Explicit Health Care Priority Setting in Practice

-Clinical managers’ views of performing vertical prioritization in Västerbotten County Council

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Abstract

**Background:** Västerbotten County Council in Northern Sweden has in 2010-2011 engaged in an explicit priority setting process. The process consisted of three steps: vertical prioritization, horizontal prioritization and political decision-making. The purpose of this thesis is to explore how the different departments in the County Council organize and perform vertical prioritization. However, the vertical prioritization cannot be assessed on its own, but needs to be put into the context of the whole priority setting process, including horizontal prioritization and political decision-making.

**Method:** A qualitative study was conducted using semi-structured interviews with eight clinical managers, each responsible for one department in Västerbotten County Council. The interviews were transcribed verbatim and analysed with a content analysis approach.

**Results:** The performance of vertical prioritization is explained in four stages: Information to employees; identification of prioritization objects; discussion and ranking; economic calculation and compiling the final list. All clinical managers engaged in these four stages but they differed in terms of how and by whom. Concerning the clinical managers’ assessment of the process one major theme emerged: Trust in and satisfaction with own performance, suspicion and distrust toward fellow departments’ and politicians’ performance.

**Conclusion:** There are several ways of performing vertical prioritization and based on this study it cannot be concluded that one way is better than another. Different solutions seem to fit different departments. In addition, more transparency and active communication between actors participating in different steps of the process could reduce suspicion and benefit the feasibility.
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1. Background

Priority setting can in short be defined as the act of ranking one thing before another. [1] The act of ranking is often implicit but yet constantly present in our everyday life. Resource allocation is used as an interchangeable concept with priority setting. Scarce resources are most often the reality, even in the most affluent societies, and they need to be allocated in some manner, consequently priority setting is inevitable. Resources have to be allocated to make it possible to implement new technology, methods, practices and drugs. An additional reason for priority setting is a desire to reduce arbitrariness in medical practice. [2] The priority setting process within the health care sector might therefore need a more comprehensive definition that includes the reality, namely scarce resources and several restraints. Hauck, Smith and Goddard [3] define priority setting as “a more or less systematic approach to distributing available resources among demands to fashion the best health care system possible, given the restraints.” (p. 17).

Priority setting in health care is made in several contexts. A common way to divide the allocation is macro, meso and micro level. Macro level prioritization is national or provincial decision-making, e.g. decisions of overall funding to the health care system. Meso level prioritization is regional or institutional and concerns regional distribution of budgets and decisions on which patients should receive care. Micro level prioritization takes place in service delivery, at the actual point of care, e.g. physicians’ decisions on whom to prioritize in the emergency room. [4-5] Macro and meso level prioritization are generally horizontal, i.e. between patient groups with different illnesses and needs, meanwhile micro level prioritization is vertical and among patient with similar problems, although different levels of need. [5]

1.1 Outline of the Thesis

I will start by describing the theoretical and ethical base for priority setting in health care, and then how these are translated into practice. A review of priority setting in Sweden will follow and the background will end with a description of the explicit priority setting process carried out in Västerbotten County Council 2010-2011. The aim and research question will then be stated and followed by a presentation of the results. The thesis will end with a discussion of the findings and a conclusion.

1.2 Theoretical and ethical base of priority setting

The basis for priority setting is ethics and values, with the central ethical concept being justice. Consensus of the definition of justice and how to set limits fairly is however not reached, and views of justice also vary greatly between different disciplines and political stands.

According to neo-classical welfare economics, aiming for efficiency or health maximisation is the most fair. The extreme would be to only prioritize in order to get the most health benefits possible from the existing recourses, the utilitarian stand. [4] In the beginning of the 1990s this approach was launched in Oregon, USA. The ranking was based on cost effectiveness and no priority was given to the seriously ill patients. The approach became highly criticized when it turned out that basic standard procedures got prioritized before life-saving surgery and consequently the approach was adapted and changed. [6] Another example illustrating the problems with this approach is palliative care. The resources used in palliative care will barely improve health and will unlikely provide future monetary benefits, but it will hopefully im-
prove the quality of life. With a strict utilitarian view palliative care will not be prioritized even if the patients are very sick. [6]

Libertarians would, on the other hand, say that justice requires individual freedom and freedom of choice, hence prioritization should be done in accordance to patients’ demands. A more egalitarian view instead holds equity as the core of justice, i.e. equity in terms of distribution, universal health care coverage and prioritization with respect to equal value and the dignity of individuals. [4] The Swedish parliament, as an example, has decided upon three ethical principles to guide health care decision-making; the principle of human dignity, the principle of needs and solidarity and the principle of cost effectiveness, and with the two first being superior the third. In other words, the sickest patients will be given priority first. [7] Hence, it has nothing to do with cost effectiveness, freedom of choice or expected health benefits. However, it can be argued from a utilitarian stand that this approach is unjustifiable because it means sacrificing potentially much greater health benefits but for less sick patients. [6] This also illustrates the need to balance between the common good and the good of individuals in priority setting. [2]

The National Centre for Priority Setting in Health Care (the Prioritization Centre) in Sweden proposed in 2007 a revision of the current ethical template. They argue for an update and clarification of the three existing principles but also suggest a forth principle, that of personal responsibility. Three main reasons are stated; First, people should be respected as free and capable individuals that take responsibility for their actions and their consequences. Second, as patients’ power and influence increase, responsibility should follow. Respecting human dignity is both about autonomy and assigning responsibility. The third reason is more symbolic and states that patients should have an active and participative rather than a passive role in the interaction with the health care sector. [8] On the other hand, The Swedish National Council on Medical Ethics disagrees and sees many problems with the principle of personal responsibility. The Council means that it is virtually impossible to define and draw the line of what is self-inflicted. It also refers to social stratification when it comes to individual risk behaviour and to individuals having different capabilities to understand information, due to biological and social reasons. [9] There is a lot more to this particular discussion but in summary consensus is lacking on what fair priority setting is and should be.

1.3 Priority setting in practice

Ethical guidelines and principles are important in establishing key values that everybody working in health care should have at heart, but is it enough to make decisions in the real world of health care? According to Martin and Singer [10] a normative approach is insufficient because the different ethical principles can lead to different conclusions and no definite answer about what is fair or not. On the other hand, they mean that empirical approaches also are insufficient because they can only tell us what could be done, but not what should be done. Ham and Coulter [11] mean that ethical values often remain at a macro-level and efforts to put the values in practice at a meso and micro level, into actual decision-making and day-to-day medical practice, are lacking. Martin's and Singer’s suggestion for making fair priority setting in practice is to focus on the process instead of the decisions. They mean that if the procedures to reach the decisions are fair, the decisions will be fair as well. [10]

In countries like Sweden, with universal coverage systems, focus is rather on how the authority is exercised than on who exercises it. Daniels and Sabin [6] have developed a conceptual framework for arranging or evaluating fair priority setting processes
called Accountability for Reasonableness (A4R). The framework contains four conditions (see Box 1), and again puts emphasis on the priority setting process instead of the end-result in terms of decisions and effect.

<table>
<thead>
<tr>
<th>Relevance</th>
<th>Rationales for priority setting decisions must rest on reasons (evidence and principles) that “fair-minded” people can agree are relevant in the context. “Fair-minded” people seek to cooperate according to terms they can justify to each other—this narrows, though does not eliminate, the scope of controversy, which is further narrowed by specifying that reasons must be relevant to the specific priority setting context.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicity</td>
<td>Priority setting decisions and their rationales must be publicly accessible—justice cannot abide secrets where people’s well-being is concerned.</td>
</tr>
<tr>
<td>Revision/ Appeals</td>
<td>There must be a mechanism for challenge, including the opportunity for revising decisions in light of considerations that stakeholders may raise.</td>
</tr>
<tr>
<td>Enforcement</td>
<td>There is either voluntary or public regulation of the process to ensure that the first three conditions are met.</td>
</tr>
</tbody>
</table>

Box 1. The Four Conditions of “Accountability for Reasonableness” [6]

Further they argue that ‘The question of how to make limit-setting decisions form the core of the legitimacy problem.’ (p. 6). The legitimacy problem is a fundamental ethical problem in all health care systems. When is it acceptable for a society to give legitimacy to institutions or individuals to make prioritization in health care? [6]

The question of how leads to the central discussion about implicit and explicit priority setting. Implicit prioritization implies more pragmatic and muddling through strategies, meanwhile explicit prioritization is systematic and accountable. An implicit strategy could possibly be more sensitive to the cultural context, personal preferences, the complexity of medical decisions, and build on respect for the autonomy of medical practitioners. Implicit strategies might be most suitable for micro level priority setting, and probably completely necessary at the point of care. Advocates of explicit strategies instead refer to fair processes and equity. They suggest that an explicit process makes decision-makers reflect on their decisions and their consequences. Explicit processes will make it possible for citizens to know what can be expected from the health care sector, and if it is not acceptable, citizens have an opportunity to object through democratic processes. However, explicit priority setting is more demanding in terms of administration and also use of different techniques are necessary, e.g. scoring systems, cost effectiveness analysis and information of costs and outcomes. [2, 6]

The question of who is nevertheless also important. The ethical guidelines are decided on a macro level but the ultimate responsibility for the services provided, the access to health care, is often put on meso level health authorities. Ham and Coulter [11] refer that to a tendency for politicians to avoid blame. This results in politicians being more likely to facilitate priority setting by developing guidelines and frameworks rather than defining lists of what services and treatments to be subsidised or not.
1.4 Priority setting in Sweden

1.4.1 A short introduction to the Swedish health care system
The Swedish health care system is highly decentralized and publicly financed. All three levels of government (central government, county councils and municipalities) are involved in health care. The state has the overall responsibility and formulates the national health policy. The 21 county councils and regions are responsible for service delivery. Due to different local conditions and priorities the organization of service delivery may vary between county councils. The county councils are also organized into six larger regions that are providing highly specialized care at the region or university hospitals. Sweden’s 290 municipalities have the main responsibility for elderly care and care for the disabled. [12]

