

The Politics of Priority Setting in Health: A Political Economy Perspective

Katharina Hauck and Peter C. Smith

Abstract

Many health improving interventions in low-income countries are extremely good value for money. So why has it often proven difficult to obtain political backing for highly cost-effective interventions such as vaccinations, treatments against diarrhoeal disease in children, and preventive policies such as improved access to clean water, or policies curtailing tobacco consumption? We use economic models of public choice, supported by examples, to explain how powerful interest groups, politicians or bureaucrats who pursue their own objectives, or voting and institutional arrangements in countries have shaped health priority setting. We show that it may be perfectly rational for policy makers to accommodate these constraints in their decisions, even if it implies departing from welfare maximizing solutions.

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The Politics of Priority Setting in Health: A Political Economy Perspective

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Foreword

Amanda Glassman

If you have \$200 to spend on health in a developing country, would you vaccinate 10 children against deadly childhood diseases or provide AIDS treatment to one woman to prevent transmission of HIV to her unborn child? Policymakers routinely face such tough budgetary dilemmas with little expert guidance. The reality is that there are many objectives and interests competing for limited resources—and in many low- and middle-income countries (LMIC), ad hoc processes drive choices that can result in low value and inequitable resource allocation.

Starting with the working group on [priority-setting institutions for global health](#), CGD's global health policy team has worked to aid in the difficult process of assessing costs, benefits, and trade-offs of new technologies and to inform decisions on public and donor spending.

We don't have a full understanding of what prevents a government from making goal-consequent resource allocation decisions that use technical information such as cost-effectiveness analysis. The study of politics and political economy, which is fundamentally concerned with conflict of interest, is one lens through which to gain greater understanding of these issues. With a clearer picture, perhaps we can work with governments to formulate strategies to manage competing objectives, demands, and interests—and give donors greater visibility into government processes and preferences so they can better align their decisions with those of government.

Unpacking the complexities of political economy of priority-setting in health is important, but how do people currently study this topic? The answer is that thus far, we don't know—there is no defined framework or method of study. This is why Katharina Hauck and Peter Smith's paper, "The politics of priority setting in health: A political economy perspective" is a needed addition in this field. Hauck and Smith examine models of political economy and public choice and describe how decision makers react to political realities. It will spark discussion and further research among the global health community, and serve as a starting point for LMIC policymakers in making sound choices in resource allocation for health.

Introduction

Many health improving interventions in low-income countries are extremely good value for money. Simple primary care interventions, for example vaccinations against communicable diseases or treatments against diarrhoeal disease in children, and preventive interventions such as improved access to clean water, or policies curtailing tobacco consumption are often relatively low cost interventions that produce substantial health gains. Where evidence on cost-effectiveness is available, many of these preventive and primary care interventions fare very well when compared with more conventional healthcare interventions. So why are not more public funds invested in highly cost-effective primary care and public health interventions? And why in some situations has it been so difficult to implement common-sense policies such as sewage treatment, or taxes on cigarettes? One may argue that it is the poor evidence base that made policy makers shy away from making these investments, and that the scientific community failed to produce the kind of evidence that would convince decision makers to do the right thing. However, the methods and application of cost-effectiveness analysis (CEA) of health technologies have reached an advanced stage of development (Drummond, Sculpher et al. 2005). There is widespread agreement that the principles of CEA represent a valid and feasible approach towards setting health priorities, and many countries are seeking to embed the method into their decision-making processes. Still, the recommendations arising from CEA are often not implemented as intended.

We will argue in this paper that it is often the realities of the political decision-making process that militate against political backing for common sense health investments, rather than the methodological shortcomings of CEA. Although economic evaluation offers a powerful rational approach to setting priorities, there may be alternative perspectives from which it is rational for decision makers to disregard the recommendations. One major class of factors that may explain why strategic decision-makers depart from national or international guidance are the wide range of political constraints that necessarily influence many decisions. We will discuss whether CEA ignores important elements of the priority-setting process that impinge on practical decision-making.

In practice the process of priority setting takes place in a profoundly political context, in which numerous influential political interest groups seek to participate. Models of political economy describe how decision makers react to political realities, and how priority-setting decisions may be influenced by them. They try to explain why the political decision-making process fails to generate apparently welfare-improving policy changes. This phenomenon is often referred to as government failure, although it can sometimes be better characterized as 'realistic politics'. There is surprisingly little research investigating the political economy of the health sector. According to Tuohy and Glied (2011) the presence of health care in the substantial literature on political economy in economics is "less than proportionate to the size of health care in government activities" (p. 58). Hauck, Smith and Goddard (Hauck, Smith et al. 2004) and Goddard et al (2006) demonstrated that viewing priority setting from a political economy perspective can substantially enrich our understanding the choices made in real-life decision-making.

Following on from previous research, we therefore consider the various political constraints that affect the decision options available to decision makers. We use models of political economy to explain why even benevolent social welfare maximising decision makers may diverge from the traditional economic evaluation approach, and more broadly, why they may discard interventions that are considered welfare- and health-improving. The objective of this paper is to collate and discuss evidence from empirical and theoretical models of public choice and political economy applied to decision-making in healthcare and public health. The models help us move from the normative approach to priority setting, based on what should be done to maximize some concept of social welfare, into the realm of positive approaches that attempt to understand what happens in practice.

We examine the following theories:

- Models of competing interest groups, based on the assumption that powerful interest groups – for example provider organizations – may seek to skew decisions in their own favour at the expense of less organized stakeholders.
- Voting models, such as the median voter model, (Ahmed and Greene 2000), which assert that political decision-makers will seek to develop policies that attract particular voter groups, in an effort to maximize political support. The implication of this insight for priority setting is that the size and contents of a public benefits package may be skewed towards the preferences of key voting groups.
- Bureaucratic decision-making models, which assert that ‘bureaucrats’ may make decisions in their own interests, rather than the interests of the population as a whole.
- Institutional economics to explain how governmental institutions and more generally the organisation of the political system influence decisions
- Decentralization and contracting-out to non-governmental organizations, and implications on provision of public services.

Models of political economy offer different explanations of why the allocation of health system resources may differ from that predicted by the naïve economic model. However, they all acknowledge that priority setting takes place in a political environment. Choices will be to the advantage of some groups and to the disadvantage of others. It is therefore important to examine the utility function of those responsible for setting priorities, often generally referred to as “the government”, although it may sometimes be important to bear in mind the importance of individuals acting within government. A large class of political-economy models assume that the same behavioural model that can be used to explain decision making in ordinary markets can also be applied to decision making in the public sector. Public policy makers are not necessarily benevolent maximizers of social welfare, but may be motivated by their own self-interest. Firms seek to maximize profits, consumers seek to maximize utility, and policy makers seek to maximize political support, or their own personal gain.

The models further assume that, while policy errors are certainly possible, it is more informative to assume that the intended effects of a policy can be deduced from the observed effects, especially when such policies persist over time. Therefore not all models of political economy necessarily imply errors in priority setting. In acknowledging political constraints, we do not of course argue that such behaviour is desirable, or that it happens in all circumstances. Individuals have various motivations and we acknowledge that many decision makers will act with predominantly altruistic and welfare maximizing considerations in mind. Our aim is merely to offer a framework for explaining apparently perverse actions on the part of decision-makers.

