Healthcare Funding Priority Setting : A Contested Health Policy Issue

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Abstract

This paper critically reviewed interdisciplinary literatures on a topical issue of priority setting in health care funding and proposed an Integrated Health Care Policy Scoping Framework and a corresponding Integrated Healthcare Funding Model, which is consistently applicable across global health care organizations to generate further debate on the subject. There is an existing unique gap in terms of a universally acceptable framework for allocating health care funding resources that is applicable to National Health Care Systems, which provides managers with health care resources to achieve sustainable profitability in both private and public healthcare organizations. Based on an international business perspective of healthcare both as a public good and a commercial entity, the topical debate appraised the close relationships that exist among the benchmarking variables of health policy and health care marketing in proximity to internal and external systems; social-political-economic factors and organizational strategy; as a way of demonstrating an open venture inventiveness to maximize sustainable organizational value at a competitive cost leadership and product differentiation advantage to both existing and new competitors.

Keywords : **priority setting, healthcare funding, healthcare resource allocative efficiency, healthcare economics, health policy**

JEL Classification : I11, I12, I14, I15, I18, I19

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Within several publicly financed health care systems, priority setting in healthcare funding is not new, but has recently become an issue of growing importance to achieve equity, efficiency, and responsiveness. Repetitive economic rationing events across global health care organizations to manage the growing contentious issue of supply and demand have created a strong relationship between business and clinical issues. According to Lewis (2005), health typifies a strongly contested policy sector with media coverage of latest health crisis ensuring that health rarely escapes the public's attention as governments, health service delivery organizations, health insurers, professionals, consumers, and the public stake claims and make demands. The turbulence of health politics and policy making is sometimes so violent that observers struggle to understand the nature of debate among those who fund, organize, and deliver health care. In other words, health policy that transacts mainly within political terrains is a non-linear chaotic process, which is marked by dual contrasting discourses such a generally agreed public perception of the deteriorating standards in health care provision and management ; yet, there is a remarkable increase in life expectancy.

Globally, as Anderson and McDaniel (2000) observed that health care resources are becoming increasingly scarce because of multiple factors, which has created a marked interdependence between administrative issues and clinical issues with the importation of conflicting non clinical decisions into clinical practice domains in search for a balance of economies of scale. The changing variables of supply and demand in healthcare resource

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allocation attest that priority setting occurs in an ever-changing context. Annually, global health care budgets contribute a significant proportion of gross domestic product revenue expenditures for several economies, owing to the high rate of opportunity costs associated with the health care industry such as natural disasters, disease epidemics, changing population demographics, and costs linked to unforeseen health reform initiatives (Duckett, 2007). The integration of clinical and financial subjects in a field of health care that has traditionally been perceived as a common public consumer product in the form of good health care has heightened the issue of rationality among several health care stakeholders. According to Daniels (2000), at issue in the healthcare funding priority setting discourse are the matters about the overall responsibility for resource allocation in terms of involving the public, consumers, or patients in the decision-making process for maximum population health improvements.

Davis and Ashton (2001) and Stone (2002) posited health policy as a complex political phenomenon, with push and pull political factors determining the set of rules or guidelines proposed or taken by a government to guide action, prioritize, and allocate limited resources in both the private and public health sector in order to achieve its goals. Health policy formulation has very close non-linear links to the larger public policy that affects healthcare institutions, organizations, services, and finance on issues such as the demographic arrangement of the nation, technology in the health sector, politics, social values, health professionals, and the media. From this perspective of health policy, the subject of health care funding priority setting, which is fundamental to health policy formulation, is set within the broader public health policy analysis in terms of complex cycles of interdependent non-linear intellectual activities embedded in the policy making process shown through time, agenda setting, policy formulation, adoption, implementation, assessment, adaptation, succession, and termination.

Advancing the debate on health policy formulation, Kingdon (2003) proposed a model for policy agenda setting that is composed of three streams in form of the problem, policy, and political streams, which coalesce to form a policy window to facilitate action. The Kingdon model underscored the importance of understanding the contributing values of evidence base, systems capacity, and capability of the localized practice terrain, prevailing political drivers, and the willingness of groups and individuals to change. In other terms, for an issue to be perceived as a problem, the issue must be recognized in the public domains, and the proposed solutions publicly perceived as good advice within a responsive prevailing political environment.

Existing Research Literature Gaps in Conclusive Healthcare Funding Models

Across the globe, the subject of priority setting in health care funding as the main foundation for achieving set global strategic healthcare accreditation benchmarks moves the discussion beyond the institutional structural parameters because of the complexity of the health care industry both as a public consumer good, the high risk to life issues, multiple active stakeholders, and the need to curtail rising health care budget expenditure costs. To date, Henisz and Swaminathan (2008) alluded that healthcare resource allocation priority setting initiatives to collect stakeholder voice intelligence has taken place in expenditure vacuums or economically restrictive budget systems, which presented a unique challenge for managers to identify sources of additional resources.

Firstly, Henisz and Swaminathan (2008) interrogated the influence of developed world institutions such as health care firms on international business by drawing key insights from comparative health politics, entrepreneurship, industrial organization, marketing, political economy, sociology, strategic management, and even international business. This viewpoint is particularly relevant given the high fluidity of health care professionals as key economic, social, political, and historical shakers and movers across many economies. Secondly, the long-term planning process of individual health care firms has to closely examine how institutional level performance strategy shapes the path of attainment of identified better health care benchmarks and population outcomes. In doing so, the international health care organizations accreditation benchmarks have become central drivers of institutional health policy change for several businesses at both individual and national scales.

