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

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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, between March and November 2012. 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. While local priority-setters had begun to develop more explicit processes, public awareness and input remained limited. The leadership behaviours required to navigate the political complexities of working within and across organisations with differing incentives systems and cultures remained similarly underdeveloped.

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 & 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, Mitton, Bate, McCoy, & Donaldson, 2009).

While each healthcare system is unique, they face similar 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 (Department of Health, 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 (The Nuffield Trust, 2011). Furthermore, many of the difficulties

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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, Dickinson, Williams, et al., 2011). The study was designed to explore:

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

Two phases of research were undertaken: a survey to identify the types of priority-setting work undertaken within English PCTs (Robinson, Dickinson, Williams, et al., 2011; Robinson, Dickinson, Freeman, Rumbold, & Williams, in press); 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, Hiller, & Moss, 2008; Robinson, Dickinson, Freeman, & Williams, 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 (Daniels, Williams, Spence, & Robinson, in press; Williams, Robinson, & Dickinson, 2012). It is the latter which is often the most controversial form of disinvestment and therefore such decisions can be complex and fraught with difficulty (Puffit & 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, Dickinson, Williams, et al., 2011, in press) and the priority-setting literature which informed our study.

Background

The literature identifies a diverse range of requirements for local priority-setting including: the design and implementation of models and processes; the application of evidence and decision analysis tools; wider engagement and involvement; and leadership (Daniels & Sabin, 1997; Dickinson, Freeman, Williams, & Robinson, 2011; Ham & Robert, 2003; Klein & Williams, 2000; Sabik & 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 (Ashburner, 2001; Child, 1984; 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 healthcare 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, Dickinson, Williams, et al., 2011, in press). The risk is that priority-setting is not embedded within the broader organisational (and inter-organisational) systems (Williams & 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 & Sabin, 2008). This consists of four conditions of procedural justice 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 (Hewison, 2004; Niessen, Grijseels, & Rutten, 2000). 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, Smith, & Goddard, 2004; Mitton, Peacock, Donaldson, & Bate, 2003; Robinson, Dickinson, Williams, et al., 2011, in press). In addition, there have been developments in public health and needs assessment, predictive modelling, health intelligence, nationally-held datasets and other knowledge resources (Department of Health, 2010b; Donaldson & Mooney, 1991).

However, a range of factors 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) (Holm, 1998; Kaplan, 1992).

Engagement and involvement

For healthcare commissioners to become trusted guardians of the public purse, more involvement and engagement is required (Dickinson et al., 2011; Williams et al., 2012). However, findings from the national survey undertaken in phase one suggested that one of the main difficulties and weakness in priority-setting