Interest groups

The interest group model demonstrates that some groups of the population are more successful in promoting their interests than other groups, and seeks to explain the impact this has on priority setting, resource allocation, redistribution of wealth, and even the survival of governments. Within health care, small groups with a clearly defined common objective – for example, the pharmaceutical industry or patients with a specific disease – have lower costs in organizing themselves, securing cohesion and effectively lobbying decision makers to their advantage, at the expense of the larger population whose interests may be more diffuse and experience higher costs of organizing. Olsen's (1971) theory of collective action suggests that interest groups are able to exert such influences because the benefits of action accrue to a narrow, well-organized group, whilst the costs are dispersed broadly across a diffuse group. The narrow, well-organized group can effectively monitor the behaviour of its members to discourage free-riding. The substantial benefits of legislative action to each member further encourage the membership to exert effort to gain legislative ends.

In contrast, the dispersed, disorganized group who will pay the costs of the new legislation often cannot even identify the other members of their group, let alone compel their participation in efforts to stop the legislation. Each member of the group will incur only a minuscule cost because of the new legislation, so it is not in any individual's self-interest to exert much effort. The theory can explain underinvestment in public health policies; because the potential beneficiaries of public health actions are unknown and may not even yet be born, public health policies, by design, have no clear apparent constituency to support it (Glied 2008).

The 'capture' theory describes interest groups as 'capturing' the regulatory power of the state to achieve a redistribution of wealth between different groups of the population in the form of transfers that may be cash or favours (Stigler 1971). Some interest groups have privileged access to information that gives them a comparative advantage. We discuss examples from the health sector where powerful minority groups with the interest, the means and the opportunity to organize themselves have influenced political decisions to their advantage. The literature is moving from a focus on single interest groups to the view that various interest groups are linked in shifting alliances and form tightly linked oligarchies or

professionalized networks of medical, hospital, and business interests, depending on the institutional context (Tuohy and Glied 2011).

Providers of health services – the health care professions – form a crucial interest group in many countries, and governments are often wary of alienating doctors who are in a strong position to mobilize opposition to chosen priorities. The performance of all health systems relies on a vibrant, well-trained and motivated workforce. If the adoption of certain priorities risks alienating key clinical groups, perhaps leading to a collapse in morale, early retirement, or emigration, then decision-makers may choose to adopt second best solutions that avoid such risks. It is of course a matter of political judgement as to when to accommodate and when to confront powerful interest groups. While providers would certainly not want to be seen to actively work against the interest of patients, it is unlikely that investments in public health and cost-effective care in community settings feature prominently amongst their priorities, especially if such investments are made at the expense of curative health care interventions in urban areas, or even reduce demand for their services. Health staff may have credible threats that can undermine the implementation of policy shifts, ranging from overt threats such as quitting the workforce, emigration, or shifting employment from the public to the private sector, to subtle non-cooperation and adherence to traditional patterns of care. Such alienation may have profoundly important consequences for a healthcare system.

A central feature of almost all health systems is effective organisation and strict licencing regulation of the medical profession. Licensing is defended on the grounds of guaranteeing quality standards that are predicted to improve the average quality of service offered by practitioners when the entry of less competent practitioners is prevented or when less competent practitioners are forced to increase their investments in human capital, e.g. see Shapiro (1986). However, it also could be argued that it reduces scope for market entry, defends inefficient practices, and leads to practitioner rents, as predicted by the capture theory. The social loss due to these negative effects may be outweighed by the social gains from a higher quality of service. Reliable empirical evidence that licencing improves the average quality of service offered by practitioners is rare, mainly due to the difficulty of obtaining accurate measures of practitioner quality (Kugler and Sauer 2005).

The pharmaceutical industry is another powerful interest group that may favour certain health care interventions and drug treatments over others. For example, The Council of the Europe Assembly quite openly voiced the suspicion that the pharmaceutical industry influenced the World Health Organization's response to the H1N1 flu pandemic. The Council accused WHO of exaggerating the seriousness of the epidemic which resulted in public funds being spent on vaccines and antivirals that were never needed, so goes the accusation (Taylor 2010). Patient associations have successfully lobbied governments to fund drugs publicly, even if there is doubt about their cost-effectiveness, or even clinical efficacy and safety, for example the breast cancer drug Herceptin in the English National Health Survey (NHS) (Berg 2006). As public choice theory predicts, chronic illnesses with comparably low prevalence are at an advantage, for example HIV/AIDS, at least partly due to the fact that costs of organizing are lower (McIntosh 1990). Preventive public health

interventions are at a disadvantage because there is no clearly defined patient group lobbying in their favour, and they have to rely on individuals or groups with altruistic motivation for support. There is evidence that FDA drug approval times are shorter for drugs with more active and wealthier disease-interest groups (Carpenter 2002).

Further, governments often prioritize sensitive political issues concerning highly visible aspects of health care services, at the expense of investments in public health. For example, some countries place a high priority on tackling waiting times for elective surgery, which affect a relatively small group of patients. This preoccupation could be interpreted as a response by politicians to the more media-friendly interests of waiting patients when compared with interventions aimed at the whole population, or large and difficult to delineate subgroups of individuals at risk, such as preventive screening or healthy lifestyle campaigns.

Other commercial companies that are driven by economic interests have formed powerful interest groups. The tobacco industry adopted various strategies to frustrate highly cost-effective public health interventions aimed at reducing consumption of cigarettes. Many of the strategies came to light only when an extensive library of internal tobacco industry documents was released publicly as a result of the 1998 settlement agreement (LTDL 2002). For decades before, the tobacco industry successfully pre-empted efforts to limit advertising and sale of cigarettes, by publicly disputing evidence that smoking cigarettes damages health, half-hearted self-regulation such as the Cigarette Advertiser Code, and public messages and advertising that emphasized individual responsibility to deflect blame from the industry (Richards, Tye et al. 1996). Some now fear that history will repeat itself by comparing the tobacco industries' strategies with current efforts by the food producing industry to deny the contribution of their products, in particular soft drinks and highly processed snack food, to the obesity epidemic and to rally against policy proposals such as taxes on soft drinks (Brownell and Warner 2009).

Interest groups: Soft drink and fast food industries in low- and middle-income countries



Market entry marketing in Burkina Faso

Advertising for soft drinks in the poorest countries of the world is a deliberate marketing strategy of the beverage industry. While most consumers in Burkina Faso cannot afford to purchase the beverage, the industry is deliberately raising awareness and liking of the product so as to increase sales in the future when income levels increase. Global soft drink and fast food companies follow so-called ‘loss leading’ and ‘value’ strategies to encourage consumption initially with low prices and small package prices, but then later increase package sizes and prices. Fast food companies adapt menus to suit local tastes, and soft drink companies seek to increase ‘cold availability’ of their products with heavy investments in distribution and refrigeration facilities at local suppliers. Hawkes (2002) provides a review of the marketing activities of global soft drink and fast food companies in emerging markets.

