

TITLE: Incorporating Public Values and Technical Information into Health Care Resource Allocation.

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OBJECTIVES

1. To synthesize existing research on factors considered during health care resource allocation decision-making, and assess its utility (i.e., impact on policy). These factors include public values, health law and legislation, and health technology information.
2. To assess the current and potential influence of “public values” on local priority-setting in Alberta
3. To identify options for obtaining the information required in order to incorporate public values along with evidence into local resource allocation decisions

METHODS

1. A comprehensive, systematic literature review of published, peer and non-peer reviewed literature, as well as grey literature, was completed. To accomplish this, detailed search strategies were applied to 14 bibliographic sources. Additional citations were identified through manual searches, and relevant review articles.
2. To assess whether or not the literature reviewed influenced relevant policy, corresponding authors of published, peer-reviewed (i.e., not grey literature) papers on priority-setting processes and/or eliciting public values/opinions were sent surveys, via e-mail, fax, or post (depending on contact information provided in the papers). Three attempts to contact each author were made.
3. To examine current priority-setting processes within Alberta and determine the extent to which they involve the public, a demographically representative sample of Regional Health Authorities (RHAs) (8 out of 17) and all 3 provincial Boards/Committees were selected to participate in key informant interviews. Three members from each of these 11 bodies were interviewed: 7 CEOs, 1 Executive Vice-President, 7 Board Chairs, 1 Vice-Chair, and 8 Medical Directors from the RHAs, and 1 CEO, 3 Board Chairs and 5 committee members from the provincial Boards/Committees. The interview contained 7 open-ended questions addressing how priorities are set and opportunities, if any, for public involvement in the process. Interviews were audio-taped and transcribed. Their content was then verified by performing member checks with a sample of key informants. Through a series of iterations, transcripts were analyzed using content analysis.

RESULTS

1. Of 14 591 papers initially identified by the literature search, 117 were selected for full review and, subsequently, classified into one of three categories: actual (e.g., processes actually instituted), hypothetical (e.g., demonstration projects) and conceptual. Forty-nine papers described priority-setting at the health care system level (where choices must be made among competing services for different diseases and conditions). In general, they focused on approaches employed at the national or state level which resulted in the establishment of a list of principles or factors to be considered during priority-setting. However, those that outlined approaches employed at a regional level typically described techniques for generating an explicit, prioritized list of health care services (e.g., Programme Budgeting and Marginal Analysis) Sixty-eight papers presented methods for eliciting public values to inform resource allocation decision-making. These methods included: ranking of services or programs, rating of options using Likert-type scales, making explicit choices between options, individual interviews, a Delphi process, focus groups, citizens' juries and town hall meetings. Based upon the literature reviewed, no single "generic" approach has been identified as the gold standard. Further, selection of which approach to use required consideration a variety of population-specific factors.
2. Twenty-seven legal cases relating to resource allocation were reviewed. Most of them described challenges to the Charter of Rights and Freedoms, malpractice suits, or the restructuring of hospital services. Decisions were made either by the Supreme Court of Canada, provincial Courts of Appeal or Trial Courts. Key questions underlying such decisions included whether health care providers and health services are governed by or protected under the Charter, and were resolved by applying the Charter. With respect to malpractice suits, the evidence provided during trials appeared to be non-existent, or at best, sketchy and anecdotal. Nonetheless, Courts have commented on the importance of not sacrificing individual or group welfare for resource allocation reasons, although they have yet to explicitly discuss the repercussions of enforcing these entitlements on health care systems.
3. Authors of 27 of the 30 (90% response rate) published, peer-reviewed papers on priority-setting and authors of 58 of the 68 papers (85% response rate) on eliciting public values/opinion responded to the survey by completing and returning questionnaires. Both groups were deemed representative of the populations surveyed. For the priority-setting literature, 89% of the authors reported that they knew decision-makers who were aware of their papers. In contrast, for the literature on eliciting public values, this was indicated by only half (n= 29) of the authors. Nevertheless, authors' responses regarding the ways in which information was used by decision-makers were similar across literature types. They included: for developing or revising priority-setting

criteria/guidelines, to stimulate discussion about current priority-setting policies, as a guide for implementing a priority-setting framework, to support a current government policy/position, and to form the basis for a priority-setting “pilot” study. The two key reasons for using the information were: the paper had been done as a result of a request by decision-makers, and findings supported current government policies.

4. Key informant interviews with local decision-makers indicated that the most common approach used by RHAs to engage the public in priority-setting has been the creation of advisory groups (e.g., Community Health Councils). All 3 provincial Boards/Committees haven’t yet directly involved the public in their priority-setting decisions. Nevertheless, the majority of those interviewed from both RHAs and provincial committees viewed input from elected Board members as “public” input. Further, during actual priority-setting, two types of public values-based “evidence” were identified: information from formal needs assessments and the Board’s awareness of the public’s acceptability or support of a specific “need”. Within RHAs, priority-setting decisions were communicated directly to health care providers and indirectly to the public through the media. In contrast, provincial boards/committees were found to rely exclusively on the media. In general, key informants considered current processes to be fair, from a public health perspective, but agreed that better ways of involving the public, which prevent domination by “special interest” groups, need to be examined.

CONCLUSIONS AND RECOMMENDATIONS

Based upon the results, recommendations include:

1. A two-day decision-makers’ forum to share the results of this review and develop a consortium between decision-makers and researchers to identify and conduct demonstration projects,
2. Further research on a) economics-based approaches, b) techniques for collecting and analyzing data from priority-setting studies, c) and the willingness of individuals to participate in research that might involve trade-offs between population sub-groups,
3. Surveys to determine decision-makers’ views on existing research gaps and to establish the utility of commissioned reports during priority-setting, and
4. A more detailed, focused review of public involvement literature.