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Hospital priority setting with an appeals process: a qualitative case study and evaluation☆

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Abstract

Objective: To describe and evaluate priority setting in the context of hospital priority setting and more specifically to evaluate the use of an appeals process.
Design: Qualitative case study and evaluation using the ethical framework 'accountability for reasonableness'.
Setting: The University Health Network (UHN), a network of three large urban teaching hospitals affiliated with the University of Toronto in Toronto, Canada. This study focused on Clinical Activity Target Setting (CATS), the final component of the strategic planning process.
Participants: Sixty-six board members, senior administrators, managers, clinical leaders and other hospital staff who participated in the hospital strategic planning exercise.
Data collection: Three primary sources of data were used: key documents, interviews with participants and stakeholders and observations of group deliberations.
Data analysis: Open and axial coding using an explicit conceptual framework 'accountability for reasonableness'.
Results: This was the first time an appeal process has been described and evaluated. The appeals process was found to be a fundamental component to overall perceived fairness of the priority setting process. The appeals process also enhanced the involvement of stakeholders and increased overall participant satisfaction. In addition, four areas of 'good practice' and ten recommendations for improvement of the larger priority setting process were identified.
Conclusions: This case study has provided an in-depth analysis of a priority setting process at a hospital, with a particular focus on the appeals process. Also, we compared the lessons learned from this study with those from a previous study at a different hospital.

Keywords: Priority setting; Hospital strategic planning; Appeals; Accountability for reasonableness

☆ The views expressed herein are those of the authors, and do not necessarily reflect those of the supporting groups.

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1. Introduction

Priority setting (also known as rationing or resource allocation) occurs at all levels of every health system. It is a particularly thorny problem for hospitals because of budget limits, expanding need and restructuring. Several studies have focused on priority setting and policy making in hospitals [1–3] regional health authorities [4,5], new technologies [6], and in pharmaceuticals [7,8].

Coming to consensus on the 'correct' criteria for setting priorities is difficult for any health care institution; as a result, a key goal for priority setting is procedural fairness. Consensus is important in priority setting since consensus can be taken as a form of validation. To evaluate the fairness of priority setting, an explicit ethical framework is required. Daniels and Sabin have developed "accountability for reasonableness" [9,10], a framework for fair priority setting that can be used to identify good practices and opportunities for improvement.

Despite the lack of consensus on priority setting criteria, there can be agreement on *how* decisions should be made. That is, there can be agreement on a fair priority setting process. Therefore, priority setting decisions can be 'worked out' locally, using a fair priority setting process that is reason-based, transparent, and able to engage all relevant stakeholders. 'Accountability for reasonableness' involves four conditions: relevance, publicity, revisions/appeals and enforcement (described in Table 1).

In particular, the use of a revisions/appeals process is innovative in hospital priority setting. An actual appeals process has not been studied. If it is carried out correctly, the "revision and appeals condition closes the loop between decision makers and those affected by their policies" and "engages a broader segment of stakeholders in the process of deliberation" [11]. A revision process not only provides a platform to challenge reasons for decisions, it also enforces the need for the reasons to be explicit and clear throughout the process. On a larger scale, this condition engages a broader societal deliberation about the existing limits of healthcare itself.

The purpose of this study was to describe priority setting in a hospital and evaluate it using 'accountability for reasonableness', with particular attention to the appeal process.

2. Methods

2.1. Design

To describe priority setting we used qualitative case study methods. A case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context [12]". This is an appropriate method because priority setting in hospitals is complex, context-dependent, and involves social processes. To evaluate the description we used the four conditions of 'accountability for reasonableness'.

2.2. Setting

The University Health Network (UHN) is a network of three large urban universities affiliated teaching hospitals in Toronto, Canada. The focus of our study was the clinical activity target setting (CATS) process, which was the final phase of a 2000–2001 strategic planning exercise.

