

**Evaluation of the
District Health Board-Ministry of Health
Prioritisation Framework:**

The Best Use of Available Resources

**December 2004
National Health Committee**

The National Advisory Committee on Health and Disability (the National Health Committee or the NHC) is an independent committee appointed by, and reporting directly to, the New Zealand Minister of Health.

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RECOMMENDATIONS

The National Health Committee recommends that:

- 1) The prioritisation framework highlights the importance of the process of framing an appropriate prioritisation question, and includes more extensive support in this area.
- 2) With regard to the principle of equity, the prioritisation framework explicitly notes that the needs of people with disabilities must be considered in all services, not just disability support services.
- 3) The prioritisation framework includes more explicit discussion of the relationship between whānau ora and the principle of equity.
- 4) The prioritisation framework explicitly discusses how to realise whānau ora in the context of decisions around services specifically by Māori for Māori.
- 5) The concept of acceptability be moved from the Decision to the Analysis phase of the prioritisation framework and positioned as a key prioritisation principle.
- 6) A simplified and accessible two to three page overview of the prioritisation framework be developed. This overview should focus on underlying issues of prioritisation and discuss the framework process at a broad, rather than detailed, level.
- 7) A flowchart be developed that clearly demonstrates how the different components of the prioritisation framework can fit together.
- 8) The Ministry of Health, in partnership with other health sector stakeholders, develop an integrated information and support strategy to promote understanding of prioritisation and further develop prioritisation capacity. Initiatives within this strategy could include:
 - a. Developing and maintaining a central library where examples of prioritisation analysis could be lodged.
 - b. Considering how best to provide specialised technical support for analysts and analysis.
 - c. Maintaining an email list for sharing information, advice, and best practice models amongst both those undertaking prioritisation analysis and other interested parties.
 - d. Running annual symposia on best practice in prioritisation.
 - e. Developing workshops for analysts to provide training in prioritisation tools and processes, and improving the availability of training in prioritisation amongst health professionals at both undergraduate level and in continuing professional development. Aspects of these initiatives could be included as part of the above symposia.

INTRODUCTION

When discussing prioritisation processes you should never forget the place of informed intuition, that a prioritisation process will never make the decision for you ... Tools assist and they give you a structure and an order, but actually if you think about the decisions, it's about people bringing to the table their experience and overlaying the tools with that. That's the most important thing.¹

The National Health Committee (NHC) has a long-standing interest in the prioritisation of health services. The Committee began life in 1992 as the Core Services Committee, with an explicit mandate to explore the question of how to best prioritise resources to provide health services in New Zealand. Although its role has since expanded, its fundamental purpose remains:

To advise the Minister [of Health] on the kinds, and relative priorities, of public health services, personal health services, and disability support services that should, in the committee's opinion, be publicly funded.²

The creation of the Core Services Committee marked the beginning of New Zealand's experiences with explicit prioritisation.³ One of the most contentious issues since the beginning of this period has been the question of how different "meso-level" organisations in the health sector – firstly Regional Health Authorities, then the Health Funding Authority, and now District Health Boards (DHBs) along with some parts of the Ministry of Health – should make prioritisation decisions. While all these structures have developed processes for guiding resource allocation, both research and anecdotal evidence has identified dissatisfaction with the current prioritisation landscape at this level.⁴

In order to address these concerns, a Working Group composed of representatives from both District Health Boards and the Ministry of Health has developed a framework to assist decision-makers in thinking about and conducting prioritisation: *The Best Use of Available Resources: An approach to prioritisation*.

After development of this framework, the Working Group approached the National Health Committee and invited it to evaluate how different organisations have piloted the framework. The Committee agreed to this on the grounds that not only does it support the overall goals of the Working Group in developing this framework, but also that the evaluation aligned well with other work of the NHC, such as its current investigation of decision-making around new health interventions in New Zealand.

Furthermore, and given that prioritisation is one of the fundamental aspects of the Committee's statutory role, the NHC has begun considering how it can best contribute

¹ Anonymous interviewee in round one of the National Health Committee's evaluation.

² *New Zealand Public Health and Disability Act 2000*, s. 13(1).

³ An overview of the development of these experiences can be found in National Health Committee. 2004. *Prioritising Health Services: A background paper for the National Health Committee*. Wellington: National Health Committee.

⁴ Ministry of Health. 2003. *Current Prioritisation Processes in New Zealand*. Wellington: Ministry of Health.

to the development of New Zealand's overall prioritisation environment. The Committee has therefore seen this evaluation as not only providing useful assistance to the Ministry-DHB Working Group and those who will use the framework, but also as providing information that allows its future work in this area to be based on empirical, experience-informed insights into the issues surrounding prioritisation. This is particularly important given that prioritisation tools are not capable of producing a decision in themselves – they can only provide input into a wider process.

This evaluation is divided into four sections, commencing with a discussion of the methodology behind the evaluation. The paper then moves to discussing background issues identified by pilot sites as influencing their ability to both utilise *The Best Use of Available Resources*, and undertake effective prioritisation in general. The third section of the paper, based primarily on interviews with analysts at the sites, outlines identified strengths and weaknesses of both the content and presentation of the framework. Finally, the paper outlines suggested ways in which the centre can support implementation of the framework.

The National Health Committee would like to thank the pilot sites and interviewees that participated in this evaluation. Throughout its research, the Committee has been impressed with the level of commitment and drive displayed by all those it interviewed – from analysts, to community members, to senior decision-makers – to engage with what is a difficult and contentious issue.

METHODOLOGY

The National Health Committee has approached this evaluation from the standpoint that the ultimate factor in the success or failure of *The Best use of Available Resources* will be the opinions of those to whom it is addressed: the decision-makers, practitioners, and analysts who work in District Health Boards and those parts of the Ministry that retain a funding role. This is particularly the case given that all DHBs and Ministry funders already have established explicit prioritisation processes. If these sites are to use the framework, then they must feel that doing so adds some value. The Committee's evaluation has therefore focused on the experiences and opinions of those interviewed in the course of this project.

The pilot sites that have participated in this framework were determined by the DHB-Ministry Working Group that developed the framework, and initially included five District Health Boards and one Ministry of Health funder. These sites displayed a large range of characteristics, including whether they are primarily urban or rural, the nature and size of the population and region they serve, and differing financial status.⁵

One DHB site was forced to withdraw from the piloting before the project began due to time constraints. The remaining five sites chose to use the framework on the following projects:

⁵ A member of the National Health Committee is a senior figure at one of these pilot sites, and was also interviewed as part of this evaluation. The Committee dealt with this by the member withdrawing from discussion of the evaluation and not providing input into the Committee's conclusions and recommendations. The Committee had no other conflicts of interest.

- Adapting the framework as a tool to guide allocation of an annual contestable fund.
- Choosing between two competing services for a specified quantum of funding.
- Choosing what services should be included in a contract with a local provider. (two sites)
- Identifying areas for possible disinvestment.

