QUALITATIVE METHODOLOGIES IN HEALTH-CARE PRIORITY SETTING RESEARCH

NEALE SMITH\textsuperscript{a,*}, CRAIG MITTON\textsuperscript{b} and STUART PEACOCK\textsuperscript{b}

\textsuperscript{a}Faculty of Health and Social Development, University of British Columbia Okanagan, Kelowna, BC, Canada
\textsuperscript{b}Centre for Health Economics in Cancer, British Columbia Cancer Agency, Vancouver, BC, Canada

SUMMARY

Priority setting research in health economics has traditionally employed quantitative methodologies and been informed by post-positivist philosophical assumptions about the world and the nature of knowledge. These approaches have been rewarded with well-developed and validated tools. However, it is now commonly noted that there has been limited uptake of economic analysis into actual priority setting and resource allocation decisions made by health-care systems. There seem to be substantial organizational and political barriers.

The authors argue in this paper that understanding and addressing these barriers will depend upon the application of qualitative research methodologies. Some efforts in this direction have been attempted; however these are theoretically under-developed and seldom rooted in any of the established qualitative research traditions. Two such approaches – narrative inquiry and discourse analysis – are highlighted here. These are illustrated with examples drawn from a real-world priority setting study. The examples demonstrate how such conceptually powerful qualitative traditions produce distinctive findings that offer unique insight into organizational contexts and decision-maker behavior. We argue that such investigations offer untapped benefits for the study of organizational priority setting and thus should be pursued more frequently by the health economics research community. Copyright © 2008 John Wiley & Sons, Ltd.

Received 15 April 2008; Revised 11 August 2008; Accepted 20 August 2008

KEY WORDS: priority setting; resource allocation; qualitative research; narrative inquiry; discourse analysis

1. INTRODUCTION

While the larger social science research community has been divided in recent decades by an on-going battle between quantitative and qualitative purists, ‘health economics as a sub-discipline has remained remarkably insulated from [these] important theoretical and philosophical debates’ (Small and Mannion, 2005, p. 221). Relative to other social science disciplines, [health] economics has made limited use of qualitative research.\textsuperscript{1} This may be because the worldview of most economists – ontological beliefs about the nature of reality, and epistemological beliefs about what can be known of that reality – has been traditionally defined by a post-positivist paradigm. While some qualitative methods can be associated with this paradigm, more opportunities exist for the qualitative modes to align with interpretivist or critical orientations (Coast, 1999; Lin, 1998)

\textsuperscript{*Correspondence to: Faculty of Health and Social Development, University of British Columbia Okanagan, 3333 University Way, Kelowna, BC, Canada V1V 1V7.

\textsuperscript{1}Qualitative research can be defined as ‘[a] process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem [where] the researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting’ (Creswell, 1998, p. 15).
The objective of much health economics research is to inform policy debate and support policy making. However, translating this research into practical influence in health organization management and priority setting has proven to be challenging. We argue in this paper that understanding and addressing the barriers to practical influence will depend upon the application of qualitative methodologies and methods. In particular, these may inform us of the cultural, personal, and structural barriers to the uptake of economic techniques by decision makers. There has been growing advocacy for such methods (Coast, 1999; Coast et al., 2004). This paper outlines some strategies that will give a better understanding of the organizational contexts within which health economics approaches can be deployed.

We argue further that new insights into the problems of such knowledge translation can be achieved through a greater use of research inspired by non-positivist paradigms, in particular interpretive and critical social science models (Small and Mannion, 2005; Veenstra, 1999). Post-positivists emphasize rationality, empirical study, and belief in a single, inter-subjectively knowable reality. Interpretivists believe by contrast in the possibility of multiple but equally valid realities arising from the subjective interaction of knowers with specific world or organizational circumstances. Critical theory starts with the assumption that there is a real world, but one where certain powerful interests dominate others, and the task of research is to reveal these patterns of domination to help the oppressed and vulnerable take action to bring about change. A more detailed summary of key differences between these worldviews is presented in Table I. Note that while these are perhaps the most commonly conceived views, they do not exhaust the options. Strega (2005), for instance, argues that positivism, interpretivism, and critical theory can all be considered modernist approaches, and might collectively be contrasted against a postmodern alternative (which we do not have the space to describe here).