There is a universal coverage and a free choice of provider. The system is mainly financed by local and state taxes (72%). About 3% of the revenues come from out-of-pocket payments. [13] Patients pay 100-150 SEK for physician visits, but never more than 900 SEK for a 12-month period. Private health care providers carry out about 10% of the publicly financed health care. Private care where patients pay the whole cost themselves is a very small part of Swedish health care. [12] The total health expenditures is 8.9% of GDP. [14]

1.4.2 Priority Setting in Swedish Health Care
The Swedish parliament adopted in 1997 the ethical foundation or template for priority setting in health care. It was preceded by the final report by the Parliamentary Priorities Commission (The Commission Report) in 1995. To repeat, the three principles are: Human dignity, needs and solidarity and cost-effectiveness. Important to note is that the last principle is subordinated the other two and should only to be used when comparing alternative treatments for the same condition. Alternative principles that were discussed but excluded by the Commission were: the utility principle, the lottery principle, the inquiry principle and self-determination. Other principles that was viewed as not acceptable and therefore banned were: age, self-inflicted conditions, merits and demerits (responsibility). The Commission also proposed four priority groups to guide prioritization (see Box 2). [7, 15]

| I. | Emergency care for life-threatening conditions. Care for conditions that if not treated would lead to lasting impairment and premature death. Care for severe chronic diseases. Palliative care at the end of life. Care for people with reduced autonomy. |
| II. | Prevention. Habilitation and rehabilitation. |
| III. | Care for less severe acute and chronic conditions. |
| IV. | Care for reasons other than illness or injury. |

Box 2. Priority groups, as proposed by the Commission. [7]

The National Board of Health and Welfare (the NBHW) was assigned by the Parliament to develop guidelines in accordance to the decision. There have been critics to the applicability of ethical guidelines in Sweden as well. [8, 16] Swedish health care management staff have expressed that they are aware of the ethical platform but believe it is hard to use in practice. [8] It has also been suggested that the priority groups are confusing. Groups by themselves are not enough, but need to be connected with a disease or an intervention. They have, in some cases, been shown to
block priority setting with the arguments that services to highly prioritized groups can no further be discussed and hence constitute an obstacle to prioritization. The NBHW’s and the Prioritization Center’s point of view is removal or major revision of the groups. [5, 8]

Although the NBHW had wished for more concrete and national top-down limit setting they set out to develop managerial methods for practical priority setting. The focus was on vertical priority setting rather than horizontal. [5] Together with the Prioritization Centre, and with the help from several other organizations involved in vertical priority setting, the NBHW developed a national model for explicit vertical priority setting (See Figure 1). The model is based on the ethical framework and with the ultimate outcome in form of a ranking list ranging from 1-10, where 1 is the highest and most prioritized and 10 is the lowest and least prioritized. In addition, instead of a rank the two labels ‘don’t do’ and ‘Research and Development’ can be assigned in cases where there is no proof of benefits, proof of harmfulness or when something needs to be further evaluated. To simplify it, the rank order can be divided into three larger groups where rank 1-3 signifies what needs be done and are considered the core activities, rank 4-6 are what ought be done and are perceived as expected services, and rank 7-10 are what could be done if economic circumstances would allow it [17].

<table>
<thead>
<tr>
<th>Health condition/ Intervention</th>
<th>Severity level of health condition</th>
<th>Patient benefit/ effects of intervention</th>
<th>Evidence of effect</th>
<th>Cost per life years gained/ QALY</th>
<th>Health economic evidence</th>
<th>Rank order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition and actual state/ action or intervention</td>
<td>Level of severity: Very high High Moderate Low</td>
<td>Benefit/ effects: Very high High Moderate Low</td>
<td>Evidence grades 1-4, or Very good to insufficient scientific evidence or Standard clinical practice</td>
<td>Low, Moderate, High, Very high or Cannot be appraised</td>
<td>Good Some Calculated or Estimated</td>
<td>1-10, “Don’t do” and R and D (unknown benefits and in need of evaluation)</td>
</tr>
</tbody>
</table>

Figure 1. The National Model for Transparent Vertical Priority Setting, slightly simplified by Waldau 2010. [5]

The model is designed to work in most areas of vertical prioritization, but when and how it should be carried out is left to local and regional authorities. In February 2011 the NBHW announced a working process to revise the national model. They claim the model is in need of revisions but also assured that there will be no fundamental changes. [18]

In the beginning of the 21st century the NBHW also started to use the model to develop national guidelines for all levels of health care decision-making and prioritization. The guidelines are made in resources demanding areas, e.g. large patients groups with chronic diseases. Some examples are guidelines for: Breast, colorectal and prostate cancer; dementia; depression and anxiety disorders; diabetes. The guidelines are based on thorough literature reviews and health economic calculations. The end-result is a ranking list from 1-10 and recommendations of what should not be done at all as well as areas in need for further research and development. [19] Waldau [5] means that the guidelines are in line with the A4R framework: ’The Board (NBHW) practices broad participation in guidelines production as well as inclusive forms for information. Because its arguments and recommendations are made public, an analytic “gold standard” tool is used and participation and perspectives are
multi-professional, guidelines are revised regularly, and the Board enforces these procedures, they can be judged to meet the A4R framework.’ (p. 22).

1.4.3 Explicit Priority Setting in Swedish Health Care

Emphasis of the importance of explicit prioritization in Swedish health care is found in many official reports, e.g. reports by the NBHW and the Swedish Society of Medicine. [16, 20] The Swedish Parliament mean that open presentations and discussions of prioritization is a question of democracy and is important in order to sustain trust in the health care system. [7] The Swedish National Audit Office performed in 2004 an audit of the government’s and national authorities’ efforts of putting the content of the government proposition into practice, i.e. the ethical principles and the issue of making prioritization explicit. Their conclusion is that the government has not done enough in order to make the proposition applicable in practice. On the other hand, they mean that the NBHW’s work with explicit priority setting has been satisfactory and prioritized within the organization. [16] In 2007 the Prioritization Centre also followed up the implementation of the government proposition and their conclusions are in line with the Audit Office’s in the sense that most Swedish health care priority setting still is implicit. However, there have been some local efforts of vertical priority setting and few attempts to systematic horizontal priority setting. The county council of Östergötland was first out to perform a transparent and systematic priority setting process in Sweden. Even though the process was considered fair and legitimate, as well as reasonable and accepted by a majority, the process was heavily criticized. It was subject to a lot of negative media attention when the county council presented their list of services that would no longer be publicly financed. This was primarily due to an information problem, arising from the fact that the presented list was a mix of service limitations, transfers to other care providers and care levels as well as tightening up of indications for care, and the public not being able to distinguish between these. Despite the criticism, the county council of Östergötland has continued developing its own explicit priority setting process. [21- 22] A few other county councils have worked in different scopes with explicit priority setting, e.g. the county councils of Värmland, Jämtland, Västra Götaland, Örebro and Kronoberg. [22- 23] The thesis will however focus on Västerbotten County Council that in 2008 initiated a comprehensive explicit priority setting process including three steps: Vertical prioritization; horizontal prioritization and political decision-making.

1.5 Priority Setting in Västerbotten County Council

1.5.1 The setting – Västerbotten County Council

The county of Västerbotten is located in the northern part of Sweden and is about the size of Denmark. Västerbotten has almost 260 000 inhabitants, the majority of them lives in the capital Umeå (114 000 inhabitants) and the city of Skellefteå (72 000 inhabitants). Except the two city regions and the town Lycksele (12 500 inhabitants) the county is very sparsely populated (county average: 4,7 persons per square kilometre). [24]

The Västerbotten County Council (VCC) is a politically managed regional body with 10 000 employees, one university hospital in Umeå, two district hospitals in Skellefteå and Lycksele and 36 primary care units. [25] Their main mission is health care, dental care, care for the disabled and public health, but the VCC is also responsible for highly specialized care in the northern health care region (including the counties of Västerbotten, Jämtland, Norrbotten and Västernorrland), research and development as well as some cultural and educational activities. There is a clear cut between the political and the professional organisation. The politicians form the County Council Assembly and have the overall responsibility of establishing goals,
financial framework and a sense of direction. The County Council Executive Committee functions as the ‘government’ and manages the operations (see figure 2). The politicians are elected through general elections every four years.

![Diagram of the organisation of elected representatives](image1)

Figure 2. The organisation of elected representatives. [26]

The professionals form the County Council’s administration, which is divided into five countywide operations: local medical care; specialized care; diagnostic and medical service; disability operations; internal service. Further the VCC has two internal companies: the Swedish Public dental Service and primary care. Each of these seven departments has one executive officer. The County Council Management Group is led by the County Council Director who is the highest-ranking official and consists of the executive officers, staff for research and development, secretariat, organizational management, growth and regional development as well as management support (see figure 3).

