Limits to rationality: economics, economists and priority setting

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Abstract

This paper investigates why economic approaches to priority setting have had only limited impact in practice. It argues that obstacles to the take-up of the economic approach centre on (1) limitations in the theory and practice of economic evaluations, and (2) the nature of the wider context within which decisions on priority setting take place. On the first point, it argues that, despite advances in research methods, there is still debate about the theoretical basis of measures typically used in economic evaluations, such as QALYs, and that much of the extant empirical data is of questionable quality. On the second point, it maintains that politicians, health care professionals and local people attach importance to other factors besides allocative efficiency. If economic approaches are to have more impact in the future, it argues that health economists need to adopt a wider research agenda, focusing on public sector decision-making and, in particular, the incentives and constraints governing the use of economic data in different types of health care organisation. © 1999 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

Concerns about rising public expenditures on health care have led policy-makers around the world to focus their attention on the subject of rationing or priority setting. Faced with the need to reconcile increases in demand, with an apparent inability of public funding to meet all these demands, various methods and institutional arrangements have been devised to help cope with the problem [1–3]. Among these methods, economic approaches to priority setting have received considerable attention.
Given that a central concern of the branch of economics known as welfare economics is how to allocate scarce resources in a way that maximises social welfare, the attention devoted to the economic approach to priority setting is hardly surprising. It is noticeable, however, that, in practice, approaches advocated by economists have had only limited impact. This paper seeks to investigate why this is so, by examining the limitations and obstacles to economic approaches to priority setting in health care.

The paper is divided into four main sections. The first section describes briefly the economic approach to priority setting and points to the growing body of empirical evidence that is available to assist the process. The next section discusses how particular methods of economic evaluation have been developed for application in the context of priority setting. It highlights how disagreements over the theoretical bases of these methods, and shortcomings in the available empirical evidence, have limited the practical application of the economic approach. The third section focuses on the wider context within which decisions about health care priorities are made. Most attention is devoted to the meso level of decision-making where local collective decisions are made by health authorities, local health boards or sickness funds, although the impact on these decision-makers exerted by central government (macro decision-makers), medical professionals (micro decision-makers) and the general public is also considered. The final section reviews the role played by health economics in the priority setting process and discusses the tension between the explicit, rational approach to decision-making favoured by economists and the less formalised, implicit approach recommended by some health policy experts.

2. Economic approaches to priority setting

Health economics as a sub-discipline of economics has devoted a considerable proportion of its research effort to the theory and practice of economic appraisal or evaluation; that is, the systematic identification, enumeration and valuation of the costs and benefits (or consequences) of alternative health care interventions or programmes. This area of work—which encompasses cost-effectiveness, cost-utility and cost-benefit analyses [4,5]—provides the basis for ranking health care services in terms of their relative ‘value for money’. As such, it is central to the economic approach to priority setting.

Outside the USA, research on economic evaluation has dominated health economics [6]. Moreover, judged in terms of the number of research publications, the volume of work on this subject has been increasing rapidly over recent years. In the UK, for example, a survey of economic evaluations carried out in 1987 identified only just over 70 studies in total [7]. By 1994, however, the Register of Cost-Effectiveness Studies compiled by the Department of Health indicated that this number had more than doubled with just under 150 economic studies of health care interventions included in the register [8].

Other data sources suggest an even more dramatic increase in research in this area. The Health Economic Evaluations Database compiled by the Office of Health
Economics in London contains details of over 11,500 health economic studies carried out worldwide dating back to the early 1970s. While less than 2000 of these studies appeared in the period up to 1984, thereafter annual rates of publication grew sharply so that, by the 2-year period 1994–1996, 4053 studies were produced [9]. Another indication of the current emphasis placed on economic evaluation can be gleaned from the leading applied health economics journal, *Health Economics*. In 1997, for example, nearly one-third of the papers published in this journal (13/41) were on the subject of economic evaluation.

With this level of investment in the economic evaluation of health care, there is now a substantial research literature, both methodological and empirical, that policy-makers can draw upon to assist in the task of prioritising services. Probably the most ambitious and widely publicised example of the use of these methods was in the initial stages of the Oregon experiment when data on costs and quality-adjusted life years (QALYs) were used to rank some 1600 condition–treatment combinations [10]. Elsewhere evidence from economic evaluations has been used to assist policy decisions in particular sectors of the health care system. Thus, in Australia, for example, data from economic evaluations is required for the inclusion of pharmaceuticals in a ‘positive’ list qualifying for public reimbursement, while in the Netherlands decisions regarding the diffusion of new technologies have drawn on the results of economic appraisals [11].

