‘The more people we keep alive, the more it will cost the service’

Developing a discursive approach to the British health economics phenomenon

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Introduction

Health in the United Kingdom (UK) and elsewhere has improved in recent decades but these innovations are costly, especially in a publicly-funded health care system such as the UK. The National Health Service (NHS) has a total spending in England nearing £124 billion in 2017/18 (Full Fact 2017). Therefore, the economic, manpower and wider societal importance of the NHS cannot be underestimated, as famously observed by Norman Lamont in the 1980s when he likened the NHS to the closest thing that the English have to a national religion.

The way we think about health care and how health policy is formulated and delivered have however drastically changed since the creation of the NHS in 1948. Which treatments are made available and to whom has become influenced and even dominated by economics concepts and methods. To the point where the editor-in-chief of the leading British and international medical journal *The Lancet*, Richard Horton, wrote an editorial in 2017 where he declared:

> *“Economists are the gods of global health. It’s time for a radical dose of apostasy. […] The task of health professionals is to resist and oppose the egregious economics of our times” (The Lancet, 8th July 2017, Vol. 390, p. 110)*

Regularly, a new NICE (National Institute for Health and Care Excellence) guideline, the independent body tasked with overseeing whether treatments are clinically and cost-effective, makes headlines, newspapers arguing that the new decision will mean patients will die, such as when “a ‘game changing’ drug which was denied to restaurant critic AA Gill on the NHS […], Nice issu[ing] draft guidance which said nivolumab was not cost-effective for all patients with [particular lung cancer]” (The Telegraph 2017). This and other examples highlight how far health economics has come to dominate how health care is planned – e.g. resource allocation formula –, delivered – e.g. purchaser-provider split, competition, GP fundholding –, evaluated – e.g. quality-adjusted life-years (QALY) measurement – and even thought of.

The puzzle revolves around why and how a discipline that was inexistent in the 1960s has come to play such an important – even hegemonic – role in health policy-making. Understanding this is central to bringing a critical gaze to current debates in health care. Yet, very little critical research has been conducted over the origins and politics of health economics, most of it being led by economists themselves.

I believe that discourse can yield interesting insights into understanding this development, emphasising issues of conflict, mess and power, and moving beyond often-made claims that economics is a rational and objective science. Thus, drawing on discourse theory as conceptualised by poststructuralists, a logics approach, and data gathered from a 2.5-year project examining archives and 44 semi-structured interviews with civil servants and academic health economists, this paper explores this puzzle by constructing a genealogy of the phenomenon of health economics in the UK and problematising its mobilisation in the health policy sphere.

The paper is structured as follows. First, I review the literature on the emergence and influence of health economics and I outline the analytical framework for this research. Third, the emergence and rise of economics in health policy is analysed based on three problematisations focusing on (1) the origins of economics in health policy; (2) how and why it became mobilised by successive governments; and (3) how they dealt with competing discourses, especially medical ones. I conclude on contributions and future research avenues.

A lack of critical research and the space for a discursive approach

The historiography of British health economics suffers from two main issues: its limited size and its anthropophagic nature. Sixty-nine sources were collected over nine databases using the search terms 'history' AND 'health economics' and 'emergence' AND 'health economics'. Some only dealt sporadically with the history of health economics (e.g. Smee 2000 on UK health *system* rather than economics; Lee 1961 on medical economics; Louviere & Lancsar 2009 on the history of a particular health economics methods; Wagstaff & Culyer 2012 on bibliometrics of health economics; Wiktorowicz 2003 looking at the emergence of pharmaceutical industry regulation). Others looked at health economics from an exclusively foreign perspective. Among the remaining sources retained for in-depth review, only four are written by non-health economists (Kernick 2002; Klein 1989; Klein 1999; Stanton 1999).

Although there are scholars analysing the symbolic value of expertise such as economics can be helpful in a contested policy area such as health care (Markoff & Montecinos 1993) and the growing 'depoliticisation' of policy matters via economics' supposed objectivity and value neutrality: e.g. cost-benefit analyses (Self 1975), there is a dearth of research on the question

of the emergence and influence of economics on health policy, on the politics of this phenomenon. I seek to address this issue by calling on an approach which would allow me to critically analyse how and why this body of knowledge was able to gain such prominence, how it gained support within government and elsewhere, and how it dealt with opposition and competition from other types of expertise such as medicine.

Discourse theory

In this paper, I mobilise discourse theory in its Laclauian shape (Howarth 2013; Laclau & Mouffe 2001). Discourse presents three advantages here. First, it allows to unpick the origins of a given phenomenon, especially one that is as normalised and part of everyday practices as economics is in British health policy and the NHS today. Second, discourse is also helpful for examining the alliances built and conflicts fought over the years by given sets of ideas, norms and beliefs – or discourses – in gaining prominence. For instance, it allows asking how a given discourse dealt with resistance, how it brings in and excludes various grievances, or how it builds alliances and forges consent, notably examining how it appeals to disparate ideas and interests. Finally, discourse allows the researcher to interpret a given phenomenon, mobilising rich qualitative data alongside various theoretical concepts – which I will come to next – and tools from rhetorical political analysis to make sense of a complex puzzle by focusing on specific occurrences (Finlayson 2007).