![Diagram of the County Council’s administration](image2)

Figure 3. The County Council’s administration [26]
1.5.2 The Explicit Priority Setting Process in Västerbotten County Council

Västerbotten County Council’s vision is to have the world’s highest quality of health and the healthiest population by 2020. [26] In the work towards this vision the organization has recognized the importance of open and systematic priority setting. [27] The VCC priority setting process is a practical application of the government proposition with the aim to achieve a higher standard of health without higher costs, made possible by the redistribution of existing resources. Funding of new medical technologies will be possible through disinvestments in low priority services. [5, 28] The VCC writes that it is about reallocating resources fairly; health care decision-making needs to be fair and ethically justifiable and the way to accomplish that is through an explicit and systematic priority setting process that involves the whole organization. [29] Hence, implementation of a top-down policy decision using a bottom-up approach. [5] Moreover, the VCC clearly distinguishes prioritization from rationalising and cutting costs. Prioritization, they mean, is about allocation and using the existing resources in new and better ways. [27]

In the autumn of 2010 the VCC started its second priority setting process, two years after the first one, which was performed during 2008. The process consisted of three main steps. The first step was vertical prioritization (September- November 2010). All clinical managers were responsible for identifying the lowest prioritized services, interventions and activities, equal to 10% of each department’s net budget. For the identification they used the national model for vertical prioritization. Non health care department used a simplified version. Departments that shared the same scope of practice collaborated and presented one common ranking list. [30]

The second step, horizontal prioritization, took place between departments (February-March 2011). Departmental representatives, often the clinical managers or the senior clinician, got together in groups and worked for three days with each other’s material. Their work aimed to assure the quality of all ranking lists and a levelling of ranks, and was supposed to result in a proposal of the lowest prioritized activities that corresponded to 5% of their common net budgets. In contrast to the process in 2008 the health care departments and the non health care departments did not work in the same groups. The health care departments formed seven groups with a maximum of ten representatives in each group. All groups had an external leader and a secretary and should represent as many different departments as possible and cover the span of health care provided by the VCC. Diagnostic and medical service, public service, professional and political administration and a few similar departments performed a parallel horizontal priority setting. [5, 30- 31]

The third step started with a forum-meeting with representatives from the clinical departments, the VCC administration and politicians (April 2011). The purpose was to present the ranking lists, the lists formed the basis of the following political decision-making. Before the meeting the VCC’s administration reviewed the lists, e.g. to made sure of their quality and the accuracy of economic calculations. Hence, the lists were left for political processing and decision-making. The final decision should constitute 3% of the VCC’s budget (political decision in June 2011). The implementation was planned for year 2012-2013. [28] This process of explicit priority setting is the focus of this thesis.
1.5.3 Justification of the thesis

My interest in the Västerbotten priority setting process started with a lecture by Susanne Waldau, PhD and strategic prioritization adviser at the VCC. It turned out that the VCC themselves as well as the Prioritization Center had performed different types of evaluations of the process. One of the evaluations of the 2008 priority setting process showed some evidence of very different ways of organizing the vertical prioritization. Knowledge of how the vertical prioritization actually was performed was however lacking. This gap of knowledge raised an interest to look further into the vertical part of the priority setting process and compare the work of different departments.

I view this thesis as a presentation of new knowledge that could be used to strengthen the prioritization process, but also as a foundation for further research in the area. The results can be used to study the vertical prioritization in a more quantitative manner, e.g. the thesis can be used as a pilot study for a larger quantitative study by developing a questionnaire based on the new knowledge presented.

2. Aim

The Västerbotten County Council has developed an explicit priority setting process to apply the ethical framework in practice. But how is the process carried out?

The purpose of this thesis is to explore how Västerbotten County Council’s departments perform vertical prioritization. Emphasis is put on vertical prioritization because clinical managers are themselves responsible for developing and carrying out that part of the process. However, the vertical prioritization cannot be assessed on its own, but must be put into the context of the whole priority setting process, including horizontal prioritization and political decision-making. I aim to explore and gain an understanding of the VCC’s priority setting process by using eight clinical managers’ experiences, knowledge, opinions and attitudes.

2.1 Research questions

1. How is the vertical prioritization organized?
2. How do clinical managers assess their own performance?
3. What problems and difficulties occurred during the vertical prioritization?
4. How do clinical managers assess the whole priority setting process?
5. What strengths and weaknesses of the whole priority setting process are identified?
3. Method

3.1 Data collection and sample

The data collection has been made in collaboration with Susanne Waldau, priority setting strategist at Västerbotten County Council (VCC). Currently, Waldau plans and performs most of VCC’s own evaluation of the prioritization process and has therefore been important as a gatekeeper in order to gain access and to avoid asking the same people the same questions twice.

The data collection took place in two steps. The first step was a short questionnaire distributed to all clinical managers in the VCC and the second step was qualitative interviews with eight clinical managers.

The short questionnaire was developed to fulfil two purposes. Most important was to get a selection base for the sampling of informants to the qualitative interviews, but the questionnaire also aimed to provide an overall picture of how the vertical prioritization was organised by the clinical managers. Earlier evaluations of the priority setting process indicated that different ways of organizing the vertical prioritization existed. To obtain more comprehensive knowledge of this part of the process qualitative interviews were chosen as the most appropriated method. Qualitative interviews are suitable when searching for more detailed and profound information. [33] Another reason for choosing qualitative methods was the existing knowledge gap, when ideas of what is going on and why are lacking, open-ended and flexible questions are necessary.

The questionnaire contained questions about who was involved in the vertical priority setting process, what professions and positions the involved had and how many they were. The managers were also asked to state their own profession. The questions were discussed and developed together with members of the VCC’s reference group for the priority setting process. This was in order to increase the possibility of an acceptable response rate. The reference group consisted of well-renowned members representing several medical fields, most with a research background as well. Attached to the questionnaire was an information sheet that stated that the aim of the study was to research how the vertical prioritization was performed, that the results would be used in my master thesis and would work as a selection base for future interviews. It was also stated that their individual answers would be known only to my supervisors and me.

An intranet site for managers only ("Chefskanalen") constitutes a main internal information channel for the management in the VCC. The questionnaire was distributed to the managers through this channel, which was believed to improve the response rate.

According to a VCC project report after the first priority setting process 2008 there was 96 clinical managers, 55 (57%) women and 41 (43%) men. [32] In total 38 responses were sent back by 37 persons (one clinical manager had responsibility for two different departments), 22 (59%) women and 15 (41%) men. Six responses were not complete. Low response rates have been a consistent problem in several surveys carried out within the VCC in the 2000s. [5]

Because the response rate unfortunately turned out low, about 39%, the results will not be presented. Hence, the completed questionnaires were only used for the first of the two original purposes, namely to acquire informants.
3.2 Sampling for qualitative interviews
The sampling procedure was purposive with the aim to obtain a theoretical representative sample. Dahlgren et al [32] describe the aim of such a sample as “... we want to reach people within the study area who can share their unique slice of reality, so that all slices together illustrate the range of variation within the study area” (p. 33), and mean that purposive sampling is appropriate when the research question is about how and why.

Of respondents, 37 completed the questionnaire and formed the selection base. The sample differed in certain characteristics, in this case clinical managers that had worked differently with the vertical prioritization. Differences in terms of who and how many they involved in the process, but also the departments’ sizes and scope of practice were considered. Geographical considerations also played a part due to practical reasons. Only informants located in Umeå were selected. Of the Umeå-based respondents I wanted to interview managers who only involved the departments’ steering group as well as managers who involved a large part of the personnel in the process. Of the five countywide operations in the VCC, four were represented and one of the two internal companies was represented in the interviews. The size of the departments varied from about 45 to 420 employees. I also strived to obtain a gender balance, and so three informants were women and five were men.

Together with the two supervisors it was decided that eight interviews would be appropriate. It would be enough to obtain a proper amount of data and still feasible out of consideration for time constraints.

The informants were contacted by phone in December 2010 and January 2011 and invited to participate in the study. I referred to the questionnaire where it was stated that they would possibly be contacted for further interviews. One contacted manager declined participation.

3.3 Interviews
Eight interviews were performed in Swedish and lasted in average 52 minutes. The interviews took place in December 2010 and January 2011, and for practical reasons at the managers’ offices or in nearby conference rooms during working hours. The interviews were made in an undisturbed manner, except one that briefly got interrupted when the manager’s co-worker needed to ask some questions.

The question guide was developed together with Susanne Waldau (second supervisor). It was loosely divided into three parts: 1) How the vertical priority setting was done; 2) reflections of the vertical priority setting; and, 3) general knowledge and attitude towards the priority setting process. All questions were basically put to everyone, but the interviews were semi-structured and the questions did not follow a particular order. However, all the interviews started with me asking the informants to describe how they had performed and organized the vertical prioritization. All interviews were recorded digitally.

3.4 Data analysis
The recorded interviews were transcribed verbatim. After the two first interviews it was discovered that the recording device was not working properly. The recorder recorded bits and pieces and the recorded material was about half the length of the actual interviews. These two interviews were therefore not only transcribed but also summarized immediately after the interviews in order to try making up for the lost data at the recorded files. The recording device was then exchanged.
A content analysis [35] approach was used in the analysis. Meaning units were transformed into condensed meaning units that could speak for themselves but were very close to the original text. The condensed meaning units were labelled one of nine content areas. Condensed meaning units were then organized into content areas for further analysis. This was made in order to get an overview of what areas had been discussed and what each informant said about that specific area. The content areas were mutually exclusive with a few exceptions, which were marked and put in both content areas until further analysis (see Table 1).

Table 1. Example of meaning units, condensed meaning units, content areas and categories.