<table>
<thead>
<tr>
<th>Table I. Comparison of three philosophical paradigmsa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontology</strong></td>
</tr>
<tr>
<td>Positivism or post-positivism</td>
</tr>
<tr>
<td>Reality is stable, exists independently of human perception, and is made up of facts that persist long enough to be generalizable</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
</tr>
<tr>
<td>Knowledge is gained through experience, but experience must be firmly established as verifiable evidence on which all will agree</td>
</tr>
<tr>
<td><strong>Purpose for research</strong></td>
</tr>
<tr>
<td>Seeks causes and effects of human behavior to enable prediction and control</td>
</tr>
<tr>
<td><strong>Perceived role for values</strong></td>
</tr>
<tr>
<td>Value-free: values can be controlled with appropriate methodological procedures (neutrality)</td>
</tr>
<tr>
<td><strong>Conception of data</strong></td>
</tr>
<tr>
<td>Objective: data are independent of people’s perceptions</td>
</tr>
<tr>
<td><strong>Typical methods</strong></td>
</tr>
<tr>
<td>Structured survey research allowing for statistical analysis of data</td>
</tr>
<tr>
<td><strong>Expected results</strong></td>
</tr>
<tr>
<td>The design and procedures are intended to ensure accuracy and replicability</td>
</tr>
</tbody>
</table>

*aAdapted from material (unpublished, 2004) kindly provided by Dr Blake Poland, University of Toronto.*
We propose, building on recent work by other authors (Coast, 1999; Coast et al., 2004), that health economics research should place greater emphasis on both the use of qualitative methods and the application of critical and interpretivist qualitative methodologies. We apply this argument in a discussion of priority setting and resource allocation, including an illustration of data analysis using two alternative approaches.

2. THE EVOLUTION OF QUALITATIVE METHODS IN HEALTH ECONOMICS

Economic study begins with the presumption of scarcity. There are insufficient material resources to satisfy all needs, wants and desires, and therefore choices among possibilities must be made. Much of applied health economics has attempted to arm choosers with formal tools and procedures for making choices, for instance through better identification of all options or measurement of benefits. This has had a highly quantitative cast. Cost-effectiveness analyses are one example. However, such studies can be resource-intensive and are unlikely to compare the full range of options available to policymakers; they often fail to account for the opportunity costs involved in obtaining the resources to fund the ‘preferred’ treatment or service (Mitton and Donaldson, 2003).

Such studies are what, in another context, others have called ‘analysis for policy’ (Smith-Merry et al., 2007). The objective of such analysis, given an assumed ‘rationalistic model’ (p. 4) of organizational behavior, is to provide technically proficient means of addressing decision maker issues. This contrasts with ‘analysis of policy’, which ‘gives more attention to uncovering the reasons why particular policies are adopted – often at the expense of technically more efficient alternatives’ (pp. 5, 6). In short, the emphasis on technique has been rewarded; tools are now quite extensively refined. However, an understanding of how these work in real world settings has lagged. Herein lies the promise of qualitative analysis.

Health economists have begun tentatively to work with qualitative data. In some cases, this does not necessarily mean moving far from more familiar quantitative techniques. Baker et al. (2006, p. 38), for example, advocate the use of Q methodology, which they suggest ‘offers a means of exploring subjectivity, beliefs and values while retaining the transparency, rigor, and mathematical underpinnings of quantitative techniques’. This type of work demonstrates the point made by Coast et al. (2004) that we may be seeing greater acceptance of qualitative data, but not qualitative methods – and not qualitative methodologies as defined here.

Other authors incorporate qualitative work as a means of refining quantitative instruments. This has been done, for instance, with discrete choice experiments (Coast and Horrocks, 2007) and willingness-to-pay techniques (Wagner et al., 2000). Qualitative methods can also be used to study the thought processes used by participants when employing decision tools, such knowledge again leading to refinement of quantitative instruments (Baker and Robinson, 2004; Grewal et al., 2006; Smith, 2007). This use of qualitative methods, to support primarily quantitative work, makes valuable contributions to knowledge. However, there are other uses for qualitative methodologies not captured within these approaches, which we wish to focus on here.

