Available online at www.sciencedirect.com
ScienceDirect
Health Policy 84 (2007) 249–261
HEALTH policy
www.elsevier.com/locate/healthpol

# Managing to manage healthcare resources in the English NHS? What can health economics teach? What can health economics learn?

Angela Bate *, Cam Donaldson, Madeleine J. Murtagh

*Institute of Health and Society, Newcastle University, 21 Claremont Place, Newcastle upon Tyne, NE2 4AA, UK*

**Abstract**

*Objectives:* : To provide a 'thick description' of how decision-makers understand and manage healthcare prioritisation decisions, and to explore the potential for using economic frameworks in the context of the NHS in England.
*Methods:* : Interviews were conducted with 22 key decision-makers from six Primary Care Trusts (PCTs) in northern England. A constant comparative approach was used to identify broad themes and sub-themes.
*Results:* : Six broad themes emerged from the analysis. In summary, decision-makers recognised the concepts of resources scarcity, competing claims, and the need for choices and trade-offs to be made. Decision-makers even went on to identify a common set of principles that ought to guide commissioning decisions. However, the process of commissioning was dominated by political, historical and clinical methods of commissioning which, failed to recognise these concepts in practice, and departed from the principles. As a result, the commissioning process was viewed as not being systematic or transparent and, therefore, seen as underperforming.
*Conclusions:* : Health economists need to acknowledge the importance of contextual factors and the realities of priority setting. Our research suggests that the emphasis should be on integrating principles of economics into a management process rather than expecting decision-makers to apply the output of ever more seemingly 'technically sound' health economic methods which cannot reflect the dominating and driving complexities of the commissioning process.


*Keywords:* Health care economics; Resource allocation; Health planning; Qualitative research

## 1. Introduction

In healthcare, the availability of resources – money, time, or human capacity – is often insufficient to meet all the claims (wants and needs) on them. In this respect resources are considered scarce and have to be managed. Given this, healthcare organisations decide *what* health services to provide and prioritise, for *whom*, *how*, and *where*. This is a global phenomenon and evident at all levels in health services.

Despite this, there is little consensus on the appropriate way to manage resources [1–6]. Economics is

* Corresponding author. Tel.: +44 191 222 3813; fax: +44 191 222 6043.
*E-mail address:* a.s.bate@ncl.ac.uk (A. Bate).

0168-8510/$ – see front matter © 2007 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2007.04.001

founded upon the notion of scarcity and so *should* provide theories and solutions to help healthcare organisations determine what to fund, to what extent, and at what sacrifice [7]. Indeed, promoting and teaching health economics for this purpose is widespread. Attempts to use economic information in prioritisation decisions have been predominantly at the national level in health technology assessment and centralised drug review processes [4,8]. Yet, beyond this, the impact of economic information and health economic methods in prioritisation decisions is debatable [9,10]. In particular, research on the use of economic evaluations by decision-makers in practice has highlighted several barriers to the adoption of health economic methods. These include difficulties in accessing relevant information, lack of interpretation skills, insufficient supply of information in a timely fashion, and the relevance of the information in a given decision-making context [8,11–13]. This has led some to question the usefulness of health economics methods for priority setting at the local level [10,14–16].

In considering such debates, Mooney and Wiseman [17] hypothesise that decision-makers *do* want transparent 'rational' processes and state that "health economists ... [need to] look into the decision-makers' minds and to try to understand what the objective function is with which they are working". The implicit assumption is that better understanding will lead to better developments in methods and research. Moreover, Jan *et al.* assert [18]: "because health economic analysis has tended to be largely normative, there has generally been a lack of appreciation of why such decision-making sometimes 'fails"', therefore studies "that examine economic decision-making *within* its institutional context" offer "greater insight into why such failure occurs and ultimately provide a more realistic basis for decision-making."

This paper seeks to undertake such an examination. This work is the product of broader research which aims to examine how prioritisation decisions are understood and managed by decision-makers, to explore the potential for using economic frameworks, and to identify how these frameworks can be informed by, and inform, 'real-world' decision-making. Specifically, this paper addresses the first two of these in the context of the NHS in England. This involved conducting interviews to investigate how decision-making was understood in principle by decision-makers (i.e. how commissioning *ought* to be undertaken), how this translated into practice (i.e. how commissioning *was* undertaken), and finally, decision-makers' reflections on this. The paper draws on the results of the empirical analysis of the interview data to provide a 'thick description' [19] of local level decision-making. Thick description allows us to explore and present the uniqueness and complexities of local level decision-making which may otherwise be overlooked in a comparative study. The results are presented under the following themes: (1) strategy – the concepts and principles that guide decision-making; (2) process – the structures utilised in decision-making and methods that drive decision-making in practice; and (3) performance – the outcomes of and constraints in the decision-making process. These results are also presented in a schematic model to illustrate how these themes relate to and impact on each other. We discuss these results with respect to the national and international literature on decision-making in healthcare organisations, and conclude by suggesting what health economics can learn from such research.

## 2. Materials and methods

### 2.1. Context, setting and sample

In England, responsibility for making prioritisation decisions has been devolved to Primary Care Trusts/Organisations (PCTs/Os). PCTs receive 80% of the total NHS budget [20] and are charged with commissioning health care and services for their local communities [21]. The role of commissioning has been well articulated by Smith and Mays [22] who have conceptualised it as the 'conscience' (setting out what the system should aim to achieve and how) and the 'brain' (identifying and implementing the optimal solutions for delivering these aims) of the health system. In fulfilling this commissioning role, PCTs are expected to: assess local health needs; plan and secure health services; improve health, within the framework of National Health Service standards and guidance; and remain accountable to the Secretary of State, through the Strategic Health Authority (SHA) [21]. Moreover, PCTs are required to adhere to the financial duties