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensed meaning unit</th>
<th>Content area</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I believe so. You know your own department and the situation. It is very important that organize it wisely so that employees feel that this is reasonable, plausible and important. Absolutely, the process cannot be more top-down than it already is.</td>
<td>The clinical managers should organize the vertical prioritization because they know their departments. It is very important to organize it in a manner that makes the employees feel that this is reasonable, plausible and important. It cannot be more top-down than it already is.</td>
<td>Reflections of vertical prioritization</td>
<td>Clinical managers organize the vertical prioritization in the best manner</td>
</tr>
<tr>
<td>And this has to be very hard, but then, because all I have spoken to describe that the money exists first when talk about what “should be done” and then the question is: Will this decision be executed, will it be possible to execute it?</td>
<td>All I have spoken to describe that the money first exists when it comes to what “should be done”, the question is then if the decision will be possible to execute.</td>
<td>The political process</td>
<td>Uncertain if politicians will dare to make a hard decision</td>
</tr>
<tr>
<td>Yes, it is, I think so, it’s because we have to use the resources we have in the best possible manner. Use the values we get the most utility and effectiveness from. We should not use money and resources on things, yeah, for example, if we don’t know for sure it is working we should not do it.</td>
<td>We have to use our resources in the best possible manner to get the greatest value and utility. We should not spend money on things not proven effective.</td>
<td>The whole priority setting process</td>
<td>The aim with the process</td>
</tr>
</tbody>
</table>

Each content area were analysed and the condensed meaning units were assigned categories. Since each of the nine content areas were analysed separately the amount of data became quite manageable and assigning codes before categories was perceived as an aggravating factor rather than facilitating the analysis and hence was not done. Some of the content areas were mostly descriptive, e.g. “department organization” and “description of vertical prioritization”, others were predominantly reflective, e.g. “reflections of vertical prioritization” and “the political process”. The content area “description of vertical prioritization” was analysed in terms of stages in the process and hence the stages formed the categories. In the more reflective content areas the theme “Trust in and satisfaction with own performance, suspicion and dis-
trust towards fellow departments’ and politicians’ performance” was identified (see Table 2). Table 2 will be further explained and discussed in the results (p. 29).

Table 2. Theme, sub-themes and categories.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Trust in and satisfaction with own performance, suspicion and distrust towards fellow departments’ and politicians’ performance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-themes</td>
<td>Positive self-judgement</td>
</tr>
<tr>
<td>Categories</td>
<td>Satisfaction with own performance</td>
</tr>
<tr>
<td></td>
<td>Clinical managers organize the vertical prioritization in the best manner</td>
</tr>
<tr>
<td></td>
<td>Limited self-criticism</td>
</tr>
</tbody>
</table>

3.5 Data trustworthiness
The interviewer and the researcher (in this case the same person, the author) are human research instruments in qualitative research and/because it is in interaction between people that knowledge is generated. Hence, the interviewer will influence the interviewees and subsequently the data. In qualitative research this is not a weakness but one needs to be aware of it and try to be reflexive about it. [32] However, these interviews were about the informants’ professional life, their work and their views as clinical managers. It did not touch upon their personal lives, it was more a matter of telling me how they had worked. The power-relation that could make informants say what they believe the interviewer wants to hear was not considered an issue in this study. [36] The informants had high autonomy and a high status in society due to their professions. The interviewer had never worked within the health care sector and had therefore the same pre-understanding for all the departments and should therefore not be biased in that aspect.

The aims of the study were developed with the help of the second supervisor who had a lot of experience and knowledge of this specific setting and in the field of priority setting in health care. She also helped assure that the question guide was of high quality in terms of logic order and relevance of the questions.

3.6 Ethical considerations
The informants were contacted about interview participation by phone, and if consent were given a time for interviews was scheduled. The majority received a confirmation e-mail with additional information. Before the interviews started the informants were assured anonymity in the study and gave their oral consent to the use of recording device.
4. Results
To start with, the eight interviewed clinical managers headed quite different departments in terms of size, type and scope of practice, but also in terms of organisational structure. The number of employees varied between 45 and 420, with a mean of 174. As described in the background the VCC is divided into five countywide operations and two internal companies. The informants represented specialized hospital care, dentistry, diagnostics and medical service, disability operations and internal service departments.

The basis of departmental organisation was the base units, often organised after disease categories, field of specialisation or geographical cover. Each base unit consisted of several professions, had one unit manager and the health care units also had a senior clinician. Employees in the base units, and some time across them, formed additional constellations, e.g. process groups and teams. A few base units also had their own boards consisting of the unit manager, the senior clinician and representatives from the unit’s different professions, the members were not fixed but varied depending on the issue discussed. Some departments had their base units spread across the county meanwhile others’ were all situated in Umeå University Hospital.

The clinical managers ran the departments together with a steering group, always consisting of the unit managers and sometimes including the senior clinicians and other staff such as a human resource specialist, computer specialist, controller and secretary. The departments were independent in various degrees. A few departments had the same scope of practice but in different areas of the county and with independent budgets but followed common guidelines and collaborated in deciding processes and way of working, e.g. through a county wide steering group consisting of the departments’ clinical managers. The departments also had a varying degree of regional health care, i.e. highly specialized care performed at six university hospitals in Sweden. Regional care is often strictly directed by national guidelines from the NBHW.

4.1 Performing vertical prioritization
The performing of vertical priority setting could be explained in four stages:

1. Information to employees
2. Identification of prioritization objects
3. Discussion and ranking
4. Economic calculations and compiling the final list

All eight departments worked through all the stages, more or less in the stated order, but quite differently in terms of how and by whom. Four main actors or group of actors can be identified: the clinical manager; the department steering group; the base unit management and the employees.

4.1.1 Stage 1, Information to employees
The informants informed their staff about the prioritization process first and foremost orally at workplace meetings, but also through additional e-mails. None of them organized extra meetings for the information but exchanged the content of planned meetings with information about the priority setting process. Informant C, D and F emphasized that they personally gave the information to all their base units, including the ones outside of Umeå. The majority of the informants had however all their base units in Umeå.
The timing of the information differed somewhat. Most provided the information in September 2010, shortly after a management meeting where detailed information about the whole priority setting process was given by the County Council Director and administration. Informant B started already in March 2010 to encourage the employees to think about prioritization even though the detailed instructions were lacking at that time.

The information consisted of how the process was to be performed but also more general information about priority setting as a concept. An important part has been to clearly differentiate the priority setting process from cutting costs, rationalization, downsizing and other types of budget cuts.

“It is very important that you say that this is a prioritization [...] But it is very hard to understand that when you are in the peripheral parts and only see cuttings, cuttings, cuttings and saving. We have had a lot of savings during the years and it has been a fastidious task to explain that this is a prioritization and we have to wait and see what happens. I have myself gone through this with each base unit.”

Informant D

All recognized the obvious importance of providing information of the process beforehand. Informant E also emphasized the importance of continuous information and transparency during the process. Through the creation of a common computer-folder he ensured the possibility for all employees to follow the base units’ working progress of the vertical prioritization.

4.1.2 Stage 2, Identification of prioritization objects

The way of identifying prioritization objects differed between the departments predominantly in terms of involvement. Generally there were three different constellations of participants, however with no clear cut between them. For departments C, D and H identification of prioritization objects was mainly a task for the clinical manager and the department steering group or just the clinical manager in collaboration with other clinical managers from the same type of department but with different geographical cover. At departments A, E and F the mission of identification went to the base unit management, i.e. the unit manager, the senior clinician and sometimes specialist doctors, or to the unit board. Departments B and G had the most structured way of including all employees and started the identification at the base of the organizational hierarchy.

Many departments changed the way of identifying objects from the first priority setting process in 2008. Department C started the process in 2008 by asking all employees to tell their unit manager what they would exclude from their job assignment if they would work 10% less a week. That extensive work still felt up-to-date and informant C suggested that only the steering group would identify prioritization objects this time. Department G did exactly the opposite. In 2008 they experienced a lack of time in the process and just engaged the steering group in the identification stage. This time the department’s process groups got the mission to identify prioritization objects by making employees suggest objects, with the aim to anchor the process more broadly this time and obtain suggestions from the whole staff.

Many of the departments that did not engage staff in a structured way stated that they welcomed suggestions from employees. Informant F did not know exactly how the employees’ suggestions had been taken into account in the base units’ identifica-
tion work, but stressed that a few individuals did not make the identification themselves. Further he said that the whole staff could not possibly participate. Instead, delegation and dissemination of information upward and downward in the organization would ensure an elaborative identification stage.

"...we have a certain kind of organization and we have many hundred employees and then all 400 can't sit in on the meeting, we don't have that kind of space. You have to delegate and disseminate the information downwards and then upwards. I trust my colleagues in that they are good communicators. [...] But whether all nurses at unit X have felt participative or not I don't know."

Informant F

The identification stage was either about systematically going through the activities performed at the department or about brainstorming possible prioritization objects. Many departments had based the identification on the work done in 2008. Some objects that were then suggested in the vertical prioritization were excluded in the end and could therefore be suggested again. Many informants also stated that they work with prioritization continuously, although not in this systematic manner, but had therefore already identified some objects. Some units had worked with different international quality assurance systems and could use that work as a base. Others, like one of informant E's units, had had a change in type of patients, which made it impossible to use the work from 2008. At department H they did not only think in terms of objects, but more in terms of size of possible impact.

"To get any effect and reach such big numbers you have to identify prioritization objects that are done very often. Nothing happens if you exclude something that is done once a year, no money or time to save. It has to be something that has a bigger impact, e.g. things like how often we examine a risk group. And then you value possible negative consequences for the health of the patients."

Informant H

Departments had access to internal consultants for methodological support. The extent of using the support and experiences of it varied. Informants B and G consulted them in the previous process, but not this time. Informant B experienced it useless in 2008 and did therefore not want the support in this year's work. Informant G had a member in the steering group that were experienced in the priority setting process and did not feel the need for extra methodological support. Informants C, F and H involved the consultants. Informant H appreciated the help and meant that the consultant got a lot of questions from the steering group. Informant F was more vague and talked mostly about the difficulties in actually scheduling a meeting with a consultant, something that also informant B mentioned.

4.1.3 Stage 3, Discussion and ranking

After identifying objects in one way or another, the proposed objects were discussed further. Some departments chose to identify and rank all their activities and others started at the bottom, among the lowest ranked activities and working their way up to cover 10 % of their net budgets. The departments often started with trying to exclude their core activities and what they felt were absolutely necessary for them to continue doing. Informant D also mentioned that they kept their bordering departments in mind and were careful to not suggest objects that would imply extra work for other departments.
“Sometimes it was difficult and then we thought about what our core activities really are. What it is we absolutely have to do, that no one else can or has knowledge about. And then we had to think about that.”