Tools alone are not enough to impact practice. There is now a body of literature noting the limited uptake of economic analysis by decision makers in Europe, Australia, and elsewhere (Eddama and Coast, 2008). It would seem the problem is not that decision makers do not understand basic economic principles, but rather that the application of these principles is constrained by the real-world
organizations and systems within which decision makers function (Bate et al., 2007; Drummond, 2004; Williams and Bryan, 2007). Conventional health economics lacks ‘an appreciation of broader institutional characteristics, including the prevailing values and norms within a decision making context that are potentially important in … the prospects of implementation’ (Jan, 2003, p. 17). Williams and Bryan (2007, p. 138) argue that ‘there is a need for qualitative exploration of the processes involved in reaching decisions’. Some research with decision makers has attempted to do this (Mitton and Donaldson, 2004). Recent developments in priority setting research have focused on broader approaches to addressing this problem, drawing on the organizational theory, management and ethics literature (Donaldson et al., 2006; Gibson et al., 2006; Patten et al. 2006; Peacock et al., 2006). While strides have been made, more work is required through the application of alternative, and to date in health economics research, underutilized, qualitative methods. Nevertheless, so far, few of these studies have grappled in depth with the interpretive and political aspects of organizational behavior and decision making. In order to advance the state of the science and the art of practice, we would argue that much greater focus in these latter areas is required.

3. THE CURRENT STATE OF QUALITATIVE METHODS IN PRIORITY SETTING RESEARCH

Even explicitly qualitative work in health economics and health policy research has rarely been deeply grounded in the theoretical traditions of qualitative analysis (though there are notable exceptions – for instance Coast, 2001; McDonald, 2002). It seems that qualitative health economics research, when it has considered contextual factors around evidence based priority setting, has been mostly ‘generic’, studies ‘that exhibit some or all of the characteristics of qualitative endeavor but rather than focusing the study through the lens of a known methodology they seek to do one of two things: either they combine several methodologies or approaches, or claim no particular methodological viewpoint at all’ (Caelli et al., 2003, pp. 3, 4). Results are frequently presented as ‘thematic’ analyses and each theme is treated at face value as an accurate representation by the interviewee of a single shared and knowable reality. This neglects the larger issue of methodology and its intimate links to ontological and epistemological positions (Crotty, 1998, p. 5). Of course, it may be that the limits are in the reporting of such studies rather than in the researchers’ techniques, and in the unfamiliarity of health economics journals, editors and referees, and their readership in the detailed reporting and philosophical reflection that is emphasized in the qualitative style.

Several ‘qualitative case studies’ in priority setting have been published. For instance, there have been a number of investigations of priority setting in Canadian healthcare organizations based on the Accountability for Reasonableness (A4R) framework (Bell et al., 2004; Madden et al., 2005; Martin et al., 2003). Other Canadian research into priority setting and resource allocation also has been self-characterized as case studies, reporting results in the form of themes developed inductively (Mitton et al., 2004; Patten et al., 2005). Recently published studies of the UK’s National Institute for Clinical and Health Excellence adopt the same label (Bryan et al., 2007). However, such case studies have not collectively gone far enough in their incorporation of recognized qualitative methodologies. Of note, they rarely acknowledge or cite the best-known source references on case study, such as Yin (2003) or Stake (2005).

More substantively, there are on-going debates within the qualitative research community about the proper status of ‘the case study’. Creswell (1998), for one, treats it as a methodology. Other writers, such

3A challenge for those used to working with numbers is that qualitative methods are not about counting up or quantifying the frequency of mention; the assumption that more common occurrence is necessarily a sign of greater importance or substance does not necessarily hold true. ‘The way in which an issue [is] represented rhetorically, or how it [is] said, can be more important than the number of times the issue is mentioned’ (Lupton, 1992, p. 147).
as Crotty (1998), suggest that it should be seen as a method. Stake (2005, p. 438) avers in fact that ‘case study is not a methodological choice but a choice of what is to be studied’ and VanWynsberghhe and Khan (2007) assert that it is neither methodology nor method, since it offers no clear guidance about exactly how data collection and analysis ought to proceed. What this amounts to, in sum, is that ‘case study’ seems both too simple and too contested a concept to serve adequately alone as a rigorous approach to qualitative research methodology.