Image source: <http://www.infectiousmedia.com/markin-the-case-for-banners>

Employers form an interest group that has traditionally supported cost-effective public health interventions if they improve and preserve the productivity of their workforce. Historically, investments in the control of diseases in low-income countries were driven by the economic interests of colonial countries, and the need to guarantee the health of the workforce sent to work there (Hauck and Smith 2014). For example, in Britain in the 1890s, the Colonial Secretary Chamberlain was aware that the poor health of the native workers and the officials sent to serve in the Colonies was a threat to Britain’s growing empire. Mortality among officials in some parts of the world, particularly the Gold Coast of West Africa, was soaring and to compensate, salaries were sometimes 100% higher than those of colleagues elsewhere. The economic significance of the control of tropical disease led to the establishment of institutions and schools of tropical medicine in colonial countries. Nowadays, some mining companies are providing free Anti-retroviral therapy to their HIV positive employees, sometimes even including their families (AngloAmerican 2008). As HIV/AIDS predominantly affects working age adults, companies are possibly motivated by

a combination of humanitarian interests and the commercial interest to preserve the human capital established in their workforce (News 2002).

The globalization of economies and increase in trade since the 1980s has strengthened the role of institutions that govern the complex international economy such as the World Bank, the International Monetary Fund, and the World Trade Organization. Like in national economies, effective international regimes are required to support the global economy by reducing uncertainty, minimizing transaction costs and preventing market failure, although international institutions often lack the power to enforce compliance. International governmental and non-governmental organizations (IOs) are involved in resource allocation decisions and health policies of developing countries. In some key programmes, such as childhood immunizations, less than half of funding comes from national sources (GAVI 2008).

The assessment of transnational actors is largely optimistic, suggesting they herald an emerging global civil society that is assumed to rest upon shared liberal norms and values that motivate their action and explain their supposedly benign influence. Cooley and Ron (2002) question this view and analyse IOs with a political economy approach and argue that many aspects of their behaviour can be explained by materialist analysis and an examination of the incentives and constraints produced by the transnational sector's institutional environment. They argue that the growing number of IOs within a given transnational sector increases uncertainty, competition, and insecurity for all organizations in that sector. The marketization of many IO activities -particularly the use of competitive tenders and renewable contracting- generates incentives that can produce dysfunctional outcomes. Glassman and Chalkidou (2012) point out that health aid mechanisms have done little to support countries to make the connection between what is best value and affordable, and what is included on public budgets. The authors cite a study by Bump et al (2013) that analysed trends in scientific publications. While diarrheal disease burden remained high, publications on infant diarrhoea in developing countries rose quickly in the 1980s and tapered off in the late 1990s and 2000s. Over the same period, publications on malaria and tuberculosis have grown steadily, likely due to donor funding emphasis.

Ruger (2011) discusses that the current regime of global health governance needs to be understood as transnational and national actors pursuing their own interests under a rational actor model of international cooperation that fails to provide sufficient justification for joint actions to correct and avert global health injustices. She develops an alternative model of shared health governance, which aims to provide a framework for various global health actors to better promote cooperation that is based on shared ethical commitments. Global health payers including the Global Fund, the GAVI Alliance, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) have set up co-financing requirements. This is to share financial burdens, support country ownership of programs (Glassman and Chalkidou 2012), and ensure greater alignment with national priorities.

Interest groups: Topic selection by the National Institute for Health and Care Excellence (NICE)

NICE provides evidence based guidance on the clinical efficacy and cost-effectiveness of health care technologies, and is generally viewed as an international leader among such agencies, however, the choice of technologies that NICE puts forward for appraisal has come under criticism in the past. The Government's Response to the Health Select Committee's First Report of Session 2007-08 on the National Institute for Health and Clinical Excellence stated *"It seems to us appropriate that topics are selected for interventional procedures, clinical guidelines and public health guidance. It is not appropriate, however, to limit technology appraisals to selected, often new and expensive, products. Instead, ... , all new drugs should be assessed"* (p. 2 in DoH 2010).

The concern was put forward that NICE's focus on acute treatments, in particular medicines, could skew NHS spending towards selected new and expensive (NICE approved) drugs for acute illness. It was commented that this reflects current trends in drug development and drug discovery, where the prevalence of new drugs for conditions such as cancer means that many new drugs initially impact on secondary care (p. 4 in DoH 2010). The Governments' Response acknowledged that it may not be feasible to appraise all new drugs and treatments, and that a topic selection needs to be in place.

Department of Health. The Government's Response to the Health Select Committee's First Report of Session 2007-08 on the National Institute for Health and Clinical Excellence. House of Commons Health Select Committee, Department of Health. CM 7331, 2010.

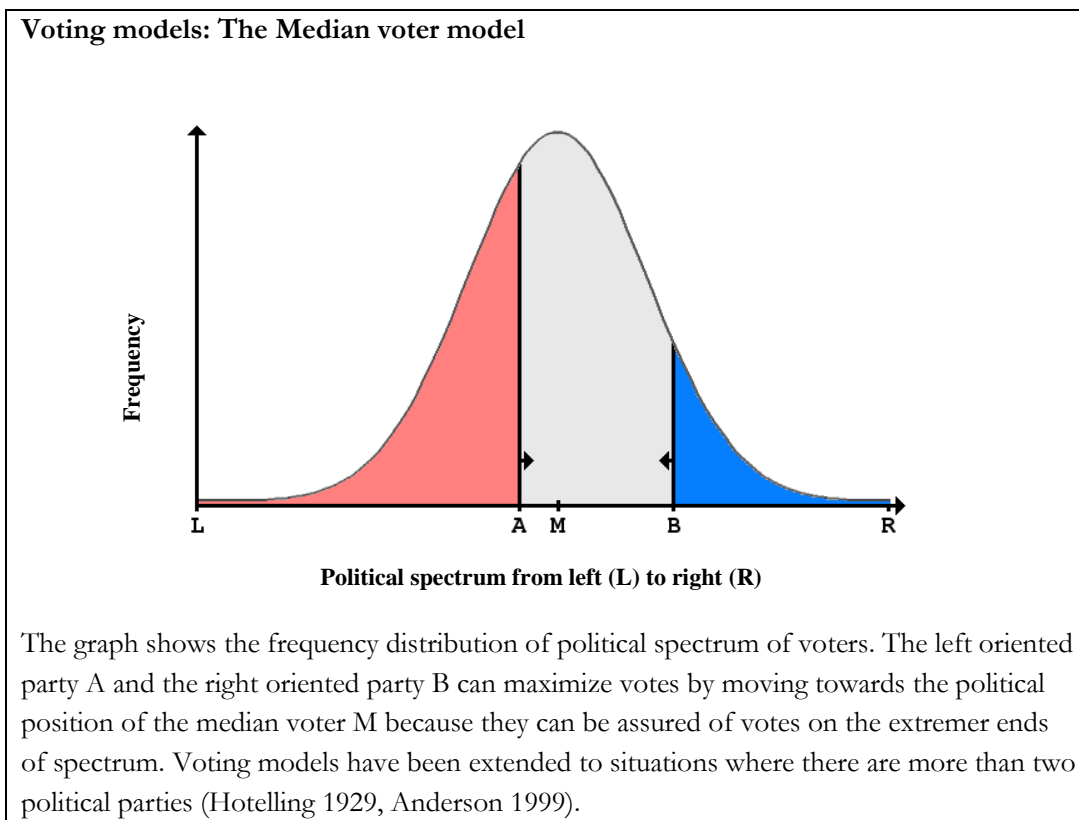
Even organizations seeking purely 'technocratic' solutions to priority setting by providing scientific evidence on the cost effectiveness of interventions (e.g. health technology assessment agencies) may risk capture. A problem is to find sources of expert advice that do not have direct or indirect links to interested parties; further, the influence of interest groups may affect selection of interventions chosen for assessment, although it can also be seen as an attempt to increase political support for decisions.

