Priority-setting and rationing in healthcare: evidence from the English experience

Social Science and Medicine

Suzanne Robinson,
Iestyn Williams,
Helen Dickinson
Tim Freeman,
Benedict Rumbold

Abstract

In a context of ever increasing demand, the recent economic downturn has placed further pressure on decision-makers to effectively target healthcare resources. Over recent years there has been a push to develop more explicit evidence based priority-setting processes, which aim to be transparent and inclusive in their approach and a number of analytical tools and sources of evidence have been developed and utilised at national and local levels. This paper reports findings from a qualitative research study which investigated local priority-setting activity across five English Primary Care Trusts.

Findings demonstrate the dual aims of local decision-making processes: to improve the overall effectiveness of priority-setting (i.e. reaching ‘correct’ resource allocation decisions); and to increase the acceptability of priority-setting processes for those involved in both decision-making and implementation. Respondents considered priority-setting processes to be compartmentalised and peripheral to resource planning and allocation. Further progress was required with regard to disinvestment and service redesign with respondents noting difficulty in implementing decisions.

In conclusion, while local priority-setters had begun to develop more explicit processes, public awareness and input remained limited, compromising the legitimacy of decisions. The leadership behaviours required to navigate the political complexities of working within and across organisations with differing incentives systems and cultures remained similarly underdeveloped.

Word count: 7995
Introduction

Resource scarcity continues to create problems for most healthcare systems. In a context of supply constraints, the increased demand associated with demographic changes and rising consumer expectations has intensified pressure for effective healthcare resource allocation. Public sector service reductions are apparent within many countries, and as tough decisions on resource allocation are required to be made it is perhaps unsurprising that explicit priority-setting has gained political salience (Sabik and Lie, 2008). In contrast to the informal ‘bedside’ rationing that has traditionally been a common feature of healthcare delivery, explicit priority-setting focuses on the processes and systems required for making resource allocation decisions according to agreed criteria. The priority-setting literature contains many discussions of the best way to organise effective and explicit resource allocation systems. The limitations of a purely technical approach to priority-setting have been recognised and the focus has now shifted to how information, evidence and other inputs can most usefully be deployed (Drummond et al, 2008; Peacock et al, 2009).

While each health care system is unique, they face common financial challenges and there is likely to be benefit in comparing the priority-setting strategies adopted in different settings. In England the current resource allocation challenge coincides with major government reforms which will reorganise the way local funding bodies operate. Until recently, the English NHS charged Primary Care Trust (PCTs) to lead on explicit priority-setting of healthcare services. Being responsible for approximately 80% of the total NHS budget, their role was to define the health needs of the local population and contract with organisations for the delivery of appropriate services. Clinical Commissioning Groups (CCGs) are now set to inherit this role (DH, 2010a; 2011). While it is unclear precisely where priority-setting functions will sit in the new structure, it is certain that efficiency savings of around £20 billion are required to be made over the next few years (Nuffield Trust, 2011). Furthermore, many of the difficulties which PCT priority setters have faced will continue to challenge the newly developed CCGs.
Whilst there has been a lot of effort devoted to developing techniques and frameworks to aid decision-makers, comparatively little research has been undertaken into the application of priority-setting systems locally or the practices required to make them function as anticipated. This gap is addressed in this paper, which reports on a study of national priority-setting activity by local healthcare funders in England (Robinson et al, 2011a). The study was designed to explore:

- current priority-setters’ arrangements and processes;
- the impact and effectiveness of these arrangements and processes;
- the implications for future priority-setting both in England and other health care systems.

Two phases of research were undertaken: a survey to identify the types of priority-setting work undertaken within English PCTs (Robinson et al, 2011a; 2012); followed by a series of case studies investigating specific aspects of explicit approaches to priority-setting, including overall budget allocation (core budget spend); reprioritising across programme budget areas; disease/care pathway redesign; and substitution of, and disinvestment in, interventions and services.