For example, Orr and Scott (2008), using an Institutional Theory in Sociology Perspective to inform an inductive analysis of the drivers of unforeseen costs in 23 large global projects, examined the process by which managers come to terms with project level variation in the institutional context and generate a response to that variation in terms of generated business practices or norms that reduce conflict and promote stakeholder conformances in health policy formulation. These generalized business findings stress that the institutional environment in a country, in this case the regulatory environment such as the Treasury, affects the distribution of entrepreneurial activity across the formal and informal sectors of an economy. Simply put, what should priority setting in healthcare funding demonstrate? : Equity, transparency, consistency, or professional or lay values?

On the other hand, Burns (2014) adopted a systems perspective of a transitioning world's healthcare priority setting such as India's health care system - where exist little health insurance or other forms of risk pooling, little regulation and accountability of providers, a questionable efficiency, and a predominance of fee-for-service payment - by analyzing some invariant principles across cultural contexts of healthcare systems based on a logic of an Iron Equilateral Triangle. Burns (2014) posited the iron triangle as a balancing act among intermediate outcomes involving some inevitable cultural trade-offs in pursuing for goals or vertices in the triangle such as efficiency or cost containment, high quality care, and patient access. By explanation, the equilateral triangle has sixty degrees at each of the three sides, whereby policy initiatives that expand one side beyond sixty degrees force one or two angles to contract beyond sixty degrees.

Expanding this discourse, Burns (2014) pointed out that any policy initiative to promote patient access to care leads to higher demand for care, increasing utilization, and higher costs in the form of out of pocket or taxation based costs. In other words, equity seeks to provide all citizens with reasonable access to agreed core health services according to their health care needs, with particular attention given to equal access to core services instead of equal outcomes on expenditures. Similarly, efforts to promote high quality care through technological innovation for better market share prices, results in higher utilization and higher costs. According to Burns (2014), determining the right thrust and mix among the three angles constitutes the balancing act in resource allocation faced by most countries using policy levers such as the financing, payment, organizational, regulatory, and behavioural change initiatives enshrined in the country's economic, social, and cultural contexts . Subsequently, some lack of a balanced act on cost containment and efficiency, patient access and access to high quality care results in poorer health outcomes, rising costs and patient access to high quality health care.

Briefly, at issue in this discourse is a lack of an explicit approach of prioritizing health care services and patients on the basis of need and lack of a sound purchasing and prioritization framework to ensure equitable access of high quality services for attaining improved population health outcome measurement systems, establish quality management systems, culturally appropriate indigenous health and primary health care outcomes, health budget cost containment, and establishing strategic information to support service integration, pharmaceutical consumer demand management strategies, seamless local health service planning and management frameworks, and attainment of nationally identified emergency, acute, non-acute services, and elective surgery performance targets. Another unforeseeable challenge in public health care priority funding setting involves the issue of crisis management of disease epidemics in the form of adopting sound human, financial, and material resource management principles needed to comprehensively eradicate the new health threats and to enact long term integrated preventive measures for sustained better population health outcomes and competitive business outcomes.

Discussion

Mullen (2004) underscored a lack of an explicit priority setting in healthcare in terms of a single agreed objective or outcome measure, continues to evoke considerable interest on the subject within contemporary health services research. At the epicentre of priority setting is the resource allocation discourse, which entails striking a sustainable balance between the macro-economic variable of equity and efficiency; a strategic sound understanding and knowledge about disease and population health care needs, a sound overview of available

treatments, effectiveness, health outcomes, and care costs. Gray (2006) and Roberts, Bryan, Heginbotham, & McCallum (2009) expanded this discussion from a socioeconomic perspective by positioning priority setting as a value-laden and rights to particular forms of care perspective. The socioeconomic school of thought portrayed equity as an equal access for people of equal needs, where efficiency is concerned with achieving the greatest outputs for any given inputs. On one hand, effectiveness of care stems from a viewpoint of a ratio of outcomes measured against previously established objectives. At issue in this contested healthcare resource allocation discourse, is the expert nature of the knowledge that underpins health care provision and the perceived limited lack of technical expertise that individual health consumers have in distinguishing between high and low quality care, and the technical challenges associated with ascertaining quality from the consumers' perspectives.

Notwithstanding, health has enormous political immediacy compared with other sectors because of community expectations regarding health care amplified by the high stakes attached to clinical accountability issues because of life-and-death issues. In response, Ham and Robert (2003) utilized the Oregon empirical research approach in an attempt to resolve at an international level, the healthcare resource allocation priority setting issue based on accountability for reasonableness. A key research finding showed that health funding priority setting is premised on achieving equitable five categories of health services and treatments that are adequately prioritized on political, administrative, and clinical terms.

Another observation from this research alluded to the unavoidable disagreements among main stakeholders involved in setting priorities for financing both public and private health services leading to adoption of difficult choices and the exclusion of other services from funding. Overall, the key research finding revealed five health service categories: treatment of life-threatening and severely disabling acute diseases; preventive medicine; palliative medicine or chronic disease management; treatment of less severe acute and chronic diseases; then borderline cases and care for reasons other than disease or injury. In following this process, as Ham and Robert (2003) argued, reasonable rationing is premised on four conditions involving publicly accessible decisions, mutually agreed rationales for decisions on the basis of fair-mindedness, a clear set mechanism for resolving challenges and disputes, as well as an enforcement mechanism to regulate the policy making process of transferred concepts from paper into practice.

Activity based funding (ABF) and costing, clinical benchmarking, and associated resource allocation trends, as the central feature of the Oregon reform framework, is a re-orientation of health services funding towards clinical care. According to Kimmel, Weygandt, and Kieso (2011), ABF is a method of allocating funds based on the activity or outputs of an organization of service with the aim of funding the actual work performed within agreed targets. Based on this definition, essential elements of the ABF target a specific volume of a healthcare activity undertaken by a facility or service, reveals a classification system that groups a clinical activity into classes with similar clinical profiles and resource use, costing is shown as an indicative resource use of forecast activity targets referred to as weighted activity units, and a price to be paid is accorded to the weighted activity unit. In other words, funding is equivalent to the price paid multiplied by weighted activity unit.