Three sites completed their projects in the time available while two were unable to complete. Those projects that were not completed consisted of one of the contract evaluations, and the disinvestment identification. These sites were still included in the Committee's evaluation.

The National Health Committee's evaluation consisted of two rounds of interviews. In the first round, the research team undertook a series of semi-structured interviews at each pilot site including analysts, senior decision-makers and management, representatives of Māori stakeholders, health professionals, and the local community. These interviews focussed on the background context for prioritisation at each site, and, where applicable, initial impressions of *The Best Use of Available Resources*.

After the pilot sites had completed using the framework, the Committee undertook another round of interviews with the analysts who had been responsible for using the framework. These interviews focussed on opinions of the framework in practice, including the content and accessibility of the framework, its potential value in addressing issues raised in the first round of interviews, what difficulties were faced in using it, and how its use could be supported by the centre. The two sites that did not complete their pilot projects were still included in this phase, and their reasons for not completing were explored.

Unless indicated otherwise, all quotations in this paper come from informants interviewed during the course of this evaluation. In order to maintain confidentiality, each interviewee is described only in general terms, for example as "a senior manager" or "a representative of Māori stakeholders". The term analyst, which has been commonly used throughout this report, refers to those interviewees whose relationship to prioritisation is primarily an analytical one. This term has also been used to refer to those individuals who had primary responsibility for the pilot project at each site, as these were usually figures from the analytical area.

BACKGROUND ISSUES

In discussing the background to this evaluation, it is important to distinguish between discussing prioritisation processes themselves, and the environment in which these processes are used. With regard to the first of these, all those interviewed agreed that prioritisation was inevitable and that having an explicit process for making such decisions was desirable. Most interviewees also felt that their existing prioritisation processes were capable of generating reasonable decisions. At the same time, however, most also felt that they could be improved – primarily through enhancing consultation. It was noted, however, that effective consultation is dependent on the willingness of stakeholders to engage with both the consultation process itself and the concept of prioritisation in general.

Many informants also noted that, while official processes for prioritisation were well-developed, their actual use in practice tended to be far more implicit and *ad hoc* than seemed to be so from the outside. All interviewees recognised the vital role that individual judgement and experience plays in balancing the different elements of prioritisation against each other, and none argued for a rigid and formulaic style of decision-making. However, most also felt that there existed a need for something to improve rigour in, and consistency between, applications of their processes.

Processes for considering the needs of Māori in prioritisation processes were generally seen as of a good standard by representatives of Māori stakeholders both inside and outside pilot sites, and other interviewees. All sites had developed close relationships with local iwi and other external structures representing the interests of Māori, in order to ensure representation of Māori viewpoints in these processes. Representatives of Māori stakeholders felt that the sites concerned were generally supportive of the need to address Māori health needs.

However, all sites remarked that there still remained room for improvement in addressing Māori health by refining and building on these existing processes. Several interviewees also highlighted the importance of having specific individuals with a commitment to addressing Māori health in pursuing this issue effectively. This point usually went hand-in-hand with a description of there being a variable understanding by people at the pilot site of how best to address Māori health. As one representative of Māori perspectives within his pilot site noted:

“People like [a senior analyst at the site], he’s got a built-in equity lens, just through his experience, and having people like him on the management team is very important to a guy like me, who probably comes more out of left field than anybody else. I’m the one who’ll bring up inequalities training. I’m the one who’ll bring up the Treaty of Waitangi. It’s still very monocultural [at this site].”

Critically, however, the strongest background theme to emerge through all interviews was the overwhelming impact of context on the ability to make prioritisation decisions. As noted above, existing processes were felt to be capable of delivering an acceptable standard of quality – albeit with several caveats. However, many interviewees felt that the environment in which they operated involved specific

factors that influenced the type of decisions that could be made, and created particular barriers to many ways of allocating resources.

Consequently, most felt that the type and mix of services they provided was primarily determined by historical patterns of provision rather than robust analysis of community need, effectiveness, and similar principles. Particularly revealing in this regard was that most people interviewed initially assumed that questions about “prioritisation” referred to prioritising the allocation of new resources, rather than reallocating existing resources. Several interviewees, especially those outside the analytical realm, initially made comments to the effect that “we don’t prioritise here, since we don’t have any new money coming in.”

Interviewees did not feel that this was having a directly harmful effect *per se* on the health of the communities they served. Several informants, for example, argued that these historical patterns have probably evolved informally to address the traditional health needs of their communities. What was consistently identified as a problem, however, was the difficulty that this inertia poses when attempting to change the mix of services and interventions they provide. This, in turn, can impair the potential ability of sites to improve the overall quality of care they provide, and to address newly identified needs.

In addition, those sites that were experiencing significant resource pressures pointed out that these contextual issues were particularly relevant for their positions. These sites were facing a very real need to prioritise their resources, and often this required prioritising disinvestment rather than investment. However, the constraints described below were having important negative impacts on their ability to do this.

Across all pilot sites, three consistent contextual issues were highlighted as most important in this regard: time, social and political context, and information.

Time

The first of these issues was the time available in which to use a prioritisation process. This includes several aspects, including the time available to those undertaking the analysis portion of the process, the time those with specialised knowledge – such as health professionals – have to participate in relevant aspects of prioritisation, and the time available in which to consult with stakeholders. It was this factor that was partially responsible for two pilot sites being unable to complete their pilot projects, and it also constituted an aggravating factor in other sites’ experiences with the framework, as discussed later in this paper.

Prioritisation will always be a time-consuming activity, and it is instructive to note that even larger pilot sites, with correspondingly greater numbers of staff, felt that time remained an issue. In this context, many interviewees pointed out that it is therefore important to be realistic about the depth and sophistication involved in a given application of a prioritisation process. Ideally, all decisions would be subject to the same level of detailed analysis. In practice, however, this is unrealistic and smaller allocations of resources will inevitably be analysed in less detail than larger ones. One of the consequent points raised by several interviewees was that a good prioritisation framework should be able to account for this, and analysts should be

able to use it at different tiers of depth and complexity. If it requires an impractical investment of time and capacity, even a highly sophisticated framework will be of little value and is likely to be used only occasionally.

However, it is possible to reduce the impact of these time constraints. Many measures to make time less of a factor are beyond the scope of this evaluation, as they concern underlying issues of health sector structure, staffing, and funding. While these are clearly topics worthy of wider discussion, this is not an appropriate document in which to begin such a debate. One of the issues that is worth highlighting, however, is the sentiment of most pilot sites – specifically the District Health Board sites – regarding the time involved in meeting reporting requirements and implementing strategies developed by the Ministry of Health.

Clearly, it is necessary for the activities and performance of meso-layer decision-makers to be subject to oversight by the centre. Nevertheless, there exists a strong sentiment that current arrangements for this are excessive. At several sites, interviewees complained that fulfilling these requirements takes up the majority of their time, leaving them with comparatively little capacity to undertake the level and type of assessment and analysis they desire. Ironically, given the subject of this evaluation, these informants felt that current requirements meant that their own time was not being prioritised effectively.