Some sources in the literature also adopt a discourse-inspired approach in analysing various problematics related to health economics. Only 35 such sources were found with the search terms ‘discourse’ and ‘health economics’ across three databases. For space matters, I here concentrate on three. McCloskey (1983) looks at the rhetoric of health economics, discussing its scientism, such as its focus on prediction, falsifiability, objectivity, emphasis on numbers, causal laws and the lack of emphasis on values. McCloskey also argues that everywhere in economics “one is met with premises that are un-argued, tricks of style masquerading as reason […], forms of evidence that ignore the concerns of the audience, and other symptoms of a lack of self-consciousness in rhetoric” (1983, pp.493–494). This research also reviews the metaphors perpetuated by economics in health, such as the demand and supply curves of markets, comparing them to non-economic matters such as elasticity, equilibrium and competition, which are powerful and echoed across government and other documents, persuading readers of their truthfulness. Nevertheless, its focus remains on the rhetorical rather than wider discursive aspect of this discipline and issues such as how and why it gained prominence in the policy sphere are not discussed. Franken and colleagues (2016) also look at health economics from the rhetorical angle, comparing and evaluating whether the discipline actually impacts funding decisions in four countries, here rhetoric is limited to hiding the truth. They argue that although the discourse of health economics appears hegemonic, “health economics evaluation, however, seems to have had limited impact on

restricting access and/or explicit denial of controversial drugs", as in the case of the creation of the Cancer Drugs Fund in England (2016, p.954). Although these studies are useful in beginning to examine health economics discursively, I draw on additional literatures. Building on Foucault's theory of the all pervasiveness of power, Rose and Miller examine how in health Government increasingly instrumentalises and mobilises "techniques and agents other than those of the State in order to govern 'at a distance'", notably at the local or 'street-level', for instance via methods such as expertise, technology, persuasion, management, education and so forth, so that State power appears absent or invisible (Rose & Miller 1992, p.181). They refer to economics but without much detail.

My understanding of discourse builds on Laclauian poststructuralist discourse theory (PDT) which contends that reality – including society and politics – is the result of discourse; beliefs, identities, objects and rules all being subject to discourse, or the articulation of meaning into chains of equivalences (Laclau & Mouffe 1985, p.105). Another crux of PDT is that reality and thus meaning are never fixed and thus alternatives and contestation are always possible, even though discourses always have hegemonic intent – seeking to determine and sediment meaning – and thus will aim to emphasise how norms are sedimented, identities fixed and beliefs taken-for-granted and thus unquestionable. In the case of health policy, the meaning of health or care or how to deal with end of life will always be in flux, being contested by this or that discourse articulating a new solution (or even a new problem) within a given policy sphere. PDT deals with power by reworking the Gramscian concept of *hegemony*, where discourses will seek to gather consent and control meaning by articulating meaning in novel ways, offering alternatives or covering over these possibilities. Demand is another important PDT concept. Demands begin as grievances, such as those requesting greater resources for primary care, more independence for hospitals or new cancer treatments (Laclau 2006). If these diverse grievances become articulated together, they become demands in a discourse or project where they are united against a common enemy, such as the 'wasteful doctor' or 'heartless government denying drugs to terminal patients'. This opposition or drawing of a frontier illustrates the logic of equivalence. Conversely, the linking of these various demands together as synonymous or united against another illustrates the logic of difference. Finally, PDT addresses the question of emotions and how political projects appeal to people by positing that individuals are inherently lacking and thus seeking an (impossible) fullness by identifying with disparate subject positions offered by discourses. To appeal to individuals, discourses mobilise individual fears – e.g. of growing waiting lists, ward closures and the end of the NHS – and desires – e.g. for a health service providing the latest and best care available for all patients – into what Griggs and Howarth (2013) term 'fantasmatic narratives' which manage to grip contradictory demands around a given empty signifier – a demand seeking to represent everything and thus appeal to all (Laclau 1996).

Logics of critical explanation

To characterise these changing discursive articulations, I mobilise logics of critical explanation (LCE), a set of methods formulated by poststructuralists to apply what remains a complex theory of discourse (Glynos & Howarth 2007). LCE are well-suited to critically analysing messy and complex phenomena, such as health policy-making and how ideas influence a given policy sphere. This five-step approach allows problematising the ignoble origins of a given phenomenon – e.g. why and how did economics gain influence in health policy? What were the conflicts occasioned by its articulation? How did government seek to gather consent over its chosen economics-informed health reforms? (first step). The second step mobilises retroduction, the researcher generating hypotheses to understand said problem. The third step revolves around characterising three types of logics which are indispensable in helping us to explain, criticise and evaluate health policy-making. Social logics question the rules, norms and values in a given policy arena. Political logics seek to characterise which demands are included or excluded and how this is done, such as via equivalential and differential logics of 'us versus them' and alliance-building. Fantasmatic logics identify how a discourse appeals to individuals, examining the fears and hopes it articulates. The fourth step revolves around articulation, a crucial tool in reviewing the problematised phenomenon, theory and empirical data being considered *in situ* by the researcher to develop new understandings. Finally, the fifth step aims at a situated critique by emphasising conflicts and excluded possibilities.