From the above perspectives, I, therefore, revisited some key issues on healthcare resource allocation priority setting in order to draw useful insights into an ideal health care funding model that is applicable at an international level across health care organizations operating in the developing world, transition world economies, and the developed world. The key issues are as follows :

⇨ **Cost-Utility Review:** Feldstein (2011) underscored expanding access to care and controlling the rapidly rising healthcare costs as important health economics variables for any health care systems that seek to achieve successful reform. Similarly, dwindling health resources supply and growing consumer demand for policy makers striving to enact an equilibrium framework to achieve high-quality responsive services available at a high cost prize versus the need to demonstrate openness, consistency, and accountability in priority setting for legal reasons. In addition, Dolan (2008) closely linked the quality-adjusted life year (QALY) with the cost-utility analysis in order to calculate the ratio of cost to QALYs saved for a particular healthcare treatment. The resultant ratio from this calculation is then used to prioritize healthcare resources allocation, whereby a medical treatment with a lower cost to QALYs saved is preferred over a treatment with a higher ratio.

⇨ **Cost- Efficiency Review:** Ashton (1999) posited this notion within the context of having the ability to integrate and re-align the allocation of health care resources among service categories for innovation in the way services are provided and for modifying the role of primary, public, and private sector provider groups. The need to balance the promotion of private and public health funded insurance systems, and devolution and integration of health services, in view of a growing national gross domestic product (GDP) health budget is based on the principle of cost-efficiency. The cost efficiency perspective, in turn, expands consumer choice of care because of increased competition in service provision, price, quality, technology to increase market share that can facilitate better healthcare and ability to shift resources across services and service providers.

⇨ **Cost - Benefit Analysis (CBA) :** Bhatia and Fox Rushby (2002) viewed CBA as a measure of both costs and the consequences of the options being analyzed in money based on a study of 80 villagers' willingness to pay for insecticide mosquito nets to reduce the malaria infection risk. The study outcome stressed the importance of individual cases in bringing priority setting to public attention based on the principle of need and solidarity. Arguably, the CBA technical efficiency principle implies that health resources should be committed to the person or activity most in need of them in terms of opportunity cost. The CBA healthcare economics principle takes into consideration the willingness to pay as a useful economic variable that allows benefits to have a monetary value placed on the intervention in question.

⇨ **Quality Adjusted Life Year (QALY) Review :** Dolan (2008) posited the QALY principle as a measure of a burden imposed by a disease on a person, including both the quality and the quantity of life lived. A QALY review, therefore, highlights the importance of variety of levels at which priorities are assessed to determine the value for money of a specific medical treatment on the basis of the principles of benefit (how effective is it? Does it do the patient any good or harm?), value for money and fairness (is the person who can benefit from the service the one receiving it?) in terms of their incremental cost per QALY gain.

⇨ **Program Budgeting and Marginal Analysis (PBMA):** According to Edwards, Charles, Thomas, Bishop, Cohen, Groves, Humphreys, Howson, & Bradley (2014), PBMA is a process that helps decision-makers to maximize the impact of healthcare resources on the healthcare needs of a local population or to meet other specified goals such as equity considerations. Edwards et al. (2014) described programme budgeting as an appraisal of past resource allocation in specified programmes, with a view of tracking future resource allocation in those same programmes. On the other hand, marginal analysis is premised on the appraisal of added benefits and added costs of a proposed investment or the lost benefits and lower costs of a proposed disinvestment.

Key PBMA features involve a sound understanding of programme expenditure information, the political context, system capacity to fund the healthcare programmes; consumer perspectives of essential core health services, and the exclusion of some health services from funding on principles of benefit, value for money, fairness and responsiveness to communities' health care values and priorities. Roberts et al. (2009) and Tsoupas and Frew's (2011) empirical study of 28 PBMA applications across New Zealand, Canada, UK, and Australia posited PBMA as the most pragmatic and successful fundamental concept that allows decision makers to develop timely responses to pressing questions while enabling consideration of multiple inputs in form of literature evidence, local data, and local expert opinion.

⇨ The role of professional or lay values and ethics in priority setting (Abbott, 1988).

⇨ **Cost Minimization Analysis (CMA):** CMA compares the cost of two or more treatment options such as generic or non-generic drugs for pain, and it assumes that the treatments achieve the desired outcome to the same extent on the basis on costs alone. An attempt to consult and involve the public to justify political/administrative prioritization versus clinical prioritization based on the principle of human dignity, thereby measuring the differences in cost (Briggs & Grey, 2000).

The discussed topical issues regarding the prioritization of scarce health resources and the identified need to cut costs have confounded several organizations with unique health policy decision making complexities across the globe. Briefly, the acquisition of new transformative leadership mental models that offer valid and useful ways for effectively dealing with complex challenges of healthcare policy leadership needed to meaningfully scope health policy analysis bearing in mind that policy action and inaction at the broader level shapes and constrains decisions within organizations at agenda setting, policy formation, adoption, implementation and evaluation stages operating as Dunn (2004) argued, within comprehensive economic rationality, second-best rationality, disjointed incrementalism, bounded incrementalism, erotetic rationality, critical convergence, punctuated equilibrium, which is incremental with occasional large jumps and mixed scanning models, which is a mixture of several policy models.

In the above discourses, public health problems are brought into the political framework through problem identification and interpretation on the basis of broad issues and also in urgent need of government action. The policy formation stage is both a social and political construction that ensures that policies are designed, created, or changed prior to implementation. Finally, the policy evaluation processes involve monitoring, analysis, criticism, and assessment of existing or proposed policies. Briefly, Dunn (2004) hails the critical role of the ethically controversial policy analysis process for its ability to forecast future consequences and consequences when implementing existing policies, whilst serving also as a monitoring and evaluating tool.