In this context, the Committee welcomes and supports the intentions of the Ministry of Health's Monitoring System Rationalisation project. Aimed at re-evaluating and streamlining the Ministry's current arrangements for monitoring the performance of District Health Boards, the first phase of this project consists of a stocktake of every Ministry Directorate's monitoring requirements. Then, in early 2005, work will begin on ways to rationalise these requirements. This work has clear potential to address at least some of the concerns articulated in interviews. However, if it is to be successful in this, it is vital that DHBs are active participants in determining how and what arrangements are to be rationalised. It is also important that this work – and similar work conducted in the future – is appropriately supported and resourced.

Social and Political Context

The second main theme common to most interviews was the highlighting of the social and political context in which decisions are made. Inherent in the development of prioritisation processes is the assumption that decision-makers are able to follow the results of applying these processes. At all pilot sites, however, there existed a strong sentiment that this situation does not exist in practice. Regarding disinvestment decisions, for example, all pilot sites could point to specific examples of services and interventions they currently offered that they would reduce or withdraw from supporting if other factors in the socio-political environment would allow them to do so. As one interviewee remarked when asked their opinion of the framework:

“It could be useful for us if the political context were changed to allow us to actually make some meaningful prioritisation decisions. But in the context that we currently work in, its value for us is likely to be limited

... What actually is required to prioritise better is not so much a new framework, but actual change to the political context.”

Several interviewees, though not all, felt that a significant source of this inflexibility consisted of constraints imposed by central structures. These informants argued that most of their resources are effectively “pre-prioritised” before they receive them, whether through tagged funding for specific interventions or requirements to provide certain services. Consequently, sites have the ability to prioritise only around the margins of the services that they provide. While many central directives accord with what decision-makers would elect to support in any event, in a significant number of cases it was felt that they represent an inefficient use of resources and may sometimes actually have such perverse outcomes as effectively increasing health inequalities.

Central constraints were not, however, the only type of political barrier to be highlighted. All sites highlighted the role that the general social and political influence of particular individuals and/or groups plays in decisions over allocating resources. Interviewees agreed that a level of this is legitimate: all recognised the importance of consultation and accounting for community preferences in decision-making, for example. What was regularly cited as an issue, however, was the “squeaky wheel” phenomenon: specific groups or individuals who exercised an undue influence over resource allocation. One site raised the example of a particular geographic community that, in an archetypal example of the “inverse care law”, had generally lower health needs than the rest of the population the site served and yet, due to their social and political power in the community, enjoyed disproportionate benefits from the site’s pattern of service provision.

On a related note, many interviewees expressed frustration at the general level of engagement with the concept of prioritisation. Those from an analytical background were particularly convinced that the idea of prioritisation needs to be far more firmly embedded amongst the health sector, decision-makers, and the community at large. These informants felt that while there may be specific individuals who accept the concept of prioritisation, the majority of people both inside and outside the health sector do not fully appreciate the complexity and nature of the issue. One health professional interviewee, when discussing the extent to which health professionals engage with the idea of prioritisation, described this in terms of different “worlds”:

“I see healthcare as divided into four sorts of worlds that represent different groups or forces. The first is the political world, where social decisions are made around health. And then there’s the academic world, then there’s the business world, and then there’s the clinical world. And each of these worlds has their own languages and ways of communicating. So when we’ve got something coming into the clinical world which is a political thing, the language doesn’t translate ... So when you try explaining to an [audiology professional] why audiology equipment isn’t a priority, well they see a definite priority because it’s what they’re faced with.”

Prioritisation will always be ultimately a political process and reach conclusions that parts of the community and health sector do not agree with, and no framework will be able to completely deal with this. To quote one interviewee:

“The perfect prioritisation tool has not been invented and will never be invented – there are always going to be ways in which it can be improved or ways in which people will be able to poke a stick at it and say ‘no, that’s not right.’”

However, as with the time constraints discussed earlier, this does not mean that attempts cannot be made to make decisions more acceptable. In this regard, a particularly strong desire that emerged from the interviews was for a framework that sets out a clear, defensible rationale for why a decision-maker chose to allocate resources in a particular manner. This would at least provide a basis for reasoned discussion over decisions.

In addition, almost all interviewees argued that there is a need to promote discussion, debate, and appreciation of prioritisation throughout all sectors of society. Without a fundamental acceptance of the idea on the part of both the community at large and health professionals that resources are finite, and that there is a need to allocate them in an effective fashion, most informants argued that the current situation will not be able to change. To use the above analogy of different healthcare “worlds”, prioritisation is often associated with the “business”, and possibly academic, worlds. Effective prioritisation, however, requires the issue to be translated so that those in other worlds begin to appreciate the issues involved.

Unsurprisingly, these political constraints become particularly strong in relation to decisions regarding the reallocation and/or withdrawal of existing resources; the allocation of any new resources was seen to be less difficult and controversial.⁶ Consequently, they were identified as of particular concern by those sites experiencing resource shortages. These sites are, as noted earlier, often faced with the need to disinvest from services, and yet the environment in which they operate inhibits them from this course anywhere except at the margins of their service mix. This in turn, can aggravate resource pressures as sites cannot reconfigure the pattern of provision that is causing these pressures in the first place.

At one pilot site, an interviewee noted that *The Best Use of Available Resources* had some potential value in this regard. This informant felt that the framework could be used as an education and information tool to explain to those not involved in health sector management or policy-making why prioritisation is necessary, and a starting point for discussions as to the basis for making such decisions. It was also noted, however, that if this was to be case, the presentation of the framework would need to be considerably simplified and made more accessible.

Information and Evidence

In general, interviewees felt that they possessed a good base of information regarding the health needs, demographic profile, and other relevant characteristics of their relevant regions. In particular, District Health Board sites identified their health needs assessment processes as being of value in bringing information together, and several

⁶ Of course, allocating new resources still involves important political questions and decisions.

had also undertaken independent information-gathering exercises to support action in specific service areas. Although many informants noted that this information could be improved, this was usually framed in terms of the point that information can always be improved; interviewees felt that they possessed enough information, of sufficient quality, to make workable prioritisation decisions.

However, although most sites were satisfied with the situation regarding this “contextual” information, there existed more concern regarding the second main type of data used in prioritisation: information and evidence regarding services and interventions themselves. While sites had a good knowledge base concerning the demographics and needs of the populations they served, the situation around evidence regarding the ability of interventions to address these needs was often seen as more problematic.

This point was emphasised particularly strongly at one site, where interviewees in the second round raised significant concerns regarding the actual availability, or lack thereof, of appropriate evidence to support decision-making. Importantly, of all the pilot sites that completed their use of the framework, this site’s project was the one most reliant on available evidence, as it involved deciding which of two interventions should hypothetically be supported – a clear “A” versus “B” prioritisation decision. While the comments made at this site related specifically to the use of *The Best Use of Available Resources*, they also raise points relevant to the wider position of evidence in prioritisation.

