Towards a greater understanding of priority setting: role of an economic approach?

Findings from a workshop to local decision makers

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Abstract

Objectives To explore the value to local health care decision makers of a two-hour priority setting workshop.

Design Qualitative study using observation of commissioning meetings, a workshop, and in-depth interviews.

Participants Decision makers, including those responsible for providing and commissioning care.

Setting One Primary Care Trust (PCT) in England.

Results A workshop on economics (delivered by JB) was attended by managers responsible for commissioning and providing care, as well as hospital doctors and nurses. GPs were invited but did not attend because of their busy working schedule. Although some participants could see the usefulness of the workshop, most suggested that its acceptability in practice was limited because of national constraints on local decision-making, as well as differing perspectives about what the priorities should be. A priority setting exercise that was meant to follow the workshop did not occur because of debate over priorities for funding which took place between participants. Some participants felt that they would also need help in prioritizing in practice; showing the importance of the workshop in highlighting deficiencies of the group.

Conclusions Workshops are useful in 'opening the eyes' to methods of priority setting using economics among local decision makers. They can potentially increase decision makers' awareness of the need to prioritize. However, there needs to be more freedom and greater incentive to set local priorities.

Introduction

In the UK, the local level of care provision (where care is commissioned and provided) is centered on PCTs who have considerable scope to decide on the basket of treatments and services they provide to their citizens.[1] As one explicit method of priority setting, economic evaluation can be a useful aid to decision-making, assessing the costs and benefits of various programmes and providing information about efficiency. In practice, the use of economic evaluation in local decision-making is questionable, with evidence pointing towards lack of use,[2,3] perhaps because studies focus on individual treatments or interventions, rather than baskets of services.

One way of incorporating economic principles (such as opportunity cost and the margin) into local priority setting for a basket of services is through programme budgeting and marginal analysis exercises with local decision makers.[4] This is essentially a management technique,[5] which aims to establish how resources are currently being used and then address how any changes in resource use can be made, either through redeployment, reduction, or expansion of services, in terms of costs and benefits. Programme budgeting and marginal analysis might be a useful technique for bridging the divide between doctors and managers; however it is unclear how use can be sustained in practice.[6] The exercise also tends to be relatively resource intensive because it requires the sustained commitment of a panel of decision makers (who review a wide variety of evidence to make their decisions and give objective weights to specific decision-making criteria, such as equity, efficiency, *etc*), and is also relatively time and data hungry. An alternative way of incorporating economics into decision-making is to provide brief training sessions, or workshops, which focus on using economics in priority setting. Such workshops have the advantage of being potentially less resource intensive, but their value is currently unknown. In this paper, we explore the value of a workshop on health economics to local decision makers.

Participants and methods

Our study was approved by the local research ethics committee. We based research in one PCT (the location of which has not been specified here in order to retain participants' confidentiality) and particularly on one commissioning group within that PCT. These

meetings were a formal part of local decision-making and brought together providers and commissioners of care to decide on the funding and delivery for one service area in their local population. OA observed the commissioning group over a twelve month period prior to the workshop, examining roles and behaviours within the group and exploring different themes that emerged in discussions. The chair of the commissioning group proposed the idea of the workshop for those attending the commissioning meetings as he was keen to engage the group in explicit priority setting.

Workshop

The workshop took place over two-hours. All participants of the commissioning group were invited to attend. JB ran the workshop. JB presented concepts and explanations regarding basic economics and economic evaluation; after which she opened the discussion to the group, distributing hand-outs which listed the programmes for commissioning in the one area of service provision, that for which the group was responsible. The list of programmes had been developed by the group during the meetings over the previous few months. JB advised members to consider the costs and benefits associated with these programmes. In particular, she encouraged members to perform an exercise which involved deciding which of the programmes were related to guidance set nationally, had evidence about their effectiveness or their cost effectiveness, and what the opportunity costs might be, taking into account a hypothetical budget constraint.

In-depth interviews

Following the workshop, OA conducted twelve in-depth interviews. Participants were purposefully selected on the basis of their attendance at the workshop or their importance in the decision-making process. Interviews were similar to a stylized form of ordinary conversation, being largely interviewee-led. An interview guide was only used by OA if the conversation faltered. The majority of interviews were audio-recorded and were fully transcribed by OA.