Data

This paper builds on a variety of data collected over the last two and half years for a research project examining the history of health policy-making in the UK since 1948. Over that time, I gathered data from a number of sources. Firstly, I took photographs of archives such as Department of Health and other files at the National Archives (142 files; 10,380 pictures), DH's own archives of not yet released files (50 files, 10,454 pictures) as well as archives from universities with established health economics centres such as York, Aberdeen and Birmingham; and the British Medical Association, a key medical trade union-type body. Secondly, I conducted 44 semi-structured interviews with civil servants, academics and other professionals such as doctors who played important roles in British health policy-making since its inception. Generic questions focused on what they thought were the factors influencing health policy-making, whether economics had/has an influence, or what were the key changes. Thirdly, I organised with my team colleagues witness seminars on the origins and influence of health economics and on the formulation and implementation of the NHS internal market in 1989-1991. These events brought together key politicians, civil servants, professionals and academics into discussing these events together over a few hours; these events were fully recorded, transcribed and edited for publication. Finally, fourthly, I collected secondary data from specialised literature within health economics, health services research, policy studies and newspapers in order to paint a broader picture of the changes to British health policy and the NHS over the period.

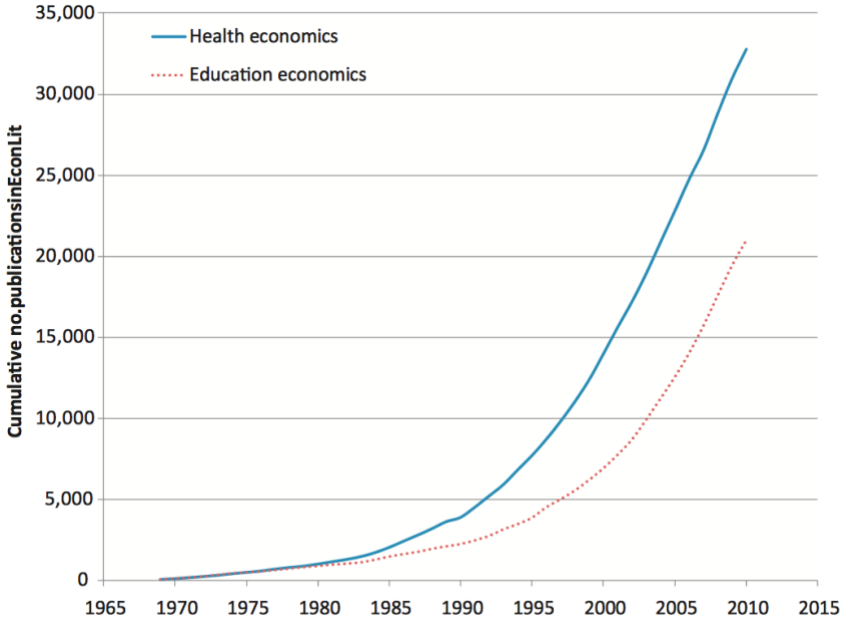
These data were coded within the qualitative data analysis software NVivo 11, building broad themes such as how economics emerged in health or key events, and later specific nodes such as regarding the relationship between NICE and health economics or the level of access of economists to policy-makers. Following a logics approach, this qualitative and critical focus allowed me to constantly rework and question my emerging understandings of the question of the role and influence of economics in health, prodding how disparate demands became linked or excluded within various discourses (step 2 of LCE) as well as permitting to emphasise the political and fantasmatic logics articulated by various projects in gaining consent (step 3 of LCE). I was able to problematise how and why economics gained such prominence thanks to the long-term scope and varying scale of the data I collected (step 1), examining how economics had 'infiltrated' these spheres and how this was communicated to form a consensus around cost and efficiency via rhetorical tools (Finlayson 2007). I was also able to articulate a situated critique of the process of health policy-making by emphasising how alternatives and certain voices had been excluded (step 5). Finally, it is important to stress that a discursive approach combined with logics places the researcher and her judgement at the centre of the analytical process, requiring constant retroduction and critique to make sense of data alongside theory and to develop the best possible explanation for a complex puzzle.

Problematisation 1: Problematising the origins of economics in health policy

To start examining the changes to the health service and how economics gained influence, I formulate a first problematisation which looks at unearthing the 'ignoble origins' of this body of ideas and its changing articulations by different discourses over the years (Problematisation 1) (Howarth 2010).

The 1970s is usually considered to be the "take-off" decade for health economics, the number of economists working in health growing and the interest in such questions increasing in public debates and academia (Blaug 1998, p.S63; Cooper & Culyer 1973; Forget 2004; Stanton 1999). The association bringing together health economists in the UK, the Health Economists' Study Group (HESG), was created in 1972 with just 12 attendees when it now counts 450 members. From the first health economics academic centre created in the UK – Aberdeen's Health Economics Research Unit (HERU) in 1977 – over 14 centres provided taught postgraduate health economics programmes in 2017. The figure below (Figure 1) highlights the growth in the health economics literature, from non-existent until the late 1960s to over 33,000 references in 2010. Within government itself, from no economist working in the Department of Health in 1968, there are now over 50 working on health and social care issues, with over 1000 economists working across Whitehall on any policy area (DH email exchange,

19 June 2017). In addition, an unknown but growing number of health economists are working in the private sector, mainly for pharmaceutical companies aiming to gain a positive decision from NICE and in consultancies (based on various interviews with health economists in academia).