These interviewees pointed out that information of the sort needed to perform analysis of a prospective service or intervention can be difficult to locate. Firstly, they noted that many potential sources of evidence, such as academic journals, require subscriptions to which a site might not have access. Even when appropriate evidence can be sourced, however, it is not always immediately applicable to the case in question. For example, this site was considering interventions aimed at people in a specific age-group, but most of the evidence on the effectiveness of these interventions did not distinguish between different age groups.

Similarly, these interviewees pointed out that there exist questions as to how applicable analysis from other countries might be to the specific New Zealand context, or how differences between rural and urban settings might impact on evidence. Thus, analysts do not only have to spend time locating evidence, which in itself can be difficult, but also interpreting its relevance and adapting it to their specific situation. While this is partly the role of analysts, the specialised nature of some forms of evidence can make this interpretation difficult and time-consuming for non-specialists – a point linked with the issue of time constraints identified earlier in this document. Some interviewees were also unsure about where to locate relevant information – although others pointed out the information contained in the framework regarding potential sources of evidence was useful in addressing this.

The basic issue raised here – the point that evidence often needs to be analysed and cannot simply be used directly – was also highlighted at other sites. Although interviewees at these sites did not generally feel that the (un)availability of evidence was a significant issue in and of itself, almost all sites – and, in particular, analytical informants at most sites – did highlight the need for assistance in interpreting

evidence. Several informants made the point that often evidence is found in forms that are highly technical and require specialised knowledge to analyse. The most commonly cited example of this was economic evidence used to analyse cost-effectiveness, with clinical effectiveness being another area where some analysts felt they lacked the expertise to adequately interpret and evaluate the results of, for example, clinical trials.

This issue is of particular concern given that evidence is often not conclusive or clear-cut, and that analysts may be confronted with different examples of evidence that each reach different conclusions. While there may be some cases where evidence is unanimous or nearly so, it is not unusual for research findings to differ notably based on differences in methodology or the nature of the data analysed. This is particularly the case when comparing qualitative and quantitative research, whose fundamentally different approaches to the research process means that comparing the two types of evidence can be difficult, and this can have important implications for the outcome of analysis. As Ashton *et al.* pointed out in their evaluation of the prioritisation process developed by New Zealand's Health Funding Authority:

There is often a tendency for people to accord more weight to quantitative evidence than to qualitative evidence. Given the important role that qualitative evidence is likely to play in the prioritisation process – in thinking about effectiveness beyond that available in clinical trials and including benefits such as caring, and in weighing up the various principles – there is a need for particular vigilance that quantitative evidence does not dominate the process.⁷

EVALUATION OF THE PRIORITISATION FRAMEWORK

Content

Response to the actual content of *The Best Use of Available Resources* was generally positive. The prioritisation principles listed in the framework were believed to provide a good basis for such decision-making, and the tools provided for making decisions were seen to be useful. In addition, the underlying philosophy of the framework – that it provides guidance and tools that can and should be adapted to different decision-making contexts, rather than a rigid formula to follow – was welcomed by all interviewees.

Several analysts also noted that they would feel comfortable using the framework at varying levels of detail depending on the specific nature of the topic they were applying it to. This sentiment links well with the previous point that processes need to take account of the time available in which to use them. Only one pilot site remarked that they would be unlikely to use some version of the framework over their existing process, and this related primarily to the presentation issues discussed later in this document.

⁷ Ashton A, Cumming J, Devlin N. 1999. *Prioritising health and disability support services: principles, processes and problems, a report to the National Health Committee on the HFA's proposed prioritisation process*. Wellington: National Health Committee.

The transparency and consistency provided by using the framework was highlighted as a particular strength. As noted earlier, a key feature of a prioritisation framework that all interviewees desired was the ability to produce something that could be used to clearly justify why a particular decision was made. Those analysts who completed using the framework remarked that they felt better prepared to defend the results of their analysis both to the general public and to internal decision-makers. Therefore, even when the analysis produced the same results that would have likely been produced with existing processes or purely through their own intuition, analysts felt that using the framework had added value.

Similarly, even though one pilot site's analysis resulted in a recommendation that interviewees felt was unlikely to be supported by actual decision-makers, analysts here felt that the framework's results made it clear that the eventual decision that was likely to be made would be based on political grounds rather than simply the results of analysis. The framework thus had the potential to highlight the political constraints around prioritisation, and so make the nature of prioritisation decision-making clearer.

The piloting process did, however, identify several perceived weaknesses in the content of the framework. Firstly, several sites pointed out that the framework appeared most suitable for straightforward "A vs B" prioritisation decisions: making a clear choice between two (or more) competing options for involvement. Where it was applied to other types of prioritisation-related decisions, analysts felt that it was more difficult to use. Other comments related to specific elements in each of the three prioritisation phases outlined in the framework: Identification, Analysis, and Decision.

Identification Phase

The Identification phase of prioritisation concerns the determination of what particular services the framework will be used to analyse. This section of the framework discusses ways in which topics might appear on the prioritisation agenda on the decision-maker, and methods for identifying potential topics.

The information provided in this section of the framework was generally seen to be weaker than other sections. Several sites commented that the framework does not assist with the previously noted underlying issue of how to start making decisions around the "core" group of services. While they felt that the framework would be of some help when new money with few strings attached is available, it does not assist with the issue that many decision-makers are unable to meaningfully prioritise at anything other than the margins of services. This is of concern given that many interviewees identified the weight of the historical core as an overarching issue in their approach to prioritisation.

One analyst remarked, however, that they believed the Identification section is unlikely to be used in most cases, as usually the decision regarding the topic(s) to be the subject of a prioritisation process will be made before it is decided to actually use the framework. In other words, the reasons for a given service or intervention being on the prioritisation agenda are often implicit and based on a complex array of

factors.⁸ Similarly, as noted earlier, the political context in which decision-makers operate may be more likely to influence what can be subjected to prioritisation than an explicit list of criteria. These twin factors suggest that the perceived weakness of this section may not be a particularly serious issue, and may relate more to informants' dissatisfaction with contextual constraints around prioritisation itself than anything that can be addressed through *The Best Use of Available Resources*.

Analysis Phase

The Analysis phase occurs after identification of the topic to be prioritised and consequent framing of the question, and concerns the collection and interpretation of evidence regarding the topic(s) of the process. Here, *The Best Use of Available Resources* posits five prioritisation principles that comprise the different dimensions in which the value and impact of providing or withdrawing a given service and intervention should be evaluated. These principles follow those that have traditionally been used in New Zealand's approach to prioritisation, and consist of:

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

This section of the framework was generally seen as having the strongest and most useful content. It was noted by two of the sites that completed their pilot projects that the initial step in this phase – the framing of the question to be analysed – was of particular importance. One site in particular refined their question several times after seeking advice from others. Interviewees at this site recommended that the importance of this step needs to be emphasised and that more advice could be included on how to do this.