2.3. Sampling and sample size

We sampled key documents and people, using a combination of convenience sampling (e.g. documents that were available) and theoretical sampling (e.g. peo-

Table 1
The four conditions of 'accountability for reasonableness'

Relevance	Rationales for limit-setting decisions must rest on reasons (information and values) that fair-minded parties (managers, clinicians, patients, and affected others) can agree are relevant to meeting health care needs under resource constraints in the context
Publicity	Limit-setting decisions and their rationales must be publicly accessible
Revision/appeals	There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments
Enforcement	There is either voluntary or public regulation of the process to ensure that the first three conditions are met

ple who were involved in a significant aspect of the priority setting initiative).

2.4. Data collection

There were three primary sources of data for this case study: (1) key documents (e.g. strategic planning documents), (2) interviews with key informants (e.g. administrators, physicians, and nurses), and (3) observations of group deliberations (e.g. planning retreats and meetings). Key documents were obtained in electronic form wherever possible. Key informant interviews were audiotaped and transcribed. An initial interview guide was developed based on relevant literature and previous research (see Appendix A). The interview guide was revised during data collection and analysis to explore emerging findings [13]. The interview guide contained five questions related to the CATS process, fairness, and suggestions for improvement. We interviewed 66 people—26 individual and 6 focus group interviews—including board and senior management, clinical leaders, program element leaders, allied health professionals, middle managers and members of the Community Advisory Committee. The Community Advisory Committee is a committee of volunteer public members who helps with information sharing and awareness raising, and who provides policy and strategic advice to hospital senior management. Members of the research team were participant observers in several strategic planning meetings.

2.5. Data analysis

The description of data analysis involved a modified thematic analysis with two steps: open and axial coding [14]. In open coding, the data were read and then fractured by identifying chunks of data that relate to a concept or idea. For example, communication and process were two codes that were produced from the data. In axial coding, similar ideas were organized into overarching themes. The themes were the four conditions of the conceptual framework 'accountability for reasonableness'.

The 'input' to the evaluation phase of the analysis was the description developed in the case study. We compared the description (i.e. what they did) with the conditions of 'accountability for reasonableness' (i.e. what they should do)—correspondence with the framework indicated good practices; gaps indicated opportunities for improvement.

We addressed the "validity" of our findings in five ways [15]. First, the data was triangulated from three different sources (documents, interviews, and observations) to maximize comprehensiveness and diversity [16]. Second, two researchers (SM and DKM) coded the raw data to ensure accuracy. Third, members of an interdisciplinary research team enhanced the reflexivity in the analysis by becoming familiar with the data and participating in the analysis. This helped to identify and address prior assumptions. Fourth, 15 participants verified the results of the study—traditionally called a member check. Finally, all research activities were rigorously documented to permit a critical appraisal of the methods [17].

2.6. Conceptual framework

'Accountability for reasonableness', developed by Daniels and Sabin, is a conceptual framework for fair priority setting. It is theoretically grounded in justice theories emphasizing democratic deliberation, [e.g. 18,19]. It has become a preferred conceptual framework of priority setting researchers and decision makers internationally [20–24].

According to 'accountability for reasonableness', an institution's priority setting decisions may be considered fair if they satisfy four conditions: relevance, publicity, revisions/appeals, and enforcement (described above).

According to Daniels, 'accountability for reasonableness' provides a common language for discussing priority setting and so facilitates "improving [the public's] grasp of the need for limits and the appropriate grounds and conditions for making decisions about them . . . A transparent and responsive process of revision and appeal similarly contributes to a grasp of the kinds of reasons that appropriately shape policy decisions [25]." In addition, 'accountability for reasonableness' facilitates social learning about limit-setting and so connects priority setting to broader policy processes.

2.7. Research ethics

UHN agreed to participate in this project and approval for this project was obtained from both the committee on the use of Human Subjects of the Univer-

sity of Toronto and the UHN Research Ethics Committee. Written informed consent was obtained from each individual before being interviewed. Interviews, transcripts and observations were protected as confidential and available only to the research team. No individuals have been identified in reports without their explicit agreement.