Set against this trend, however, a number of countries have expressed scepticism about approaches to priority setting based upon explicit economic criteria. In this connection, national committees charged with developing policies on priority setting in both Sweden and New Zealand have recently rejected an Oregon-style approach[3]. In the UK, earlier enthusiasm with economic approaches on the part of some health authorities has been replaced by doubts about its practicality [12]. What has led to this disenchantment? In seeking an answer to this question, two factors may be identified: (1) limitations in the current state of the theory and practice of economic evaluation which restrict its usefulness to policy makers, and (2) the nature of the wider medical, social and political context within which decisions regarding priority setting have to be made.

### 3. The theory and practice of economic evaluation

Methods of economic evaluation used by health economists have been adapted from the general, applied welfare economics area of cost-benefit analysis. Early applications of the cost-benefit approach were undertaken in the USA during the 1930s in connection with flood control programmes and, from the 1960s onwards, have been applied widely in a number of public sector areas including transport, urban planning, education and health care. An important component of the cost-benefit approach is to determine the level of ‘benefits’ resulting from public expenditure programmes when the outputs are provided free (or at least substantially below their costs of production) or when the prices charged to the user do not reflect the full social benefit of the service. In these circumstances, the theoretically
favoured approach of the welfare economist has been to use consumer ‘willingness-to-pay’ as the measure of individual utility and to use the potential Pareto principle for aggregating utility across a population [13]. For most of the last 20 years, however, economic evaluation in health care has not adopted this approach to benefit valuation.

Because of the special nature of health care, as a commodity, the majority of economic evaluations have measured benefits in terms of clinical effectiveness; that is, outcomes have been measured in terms of common natural units such as reductions in diastolic blood pressure for treatments of hypertension or symptom-free days in the case of drug treatments for duodenal ulcers. However, while cost-effectiveness ratios are valuable in assisting choices between different treatments for particular diseases and disabilities, they are of limited use in making broader priority setting decisions between service areas or programmes with different clinical outcomes. For this reason, considerable amounts of research effort on the part of health economists have gone into the development of generic utility-based measures of outcome which are designed to permit comparisons across a broad spectrum of interventions or programme areas.

The most widely used utility-based measure of this type is the QALY. QALYs permit the outcomes of alternative interventions to be expressed in common units—combining measures of both the quality and quantity of life gained—and enable choices to be expressed in comparable terms, i.e. costs per QALY gained. The QALY approach has, however, been subjected to strong criticism from both non-economists and economists themselves. Examples of the former have been philosophical criticisms of the utility-based, or utilitarian, approach to priority setting [14,15]. QALYs have also been accused of discriminating against elderly people, making illegitimate interpersonal comparisons, disregarding equity considerations and ignoring ‘process’ aspects of health care [16–19]. These debates are well documented and will not be rehearsed here. But it is important to note that their existence can be an impediment to the adoption of a QALY-based approach to priority setting when agreement on principles is necessary among multi-disciplinary groups of policy-makers, not to mention acceptability by the general public.

The health economics profession has not stood still in the face of these criticisms. Responding to the need to refine measures of health status and outcomes, a good deal of recent research has sought to develop more sophisticated methods for eliciting consumer preferences in relation to health outcomes. This work has embraced: visual analogue scales seeking to estimate utilities within QALY frameworks [20]; developments in standard-gamble and time trade-off approaches to establishing utility scores associated with different health outcomes [21]; the application of willingness-to-pay techniques seeking to measure utility in monetary terms [22]; and, most recently, the development of conjoint analysis as a technique for establishing the satisfaction an individual derives from the multiple attributes—including process measures—of different health care services. [23]. Despite this considerable research agenda, however, it still remains the case that the main body of extant knowledge available to assist policy makers is subject to a number of theoretical limitations.
Moving from theory to practice, some of the problems encountered with the application of data derived from economic evaluations can be illustrated in relation to Table 1. This table was assembled by Maynard [24] who collected data from a number of existing studies in order to illustrate the relative costs per QALY incurred through a range of alternative health care interventions.