Note: Health and education publications in EconLit are identified using the health and education JEL codes.

Figure 1: Cumulative number of publications in economics literature in health economics and education economics (Wagstaff & Culyer 2012)

As a means of sampling interest for this matter in newspapers, a search of one UK broadsheet's archives, *The Guardian*, demonstrates how, out of 1372 articles mentioning health economics, 219 were published during the 1980s (when the QALY was being formulated) and 613 in the 1990s (when the internal market was being formulated) illustrating the growing public attention towards these ideas.

The question of *why* health economics emerged is contested within the discipline itself. For Croxson, "the economic analysis of health care was an idea whose time had come, evident in an increasing supply of and demand for the services of economists working in the area" (1998, p.S11). In contrast, for Williams, there were 'pushes' such as the 1967 British Medical Association (BMA) report on the financing of the NHS playing a key role (1998, p.S6). Croxson also emphasises how health economics was allowed to emerge thanks to the financial support of the Government, NHS and non-governmental organisations such as the Nuffield Trust, highlighting the growing role of government (1998: S38).

But how did we reach this state of influence? A recurring issue at the heart of health policy in the UK has been that of the cost of health which economists progressively succeeded in problematising with key economics ideas of cost-effectiveness, opportunity costs and markets. When searching the National Archives' catalogue at Kew for "cost" and "health", 600 results were found for the period 1910-1970, more than half of these concentrating around the 1953-1970 period, immediately following the creation of the Guillebaud Committee (see below). 311 results were found for the period 1970-1987, illustrating the continuing interest in the cost of health question. World War II appears to have played an important role in emphasising this issue, with for instance a British war poster entitled "How much does a cold cost" being published on 25 November 1943 (Nottingham University Library Archives) or "Liability for treatment and cost of maintenance of immigrant Irish workers in institutions for tuberculosis cases" (TNA/MH55/1151).

Already when the NHS was inaugurated, debates in the House of Commons illustrate the fears and hopes articulated around this new public service and the burgeoning problematisation of the NHS as one of cost and how to reign it in. In 1948, the MP for London University, Sir Ernest Graham-Little, asked Aneurin Bevan, then Minister of Health:

> *"why the Estimate for the National Health Service is already increased by more than £100 million a year, as compared with the [1944] Estimate [and whether Bevan could provide] an estimate of what the service will cost when it is in full operation". (HC Deb 08 April 1948 vol 449 c23W)*

A few months later, the Labour MP for Clitheroe, Harry Randall, asked Bevan whether doctors would be "free to prescribe for their patients, without restriction, every kind of drug and appliance necessary for their treatment and will not have to work within the limits of averages of cost per insured person." To which Bevan answered, unequivocally, that "[a] doctor has a duty to prescribe under the National Health Service all drugs necessary for the proper treatment of the patient without any limit of cost whatever" (HC Deb 15 July 1948 vol 453 c130W). These snippets already illustrate the contradictory demands being articulated around the new service, from providing care to all to limiting its cost.

Several events during the 1950s illustrate how the NHS becomes problematised within a narrative of the cost of health around key demands of cost and of the strong catastrophic image of NHS costs spiralling out of control. A first sign is the creation of a Cost Investigation Unit in the Ministry of Health (MoH) to examine the cost of health services. In this file, a letter from the MoH to the Department of Health for Scotland explains how:

> *"the PAC have been rather critical of what they call a failure to exercise any sort of control over the cost of drugs, spectacles, etc.." (Letter, 20 August 1951, TNA/MH135/748)*

Interestingly, when examining the files of this era, accountants within the MoH and other departments dominated this area of advice and expertise, for instance AJF Danielli, Department Accountant General in the MoH, with no economist working in this department until 1968. In 1952, the MoH even asked the Board of Trade and the Ministry of Supplies to provide accountants (Letter from EM Firth to EJ Mares, 15 November 1952, TNA/MH135/748). Based on these files, it transpires that these accountants were directly liaising with the PAC on accounting issues such as "methods of comparing cost of materials" or how to separate earnings and activities in the NHS (Letter from Danielli to Miss Feibush, 28 January 1953, ibid.). Furthermore, during the second half of the 1950s, these PAC enquiries appear to play an important role in problematising health from a cost perspective (e.g. PAC investigation of remuneration of chemists, TNA/MH168/42; or hospital catering, TNA/MH96/2286), with the AGD1 division in MoH, which is the Finance and Accounting division, managing the control of public expenditure sub-committee on health services (TNA/MH55/2326). PAC enquiries become part of an almost ritualistic process via which the cost of health problem is identified and addressed, where accountants and later economists play a key role.