Although the concept of disinvestment is a relatively new area in priority setting, the economic challenge facing healthcare organisations has led many decision makers to look beyond simple efficiency and productivity savings and focus on possible disinvestment strategies – primarily as a means to release resource (Elshaug et al, 2008; Robinson et al, 2011b). Much of the literature treats disinvestment as a means of optimising healthcare through the complete or partial withdrawal of resources from health services or technologies providing relatively little health benefit relative to their cost (Elshaug et al, 2008). A wider definition of disinvestment includes the withdrawal or reduction of relatively ineffective healthcare, as well as full withdrawal or rationing of equally worthy alternatives due to resource constraints (Williams et al, 2012; Daniels et al, forthcoming). It is
the latter which is often the most controversial form of disinvestment and such decisions can be complex and fraught with difficulty (Puffit and Prince, 2012). Given the economic constraints facing public sector services in England this study was interested in all aspects of disinvestment being considered and implemented locally.

This paper reports the findings from the case study investigations, detailing experiences of priority-setting within specific locales and deriving lessons to guide future priority-setting activity. Before outlining our methodology, we set out a number of important considerations derived from findings of the national survey undertaken in phase one (Robinson et al, 2011a; 2012) and the priority-setting literature which informed our study.

**Background**
The literature identifies a diverse range of challenges for local priority-setting processes including: the design and implementation of models and processes; the application of evidence and decision analysis tools; wider engagement and involvement; and leadership (Dickinson et al, 2011; Daniels and Sabin, 1997; Ham & Roberts, 2003; Klein & Williams, 2000; Sabik and Lie, 2008; Williams et al 2012;). These are briefly summarised here and returned to in the light of findings from the study.

**Priority-setting models and processes**
Healthcare priority-setting processes are located within decision, delivery and performance management systems and this context will have an impact upon the operations and outputs of priority-setting. Although there is a substantial literature on healthcare organisations and institutions (Child, 1984; Ashburner, 2001; Ferlie & Dopson, 2005), relatively little is known about the specific implications of these for local level priority-setting. The English system, in common with many others, delegates much of the responsibility for designing local systems to local health care funders (‘commissioners’). Consequently, there is potential for significant variation in relation to
factors such as: the remit, legitimacy and power of priority-setting bodies; the stated role and expectations of individual participants; and the linkage between decisions reached and actual resource allocation processes within and across organisations (Robinson et al., 2011a; 2012). The risk is that priority-setting is not embedded within the broader organisational (and inter-organisational) systems (Williams and Bryan, 2007). Clearly, the governance of such systems is an area of crucial importance if priority-setting is to become an effective component of resource allocation decisions.

Given the pluralistic nature of the value judgements inherent in resource allocation decisions there has been increased emphasis on the need for procedural justice and “fair” decision-making processes. One influential model in this tradition is the ‘Accountability for Reasonableness’ (A4R) framework, (Daniels and Sabin, 2008). This consists of four conditions of fair process which, if met in full, are intended to ensure the fairness of priority-setting decisions, even in the absence of any prior agreement on ethical principles.

**The use of evidence and decision analysis tools**

Explicit priority-setting is informed by parallel developments in evidence based decision-making (Niessen et al., 2000; Hewison, 2004; Williams et al., 2012). This has led to an upsurge in technical processes that rely on quantifiable epidemiologic, clinical, financial and other data. Methods for formal, economic evaluation of treatments and interventions are maturing and more flexible approaches such as Programme Budgeting and Marginal Analysis (PBMA) and Multi-Criteria Decision Analysis (MCDA) have gradually become more common in local practice (Hauck et al., 2004; Mitton et al., 2003; Robinson et al., 2011a, 2012). In addition, there have been developments in public health and needs assessment, predictive modelling, health intelligence, nationally-held datasets and other knowledge resources (DH, 2010b; Donaldson and Mooney, 1991).

However, a range of barriers prevent full use of techniques such as cost-effectiveness analysis, PBMA and MCDA. These include: shortages in analytical skills and infrastructure; shortage of quality
local quantitative data; deficits in the analytical skill of decision-makers; unreceptive organisational and political contexts; and weaknesses in the methods themselves. In addition, such rational and technocratic approaches often hide the value judgements inherent in the methodological approaches (i.e. valuing quality of life) (Kaplan, 1992; Holm 1998).

