Fairness, accountability for reasonableness, and the views of priority setting decision-makers

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Abstract

Fairness is a key goal of priority setting and ‘accountability for reasonableness’ has emerged as the leading framework for fair priority setting. However, it has not been shown acceptable to those engaged in priority setting. In particular, since it was developed in the context of a primarily privately funded health system, its applicability in a primarily publicly funded system is uncertain. In this paper, we describe elements of fairness identified by decision-makers engaged in priority setting for new technologies in Canada (a primarily publicly funded system). According to these decision makers, accountability for reasonableness is acceptable and applicable. Our findings also provide refinements to accountability for reasonableness. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

As resources are limited, both private (e.g. managed care organizations) and public (e.g. Ministry of Health) health care organizations set priorities regarding which health care services will and will not be funded. A goal of priority setting is

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fairness: when does a patient or clinician have sufficient reason to accept as fair particular priority setting decisions [1]? Fairness has been addressed in theoretical analyses of priority setting [2–6]. Daniels and Sabin’s framework for fair priority setting in health care institutions, accountability for reasonableness [1,7], is gaining attention internationally [8].

According to accountability for reasonableness, health care institutions engaged in priority setting have a claim to fairness if they satisfy four conditions [1,7]:
1. rationales for priority setting decisions must be publicly accessible (publicity condition);
2. these rationales must be considered by fair-minded people to be relevant to priority setting in that context (relevance condition);
3. there must be an avenue for appealing these decisions and their rationales (appeals condition);
4. there must be some means, either voluntary or regulatory, of ensuring that the first three conditions are met (enforcement condition).

Accountability for reasonableness provides a framework by which the fairness of priority setting in health care can be evaluated [9,10]. Although derived in part from empirical studies of managed care organizations, no one has examined its applicability to actual priority setting contexts. Moreover, it was developed in the US, a primarily privately funded health care system. Its applicability in a primarily publicly funded health system (e.g. Canada, UK) has not been examined.

Therefore, it is necessary to examine whether the conditions of fair priority setting described in accountability for reasonableness are familiar and acceptable to decision makers involved in priority setting. If these ideas were alien, or worse, unacceptable to them, it would be unlikely that accountability for reasonableness could be adopted or applied.

In this paper, we will report elements of fairness described by decision-makers engaged in priority setting in health technology assessment for cancer and cardiac care in Canada, and compare them to the four conditions of accountability for reasonableness. Our analysis explores the applicability of accountability for reasonableness in actual priority setting and also yields details that can help refine its four conditions.

2. Methods

We conducted a qualitative study involving in-depth, open-ended interviews with members of two committees engaged in priority setting for new technologies in cancer and cardiac care [11,12]. We focussed on the Cancer Care Ontario Policy Advisory Committee for the New Drug Funding Program and the Cardiac Care Network of Ontario Expert Panel on Intracoronary Stents and Abciximab (a glycoprotein IIb/IIIa inhibitor). The Cancer Care Ontario Policy Advisory Committee “manage[s] the selection and introduction of all new drugs within the funds provided”. [13]. The Cardiac Care Network of Ontario Expert Panel on Intracoronary Stents and Abciximab was mandated to “review current literature and
practice... and recommend, where possible, a cost-effective, multi-year plan for stent volumes and use of Abciximab that supports the principles of quality of care, access and affordability”.[14]

We invited all members of both committees to participate. Of the 26-committee members, 21 were interviewed (11 of 15 from CCO and 10 of 11 from CCN). Two refused to be interviewed because they resigned from the committee due to scheduling conflicts; three did not respond.

The interviews were semi-structured; the interviewer asked open-ended questions, pursued emerging themes, and sought clarification. Participants were asked to describe their role on the committee, describe the committee process, comment on whether they thought the committee’s process and decisions were ‘fair’ and indicate the criteria on which their answers were based, and describe how fairness could be improved. Interviews were audiotaped, transcribed and analyzed. The interview transcripts were read and participants’ views regarding fairness in priority setting were identified. These units of text were underlined and descriptive notes were written in the margins of the transcripts; this process is referred to as coding. Coded units were then labeled as specific concepts relating to fairness. For example, units that related to the concepts of multiple disciplines, content expertise and different perspectives were identified. Labeled units were then grouped together under one overarching theme label (e.g. multiple perspectives), and the data were recorded by theme. The themes were organized according to perceived importance, which was based on both prevalence and the participants’ emphasis. Finally, descriptions of the themes were developed using the participants’ own words. The findings were presented to the chairs of the two committees as a ‘member check’ to corroborate our interpretations.

This study was approved by the Committee on Use of Human Subjects of the University of Toronto. All participants provided consent for the interview.

3. Elements of fairness according to decision makers

The decision-makers we interviewed described two general and 11 specific elements of fairness. These elements are described below and summarized in the second column of Table 1.