Voting models

Many health interventions are targeted at conditions that predominately affect disadvantaged groups of the population, and some even have the primary objective of reducing inequalities in health. This in itself may imply a need to depart from pure cost-effectiveness criteria, which imply an objective of maximizing aggregate health outcomes. For example, the median voter model may explain why such health interventions often receive less political backing than others that benefit a wider or different spectrum of the population. The model focuses on the politician as a maximizer of votes (Hotelling 1929, Anderson 1999). The "median voter" theorem shows that in a representative democracy, political parties tend to move towards the political position of the median voter in order to secure election. Among many other considerations, people also vote on the level of health care services that should be provided by the public system. This implies that the level of health spending and its

allocation across different types of services will correspond to that demanded by the median voter. It may explain why policy makers seek to direct resources towards interventions and services favoured by key population groups at the expense of others, notwithstanding the apparently reasonable claims of the latter on resources from an efficiency or equity perspective.

For example, median voters are likely to perceive that they or their family benefit from screening services for common conditions such as cancers. Therefore, the provision of such services is likely to receive widespread support, even if evidence of cost-effectiveness is weak, or indeed they might do more harm than good. On the other hand, policies directed at the poor may receive less popular support because the median voter does not perceive any personal or family need for such services. Even if the latter services are very cost effective, politicians seeking re-election may find it difficult to attach high priority to them. Similarly, many common healthcare interventions, such as treatment for acute myocardial infarction, hip and knee replacements, or cataract removals are likely to be demanded by the median voter at a certain point in life. Although a great simplification of electoral pressures, the median voter model highlights the importance to any government of obtaining the support of crucial electoral constituencies.



Gaining taxpayer support for health policies has high importance for policy makers, in particular in many low-income countries with high levels of informal employment where tax contributions are concentrated among a relatively small, urban elite. These citizens may often

hold disproportionate influence over governments, and tend not to suffer to nearly the same extent from the communicable diseases and certain chronic conditions suffered by poorer citizens. The interest group model can explain why expenditures are often focused on health care services for richer areas or social groups at the expense of preventive and public health services for the poor, even where the latter offers greater cost-effectiveness. In a democratic system, as the proportion of poor in the overall electorate is relatively large, most tax-financed health care expenditure would be devoted to illnesses of the poor in order to secure support of the majority of voters. However, such a policy choice would imply very large financial transfers, through the tax regime, from the rich to the poor. In short, the rich may have to make big tax contributions to public interventions that do not benefit them greatly. This may lead to resistance amongst the rich, tax evasion, increased collection costs, or even emigration. The urban bias is explained in that groups and populations based in rural areas may be less informed, less literate, and have an under-developed infrastructure for the dissemination of information compared to wealthier groups or those based in the urban areas, where access to information resources is better.

Economic theory of tax compliance predicts that tax evasion should be much greater than it actually is, given the low deterrence in most countries - conceptualized as the product of the probability of being detected and the size of the fine imposed. The literature alludes to an effect known as 'fiscal exchange', a psychological tax contract between taxpayers and the government (Alm, Jackson et al. 1993). The more governments provide public services according to the preferences of taxpayers in exchange for a reasonable tax price, the more taxpayers comply with the tax laws. Citizens are willing to honestly declare income, even if they do not receive a full public good equivalent to tax payments, as long as the political process is perceived to be fair and legitimate (Feld and Frey 2007). The concept of "fiscal exchange" has important implications for health care priority setting. In order to limit tax resistance of this kind among the rich, the government may feel constrained to include some provision for the health care needs of the rich in the essential package of care in order to retain the viability of the tax base, even when the associated treatments do not qualify for inclusion on strict cost-effectiveness criteria. There is empirical evidence that regional distribution of advantaged groups is strongly correlated with access to public goods: for example, in India, areas with a high concentration of Brahmans and Christians enjoy better access to public services (Banerjee and Somanathan 2007).

Some voters will have a demand for healthcare that is not met by the contents or the quality of the public package, and theory predicts that these are the ones with higher need for healthcare, and with higher incomes (Epple and Romano 1996). Because the income elasticity of health care is positive, individuals with higher income have greater willingness and ability to pay for healthcare, for example, either out-of-pocket or via supplemental private health insurance if this is allowed. They may also prefer not to cross-subsidize poorer, sicker people through public spending. High-income voters may therefore prefer a lower level of public health spending, especially when they have the option of private health insurance, and this will move the median voter demand down. Evidence for this has been found for OECD countries (Tuohy, Flood et al. 2004). Permitting some private purchases of

health care does enhance aggregate societal welfare but also increases inequity in its distribution.

Re-election possibility in general has been shown to affect economic policy choices (Besley and Case 1993), and the distribution of voter incomes and the expected change in voter support from varying levels of public provision affects the allocation of government expenditure (Tridimas 2001). There is evidence that taxes are spatially dependent (Besley and Case 1992); an important possible explanation is the competitive pressures that local and national governments face from mobile household that 'vote with their feet' (Tiebout 1956). Generalizing this insight suggests that governments may feel some competitive pressure to provide health services in line with those available in neighbouring countries.

The voting model: Women's suffrage and child survival



Women's choices appear to differ systematically from those of men, and emphasize child welfare more than those of men. Miller (2008) presents evidence on how suffrage rights for American women enacted between 1869 and 1920 helped children to benefit from the scientific breakthroughs of the bacteriological revolution. Consistent with standard models of electoral competition, the extensions of suffrage laws were followed by immediate shifts in legislative behaviour and increases in local public health spending by about 35%. This spending growth fuelled large-scale door-to-door hygiene campaigns, and child mortality declined by 8–15% (or 20,000 annual child deaths nationwide) as cause-specific reductions occurred exclusively among infectious childhood killers sensitive to hygienic conditions.

Miller, Grant. *Women's suffrage, political responsiveness, and child survival in American history*. *The Quarterly Journal of Economics*, 123(3) p. 1287, 2008

Image source: http://college.cengage.com/history/primary_sources/us/give_mother_the_vote.htm

The determinants of government responsiveness to voters are important in this context, and having a more informed and politically active electorate strengthens incentives for governments to be responsive. This suggests that there is a role for both democratic institutions and mass media in ensuring that the preferences of voters are reflected in policy. Besley and Burgess (2002) show that Indian state governments are more responsive to falls in food production and crop flood damage via public food distribution and calamity relief expenditure where newspaper circulation is higher and electoral accountability greater.