Analysis

Constant comparison methods were used to analyze the interview data, whereby accounts were compared to facilitate richness in data analysis.[7] Negative or disconfirming cases were sought to extend and enrich findings, hence saturation was only reached once all these cases had been accounted for.

Results

Attendance at workshop

Ten participants out of fifteen attended the workshop. GPs were invited to the workshop but did not attend, feeling that it was not possible to avoid surgery sessions:

> "I was just wondering why you weren't at the workshop?" (OA)
> "Didn't have time…I had clashing appointments basically." (GP)

Lack of interest in the workshop, however, appeared to be a further reason for not attending:

> "Well it's not the lack of time. It's if something else is happening at that time that's more important then I have to go to the most important meeting, it's as simple as that." (GP)

The remainder of this paper concentrates on the two major obstacles that were associated with trying to use an economics approach to priority setting in practice.

Acceptability: Usefulness given conflicting bases for setting priorities

National targets

Decision makers perceived little freedom for local level decision-making because of the large number of national imperatives. These concerned wait time targets, NICE guidance, and other policies particularly related to expansion of screening programmes. One participant noted that:

> "It seems to me that the prioritisation [during the workshop] came in line with entirely what the Government were putting forward and forced us to ignore all the other important issues." (Clinician)

Thus, the majority of participants could not see the practical relevance of the workshop given the imposed constraints. This issue was raised during the workshop but was highlighted also during observations and interviews.

Different perspectives

The exercise which was intended for participants to complete following the workshop did not actually take place, since there was a debate on what should be the priorities that consumed most of the time. We found that a local strategy could not be agreed upon because decision makers found it difficult to discuss priorities from a societal perspective and were protective of their own interest groups. Part of the reason for this was that the PCT comprised both the executive or board level functions along with a number of commissioning groups acting as its agents in developing policy and making decisions. The notional responsibility for decision-making was therefore diffuse so that hospital doctors and GPs who are usually regarded as being confined to a separate clinical decision-making level, here were part of the process of population decision-making. Those with clinical roles participating in the commissioning group had a clear impact on the decisions that were made and, of course, brought with them to this role their perspective of focusing on the individual patient or patient group. As one service manager pointed out:

> "If you're looking at… health economics, I think oncologists would be swamped because doctors tend to make decisions on the individual, not in the general sense." (Service manager)

In practice, most participants did not recognise that they were not making any disinvestments in cancer care despite limited funds and the inability to fund all their priorities. To ameliorate this problem would either require the development of a clearer common purpose among the commissioning group (such as might be achieved with the ongoing relationships envisaged in PBMA) or the use of incentive mechanisms which encourage people to act from a particular

perspective. Neither approach was possible within the relatively minor intervention of the workshop.

Accessibility: Understanding of method and whether able to apply it

Around half of the participants felt that the workshop had increased their recognition of the need to prioritize. They suggested that they were not previously aware of how priorities could be set using an economic approach:

> "There were a lot of things that I never appreciated before, about how decisions could be made, about setting priorities, so the whole economics part of it." (Hospital manager)

The chair of the commissioning group felt that participants would have gained an appreciation for a "learned approach", which they were not aware of previously:

> "The concepts that came out, that were elaborated, were not new to me. But they were very clearly new to others round the table. At first I thought they were going to dismiss a lot of it and say, 'This is common sense, we know all of this', but I think several of them hadn't realised that there was a systematic and almost learned approach." (Chair of commissioning group)

Despite such initial enthusiasm, it was not apparent that any economic concepts were applied during actual priority setting following the workshop; the list of priorities remained the same and there was no discussion of the disinvestments that would need to take place to fund investments. This is unsurprising perhaps given the short duration of the workshop and the fact that many of the priority setting decisions had already been agreed with the PCT. However, there appeared to be some other concerns among participants which rested on the nature of the techniques used by health economists to value outcomes. Multi-attribute utility measures such as Quality Adjusted Life Years (QALYs) might be seen as irrelevant to programmes where patients' preferences are the important outcome:

"…It may be very easy to compare some of these things and certainly in relation to breast cancer screening and cervical cancer screening we should have some evidence to support that decision-making…but how do you compare them with the ones that are not so easy and it is about quality of life rather than more absolute health outcomes?" (Service manager)

How to apply QALYs was therefore deemed to be confusing to this participant:

