the health and disability sector. This process, involving the Ministry of Health and the District Health Boards and other funders of health and disability services, sits at the ‘meso’ level between the decisions taken by government regarding the overall level of (and priorities for) Vote Health and the decisions made by clinicians and providers.
Figure 1: Levels at which prioritisation occurs

Prioritisation at the meso-level cannot take place in isolation from macro and micro-level decision-making responsibilities and prerogatives.

**Meso and macro-level prioritisation**

Meso-level prioritisation is driven by the direction set in priority-setting documents such as the New Zealand Health Strategy, the New Zealand Disability Strategy, He Korowai Oranga, the Primary Health Care Strategy, District Strategic Plans and the Ministry of Health’s Statement of Intent. Along with the Service Coverage Schedule these documents serve to define the boundaries within which prioritisation processes can be carried out.
Prioritisation and strategic planning

Strategic planning at the meso-level will reflect national priorities and the priorities and needs of local communities. Comparing these plans with current spending should help to identify areas for further analysis, either because the services identified appear not to fit with the strategic direction desired by the community, or there are service gaps. This type of exercise helps to answer the question:

- Are we funding the right things?

Further analysis of the identified services or service gaps will help to answer questions like:

- Are we doing it right? (that is, is the service effective in achieving our strategic goals?)
- Are we doing it in the right amounts?

Answers to these questions may provide useful input into future strategic planning. For example, a finding that services designed to treat a particular condition, or a particular population, are ineffective may lead to a change in strategic direction to focus on preventive care, or focus instead on interventions that may be more effective in improving the health and independence of the disadvantaged population group. In this way, prioritisation at the meso-level helps to inform strategic planning as well as ensuring that the services delivered are effective in achieving the goals underpinning strategic plans.

Prioritisation at the meso-level can provide funders of health and disability services with a mechanism through which they can identify the need to seek agreement to service change or the need to develop a business case for capital development. These processes can also ultimately inform and influence overall priority setting for the health and disability sector.
Meso-level prioritisation and ethics

Prioritisation decisions are rarely ‘purely good’ in that they almost always result in winners and losers, sometimes with tragic consequences for individuals and whānau. The morality and ethics of those involved in the prioritisation processes at the various levels are derived from a ‘special morality’, that is, there are special duties, obligations and rights of a role that do not apply to those not in that role. The ‘moral authority’ for that role is derived from it being part of an institution (for example, a District Health Board) that is thought to be socially beneficial.

At each level of the prioritisation process individual decision-makers can be seen to be operating within the special morality of their particular role. The special morality of each of these roles can be seen to have limits. Accountability to the public limits the actions of politicians operating at the macro-level. Professional ethics limit the actions of clinicians operating at the micro-level. The role of the non-elected official operating at the meso-level is, however, more ethically problematic and less clear cut. It is dependent on decision-making processes that are principles-based, transparent, inclusive and avoid deception.

Meso and micro-level prioritisation

It is important to recognise that prioritisation at the meso-level impacts on the scope of the decisions that clinicians can make at the micro-level. Clinician involvement in the prioritisation process will be vital for the successful implementation of prioritisation decisions. Clinicians are also a source of expertise for advice on the effectiveness of health and disability services. Their involvement will contribute to the robust analysis of prioritisation proposals and to informed decision-making.
Prioritisation and its Contribution to He Korowai Oranga

He Korowai Oranga (Minster of Health and Associate Minister of Health 2002) reflects an expectation that there will be a gradual reorientation of the way that Māori health and disability services are planned, funded and delivered in New Zealand. It outlines how funders of health and disability services should work to achieve whānau ora by:

- working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- involving Māori at all levels of the sector including decision-making, planning, development and delivery of health and disability services
- affirming Māori approaches to health and disability.

The prioritisation process outlined in this document provides a mechanism for funders of health and disability services to meet these expectations.

The relationship (and the difference) between whānau ora and equity

The overall aim of He Korowai Oranga is whānau ora: Māori families supported to achieve their maximum health and wellbeing. Whānau is recognised as playing a central role in the wellbeing of Māori and is key to improving Māori health and wellbeing.