3. Results

This section is organized into two parts. In Part 1, we will describe the CATS priority setting process. In part 2, we will evaluate it using the four conditions of 'accountability for reasonableness'.

3.1. Part 1: description of CATS priority setting process

In 2000–2001, UHN conducted a strategic planning process to guide its activities for the next 5–10 years. The process consisted of four parts. First, six task forces analyzed major global and environmental factors. Second, seven program groupings were formed. A program grouping "is an organized system of services or interrelated activities designed to address the health needs of a target population" (UHN Document). Third, a reassessment of UHNs mission, vision, and values was completed resulting in a new organizational direction: "*achieving global impact*". Fourth, the hospital engaged in the CATS process to set 5-year activity targets for each of the 53 elements within the new program groupings. The CATS process had a number of phases within it. While each phases is important to the next, the last phase, the appeals process, is the focus of our study.

The goal of the CATS process was "to ensure that there is a balance between excellent leading edge clinical activity and the resources available to carry out this activity" (UHN Document). It was designed to operationalize the strategic plans. The primary decision makers in CATS were the planning and priorities council (PPC)—a group of senior level managers, including both clinicians and non-clinicians. The PPC, chaired by the CEO, was to advise the Board of Trustees regarding planning decisions, and recommend the creation, expansion, or downsizing of services consistent with the strategic directions.

Box 1: Criteria used to rank program elements

1. Ministry of Health specific funding/Revenue generating
2. Uniqueness of element
3. Interdependence to other programs/elements
4. Linkage with UHN priority technologies
5. Research strength
6. Educational need

The first phase of CATS consisted of the completion of workbooks by each clinical leadership team for each element within each program grouping—these were submitted to the PPC on 7 September 2001. Workbooks included a decision tree focused on: funding, research, education, need, purpose, and relationship to services in other area hospitals. Since every program wanted to increase volumes by an average of 25% over the next 5 years, it became necessary to develop criteria with which to rank each program element. The Director of Planning and Performance Measurement, the CEO and the CFO proposed six criteria that encompassed the mission and values of UHN and the overarching vision of *global impact* (see Box 1). They also created a 10-point scale for each criterion to give guidance and add objectivity to the ranking (1 (lowest) to 10 (highest)). The criteria and the rating scales were approved by PPC.

Phase 2 was two retreat days, where the PPC developed recommendations on the growth, maintenance or reduction of clinical volumes for each program element by the year 2006. Program elements were ranked and placed into one of five graded categories (see Box 2).

From the retreat days, preliminary recommendations regarding the clinical activity target volumes for the program elements were established based on ranks and other strategic decision factors. These preliminary recommendations stated the decisions for reduction or expansion of the program elements. Summaries of the results were made available for the program group leaders and communicated throughout UHN.

3.2. Appeals process

An appeals process was launched on 29 October 2001. The appeals process was created to: (1) ob-

Box 2: Graded categories for program elements

A. Significant growth in volumes for the program element, >15%
B. Small growth in volumes for the program element, 0–15%
C. Hold volumes (0 growth)
D. Small decrease in volumes for program element, 0 to −15%
E. Significant decrease in volumes for the program element, >−15%

NB: 15% represents the anticipated growth in population and impact of aging of the hospitals catchment population over the 5 years.

tain feedback on the draft 5-year clinical activity recommendations, and (2) provide UHN stakeholders (Hospital Staff and Community Advisory Committees) with an opportunity to appeal the draft recommendations. Appeals were to be based on: (1) new information or new arguments, or (2) lack of due process. Letters of intent to appeal were submitted and an appeals advisor helped ensure that all necessary data was collected and presented accurately. The appeals also provided an opportunity for the Community Advisory Committee to participate in this priority setting process—up until the appeals process this group had not been directly consulted.