In recent years, a literature on public involvement in decision making has developed (Edwards and Elwyn 2009), (Price 2009) and with applications to patient and public involvement in healthcare, and also involving online media (Price 2009). The discussion over whether community preferences have a legitimate role to play in priority setting has been highly polarised, and about how such involvement can be achieved (Lenaghan 1999). Sceptics warn of the risk of establishing a ‘dictatorship of the uninformed’, while advocates proclaim the legitimacy of the participatory process. Empirical evidence on how members of the general public choose to prioritise health services and treatments has revealed that acute interventions receive greater priority, whereas preventative measures, such as family planning or education, and care for people with chronic illnesses and disabilities receive lower priority (Lenaghan 1999, Wiseman, Mooney et al. 2003). In the US, the public consultation exercises of the Oregon health commission found that the highest ranking priorities were treatments for life threatening conditions, maternity care and palliative care (Hasnain and Garland 1990, Brown 1991).

Patient involvement: Health and social care personal budgets in the English NHS

The Integrated Personal Commissioning Programme will be piloted in England from April 2015. People with complex care needs will be given the chance to control a merged NHS and social care personal budget to purchase support. Councils and local NHS services will offer people a combined health and social care ‘endowment’ based on each individual’s assessed annual care needs. Local areas will be invited to bid to pilot the scheme in 2015-16. People who take up the personal budget option will decide how much personal control to take over commissioning services to meet their needs. Voluntary sector organisations will be commissioned locally to support people’s care planning and provide ‘brokerage’ and advocacy.

<http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/MakingPHBshappen/Integrating/>

Mitton et al. (2009) undertake a scoping review of public participation in health care priority setting. They find that governments appear to recognize benefits in consulting multiple publics using a range of methods, though more traditional approaches to engagement continue to predominate. There appears to be growing interest in deliberative approaches to public engagement, which are more commonly on-going rather than one-off and more apt to involve face-to-face contact. However, Mitton et al. also find that formal evaluation of public engagement efforts is rare, and it is difficult to assess the extent to which public involvement is vulnerable to capture by interest groups. Also absent is any real effort to demonstrate how public views might be integrated with other decision inputs.

Bureaucratic decision making

Models of bureaucratic decision making argue that policy outcomes and resource allocation result from a game of bargaining among a small, highly placed group of governmental actors, such as ministers, their advisers, and permanent civil servants at national and sub-national

governments. Tullock's (1965) and Niskanen's (1971) institutional theories focus on the interests of 'bureaucrats' in maximizing their influence and the effect of their behaviour on the level and nature of government output. According to these theories, bureaucrats are akin to decision-makers in private firms, with the substitution of budget maximization for the profit-maximization motive. The concept of the bureaucrat is interpreted broadly to embrace all public sector actors with significant influence over the allocation of resources. The essence of this approach is the belief that such bureaucrats receive power and remuneration in proportion to the size of their enterprise, with the implication that bloated and inefficient public services emerge if there is a lack of effective control on the growth of government. Under the bureaucratic model, government agencies will seek to implement policies that maximize the size of their own enterprises and to undermine activities that are outside their direct control. They are able to do so because they have an informational advantage over their political counterparts. 'Bureaucrats' may therefore influence the pattern of health care expenditures in ways that do not accord with efficiency and equity considerations. If this model applies, it would also suggest substantial inertia in spending, making it difficult for politicians to change entrenched patterns of services.

It is difficult to find hard evidence, but the tendency of bureaucrats to maximize their own budgets and sphere of influence at the expense of others can be observed across many government sectors. For example, bureaucrats in health ministries often find it difficult to persuade bureaucrats in other ministries, such as education or social care, to adopt policies designed to improve health, because of the reluctance of each sector to relinquish control and share budgets. Health care and public health interventions, perhaps more than other government activities, requires collaboration across sectors and cross-departmental actions for which responsibilities cannot be clearly delineated.

Hsiao (2007) used the decision choices facing China's health reform to illustrate the importance of political economic analysis and argues for more integrated political economy studies, particularly ones examining the roles of the health bureaucracy and the medical profession. Hsiao commented that in China, there is a dissonance of goals between the top political leaders who wish to address the social unrest by providing effective basic health services to everyone, and the agents (the bureaucracy) who wish to pursue their own bureaucratic interest, in particular to increase bureaucratic power through larger budgets, larger workforces, and greater regulatory power.

Lipsky's concept of 'street-level bureaucracy' (Lipsky 1979) has been found to be particularly pertinent in healthcare because of information asymmetries and the complexity of the clinical management of patients (Rothstein 1998). Lipsky (1979) termed public workers 'Street-level Bureaucrats' if they interact directly with citizens in the course of their work and have substantial discretion in their treatment of their clients. They generally work in conditions that are not conducive to the adequate performance of their jobs, facing high demand for their services but lacking the organisational and personal resources necessary to do the job well; and they routinely make difficult resource allocation decisions about who gets services or not. They must have discretion in taking decisions that allow them to

respond effectively to variable client needs, and the high demand for their services forces them to develop informal routines for mass processing of patients. On the other hand, the considerable degree of discretion accorded to health care workers in determining the nature, amount, and quality of services provided by their agencies has a powerful impact on the rationing of resources, and the factors governing their decisions might not be based on cost-effectiveness or similar principles. Providers have considerable influence on resource allocation decisions made at the lowest administrative level, therefore changing such resource allocation requires improving implementation by dealing with street-level bureaucracy. Clearly, given the importance and considerable autonomy of many front-line professionals in delivering health services, the notion of a 'street-level' bureaucrat has a high degree of relevance in the health sector.

Bureaucratic decision making: Cleaning up the Plague

The outbreak of the plague in the 2.2 million Indian city of Surat in 1994 was largely attributed to the high proportion of the city's population that lived in slum dwellings with poor sanitation and ineffective waste disposal. A little known civil servant Suryadevra Ramchandra Rao was appointed head of Surat's municipal corporation in 1995. Rao, a psychology graduate, initiated a program to improve waste disposal and slum conditions, and introduced 'AC to DC': go from air-conditioned offices to daily chores. Heads of municipal divisions were required to spend about half the day on walkabouts, to keep track of problems with basic services and pipe repairs, manage performance more effectively, and importantly, according to Rao, to help them appreciate the hard work of city employees. Self-esteem among the 15,000 demoralized city employees increased considerably. Where before the outbreak only 40% of the daily garbage was cleared, the figure was close to 97% a few years later. Morbidity due to infectious diseases fell by 65% within two-and-a-half years.



<http://www.outlookindia.com/article/Cleaning-Up-The-Plague-City/202600>

<http://edition.cnn.com/ASIANOW/asiaweek/features/asiacities/ac1999/data/improved.surat.html>

Image source: <http://www.virginmedia.com/science-nature/amazing-bodies/outbreak-history-of-epidemics.php?ssid=10>

A few studies investigate the impact of street-level bureaucrats on the implementation of national health policies in low-income countries, for example a change in national health policy in South Africa after 1996 (Walker and Gilson 2004) and implementation of a basic package of health services in post-conflict Liberia (Petit, Sondorp et al. 2013). Both studies found that street-level bureaucrats' views and values inform their implementation of the

health policy, and that failures in implementation are related to exclusion of bureaucrats from the process of policy change, and insufficient incorporation of social, financial and human resources into the policy implementation process. To overcome these problems, Walker and Gilson (2004) and Petit et al. (2013) suggests that policy makers should improve planning and management in ways that demonstrate respect and trust for street-level bureaucrats. These suggestions rest on the (contestable) assumption that bureaucratic motivation is not fixed, but can be modified by deliberate policies.