Informant B

At department C, D and H, where the steering groups were responsible for the identification, all steering groups to a varying degree brought the suggested prioritization objects to the base units and the employees. Informant C informed employees at workplace meetings and let them discuss the matter with and without her. The unit managers were then responsible for bringing the suggestions back to the steering group. Informant D had a similar approach and informed the employees about the objects and how she and the steering group had been thinking about them. She acknowledged that employees could have difficulties in criticizing or coming up with other suggestions at that time but that the main purpose was to inform. Department D also discussed their objects with bordering or interdependent departments. Together they went through potential consequences of prioritization at each other’s departments. Informant H informed about the process and accepted suggestions from employees, but not in a very organized manner.

Departments A, E and F that started the identification at a base unit level, and also let the base units do most of the discussion and ranking. All the base units ranked the objects by using the National Model. At department A, all unit managers brought their unit’s ranking list to the steering group and there they had a small horizontal prioritization. At department E, the base units’ work involved different groups in the discussion and ranking, some had discussions at workplace meetings, others mainly with the teams or profession groups at the unit. Department F had a one day prioritization seminar where the clinical managers, unit managers, senior clinicians (the steering group) and specialist doctors participated. Each unit presented their objects and their ranking in the National Model and then discussed them together.

Departments B and G, that started the identification by asking the employees, let the steering groups do the discussion and ranking. Informant B mainly worked with the ranking herself. In this case the employees had not discussed the objects by using the National Model but they used the ranking groups: 1-3, 4-6 and 7-10. At department G the identified objects where discussed in the county steering group, however the process leaders participated in the meeting and took the steering group’s suggestions into account and finalized the ranking.

The usage of the National Model differed between the departments even if they all presented their end-result in it. The non-health care department used a simplified version. The evidence base and cost effectiveness were rather based on estimations than on scientific research.

“...when it comes to cost effectiveness it has mostly been our own estimations, that’s because this is an extremely difficult thing to do...how does one calculate the value of quality of life?”

Informant F

Informant H did not know exactly how the economic calculations had been done but cost effectiveness studies were not used to decide the ranking. Informant A said that cost effectiveness studies were used sometimes, when they could be found.
4.1.4 Stage 4, Economic calculations and compiling the final list
The final stage was similar at all departments. The clinical manager was responsible for the final list and ranking of prioritized objects. To his/her help economists and controllers at the departments helped with the economic calculations to make sure that the final list covered 10% of the departments’ net budgets. Some informants stated explicitly that an economist performed the calculations, others said that the steering group made the calculations, in which economists could participate. See Table 3 for a summary of stage 2-4.

Table 3. Actors in vertical priority setting

<table>
<thead>
<tr>
<th>Department</th>
<th>Identification</th>
<th>Discussion &amp; ranking</th>
<th>Calculation &amp; compiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The base units identified prioritization objects. Employees could make suggestions.</td>
<td>Discussion and ranking took place in the department steering group.</td>
<td>Controllers checked it through and did economic calculations.</td>
</tr>
<tr>
<td>B</td>
<td>Employees suggested prioritization objects after brainstorming.</td>
<td>Discussion and ranking took place in the department steering group.</td>
<td>The clinical manager compiled the list, an economist made the calculations.</td>
</tr>
<tr>
<td>C</td>
<td>The steering group identified prioritization objects.</td>
<td>Discussion took place at workplace meetings with employees. Base units gave employees’ suggestions to the department steering group that did the ranking.</td>
<td>The department steering group compiled the list.</td>
</tr>
<tr>
<td>D</td>
<td>The steering group identified prioritization objects.</td>
<td>Discussion took place at workplace meetings with employees and bordering departments. Base units gave employees’ suggestions to the department steering group that did the ranking.</td>
<td>The department steering group compiled the list.</td>
</tr>
<tr>
<td>E</td>
<td>The unit boards identified prioritization objects. Employees could make suggestions to the boards.</td>
<td>Discussion took place at workplace meetings with teams and professional groups.</td>
<td>The clinical manager compiled the list.</td>
</tr>
<tr>
<td>F</td>
<td>The base units identified prioritization objects. Employees could make suggestions.</td>
<td>Prioritization seminar with department steering group and specialist doctors.</td>
<td>Final list compiled at the prioritization seminar and an economist made the calculations.</td>
</tr>
<tr>
<td>G</td>
<td>Employees suggested prioritization objects to the process groups, who were responsible for the identification.</td>
<td>The county steering group and the process leaders discussed and ranked.</td>
<td>The county steering group compiled the list and performed the economic calculations.</td>
</tr>
<tr>
<td>H</td>
<td>The county steering group identified prioritization objects.</td>
<td>Discussion and ranking took place in the county steering group.</td>
<td>The county steering group compiled the list, economic calculations were performed in smaller groups.</td>
</tr>
</tbody>
</table>

4.1.5 Experienced problems and difficulties with performing vertical prioritization
The greatest difficulty, all agreed, was to identify enough low prioritized objects. High ranked objects were included in the final lists in order to reach 10% of the net budgets. Many informants described the task as impossible or more correctly it would be impossible to actually remove all the ranked objects in practice. Department D had
no object with ranking 10 and just one 8 and one 9, which contributed barley nothing to the 10%. Informant F concluded that ranking 7–10 at his department accounted for only about 2% of the amount they needed to identify.

“Last time we had a couple of 10’s and 9’s. This time we have three 8’s that give 1,6 million of the 12 million that we should identify. The big money start to exist at ranking 6, 5 and we have some 3’s and 4’s.”

Informant G

According to informant F this problem was based in the fact that the departments continuously remove ineffective methods if better options were possible and therefore there should remain few unnecessary objects. The problem, he continued, was that most new and more effective activities, methods, technologies and drugs were more expensive than the old. Consequently, if the process in 2008 were done properly it would be a surprise if unnecessary activities still were carried out. Informant G believed that there was a limit somewhere where it would take more resources to motivate, explain and justify the new range of services than it would been to just keep the original ones.

As previously mentioned the departments did not systematically go through cost effectiveness studies and other scientific articles to fill the National Model with exact numbers and facts. Instead, the model was used in more a pragmatic manner. One reason was the imbalance of research in different fields of health care. Good quality research was not available or applicable to all activities performed in health care.

"How do we put the experience-based knowledge into words? The research on friends and family as support persons is, for example, a drop in the ocean in comparison to biological research."

Informant E

Informant E meant that this problem could bring something positive to the departments. He pointed out other types of evidence, like years of practical experience and internal quality assurance work. Description and justification with experienced-based knowledge is also evidence, he meant. Important, however, was to be honest about it an actually look for and state the evidence. Another problem with the National Model was that some types of activities were experienced more compatible than others. Informant B meant that treatment activities were easier than caring activities to calculate in money and make entities of. This was because caring often consists of several components and forms a part of the treatment. Informant E was of the same opinion and said that when it came to patient care it was mostly about sorting out and separating activities.

Time aspects of the process were an additional issue. Some informants felt that the priority setting process collided in time with the business planning and budgeting, others that it was too close in time to the last process, but all were positive to the fact that they had more time for the vertical prioritization this time than in 2008. The vertical prioritization, which results should be implemented in 2012-2013, was performed just before the budgeting for 2011. Informant B meant that it would have been better to have the end-result of the prioritization process before planning for the next year. Informant D proposed the prioritization process to start in the spring so it could be done before the budgeting. Even though the results would not be implemented for the coming budget-year they believed it would be beneficial to have that knowledge. On the other hand, informant G wished to have the budget done before
he started with the prioritization. He meant that while discussing prioritizations, ways of cutting costs emerged, which could be used in the budgeting, but the identified prioritization objects included in the ranking list could not then also be a part of next year’s budget, i.e. those objects were “burned”.

The prerequisites for performing vertical priority setting differed among the departments. The health care departments need to follow the Swedish Health and Medical Service Act, in which prioritization is an intrinsic part. Departments dealing with disability operations worked instead mainly with the Act concerning Support and Service for Persons with Certain Functional Impairments, where individual rights is the core. The law prohibited such departments from proposing exclusion of certain activities. Instead they tried to think in terms of limitations and division of activities. They suggested limited services for some groups, e.g. differentiated patients in regards to their autonomy and gave lower priority to patients with higher autonomy or some kind of support network such as family members or a legal representative. Other departments had a high share of regional health care that to a high degree was guided and directed by national guidelines. The informant for such a department had discussed the topic with the County Council Administration and received the answer that it is reasonable to exclude regional health care from the prioritization process but that 10% of the department’s budget still needed to be identified. To add to the difficulties regional health care was about treating severe conditions and diseases where patients could die if they do not receive treatment.

“If we remove the regional health care I think that we should get to recalculate the budget and exclude the costs for regional health care and prioritize 10 % of the remaining budget. But we got a no on that. This means that we almost identified 20 % of the remaining activities. At base unit X 50-70% are emergencies and hard to do anything about [...] We almost had to suggest all other activities at the department to reach 10 %.”

Informant F

Informant A was the manager of a diagnostic and medical service department and genuinely believed that they should not prioritize like everybody else. The county council health care departments order diagnostic and analytical services based on their operations, activities and patients. Department A does not decide for themselves what activities to engage in and hence should not prioritize these activities.

“No, I would rather see that this prioritization was based on the users, the ones who use our department as a service organization, they are the ones who should prioritize. And what they don’t need we should not do, and the opposite, what they do need we should do.”

Informant A

An issue brought up at one of the smallest departments was the potential threat that prioritization imposes to individual employees.

“...not put individual persons behind the work tasks /prioritization objects/. But they /employees/ also know that if tasks are removed, employees will follow, there are no other incomes, so it is a bit sensitive.”