There were a total of 15 appeals from the program elements and the Community Advisory Committee. All appeals were based on the first criterion, new information or new arguments (for example, stating distinctiveness in service for the catchment area). All appeals asked for increased scores for one or more of six criteria and a change in assignment of their preliminary growth category based on other strategic decision factors. There were no appeals which came forward concerning a lack of due process.

On 13 December 2001, 15 appeals, involving written submissions and oral presentations, were presented to PPC. Through discussions and re-visitation of original scores during the appeals process, along with consideration for the pre-determined strategic decision factors ('achieving global impact'), changes were made to the scores of a number of elements that had appealed. As a result, upward changes in the original rankings were made in nine elements, with a significant change to five of them (i.e. the growth/reduction category changed). While the ranking of other elements, who did not appeal, might have shifted as a result of the changes made to elements that did appeal, changes were not made to these other elements' growth category. Final results were released the next day on the hospital's intranet, along with a commentary from the CEO.

At the 16 January 2002 UHN Board of Trustees meeting, the final recommendations from the PPC were presented and approved.

Nine months after the final recommendations were made, two meetings were held to present the analysis of the recent priority setting process (this research). At the PPC meeting, the majority of those present supported the research, its findings and the proposal to use the lessons learnt in the next CATS process. Members of the PPC also felt that a similar process should be considered for other priority setting process, such as capital equipment budgets. At the board meeting, the results were also positively received and the value of the analysis was recognized.

3.3. Part 2: evaluation of CATS using 'accountability for reasonableness'

In this section we will evaluate the CATS process according to the four conditions of 'accountability for reasonableness': *relevance*, *publicity*, *revisions*, and *enforcement* (described in Table 1). We have included verbatim quotes to illustrate key findings.

3.4. Relevance

A large volume of data was collected to support the decision-making (this included information on case load, current ministry funding, market share as compared with other area hospitals, demographics of the catchment area and up-to-date research and education information). Some participants felt they were not given the data set in time to become familiar with it and make fully informed decisions. The decision criteria were clear, but some participants felt there was an over-emphasis on teaching and research at the expense of other facets of patient care such as patient satisfaction.

Attempts were made to consult all hospital staff in decision-making. However, some decision makers wore 'two hats' (e.g. being a program leader and a member of the PPC), and some participants argued that this made the process unbalanced and underrepresented.

"I think if you are going to put decision-makers that have conflicts of interest, the least you can do is have it balanced."

To address this imbalance, a large number of participants endorsed two potential solutions: include all program leaders in the decision-making process, and involve an external facilitator throughout the process.

3.5. Publicity

CATS decisions and the reasons behind them were readily accessible to the members of the PPC. The decisions and scores were communicated to program grouping leaders and other hospital staff through the UHN intranet. Some of the communication did not explain the reasons behind the decisions, and as a result caused fear or misunderstanding in some of the participants.

"But to say, about a program that people have invested time and energy and a patient population that they care about, that there's no strategic advantage to that program, was very, very problematic."

The CEO presented the CATS draft results to the hospital's Community Advisory Committees and who allowed an opportunity to appeal. There was no communication of the CATS process outside the hospital.

3.6. Revision/appeals

Despite the newness and general unfamiliarity with the use of an appeal process, the inclusion of an appeals process was felt by many to be a positive part of the overall CATS process. The appeals process was thought to be rigorous and thorough. The appeals process allowed for an even more inclusive process, increasing the participation from individuals who may not have been involved in the original decision-making process.

"(The process was) communicated . . . as broadly as (possible) to various stakeholder groups. Actually, in the appeals, we allowed stakeholder groups beyond the programs to make submissions, like our Community Advisory Committee, all were presented to them . . . we listened to what they had to say."

Programs who appealed were helped by senior management to ensure their appeals were strong and comprehensive. The appeals process itself permitted time to examine each appeal.

"(We) tried to find evidence to support the (appeals), based on new information or new argument that they wanted to make. Then PPC held another meeting where they heard every individual program element appeal, reassessed subgroups, reassessed the recommendation based on the criteria to see whether or not they recommended adjusting the [scoring of the] criteria."

