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3 **Decisions of Value: Going Backstage**

4 Comment on “Contextual Factors Influencing Cost and Quality Decisions in Health and Care:  
5 A Structured Evidence Review and Narrative Synthesis”

6 Michael Calnan

7 **Abstract**

8 This commentary expands on two of the key themes briefly raised in the paper involving  
9 analysis of the evidence about key contextual influences on decisions of value. The first theme  
10 focuses on the need to explore in more detail what is called backstage decision-making looking  
11 at how actual decisions are made drawing on evidence from ethnographies about decision-  
12 making. These studies point to less of an emphasis on instrumental and calculative forms of  
13 decision-making with more of an emphasis on more pragmatic rationality. The second related  
14 theme picks up on the issue of sources of information as a contextual influence particularly  
15 highlighting the salience of uncertainty or information deficits. It is argued that there are a  
16 range of different types of uncertainties, not only associated with information deficits, which  
17 are found particularly in allocative types of decisions of value. This means that the decision-  
18 making process although attempting to be linear and rational, tends to be characterised by a  
19 form of navigation where the decision-makers navigate their way through the uncertainties  
20 inherent and overtly manifested in the decision-making process

21 **Keywords:** Context, Uncertainty, Allocative decisions

22 The importance of understanding the contextual influences on decision-making about cost and  
23 quality related questions in the organisation and provision of health care is well recognised<sup>1</sup>.  
24 However, this paper<sup>2</sup> goes one stage further by carrying out a structured evidence review and  
25 narrative synthesis trying to identify the evidence from the international available literature  
26 about the key contextual influences. A distinction is made between allocative and technical  
27 types of decisions of value with the bulk of evidence being found in relation to the former  
28 rather than the latter type of decision making. The analysis, drawing on the framework provided  
29 by Pettigrew<sup>3</sup>, identifies a number of inner and outer contextual influences on what the authors  
30 call ‘decisions of value’. In terms of the contextual influences these are categorised in terms

1 of sources of information; interests; organisational characteristics, governance and leadership,  
2 geography, economics and relationship to government. The focus is at the meso level, as  
3 opposed to the micro-and macro levels, and on more formal aspects of decision-making.

4 The paper provides a useful presentation of the state of the evidence about contextual  
5 influences but tends to pay limited attention to what might be called backstage<sup>4</sup> as opposed to  
6 front stage decision-making. This is alluded to in the paper but it is central to understanding  
7 how decisions get made. For example, in the area of priority setting these decision- making  
8 processes have been described, at least some time ago , as ‘muddling through elegantly’ where  
9 there is more evidence of negotiation rather than rationality or instrumentality in decision-  
10 making<sup>5</sup> This type of decision-making process is messy and non-linear, and in spite of apparent  
11 significant changes in the quality of evidence available and the sophistication of techniques  
12 used to analyse these data, has still been found at different levels of decision-making in the  
13 public funded national health service in England. For example, research focusing at the national  
14 level involving the ‘fourth’ stage of medicine regulation and which has explored decision-  
15 making by NICE about the appraisal of expensive medicines has identified the difference  
16 between front stage and backstage decision-making. The discourse associated with front stage  
17 decision-making emphasises the dominant influence of the technical criteria of cost-  
18 effectiveness although in some cases social values tended to receive some explicit recognition  
19 in the decision making such as in the treatment for younger children. The attempt to explicitly  
20 incorporate social and ethical values was shaped by an approach described as ‘accountability  
21 for reasonableness’ which emphasised the conditions of transparency, relevance and  
22 revisability<sup>6</sup>. Evidence about the implementation of policies in some countries based on this’  
23 accountability for reasonableness’ approach is available<sup>7</sup>. However, this evidence tends to  
24 focus on decision-making at the formal level and the research evidence from ethnographic  
25 studies involving interviews, documentary analysis and observation points suggests that while  
26 the discourse particularly on cost-effectiveness did generally frame the approach taken a less  
27 than rational or calculative approach in the backstage decision-making was prevalent.. This  
28 research identifies the implicit social influences about how decisions are made and suggest that  
29 the decision-making process is characterised by a form of navigation,(rather than ‘muddling  
30 through’) where the decision-makers navigate their way through the uncertainties inherent in  
31 what is formally described as evidence-based decision making process.<sup>8</sup> The paper suggests  
32 that ‘*cost effectiveness analysis which has been applied with some success to allocative*  
33 *decision-making at a macro level.*<sup>2</sup>.p11’. The evidence from ethnographic studies<sup>9</sup> suggest that

1 this account may only present a partial picture of the nature of the decision-making process and  
2 what shapes it.

3 Similarly at the more local level decisions about the commissioning might also be  
4 characterised as practical rationality and involve intuition and experiential knowledge <sup>9</sup>and a  
5 ‘case and judgement based’ approach.<sup>10</sup> In both these national and local level contexts the use  
6 of practical rationality is evident but appeared to complement the dominant instrumental  
7 discourse, although in the local context emphasis in the discussion on ethical issues in relation  
8 to the allocation of resources was not only more overt but related more directly to individual  
9 circumstances.