4. THE FUTURE – ALTERNATIVE PARADIGMS FOR QUALITATIVE RESEARCH ON PRIORITY SETTING

In our view, the next step is applied health economics studies that explicitly draw on established, philosophically grounded research traditions – for instance narrative inquiry or discourse analysis. We address these two options here for several reasons. First, they are the methodologies with which the authors are most familiar. Second, they appear to be a good fit with the interpretivist and critical paradigms discussed above – though this is not a necessary link. Third, we believe they offer distinct perspectives that effectively illustrate how different aspects of organizational behavior can be illuminated when approached with different methodological lens.

There are other well-established qualitative methodologies as well, such as grounded theory and ethnography (Creswell, 1998). Due to space constraints, we can only briefly describe these alternatives. Grounded theory may be one of the most structured qualitative methodologies. It has clearly outlined procedures for data analysis – open coding, axial coding, and selective coding. The objective is to build theory inductively from data. Creswell (1998, p. 58) elaborates: ‘the primary outcome is a theory with specific components: a central phenomenon, causal conditions, strategies, conditions and context, and consequences. These are prescribed categories of information’. Grounded theory is considered by many to have positivist origins (Charmaz, 2006). This perhaps might make it a suitable entry point into qualitative research design for some health economists. Unfortunately, since grounded theory is perhaps the most widely known of the established qualitative traditions, some researchers seek legitimacy through applying that label to their work regardless of the procedures they actually employ. As a result, some of the so-called grounded theory studies found in the literature are anything but that (Stern, 1994).

Ethnography has its roots in cultural anthropology, but has been extended into investigation of a range of communities, organizations, and contexts. Creswell (1998, p. 59) suggests however that in all cases its focus is ‘people in interaction in ordinary settings’. Ethnographic method typical involves prolonged observation, with researchers attempting as much as possible to become immersed in the daily lives of the group they study (Fetterman, 1989). From this, they hope to understand patterns of behavior and to depict ways of life in great detail. Ethnographies, however, must balance their rich amount of data about individual actions with recognition of structural and systemic conditions within which the actors are located. Reed (1997, p. 25) for instance accuses recent studies of collapsing the distinction and losing sight of structural factors in a ‘myopic analytical focus on situated social interaction and the local conversational routines through which it is reproduced’.

We return to our two contrasting approaches to analysis. An important goal of narrative research is to put the person at the center of the analysis, rather than to come up with ‘themes’ that emerge from analysis across many cases and which are thus often highly abstract: ‘What distinguishes narrative inquiry is the focus on narratives and stories as they are told, implicitly or explicitly, by individuals or groups of people, not on texts that are independent of the tellers or institutions where they are scripted’ (Ospina and Dodge, 2005, p. 145). However, this analysis should be employed in the priority setting research context with the understanding that the program or policy under study remains the focus; as Kushner (2000, p. 13) argues, we must ‘seek to understand programs through experience – not displace them with it’.
Identifying story devices such as the act(ion), the actors or agents (heroes, villains, victims, bystanders), the context or scene, and the plot (beginnings, middle, climax, denouement) is one direction that narrative researchers can take (Greenhalgh et al., 2005). In this approach, interpretation can and does go beyond looking at the literal meaning of what the storyteller thinks she has said. Shacklock and Thorp (2005, p. 156) suggest that all stories are a blend of fact and fiction. Whether purposefully and consciously or not, people may dwell on, downplay or omit details, minimize or exaggerate events and relationships. This is part of the individual’s effort to present himself or herself in a certain light to various perceived audiences. Thus, narrative researchers need to reflect upon their position as audience in relation to the research participant (particularly where interviews or participant observation are the data source) and how that influences qualitative interpretation.