Political Institutions and Fiscal Federalism

Models of political economy tend to focus attention on the influence of individuals or small groups on resource allocation. It is important to recognize, however, that the behaviour of policy makers, bureaucrats, interest groups and voters are often affected by the institutional context in which they operate (Tuohy and Glied 2011). Immergut (1992) argued that in order to understand the politics surrounding the introduction of national health insurance, we must look beyond the clash of ideologies and the clash of interest groups to the political context in which these interests are defined. Theoretical and empirical economic studies have explored the role of institutional differences in explaining cross-national and in-country variations in health policies, resource allocation and health system characteristics.

Some of the studies discussed in this section can perhaps not strictly be classified as models of political economy, but rather as economic analyses of political decision-making processes. However, they share a common objective, to explain why resource allocations may diverge from interventions that are considered welfare improving. They further analyse which particular features of institutional systems may foster implementation of beneficial interventions. The fundamental contrast typically made in this regard is between parliamentary systems, which strengthen the executive, and congressional systems marked by separation of powers that provide more opportunities for interest groups to influence and veto decisions (Tuohy and Glied 2011). For example, research has shown how the establishment of strong executives in parliamentary systems of France and UK after the 2nd World War enabled the countries to impose controls on doctors and hospital and the establishment of the National Health Service that had been impossible under previous constitutional regimes (Wilsford 1991, Hacker 1998). On the other hand, the separation-of-powers of the congressional model in the US has obstructed attempts to adopt national health insurance over many decades (Steinmo and Watts 1995). Concentration of authority has downsides; it could make government actors risk averse because it also concentrates accountability, thus making it difficult for governments to spread the blame for unpopular decisions, and it may shift opposition to the implementation rather than the legislative phase of policy making (Tuohy and Glied 2011).

Decentralization

Most healthcare systems make extensive use of subsidiary levels of government, and many resource allocation decisions are made at those levels. It is therefore important to understand

how devolution of decision-making influences implementation of welfare-enhancing interventions. There is a substantial economic literature on how fiscal federalism (or decentralization) affects provision of public services, although less research has focused directly on health care services (Petretto 2000). The principle underlying local government is that for some kinds of public goods, the benefits accrue to local residents, and there is therefore a presumption that – at least up to a point – local people should determine their nature. Multiple levels of governance add complexities that affect variations in spending on public health and provide multiple access for interests group (Tuohy and Glied 2011), although the direction and magnitude of effects is likely to depend on specific funding arrangements for such policies. A system under which sub-national governments make policy decisions but a significant share of the associated costs is covered by the national government may generate moral hazard, leading to health spending in excess of efficient levels.

In contrast, a system where national governments provide a fixed payment to sub-national governments which then pay the full marginal cost of services (e.g. Canada for primary and secondary care, and Australia for secondary care) may lead to underfunding at the sub-national level. Further, decentralization may lead to a system of dispersed facilities that fails to secure the economies of scale and scope offered by more concentrated patterns of infrastructure (Levaggi and Smith 2003). There may also be under-provision of public goods such as medical training or research because jurisdictions seek to free-ride on the efforts of others. Numerous other theoretical effects of decentralization can be predicted, some of which serve to improve welfare and others to compromise welfare. For example, decentralization could lead to reduction in spending below society's optimal levels, because blame can be shifted to other levels of government. Conversely it could lead to increased spending or improved performance as a result of increased horizontal competition between devolved governments. The table 'Economic arguments pro and con decentralization' lists some of the economic arguments that tend to support decentralization of policy making to lower levels of government. It also lists arguments against decentralization, some of which directly contradict the arguments in favour. The predictions are mostly based on theoretical economic models, and it has proved hard to validate them empirically, either in the health sector or the broader public services. From the point of view of this paper, the important point is that choices about the extent and nature of decentralized decision-making may profoundly affect the outcomes of the health system.

In a theoretical contribution, Bardhan and Mookherjee (2006) study the trade-offs between allocation distortions resulting from monopoly power of unregulated and corrupt bureaucrats in a centralised delivery system, and the tendency under decentralisation for local governments to be captured by local elites. They assume that the central government is uninformed about local need and unable to monitor service allocations. Effects of decentralisation on service volumes, efficiency and equity are analysed under different financing arrangements for local governments. Bardhan and Mookherjee (2006) demonstrate that results depend on the method chosen for financing local governments, and they urge caution in inferring that greater revenue decentralisation would be welfare enhancing. In a

related study, the same authors analyse the effects on accountability in government service delivery of decentralizing administration of an antipoverty programme (Bardhan and Mookherjee 2005). While governments at both central and local levels are vulnerable to antipoor policy biases owing to political capture, centralized delivery systems are additionally prone to bureaucratic corruption, owing to problems in monitoring bureaucratic performance. The authors conclude that the net effect is unclear. Decentralizing the delivery system may improve or deteriorate intraregional targeting, depending on whether it promotes cost-effectiveness at low programme scales, or whether central grants to high-poverty regions shrink, owing to high capture of local governments by local elites in such regions.

Empirical evidence on the effects of decentralization is scant and difficult to compare, because results are likely to depend upon many other factors, including the institutional structure at each governmental level. A study of the Spanish national health system found evidence that vertical competition had significant impacts for policy innovation and welfare state development (Costa-Font and Rico 2006).

Despite uncertainty about the overall societal benefits of decentralization, many developing countries are experimenting with devolution of public service delivery to elected local governments instead of bureaucrats appointed by a central government. Lower infant mortality rates were found to be associated with higher fiscal decentralization for a panel of high and low-income countries (Robalino, Picazo et al. 2001). The authors suggest that fiscal decentralization can improve implementation of health improving policies in poor countries, and that positive effects increase in institutional environments that promote political rights, and decrease in environments with high levels of ethno-linguistic fractionalization. They further speculate that fiscal decentralization may improve health outcomes in environments with high levels of corruption. This is confirmed by a study in Brazil, which found that infant mortality decreased with a greater proportion of ambulatory care facilities directly under control of the municipal government (Guanais and Macinko 2009). However the authors recommend that introduction of decentralization should be gradual until municipalities gain the skills to manage care independently.