The National Health Committee recommends that the prioritisation framework highlights the importance of the process of framing an appropriate prioritisation question and includes more extensive support in this area.

As noted earlier, the principles listed in the framework as the basis of prioritisation analysis were seen by all interviewees as being generally appropriate grounds for decision-making. The checklist of sample questions to ask when considering each principle was identified by all sites that completed the project as being particularly

⁸ The National Health Committee is, in a separate project, currently exploring how decisions specifically regarding new health interventions are made and the factors that influence their appearance on the agendas of decision-makers.

helpful, as it provided clear examples of how to translate these principles into practice. Given that several interviewees in the first round of interviews identified this translation as a common problem in using prioritisation processes, this section of the framework seems to be particularly useful.

At one pilot site, however, the analyst leading the project was uncomfortable with how the needs of people with disabilities were incorporated into consideration of the equity principle. *The Best Use of Available Resources* does not generally mention specific groups whose needs should be considered under this principle. If the framework did list specific groups that should be considered with regard to equity, then users may focus only on those particular groups. As the particular groups whose needs should be considered in terms of equity may vary in the context of both the particular site and the service(s) and intervention(s) being analysed, this is an appropriate approach to take. By providing tools for looking at equity generally – such as the Health Equity Assessment Tool (HEAT) – the framework instead promotes analysis of those populations specifically relevant to the issue under consideration.

However, this analyst felt that the formatting of the checklist of questions relating to the equity principle had the potential to marginalise people with disabilities. For each principle, questions in the checklist are categorised into those to be asked when looking at:

- providing a new disability support service;
- providing a new health service; and
- looking at reallocating or withdrawing funding for an existing service.

While this interviewee was not concerned with this format in relation to other principles, she felt that highlighting services specifically for people with a disability in this section could lead users to take account of equity for this population only in regard to disability support services. Consequently, she recommended that the tripartite categorisation should be dropped for this specific section.

The National Health Committee appreciates these concerns, and would be alarmed if this situation were to occur. It also notes, though, that including disability support services in this section can be seen as making visible the equity needs of people with disabilities. The Committee therefore believes that the checklist of questions should not be amended. However, the text in the framework discussing the principle of equity should include explicit direction that equity issues for people with disabilities should be included in considering all health interventions – not simply disability support services.

The National Health Committee recommends that with regard to the principle of equity, the prioritisation framework explicitly notes that the needs of people with disabilities must be considered in all services, not just disability support services.

Whānau Ora

The portion of the framework's content to attract the greatest comment, both in the Analysis section and in general, was that regarding the principle of whānau ora. In the initial phase of interviews, this section was generally received positively by interviewees. However, one interviewee who had been involved in developing this section of the framework did note that there existed very diverse opinions of the content, ranging from enthusiasm to suspicion.

One analyst was also uncomfortable with the framing of whānau ora as being about addressing the cultural needs of Māori, and felt that positioning this element of the framework in terms of the principles of the Treaty of Waitangi would be more useful. This analyst felt that, as written, the framework opened decision-makers up to criticism that the cultural needs of all ethnic groups should be explicitly considered during the prioritisation process. Framing this step as ensuring that the decision was consistent with the principles of the Treaty of Waitangi, however, would both at least partially address this criticism, and from a principle point of view, recognise the unique status of Māori in New Zealand. She did, however, also note that in practice the difference between using the Treaty and using whānau ora would be marginal, as the sort of questions to be asked and conclusions that would likely be formed were likely to be similar in either case.

On balance, the National Health Committee believes that it is appropriate that the framework use whānau ora as a guiding principle, particularly given its position as the overall aim of *He Korowai Oranga: the Māori health strategy*. The committee believes that it is important to note, however, that the specific ways in which the concept of whānau ora is framed can and will vary from site to site. Thus it is perfectly acceptable for decision-makers and analysts to position achievement of the overarching policy goal of whānau ora as being about meeting obligations under the Treaty.

In the second phase of interviews, however, opinions of the whānau ora section were significantly different, and it is instructive to note that this shift occurred once analysts had actually used the framework. In general, these related to a sense of uncertainty regarding how whānau ora related to other elements of prioritisation. Informants at one site, for example, noted that they had significant trouble clarifying how this principle related to that of equity – an analyst here admitted that she initially believed that equity analysis would cover all relevant issues, and it was only after discussing the issue with a senior Māori manager and looking at other examples of prioritisation analysis that she realised that this would have left important questions unanswered.

Similarly, an analyst at another site commented that she found the material in the framework confusing and wasn't clear how it related to and differed from their pilot site's existing obligations under *He Korowai Oranga*. This site also noted that they did not understand how the concept of whānau ora should be reflected in a project of

their type, which concerned evaluating the type of services that should be included in a contract with a Māori provider to supply services to a primarily Māori population.⁹

This experience suggests that the material in the whānau ora section of the framework is in need of revision. In the first place, there is need to more explicitly clarify the relationship between the principles of whānau ora and equity. This could involve including some discussion of this issue in the materials provided to support the equity section of the framework.

Secondly, it appears that, at least for some analysts, the material provided in the framework is most applicable to considering how to account for whānau ora in making decisions about services that are not designed for populations of a specific ethnicity. Providing explicit advice for how to reflect this principle when considering services aimed specifically at addressing Māori health needs would be useful.

The framework does note that the concept of whānau ora is still developing, and that the advice it provides:

can only be preliminary at this stage given the stage of development of work on the concept of whānau ora ... Further, it would be inappropriate to attempt to give definitive advice on the meaning of whānau ora, how to achieve whānau ora or assess proposals against it. As those most affected, it is whānau and Māori communities who must ultimately provide that advice, based on their own values, priorities, knowledge and circumstances.¹⁰

The Committee acknowledges that these factors create difficulties in providing guidance for analysts. However, addressing the previous points may simply be a matter of refining and simplifying what material is already in the framework. One analyst, for example, felt that the material in the framework was excellent in terms of quality, but too lengthy in terms of what an analyst requires from the framework. Underlying these issues, however, and in particular one site's confusion between whānau ora and *He Korowai Oranga*, is an apparent general need to improve overall understanding of the notion of whānau ora in the health sector.

The National Health Committee recommends that the prioritisation framework includes more explicit discussion of the relationship between whānau ora and the principle of equity.

The National Health Committee recommends that the prioritisation framework explicitly discusses how to realise whānau ora in the context of decisions around services specifically by Māori for Māori.

⁹ As this pilot site was the only one to use the framework on a decision of this type, there is, unfortunately, no basis for comparing their experience with others.