A concern, as expressed by Wainwright and Forbes (2000, p. 267), is that ‘too often the obsession with ‘lived experience’ blinds interpretivist researchers to the broader social context in which those experiences are played out’. Yanow (2006), however, persuasively argues that such problems are largely alleviated when the research takes place within particular contexts, such as health-care organizations, where positioned relationships and competing perspectives are almost unavoidable. As an example, Ospina and Dodge (2005) have found narrative analysis useful for exploring phenomena like leadership and organizational change; Feldman et al. (2004) also make use of narratives in studying organizational change. Fischer (2004) in fact argues that narrative inquiry is one of the most powerful methodological approaches available for studying organizations.

By contrast, in discourse analysis, organizations are conceived as political and power systems and sites for the contestation of different values and desires, located within larger political and power systems (Buchanan and Bryman, 2007; Fischer, 2004). ‘In discourse analysis, struggles for hegemony and the establishment of hegemony by political projects are of the utmost importance…. hegemony is achieved if and when one political project or force determines the rules and meanings in a particular social formation’ (Howarth, 1995, p. 124). Power is understood here in the Foucauldian sense of a web or network. People and groups do not ‘hold’ power so much as they are positioned within it (Strega, 2005) and any exercise of power is inevitably confronted with forms of resistance or subversion initiated by those who are affected. Many discourse studies in the health-care field have focused on clinical encounters and professional interactions (Iedema et al., 2004; Lupton, 1992); relatively few appear to have looked at policy making situations and, to our knowledge, none has directly addressed priority setting.

We now move to some examples of the kinds of studies that could be conducted in a manner informed by these traditions. What follows are two brief outlines, based on interviews conducted with senior decision makers in a Canadian regional health authority, of how such analysis might proceed. These are meant to be suggestive of how such techniques could be used. However, as Cheek (2004) cautions, we must not imply that there is a single set of rules for doing qualitative analysis. Thus, we offer a broad range of ideas to suggest how such analysis might evolve and generate additional relevant research directions.

---

4Hegemony is a concept articulated by the Italian political philosopher, Antonio Gramsci. It represents ‘the ability of the ruling class to maintain dominance by projecting its own ideological vision of the world so that it is accepted as natural and common sense’ (Bambra et al., 2007, p. 572).

5Well-established qualitative research traditions like those discussed here do not only differ in their approach to data analysis but they also provide principles that inform all stage of the research design. If we were led by our methodology we would likely set up interviews to ask different questions. However, a comparison of approaches even when starting with the same data can be a valuable lesson. This has previously been demonstrated elsewhere in the literature (Burck, 2005; Riley and Hawe, 2005; Wilkinson, 2000).
4.1. An outline of a narrative analysis

In examining this particular health authority, the key action is the introduction of a new, formalized economic method for priority setting and resource allocation. In narrative analysis, we could consider how significant a change this is viewed to be – is it a major step forward (or backward) for the organization, a turning point? One respondent viewed the introduction of the new process as a potential lever for shifting the organization’s overall focus: ‘I see this as one of the few ways in which we might be able to shift our thinking…. I think it’s a great chance for us to see how we really measure success. Not by the number of patients that are still alive when they leave the hospital doors, but health status’. (P13 – physician leader). For others, by contrast, the change appeared as simply a continuation of past practices. ‘There really wasn’t a lot of buy in other than the fact that we said OK here’s just another process that we are going to use for budgeting purposes. It may be better, may be worse than what we have seen before…. I’ve been around for 27 years and have seen tools come and go’. (P11 – manager).

A shifting balance among these different narratives will affect how receptive the organization ultimately is to its new priority-setting approach. Tracking the ascent and decline of these stories over time can reveal the extent to which economic analysis may or may not likely become institutionalized.

Impressions of potential impact are framed by views of past and present organizational context. One respondent presented a narrative of incremental organization growth and maturation. ‘Last year was sort of the next stage in the evolution of our probably 5 or 6 year history of trying to do resource allocation in this organization’. (P15 – manager). This fits with comments made by several others, which call for organizational learning and depict the new priority setting process as something that will be developed and refined incrementally over a number of budget cycles. Further research might explore if this is a condition for success, or the extent to which it affects the place that formal priority setting processes are seen to merit within the organization.