**Engagement and Involvement**
For healthcare commissioners to become trusted guardians of the public purse, more involvement and engagement is required (Williams, et al, 2012; Dickinson et al, 2011). However, findings from the national survey undertaken in phase one suggested that one of the main difficulties and weakness inherent in priority-setting processes is the inability of decision-makers to sufficiently engage with a range of stakeholders, especially the general public (Robinson et al, 2012). A common criticism of the A4R framework is that the ‘publicity’ criterion is weak when compared to democratic decision-making (Friedman, 2008; Kapiriri et al, 2009). This unfavourable comparison is rooted in different understandings of the individuals involved in priority-setting either as stakeholders with a direct interest in the decision to be reached, or as citizens with rights and an attendant duty to act in a disinterested manner. Involving either group in priority-setting has its attendant problems.

In relation to stakeholders, a central concern is the exercise of undue influence and/or the neglect of groups which are relatively less organised or less likely to be heard. In contrast, mobilising the public as citizens with a stake in priority-setting decisions is technically difficult and politically fraught. Yet, despite the challenges posed by either model of involvement there has been a marked policy shift in favour of explicit decision-making, suggesting that the legitimacy provided by public and stakeholder acceptance of the fairness of decisions will become increasingly important for healthcare commissioners. A growing body of work explores and assesses a range of engagement methodologies including: citizen juries; deliberative polling; citizen summits; and consensus
conferences (Abelson, 2003; Mitton et al, 2009). However, there remains little formal specification of the relative merits of these within the specific context of healthcare priority-setting.

**Leadership**

Dickinson et al (2011) note that leadership is an important component of priority-setting especially in relation to stakeholder engagement. Leaders are required to engage with a plethora of local stakeholders and citizens in making difficult decisions in an unfavourable economic climate. Far from being a purely technical or procedural process, priority-setting requires political acumen and skills in relationship management and coalition building, so that ‘tough choices’ can be taken and implemented without undermining trust in institutions (Dickinson et al, 2011). In essence, leaders are being tasked with being more ‘political’ within a context that has not always privileged such behaviour.

**Methods**

The research employed a qualitative case study design in order to obtain the perspectives and experiences of a wide range of stakeholders involved in priority-setting processes (Yin, 1994). Case studies are particularly well-suited to the evaluation of complex interventions, especially where programme aims and intended outcomes are unclear and subject to a range of possible interpretations from those involved. In total, five sites were sampled on a ‘critical case’ basis (Patton, 2001). Each was recruited on the basis they had adopted formal prioritisation processes for disinvestment decisions, and/or had experience of specific exemplary practices in relation to priority-setting. This approach was chosen to reflect the current focus on disinvestment and service redesign in light of the recent fiscal challenge (Robinson et al, 2011b). Given the wider literature is relatively silent about disinvestment (Elshaug et al, 2008; Robinson et al, 2011b; Hass et al, 2012; Williams et al, 2012), we sought exemplars to identify findings on these topics.
Case studies were undertaken in two phases. Initially, two case studies were selected for a detailed consideration of priority-setting in terms of the full range of activities conducted in this locality. Explicit selection criteria for these cases included recognition by others of good practice in priority-setting, as indicated in composite data derived from: peer review; Government documentation; academic literature.

In a subsequent second phase, three additional case study sites were selected in order to explore the experience of specific aspects of priority-setting processes, for example new resource allocation or disinvestment. The sampling frame for selection was provided by a national survey of priority-setting activity recently undertaken by the authors (Robinson et al, 2011a; 2012), sites selected on the basis of their stated adoption of specific and exemplar approaches to priority-setting.

**Data collection**
Consistent with the case study design, multiple data sources were collected to inform our analysis. Three main methods of data collection were employed: documentary analysis, interviews with priority-setters and overt non-participant observation of priority-setting boards. Application of these methods varied between sites. Documentary information relating to priority-setting activity was analysed where it provided a formal account of priority-setting processes and as context to data derived from interviews and observation. Face-to-face interviews were conducted with senior management teams to explore assumptions and experiences of priority-setting in that locality and provide an insight into the planning, strategy and operation of priority-setting. Following additional observation, interviews with wider stakeholder groups were conducted to ascertain the views and experiences of all parties in relation to priority-setting activity.

