

Using the ethical framework of accountability for reasonableness to evaluate priority-setting decisions at the local level

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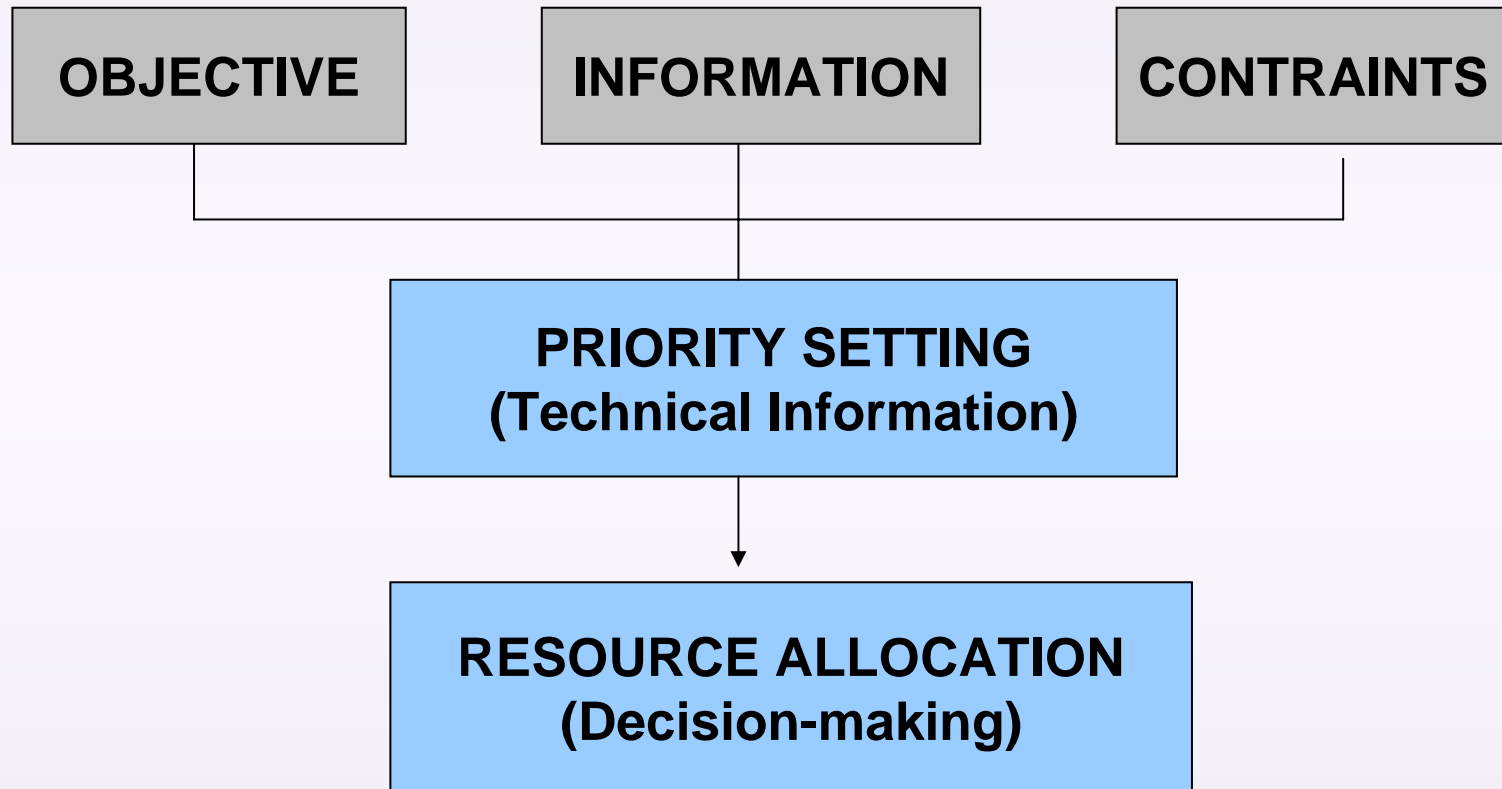
Why priority setting?

- Resources are scarce
- Choices need to be made:
 - What treatments should be produced?
 - How many treatments should be produced?
 - Who should get what treatments?
 - Many safe, effective health care interventions that could be funded
- Who should do what to whom with what health care resources and with what relation to other health services?
- Need information to make choices that will maximise benefits within our current resource restraint

Priority setting

- What is it that we want?
- Information to set priorities:
 - Maximise something (objective) subject to a constraint (budget/resource)
 - What is the objective?
 - What improves health?
 - What improves wellbeing?
 - What is the budget constraint?
 - What resources are available?
 - How do we maximise?
- Mechanisms that allow us to allocate resources in line with priorities

Priority setting & Resource allocation



At the area/hospital (local) level

- Resource allocation decisions can not be avoided
- Genuine budget constraints (capped budget)
- Inefficient resource allocation → impact
- Need to strengthen institutional process in which decisions are taken



Resource allocation

- “Due process” for decision making
- Fairness – key ethical goal of priority setting
- Fair process (i.e.. procedural fairness)
- Establish the legitimacy of priority setting decisions
- “Accountability for reasonableness”

Accountability for reasonableness

- Ethical framework developed by Daniels and Sabin (1997)
- Grounded on theories of procedural justice
- Emphasis on democratic deliberation
- To make legitimate and fair decisions on priorities four conditions need to be met.