Narrative research would be interested in detailed analysis of how each participant understood his or her role in relation to the introduction of this new approach to resource allocation – as a key mover or someone who is acted upon, as a willing or unwilling participant. The interviews would have proceeded somewhat differently if that explicit aim had been established at the start; as it was, the interviewer often cut off or ended this line of questioning too early. Still, we find interviewees describing themselves as differently positioned vis-a-vis this initiative:

‘[My engagement] was high. I had a vested interest. I had an initiative that I thought was of high value to the organization so therefore put a lot of time and energy into preparing the submission’. (P10 – manager).

‘I was in the periphery…. [I came in at] the same point as anybody else when we got the instructions of what we were supposed to do’. (P1 – vice president).

Regardless of whether they had a role to play in bringing the new formal priority setting process into the health authority, interviewees emphasized their diligent efforts to comply with its requirements. ‘We were really committed to engaging in the process’. (P7 – physician leader). ‘We worked so hard last year to get [pause] everybody worked really hard’. (P16 – physician leader). Several respondents do suggest that there were recalcitrant players who avoid, sabotage, or game the new system: ‘Some programs in the portfolio, for example [name] chose not to do the exercise at all …. They said that they were given some sort of pre-approval not to do it… but it really wasn’t true’. (P17 – senior manager).

However, no one self-identifies as being among those. This would possibly suggest that the interview pool should be expanded to include that seemingly unrepresented perspective; alternatively, further analysis might focus on identifying contradictions between the respondent’s portrayal of their role(s) in

---

6This approach included the development by each major portfolio of several evidence-based cases for new investment and disinvestment. These would be ranked by Executive Team members using explicit and weighted criteria.

7Within this health organization, each major division is co-headed by a senior manager and a clinician–executive (physician leader). Within each division, there are multiple departments headed by mid-level managers.
this story and their actual behavior. Participant observation data gathered by the researchers, were they available, would be a helpful addition to this analysis. As well, further analysis could attempt to ascertain whether these claims are genuinely held, or whether they are being employed rhetorically in the interviews in an effort to strengthen a particular organizational narrative being offered by the respondent to the interviewer.

Stories can be individual, shared, or contested. Narrative analysis may be an effective way to investigate the experience of health system leaders and managers in making rationing choices. Such personal experiences and local knowledge color how priority setting is received and shape organizational willingness to employ formal economic approaches to decision making; thus if we wish to affect decision-making practice, we need to know more about these factors.

4.2. An outline of a discourse analysis

Our discourse analysis might begin by looking for manifestations of power relations within the organization and between organization members and outside bodies. To begin, discourse analysis could investigate the dynamics within the priority setting meeting itself. Did the involvement of senior leaders make it harder for others to feel comfortable and confident in advocating for their interests and priorities? ‘The president and the two executive vice presidents were there and did ask questions and make comments and whether it was intended to be a peer type of situation, when the big guys make comments it tends to influence’. (P10 – manager).

At the ideological level, discourse analysis would closely read these transcripts to reveal the speakers’ beliefs and values about how decisions on priorities ought to be made. It could reveal, for instance, an insistence that the organization should perform in a ‘business-like’ way, seeking all possible efficiencies and effective resource allocation. Respondents also expressed the perceived importance of basing decisions on the best available evidence. Additional analysis could probe and deconstruct this claim, inquiring into who determines what counts as acceptable evidence, and the degree to which certain positions are privileged or threatened by that definition.

Further, we might uncover in the interviews the respondent’s views about what constitutes proper process, how participants in priority setting ought to conduct themselves, and what forms of claims making ought to be credited. A widely held belief is that if the ‘right people’ are present, then the right decisions will be reached. Participants are seen as entitled to equal opportunity to present their case to peers. However, these appeals ought to follow certain rules of engagement – use of evidence, as opposed to emotional claims, for example. When one interviewee remarks that this process ‘puts the onus on [presenters] to convince their colleagues on the merits of their proposal’ (P19 – vice president), we might consider how the concept of merit pre-supposes this form of argumentation. Another interviewee criticizes some colleagues who seemed to circumvent the presumed rules, who ‘invited themselves’ to an executive meeting prior to the priority setting session, to present their ideas ‘those ones that did their, that presented their proposed projects two weeks before, were the top two ranked ones’. (P17 – senior manager). This follows the most common thinking on communicative rationality, though it is a position that has been challenged by critical thought that argues that decision-making processes should be structured to emphasize relationship rather than rationality (King, 2000; Ryfe, 2005).