**Analysis**
We adopted an inductive approach to qualitative data analysis, informed by our reading of the literature as presented above. Data collection and analysis were undertaken concurrently in an
iterative process, in which data were both an outcome and a shaper of subsequent field work (Miles and Huberman, 1994). Data analysis was performed independently by two researchers, who met periodically to discuss emerging themes and data categories for the purpose of inter-researcher reliability. In order to maintain confidentiality, sites have been given pseudonyms and we avoid the reporting of verbatim quotation from priority-setting board meetings. However, verbatim (‘raw’) interview data are reported where they exemplify salient points and key themes within the inductive analysis, either due to their typicality, or where they provide an alternative perspective.

Results
Our findings in relation to local decision-making processes are reported below, organised on the basis of themes indicated as important by respondents and informed by the wider literature on investment and disinvestment processes. Table 1 provides a brief overview of the priority-setting processes and decision analysis tools used at each of the five sites. Four had developed an analytical decision tool, three of which were using a MCDA approach.

Priority-setting models and processes
Two of the five sites had developed priority-setting processes which focussed exclusively on new resource allocation, although one site in particular was starting to expand this work to include disinvestment. Respondents suggested that the reason for such a focus was because developing processes around new investment was less complex to undertake than the prioritisation of core spend or disinvestment. However, there was awareness of the need to extend the work into core funding services, and a desire to ‘get the process right’ before rolling it out more widely.

Despite variation in the form and function of formal priority-setting mechanisms, some common factors driving their development were identified. PCTs were concerned to avoid spending deficits and saw priority-setting as a means of keeping within their allocated budgets. In recent years central government has encouraged explicit priority-setting through the introduction of initiatives
such as the World Class Commissioning (WCC) programme. This had provided a strong motivation for PCTs to examine their priority-setting processes (DH, 2007). The WCC assessment criteria aimed to increase the transparency, efficiency and quality of services (McCafferty et al, 2012) and commissioners in this study indicated that the performance management of these criteria had helped them to engage with stakeholder groups. The more recent Quality Innovation Productivity and Prevention (QIPP) agenda (DH, 2010c) also served to draw attention to efficiency and quality and was seen as compatible with a health economy-wide approach to priority-setting.

“The QIPP agenda has been helpful in getting everyone signed up. It’s really given us a focus in terms of having that shared understanding and drive … it was a natural home for the priority-setting work” (lay manager)

In contrast, the turbulent nature of the wider national policy context was perceived by some respondents as a potential impediment to the development of local arrangements. All sites noted the difficulties and tensions in managing competing imperatives. These included the need to deliver on nationally derived expectations and respond to the local political climate, while also attempting to institute an evidence-based approach to priority-setting:

“There is always a change to policy or something that comes left wing [sic]. It’s difficult to set priorities and make changes when you have a workforce who are worrying about their jobs. The NHS is really unstable. There is constant pressure to do things quickly, meet targets, save money and on the other hand we don’t take time to look at what is stable. We don’t really know where we are going - just a constant reaction (Lay manager).”

All sites had started to focus on disinvestment, which was seen as crucial given government pressure to secure efficiency savings. Four sites spoke explicitly about their attempts to explore disinvestment
options that focused on reduction or withdrawal of services that provide relatively little health benefit relative to their cost. They reported mixed success in terms of this type of disinvestment activity, although there was a general sense that these sites had targeted technologies that could be more easily discontinued without too much controversy. Barriers to disinvestment included lack of evidence to support the need to disinvest and a lack of commitment amongst providers to change current practice.

“We have stopped providing and reduced some services and I suppose we have gone for the easy hits – the things that there is evidence to support like tonsillectomies, although even this can be difficult. You need evidence to say something is not providing value for money, otherwise how do you convince people that this is the way to go? … Even with the evidence it is not easy to get providers on board” (Lay manager).

All sites indicated that this type of disinvestment activity alone would not provide the efficiency savings needed to meet the economic challenge.

“Just stopping the low value stuff is not enough, we need to look at whole pathway re-design and even more than that we need to have an honest discussion with patients and the public about what we can and can’t afford to provide on the NHS- and this needs to happen at local and national level” (Lay manager).