This narrative of cost and containment continues in early 1950s, the government created the Guillebaud Committee into the cost of the NHS in 1953 (Timmins 2001). Chaired by the Cambridge economist Claude Guillebaud, with an economically-trained researcher and future special adviser Brian Abel-Smith, the Committee evaluated whether the NHS was value for money, cataloguing vast amounts of data in a social accounting way. It concluded in 1956 that the early service was sustainable but would require additional funding – needless to say, this was not what the government expected from the report (TNA/MH137/225). Following this, a number of committees and other initiatives are set up by government departments – mainly the Board of Trade and the Ministry of Health – to press further for health to be problematised as a cost issue, for instance to evaluate how much a given treatment would be costed under the NHS e.g. the Dental Estimates Board approving estimates for dental work carried under the NHS (TNA/MH/Division 18) or the cost of spectacles (TNA/BT94/453). A Committee on the Cost of Prescribing (Hinchcliffe, 1957-1959) follows, as well as frequent PAC reports. It is during this decade too that regional medical officers are made responsible for investigating the cost of prescribing medicines by GPs which may be presented to local medical committees for debate (TNA/MH117). Following this first phase of cost becoming 'the problem' of health policy, the problematisation becomes extended to other areas of the service, notably capital schemes and how these are costed with reports entitled 'The cost of hospital buildings' (TNA/MH123/241) and 'Major capital works estimated to cost £100,000 or more' (TNA/MH137/27 in 1959-1960; and revenue allocation for different administrative levels and different areas e.g. TNA/MH170/67 and TNA/MH160/231.

Until 1968, the Ministry of Health (MoH)[1] remained ignorant of economics, with some notable exceptions such as Brian Abel-Smith providing economic advice in his special adviser function (Sheard 2013). From the late 1950s but especially the 1960s, a new group of analysts is created in the MoH: the Statistical Branch with statisticians and later operational researchers coming to provide new analytical means of collecting data on the NHS, especially cost-related. For instance, from 1959, the Statistical Branch is tasked with developing prescription cost analysis to deal with the Hinchcliffe report on prescribing (TNA/MH148/546; TNA/MH148/318). But from 1967, a political push developed within Government for a greater mobilisation of economics in health policy-making, leading eventually to the creation of the Economic Advisers' Office (EAO). A key report in the MoH discussing the role that economists could have for the Department, is the one delivered in October 1967. The MoH commissioned a Mrs O. Osmond, wife of Sir Paul Osmond, then Deputy Secretary in the Civil Service Department, to conduct a study on the appointment of economists in the MoH/DHSS, considering especially the use of economic techniques of cost/benefit analysis (CBA), cost effectiveness and output budgeting in the NHS (TNA, BN 155.4, *EAO – Economic Analysis*). This demonstrates a clear strategy at the heart of government of deploying economics techniques and staff across government. Osmond concluded that economists may be most useful in three fields:

> *"advising on the best use of resources available to the NHS, examining the advantages and disadvantages of particular projects from an economic point of view; and taking part in research either actively or in an advisory capacity" (p. 1)*

Within six months of this report and following the premiership of Wilson and the creation of a Treasury unit – The Government Economic Service (GES) – dedicated to hiring and dispatching economists across Departments and with support from Brian Abel-Smith among others on issues of CBA in hospitals (TNA, BN 155/4), the Economic Adviser's Office (EAO) was born in 1968 in the Department of Health and Social Services (DHSS). This unit began to advise DHSS administrators on economics of health matters, and progressively grew in influence, to the point where David Pole, the first Chief Economist in DHSS during the 1970s, recounted:

> *"In time, our tentacles penetrated practically the whole of the Department, to the extent that anything that looked analytically difficult tended to be labelled 'economics' and pushed in our direction." (email correspondence)*

This labelling or framing is especially interesting. The EAO not only hired economists and influenced policy within DHSS, but it also argued in favour of the funding by DHSS of a number of health economics research projects and units in universities, chief among these were the

[1] In Britain, the Department tasked with health issues changed name several times since the creation of the NHS in 1948. Until 1968, this Department was named the Ministry of Health (MoH), then becoming DHSS, and finally being divided into two new Departments in 1988 with the Department of Health (DH) and the Department for Work and Pensions.

Institute of Social and Economic Research (ISER) at York University, the funding of its Masters in health economics from 1978 and, in 1983, the creation of its Centre for Health Economics (CHE).

Although other analysts in the DHSS such as statisticians and operational researchers were already advising policy-makers in health issues (CHE archives, *Allocation of the balance of care working paper, February 1971*), some of these projects failed, notably the 'balance of care' project which, albeit supported by Keith Joseph, was not so valued by his successor David Owen who was a key ally for economists in the DHSS.

Problematisation 2: How and why was health economics mobilised in successive governments' health policies?

Now that the origins of the discipline and its historical influence on health policy has been discussed, I will focus on what appealed to policy-makers and other stakeholders in the health economics discourse; in other words, how these ideas 'gripped' these players, mobilising fears and hopes in powerful narratives to explain and offer solutions that appealed to disparate demands.