Discourse analysis would also draw attention to internal fractures within the health authority. In other words, it probes into who wins and who loses from attempts to change the priority setting and resource allocation process. What strikes us are the claims by different groups or sectors to be uniquely disadvantaged by the proposed process, and the rebuttal or counter-claims raised during the individual interviews. Support services and public health proponents felt that they historically had little influence and that the new process would not substantially change this. However, their complaints were also dismissed by other individual interviewees: ‘Public health… so seniors, mental health, from my
perspective they have always done fairly well, as far as that goes. I don’t know why there is this perception that they are so hard done by’. (P15 – manager).

Like most healthcare organizations, in this health authority, a medical model of health has been historically privileged: ‘part of the culture here is that physicians have had a lot of influence on resource allocation in the past, so they would prefer I think more of the traditional ‘if I threaten enough, that’s how I get my money’. (P19 – vice president). Nevertheless, acute care representatives too claimed to be hard done by as a result of the new priority setting approach:

‘Mental health, community development processes, building residential care [for] seniors, these are some things that you can’t compare with acute care. … Acute care is more procedure oriented, more technology oriented… the technology is used so many times and it wears out. These other specialties, they don’t have technology, they don’t have equipment that wears out’. (P16 – physician leader).

Of course, all such claims could be contrasted against actual organizational budgets and resource allocation.

The creation of health regions with responsibility to deliver a wide range of health services is a change to State structures that opened up new avenues for local authorities to meet health needs and to consider the broader determinants of health. However, as our interview respondents suggest, their ability to decide was constrained by larger political factors. Certain proposals were deemed in advance of the priority setting process to be essential – ‘must-dos’ – and thus exempt from scrutiny. In many cases this was attributed to provincial mandates imposed upon the health region: ‘Must dos tend to be, from what I now find out … really based mainly on political decisions. Someone has said, ‘OK you are going to do this whether you like to do it or not, or whether you think you should do it or not, so therefore you are going to fund that’. (P11 – manager).

Nikolas Rose has argued (informed by critical theory) that the development of new administrative systems and decision-making procedures and efforts to hold groups accountable to deliver on commitments through evaluative and performance measurement regimes is characteristic of (health) governance in advanced liberal political systems (Rose, 1993, 1996). The provincial State, in this instance, holds health regions to account through written performance contracts, the impact of which has been little investigated. The provincial government’s willingness to allow the expansion of private sector alternatives for health service delivery is another background factor that may directly or indirectly impinge upon local priority setting. A discourse analysis in its fullest would explore the role of the State more generally in shaping the context within which health professionals and managers perform.

5. DISCUSSION AND CONCLUSIONS

We need to improve our understanding of organizational environments in order to better impact the real world with economic principles and approaches – thus more in-depth qualitative work is needed. In the terms used earlier, more attention needs to be paid to research of priority setting, as opposed to research for priority setting. Key issues and problems such as organizational change and change management, the nature of leadership, and the balance between research evidence and other forms of information are all areas in which qualitative insights would be of considerable interest. Since applied health economics research often investigates the introduction into organizations of new systematic ways of setting priorities (for instance, Carter et al., 2000; Mitton et al., 2003, 2006; Peacock et al., 1997), qualitative research is an appropriate way to assess the experience and perceptions of health-care managers and health professionals in such situations.