Disinvestment was distinctly counter-cultural for many individuals and organisations across local health systems. Whilst there was some enthusiasm to explore different ways of working, especially in relation to developing and delivering new innovations, discussions and decisions over pathway redesign involving disinvestment of services was experienced as profoundly unsettling. Commissioners noted that ‘stopping doing things’ was not something that NHS providers were used
to. It was also noted that if large scale disinvestment and efficiency savings are to be made then this needs to involve a number of relevant stakeholders from across the health economy.

“Disinvestment is not easy. That could be a big chunk of our income being removed... It’s a balancing act but we need to look at things as a health economy rather than having organisational boundaries. Egos get in the way and the focus is on my organisation and what we are set out to do, rather than a shared approach. If you were an alien landing from mars you would never understand that the NHS was one organization” (Lay Manager).

Whilst there was recognition of the difficulties inherent in disinvestment there was also a sense that the timing was right and the sense of ‘if not now, when?’ came over clearly from PCTs:

“If we can’t have discussions with the public and staff about the need to disinvest and redirect resources now when there is no money then we can never do it. We can’t provide everything and we need to say that” (clinician).

Many of the decision processes considered in this study can be explored with reference to Daniels and Sabin’s Accountability for Reasonableness (A4R) framework (Daniels and Sabin, 1997). Under the relevance criterion, all sites included combinations of evidence in the form of research data, prevalence and cost statistics to inform the priority-setting process. However, in some instances such information was superseded by clinical expertise. There were also instances where evidence was lacking due to either the ‘bluntness’ of the criteria used in priority-setting tools, lack of clinical evidence in relation to a service or intervention, or an inability to access existing evidence. Sites generally had limited mechanisms for both appeals and enforcement. While the publicity criterion is considered in more detail below, the overall finding is that while all sites involved stakeholders from across the health economy, this tended to be limited in scope.
The use of evidence and decision analysis tools
Decision-making processes which involved the use of priority-setting aids (such as MCDA and business proposal templates) tended to be more explicitly supported by evidence for example via either individual or collective scoring of investment proposals. All respondents valued the opportunity to receive evidence, suggesting this enhanced perceived transparency as they were able to subsequently articulate decision processes to stakeholders. Furthermore, commissioners suggested this type of deliberative process enhanced clinical engagement and as such gave the priority-setting process greater legitimacy.

“Having a process that allows for discussion is really important for transparency. It allows us to have some really difficult discussions about what to and not to fund. The scoring tools help you focus and understand what is important to others in the group. This sort of process helps to legitimise decisions. Even when you don’t always get the things you would like funded, you do agree with the process. It is also helpful when you need to go back to individuals and tell them why they did not get funding (Lay manager).”

There was a general consensus that explicit priority-setting tools helped to provide a structured setting for deliberation and coalition-building, thereby facilitating the decision-making process rather than algorithmically deriving the ‘answer’. While the majority of respondents welcomed a more transparent and deliberative process, some raised concerns over the subjectivity of the scoring systems and a minority expressed frustration that decision tools did not provide the definitive decision. Furthermore, the MCDA tools used were often more aligned with clinical interventions than those around public health which usually have ‘softer’ outcomes and a less ‘scientific’ evidence base. It was often more difficult to make the case for efficiency savings and outputs for public health and preventive interventions in the format demanded, than it was for clinical and curative interventions.
Respondents from all sites suggested that both clinical and cost information played important parts in priority-setting. Priority-setters at Morebeck suggested the use of evidence in the PBMA approach acted as both a ‘carrot’ and a ‘stick’, providing a common language with which to engage clinicians with policy directives (‘carrot’), whilst helping commissioners when they needed evidence to challenge poor performance (‘stick’).

Respondents indicated frustrations in relation to dimensions which diluted the influence of evidence including: exigencies of the NHS financial planning context; political processes; difficulties in accurately estimating savings from disinvestment and or service redesign; and not having the expertise and sophistication to produce and understand evidence. There was also some suggestion that gathering accurate evidence could be difficult and that national evidence around cost-effectiveness had often been poorly translated at the local level. A common theme was the perceived tendency for proposals to be over-ambitious, especially in terms of potential savings.