¹⁰ Joint District Health Board and Ministry of Health Working Group on Prioritisation. 2004. *The Best Use of Available Resources: an approach to prioritisation*. Wellington: Joint District Health Board and Ministry of Health Working Group on Prioritisation.

Decision Phase

The final phase of *The Best Use of Available Resources* is where decision-makers actually choose how to allocate new resources or alter existing patterns of resource allocation. This involves taking the analysis performed in the previous phase, placing it in the context of an institution's ability to deal with issues raised during by analysis, legislative requirements, and similar factors, and then coming to a final decision as to how resources are to be allocated.

Few comments were made regarding the Decision section of the framework. This is largely because those involved most directly in the pilot projects were not those who would ordinarily be involved in this phase of a prioritisation process. However, the content of this section did not generally raise any objections from interviewees.

The main exception to this came from one analyst who recommended that considering the acceptability of a decision to the community should be shifted from this phase of the framework to the Analysis phase. The basis for this was a belief that acceptability is a key principle that needs to be considered by analysts in as much depth and detail as elements like effectiveness and equity.

The general thrust of this position – that the social and political dimension of decision-making needs be acknowledged – was made even more strongly by an analyst at another pilot site. This analyst argued that this dimension needed to be made even more explicit throughout all sections of the framework. Although the informant noted that the framework does discuss the importance of this aspect, he also felt that this aspect has such a fundamental impact on what prioritisation decisions can be made that it needed to be strengthened considerably.

Those principles outlined in the Analysis phase are clear continuations of those that have been developed through the Core Services (later National Health) Committee, Midcentral Regional Health Authority, and the Health Funding Authority thread of New Zealand's thinking about prioritisation.¹¹ All of these bodies recommended that acceptability be considered on an equal basis to those currently in the framework's Analysis phase. The Committee therefore believes that it is appropriate for this element to be included as part of the Analysis phase of the framework.

Presentation and Accessibility

While the content of *The Best Use of Available Resources* was generally received positively, the manner in which this content was presented was the subject of significant criticism. Reactions to this aspect of the framework did, however, differ somewhat between the first and second interview phases. In initial interviews, the majority of informants that had seen the framework remarked that it appeared to be reasonably straightforward and easy to use.

¹¹ For an overview of the development of approaches to prioritisation in New Zealand see National Health Committee. 2004. *Prioritising Health Services: A background paper for the National Health Committee*. Wellington: National Health Committee.

Even at this point, however, there existed a notable current of opinion that the framework was quite long, and some interviewees were unsure how well it would be received by those who were not familiar with prioritisation generally or had not been involved in the development of the framework. This sentiment was even more evident in the second round of interviews, with almost all informants involved here criticising the framework's presentation and accessibility. Furthermore, the one pilot site that still felt presentation was not a problem – this site feeling that the lack of jargon in the framework was a particular strength in this regard – was one of those that could not complete their project and therefore did not actually use the framework to as great an extent as those sites that did.

Most analysts involved in using the framework found the amount of information in the framework intimidating, and reported being unsure exactly how and where they should begin using the framework. Although it did become easier to use once they were familiar with it, developing this familiarity took a relatively long time. This was a particular issue in light of the time constraints on analysts and decision makers noted earlier. As one interviewee remarked:

“It’s quite cumbersome, and our capacity is stretched to the limit ... So I think to be really useful it has to be something that you can look at quickly, can get right to it, because CDs and volumes of pages – I can’t use that.”

Similarly, another informant at the same site noted that:

“A lot of the stuff is really helpful if you do get to it, but you lose yourself in it. You can get into one thing that’ll take you to another, and then all of a sudden you’re fifty pages in and you’ve got no idea what you’re doing ... It’s good for [the information] to be there in case you do need it, but if you’re actually going to have to go through that as part of the process it’s too much.”

All three pilot sites that completed their pilots commented that the amount of time involved in using the framework in full was probably unsustainable in the long term.¹² In addition, analysts leading the pilots at two sites noted that they had spent a considerable amount of their own time, outside normal working hours, on the project. While bringing in others to help use the framework would probably have alleviated this somewhat, time constraints on other analysts and relevant people made this impractical – especially given the time required to familiarise oneself with the framework.

This presentation issue was felt to be a particular issue for promoting wider engagement with the process of prioritisation. One intention of the framework is that it provides an information base for all levels and types of people involved in prioritisation:

¹² It is, however, important to note that most analysts also felt comfortable with adapting the framework and using it at a less detailed level.

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.¹³

However, it was felt by almost all interviewees that the framework as it currently stands – even the overview booklet provided to the pilot sites – was not sufficiently short and straightforward to engage those outside the analytical “world”. This was felt to be particularly the case with regard to the governance level at pilot sites, but was also seen to be a barrier to engaging health practitioners and wider stakeholders. The size of the framework meant that it was unrealistic to expect people to spend the time to familiarise themselves with it. This also led to some negative reactions from those not directly involved in the framework – one interviewee reported showing the framework to a senior decision-maker at her pilot site and being told that it was “bureaucratic gobbledegook”.

Interviewees suggested two possible refinements that could help in addressing this accessibility issue. Firstly, all sites recommended the development of a brief two to three page outline of the prioritisation process to give to non-analysts – senior decision-makers, stakeholders outside the pilot site, and health practitioners. The point of this outline would be to firstly identify why prioritisation decisions need to be made, and secondly, how the framework supports making them. The important point here is that this outline needs relatively little detail specific to the framework itself. Rather, it should focus on underlying principles of prioritisation, and paint the process itself in broad strokes.

Even the pilot site that remained largely content with the presentation felt that this would be a positive step. While interviewees at this site felt that the relative lack of jargon was a strength of the framework, it was also felt that something intended to engage those outside the analytical world needed to be shorter and written in more accessible language. The hardcopy overview that was included with the pilot sites’ copy of the framework was seen as too long for those not regularly involved in prioritisation to engage with.

The National Health Committee recommends that a simplified and accessible two to three page overview of the framework be developed. This overview should focus on underlying issues of prioritisation and discuss the framework process at only a broad level.

While the previous refinement involves improving accessibility for non-analysts, several sites also recommended the development of a step-by-step flowchart for analysts to make it more accessible for this group. As noted earlier, interviewees

¹³ Joint District Health Board and Ministry of Health Working Group on Prioritisation. 2004. *The Best Use of Available Resources: an approach to prioritisation*. Wellington: Joint District Health Board and Ministry of Health Working Group on Prioritisation.

commonly reported that, while they found the material in the framework useful, they were unsure how to begin approaching using it.

While it could be argued that developing a model of the prioritisation process conflicts with the idea that the framework should be as flexible and adaptable as possible, this is not necessarily the case. Indeed, the framework is already arranged in a fashion that implies a linear progression through the tools and processes. What those analysts who argued for a flowchart were asking for was clear and explicit guidance on how the various elements in the framework fit together and thus where exactly they should begin and where tools should be used.