As discussed, the key narrative of health policy in Britain since 1948 has been one of the cost of health, appealing to the beatific possibilities of a cost-effective and efficient NHS that provides for all the best and latest treatments available, and mobilising horrific *scenarii* of wasted resources, over-prescriptions, ward closures and, possibly the worst threat, the end of the NHS. As mentioned *supra*, from the creation of the NHS in 1948, cost becomes the key grievance articulated by the Right against the NHS. Following the Guillebaud report (cf. *supra*), in the 1960s, Enoch Powell, then Minister of Health, made two speeches on the bottomless cost of the NHS (1961;1966) which continued to problematise the NHS as a cost issue, mobilising horrific visions of a service sucking resources out of other government spending areas. Pushing the cost narrative further, Powell argued that rationing was inevitable and "not made easier by the political convention that the existence of any rationing at all must be strenuously denied", adding a new demand of protecting patients and the need to limit "cascades of medicines pouring down British throats" (Powell 1966). During the same decade, even the Left starts problematising the NHS around cost, questioning the universality and equality principles of the NHS and its efficiency e.g. Houghton for on need for selectivity in 1967 (cited in Seldon 1968). Now, cost was becoming a commonplace in talking about health care, on the Left and the Right.

The 1960s marks the arrival of new and important players in this cost of health debate: the Treasury, Cabinet Office and the Prime Minister's Office, illustrating how this issue is not

limited to health but is now being framed as a government-wide problem along line of financial stability and fairness with other departments with titles such as 'Costing and cost consciousness in MoH' (TNA/T316/15), 'Cost of NHS: ten year forecast' (TNA/T227/1376) or 'Cost of NHS: discussions on suggested economies' (TNA/PREM/11/4952). Thus, the metaphor according to which health worked like any other part of the economy/government and required efficiency measures was becoming commonplace with the arrival of these actors. It is important to note here that economists, especially in the Treasury, had become embedded in advising on financial policy since WWII (Allan 2008). From the 1960s, the question of cost of the NHS becomes linked to demands for control, targets, charges and economies, with every aspect of the service becoming investigated through this lens: from dentures, laundry services, medical education, off-site facilities, private out-patient charges, comparative cost of psychiatric services, amenity beds, or blood transfusion.

The context seemed set perfectly for health economics to offer a convincing yet simple supply-demand narrative to politicians: health care is provided on the basis of limited resources (e.g. medicine, nurses/doctors, beds) but is faced with bottomless demand (e.g. people's expectations of health being portrayed as growing). Therefore, it is required to make choices and set rationally-determined and 'objective' frameworks for making decisions: calculating cost-benefits and evaluating performance of services. This formulation also followed a logic of depoliticisation of the NHS, whereby decisions about costs and resources were not to be discussed ideologically anymore but based on rational and objective bases such as economics. This seeming simplicity of economics and its mobilisation by policy-makers in depoliticising the 'hot potato' of health are important in explaining the grip of this body of ideas in health policy.

By the beginning of the 1980s, health economics had begun to carve its niche at the national level, in the EAO and academic centres. As Lee and Mills wrote in 1979, "health economics ha[d] all the signs of an emerging industry" with demand for it set to increase (1979, p.158). This was preceded by the growth of the language of economics with concepts such as cost-effectiveness, resource allocation or cost-benefit becoming topics of conversation in government from as early as the 1960s – e.g. 1960 Treasury report on cost-consciousness in the Ministry of Health (pre-DHSS), Plowden and Fulton Reports in 1961 and 1968 respectively, and even earlier, the Advisory Committee on Management Efficiency set up in 1959 to review NHS management practices. Following Rose and Miller (1992), the knowledge and expertise of health economics can be seen as supported by national politicians (e.g. Barbara Castle – Secretary of State for Health, 1974-76 – and later Ken Clarke – Secretary of State for Health, 1988-90) and senior civil servants (e.g. Douglas Black, DHSS Chief Scientist, 1974-77) not only to limit spending in the regions, but also to control the NHS 'at a distance', especially its use of resources. A number of techniques were being developed at the time by health economists or other individuals mobilising economic knowledge, and funded by DHSS, for instance the greater use of surveys and, from 1972, computers to collect data on demand and use, a key

first step for economics to be conceivable at the local level (Interview with Geoffrey Rivett, medical civil servant in DHSS during 1970s-1990s), clinical budgeting – whereby doctors were given greater control of resources within their speciality (Wickings et al. 1983) and QALYs (see next section).

By the 1980s, economists had an advantage over OR in that people on the street and administrators had an (albeit often minimal) understanding of what the discipline entailed:

> *[N]obody in the wider world had a clue what they [OR] did. Economics by then were beginning to be a word that you saw fairly frequently. People were beginning to see it in newspapers that anyone takes any notice of. (Clive Smee, former Chief Economic Adviser, DHSS then DH, Interview 2017)*

Thus it could be argued that economics was becoming taken-for-granted in society and politics, part of the new *lingua franca* (Markoff & Montecinos 1993), its ideas and concepts suggesting simplicity, objectivity and rationality (McCloskey 1983; Self 1975).

Problematisation 3: Dealing with resistance: The example of QALYs

The influence of the health economics discourse did not, of course, go unopposed and there are a number of events to review to illustrate these battles and how alliances were built by successive governments around the discourse of health economics. Here, I will concentrate on the formulation of the QALY during the 1980s, economics concept which assesses the combined impact of a medical intervention on mortality and morbidity in order to evaluate whether such a treatment is cost-effective.