*Engagement and Involvement*

A wide range of stakeholders were involved in priority-setting activities in each of the sites, including: local authority professionals and representatives; local councillors; health organisations such as primary care providers, acute providers, voluntary sector and mental health providers; practice based commissioning groups; and GPs. However the levels of such involvement varied between sites. Three had involved multiple provider organisations. For example, Morebeck reported involvement from all Chief Executive Officers (CEOs) from both primary and secondary care and had moved towards a more “joined up” approach to priority setting. This meant that all organisations had representation at the priority-setting board although in practice the extent of engagement from commissioners and acute providers varied.

Other sites had less formalised involvement with Chetwynd involving only commissioners and public health specialists on the decision-making group. One observation during our research was the
emerging relationship between the PCT commissioners and clinical community commissioners. This relationship was considered ‘fruitful’ as a mechanism for shaping discussions with the acute hospital trusts. The involvement of clinical commissioners was seen as a helpful way in which to engage acute partners in discussions about priority-setting across the local health economy.

All sites noted the difficulties in engaging the acute sector in priority-setting. Even in the two sites where there was engagement and signs of fairly strong partnerships (between the acute and commissioners), the power of the hospital sector, differences in culture, focus and strategy made priority-setting a challenge. Successes tended to relate to modifications to patient pathways, rather than engagement in decisions over the explicit rationing of resources. Furthermore, activity based funding (payment by results) meant that hospitals had little incentive to engage with commissioners especially when the discussion was around re-designing services and potentially reducing hospital admissions.

The research suggested limited engagement of citizens in decision-making. Although respondents generally declared themselves to be receptive to the idea of greater public involvement and engagement, they were less clear about when and how this ought to be instigated. Indeed, three sites had taken a conscious decision not to involve the public in their priority-setting activities in order to get the process established ‘in-house’. The assumption here was that organisations from across the health economy needed to agree on decisions before involving patients or the public.

By contrast, Donative felt that engaging with the public was important and should take place at an early stage of decision processes, involving the public in planning and setting priorities as part of their five year strategy. However, respondents felt that they struggled to gain engagement on population-based priority-setting with those members of the public in attendance. They did have more success in engaging the public in debates about specific issues such as the provision of services.
in particular locations. The issue of ‘representativeness’ was considered to present difficulties for commissioners who were broadly unaware of existing methodologies for overcoming some of these challenges.

Overall, it was clear that legitimacy was considered important in priority-setting, especially when this involved removal of high profile services. Interviewees identified political and clinical support as key factors in the struggle to establish the legitimacy of decision-making. Although direct public involvement was limited there was considerable support for tackling this shortfall - and a general sense that fiscal restraint made public discussion of the limits of health care resources more acceptable.

**Leadership**

Interviewees frequently cited management and leadership as being important components of effective priority-setting. This was considered to involve a range of activities including project management support, stakeholder engagement through negotiation and dialogue, and the development of incentives systems to encourage behavioural change. While some of these roles require relatively simple managerial behaviours, the majority pertain to more complex relationship-based activities.

Whilst senior leaders/managers from across the health economy acted as decision-makers in the priority-setting processes, they did not always involve or engage individuals from within their own organisations. This lack of transparency and communication to internal stakeholders can serve to restrict priority-setting processes. For example, where there was evidence of limited success in the implementation of resource allocation decisions, there was generally criticism of leaders’ communication of information and the inability of senior leaders to ‘reach’ lower tiers in the organisational hierarchy.
“CEO group have a strong presence but information is not passed down the organisation
...there is lots of activity at the strategic level and not at the ‘doing level’” (Clinician).

Another perceived blockage to full implementation of decisions related to organisational reluctance
to ‘take the losses’ implicated in disinvestment decisions.

“The real issue which no one wants to discuss is who realises the benefit or loss of a
decision... We just can’t seem to have these discussions. We have not got the sophistication
and managerial competencies to do this” (Lay manager).