Economic arguments pro and con decentralization

Arguments pro decentralization		Arguments con decentralization	
Information	Remote national governments cannot understand all the opportunities and constraints that affect the supply of local services.	Information	Information asymmetry between locality and centre may lead to worse outcomes under decentralization, if local governments act strategically in an effort to secure more than their fair share of central resources
Preferences	Local governments can respond to local preferences and seek to design services that reflect local priorities.	Economies of scale	There may be higher production, purchasing or managerial costs associated with decentralization.
Local co-ordination	Health care requires local co-ordination of a variety of statutory and voluntary agencies.	Transaction costs	Decentralization may impose higher burdens in terms of information flows or the need for local managerial expertise to design and monitor local contracts
Efficiency	Local managerial boards may be able to identify and root out sources of inefficiency because they are closer to local institutions and citizens	Spillovers	Local governments may be inter-dependent if services provided by one jurisdiction affect citizens from another (e.g. vaccinations).
Accountability:	Those who (individually or collectively) benefit from a good or service should bear the financial consequences.	Macroeconomy	The actions of local governments may collectively create important adverse macroeconomic effects.
Equity	Local governments may be better placed than national governments to ensure that resources are allocated equitably within their borders.	Equity	Sub-national variations services, standards, taxes, user charges and outcomes may compromise important equity objectives held at a national level
Innovation	Autonomous local governments may be more willing and able to experiment with new modes of delivery.		
Competition	Autonomous local governments may effectively compete with each other to provide efficient and effective services ('yardstick competition')	Competition	Local areas may perversely have an incentive to perform poorly on certain types of chronic care to deter potentially expensive patients from settling in their locality.

Source: Levaggi R, Smith PC. Decentralization in health care: lessons from public economics. In: Smith, P., Ginnelly, L. and Sculpher, M. (eds) (2005), *Health policy and economics: opportunities and challenges*, Maidenhead: Open University Press.

Contracting out of service provision to non-governmental organizations

The contracting out of service provision to non-governmental non-profit organizations (NGO) can be interpreted as a specific form of decentralization in low-income countries (Loevinsohn and Harding 2005, Palmer, Strong et al. 2006). It is increasingly being promoted in fragile states - countries affected by conflict, emerging from conflict, or otherwise lacking the will or capacity to implement pro-poor policies. In some circumstances, contracting out to NGOs has been shown to be an effective way to expand services quickly to poor population subgroups. Contracting out is likely to influence resource allocation in country, because NGOs will have discretion on how their funds are spent. There is however very little research on whether decisions by NGOs are in any sense optimal, and how they compare with decisions made by national and local governments.

In a pilot project in Cambodia, NGOs were contracted to provide district health services on behalf of the government (Palmer, Strong et al. 2006). An extensive evaluation showed that districts with health services that were contracted out to NGOs delivered care more efficiently and equitably than those that remained under government control. It has been shown that provision of a package of basic services by contractors costs between roughly US\$3 and US\$6 per head per year in low-income countries (Loevinsohn and Harding 2005).

Decentralization: Contracting out of health service provision in Afghanistan



A collaboration of the Ministry of Public Health and US agencies is funding contracts with NGOs to provide a standardised package of care in all Afghan provinces. NGOs can bid for contracts that last up to 36 months. Three provinces are run under contract to the Ministry of Public Health itself—in a scheme known as the strengthening mechanism, which is funded by the World Bank. The same services are delivered but using existing government mechanisms. There are now 27 NGOs with contracts, 17 international and 10 Afghan, and they include Save the Children, the Swedish Committee for Afghanistan, HealthNet International, the Bangladesh Rural Advancement Committee, the Aga Khan Development Foundation and Ibn Sina, a large Afghan NGO. Since the scheme started, many new Afghan NGOs have been established.

Palmer N, Strong L, Wali A, Sondorp E. Contracting out health services in fragile states. British Medical Journal, Vol. 332(7): 718-21, 2006. (also source of image)

NGOs may be less vulnerable to capture by local interest groups than national or local governments, and are therefore in a stronger position to implement policies that satisfy universal cost-effectiveness criteria but are unpopular with influential elites. NGOs are often more flexible than government in their ability to recruit new staff and set up services rapidly. In addition, some NGOs have the financial and logistical backing of large international organisations and they may supplement contract funds with their own resources.

International organizations often prefer to channel funds through NGOs rather than through government agencies that are perceived as corrupt and inefficient (Doyle and Patel 2008). Lastly, the motivation of NGOs is generally expected to be closer to that of public providers than that of the for-profit private sector, resulting in greater innovation and staff morale. Of course, the downside to such autonomy is that governments with weak capacity to deliver services may also be weak in a stewardship and monitoring role, and this in turn may result in misalignment of the policies implemented by the NGO and national preferences. Further, contracting to different NGOs may fragment the health system and continued reliance on external support may delay development of independent national public service provision. Doyle and Patei (2008) discuss several concerns about the rising influence of NGOs, including that the promotion of NGOs may destabilize democracy within countries, that the NGOs legitimacy may be undermined by their own lack of accountability and transparency, and a sometimes opaque relationship between global organizations and local NGOs.

Models of political economy and economic priority setting tools

The purpose of this paper is to highlight from an economic perspective the important influence that political forces may have on policy making and priority setting in publicly funded health services. It seeks to explain why the predictions and recommendations of conventional economic analysis – most importantly cost-effectiveness analysis – may apparently be ignored, in favour of actions that do not appear to be in any sense welfare-maximizing. Most normative economic analysis continues to seek to optimize simple welfare functions (usually based on health and equity objectives). There are many reasons why this should continue, not least because it indicates the opportunity costs of failing to optimize apparently beneficial policies. However there has also been some recognition that conventional CEA does not reflect all of the decision-makers' concerns, and that there is a need to adapt such normative models to reflect the political realities of decision-making. This section briefly sketches some of the approaches that have been proposed.

The neoclassical economic model is built on the presumption that there is only individual rationality and all interaction is instrumental; in this situation the market is the only relevant form of exchange. Institutional economics, on the other hand, acknowledges that what is considered rational is institutionally dependent and hence there exist distinct types of rationality. The concept of social, cooperative or reciprocal rationality is distinct from individual rationality; it is the propensity to respond positively to sympathetic actions and negatively to apathetic behaviour, despite individual losses from such a response. There is evidence for such rationality in the health care sector; most countries incorporate considerations of equity into resource allocation decisions even if it implies a departure from the utility maximization principle that is underlying the traditional economic theory of decision-making. If reciprocal rationality influences decision making, then alternative forms of exchange to markets need to be found to negotiate resource allocation (Vatn 2007). The concept of deliberative institutions is one such alternative form of exchange (Smith 2000). It acknowledges that the ideal solution is the consensus, which is based on coercion free

communication and evaluation of arguments. Through communication and learning individuals change preferences and positions so that agreement on what solution to prioritize can be reached. Vatn (2007) suggests that in order to find a solution to the decision making problem that incorporates political relations, societies have to choose an institutional structure that is consistent with the problems faced, and that strikes a balance between individual and social rationality.

CEA analysis and associated economic tools rest on the assumption that rationality is welfare-maximizing and that a decision problem has an optimal solution. It also assumes that individual preferences are stable and can be aggregated, that values are commensurable (all values can be transformed into the same measurement scale) and compensable (a loss in one attribute can be compensated by a gain in another). In response to these somewhat unrealistic assumptions, health economics has developed priority-setting tools that aim to foster discourse-based resource allocation. They can be complementary to the more traditional economic models, for example, the recommendations of CEA may feed into the decision problem as one of the criteria (see the example). Multi-criteria decision analysis (MCA) acknowledges that goods are multidimensional and decisions are complex, and further that attributes are often incommensurability and non-compensability, i.e. they are not easily transferred into one dimension and often trading-off one attribute against the other may not be possible. MCA is focused on conflict resolution, i.e. finding a compromise between conflicting interests.