QALYs

Since the creation of the NHS, there were growing expectations regarding access to and quality of health care (Smith 1987). One DHSS economist expressed part of this conundrum:

> *"[H]ealth services all around the world are absolutely confronted by a wave of new technology. […] And meanwhile, the health service is always, this is the elephant in the room, always short of money. So on the one hand, these new technologies are welcome because they offer benefits although sometimes very marginal benefits and on the other hand, they cost an arm and a leg. So what do you do?!" (Jeremy Hurst, Former Economic Adviser, Department of Health)*

The then-influential human capital theory was built on an understanding of elderly lives as less 'valuable', as they no longer contributed directly to the economy (Blaug 1998). A gap was hence emerging between societal values and NHS principles. This economist continued by saying that "[t]he initially unproven effectiveness and obviously high cost of innovations such as heart transplants were of much concern to the Department's civil servants" (Interview Jeremy Hurst). One handwritten DHSS note from 1970 remarked that "the more people we keep alive, the more it will cost the service" (TNA, BN13.197). There was a perception in the DHSS that rationing was inevitable, one academic economist explaining that:

> *"initially of course, a lot of the intellectual work was on economic evaluation and this rang bells with the DH because they saw it as a rationing device […]. The Department were interested in value for money." (Academic 3)*

Ministerial support was critical to securing the influence of economists in DHSS and making the QALY politically palatable. Barbara Castle (Secretary of State for Health and Social Services 1974-76), her junior Minister of Health David Owen (1974-76), and high-ranking civil servants, such as Douglas Black (Chief Scientist 1973-77), were enthusiastic about economics and what it could bring to health (Williams 2005). Their support was apparent to the economists themselves, both within DHSS and academia:

> *"I think the economists within the DH had a bit of a golden period. They obviously had the ear of particular ministers. Some ministers would be more interested in it than others. I think David Owen was one who was particularly interested but perhaps not the only one. I think it was about the power of the economists in DH" (Academic 2)*

Yet there were some within DHSS who were not immediate converts to the use of economics, especially within the medical civil service. An interviewee recalled an economist who had proposed ways of measuring health outcomes being "hauled up before the Chief Medical Officer" (interviews CS1; also reference in CS2).

Within two years of Williams' Coronary Artery Bypass Grafting paper in the BMJ where he formulated a league table of treatments for angina, and used QALYs to rank them, there was sufficient public awareness of the concept, and concern about its use, that academic health economists found themselves with an opportunity of using media appearances to articulate striking beatific and horrific narratives around the NHS and its cost. Newspaper headlines such as 'Who lives and who dies', "A game of chance" (*The Times*, 21 December 1987) and "Health care roulette" (*The Guardian*, 5 November 1986) (Ashmore et al. 1989, pp.70–71) were growing. Two key health economists from York, Alan Williams and Alan Maynard, were both invited to make radio, TV and media appearances. On 16 October 1986, Maynard appeared on Dimbleby's 'This Week' on ITV to discuss QALYs with a neonatal intensive care doctor. The same week, he took part in an ITV game show entitled 'The Life and Death Game', which used ideas of priority-setting and opportunity costs (Ashmore et al. 1989). In 'The Heart

of the Matter' on BBC One in October 1986, a fictional health authority was given £200,000 for its population, and had to decide whether "it would get 10 QALYs from dialysis of kidney patients, 266 QALYs from hip-replacement operations or 1197 QALYs from anti-smoking messages" (Harris 1987).

Any proposal to introduce further payments in the NHS or to change its financing would be politically risky, as Margaret Thatcher's cautious attitude towards the NHS from 1979 suggested. Policy-makers had to reflect on how decisions around treatments were made. Clinical autonomy in decision-making prevailed: a patient was given treatment without consideration of whether it would benefit them more than another patient, or whether giving them treatment would deprive other potential patients of other treatments ('opportunity cost' in economic parlance). Economists such as Williams began mobilising medical professionals as 'the enemies of the NHS' with their wastefulness and monopoly over patients:

> *"doctors' specialist skills lie in their ability to diagnose and to know the effects of various courses of action which might then be adopted; and in their ability to implement […] whichever course of action the patient selects. They have no legitimate claim to impose their judgments about the relative valuations of different courses of action upon their patients."* (Williams 1985, p.6)

The health economics discourse surrounding QALYs supported this opening-up of clinical management. As one government economist interviewed put it: "it is about exposing the consequences of the decisions and the inherent inconsistency that those decisions" can lead to (CS7). An academic economist involved in NHS decision-making noted how QALYs redrew the ideal of health care as QoL rather than survival at all cost:

> *"Alan [Williams] used to describe it so nicely: 'vertical and horizontal'. People left hospital alive or dead. Literally. The statistics were dead or discharged. And all the medical stuff was about survival and not QoL and so it was a huge step forward." (A1)*

One of the first health economists who was closely involved in introducing the QALY tool (through regional projects) noted in interview that it "was really uphill work" and that there was significant clinical "resistance to the idea of QALYs" (A10). Alliances between economists and specific medical professionals and health authorities to trial QALYs were vital in building consent around this idea and economics in health more generally.