It is recognised that to be effective, health care for Māori must be delivered in partnership with Māori and in ways that accord with Māori culture, practices and beliefs.

Equity requires that current disparities in health and wellbeing are addressed. Disparities between the health status of Māori and other New Zealanders are well documented.
An equity approach recognises that it may be important to work with people differently in order to work towards more equal outcomes.

Whānau ora in the prioritisation process provides a framework for analysis and decision-making that will contribute to reducing inequalities for Māori and lead to effective health care for Māori and whānau ora over time.

**Overview of the Process**

The diagram below illustrates the structure of the prioritisation process.

The adoption of the triangle motif for the prioritisation process reflects the foundation of identification and analysis as the basis for decision-making and the alignment of this process with He Korowai Oranga.

In practice there will be iteration between the identification, analysis and decision-making points of the triangle. But for the purposes of explanation, the process is outlined as follows.
Identification

The identification of services for prioritisation will arise out of the needs assessment process, other planning, monitoring and prioritisation processes and consultation with stakeholders. Other services for prioritisation will be identified as potentially contributing to the direction set in the New Zealand Health Strategy, the New Zealand Disability Strategy, District Strategic and Annual Plans, the Ministry of Health’s Statement of Intent and He Korowai Oranga.

Analysis

Within a principles-based prioritisation process it is important that decision-makers are provided with evidence about how services will contribute to the principles that guide funding decisions. This document provides guidance on how to gather evidence and make recommendations about how services will contribute to the principles of equity, effectiveness, value for money and the achievement of whānau ora. Because prioritisation decisions must be made within constrained resources, this resource also provides guidance on the information required to assess the impact of the proposal on the budget and other resources.

Decision

The process outlined here is a resource to assist the funders of health and disability services to make prioritisation decisions. The analysis undertaken as part of this process will not deliver ‘the decision’. The process does provide a means for the decision-making body to make decisions based on the evidence, consistent with its principles, its goals and obligations, and within its budget. In making the final allocation decision, consideration will also need be given to the objectives and priorities set for the health and disability sector, ethical considerations, and how acceptable the decision will be to stakeholders within the community, including Māori and providers.

The three keys stages of the prioritisation process are outlined more fully in the sections that follow.
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The Identification of Health and Disability Services for Analysis

There are various processes already undertaken by the funders of health and disability services that can help identify services or service areas for analysis. These include:

- the needs assessment process\(^2\) which identifies health status and inequalities in health status between different population groups
- service provision information which identifies gaps and duplications in service provision
- inequalities in access to services already provided
- local consultation and feedback from clinicians, the public and interest groups including iwi, hapū, whānau and Māori communities
- shifting priorities caused by changes in the social, political or demographic environment
- other planning processes which have identified new initiatives with the potential to achieve the objectives and priorities in the

\(^2\) Needs assessment is required of District Health Boards under the New Zealand Public Health and Disability Act (2000).
New Zealand Health Strategy, the New Zealand Disability Strategy, District Strategic and Annual Plans, the Statement of Intent and He Korowai Oranga

- national initiatives, including the New Zealand Health Strategy
- programme approaches\(^3\) that reveal how shifting resources from one service area to another can more effectively achieve the objectives of the programme within the available resources
- the results of routine monitoring and evaluations of particular programmes or services.

Services may also come to attention because they ‘stand out’ in one or more of the following ways:

- the service is high cost (both in total and per person) relative to the budget constraint
- there appear to be constraints that are impacting on the quality and effectiveness of the service (eg, workforce or capital constraints)
- there appears to be a disparity between the research evidence and current practice
- concerns have been raised about the relative value for money of the service
- concerns have been raised about the impact of a service on current inequalities, or about access to a service by different groups, or about variations in a service between different areas
- there is a clear misalignment between the service being delivered and strategic priorities
- there is evidence of wide variation in practice either within a District Health Board or between District Health Boards
- the potential to improve outcomes has been identified.

\(^3\) An example of a programme approach is ‘reducing the incidence and severity of cancer’. Many services at different levels contribute to this objective, but overall the programme objective may be more effectively achieved through a re-allocation of resources between these services.
Funders of health and disability services may also choose to use the prioritisation process to:

- manage demands for funding new services from interest groups
- provide input to the pricing process
- provide robust evidence to support a change in service coverage agreements.