The ultimate purpose of such a QALY league table is to offer guidance in relation to resource allocation decisions; that is, to indicate how allocative efficiency could be increased by shifting resources away from those areas where marginal costs per QALY are high to those areas where similar QALY gains could be achieved at lower marginal cost. However, following the appearance of this table, a number of health economists issued warnings about the hazards of interpreting such tables. Reservations were expressed about the often poor quality data and inadequate methods that had been used in some studies. Certainly, those economists who have conducted literature reviews of economic evaluations have reported on the widespread existence of methodological failings in this area [25–27]. Specific criticisms of Table 1 highlighted the difficulties: of comparing studies undertaken in different years when different technologies and prices prevailed; about the use of different measures of health outcomes; about the appropriateness of transferring results obtained in one local setting to another [28]; and about the reliability of measures of clinical effectiveness used in some studies [29].

Table 1
Marginal costs per QALY league table*

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Cost per QALY (£, August 1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol testing and diet therapy only</td>
<td>220</td>
</tr>
<tr>
<td>Neurosurgery for head injury</td>
<td>240</td>
</tr>
<tr>
<td>Advice to stop smoking from GP</td>
<td>270</td>
</tr>
<tr>
<td>Neurosurgery for subarachnoid haemorrhage</td>
<td>490</td>
</tr>
<tr>
<td>Antihypertensive treatment to prevent stroke</td>
<td>940</td>
</tr>
<tr>
<td>Pacemaker implantation</td>
<td>1100</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>180</td>
</tr>
<tr>
<td>Valve replacement for aortic stenosis</td>
<td>1140</td>
</tr>
<tr>
<td>Cholesterol testing and treatment</td>
<td>1480</td>
</tr>
<tr>
<td>Coronary artery by-pass graft (left main vessel, severe angina)</td>
<td>2090</td>
</tr>
<tr>
<td>Kidney transplant</td>
<td>4710</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>5780</td>
</tr>
<tr>
<td>Heart transplantation</td>
<td>7840</td>
</tr>
<tr>
<td>Home haemodialysis</td>
<td>17260</td>
</tr>
<tr>
<td>Coronary artery by-pass graft (one-vessel disease, moderate angina)</td>
<td>18830</td>
</tr>
<tr>
<td>Continuous ambulatory peritoneal dialysis</td>
<td>19870</td>
</tr>
<tr>
<td>Heart transplantation</td>
<td>21970</td>
</tr>
<tr>
<td>Erythropoietin treatment for anaemia in dialysis patients (assuming 10% reduction in mortality)</td>
<td>54380</td>
</tr>
<tr>
<td>Neurosurgery for malignant intracranial tumours</td>
<td>107780</td>
</tr>
<tr>
<td>Erythropoietin treatment for anaemia in dialysis patients (assuming no increase in survival)</td>
<td>126290</td>
</tr>
</tbody>
</table>

* Source: Maynard [24].
Reservations about the possible impact of changing technologies and prices are demonstrated particularly vividly in the case of the most costly intervention in Table 1; namely, the use of the drug erythropoietin. Erythropoietin (EPO) is used to counteract the anaemia experienced by patients being treated by dialysis for end-stage renal failure. Before EPO was launched in 1990, this anaemia was only treatable by repeated blood transfusions. An economic evaluation of EPO carried out just before its launch suggested that it would be very expensive [30]. As Table 1 shows, the estimated cost per QALY for treatment when no increase in survival was expected was £126,290. Since that time, however, major changes in technology and prices have taken place in relation to the drug. Thus, it can now be administered in smaller and less frequent doses; patients are able to self-administer in pre-filled syringes, thus reducing the need for nursing inputs; and the price of the drug has fallen over time. According to a subsequent economic evaluation [31], the combined affect of these changes has been to reduce the cost per QALY of erythropoietin treatment dramatically. By 1992, the cost per QALY (with no mortality reduction) was calculated as less than one-sixth of the original estimate at £20,022. Pharmaceutical industry estimates suggest that, by 1997, the cost per QALY of treating patients suffering from severe anaemia (with a 10% reduction in mortality) with EPO had fallen to £2848 [32].