Many participants, even those that were not directly involved in the appeal process, felt that the appeals process was a logical and helpful next step in the larger process. The appeals process functioned to increase the information used for the final decision-making.

"What we had was a resubmission of data, if there was an impression of incorrect or incomplete data. That was very appropriate and given the attempt to quantify, it was inevitable . . ."

All of the decision makers were very satisfied with both the process and the outcome of the appeals process. Further, some participants said that the appeals process had a high degree of rigor, which in turn, increased fairness.

"I saw was a rigor, that those who felt that they had not been justly heard came back with a degree of rigor in their data collection, which far exceeded any of the rigor used in the original data collection. And so it would appear that those who took the initiative to come back and argue their position, created a firmer footing for them to go forward."

There was some confusion surrounding the role of the appeals process. One concern surrounded the label '*appeals process*'. Some participants felt that 'appeals'

denoted a quasi-judicial procedure, implying that a different body, other than the original PPC, could overrule the original decisions.

"The appeals process was difficult to feel comfortable in because it was the same body that we were going back to make the appeal to. ... You are going back to the same people who essentially saw the first sets of arguments. In most appeal mechanisms, you go to a separate body. If that was their opinion from the get-go, it was unlikely you were going to make them change 180 degrees."

Another concern had to do with the documentation and final decisions from the PPC. Throughout the appeals process, documents explaining procedure, reasoning and final decisions were not as robust as they had been throughout the rest of the CATS process. Even though a formal document outlining the final clinical activity targets was available at the end of the appeal process, there remained some uncertainty among participants regarding the reasons why appeals were or were not successful. This was the case also for programs that did not appeal but whose ranking had changed as a result of the changes to programs that had appealed.

3.7. Enforcement

The senior management was committed to ensuring the conditions of 'accountability for reasonableness' were met. Planners of the CATS process met with scholars in priority setting to develop the components of a fair process. As a result, an innovative appeals process was added to the original process to enhance its fairness.

"I was incredibly impressed at the magnitude of analysis, very careful analysis, and representation from all the programs. I was actually there for the (appeals)—they wanted to bring clarifying information to see if the rating could be influenced or changed. And the openness of the process around hearing from people and listening to their arguments, and ultimately going through, I thought, a pretty equitable approach, criteria-driven approach and principle-driven. So I was impressed with the inclusiveness, the thoroughness."

The appeals process also added to the fairness of the process by involving other stakeholders that were not involved during earlier periods of the decision-making process.

"A lot of people engaged in that process, who hadn't even really been directly involved in the larger process, in the original clinical activity target setting. They got engaged at the appeals level."

3.8. Many participants felt that, overall, the process was fair because

"At the end of the day, it was collaborative. It gave people a chance to make their case. It gave people a chance to show what their value has been for this organization over the course of the previous decade. It gave people a chance to think in a visionary way to the future. It gave a lot of people the opportunity to try to be creative and to join with others, join forces with others to form joint programs and make a greater whole through synergies. And it gave people a chance for appeal. So that's why I think it was fair."

In addition to this, the senior management and the board are committed to learning from this priority setting process as well as applying the conditions of 'accountability for reasonableness' to future priority setting initiatives.

"I've been monitoring this process. It's a very good process. We're going to put a learning platform under it. No process is perfect."

4. Discussion

We have described and evaluated priority setting at a hospital with a specific focus on the appeals process. The appeals process was comprehensive, thorough, and well received by most participants. It provided a second look at the original scores as well as an opportunity for possible revision of scores. This is a very important component of fair priority setting, since it is not always possible to get all the needed information in one round of decision-making. By allowing participants themselves to bring forward new information that might have otherwise been missed, the final decisions

were made on a more solid information base. Both participants and decision makers felt that the appeals process added to the overall fairness of the process. For decision makers, the appeals process provided the opportunity to show commitment to inclusive and thorough decision-making. For participants, the appeals process allowed a greater sense of involvement in developing the strategic directions of the organization.