Expanding the key elements of the policy-making discourse, Gauld (2001) posited the policy analysis framework within health economics, cultural, political, and societal influences, which impinge on the inputs, processes, and outcomes of health policy making on broader issues such as the exercise of power and authority and the role of the State. According to Dunn (2004), the comprehensive economic rationality model provides a clear understanding of the objectives of the policy, comprehensive information about each alternative strategy, advantages, disadvantages as well as a rational and objective method of evaluating decision making processes. On the other hand, Dunn (2004) described an incrementalist model as an adhoc muddling through approach to decision making that ensures that policy decisions are safely, expediently, and practically accomplished on an incrementalist conservative basis with a minimum policy disruption, most suitable for centralized political governments, albeit at the expense of the interests of groups with fewer resources.

A rational-comprehensive choice is employed to establish major issues that require investigation and actions whilst incrementalist decision making is applied to choose options within these areas. Dunn (2004, p.53) portrayed 'disjointed incrementalism' with features of several minor changes taken after restricted incomplete analysis as a model of policy change, which affirms that policy choices are frequently in compliance with the requirements of the economic rationality model. Finally, within the mixed scanning approach, decision makers adopt a compromise approach so that both rational-comprehensive choices and incrementalist decision making processes are employed.

Unpacking the Paradox of Healthcare Funding Reforms for Practice and Policy Management

According to McEachern (2014) profit maximizing behaviour is a shared key feature of productive and allocative efficiency in a perfect competitive market-sensitive economy. The allocation of resources is efficient when each commodity's price equals its marginal cost and is achieved when it is impossible to change the allocation of resources in such a way as to make someone better off without making someone else worse off. In other words, allocative efficiency is premised on producing consumer-oriented valuable products, which meet customers' expectations (McEachern, 2014). The profit-maximizing behaviour process entails that businesses embark on making the right stuff by producing more of the same goods and less of others in a manner that satisfies stakeholders' expectations and needs.

On the other hand, McEachern (2014) attributed productive efficiency to situations when businesses produce at the least possible cost, which is achieved in either a competitive or monopoly market. By measuring and

aligning the three key business strategic value anchors, namely, strategy as in form of a health purchasing contract, customer care, and systems reviews, health care business entities achieve maximum financial priority setting purchasing value portrayed as essential care, a priority one (P1) by reducing labour costs, streamlining the workflow for efficient healthcare, a priority two (P2) through reengineered business processes and common administrative systems, improving data centre operations through consolidation, open innovation and downsizing, cooperative business and information technology planning, implementing cost-effective health care processes as priority three (P3) in the form of new technology, outsourcing some assignments and functions, redesigning the development and support processes, and restructuring and reorganizing the information technology functions as the basis for minimizing consumer responsibility shown as priority four (P4) in meeting health care costs.

Equally important in this discourse is the critical role of consumer participation in shaping new public health policy. Baum (1999) identified the concept of a health consumer as a highly contested ideology that floats interchangeably within a democratic and market-oriented model of health care. By definition, Carter and O'Connor (2003) portrayed the democratic perspective of a health consumer from a philosophical world that centralizes the value of participation and representation as an expression of citizenship and social connection. In other words, the approach emphasizes equity and promotes the need for citizens to participate in the wider community activities beyond the health sector in order to achieve improved health outcomes. Baum (1999) linked the democratic paradigm to the 1978 Declaration of Alma Ata (WHO, 1978), a social health and human rights model that spearheaded the Health for All by the Year 2000 strategy and the key citizen participation as central to positive community health outcomes.

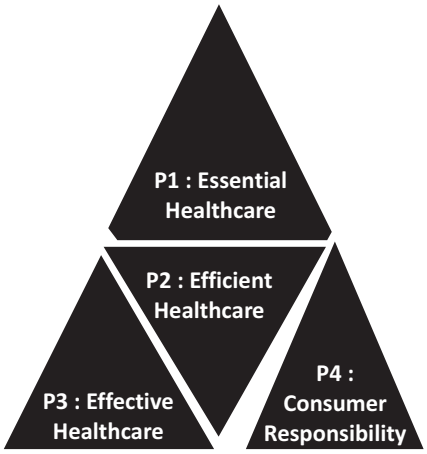
As Duckett (2007) argued, the Australian Health Care System is a deeply contested terrain characterized by conflicts over values and policy choices. Striking findings from an AIWH (National Health Strategy) (1992) review supported the notion that low and working class individuals in Australia have high morbidity and mortality rates, are more likely to use health care services despite limited access to both public and private health care services for illness care, have poor housing standards, and receive low annual incomes. This shows that there is insurmountable tension in the health resource allocation discourse regarding the relative contribution of illness care to gross measures of improvements in health status and length of life as compared to the role of social determinants of health towards better health outcomes. For example, AIHW (1992) stated that in 1983, the Enquiry into Hospital Services in South Australia rejuvenated the growing need for greater consumer rights protection and a commitment to Medicare, a free Universal Health Insurance co-funded through a government subsidy and tax-based incomes. In contrast, the market-based health consumer paradigm portrays an image of a consumer as an individual who has to deal with an individual disease to optimize the operation of the market. This approach is hugely premised on the notion of making strategic information about their treatment options and their effectiveness available to health consumers, better informs consumers to make better health care purchasing choices.