A4R Conditions

- **Publicity (Transparency)**
 - Decisions & reasons
 - Open for public scrutiny (publicised)
- **Relevance (Reasons)**
 - Reasons (criteria)
 - “Fair minded” people (legitimate decision makers)
- **Appeals**
 - Possibilities for revising decisions
- **Enforcement**

Aim

- Knowledge and views on how resource allocation decisions are made within their local area/hospital

Participants

- Survey members of the NSW Cancer Institute - Standard Cancer Treatment (CI-SCAT) reference groups.
- All CI-SCAT reference groups: oncology, nursing, haematology and radiotherapy
 - Asked about:
 - knowledge, use and views of economic evaluation in decision making.
 - knowledge and views on resource allocation decisions.



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Oncology Item - Chemotherapy Drug Protocol (01-1221.2)

GYNAECOLOGICAL, Ovarian, recurrent, Carboplatin

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Indications

Ovarian, advanced Stage II to Stage IV

Patient population

At this time, single agent carboplatin is a reasonable option as adjuvant therapy for epithelial ovarian cancer and in relapsed, platinum-sensitive ovarian cancer, particularly in the elderly who are considered unfit for combination therapy with paclitaxel.

Important additional information

Consider commencing at a dose of AUC6 in fit patients.

Drug dosages

Carboplatin 5 AUC by IV infusion D1

Frequency Every 3 weeks.

No of cycles 6

Drug only cost to community \$250 per cycle.

Premedications

Antiemetics, moderate emetogenicity, pre-chemotherapy medications.

Postmedications

Antiemetics, moderate emetogenicity, post-chemotherapy medications

Indications for dose modification

| Haematological | Nadir Blood Counts (day 14) | |
|----------------|---------------------------------|-----------------------------------|
| | ANC >2.0x10 ⁹ /L and | consider dose escalation to 120%* |

Survey

18. Please consider the following statements and indicate how accurate these are in relation to resource allocation decisions within your institution.

| | Strongly disagree | Disagree | Neither agree/disagree | Agree | Strongly agree | Not sure |
|---|-------------------|----------|------------------------|-------|----------------|----------|
| Current resource allocation processes are as good as they are ever likely to be | | | | | | |
| The only economic criterion that tends to be considered is the direct financial cost of the new technology. | | | | | | |
| Despite the fact that we operate under a capped budget, new money can usually be found from somewhere. | | | | | | |
| At my institution, the concept of cost-containment is more important than cost-effectiveness | | | | | | |
| One of the barriers for taking up new technologies is the difficulty of moving resources from one sector (budget) to another. | | | | | | |
| Budgets are so tight that resources cannot be freed to adopt new technologies. | | | | | | |
| I understand current resource allocation processes, including how decisions about the adoption of new technologies are made | | | | | | |
| Current resource allocation processes are fair | | | | | | |
| Resource allocation decisions are backed by evidence | | | | | | |
| There are avenues where I can express my opinion on matters regarding resource allocation decisions | | | | | | |
| I am not aware of the existence of a decision making process in our institution regarding the adoption of new technologies | | | | | | |
| Technologies are adapted in line with clinical priorities. | | | | | | |

Survey Results

“Participants characteristics”

| Characteristic | Percentage % |
|--|-------------------------|
| Reference group (n=74) | |
| Oncology (n=7) | 9.5 |
| Nursing (n=43) | 58.0 |
| Haematology (n=9) | 12.0 |
| Radiology (n=15) | 20.5 |
| Profession | |
| Specialists (n=25) | 34.0 |
| Budgetary responsibility (n=74) | |
| Yes (n=37) | 50.0 |
| No (n=37) | 50.0 |
| Involved in making decisions (n=74) | |
| Yes (n=36) | 51.4 |
| No (n=38) | 48.6 |

Views of current decision making processes

| | Strongly/ disagree | Neither agree/ disagree | Strongly/ agree |
|---|-----------------------|-------------------------------|--------------------|
| Budgets are inflexible (n=70) | 6%(4) | 14%(10) | 77%(54) |
| Budgets are too tight (n=69) | 17%(12) | 29%(20) | 52%(36) |
| Only criterion is direct Cost (n=70) | 19%(13) | 17%(12) | 63%(44) |

* Not sure has not been included

Views of current decision making processes

| | Strongly/ disagree | Neither agree/ disagree | Strongly/ agree |
|--|-------------------------------|--|----------------------------|
| New money can usually be found from somewhere (n=70) | 39%(27) | 16%(11) | 43%(30) |
| Cost-containment more important than cost effectiveness (n=69) | 17%(12) | 13%(9) | 67%(46) |

* Not sure has not been included

Current resource allocation processes are:

| | Strongly/ disagree | Neither agree/ disagree | Strongly/ agree |
|---|-----------------------|-------------------------------|--------------------|
| Understood (n=70) | 37%(26) | 19%(13) | 41%(29) |
| As good as they are ever likely to be (n=69) | 58%(40) | 22%(15) | 20%(14) |
| Fair (n=69) | 52%(36) | 29%(20) | 13%(9) |
| Backed by evidence (n=67) | 48%(32) | 33%(22) | 16%(11) |

* Not sure has not been included

Views of current decision making processes

| | Strongly/ disagree | Neither agree/ disagree | Strongly/ agree |
|---|-------------------------------|--|----------------------------|
| There are avenues where can express my opinion (n=71) | 39%(28) | 14%(14) | 38%(27) |
| I am not aware of the existence of a decision making process (n=70) | 37%(26) | 19%(13) | 37%(26) |
| Technologies are adapted in line with clinical priorities (n=70) | 37%(26) | 29%(20) | 33%(23) |

* Not sure has not been included

Discussion

- A4R conditions for decision making are not currently met
- Legitimacy of priority setting
- Greater focus on resource allocation processes
- Address gaps

Limitations

- Respondents don't always do what they say.
- Sample bias. Participants belong to a group and are already interested in best practice.
- Underestimating