Relationships between economists and medical professionals are illuminated through a review of *The Lancet* and the *BMJ* for the period 1984 to 1999. Some doctors appeared to be warming to the idea of a QoL type measurement to allocate resources in health, albeit still disputing QALYs *per se*. For instance, David Grimes, a doctor at Blackburn Infirmary

acknowledged in *The Lancet* in 1987 that inefficiencies resulted from rationing being "left to doctors" (Grimes 1987, p.615). He linked QALYs to a demand for transparency, arguing that it could help make decision-making more open by allowing "lay members of health authorities to decide how to spend their inadequate amounts of money in a way that gives the greatest benefit to society" (Grimes 1987, p.615.). The epidemiologist Alwyn Smith wrote a now-famous article for *The Lancet* under the title 'Qualms about QALYs' (Smith 1987, p.1135). Although he supported the health economists' supply-demand narrative that there were "more potentially beneficial health-care procedures than we have resources to carry out" and a lack of data to inform decision-making, he judged QALYs unfeasible because of the great philosophical and theoretical difficulties that would come from having to decide which patient to treat. But although the NHS was being increasingly problematised by these discussions as an issue of spending and use of resources rather than the original one of access to health care – a first step of a governmentality approach –, in the NHS world of RHAs and Health Boards, it was still doctors, and from the mid-1980s the managers, who dominated the field of expertise, with "their lines of force flowing, as it were, from the operating theatre to the Cabinet Office and not vice versa" (Rose & Miller 1992, p.188; Klein 1984).

Debates in Parliament at the time demonstrate how health care was being problematised with economics, notably via the demand and supply narrative and the question of who should access care. Ken Eastham, Labour MP for Trafford Park, made an emotional appeal:

> *"what kind of sacrifices they [i.e. elderly patients] are expected to make. It appears that some health authorities are posing questions about a system based on what is referred to as a quality adjusted life years formula. The Government are saying that they have less money for the Health Service. People who are getting on in years and reaching retirement age are asked about their possible life expectancy and the Government are asking whether they should be spending money on such people or saving it. That is creating horror in the minds of old people." (HC Deb 19 March 1986 vol 94 cc305-84)*

A year later, Frank Dobson, later the Secretary of State for Health who oversaw the inauguration of NICE and possibly the greatest victory of health economics, questioned the growing role of economics in this debate over the value of life:

> *"The measures of quality of life that have been canvassed in some quarters seem to carry with them the assumption that life after 65 does not have quite the importance of life before that age. That may be because health economists would like us to come into existence, fit and well, at 21 and to die suddenly on our 65th birthday without requiring medical treatment in between. That is the beau ideal human being for the health economist." (HC Deb 25 February 1987 vol 111 cc329-70)*

Fast forward two decades and a half and the idea of QALYs appears embedded into how the NHS makes decisions, e.g. in 2002, when asked how the QALY was being used by the NHS and the Department of Health, Yvette Cooper answered that:

> *"[QALYs] are commonly used in the national health service and elsewhere to compare different treatments which prolong life or improve the quality of life. The National Institute for Clinical Excellence uses QALY's as part of its range of tools to assess the clinical and cost effectiveness of treatments which it is appraising, prior to issuing its guidance to the NHS" (HC Deb 18 April 2002 vol 383 c1174W)*

This series of quotes from different periods in post-war health policy illustrates the considerable changes that have occurred in this field and how far health economics, an unknown and even inexistent discipline in the early 1960s, has gained influence.

Conclusion

Economics is a set of ideas that today dominate how health policy is understood and health 'problems' addressed, from allocating treatments, to building new hospitals and encouraging particular behaviours in GPs. It is therefore important to unpick how and why economics came to play such an important role. Although the economics literature attempts to analyse its own origins, I concluded that these sources lacked a critical gaze. Therefore, I articulated a discursive approach in order to understand how health economics developed in UK health policy and gained such influence since its emergence in the 1960s. Drawing on in-depth archival research combined with interviews and secondary sources, I have constructed a history of the development and implementation of health economics in health policy, problematising its murky origins in government, notably by characterising the key narrative around the cost of health; how and why it was mobilised by successive governments; and how it dealt with resistance and built alliances.

This research demonstrates how such a framework can provide further understanding over how particular ideas 'catch on', examining a number of practices at the micro, meso and macro-levels. By problematising the issue, I was able to analyse different facets of the health economics discourse, examining the different strategies that its proponents deployed. By characterising these various practices as social – e.g. equations within the QALYs, economic evaluations becoming part of health policy process –, political – e.g. dividing the arena between those in favour of saving lives and those wasting resources, as during the QALY debate – or fantasmatic logics – e.g. by gripping disparate demands around tantalising narratives of 'cost of health' and the looming demise of the NHS if things continue – allowed me to demonstrate the different dimensions and strategies deployed by governments, with the help of economists and others, in gaining consent for their reforms and exercising power.

Historical analysis can open up debates on alternatives to health economics, notably the role of medical expertise, other experts and patients. Whether the health economics discourse has exceeded its lifespan is an important question, as recently made obvious by the polemic over the creation of the Cancer Drugs Fund which allocated new cancer treatments without using NICE methods. By providing a political and historical analysis of how these ideas and methods emerged, we can also help to evaluate their future status. Comparative analysis of other health systems and whether these have experienced a similar discursive turn could gather further evidence and help draw up recommendations regarding how best to integrate various stakeholders in this process.

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