To our knowledge, this was the first time that an appeals process in the context of hospital priority setting has been examined. The description and evaluation of the appeals process presented here may be helpful to other organizations that may see themselves undertaking such a process. An appeals process can increase the fairness in priority setting and enhance the involvement of stakeholders and increase overall participant satisfaction.

A key lesson from this analysis is that strategic vision of the organization—both the substance and the process—will have an effect on the way that priority setting is implemented. This has not previously been described, even though it may be seen as a fundamental element in an organization's priority setting process. An organization that sees itself as 'inclusive', will find it necessary to include a revision/appeals component to decision-making. This applies also to overall strategic direction and goals. While we recognize that some of the criteria used in this process were somewhat ambiguous, it is nonetheless important to have pre-determined criteria that are inline with the strategic vision. Overarching goals of an organization will act as a driving force in the priority setting process, and ultimately effect the way that priority setting is operationalized.

Another key lesson from this analysis is the distinction between a *revision* and an *appeals* process. A revision process implies a 'second look' by the original decision makers. A revision helps to improve the quality of the decision-making by permitting an opportunity for stakeholders to contribute information or arguments that may have been missed or misinterpreted. An appeals process implies grievance or challenge and may require an independent or panel to review and possibly overturn decisions.

As the idea of a revisions process becomes more frequently implemented in an organization, its principles can become a part of the institutional culture. This can lead to improved decision-making at all levels of the organization. Moreover, 'accountability for reasonableness', when used as a framework for fair decision-making, fosters a learning organization for all staff—it provides a common language for learning good practices and opportunities for improvement, strategies for good decision-making and stakeholder involvement throughout the process (Table 2).

In a previous study, Martin et al. described a priority setting process at another hospital, Sunnybrook and Women's Health Science Centre (S&W), and evaluated it using 'accountability for reasonableness' [3]. Comparing the two studies is instructive. Although four differences and three similarities can be identified (see Table 3), we will be focusing on the one that is most relevant to this study, the inclusion of an appeals process.

Perhaps the most significant difference between the two processes was the presence of an appeals process in the UHN CATS process. This appeals process added to the overall perceived fairness of the priority setting process by allowing for greater participation, the inclusion of data that may have otherwise been missed, the clarification of data that may have been misinterpreted and an increase in overall participant satisfaction. In the Sunnybrook priority setting process, there was neither an appeals mechanism, nor an opportunity to present missing information. Because of this, some challenges were made regarding the fairness of the method of decision-making and agreement (open voting and abstentions). Further, Sunnybrook had to deal with negative media coverage from a group of clinicians, dissatisfied with the decision-making process. As Martin et al. found in interviewing participants, many were in favour of the addition of a revision or appeals process.

By comparing the UHN study with the S&W study, we have started to establish a database of cross-institutional learning that can be useful in all health systems. Further research, using the methods described here can capture and share lessons from other hospitals, and ultimately improve the fairness of priority setting across a health system.

5. Limitations

First, although the results (the evaluation of the priority setting process) from this study may not be generalizable to all health care organizations, other hospitals may see themselves in this work and benefit from the lessons we have described. Generalizability is not a