Figure 1 is a hierarchical conceptualization of an integrated funding-purchaser partnership approach of benchmarking and setting priorities for health care resources, which measures and aligns key business strategy in form of clear choices such as devolution, integration or sub-contracting approaches, stakeholders' perspectives in form of actionable consumer intelligence information and reviewed internal and external work processes in proximal to both internal processes and key business competitors to achieve both cost leadership and product differentiation competitive advantage in the form of business goals and client outcomes. Figure 1, as a unique health care resource allocation tool, acknowledges the importance of a partnership resource allocation and utilization model that combines integrated public funded services and health care contracts as a way to move the reform agenda away from bottlenecks of funding services and purchasing services through a competitive tendering and contracting process. In doing so, the Figure 1 offers a strategic perspective of setting customer-focused health resource priorities for use by business entities to reprioritize health resources and services, collect actionable customer voice intelligence, and identify internal weaknesses and to improve upon them as the basis to achieve both allocative and productive resource efficiency.

Figure 1. The Integrated Healthcare Funding/Purchasing Model

Health Care Contract Business Strategy

(Quality; Price; Services; Standards; Cost Containment; Purchaser/Provider Market R/V)



Stakeholders' Viewpoints **Systems Perspectives Review**

Scoping Public Health Policy

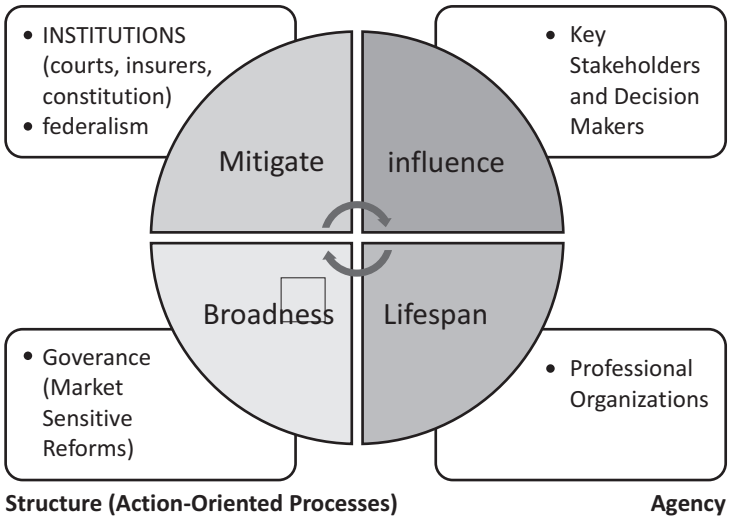
Internationally, the health care industry is in a constant panic state of volatile change in pursuit for better population health outcomes, cost-containments, and value for money health care within an economically rationed and influential stakeholder practice environment. The volatile practice contexts present unique health care leadership challenges on issues pertaining to setting up sound healthcare resources priorities within a burgeoning social, political, consumer, and economic influential stakeholder and competitor practice terrain seeking an active role in the health care product development process. According to Johnson (2013), the complex nature of leading healthcare industries because of a constant interaction of challenging factors such as the high opportunity costs associated with managing high-priority population disease epidemics, natural disasters, and terror fatalities; highly professionalized workforce, rise in consumerism, and digitalization of healthcare; have become new push factors for health services organizations to proactively re-orientate business strategies towards developing and implementing sustainable new leadership mental models that offer more valid and useful ways to deal effectively with work ambiguity.

Drawing conclusions from Johnson's views on healthcare leadership complexity, Figure 2 is a proposed change management platform striving to interrogate the issue of leadership complexity based on an integrated transformative learning framework, which clearly demonstrates a summarized perspective of the influence of health politics, health economics, the sociology of health and professional organizations on the structure and ideology of health services funding the resource allocation paradigm.

Figure 2 is an integrated systems approach to review key health policy issues with elements that are aligned further to the left side dealing with structural institutional issues while those on the right have more to do with bold actions that leaders adopt in order to successfully steer organizations out of the debilitating financial crisis. At the crux of the healthcare policy scoping framework in Figure 2 are strategic diagnostic mental thinking elements involving mitigation, influence, broadness, and crisis lifespan; to facilitate policy makers to inform and seek input from various structural and agency stakeholders as a way to identify and rank key public policy issues.

By definition, institutional structure shapes the roles and individual cultural practices of actors or stakeholders, but do not fully determine them because of several constraining factors beyond their spheres of influences (Lewis, 2005). Therefore, institutions are formal structural arrangements summarized as a health care

Figure 2. An Integrated Health Care Policy Scoping Framework



system; whose role is to lay down a series of pathways, along which policy travels. In other words, actors inhabit structures and change them to support and advance their positions or interests. Ideas become a focal point of health policy stakeholder interactions ; thus, ideas become a product of both structure and action taken by the different political, social, economic, and professional players in terms of an identified prevailing health care system policy.

The broader health care system of any given country becomes the institutional pathway through which policy travels and acts as an interconnected platform for political, social, economic, and professional debates among several key stakeholders such as the market-sensitive governance structures, institutions, and the organizational power that cuts across the medical profession, state, and institutions. Considine (2005) defined institutions as the set of elements such as courts, budgets, electoral legislation, and the appeal of political parties, which lay down rules to limit actors' options and also serve as pathways for change. In doing so, institutions shape the terms of political, social, economic, and professional discourses, conflicts, and policy making boundaries, within which strategic stakeholders make choices. As Luft and Shields (2003) alluded, based on the contingency theory is that an interaction fit between structural and agency factors will cause increased performance in healthcare funding priority setting, whereby policy makers use policy ideas to argue for what they desire, and organizational structures shape the nature of ideas in terms of being conceivable and relevant.