An example of this can be found in the checklist of questions for the Analysis phase of the framework, which was frequently cited as a model for what was desired. *The Best Use of Available Resources* does not rely on these specific questions to function, and if someone using the framework decides that a given question does not apply to a particular case, that a question needs to be phrased in a different manner, or that additional questions need to be asked, they can easily do so without impairing the operation of the rest of the framework.

Providing a flowchart of how the various tools in the framework fit together would act in a similar manner. Essentially it would provide an exemplar for how a prioritisation process can be undertaken. Individual sites could then choose to adopt this process whole cloth, mix and match certain elements of the process to follow, or use their own process and simply use the tools and guidance provided in the framework as inputs.

The National Health Committee recommends that a flowchart be developed that clearly demonstrates how the different components of *The Best of Available Resources* fit together.

SUPPORTING IMPLEMENTATION

In addition to background issues and evaluation of the framework itself, the National Health Committee also asked informants what factors and actions would help promote its implementation.

The strongest identified method of promoting implementation of the framework was addressing the presentation and accessibility issues identified in the previous section of this paper. All sites noted that the amount of time required to use the framework in its current form was impractical, and that having a streamlined flowchart of the type discussed earlier would make it significantly easier to use. In a similar vein, providing a short and accessible guide for those outside the analytical world would address some of the political barriers to its use.

An interviewee at one site also noted the potential value of having prioritisation “mentors” at each pilot. This analyst noted that since completing the pilot, she been approached by several other people at her site asking for assistance and advice in the development of prioritisation processes. The role of prioritisation “mentors” would be to undertake a leadership role in terms of not only assisting others with using the

framework, but also to act as a vehicle for promoting ideas of prioritisation within the pilot site and amongst the local community. Of course, this raises the issue of funding for such a role. Few, if any, sites are likely to possess the funding to employ a person specifically to lead prioritisation thinking.

On the flipside of promoting use of the framework, there was some concern that use of the framework would be made mandatory by the centre. Not only would this affect the ability of decision-makers to adapt the process to their own context, but such a move could hamper the acceptance of the framework by decision-makers. There was a unanimous sentiment that the autonomy of individual sites must be preserved in prioritisation processes. While the centre can provide some support, it must be phrased in precisely those terms: the centre providing support for individual sites to develop and adapt processes that are appropriate to their own context.

Furthermore, making use of the framework compulsory is arguably incompatible with the philosophy of adaptability that has underlain its development. Such a requirement would necessitate monitoring for compliance, and also the determination of what constituted compliance. In other words, to what extent could a site's process be adapted to fit local contexts before it no longer constituted using the framework? A tight definition would conflict with the intention of those who participated in the framework's development. In contrast, a relatively loose definition of what constitutes compliance raises the question of what is gained by making the process compulsory. In addition, this may add to the previously identified burden of satisfying the monitoring requirements of the centre.

Interviewees at one site made the point that the formulation of the framework has been an unusually good example of different actors in the sector working well together, and one of the main factors for this has been the commitment by representatives of the centre to developing the framework on a basis of equality with the regions. Reverting to a more directive relationship might create resentment and a negative perception of the framework that could inhibit its use. Conversely, as an informant at another site pointed out, if use of the framework remains voluntary then it provides a relatively easy method of determining how useful it is: if the framework is enjoying widespread use in the years ahead then clearly it is adding value.

Central Support

One specific aspect of promoting implementation addressed by the National Health Committee was the type of support the centre could provide to assist sites in using of the framework. Two sites, one of which completed its pilot and one of which did not, felt that there was no need for some form of central support for sites undertaking prioritisation decisions. These sites stressed the point that prioritisation needs to be fundamentally decided at the regional level. One argued that "the one thing we don't need is more contribution from the centre," while the other pointed out that effective prioritisation requires knowledge of the specifics of the services concerned, providers in the area, and the history of service provision and reasons for existing patterns.

Of the three sites that were in favour of central support, the underlying theme behind their views was the ability of such support to address capacity issues at pilot sites. The first view of such support was that of information brokerage, described by an

analyst at one site as an analysis “library”; a central structure in which all applications of the framework were placed and were thus accessible to other sites.

This “library” role is essentially a passive form of central support. In addition, sites proposed that the centre provide forms of active support. The precise nature of this support varied, however. At two sites, interviewees argued that economic evaluation was too complex and specialised to be conducted by local sites, and should be conducted at a national level. The third site argued that technical support of this type is less important than overarching strategic advice on how to use the framework, such as what questions should be being asked in analysing a particular issue. Of course, these “technical” and “advisory” roles are certainly not mutually exclusive.

Importantly, however, there were few concrete proposals as to the nature of such a structure. One of the sites in favour of a technical role did raise the possibility of the Ministry providing this function directly, or via a contract with a body such as the Christchurch School of Medicine’s New Zealand Health Technology Assessment Unit. All, however, noted that the final outcome of a prioritisation process must be determined by sites themselves. The role of any central structure must be purely one of support – the Ministry of Health’s Public Health Intelligence unit was held up by one interviewee as an example of the type of agency that was desired.

In considering the issue of central support, the NHC has decided that it would not be useful to consider support for users of *The Best Use of Available Resources* alone. Rather, the committee believes that there is a need for the centre to consider how it can best support prioritisation as a whole. To this end, the National Health Committee believes that there should be developed an integrated national strategy for supporting prioritisation decision-making, and promoting prioritisation awareness, understanding, and capability throughout the health sector.

Importantly, however, the committee believes that the development of such a strategy should be undertaken as a partnership, with the development process for *The Best Use of Available Resources* being used as a model. The NHC believes that the Ministry of Health should coordinate and provide underlying support for the development process, but the formulation of specific components should be the product of an equal association of the different health sector actors with an interest in prioritisation. These include representatives of all sections of District Health Boards – the provider arm, funding and planning, and Board members – and representatives of both health practitioners and those responsible for their training and professional development.

Given this, the NHC has not set down what should definitely be included in this strategy – specific elements must be developed to suit the specific needs of the various different stakeholders in the sector. The committee has, however, highlighted a series of potential components of such a strategy that could form a starting point for discussions over this strategy. These components can be divided into three main branches: information-sharing, technical support, and building capability.

Information-sharing

The first branch of a national prioritisation capacity-building and support strategy must be enhancing information sharing between those involved in prioritisation. The

NHC has given thought to two linked components of this branch, that together constitute an information e-strategy for prioritisation. These components consist of an electronic prioritisation library and a prioritisation e-mail list.

As noted earlier, all those pilot sites that desired support from the centre were in favour of a library-style structure for prioritisation analyses. The advantage of such a library is obvious: it would prevent multiple sites performing their own analysis of similar issues. As several interviewees pointed out, such a situation is not a sensible use of analytical time and resources – especially when both are in limited supply.

