Navigating stormy waters in times of fiscal uncertainty: mitigating the challenges

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Navigating stormy waters in times of fiscal uncertainty: mitigating the challenges

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Managers in healthcare organizations are under pressure to allocate budgets in a way that maximizes benefit to patients and populations. While historical and political forces often guide budget choices, the quest to improve performance has led administrators and researchers to explore different approaches to resource allocation such as program budgeting and marginal analysis (PBMA) and accountability for reasonableness (A4R).[1] But putting these approaches in place often involves a significant strategic and cultural shift for organizations.[2]

This may be one reason why greater emphasis is often placed on system-level reform whilst downplaying the more fundamental issue of resource scarcity and the need for explicit choice making. In fact, a recent CIHR-funded national survey revealed that over half of the health authorities and local health integration networks (LHINs) in Canada do not have a formal approach to priority setting in play.[3] Frankly, it should not be surprising that there can be substantial resistance to change in moving away from familiar historical practices and political negotiation to a more rigorous and transparent methodology for resource allocation.

In our experience of using and evaluating approaches like PBMA and A4R we have identified a number of common objections that come up time and time again, regardless of the specific provincial health system structures in place. In this short column we give attention to these points in order to help mitigate the challenges and provide decision makers with grounds on which to respond when these issues reach their desks.

Objection 1: You say this is about changing the organization culture, but it is really just another way of imposing cutbacks!

Unfortunately, the 'burning platform' for resource allocation reform is most often found in organizations that are facing financial stress. The co-occurrence of new management practices with resource scarcity can lead members of the organization to conflate more formal approaches to resource allocation with cutbacks necessitated by the economic environment. And who has ever welcomed change which leads to fewer resources? Stalling and 'head in the sand' behavior become standard practice.

> **Advice***:* Be honest. More considered approaches to resource allocation decision-making should ideally be a goal in times of both fiscal constraint and abundance. But if the objective of a resource allocation exercise is disinvestment to meet a financial gap, then say so plainly. Remind critics that the alternatives are less desirable. While a formal approach aims to optimize benefit and minimize harm resulting from budget choices, a traditional 'across the board' approach to disinvestment could in fact result in worse outcomes.

Objection 2: We took the process seriously, we played fair – but others didn't!

Some may contend that they put in feasible ideas for disinvestment and lost resources as a result, while others proposed ideas that were clearly not viable – like stopping all surgeries for the final three months

of the year. This is 'gaming' the system: if the resistors are perceived to have succeeded, then no process can have credibility going forward. This objection speaks to issues of accountability and enforcement.

> **Advice**: Managing this problem comes down to leadership and more leadership. No one can be allowed to avoid participation in the process; known sanctions must be enforced for those who fail to do so, just as would be the case for failure to comply with any other management directive. This is fundamental to fair process.[4] Senior managers have to put the overall objectives of the organization ahead of their own departmental, professional, geographical or other parochial interest. The age of silos is over.

Objection 3: You didn't engage the right people, enough people, or enough of the right people!

Therefore the results are considered in some eyes as skewed, missing important perspectives and ideas for resource allocation that would have been better than the ones which were on the table. This often presages lack of buy-in or resistance to the implementation of intended resource allocation choices.

> **Advice**: Establish a clear plan of stakeholder engagement up front and follow through on it. Multiple channels are best, including one-on-one or small group meetings (this takes leg work but it is worth it in the end). The most important decisions should be made by a credible stakeholder group with broad representation - guidelines on how individuals are selected for the panel should be clearly established a priori. If not all the important things can be funded, then surely a process of comparison and ranking of options is needed.

Objection 4: You can't use the same criteria to assess proposals from every department!

What such protestors are often really saying is, we are unique and should be treated that way: maybe the reason we lost out from the process is that it was biased against us. It is particularly challenging when the process attempts to compare clinical programs to support services, or to compare programs whose outcomes are measured by individual patient health gain with those which attempt to prevent illness and promote health at the population level.

> **Advice**: Be sure that the criteria development and weighting process is wide-ranging, open and transparent, involving as many stakeholders as possible. It is essential for there to be broad buy in and ownership of criteria from the start. We suggest multi-criteria decision analysis (MCDA) techniques, which allow a broad range of values reflective of different service lines to be accounted for.[5] Initial rankings based on common criteria are a starting point for a discussion about how sensible such rankings might look.

Objection 5: We did not know what was going on, we were out of the loop: Communication was poor!

While many organizations pay a lot of attention to soliciting proposals for investment or disinvestment, communication often falters between the time proposals are received and the time when decisions are made about which ones go forward and which do not. Staff can become frustrated when their

investment requests are not approved, and the reasons why are not shared: Is this a 'no' for now, or forever? Should they try again the next time around? What do they need to change, and why?

> **Advice***:* Senior leaders need to develop a clear communication plan, based on multiple redundant channels, and then carry it out. Include information about the process, about the results (i.e., the decisions made) and about the rationale for them. Be clear about what can be shared and what cannot (e.g., where privacy concerns arise from funding decisions that may affect identifiable individuals within the organization). There will always be some who fail to hear the message no matter how many different ways it is conveyed.

Objection 6: We are being affected by changes which someone else is implementing, but you did not account for those impacts when you approved it!

The effects from changes in service delivery can cross many department or program boundaries. Reallocation of administrative support or reduction in infrastructural support (like information management and technology) can force others to pick up the slack, or add additional resources to their own programs in order to make agreed on changes happen. No one likes to be blindsided.

> **Advice**: Consideration of cross-silo impacts should be built into business case templates; the resource allocation process might even require or privilege proposals for new investment which have explicit collaboration involvement. Separate processes for capital or information technology resource allocation may already exist. Ensuring that operational resource allocation processes run parallel to these is critical.

Objection 7: The process was too time-consuming, required too much data and had timelines that were unreasonable!

This objection is often raised when new resource allocation procedures are added atop normal practice. Without additional protected time offered to those who are asked to take on expanded roles, overwork and burnout might occur.

> **Advice***:* No question—formal resource allocation processes take time. But often much of the additional time is demanded during the first year, when processes are being set up; once it is running, incrementally there is not much additional effort over and above usual activity. There are also new software packages that can effectively streamline the work. Further data should never be used as an excuse as many millions are currently being allocated on at times sketchy data. The key is to fit the priority setting processes into the management processes that constitute the annual round of decision making about service developments and cutbacks.[6]

Conclusion

We are strong advocates of using more formal approaches to resource allocation, since they have many benefits – both in theory and demonstrated repeatedly in practice where organizations have made the effort to follow this road.[7] But they have to be put together skilfully and there will always be naysayers. Common tactics for resistance will be employed such as creating diversions, second-guessing and then

re-assessing and waiting for certainty. Process is a vehicle or tool, it is not a panacea; nor will it change the financial outlook. Done well, it can produce data or evidence that will inform choices about what will best achieve health improvement outcomes – but the choices themselves must be made by those in the healthcare system tasked with the leadership role. Too often the process per se is critiqued when in fact there is a genuine dissatisfaction with the fiscal climate more generally.

Importantly health system decision makers must not throw up their hands in despair when the above objections are raised. Few things are more important in health care management than good resource allocation practices, for which there are many examples over the last decade or more.[8] Hopefully our advice will help decision makers head off the types of objections commonly heard and will give grounds for responding to critics. Our experience and broader research shows that leadership and clinical champions are the most important influencers in doing this activity well.[9] These two groups together need to anticipate and respond proactively to the challenges in this arena.

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