In the light of the above criticisms of the present state of the theory and practice of cost-utility analysis, what conclusions can be drawn about its potential contribution to the task of priority setting? Looked at overall, it seems that although the standard of work on economic evaluation generally has improved in recent years—and the appearance of guidelines for conducting and assessing economic evaluations reflects a growing consensus among health economists about best practice [4]—it is probably true to say that it still has only the status of a ‘half-way technology’ [33]. As such, its main contribution is likely to be as an aid to decision-making in specific circumstances rather than as a comprehensive technique capable of routine application.

Recognising these limitations, some economists have recommended the use of a modified version of economic evaluation, known as ‘programme budgeting and marginal analysis’ (PBMA) [34,35], as an aid to practical priority setting. Proponents of PBMA do not dispute the fact that cost-utility analysis—as represented by the cost per QALY approach—is probably the most theoretically sound approach presently available, but their concerns about its practical application lead them to propose a more pragmatic approach.

With this in mind, PBMA involves the identification of programme budgets—which may be client-group-based (e.g. people with mental illness, care of elderly people) or disease-group-based (e.g. heart disease, cancer)—and the use of a marginal cost-benefit framework to determine which services should be expanded, or contracted, within these programmes or sub-programmes. An essential feature of the approach is the focus on expenditures at the margin (i.e. marginal met need and marginal unmet need), with a view to determining priorities for increased and reduced expenditure. In determining priorities, emphasis is placed upon locally defined measures of expected health gains rather than data extracted from cost per QALY league tables generated elsewhere.
One major application of this approach was undertaken in the Southampton and South West Hampshire Health Authority in the UK during 1994. Over the course of 2 days, members of the health authority aided by expert advisers, and in the company of invited observers, considered some 49 options for investment over the next 5 years [12]. Despite the considerable preparation that went into the exercise, a number of serious problems were encountered. First, there was the problem of information overload facing the decision-makers. Even with the organising framework offered by PBMA, the members’ ability to absorb and process the range of information associated with such a large and diverse set of options was clearly limited. In the circumstances, a solution based on extremely ‘bounded rationality’ was the best that could be expected. Second, a problem remained in relation to data availability. Despite restricting data requirements to broad measures of effectiveness and cost-effectiveness, the necessary QALY type data were only available for ten of the 49 options. Third, the exercise confirmed most vividly how public sector decision-makers need to balance multiple objectives, and how attention cannot be focused solely on questions of allocative efficiency. Political considerations, managerial objectives, professional interests and public opinion all played an important part in the final outcomes. The next section considers the role of these factors in the wider context of priority setting.

4. The wider context of priority setting

During the 1990s, reforms of the UK National Health Service—as in many other countries—separated the responsibility for purchasing services from the responsibility for providing them. Under these arrangements, major responsibilities for setting priorities were vested in district health authorities as purchasers of services on behalf of their resident populations. They were supposed to assess the health needs of their populations and then to purchase a mix of services which made the best use of limited resources in meeting these needs. Similar responsibilities for their local populations or enrollees were vested in health authorities, or sickness funds, in other European countries and elsewhere. Research on the process of priority setting has indicated the multiple pressures exerted on these organisations [36] as they seek to determine priorities and illustrates the wider context within which health economists have to operate.

Fig. 1 provides a schematic representation of this context. It shows how local health authorities need to balance the pressures emanating from central government, local providers (hospitals and doctors) and public opinion; as well as consider the technical evidence on clinical and cost-effectiveness. The priorities and approaches of these other constituencies can place considerable limitations on the role played by economic information.

To illustrate the nature of this process, consider first, the priorities of central government. In recent years a major macro-economic objective of most OECD countries has been to control the growth of public expenditure. In practically all of these countries (with, of course, the notable exception of the USA), public
expenditure represents 70% or more of total health expenditure. For this reason, containing the growth in aggregate spending on health has been a high priority [37]. At the same time, numerous policies at the micro level—ranging from regulation and control of hospital capacity to supply side competition between providers—have been implemented with the primary aim of increasing technical or productive efficiency (i.e. reducing costs per unit of output) [1,38]. Beyond this, many central governments have priorities relating to politically sensitive issues such as reducing the length of time patients wait for hospital treatment [39]. Furthermore, central governments are often sensitive to demands relating to the way in which resources are distributed between different regions within their countries.