10 A related issue is the question of sources of information which is identified as one of the key  
11 contextual elements. The paper identifies the importance of the absence of information ‘high  
12 levels of uncertainty in the face of information deficits have been shown to reduce adherence  
13 to an instrumental decision-making model and to open up determinations to greater levels of  
14 judgement and intuition’<sup>9,2</sup>. Thus, there is recognition of the salience of uncertainty in the  
15 context of these decision-making and the implications for rational decision-making. However,  
16 studies have shown that in allocative decision-making there are different types of uncertainties  
17 not only associated with information deficits and these will need to be recognised and be  
18 managed if a decision is to be made. Three different types of uncertainty have been identified  
19 which are interrelated in the decision-making process<sup>11</sup> which were epistemic (referring to the  
20 ability of biomedical methods used by the pharmaceutical industry to produce knowledge about  
21 treatments), procedural (particularly relating to the sheer volume of evidence considered), and  
22 interpersonal which (refers to the competency and motives of those providing evidence such  
23 as the representatives from the pharmaceutical industry and clinical experts). There was also  
24 uncertainty and ambiguity associated with the level of technicality and complexity of the  
25 information provided<sup>8</sup>. Agencies such as NICE recognise, attempt to address and try to resolve  
26 some of these epistemological uncertainties particularly through quantitative techniques<sup>12</sup>.  
27 However, the evidence<sup>8</sup> also suggested that navigation of these layers of uncertainty was  
28 (partially) managed through practical rationality and various forms of trust at different levels.  
29 Trust was one of a number of means used to bridge uncertainty. Both individual decision as  
30 rules of thumb and collective strategies were evident in the management of uncertainty in the  
31 decision-making process. Thus, though seemingly an objective techno-scientific evaluation,  
32 social forces necessarily emerge in the development and subsequent management of  
33 uncertainty <sup>8</sup>.

1 There is some disagreement over how these uncertainties should be tackled although there is  
2 consensus that they should be recognised and acknowledged rather than ignored and being  
3 bracketed off. However, while one approach tends to want to minimise them as they are seen  
4 as a problem <sup>13</sup>whereas the other see uncertainty more positively as a way of making rationing  
5 decisions more transparent, accountable and democratic<sup>14</sup>.

6 The review paper<sup>2</sup> identifies the significance of external and internal interests but says little  
7 about the key role of commercial interests in influencing decision-making even though some  
8 appear to have been identified in the papers reviewed. It might be argued that the profit motive  
9 which might be the primary driver of these commercial interest groups which could be at odds  
10 with the public interest and the professional values of those providing the health care. This  
11 would include the influence of corporate private companies who finance and provide health  
12 care and of the multi-national pharmaceutical industry. For example, the study<sup>8</sup> previously  
13 described also illustrated the potential risks of regulatory capture<sup>15,16</sup> of NICE in England by  
14 the pharmaceutical industry although there are both formal and informal mechanisms to  
15 attempt to manage and resist their influence. In this case the pharmaceutical industry might be  
16 characterised as both an external and internal contextual influence given that it contributes to  
17 the process by providing and controlling access to evidence about cost effectiveness but is not  
18 directly involved in the decision making.

19 More generally, the organising framework developed by Pettigrew<sup>3</sup> based on an organisation  
20 outside of health system in the industrial sector is used to analyse the difference between  
21 external and internal contextual influences. It must be emphasised that this framework relates  
22 primarily to health systems in high income countries and tends to focus on, although not  
23 explicitly stated, organisational and political influences rather than cultural context<sup>17,18</sup>. This is  
24 a useful descriptive schema for categorising and classification but as the authors suggest it is a  
25 framework mainly used for analysing change processes rather than explaining the relative  
26 importance of different layers of contextual influence. Certainly, it is difficult to assess the  
27 explanatory power of the framework given that it was not specifically designed for this  
28 particular purpose. One area that needs to be discussed in more depth is the dynamic nature of  
29 the decision-making process and the interrelationship between the different layers of the  
30 influence. These may be at the macro, meso and micro levels and the question is which are the  
31 most powerful contextual influences? Alternative theoretical approaches such as the structural  
32 interest approach of Alford <sup>19</sup> might shed more light on this. The paper proposes<sup>2</sup> that the  
33 evidence suggests that internal influences appear to be more powerful although much depends

1 upon the latitude available to local actors in their decision making. Local managers and  
2 clinicians, at least in the NHS in England, tend to have some degree of relative autonomy and  
3 discretion but it has been suggested that the interplay between corporate monopolisers and  
4 professional rationalisers<sup>19,20</sup> might shape the decision-making process in many health care  
5 organisational settings which in turn could limit in particular the influence of bottom-up  
6 pressures.

7 The influence of bottom up pressures is raised in the paper<sup>2</sup> through discussion of the role of the  
8 patients in decision-making and the importance of hearing the patient voice. This should certainly  
9 help democratise health services and mitigate against the dominance of managerial and professional  
10 interests as well enhance patient centred care and the coproduction of knowledge<sup>14</sup> However, it has  
11 proved difficult sometimes to square specific patients interests with more general decisions about  
12 the allocation of resources and disinvestment decisions ie what benefits the specific patient group  
13 may not be beneficial for the population as a whole.<sup>21,22</sup>

14 Finally, from a methodological point of view the studies discussed here have tended to adopt  
15 ethnographic designs although those reviewed in the paper seem to be short on the use of this type  
16 of methodology involving observation to directly understand how and why decisions are made in  
17 everyday contexts. The lack of such studies creates considerable limitations for gaining insights into  
18 understanding the nature of decision-making and its evidence base.

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