Similarly, another notion resonating with Figure 2 points to the revolving influential role of the four diagnostic mental thinking models involving mitigation, influence, broadness, and policy crisis lifespan in shaping the health care funding model design. For example, Palmer and Short (2010) attributed health policy in major contemporary democracies such as Australia, United States, United Kingdom, and New Zealand as a political tool that is at use at every change of political government. Specifically, in Australia, the Australian Commonwealth Government and the Australian Medical Association through a 1946 constitutional amendment of Section 96 and a successful high court appeal respectively, played a pivotal mitigating role of making health policy and steering society based on market-oriented management and professional monopolists' need to maintain dominance in health sector reforms that focus on cost containment, efficiency, and cost-effectiveness of the health sector in pursuit for improved population health outcomes, equity of access to high-quality health care, and stakeholder engagement initiatives during the planning, delivery, and management processes.

Managerial Implications

Appraising healthcare economics issues such as resource allocation alternatives in the form of associated costs has increasingly become an essential transformational and transactional decision making process undertaken by healthcare policy makers across the globe because of rising expectations for health services, consumerism, new communication technologies, and healthcare budgets. Armstrong (2008) associated transactional and transformational leadership styles with competence in dealing with daily information transactions and motivating stakeholders to embrace changes. In doing so, as Armstrong (2008) added, health policy makers as chief information disseminators adjust to the world of the stakeholder, use listening skills and stakeholder feedback review outcomes to evaluate the potential health policy recipients' level of understanding in order to enact alternative simple and direct communication channels to reinforce policy changes.

As Dolan (2008) alluded, the key feature that separates successful health-care policy makers from unsuccessful ones in terms of innovative health care resource allocation capabilities are their meaning structures in proximal to their peer competitors and the arrangement of internal workflow processes tools that are important to achieve role effectiveness, communication tools, coaching and training tools, and identified funding and reward systems. In other terms, improvements in healthcare should be appraised from an informed consumer's perspective in terms of their evaluation abilities of the health care systems in various states of doom and boom in proximal to the amount of years or health risk each consumer is prepared to accept without jeopardizing full health. The central theme of information dissemination involves the process of generating and manipulating health literacy knowledge in a dignified simple manner for the ordinary healthcare consumer. As an example, Turia (2013) pointed out that in New Zealand, health illiteracy significantly accounts for poorer population health outcomes, which is at 56.2 % of the total adult population or 1, 620, 000 New Zealand population.

The information dissemination perspective drew its main principles from a stakeholder paradigm (Dunphy, Griffiths, & Benn, 2007) that required leaders to embrace the wider interests of society through marketing and innovative information dissemination to create business customers needed to achieve success. The information disseminator role construction is discussed from a utilitarian consequentialism philosophy (Blackburn, 2008), which argued that leaders ethically act out in the best interests of the greatest number of stakeholders, including themselves, to achieve sustainable and beneficial change for their organizations. Darwall (2003) posited consequentialism as a philosophy that holds that the value of our actions derives from the value of its consequences. To achieve the desired impact, the information disseminator role needs to be carried out with appropriate enthusiasm, confidence, resilience, and personal wholeness, which inspire stakeholder trust and influence.

In other words, health care leaders, because of the high rate of repetitive failure of complex change management, need to adopt innovative diagnostic mental thinking models involving critical change elements such as mitigation, influence, broadness, and crisis lifespan through which they can view adverse events to make this shift effectively. For health policy makers, this integrative health care funding model is a proactive organizational tool for use to strategically drive maximum organizational value. The integrated healthcare funding and purchasing model allows organizations to employ a carefully championed consultative resource allocation process each time when faced with a health care industry adversity to systematically integrate issues of public concern in form of policy ideas, stakeholder expectations, political and systems capacity to enact acceptable best practice based health policies. Pertinent interrogations that occupy effective leaders' mind sets seeking to cease control of the crisis situation employ a customer-focused diagnostic process of the extent of the influence of the crisis and carefully defining the crisis lifespan to gain useful insight into the length and ripple effects of the health policy challenge.

It is equally important to identify barriers to reaching sustainable leadership goals in today's global business environment when considering the high false starts rates in global health care funding reforms. These leadership barriers are multifactorial such as a reduced leadership self-awareness in terms of relevant skills and knowledge, poor identification of desired results and operational plans, stakeholders' and business markets' expectations and

ways to gain a competitive entrepreneurship advantage. Another leadership barrier relates to poor job analysis and reduced role clarity in terms of expected roles and responsibilities resulting in poor policy management. To counter these barriers, institutions need to carry out a situational and skills audit by strategically measuring and aligning actionable customer intelligence, business strategy and systems review outcomes to determine an appropriate policy road map, key stakeholder values, appropriate business unit strategies, dynamic business unit values, key actionable policy deliverables or objectives; future business development needs and competitors and key performance priorities, which ensure that organizations avoid prolonged costly discourses on health policy legislative issues.

In the same manner, visionary health care leaders, on the basis of a shared need and policy roadmap, conduct a situational analysis and assess their team skills against current and future business standards, analyze competencies against the prevailing crisis situation, communicate formally and informally role functions, policy development plans, and competencies with all key stakeholders using simple but effective language, collect actionable customer feedback, and reinforce feedback through targeted training, policy coaching, new standards implementations, supervision and performance reviews that are linked to peer competitors and best-practice standards.

From a health politics perspective, corporate management is the new economic-political governance strand for public organizations and politicians arguing in favour of public organizations run as private enterprises based on micro-economic theories to improve efficiency through rational planning, de-regulation, privatization, and increased competition. Furthermore, health policy in Australia is shaped by a broader context of particular values, systems, and beliefs that fit interests of global capitals such as the International Monetary Fund, World Bank, and World Trade Organizations, which modify global competition and international trends in governance, reform, and delivery structures of health care (Lee, Buse, Kent, & Fustukin, 2002).