Informant D
This was however not an issue at larger departments, informant G did not acknowledge this at all and meant that his employees did not feel a personal threat because they did not have that narrow job assignments.

More specific ethical dilemmas were a part of all, except the non-medical, departments’ discussions. The dilemmas were about valuing and ranking one group against another. Such a dilemma was how to rank prevention, activities aimed at healthy people, e.g. smear test for early detection of cervical cancer, in comparison to treatments. Informant A reasoned that it would be unethical not to perform prevention since it could still save lives, however not in the earliest future. But he continued by saying that it would also be unreasonable not to prioritize life-saving activities. Informant C also acknowledged the importance of prevention but said on the other hand, that if some things had to be removed it often turned out to be prevention.

At department E one ethical discussion had been about patients’ friends and family and their role as support persons in health care. Informant E believed low priority of activities for significant others implied poor health care services, especially for patient groups with low autonomy.

“The first thing is to generally inform friends and family, the second is to make them a part of the process and the third is to let them do direct nursing at home. […] Well informed support persons have knowledge as a base instead of worry, which shows in number of contacts to health care staff”

Informant E

He feared that this type of priority setting process could leave the importance of friends and family in caring processes in the shadow.

When asked about the employees’ experiences of vertical prioritization everybody’s answers corresponded to their own experience. Informants that found the priority setting process primarily positive said that their employees had the same opinion and experienced positive participation rather than the burden of additional work tasks. They also meant that the employees, through participation in the process, were more tolerant and understanding when cuts were made. More negative informants meant, on the contrary, that the process represented a heavy burden for the employees.

4.2 Reflections of the entire the priority setting process

The informants were both positive and negative to the whole priority setting process as such. Most were positive to the general idea of the process and pointed out some appreciated strengths, but also some worrying weaknesses.

“Priority setting is obvious in theory, but it is very hard to do in practice.”

Informant C

They all understood the general aim of the process, from the VCC’s point of view, as to reallocate and free resources in order to invest in and implement new services. According to informant A, the overall aim with the process was to make the health care as good and effective as possible. Informant B meant additionally that a more hidden reason was to make the departments aware of their activities and make them realize that they had to justify what they are doing, if they could not do that services would be removed.
4.2.1 Identified strengths and weaknesses with the priority setting process

As a strength with the process, several informants referred to what informant B said to be a more hidden reason for the process, namely to scrutinize what is done at the departments. Informant F named this as a positive spin-off effect of the process.

“...there are probably many parts of the public sector that with the help of a process like this, could identify more efficient ways of working and consequently improve quality. It is easy just to continue doing what has been done for 20 years. [...] We can’t be a health care organization that doesn’t embrace the new, evaluated and more efficient, but often that demands new equipment, money and drugs etc. I think the basic idea, new in- old out, is OK.”

Informant G

According to informants A, C and D, the process was necessary, even though they emphasized that it was difficult. Informants D and H believed that this was a good way of working and that it would generate a good result. Informant D said that it was hard to start with the process again, but that it did help in her department’s daily work. She acknowledged that in the priority setting process the departments got the chance to say what they considered important and less important and then it was the politicians who had to take the final decision and be accountable for it. In an ordinary department saving the clinical managers just had to cut the costs and be accountable for it, in this process it was more about giving suggestions that possibly could become reality.

Informant E meant that in the best of worlds prioritization would be a part of the continuous business planning, however, two arguments suggested otherwise.

“First, as a department I have a hard time looking at the neighbouring departments, for that a helicopter is needed. Second, before old staff leave their positions it is very hard to get new employees with other types of skills.”

Informant E

He meant that the priority setting process provided a chance to get to know one’s neighbour and made it possible to have a bird’s eye view of the organization, which could bring about a better rotation and reallocation employees to where their skills and experiences were mostly needed. Informant G compared the process with working with Lean-Productions and meant that successful Lean-work would mean a different type of regularity and a provision of a more stable ground that include all employees. Contrary to that reasoning informant E meant that if prioritization were done too often it would become routine and less thoughtful.

However, not all were all positive. Time and resources spent on the process was seen as one main weakness.

“...I think it is quite difficult to find persons at this hospital who are positive to continuing in this manner, because it is awfully resource demanding.”

Informant F

Many suggested that the greatest drawback of the process was not the process in itself, but that it had already been done. It was considered too close in time to the previous process in 2008. They feared that a lot of resources would be used for nothing,
that the result would not be implementable in practice because of a perceived incongruity of some of the proposed prioritization objects.

Informant F experienced the process too rigid, mainly for being insensible to departments’ varying degree of regional health care. Further he meant that the health care carried out in the VCC were, in relation to national and international comparisons, very good and effective. He did not have another suggestion for a process, which could integrate new technology etc. within the current budget, but meant that it was unreasonable to believe that it would be possible to get a more effective and continuously improving health care with no rising costs. Others though preferred this process in comparison to the alternative of just making each department cut the costs with 5 %. Informant A suggested another type of process:

“I believe that it [the prioritization process] could be better if it was more process oriented instead of this organizational perspective that we have now. To look at the bigger picture, at the flow of patient groups, starting when the patients seek care and ending when they have been treated.”

Informant A

In this way, he meant, prioritization would be based on the flow of patients and hence include people with different departmental belongings in the same groups.

A way to improve and strengthen the process would, according to informant E, be to include the municipalities. He meant that the health care was discussed as if everything were taking place within the VCC. He used palliative care to illustrate his point.

“We discuss these kinds of questions like everything happened at the county council emergency ward. 50% die in the care of municipalities, 40% die at home and 10% die in the health care sector. This is an example of a health care situation that is very resource demanding, but gets lost in the priority setting process.”

Informant E

Some informants experienced the process’ fairness as a strength. The opinions of fairness were primarily based on the fact that many were given a possibility to contribute, both on department-level in the vertical step and on county council-level in the horizontal step. Informant E meant, on the other hand, that fairness had nothing to do with the process because it was not build on fairness. However, he believed that the openness in the process was a way to exclude suspicion and the possibility of cheating.

The priority setting process was not only about ranking for removal of objects, but also about finding new objects to implement instead of the current. How this was done, if at all, varied among the departments. However, the majority were quite critical to how the VCC’s administration had handled the issue. They experienced the information unclear and constantly changing and also that it came very late in time. Informant C had not had the time to even go through it yet. Informant B had no clue who proposed new investments, who decided and what the new investments were. Informant D emphasized that she wanted that information because it would be beneficial for the motivation of employees. Since the process was about reallocation of resources and not savings the process for investing in new objects and the connections between new and old objects were seen as a core of prioritization.
Informants G and H had no structured process, but came up with suggestions for new investments while they discussed the rankings. The suggestions were more in the form of a wish list, than a structured ranking list. Informant G believed that there were a lot of previous suggestions still in “pipeline” so he was not worried that it would be a lack of wanted investments. Informant E, on the other hand, engaged much more into this process and new investments were discussed in the vertical prioritization, some of them as detailed and ranked like the rest of the prioritization objects.

“I decided that we also will include wanted new investments. If we can’t report them, they still serve a purpose for ourselves. We did that the last time too, although the VCC’s administration didn’t say anything about it at that time. [...] We should also include what we want to work with, what are the news? And I mean, this increases the motivation a notch.”

Informant E

4.2.2 Potential effects of the priority setting process
Generally the informants believed that it would be harder to remove services for strong and noisy groups, e.g. groups with patient organizations. This problem was identified both in the horizontal and the political step. Informant A meant that one risk was that politicians would not dare to remove services for such groups. When the supply is limited, people who can would use their strengths and voices to emphasize their particularly needs, he argued. After the process in 2008 informant B got some phone calls from citizens about the changes. She confirmed that none of them were over 65 years and drew the conclusion that there was a risk that weaker and quieter groups, like the elderly, would be disfavoured in this type of process. Informant E meant additionally that it was not only a matter of different groups, but also about different types of activities.

“It the question about activities for friends and family as support persons is an example of an ethical discussion that sheds some light on the risk with this type of process, namely that we might overlook care interventions of great importance.”

Informant E

The issue of treatment and prevention was also mentioned in this sense, and there was a belief that the health care would become focused mainly towards the severely ill. Some meant that it was harder to include prevention than treatment in the National Model, less evidence could be found about prevention causing such activities to have a weaker position in the National Model.

Informants also raised a concern about the role of identification in the horizontal step, meaning that interventions for patients with a disease where people could feel ‘it could have been me’ could be prioritized higher than interventions for e.g. severely mentally ill patients.

Informant C believed, however, that all this potential unfairness could be avoided if the performers of the priority setting stayed close to the government’s three ethical principles.

4.3 Belief in self and distrust in others
The departments had different starting points and prerequisites for vertical prioritization and hence had different discussions and difficulties in identifying and ranking
prioritization objects. Nevertheless they all considered their own work to be of high quality and were satisfied with the work they had done in terms of choice of methodology and performance within their span of control. The criticism of and the difficulties with their own performance and the prioritization process as such was referred to conditions outside their control. This is illustrated by the main theme: Trust in and satisfaction with own performance, suspicion and distrust towards fellow departments’ and politicians’ performance.

4.3.1 Satisfaction with own performance of vertical prioritization

Two of the eight informants had a developed opinion of what a good vertical prioritization result was or what the ranking lists should be judged upon. Informant C suggested that a good result is a result implementable in practice, and preferably a result easily translated into exact tasks and groups of employees. Informant E meant that a good result should have stimulated illumination of evidence. What kind of evidence, if any, are activities based upon? Informant A emphasized instead the difference between the result in form of a ranking list and the effect of the list. He meant that it is hard to judge the result before you have knowledge about the effect.