The relevance of these considerations for our present discussion is that none of them is necessarily consistent with priorities set on the basis of allocative efficiency which is the essence of the economic approach to priority setting. Cost containment strategies are often broad brush with little concern for costs and benefits at the margin. Regulatory policies and supply side competition are similarly more concerned with productive efficiency than allocative efficiency. Waiting times initiatives usually focus on one process measure (i.e. waiting times) to the exclusion of all other clinical and cost-effectiveness criteria. And regional allocations—while they may be based ostensibly on needs-adjusted formulae—are often manipulated for political reasons.

Admittedly central governments in some countries have sought to provide a lead in addressing questions of priority setting. The Dunning Committee in the Netherlands, the Parliamentary Priorities Commission in Sweden and the National Advisory Committee on Health and Disability in New Zealand are widely cited.
examples of this approach [1,3,12]. However, it is noticeable that all of these committees have encountered considerable problems in moving from high-level principles to the practicalities of priority setting, and none of them has placed particular emphasis on the economic approach. One explanation for this neglect is that, despite public pronouncements to the contrary, making hard choices about priorities on the basis of explicit criteria—such as evidence of relative cost-effectiveness—is viewed as politically dangerous [40]. For this reason, less transparent approaches are often favoured. The tension between explicit and implicit approaches to priority setting is considered further in the final section.

Another source of pressure on health authorities depicted in Fig. 1 comes from professional and provider opinion. Any organisation—such as a health authority—which holds a budget for purchasing health services can expect to be the subject of some powerful lobbying from professionals and providers who wish to secure additional resources for their services [41]. Often the case made by these lobbyists is based upon a strong belief in the clinical effectiveness of their particular services, although the evidence is not always based upon rigorous research. Moreover, opportunity costs are seldom considered explicitly. As such, the priorities expressed by these vested interest groups are unlikely to correspond to those that could be expected to emerge from an economic evaluation.

As far as the particular contribution of the medical profession to the priority setting process is concerned, it is well known that doctors have long been the traditional rationers of care at the micro level [42]. However, although they have been used to working in an environment in which they have needed to match patient demands with the resources available to meet these demands, their underlying professional ethic is still one of responding to the needs of individual patients. This can lead to a deep unease with decisions involving inter-personal comparisons between patients and is a major reason why many doctors declare themselves unwilling to act as explicit rationers of care [43].

Of course, many doctors are involved in management roles where decisions are made relating to population levels of service rather than to the treatment of individual patients. There has also been the growth of evidence-based medicine, which seeks to bring about improvements in clinical practice through the use of guidelines and protocols based upon high-quality evidence established through rigorous trials. These types of development necessarily involve advice and decisions based on disease group or client populations, and would seem to require consideration of the same criteria to those included in economic evaluations. With some notable exceptions, however, most doctors involved in evidence-based medicine are still more concerned with clinical than cost effectiveness.

The third source of pressure on health authorities identified in Fig. 1 comes from public opinion. In market-based health care systems, users of services are able to behave in ways similar to consumers of other goods and services. If they are dissatisfied with their current provider, they can select another. This power of ‘exit’ is relied upon to encourage providers to respond to consumer preferences. In publicly funded systems, however, although there have been attempts to increase individual user choice in recent years, far more emphasis is usually placed on the expression of collective user ‘voice’.
Most of the individual country initiatives discussed so far have included a strong commitment to the involvement of the general public in decisions about priority setting. Various methods have been used for eliciting the public’s views including population surveys, public meetings, focus groups and, latterly, citizens’ juries [44–47].

Despite the enthusiasm shown by decision-makers for public involvement, the consequences can be problematic. Reflecting on the divergence of priorities between health professionals and the public in some surveys, an early sceptic of the merits of public involvement warned of the risk of establishing a dictatorship of the uninformed [48]. According to this view, public participation is inherently inegalitarian and carries the danger of attaching a low priority to the needs of people with mental illness, a mental handicap, elderly people and those who are poor and inarticulate. Writing from a Canadian perspective, Lomas argues that the limited interest and skills of the general public in relation to specific health services means that their inputs should be restricted to advice on broad service categories, and that they should not be able to actually determine priorities [49]. Recognising the problems arising from the public’s limited expertise in complex, technical areas, other researchers have pointed out that representative democracy is the traditional method for dealing with such problems and argue that direct public participation in priority setting decisions represents a break with this tradition [50]. Set against these views, advocates of mechanisms such as citizens’ juries regard public participation as a valuable supplement to the democratic process [46].