Table 2
Changes to program elements as a result of the appeals process

Program element	Original score and growth category (out of a maximum of 60)	Score after appeal and growth category (out of a maximum of 60)
Musculoskeletal and arthritis		
General orthopaedics	14.0, reduction >15%	15.3, reduction 0–15%
Arthritis and related disorders	30.7, growth 0%	30.7, growth 0–15%
Sports medicine	14.3, reduction >15%	15.0, reduction >15%
Arthroplasty	18.2, reduction >15%	23.1, reduction 0–15%
Plastics/hand	21.0, growth 0%	22.0, growth 0%
Heart and circulation		
Interventional cardiology	33.0, growth 0–15%	35.0, growth 0–15%
Vascular surgery	23.1, reduction 0–15%	29.1, growth 0%
Community and population health		
Women's health	24.0, reduction 0–15%	25.0, reduction 0–15%
Family and community medicine	17.3, growth 0%	17.3, growth 0–15%
Community and multicultural health	14.0, reduction >15%	N/A (reclassified as a "core clinical service")
Neural and sensory science		
Neuro-oncology	29.5, growth 0%	33.5, growth 0–15%
Ophthalmology	25.0, reduction 0–15%	25.0, reduction 0–15%
Balance	12.0, reduction >15%	15.0, reduction 0–15%
Neuro-ophthalmology/-otology	22.3, reduction 0–15%	22.3, reduction 0–15%
Advanced medicine and surgery		
Benign ENT	N/A (accidentally omitted)	13.7, reduction >15%

goal of qualitative research; however, the description of the priority setting process itself may be helpful in any hospital wanting to set priorities in the context of strategic planning. What is more, the method is generalizable to any health care organization setting priorities—'accountability for reasonableness' can be used to evaluate a priority setting process in a variety of healthcare settings.

Second, we have not evaluated the consequences of these decisions. It is important to study the actual operational decisions that follow each priority setting initiative. By continuing to analyze subsequent priority setting cycles all healthcare organizations can learn and grow through improved priority setting.

Third, the participants may have been influenced by a social desirability bias—participants may have de-

Table 3
Differences and similarities between S&W and UHN

	S&W	UHN
Differences		
Appeals	Absent	Present
Criteria	No pre-determined criteria	Six pre-determined criteria for decision-making and ranking
Context	Focused equally on internal and external context	Focus on teaching and research context; less focus on external
Mechanism of agreement	Voting	Ranking/scoring
Similarities		
Data collection	Extensive; workbooks and decision tree used	Extensive; workbooks and decision tree used
Inclusive process	Whole hospital involvement; 70 decision makers	Whole hospital involvement; 18 decision makers
Poor communication	Needed to be more organized; no external communication	Needed to be more organized; no external communication

scribed what they thought the researcher wanted to hear rather than actual events. Describing priority setting is not the same as conducting actual priority setting.

6. Conclusion

This case study has provided an in-depth analysis of a priority setting process at a hospital, with a particular focus on the appeals process. It has found that the inclusion of an appeals process is beneficial and improves decision-making in a number of ways. These include enhanced data and information, increased perceived fairness, and increased participation and involvement both internal and external to an organization. Also, we compared the use of an appeals process in this study with the absence of any such process in a previous study at a different hospital. By capturing the lessons from these initiatives, we have contributed to the development of an 'evidence base' for these important policy decisions.

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Appendix A. UHN Clinical Activity Target Setting Interview Guide, 22 May 2002

Thank you for agreeing to be interviewed. The purpose of this interview is to collect your views on the recent Clinical Activity Target Setting process at UHN. Clinical Activity Target Setting is a large part of our strategic planning and together they are a type of institutional priority setting. Our overall research program is designed to describe, evaluate and improve priority setting in health care institutions, such as hospitals like UHN.

You are being interviewed along with many others from many different parts of the organization in order to capture diverse viewpoints regarding the strategic planning process. Our research study has three objectives: (1) to describe the Clinical Activity Target Setting process—which tells what decision makers 'do'; (2) to evaluate the description against a leading framework called "accountability for reasonableness"—which tells what decision makers 'should do'; and (3) to develop and implement strategies for improving the process based on the description and evaluation.

In this interview you will be asked to describe the recently completed Clinical Activity Target Setting process at UHN. Before we begin, do you have any questions?

Questions:

1. Please describe the Clinical Activity Target Setting process from your perspective.
2. Please describe your role in the process.
3. What do you think about how the process unfolded?
4. Was the process fair? Explain.
5. How could the process be improved?

Note: All responses will be probed for clarity and comprehensiveness.

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