"I don't know whether everyone understands QALYs…I don't know much about quality of life indicators, I wouldn't be able to apply it, unless there was somebody there at future meetings to explain it." (Service manager)

The chair of the commissioning group also suggested that it would be difficult to prioritise different programmes where outcomes are diverse. He proposed the idea for a 'scoring' approach which he thought would be useful for decision-making:

"…You'd look at the costs, that wouldn't be difficult to do. The benefits would not be utility type benefits…I think the way we'd look at benefits would be almost a kind of impact assessment; we'd make a list…and it would be things like access, which is partly about travel and partly about…discomfort and distress and also about volumes to deal with capacity...If we were really rigorous we would score those criteria on one to five, where one is not terribly impressive and five is a good thing…" (Chair of commissioning group)

Another GP, who was not at the workshop, mentioned in interview prior to the workshop that comparing priorities was challenging, although no particular solution was proposed in this instance:

"Basically you have to prioritise a lot of quite small requests…the request for a scanner or something that's going to cost half a million compared against the requirement for secretaries in the oncology department... Trying to make a decision, to balance those two

and actually trying to say, "We can support one but not the other"…is very difficult because they're completely different things." (GP)

Such comments would support the argument that economic evaluation does not generally help with priority setting decisions at local level except perhaps where QALYs might be compared in a league table (which, as this study suggests, may be difficult where programmes have outcomes that fall outside of QALYs).

Discussion

This workshop was developed as a less resource intensive alternative to PBMA which typically involves a sustained relationship with decision makers over a period of time. Such a level of resource input may not be available for most PCTs, hence the development of this workshop. The challenges associated with the workshop included practical issues, because of the level of attendance at the workshop, acceptability and accessibility. These challenges were elucidated by the conduct of the workshop, but not solved by it. Indeed, it is not clear that these issues could be dealt with in the absence of a clear commitment of resources at a level well beyond that required for presentation of a workshop (as the participants at the workshop were not actually aware of their budget for service expenditure). Improving the accessibility of economics may require investment of the type associated with PBMA, but there are resource limitations here, not just in terms of costs involved but also the availability of health economists to engage in such work.

The study here is similar in some of its findings to another local study conducted in Canada (Alberta) by Mitton *et al.*[8] This study attempted to engage local decision makers in priority setting through PBMA, finding that a key challenge for decision makers is identifying genuine disinvestment options. Mitton *et al*, however, examined macro-level priority setting among senior decision makers, whereas the commissioning group here comprised a range of decision makers, responsible for both implementation and application of decisions (as we showed, the 'micro' level and 'meso' levels appear to be blurred). This enabled the scope of decision-making to be fully explored and revealed disagreement over funding priorities among decision makers. From the Mitton *et al*[8] study, it is not clear how the programmes for

prioritization would be implemented locally, and whether, following the PBMA there would be any disagreement or conflict.

This workshop was useful in 'opening the eyes' to methods of economics among local decision makers. Workshops can potentially increase decision makers' awareness of the need to prioritize and the methods available for such prioritisation, with a relatively unlimited resource input. However, a single workshop appears to be unlikely to result in a change in the way in which priority setting decisions are made and a more sustained approach would be required. Furthermore, improving the acceptability of economic methods for prioritizing at the local level will require clear development of a common purpose amongst decision-making bodies such as the commissioning group. Whilst such development may potentially be facilitated by PBMA, the use of economic incentives may also have a role here: indeed the incentives associated with achieving national targets are extremely strong and so tend to 'swap' other aims and objectives. Further research is needed in order to understand the decision-making process and the use of priority setting at the local level, both in the UK and internationally, since it is unclear whether PBMA is sustainable in the long run and whether workshops are indeed adequate.

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Possible points for discussion?

1. Awareness of the need to prioritize should be strengthened among local decision makers. In particular, concepts such as scarcity, efficiency, and opportunity cost need to be reinforced among decision makers. How can this be achieved in practice?

2. Less resource intensive methods such as workshops are useful in 'opening the eyes' to methods of economics, but not sufficiently to use in practice: what are people's perceptions/experiences on this?

3. Two major obstacles were associated with the use of economics in priority setting at the local level: its acceptability given the emphasis on national targets and the individual perspectives participants brought to the workshop, and its accessibility in terms of understanding and potential applicability. What are potential ways of dealing with this?

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