It is hoped that in using this prioritisation process, funders of health and disability services will, over time, develop consistent and consultative approaches in identifying services for analysis.

**Analysing Health and Disability Services**

Within a principles-based prioritisation process it is important that decision-makers are provided with evidence about how services contribute to the achievement of the principles that guide funding decisions.

Gathering and analysing evidence however, is not a ‘black box’ to be undertaken in isolation from the rest of the prioritisation process. Once a service has been identified for analysis the decision-maker will need to work closely with the analyst in framing the appropriate questions to be answered. This will ensure that the analysis will...
generate the information that will be most helpful to the decision-maker in making a decision. It is also important at the outset to determine how much analysis is required. This will depend on the nature of the proposed change (the number of people involved, the impact on the budget etc) and whether the proposed change will require a change to service coverage agreements.

This resource has adopted the principles of effectiveness, equity, value for money and the achievement of whānau ora. It provides guidance on how to answer the following types of questions.

- How effective is the service in improving health status compared to an alternative?
- How does the service address equity, that is reduce inequalities in health and independence?
- Does the service provide value for money compared to the alternatives?
- How does the service contribute to the achievement of whānau ora?
- What will the service cost?
- Are there any constraints that might limit or prevent the implementation of this service?

Making recommendations

The role of the analyst is to present the evidence in a clear and accessible manner that will allow the decision-maker to make an informed decision. The analyst’s report should therefore:

- make specific recommendations based on the analysis for consideration by decision-makers
- provide guidance on how to interpret the analysis
- recommend whether an evaluation of the service should be undertaken at some future date
- avoid recommending further research.
Your organisation may already have templates for formatting papers to your Board or Executive Team. Analysts may also find templates produced by the Scottish Intercollegiate Guidelines Network (SIGN) a useful way of presenting their analyses.

Making the Decision

Considering the evidence

The analysis should provide decision-makers with evidence about the impact of the proposal on the effectiveness and value for money dimensions of the proposal, on equity, and on the achievement of whānau ora. In providing their advice to decision-makers the analyst will also have made recommendations as to how the evidence should be considered.

The analysis will not produce ‘the decision’. The decision-maker will be required to make a judgement, on the basis of the evidence, whether funding the service will make the best use of the resources available.

4 www.sign.ac.uk/guidelines/fulltext/50/annexe.html
Many factors will impact on the final decision to support a proposal or whether a proposal can proceed. In addition to the evidence around the principles, the analyst will have provided an assessment of the:

- costs of the proposal
- other resource implications.

Decision-makers will also need to consider:

- the acceptability of the proposal, including the degree of acceptability to, and participation by, Māori,\(^5\) other population groups\(^6\) and other stakeholders
- the ethical dimensions of the proposal
- the impact on the sector
- the ability to manage potential risks
- other legislative requirements.

These points are elaborated on further below.

**Costs**

The New Zealand Public Health and Disability Act 2000 sets expectations that health and disability objectives will be pursued within the available funding (section 3(2)). All funders of health and disability services therefore have a binding budget constraint. In effect this means that any proposal that cannot be funded from within the budget must be rejected.

The analysis stage should provide decision-makers with evidence of the likely impact on the budget (both one-off and ongoing). This information will allow decision-makers to assess whether the proposal fits the binding budget constraint.

\(^5\) NZPHD Act 2000 s23(1)(d).
\(^6\) NZPHD Act 2000 s23(6).
Resource implications

Constraints on other resources, such as human resource capacity and capability, will also need to be taken into account. Where an identified constraint impacts on the ability to implement the proposal, decision-makers will need to decide whether this is a sufficient reason to reject the proposal. Decision-makers should be realistic about their ability to reduce or remove constraints. For example, where a constraint involves a shortage of people with particular training, decision-makers may have a very limited ability to reduce this constraint in a reasonable timeframe.

Ethical considerations

The New Zealand Public Health and Disability Act 2000 sets an objective for District Health Boards ‘to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations’ (section 22(1)(i)). Some proposals may have ethical dimensions that will need to be taken into account. In these cases decision-makers should seek advice from ethics expertise.