We have described narrative inquiry and discourse analysis here (see summary in Table II). However, there are barriers, such as the on-going strength of the post-positivist orientation (Coast et al., 2004), which might limit the adoption of these qualitative approaches within the economic study of
organizational priority setting. To appeal to critics, qualitative researchers may attempt to justify their work with post-positivist criteria of validity and reliability, which however are often inappropriate. Nevertheless, to adhere firmly to their own methodological standards may leave qualitative health economics researchers isolated from the disciplinary mainstream by a chasm of philosophical assumptions and perceptions (Coast et al., 2004; Buchanan and Bryman, 2007).

There are practical issues as well. To begin with, is the skill set of health economists adequate to the task of qualitative inquiry? If not, then interdisciplinary work will be required, and this of course comes with its own challenges in time management and human relations. There may be resource implications; narrative and discourse interviews tend to be longer and more in depth due to the nature of the questions that the researchers propose to ask of these texts. The emphasis in discourse approaches on explicit power questions might make many decision makers uncomfortable; they might fear to raise potential points of conflict (Buchanan and Bryman, 2007; Iedema et al., 2004). Finally, decision makers determine whether or not researchers can enter and work within health organizations. They may be unsure what value would result from the proposed qualitative research. Specific guidance for shaping policy and practice must be an explicit focus to ensure findings are applied to improve priority setting. In conclusion, the challenges in using economic analysis and formal priority setting and resource allocation tools are, we think, today less technical than they are in understanding the organizational contexts and socio-political realities within which decision makers work. This requires qualitative methods. There is some evidence that health economists are beginning to employ these techniques. As demonstrated here, these approaches have unique advantages in directing attention to organizational dynamics and complexities, and can lead us to new, innovative strategies for promoting economic techniques to meet the real and pressing needs for resource allocation within necessarily constrained budgets.

**ACKNOWLEDGEMENTS**

The authors extend special thanks to Brian Evoy and Dr Kathy GermAnn for helpful feedback and suggestions. They also appreciate comments from Joanne Carey, Evelyn Cornelissen, and participants

---

**Table II. Strengths of narrative and discourse methodologies**

<table>
<thead>
<tr>
<th></th>
<th>Narrative</th>
<th>Discourse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key points of approach</strong></td>
<td>Focus on ‘sense making’</td>
<td>Focus on power relations</td>
</tr>
<tr>
<td></td>
<td>Emphasizes individuals’ meaning making and agency within systems and social contexts</td>
<td>Emphasizes individual agency within larger organizational and social structures</td>
</tr>
<tr>
<td></td>
<td>Flexible to deal with changing or fluid research contexts</td>
<td>Builds on recognized social theories and models</td>
</tr>
<tr>
<td></td>
<td>Highlights internal differences and alternative interpretations in a way that thematic analysis typically does not</td>
<td>Highlights internal differences and alternative interpretations in a way that thematic analysis typically does not</td>
</tr>
<tr>
<td><strong>Contributions or ‘value added’ to health economics and priority setting research</strong></td>
<td>Challenges the naive view that there is a single shared organizational interest or point of view</td>
<td>Challenges the naive view that there is a single shared organizational interest or point of view</td>
</tr>
<tr>
<td></td>
<td>Recognizes that people find meaning in organizations and their behavior reflects this; draws attention to the people management dimensions of organizational change</td>
<td>Opens up space for alternative discourses; enables recognition of valuable but unarticulated or suppressed perspectives</td>
</tr>
<tr>
<td></td>
<td>Emphasizes the role of leadership that is increasingly identified as an important subject for future research</td>
<td>Draws attention to or surfaces conflicts, which can then be confronted and resolved</td>
</tr>
</tbody>
</table>
at the 2007 Advances in Qualitative Methods conference in Banff, AB. The manuscript was improved with valuable feedback from two of the journal’s anonymous reviewers. Craig Mitton is funded by the Canada Research Chairs Program; Stuart Peacock is funded by Canadian Institutes of Health Research grant no. 162964; both Craig Mitton and Stuart Peacock are Michael Smith Foundation for Health Research Scholars. The views expressed in this paper are those of the authors, not the funding agencies. The interview data reported here was derived from a project funded by the Canadian Institutes of Health Research; ethics approval granted by the Behavioral Research Ethics Board at the University of British Columbia. Conflicts of interest to declare: None.

REFERENCES