The importance of leadership in both the decision and implementation phase was noted, particularly
in relation to brokering relationships between a range of organisations and stakeholders which often
had very different – and potentially conflicting - cultures, values and beliefs. A good example of such
behaviour was the importance of clinical leaders in appealing to other clinicians, patients and the
wider public with a form of legitimacy that general managers do not currently possess. Without
clinical leadership, many respondents indicated that attempts to change processes or disinvest in
services would be unsuccessful. Moreover, without getting clinicians ‘on-side’ any plans might be
disrupted by clinicians.

“Getting clinical engagement is important but not just getting clinicians involved – we need
them leading on this (Lay manager).”

Discussion and conclusions
As far as we are aware, this is the first example of large-scale research into the PCT ‘experiment’ in
explicit priority-setting and, given the imminent demise of PCTs, it provides an important
opportunity to capture learning for both future NHS commissioners and priority-setters elsewhere.
Previous studies have tended to report either small scale research or synthesise experiences and evidence on the topic of priority-setting (Ham and Coulter, 2000; Ham and Robert, 2003; Reeleder et al, 2006; Sabik and Lie, 2008a; Singer et al, 2000; Yeo et al, 1999). This section considers findings from the research in the light of both the wider literature on priority-setting and the challenges facing the NHS as it undergoes reform of its commissioning function and responds to an increasingly tight fiscal environment.

*Effective and acceptable priority-setting*

Whilst the aforementioned survey of PCTs identified raised levels of formalised decision-making (through application of decision analysis and frameworks), the study presented here enabled a fuller exploration of how such techniques were being applied. In this respect, the case studies appear to suggest a dual function of improving the *effectiveness* of priority-setting (i.e. reaching ‘correct’ resource allocation decisions), and increasing the *acceptability* of priority process to those involved in the process. Each of these imperatives was cited repeatedly by respondents from across all five sites. In other words, respondents were simultaneously concerned with both *instrumental* effects and the wider *legitimacy* of their priority-setting activities. While the presence of this dual focus is not surprising when considered in the light of previous research (Sibbald et al, 2009), our study identifies a number of limitations in PCT attempts to meet these aims, and casts some doubt over the compatibility of seeking decisions that are both ‘right’ and perceived to be ‘right’.

*Effectiveness*

In instrumental terms, although local priority setters had made considerable strides they had not yet reached a point where their activities exerted a telling influence over resource allocation and therefore had not contributed substantively towards reduced expenditure levels or greater efficiency. This was chiefly manifest in the relative lack of priority-setting activity in areas of either core spend or disinvestment, both of which remained largely shaped by longstanding structures and
organisational relationships. Respondents reported processes that reflected an earlier financial context in which priority-setting was considered primarily as a vehicle for allocating excess resource resulting from incremental budget uplifts, rather than as a tool for ensuring efficiency in overall spend or managing budget decreases.

Re-orientation of priority-setting towards these more challenging aims had only latterly been considered by case study PCTs, and with mixed levels of success. The perception remained that priority-setting processes were compartmentalised and peripheral rather than integral to resource planning and allocation. Much of the ‘low hanging fruit’ – those interventions that could be discontinued easily and without controversy – had been picked, and greater impact on service configuration would require a greater level of mainstreaming and embedding of priority-setting within the broader commissioning process.

A second impediment to the instrumental effectiveness of priority-setting was the continued disconnection of decisions from actual rationing of services. The levers available for implementation of priority-setting decisions appeared limited, and therefore implementation was largely dependent on the voluntary co-operation of both the wider commissioning function and provider organisations. The primary strategy employed by priority setters to overcome this gap was to seek early agreement to decision-making from those parties implicated in adoption of decision recommendations (such as clinical stakeholders and representatives of provider organisations). However, continued frustration at the slow pace of change reflected the limitations of a strategy that was dependent on the benefits of ‘getting everyone around the table’. Making priority-setting a driver of substantive (and inherently contentious) decisions would undoubtedly require a more formally constituted set of implementation mechanisms than was in place in any of the sites. To make inroads into service organisation and delivery, priority-setting would also need to be connected to broader change (and
change management) processes – something that had yet to feature in the work of sites or the priority-setting literature more generally (Gibson et al, 2005; Sibbald et al, 2009).