Acceptability

Decision-makers will need to carefully consider the acceptability of the proposal to stakeholders, including providers, the broader community and Māori. In many cases evidence regarding the acceptability of a proposal will have been gathered through consultation at the identification stage of the prioritisation process.

The acceptability of the proposal to the Minister of Health will also need to be considered. District Health Boards should be guided by the protocols for service change, which set out when and how to engage the Minister in a service provision decision. This will be particularly important for any decisions that involve the reconfiguration of existing service provision.

A low degree of acceptability among any stakeholder group does not necessarily mean that a proposal would not proceed. It does, however, provide a ‘flag’ to decision-makers that further work on, and analysis of, the proposal might be needed. If decision-makers
decide to go ahead with the proposal, careful implementation planning, including further consultation, will be needed.

**Impact on the sector**

There is a high degree of interdependence in the health sector, which should be taken into consideration in decision-making. For example, the Ministry of Health will need to be aware of the impact of a decision on District Health Boards to fund or not fund a proposal, and District Health Boards will need to consider the impact of a prioritisation decision on neighbouring Boards and work collaboratively with them to manage any impact.

Decision-makers may also want to consider the impact of a decision, such as the costs and compliance costs of the decision, on other parts of the health sector and other sectors.

**Ability to manage potential risks**

There are potential risks associated with all funding decisions. The analysis stage should have identified any risks related to budget and resource constraints. There may also be political risks, industrial relations issues and implementation risks (such as the ability to meet timelines) to contend with. Decision-makers will need to consider the risks associated with the proposal, and assess the ability of the organisation to manage these risks, when making their decision.

**Other legislative requirements**

Decision-makers may need to take advice about whether the proposal meets other legislative requirements, for example the Commerce Act 1986 and the Health and Disability Services (Safety) Act 2001.

**Making the decision**

Decision-makers may use different methods of making the final decision but it will be important to document the body that made the decision and how and why the decision was reached.
Decision-makers should also identify whether information arising from the prioritisation process could lead to changes in future strategic and priority-setting documents. This stage is also an opportunity to reflect on whether the process has identified areas that could be subject to future prioritisation.

**When a proposal is not funded**

When a decision is made to reject a proposal, decision-makers will need to consider what will be required to explain the decision to those affected.

If the process involved in identifying and analysing the proposal has raised expectations amongst stakeholders, then decision-makers will need to carefully consider communication strategies and consultation.

**Implementation**

Once the decision is made to support a proposal there will remain significant work to ensure successful implementation. Decision-makers will need to carefully consider when and how to implement prioritisation decisions. Decision-makers may require a separate assessment of the implementation implications of the proposal, including recommendations as to how these should be managed. Note that some decisions may require District Health Boards to consult with their resident population about the proposed change.7

**Communication**

At this stage communication can help smooth implementation for some proposals. Where a proposal has been shown to be unpopular with stakeholders, communication with stakeholders will be especially important in achieving greater understanding, and hopefully acceptance, of why the decision has been made.

7 NZPHD Act 2000 s40.
Service change

The prioritisation process can be used to provide the evidence of a robust process to support a proposal for service change. All proposals relating to disinvestment, reallocation or reprioritisation of services currently provided by District Health Boards need to follow the Service Change process as set out in the Operational Policy Framework. The Service Change process provides detailed guidance for District Health Boards to follow in making and implementing such proposals. It is desirable that any Service Change implications arising from proposals are identified early so that the process of approving Service Change can be as smooth as possible.

Capital

The prioritisation process can also provide a first step in making a capital investment. The analysis stage should have identified any capital implications arising from the proposal. A comprehensive capital investment process has been developed for the health and disability sector. All District Health Board proposals with capital implications must follow this process.

Evaluation

For some proposals an evaluation of its success or otherwise will be planned for as part of the implementation. Highly innovative proposals will often need to be evaluated as they tend to be untested models of care. On the other hand, those proposals that have a strong evidence base probably do not need evaluation to the same extent, as all services should be subject to routine audit and monitoring processes.
References

Health Funding Authority. 2000. *Overview of the Health Funding Authority’s Prioritisation Decision Making Framework*. Wellington: Health Funding Authority.