Clearly views about the desirability of public participation in decisions about priority setting vary. From the economist’s perspective, however, the significance of public participation derives from the fact that members of the public appear to rank other criteria above that of allocative efficiency. Some recent research which sought to identify the underlying principles drawn on by the public in making decisions regarding priorities concluded that two key principles dominated; namely, the distribution of health care according to the immediate capacity to benefit (i.e. the ‘rule of rescue’ [51]) and equality of lifetime opportunity for health [52]. As the authors of this study point out, these principles conflict with the prevailing view among health economists that allocative efficiency should be pursued with the aim of maximising aggregate health.

5. Discussion

In recent years, there have been many calls for priority setting in health care to be based on rational and explicit criteria. Economists using methods of economic evaluation have an approach that seems to satisfy these requirements. Although this paper has argued that the current theory and practice of economic evaluation in health care displays a number of shortcomings which limit its direct application at the present time, the pace at which research is proceeding in this area suggests that improvements in methods and in the quality of empirical information can be expected to address many of these shortcomings. On the other hand, a more serious
impediment to the utilisation of the economic approach is likely to result from pressures in the wider priority setting environment which are less conducive to a rational, explicit approach based upon economic principles.

The preceding discussion has already shown how politicians, professionals and the public usually place less emphasis on the objective of allocative efficiency than is placed on it by economists. This is bound to place limitations on the acceptability of the economist’s approach. At the same time, there are other, more general, considerations that pose problems for the rational, explicit approach, of which the economist’s approach is one part. Of particular importance in this context is the concept of political acceptability or feasibility.

Any examination of priority setting at the macro and/or meso levels, where some system of public accountability applies, will reveal decision-makers’ concerns with the political feasibility or acceptability of a proposed course of action. If explicit decisions on priority setting, albeit based on strong economic evidence, are felt to be political unacceptable they are unlikely to be implemented.

But what exactly is meant by political acceptability? In this context it often means that the proposed course of action is sufficiently unpopular and widespread among those who are expected to suffer from the decision (and among their supporters) that their resultant political actions (e.g. lobbying, press campaigns, protest meetings, demonstrations) are likely to cause considerable social unrest. In the limit, this may lead to the decision-makers losing office. Mechanic [53] alludes to these costs associated with explicit rationing when he claims that implicit rationing is “more conducive to stable social relations and a lower level of conflict” (p. 1658). Coast [54] offers an economic formulation when she expresses the costs of explicit rationing in terms of the ‘deprivation disutility’ imposed on those who are denied services. Looked at in these terms, the decision-makers’ concern to take into account political feasibility takes on a wider guise of rationality. After all, if the costs of managing the protests arising from explicit rationing are sufficiently large to jeopardise other service objectives—or lead to a loss of office—it may be rational to adopt policies that avoid them. This is the case that leads Hunter [40] to recommend an approach to rationing based on implicit decision-making and “muddling through elegantly”.

A strategy of muddling through elegantly holds little attraction for most economists who believe that it results in inefficiency and inequity [55]. However, getting policy-makers to place more emphasis on the economic approach will involve devoting greater attention to the real-world context in which priority setting decisions actually take place than economists have generally been willing to devote to it to date.

Many economists may complain that this is not their area of expertise and claim that it takes them outside the realm of economics into political science and related disciplines. Certainly multi-disciplinary approaches have not been held in particularly high regard by the mainstream economics profession. But this case has a somewhat hollow ring when voiced by health economists. Through its preoccupation with economic evaluation, health economics (outside the USA) is a sub-discipline that has already sacrificed much of the mainstream economics syllabus in
favour of a closer involvement with medical researchers and psychologists. Research on the process of priority setting in health would simply mean a rather different set of multi-disciplinary alliances. In any case, there are flourishing literatures in, for example, public sector economics and the economics of organisations, that would permit an economic approach to be drawn upon in the analysis of public sector decision-making. A more general focus on the incentives and constraints governing the use of economic data in different types of health care organisation would be a valuable supplement to the existing, narrow preoccupation with economic evaluation.

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