Chesbrough (2003) posited an open innovation model from a broad spectrum, whereby health business entities employ both internal and external pathways to exploit technologies and, con-currently, to acquire knowledge from external sources. This business model is most appropriate for health care business enterprises in pursuit of enacting essential care using carefully modelled priority setting funding approaches because health care has high international labour mobility (Briggs, 2010); is an abundant capital intensive venturing process because of a need to balance health care provision both as a public and a commercial entity (Braithwaite, 2006) and has an intricate knowledge management from a business and consumer perspective in terms of the constituents of essential care. Lichtenthaler (2008) approached open innovation in business entities from an analysis of strategic approaches to technology transactions whereby firms combine both technology exploitation and technology exploration in order to create maximum value from their technological capabilities or other competencies such as venturing, knowledge management as in externally acquired intellectual property processes such as the licensing of patents, copyrights or trademarks, and technology exploitation.

Another market approach viewpoint by Johnson (2013) that is appropriate to priority setting in health care funding discusses relationships between traders and brokers and the high importance of trust often emerging from stakeholders embedded in formal and informal networks of explicit information exchange systems. From an institutional perspective, these economic stakeholders are seen as driven by financial markets' information to maximize rewards through their interaction with each other. Whereas, Otley (2003) identified a common trend in organizations involving the use of budgets as important control tools used to adapt their control models to numerous contextual factors such as operating environment, organizational structure and strategy, and the external environment. A resonating theme in this process is that an organization's survival demands it to conform to social norms of acceptable behaviour reflected in by the governance structure, policies, and procedures as much as to achieve high levels of production efficiency.

A key priority for both policy makers is to achieve good essential health care that embraces all three variables of cost containment or efficiency, promotes equity of access to customized high quality care, and customer-focused health services that promote high patient access. According to Ham and Robert (2003), there have been

several previous futile attempts to extrapolate the concept of good health care from the consumer's perspective which remains marked as a grey area because of multiple needs assessment variables such as increased sophistication of hospital services, increased availability of specialists, and increased equity of access to sophisticated healthcare technology such as digitalized personal care and reputation of the health entity in form of positive consumer experiences of services. Simply put, this recurring question in terms of defining good health care from a consumer's viewpoint displays the following key ambiguous policy and practice issues:

- ⇨ Is it primary health care in form of a health care service that is provided at home?
- ⇨ Does it refer to extended operational hours of a health service?
- ⇨ Increased number of general medical practitioners in a given location ?
- ⇨ Does it relate to the quality and number of emergency department services?
- ⇨ Does it relate to the number of nursing services?

The other managerial challenging variable in designing a sustainable priority funding model pertains to knowledge management in the highly professionalized health care contexts. This discourse refers to the process by which health consumers and practitioners make informed choices about core health care services based on their ability to access strategic information potentially through consumer advocate groups, media, internal hospital stakeholders; equity of access to hospital resources, support in gaining insight into complex health structures, funding, and roles and opportunities for meaningful consumer engagement in health care planning, delivery, and management.

As shown in Figure 1, an integrative resource allocation model that synthesizes open innovation, strategic benchmarking of a health business' strategies, systems reviews, and stakeholder management approaches and health care marketing is needed to achieve maximum organizational value for money essential health care. In this manner, marketing becomes the central process to inform and gain insight into stakeholders' viewpoints regarding the predominant influencing criterion for consumer choice of a health service priority setting framework. Biswas (2013) expanded the traditional viewpoint of strategic marketing principles of product, price, place, and promotion from a customer-centric aspect to involve proactive stakeholders such as employees as the greatest ambassadors of business products, perspectives of customers, personalizing the product proximal to each competitor and for each customer, and enacting partnerships with customers and competitors for co-creativity purposes. The strategic customer-oriented marketing principles, synonymous with the traditional product mix of marketing, strive to market products broadly by seamlessly integrating satisfied customers' perspectives to achieve the desired results.

Armstrong (2008) extended the discourse of customer-centricity from a perspective that stresses that a delighted customer is one who is completely satisfied with a product or service from multiple customer viewpoints. Firstly, the product or service has to meet quality expectations such as fitness for purpose, reliability, durability, and low maintenance. The issue of customer experience maturity happens only through a concerted roadmap designed to guide your organization from its initial efforts to its achievement of differentiated customer experience with sustained return on investment. It is equally important to note that in customer care management, leaders need to model the process through credible trust among team members by clarifying tasks in a respectful way to each stakeholder, setting up measurable business roadmaps, and fostering sustainable partnerships. In other words, a hallmark of a sound marketing strategy in terms of its ability to clarify business objectives is based on the ability of the strategy to convert product brand awareness captured as customer care intelligence and service referrals into high product sales or operational cash flows.

Kimmel et al. (2011) discussed the business cash flow value from an enterprising business innovation perspective; where business utilizes outstanding cash flows as a new venture capital. In doing so, successful organizations establish innovation teams across the organization to scan for business expansion opportunities and turn them into competitive product or service brands. The firms' decentralized marketing strategy set up for effective business innovation becomes a key change platform and open market place asset in terms of strategic

ability to raise product awareness, drive new customers, and proactively engage service consumers in product planning.

Implications for Healthcare Practices

At healthcare business operational levels, proactive employees enhance sustained customer care management in the form of input-action-output process by gathering customer care intelligence through listening to what customers say about the service or product. Following this process, proactive organizations create actionable customer intelligence from the voice-of-the-customer by connecting customer comments to operational data, then engage employees to cost-efficiently improve work processes in accordance with customer intelligence by ranking customer viewpoints based on customer-linked revenue or cost (customer life time value). The next stage of customer care management entails open-mindfulness engagement of functional based teams in resolving the blaring issues (improvement), thereby inspiring these teams in co-creativity around the blaring opportunities. Then employing a systems approach, businesses utilize internal open communication tools such as intranet or memos to inform and seek broader employees' perspective whilst concurrently branding internally and externally to convey business promises and value.