Of course, analysis performed at one site may not be directly applicable to another. The context for analysis in a small rural DHB, for example, will be dramatically different for that in a large urban DHB, and the conclusions of analysis may therefore (though not always) differ sharply at each site. Similarly, some sites will still need to conduct the initial analysis in the library, and the range of possible interventions to which this could be applied makes it likely that, at least in the short term, there will be no applicable sample analysis lodged in the library.

However, these issues do not meaningfully lower the value of such a library. Sites can still make use of existing analysis as exemplars that they can then adapt to their local conditions, and some aspects of analysis are likely to be consistent throughout the country. Thus, even if the equity section of a given analysis is inapplicable, the clinical effectiveness portion can still be used.

Furthermore, while an example of the exact service(s) under consideration might not be located in the library, analysts can still use existing analysis as models for the particular issue they are dealing with. This could be particularly useful when dealing with less straightforward prioritisation issues, such as what should be included in a service contract with a provider.

The NHC believes that this library should take the form of an electronic storehouse hosted by the Ministry of Health. This would both increase accessibility, and lower the cost of establishment and maintenance – though it should be emphasised that at least one person would be required to act as librarian for this library.

In addition to this electronic storehouse, the committee also believes that developing a national “e-list” for prioritisation would be an effective method of promoting information-sharing. This list would provide an active forum for peer assistance and support on specific prioritisation questions, and the sharing of best practice models, tools, and information. While this list should be designed primarily for analysts involved in prioritisation, membership should not be restricted to this sector.

Technical Support

The second branch of a national prioritisation capacity-building and support strategy is the provision of active technical support in the form of some type of centralised capacity to undertake analysis of such issues as cost-effectiveness or clinical effectiveness.

The National Health Committee believes that such a capacity has the potential to add value, through providing specialised skills and expertise that are often not available to those undertaking prioritisation analysis. However, the committee is also wary of immediately turning to the development of new structures as a solution to problems, and is conscious that, as noted earlier, while this possibility was raised during the evaluation of *The Best Use of Available Resources*, there was no consensus as to its form or specific function.

On balance, the committee believes that there would be value in investigating how best to provide some form of national technical support for prioritisation analysts, within the context of the proposed prioritisation capacity-building and support strategy. This support need not take the form of new independent structures, however, and could, for example, simply be achieved through improving access to existing technical capacity available in education and research institutions.

Building Capability

The final main branch of a prioritisation capacity-building and support strategy involves dissemination of the skills, tools, and expertise to support prioritisation. *The Best Use of Available Resources* itself can be seen as one component of this branch in its articulation of a process for prioritisation and provision to tools to assist in this process. The committee has thus recommended to the Minister of Health that use of this framework be promoted as part of a best practice approach to prioritisation.

The National Health Committee believes that there is, however, significant scope for further measures to build prioritisation capability. The first such measure proposed by the committee is the holding of annual symposia on prioritisation by the Ministry of Health. These symposia should focus on bridging the gap between prioritisation theory and practice, and demonstrating how prioritisation tools and processes can be used “on the ground” and adapted to specific situations.

In addition to these symposia, the committee also believes that there is a need to address the basic issue of training in prioritisation tools, methodology, and theory. Many issues identified earlier in this evaluation, including how to interpret specialised forms of evidence and the position of whānau ora in prioritisation, could be significantly reduced by appropriate training. The second capability-building measure proposed by the committee is thus the development of prioritisation workshops.

Lasting for two or three days, and held on an annual or biannual basis, such workshops should use expertise both in- and outside the Ministry to provide training. two-to-three day prioritisation workshops for analysts. The Ministry should fully or partially subsidise these workshops, and they should be held either in one location (Wellington being the obvious choice) or in a small number of regions – perhaps one in the South Island, one in the lower North, and one in the upper North.

In addition to the training itself, this workshop model would have several side benefits. Firstly, bringing together analysts from multiple sites would promote the development and strengthening of networks between participants. This would promote linking between players in New Zealand’s health sector, and provide avenues for information sharing regarding both prioritisation and other avenues. Secondly,

using *The Best Use of Available Resources* as the basis for such workshops would encourage sites to adopt and/or adapt this framework on return to their pilot sites. This could lead to the *de facto* development of prioritisation “mentors” – individuals with an advanced understanding of both prioritisation in general and the framework in particular, and who could be used as drivers for its implementation. Conversely, feedback from participants may aid in the ongoing refinement of the framework.

Finally, and perhaps most usefully, however, is the potential for these workshops to be used as the basis for dealing with one of the fundamental elements of prioritisation: the political element of prioritisation. Both this evaluation and previous work by the Ministry of Health¹⁴ have identified a belief, particularly amongst those from an analytical background, but also from other decision-makers and actors in prioritisation processes, that many important players in prioritisation are not currently engaging with the need to prioritise. This creates a problem when decision-makers are faced with the need to make prioritisation decisions.

Although the prioritisation workshops should be initially developed for analysts, after they have been appropriately evaluated, they should then be used as the starting point for a wider series of workshops aimed at other players in prioritisation processes, such as DHB Board members and senior health professionals. The workshops will, of course, need to be refined and refocused significantly from their original forms to take account of their new audience. For example, there will be less of a need to focus on specific tools and techniques than on the underlying reasons and principles behind prioritisation.

This discussion of the need to promote understanding of prioritisation outside the analytical realm leads to the final aspect of capability building proposed by the committee: enhancing the prominence of prioritisation as an issue during the education of health professionals. Health professionals are key prioritisation figures both in the sense that their clinical decisions are often also resource allocation decisions, and that they have significant power to influence prioritisation decisions made at higher levels.¹⁵ The NHC thus believes it is vital that health professionals are fully aware of their role as prioritisers and supported to play this role.

The National Health Committee therefore firmly believes that the proposed national capacity-building and support strategy should address how to promote awareness of prioritisation amongst health professionals. In particular, thought should be given to how basic training in prioritisation theory and methods could be improved both in their initial training and ongoing professional development.

The National Health Committee recommends that The Ministry of Health, in partnership with other health sector stakeholders, develop an integrated information and support strategy to promote understanding of prioritisation and further develop prioritisation capacity. Initiatives within this strategy could include:

¹⁴ National Health Committee. 2004. *Prioritising Health Services: a background paper for the National Health Committee*. Wellington: National Health Committee.

¹⁵ National Health Committee. 2004. *Prioritising Health Services: a background paper for the National Health Committee*. Wellington: National Health Committee.

- a. Developing and maintaining a central library where examples of prioritisation analysis could be lodged.**
- b. Considering how best to provide specialised technical support for analysts and analysis.**
- c. Maintaining an email list for sharing information, advice, and best practice models amongst both those undertaking prioritisation analysis and other interested parties.**
- d. Running annual symposia on best practice in prioritisation.**
- e. Developing workshops for analysts to provide training in prioritisation tools and processes, and improving the availability of training in prioritisation amongst health professionals at both undergraduate level and in continuing professional development. Aspects of these initiatives could be included as part of the above symposia.**