Acceptability

According to respondents, evidence and process were valued as much for their legitimising potential as they were for their use in producing correct decision recommendations (Syrett, 2003). As well as providing a defence for resource allocation decision-making in a general sense, specific reference was made to the resulting increase in clinical support for processes and decisions. Overall, ‘evidence’ was considered important in constructing a narrative that was palatable to a clinical audience that prized notions of objectivity and scientific rigour. However, these insights cast some doubt over the wider claim to explicit and evidence-based priority-setting. For example, were these ‘secondary benefits’ of legitimisation a helpful by-product or a fundamental aim of local arrangements? It is difficult to provide a definitive answer to these questions based on case study data. However, our perception was that whilst decision makers prized an overall aspiration to empirically rigorous decision-making this commitment sometimes weakened in the face of (for example) clinical opposition. Weaknesses in the empirical and analytical infrastructure of PCTs undoubtedly opened up local decision-making to more political considerations, and in these instances PCTs are vulnerable to the charge of disingenuousness in the pursuit of legitimisation (Syrett, 2003).

The drive to gain acceptance for priority-setting had not been entirely successful within the sites. On-going legitimacy deficits were particularly pronounced in relation to disinvestment and here it was increasingly recognised that proxies for public opinion – such as the media, campaign groups and so on – presented potentially damaging impediments to PCT resource allocation plans. Despite this, little substantive attempt had been made to take action in these spheres. Although some sites had come to appreciate the need to conduct conversations (albeit largely one-way) with wider population groups, PCTs showed little or no interest in understanding the social values of their
populations, either as instrumental drivers of decisions or as a means of increasing decision acceptance. This meant that the struggle for legitimacy was waged almost exclusively with stakeholders from within the healthcare ‘family’. There were practical considerations informing this approach – many respondents felt that intransigence from within the system presented a more fundamental impediment to progress. However, the exclusion of other voices may also reflect an institutional distrust of more open and explicit decision-making which would appear to run counter to an explicit model of priority-setting.

**Priority-setting: wider implications**

This study has identified disinvestment, implementation, involvement and legitimacy as key issues for consideration in priority-setting and this echoes messages deriving from experiences of other countries (Yeo *et al* 1999; Ham and Robert 2003; Sabik and Lie 2008). To be effective as a management tool, priority-setting needs to be central to local planning activity, rather than being treated as a bolt-on mechanism for allocating spare funds. It is yet to be seen whether priority-setting can form a central part of health service investment and disinvestment arrangements either in the English NHS or elsewhere. However this study suggests that a well-resourced and designed priority-setting function can help to make contentious decisions more palatable and defensible for those involved. Whether the aim of making priority-setting effective will ever lead to genuine attempts to open decision-making up to public involvement remains to be seen – and the international evidence shows only modest improvements in practice (Mitton *et al*, 2009; Yang 2005). Our study suggests that narratives of economic hardship – which are increasingly pervasive across political systems - provides an opportunity to conduct wider conversations about allocation in publicly-funded healthcare. However, ‘grasping the nettle’ of resource scarcity is likely to require ‘soft’ leadership skills alongside the design of robust and evidence-based decision-making processes. Implementing difficult decisions will be made easier when leaders are able to mobilise support and operate with political ‘astuteness’ (Hartley *et al*, 2007). Currently such leadership characteristics are
often associated with the process of change management but less frequently linked to priority-setting (Dickinson et al 2011).

Overall, therefore, although case study PCTs had developed priority-setting processes and procedures that represented a step forward from previous arrangements, problems remained. For example, the extent to which they were prepared to make a genuine shift to explicitness (which would have necessitated greater public awareness and input) was highly limited, as was the extent to which priority-setting had become a tool for meaningful service redesign and resource deployment. Finally, the requisite legitimacy for implementing potentially unpopular decisions did not appear to have been fully obtained. The lessons from the PCT experiment will be of importance to national and international public sector organisations who seek to adopt explicit priority-setting processes.
References


Daniels T., Williams I., Spence K., Robinson S. (forthcoming) How can we improve disinvestment in health care services? The views of resource allocators in the English NHS