Even though many lacked an opinion of how to judge performance, they judged themselves and their department’s performance in predominantly positive terms. All informants were satisfied with their final ranking list in the way that it was an honest list well worked through. They believed the process to be inclusive and represented the whole department, everybody had a say and got the chance to contribute, and it that sense it was a fair process. Informant H meant, for example, that his different professional groups worked tightly together and hence had good knowledge of everyone’s tasks so it did not make a difference if not all participated in the vertical prioritization. Informant C and D experienced the method easier and better this time because they had more experience and knowledge of the method than in 2008, which they believed made them perform better. Informant E believed that the success of his department’s work was mainly due to their existing organizational structure and not the prioritization method. He meant that the important issue was experience in discussing departmental activities, which goes in line with the experience of informant C and D.

“Practically and methodologically it worked very well, the only thing that was harder this time [in comparison to 2008] was of course to find objects that would generate something, […], but the method itself was not bad at all, it worked well.”

Informant H

Since the departments had different organizational structures the informants expressed the importance of letting the clinical managers themselves organize the vertical prioritization. Different methods would suit different departments, which demanded flexibility and also some intuition and gut feeling. According to informant E the directives shouldn’t be more squared than they already are.

“You know your department and you know the situation. It is very important that you organize it wisely so that employees feel the reasonableness, plausibility and importance. Absolutely, it must not be more top-down than it already is.”

Informant C

Two informants gave rise to some self-criticism. Informant E had realized that the medical secretaries at his department did not participate much, which was unfortunate, but he believed it was more a question of personalities than of systematic inac-
curacy. Informant C had wished for a complete review of all activities performed at her department, instead of just the lowest prioritized ten percent. She argued that to be sure about the lowest prioritized objects one need to scrutinize all objects at the departments. She did however not do that because of limited time. This is, on the other hand, exactly what a few of the other departments did. Informant C planned to go through all objects the following year in internal prioritization work.

4.3.2 Distrust towards the performance of fellow departments and politicians

At the time of the interviews the horizontal prioritization had yet not started. However, all but one department participated in the horizontal step in 2008. This time, due to the problems and hardship of identifying the 10 %, suspicion towards fellow departments and politicians grew before the horizontal and the political step. It was a fear that fellow departments would cheat, not being completely honest and use tactics. It was also suspicion towards the politicians that they lacked qualifications for making the right decisions, might not be able to make decisions or make them but not take the responsibility that came with them.

Informant F pointed out that horizontal prioritization in itself was a quite new thing and questioned the whole idea that it would be possible to compare a ranking 7 at two completely different departments. Informant C believed the horizontal step to be the priority setting process’s weakest link.

“Yeah, well, we are not objective people, all sharing the same pre-requisites, that gathers in a room. Different group processes start when people work together in a group for three days. First all are supposed to describe their departments and become a group and later you have to argue for your prioritization objects, and people are different. [...] I believe that there are other phenomena or movements present, others than just strictly looking at department’s prioritization objects.”

Informant C

She emphasized the importance of not just discussing what was prioritized, but also how the prioritization was made. Informant D also said that the groups were anxious to create a good atmosphere and good relations between group members. This might sometimes hinder giving criticism, for instance if departments had not really identified 10 %, which had happened last time. Informant C believed that the group composition could play quite an important part and she wondered if group leaders were trained to detect and prevent group hierarchies based on gender and prestige. It was a question regarding which professionals, departments and genders were most influential. Informant B, C and D expressed a belief that high prestige and status could work as an advantage in the horizontal step. However, when informant C looked back at the result from the last process the specialized hospital-care departments gave away more than disability operations departments, which could be viewed as a sign of the opposite or just a sign on an imbalanced starting-point.

On the one hand, informants meant that each department would be concentrated on defending themselves and representatives would have their own department closest at heart in the horizontal step. On the other hand, informants appreciated the knowledge and understanding of other departments that the horizontal step could provide.

Many informants were a bit hesitant about the political step. To start with, informant F expressed a concern for the decision-makers’ qualifications.
Politicians that have very limited knowledge about practical health care will take the final decisions. It is prepared by officials, who in many cases also have very limited knowledge about practical health care. So one can really hope that the persons deciding have some kind of self-preservation, if I may say so, and engage themselves in this very, very, very carefully and know what they decide on.

Informant F

Due to their own ranking lists informants were doubtful if the politicians actually would be able to make a decision since they predicted it to be much harder this time. Partly this concern was due to the fact that there was a general election in the autumn of 2010, which resulted in many new politicians. Last time all politicians stood behind the process and the result, which was considered very important. Informant E anticipated the politicians to united stand up for the process but not being able to agree on an actual decision. Informant G believed that the final decision would not even come close to the 3%.

An additional concern of the political step was about the issue of responsibility. Informant D questioned if the politicians really would act accountable for potentially really tough decisions. Informant G had had discussions with politicians after the process in 2008 where they stated that they were going to take on full responsibility for the decisions. In practice, that had however not been informant G’s experience of their conduct. Informant F would really appreciate if the politicians actively acted responsible for the decisions and informed the citizens about it.

5. Discussion

The eight interviewed clinical managers had organized the performance of vertical prioritization individually and created their own strategies. However, all individually designed strategies included four common stages: Information to employees; identification of prioritization objects; discussion and ranking; economic calculations and compiling of final list. The difference between departmental strategies was mainly a question of participating actors. The departments can be divided into three categories: Departments C, D and H made the vertical prioritization a task mainly for the clinical managers and the steering groups: at departments A, E and F the task of vertical prioritization was assigned to the base unit managements; departments B and G engaged the employees from the start. Quite a few used a different strategy in comparison to the process in 2008.

The decision on what strategy to use was in general based on a balancing act between a perceived acceptable level of resources used for the prioritization, and a wish to make the final list representative of the whole department as well as rooted among the employees. Interestingly, all informants, regardless of what strategy they used and who participated, believed that their department was well represented in the vertical prioritization. In line with that they also emphasized the importance of letting the clinical managers be responsible for the organization of the vertical prioritization, which implies a belief that their own chosen strategy was the best possible. Even if they were satisfied with their own performance they emphasized that they had done the best they could under the circumstances, meaning these were not optimal.

Experienced problems and difficulties with performing vertical prioritization were referred to external rather than internal conditions, i.e. conditions outside the clinical managers’ span of control. A few of these were related to the National Model, e.g.
different types of prioritization objects fit or matched the structure of the model differently, the evidence-base varied and a concern of the relativity or absoluteness of the ranking order was raised. In an evaluation of the process in 2008 the same findings occurred [37], thus nothing much had changed despite more experience and time of performing vertical prioritization.

The NBHW uses the National Model to develop disease-specific national guidelines that to a high degree are evidence-based. A conclusion based on this study and the 2008 evaluation is that the departments in the VCC are not using the model in the same thorough manner. They did, for example, not perform systemic reviews to find out the cost-effectiveness of prioritization objects. In line with this, a study based on interviews with key decision-makers in provincial health service authorities in Canada concluded that the majority of prioritization decisions were made in an ad hoc manner. In that case, an explicit priority setting process was however not used. [38] Such a process might have the capability of reducing arbitrariness in medical practice, but it does not seem to guarantee evidence-based medicine. On the other hand, explicit priority setting and the use of the National Model could possibly shed light on important experience-based and tacit knowledge, by the insistence on proper documentation and descriptions of interventions and effects.

According to the 2008 evaluation some departments used the ranking order relative to their specific operations. Hence the lowest prioritized objects at their departments got a 10, even if the object were regarded as important for the VCC as a whole. Others used the ranking in more absolute terms and therefore had very few objects with ranks 7-10. [37] The rankings done in 2010 indicated that the problem has persisted, some departments had ranking 1 on their final list and barely nothing with rank 7-10. However, it is hard so say if it was caused by different views of the ranking or on actual conditions at the departments. It was anyhow likely to aggravate the horizontal step.

The departments had different prerequisites. They worked with different laws, some had a large degree of regional health care and some were so small that prioritization imposed a personal threat to the staff. The issue with regional health care could be further discussed, if it should not be included in the prioritization (or should be prioritized on a national level instead) perhaps departments should identify prioritization objects to cover 10 % of the net budget after removal of the resources spend on regional health care. However, departments will never look exactly the same and it would be very hard, if even possible, to build a process that is sensitive to all types of variations.

Ethical dilemmas, not very surprisingly, occurred to a varying degree at the departments. According to Martin and Singer [10] ethical dilemmas are inevitably a part of priority setting. As mentioned in the background ethical principles are not always enough to make fair decisions in practice, and several researchers [5- 6, 10- 11] suggest a focus on fair processes instead of fair decisions. Assuring the priority setting process to meet the A4R conditions of relevance, publicity, revision/appeals and enforcement does unfortunately not provide much help when trying to solve the actual dilemmas. The relevance-condition only states that “fair-minded” people should agree to the decision, the publicity-condition that the decision and its rationales should be public, and the revision/appeals-condition that there should be a chance of revising the decisions. The majority of the management and the health care staff could be considered “fair-minded” people. The National Model make them state the decisions and the rationales in an explicit way, and in the following steps, the horizontal and the political, the decisions can be discussed and revised. There is no easy way to solve ethical dilemmas - the departments just have to continue discussing
them and trying to reach agreements. If other departments and the people’s representatives, i.e. politicians, disagree, this priority setting process makes it possible to revise decisions and hence the process could be said to meet the A4R standard.

The dominant problem was the hardship of identifying enough objects to cover 10% of the net budget. The majority of the identified objects were, according to the informants’ opinions, highly prioritized objects, simply because there were no low-prioritized objects left. One informant meant that it was impossible to make the health care better and more effective without increasing costs. He is probably right.

The main idea with the priority setting process is however not to make the system more efficient but to exclude some publicly funded services in order to implement higher prioritized services. A priority setting process could nevertheless lead to more efficient use of resources because the business is scrutinized. The question is what constitutes the acceptable level of publicly financed care in Sweden. To what extent should one person’s medical problem be another’s economic problem? It is a simple question, but hard to answer and ultimately it has to be answered through democratic processes. This priority setting process is based on health care professionals’ knowledge but it is politicians who execute the final decisions and therefore set the level of publicly financed care.