Programme budgeting and marginal analysis (PBMA) is a priority setting tool that aims to resolve competing claims through presentation of evidence and involvement of key stakeholders (Donaldson and Mitton 2009). It consists of two components. First, programme budgeting reveals the current activities and associated expenditures, and may help to reveal areas that should be given more attention, and to enable comparisons with other regions where possible. Subsequently, in marginal analysis, an advisory panel is tasked with identifying new services for investment or existing services that should receive more funds, and services for disinvestment. Investment and disinvestment lists are compiled where all services are ranked according to pre-defined criteria.

PBMA can be used at a micro level (within programmes of care), at a meso level (across services within the same area of care) or at a macro level (across all programme areas within a single health organization). The advisory panel should be representative of the organization or the area under interest and contain an optimum number of members. In practice, the panel may comprise managers, clinicians, programme administrators, data and financial personnel, and patients or members of the public. PBMA is used as a systematic approach to improve governmental priority-setting in health (Mitton, Patten et al. 2005, Donaldson and Mitton 2009), albeit mainly in high-income countries. Tsourapas and Frew (2011) conducted a systematic literature review to evaluate applications of PBMA, using four alternative definitions of 'success'. They found that PBMA was successful in 52% of cases when success was defined in terms of the participants gaining a better understanding of the area under interest; in 65% of cases when success was defined as 'implementation of all or some of the

advisory panel's recommendations'; in 48% of the studies when success was defined in terms of disinvesting or resource reallocation; and in 22% when success was defined in terms of adopting the framework for future use.

Institutions: Multi-criteria decision analysis for priority setting in Ghana

CHOICE	A	B
Cost-effectiveness:	not cost-effective	cost-effective
Poverty reduction:	neutral	positive
Age of target group:	young	adults
Severity of disease	severe	not severe
Health effects:	high gain for few patients	low gain for many patients
Total budget-impact:	high budget-impact	low budget-impact
Which one would you choose?	<input type="checkbox"/>	<input type="checkbox"/>
Please tick a box		

Figure 1. Example of pair of interventions

Baltussen et al. (2006) used MCA to rank order the relative importance of criteria to priority setting in health in Ghana Respondents chose between 12 pairs of scenarios that described interventions in terms of medical and non-medical criteria. Subsequently, a composite league table was constructed to rank order a set of interventions by mapping interventions on those criteria and considering the relative weights of different criteria. They find that interventions that are cost-effective, reduce poverty, target severe diseases, or target the young had a higher probability of being chosen than others.

The composite league table showed that high priority interventions in Ghana are prevention of mother to child transmission in HIV/AIDS control, and treatment of pneumonia and diarrhoea in childhood. Low priority interventions are certain interventions to control blood pressure, tobacco and alcohol abuse. Baltussen et al. found that the composite league table lead to a different and more differentiated rank ordering of interventions compared to pure efficiency ratings.

Baltussen R, E Stolk, D Chisholm and M Aikins (2006). "Towards a multi-criteria approach for priority setting: an application to Ghana." Health Economics 15(7): 689-696. (also source of image)

Disinvestment from ineffective treatment remains a challenge, despite increasing awareness even among the medical profession (Kmietowicz 2006, Elshaug, Hiller et al. 2007). For example, a proposal to advise on abandoning ineffective interventions using financial rewards and penalties was suggested (but not implemented) in the UK by the chief medical officer, Liam Donaldson, in his 2005 annual report (DoH 2005). In his report Donaldson highlighted the fact that unnecessary tonsillectomies and hysterectomies cost the NHS £21m (\$40m) a year, despite other treatment options being available. Perversely, challenges to disinvestment may sometimes be related to a lack of resources to support disinvestment policy mechanisms (Elshaug, Hiller et al. 2007). In 2006, the Department of Health announced a new mandate for NICE to help the NHS identify interventions that are not effective. Pearson (2007) discusses NICE efforts to support value in the NHS and then explores the policy options available to the Institute to meet the NHS request for guidance

on disinvestment. In particular, NICE has invested in the development of Clinical Guidelines and Quality Standards that explicitly aim to reduce inappropriate use of expensive procedures, and aims to improve implementation by developing NICE Pathways as practical online resources for practitioners. The website currently lists a total of 219 published NICE guidelines (NICE 2014). Similarly, in 2006 the World Health Organization established the Committee on the Use of Research Evidence (SURE) to improve the use of research evidence, including guidelines (Oxman, Fretheim et al. 2006). Insufficient implementation of guidelines is a concern, and there is not much research on the organizational and personal characteristics related to the health professionals that affect the implementation of guidelines (Francke, Smit et al. 2008).

Conclusions

This paper has discussed the various ways in which political considerations can impinge on the decisions made by those setting priorities for the health system. Many of those political influences are legitimate and virtuous, in the sense that they reflect the need to allow a range of voices to be heard in the priority-setting process. However, some of the political influences are malign, and may serve to undermine the principles of good priority setting, which might include transparency, consistency, efficiency and equity. In particular, such influences may lead to serious departures from the principles underlying priority-setting tools such as cost-effectiveness analysis.

The paper has indicated that many political constraints arise from the power held by important groups within the health system, such as clinical professionals, provider organizations, patient groups, and pharmaceutical companies. The main way in which such power can be limited and channelled to good purpose is through the implementation of good governance mechanisms that hold the powerful to account. These might include independent scrutiny, transparent performance reporting, and well-functioning electoral systems and provider markets. Without good governance it is difficult to see how adverse political constraints can be avoided.

The promotion of equity in health and health care can in some respects be viewed as a political constraint. Hauck et al. (2002) note the confused nature of debates about fairness in the health sector, and set out seven concepts of fairness commonly used in those debates. Some of the concepts can readily be incorporated into conventional CEA, for example by placing greater weight on health gains for disadvantaged population groups. However, the nature of equity criteria adopted in health policy is likely to vary between health systems, and so it will be difficult to develop universal 'equity-weighted' measures of cost-effectiveness (Asaria, Griffin et al. 2013). It is also important to note that the adoption of certain equity criteria can act as a constraint on adopting some technologies. For example, a health system may determine that if a treatment adopted in its benefit package, it must be made available to all who demand it, regardless of their circumstances. This may preclude adoption of a treatment that is cost-effective only for a subgroup of the population. For example, certain types of joint replacement may be cost-effective only for those below a certain age.

However, an equity requirement that discrimination on the grounds of age is prohibited may mean that the CEA can be assessed only with respect to the entire population, and not just with respect to the younger age group. Application to the entire population may render the treatment unacceptable from a cost-effectiveness perspective, and so the equity constraint means it cannot be included in the benefits package.

Priority setting is ultimately a political undertaking. To some extent, the health technology assessment agencies now being put in place across the world are an indication that politicians feel it is helpful and expedient to devolve some aspects of that process to agencies with politically determined terms of reference. At its best, this approach can lead to better informed rankings of treatments, made on a consistent basis, aligned with social preferences. However, the technical recommendations of those agencies must almost always be viewed from a broader perspective than that of narrowly defined CEA. In some cases that broader scrutiny may be undertaken within the agency (as in NICE), in others it must be left to those who are ultimately accountable for choosing priorities. In either case, a key consideration will be the political context within which the decision is being made.

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