This systems approach to product marketing that uses proactive stakeholder management about a product or service, especially in a strictly competitive market, is a key foundational basis for achieving customer experience return on investment. The third marketing principle entails personalizing the business product in a manner that differentiates the service from each competitor and for each customer as the basis for driving positive consumer experiences in form of location of services to mitigate associated hidden targeted consumer costs such as accessibility for low income, aged, and middle-income consumers such as mother and child services who enjoy good health and insurance cover, but utilize services for emergencies, extended business operational regimens, and service integration with other businesses such as shopping malls, health education, corporate wellness, obstetrics and gynecology, pediatrics, and recreational facilities for smaller target group but significant for strategic future market revenue such as young professionals and high-income customers.

Alternatively, an increase in competition for these target consumer groups has forced health care businesses to attract and keep customers by hedging their product quality with those of competitors using cost leadership and product differentiation principles such as coupons for new-product testing, loyalty discount vouchers, and personalized product return policies. At the health political debates, reasonable assertiveness can be achieved through unilateral consequentialism among all political actors, which refocusses the health resource allocation discourse towards the ultimate public beneficiaries. The final consumer group comprising the poor consumers with little or no adequate health insurance, co-located in low income neighbourhoods, and mostly reliant on public health services is carefully managed through operations such as cross-subsidization, bulk-billing, risk sharing among hospitals, co-lobbying of State Legislatures and primary health care promotions.

Finally, the marketing framework has to be approached from a partnership approach with both customers and competitors, as a central feature for co-creation innovation. For example, low cost providers' collaboration with high cost-providers in a given market is important to reduce operational costs and to maximize a business's operational efficiency. These strategic marketing approaches, deeply influenced by institutional (formal and informal rules, beliefs, and norms held by the community within which the marketing system is located such as the increasing influential role of physicians as traditional marketing stakeholders on consumer healthcare choices) and systems (the changing physical, technological, and informational) perspectives that utilize economic or political power to direct flows of transactions in ways that contribute to the goals of the health entity that is exercising power in priority setting.

The primary function of engaging a viable marketing system within a health care business entity when setting key funding priorities in health policy is to diversify customer choices in the form of a richer array of goods, services, experiences, and ideas to ultimate customers. At the operational level, frontline healthcare employees adopt marketing strategies in terms of administering recently discharged local patient surveys to ascertain that

local consumer group perspectives are vital to inform health services managers about consumer viewpoints regarding the organizations' products and those of competitors. The actionable operational data in the form of consumer feedback review outcomes is strategic in identifying sustainable funding priority setting competitive advantages needed to assist with strategic new business ventures bearing in mind that health care consumers are infrequent users with a limited lasting impression of broad health care concepts such as better health outcomes, clinical informatics, and operational costs. True to its sense, reliable health consumer input surveys focus on rectifiable data such as hotel services, staff courtesy, billing procedures, cleanliness and comfort of the health care surroundings. It is, therefore, essential for organizations to meaningfully engage actionable stakeholder intelligence when designing and managing sustainable health care funding resource allocation frameworks in order to boost organizational performance effectiveness.

Conclusion

To conclude, an interesting question is - how can the healthcare financial resource priority setting discourse be adequately addressed within contemporary global health care enterprises in a manner that achieves value for money essential health care, equitable access to better health outcomes, and what roles do individual actors play in shaping the health care funding model? The issue of health care funding should be addressed within local political, economic, professional, and socio-cultural contexts without micromanaging the essential constituents of healthcare funding priority setting such as health policy scoping and marketing and variations in service entitlements across different parts of the health care system.

Evidence stresses the need to strategically empower and utilize actionable stakeholder intelligence throughout the input-process-output health policy formulation process and extend the healthcare priority setting process to targeted stakeholders using sound customer-sensitive marketing principles in order to achieve sustainable health care funding priority setting frameworks at both a productive and allocative resource efficiency as a way to enact innovative superior competitive advantages over competitors for sustainable new healthcare business ventures.

Limitations of the Study and Scope for Future Research

A good question that arose from this review process pertains to the issue of choosing the best methodological approach to adequately address the recurring challenge of finding a comprehensive and sustainable priority setting health care funding model that is applicable across several health care systems. At issue in this review discourse was gaining an interdisciplinary insight into the key healthcare funding priority setting scoping frameworks and responsive priority setting models to achieve essential healthcare, efficient healthcare, effective healthcare, and client responsibility in a healthcare provision; the influential role of individual organizational stakeholders and systems review outcomes in shaping the process.

For programmatic reasons, the review process adopted a cross-disciplinary socio-political, professional, and economic approach to identify and discuss relevant international literatures that dealt extensively on the subject of health care funding priority setting as a global contentious issue. Nevertheless, this list of literature sources is not exclusive, but has broadened the existing evidence in the field of research. There is also a good chance to further explore the subject of health care priority funding in form of future research strategies, which are as follows:

⇨ Should quantitative approaches (Denzin & Lincoln, 2005) or qualitative approaches (Creswell, 2007) be adopted in empirical research to address the 'why and how' of the priority setting dialogue respectively?

⇨ Another action-based research (Yin, 2003) strategy points to selecting a single model healthcare enterprise that is universally representative in contemporary health care systems and carry out an in-depth review of business strategies, systems, and stakeholders' perspective in order to enact a comprehensive funding model.

⇨ Should consumers lead the process of healthcare resource funding and purchasing by setting up the policy making agenda by constantly challenging the predominant politically-biased health policy formulation process? Duckett (2007) and Gauld (2001) portrayed health policy as constant political debates at every change of political government in Australia and New Zealand respectively.

⇨ Perhaps, as Briggs (2010) alluded, Janus-like policy makers and health managers are urgently needed to solve the health care funding issue.

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