A lot of the identified problems and difficulties were the same as in the study by Teng et al. [38] yet those authors had not engaged in explicit priority setting. It would probably be foolish to expect problems and hardships to disappear just because the prioritization is made explicit and systematic. However, more clear direction and practice in using the tool, the National Model, could probably benefit the process. That is also supported by the fact that the prioritization, methodology wise, was experienced easier this time than in 2008 due to increased knowledge and experience. The VCC has acknowledged this by assisting departments with method consultants, however it seems like that is not enough. All informants did not identify the same problems and difficulties. Something that was experienced as a problem at some departments was necessarily not a problem for all, or was easily overcome.

How the departments performed the vertical prioritization was not explored thoroughly in the evaluation of the process in 2008 [37], nor did the informants seem to have much knowledge of how other departments performed the vertical prioritization. This was indicated when informants believed that all other clinical managers and the employees in general shared their individual views of the process. One informant, that was quite negative to the process as such, said that it would be very difficult to find any person at the Umeå University Hospital that liked or were positive to the process. As the interviews showed, that was not true. Hence, there could be a point of making the vertical prioritization more transparent. A greater transparency could possibly make departments learn from each other by providing ideas and potential solutions to problems. The 2008 evaluation also showed that department representatives wished for more discussion that could have created a more common ground and consensus of how to perform vertical prioritization. [37]

It is also reasonable to believe that a greater transparency could reduce the suspicion toward fellow departments. The informants thought it was difficult to identify enough objects and therefore suspected that other departments had used tactics to come around the difficulties somehow or that they even had cheated. The vertical prioritization is just one part of the process, and the process is only as strong as its weakest link. One informant meant that it is the horizontal step that is the weakest link. Others raised concerns like the significance of prestige and gender hierarchies.
There are limited knowledge and information about inequalities in priority setting processes. Waldau and Osika wrote however a project-report with a gender perspective on the VCC priority setting process in 2008. Equality and equity in the prioritization process has a lot to do with the actors, who are involved in the process and/or in the decision-making. The VCC had in 2009, 331 different professions with 9167 employees, 21% of them were men and 79% women. In VCC as a whole 31% of the staff consisted of nurses, but in the priority setting process only 13% were nurses. Doctors constituted 11% of the whole staff, but represented 50% of the staff participating in priority setting. In general, doctors were over represented and the nursing professions were under represented. This actually leads to a higher degree of gender equality in the priority setting process than in the organisation as a whole. [32] Equality in number between genders is one aspect of the gender structure, differences in positions, professions and task is the second. The third aspect is power, the hierarchy between the genders. [39] In respect to the second aspect, to a large degree men and women had different positions in the VCC, e.g. 87% of all the nurses were women. The third aspect, power differences, can be harder to illuminate. Something that indicates a power difference between genders is the fact that men had a 20% greater chance of being a manager than women.

Osika and Waldau refer to Dag Album and co-workers for their work with illuminating an order of prestige in health care. They mean that different diseases and specialities within the medical profession have different rankings, which are dependent on the disease itself, the treatment and patient characteristics. Highest ranked are for example neurosurgery and cardiology and lowest ranked are geriatrics, dermatology and psychiatry. [5, 32] The informants had similar reasoning and believed that high status and prestige was beneficial in the horizontal step. They also thought that everyone primarily would try to defend their own departments. Teng et al. [38] presented the same findings and concluded that if everyone believed their own services to be the most important, the priority setting process would be hard. In a study by Gibson et al. [40] decision-makers gave rise to many of the same issues concerning interpersonal factors. They felt, as the informants in this study, a concern for creating a good atmosphere in the horizontal groups, which could lead to reluctance to disagree with other group members. They found it probable that stronger individuals, in terms of status and ability to speak for one’s cause would have a greater impact on the decisions. They also acknowledge distrust between each other that made people more defensive. Further, the informants in this study discussed the role of identification in the horizontal step and believed that there was a potential risk of giving high priority to patients you could identify with. The NBHW wrote in a report 2004 that it seemed like advanced, new and expensive medical technologies and drugs had a tendency to reach middle-aged men first. [41]

In response to these aspects as well as the aim of creating good and fair priority setting processes Gibson et al. [40] has proposed a fifth condition to the A4R framework, the condition of empowerment. They meant that if individuals’ power of influence in a priority setting process varies, then the final decisions might be unfair. The empowerment condition would enhance efforts to minimize power differences in the process, e.g. to educate people in decision-making and increase opportunities for discussion.

Suspicion and distrust were also aimed at the politicians in the last step of the priority setting process. The informants were concerned about the politicians’ qualifications, their ability to make tough decisions and their willingness to take on responsibility. Politicians have often no personal experience of practical health care but that is neither their duty. At the time of this study the political process had yet not started and hence nothing can be concluded about the politicians’ ability to make decisions.
The focus of this thesis was neither the horizontal nor the political step, however it is reasonable to believe that informants' concern for the following steps in the process affects their performance and assessment of the vertical prioritization. The concern about politicians' inability to make difficult decisions and take on responsibility for them seems realistic. It has been showed that politicians have a tendency to avoid blame in order to maintain legitimacy. [11] A continuous dialogue between health care professionals and politicians seem to be of high importance. The politicians have to assure health care professionals that they will be responsible. If they do not, there is a risk of uncertainty and distrust in all the steps of the process, which probably can affect the performance of prioritization negatively. The informants feared that they, instead of politicians, would have to take on the responsibility for the effects of the decisions, as well as explaining and justifying them for patients and citizens. Rid [42] means that the publicity condition in the A4R framework only assures the decisions and their rationales to be publicly accessible. He believes that that is not enough because citizens might not actively seek for such information. Instead he advocates more active communication, e.g. newsletters to citizens. Such active communication, where politicians show public responsibility of the decisions, might increase the clinical managers’ trust in them and in the whole process.

Two other more concrete suggestions that, according to the informants, would strengthen the whole process are to involve the municipalities and to make the connection to new investments much more clear. The issue with the new investments was brought up after the process 2008 as well and the VCC has worked to improve that process [5, 37]. However, it seems like more effort is needed. Municipalities have not been included in this priority setting process, and they have rarely engaged in priority setting [8], even though the government has emphasised the importance of that. [7] The lack of collaboration between municipalities and county councils in this matter has been criticized. [16] For the next priority setting process this should be further looked into.

Since the process in 2008 the degree of awareness of the aim with the process seems to have changed. After the process in 2008 informants described the aim as both clear and hard to interpret. [37] This time, all informants expressed the aim in similar terms as the VCC themselves. It is hard to answer why. It could be a coincidence or a sign that the process has gained more legitimacy and therefore was more known and understandable. Even though the aim was understood as reasonable, informants have pointed out weaknesses with the process as well as potential adverse events of the future decisions. The general concern was that stronger groups could be advantaged in the prioritization just because they could speak better for themselves than weaker groups. However, there is not much research of the effect of explicit priority setting [32], with thus constitutes an area for future research.

5.2 Methodological limitation

Due to the low response rate of the short questionnaires the selection base for informants were quite small. There was a risk that selection bias occurred, i.e. the respondents did not represent the whole population. [32] Against this spoke the fact that there was a large variation in how respondents organized the vertical prioritization and their views about it. For practical reasons only informants working in Umeå were selected and I cannot know if clinical managers working in smaller towns or in more rural areas would have brought up additional aspects of the priority setting process.

Further limitations regard the data analysis. The interviews were done in Swedish and the analysis partly in Swedish and partly in English. The quotes were translated from Swedish to English. In anthropological research it is often discussed if it is
possible to translate from one language to another and keeping the same content. [43] I am not a certified translator and reserve myself from possible errors regarding the translation of data. The data have been analysed by one person, myself. Many findings are however supported by previous research, which strengthen the credibility of the analysis.

The informants’ experiences of performing vertical prioritization and their opinions of the priority setting process were subjective, however they are all connected to the same context of prioritization in Västerbotten County Council 2010-2011. The informants gave to a large degree rise to the same issues, but did not necessarily share the same opinions. The purpose of this thesis was not to come up with generalizable answers. Rather it was to raise more awareness of how vertical prioritization is performed and what strengths and weaknesses clinical managers have identified during the process. In that sense the findings of this study can be transferable to other settings engaging in explicit priority setting.

6. Conclusions and implications

There are several ways of performing vertical prioritization and based on this study it cannot be concluded that one way is better than another. Different solutions seemed to fit different departments. An implication for further research is however to analyze the actual decisions (and their effects) and connect them to the performance of vertical prioritization in terms of who participated and how it was done.

It is probably impossible to build a process that is sensitive to all departmental variations in such a large and complex organization as the Västerbotten County Council. Many problems and difficulties have also persisted since the process in 2008. What seemed to be most important was transparency, not only in the process per se, but in the decisions and rationales behind the process as well as between departments and steps in the process. There was an awareness of the aim of the process, that seemed to have grown since 2008. However, agreement of certain top-management decisions that affected the process, like the timing of the process, the handling of regional health care and the role of the service departments, were lacking. Suspicion and distrust for the following steps in the process could weaken the performance in the vertical prioritization. If it is believed that fellow departments cheat, or that the politicians will not be able to make decisions, the incentive to do a good job yourself is smaller. More active communication between actors participating in different steps of the process could reduce suspicion and benefit the feasibility.

Ethical dilemmas and hardships that prioritization imposes will not be solved with an explicit priority setting process, neither does an explicit process in itself guarantee evidence-based medicine. However, such an explicit process could possibly shed light on and demand documentation of important experienced-based knowledge that in turn could generate more well thought out decisions.

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