3.1. Two general elements of fairness

According to the decision-makers in our study, fair priority setting depends on a fair priority setting process. When asked if the committee decisions were fair, many participants said, “I have no way of knowing that”. They claimed not to know of criteria for determining fair outcomes. On the other hand, they claimed to know at least some criteria for determining whether the process was fair.
“I don’t think there’s such a thing as a right or wrong decision, or right or wrong answers. I don’t think you can judge what we’re doing based on the outcomes. It’s more of a process.”

The decision-makers we interviewed also believed that fairness is relative; that is, it is not an ‘all-or-none’ concept but, rather, a matter of degree. They identified 11 specific elements of fairness in priority setting. As the fairness of each element is improved, so is the overall fairness of priority setting decisions.

3.2. Eleven specific elements of fairness (see Table 1)

According to the decision-makers in our study, the priority setting process should be characterized by both internal and external transparency. Internal transparency means that all members know the issue being considered and the content of the deliberations. External transparency means that the processes, deliberations, decisions and reasoning of the decision making body are made available to stakeholders external to the membership.

“I believe the process that we’ve used, at least within the group, has been quite transparent. Whether it’s transparent externally, I don’t think so yet. I do not think we have anything to be ashamed of, and I think if anybody looked at what we’ve done, given the fact that we’re human beings and we don’t agree on [everything], I don’t think they’re major problems. But I think that we need to develop the tools to allow people externally to have a better idea of how we make decisions.”

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<thead>
<tr>
<th>Conditions of accountability for reasonableness</th>
<th>Elements of fairness according to decision makers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Publicity</td>
<td>External transparency</td>
</tr>
<tr>
<td>2) Relevance</td>
<td>Multiple perspectives</td>
</tr>
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<td></td>
<td>External consultation</td>
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<td></td>
<td>Consensus</td>
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</tr>
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<td></td>
<td>Identify potential conflict of interest</td>
</tr>
<tr>
<td>3) Appeals</td>
<td>Appeals mechanism</td>
</tr>
<tr>
<td>4) Enforcement</td>
<td>Leadership</td>
</tr>
<tr>
<td></td>
<td>Internal transparency</td>
</tr>
<tr>
<td></td>
<td>Understanding</td>
</tr>
<tr>
<td></td>
<td>Opportunity to express views</td>
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<td>Agenda setting</td>
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According to the decision-makers in our study, including representatives from *multiple perspectives* was the single most important element of fair priority setting. Appropriate combinations of lay and expert members who represent different stakeholder groups can bring to the surface a variety of issues, values and perspectives.

“It brings people of various backgrounds together and different skills and different perspectives, and if that group can come together and reach a decision I think it’s a reasonable decision. It’s not as though one or two people were coming together and making a decision from a very limited background and experience and perspective.”

For example, a physician may be able to describe the clinical benefits and harms of a particular treatment, but a patient can best describe the treatment’s personal impact.

“The view of the professional treating the patient may be quite different from the view of the patient and I think that that other kind of input is really critical to the acceptance of the kinds of decisions that are being made.”

They also stated that, to ensure that all relevant information and perspectives are considered, it may be necessary to seek *external consultation* from people who are not members of the committee. This input can supplement that of the members.

“Where we saw that disease site groups were making recommendations that might or might not be approved by the committee, we made a special effort to invite disease sector chairs to address the committee, often in person, to tell us about the recommendation, to ask questions.”

The decision-makers we interviewed felt that decision-making bodies should try to reach *consensus*. That is, everyone should either agree with the decision, or be satisfied that the decision was well considered and is acceptable.

“It’s not done by an individual, it’s done by a group, which gives it more credence.”

“Well I think the fairness of the process is that everybody reads over the recommendations. They are criticized. They are reviewed by all of the panel members. And then the best assessment that is possible—*consensus*—is put forward as the recommendation.”
They felt that committee members’ participation should be characterized by *honesty*. Members should contribute all relevant factual information, do it accurately, and contribute perspectives that truly represent what they purport (i.e. no ‘hidden agendas’).

“I think we’ve been able to get good honest input from a number of disciplines and that has gone a long way to trying to make the process fair.”

They also felt that each member must *identify potential conflicts of interest*.

“…There’s always lurking in the background that conflict of interest, and that perception that, when you get a group of physicians together that are totally interested in this area, you wonder if, from their perspective, you’re getting really the most balanced point of view.”

The decision-makers we interviewed stated that stakeholders dissatisfied with a particular decision, or the decision making process, should have access to an *appeals mechanism*.

“Another thing we have to work out is this whole appeals mechanism too. ’Cause it can’t just be who talks the longest and the loudest… There’s got to be some process for deciding what gets reconsidered.”

These decision-makers claimed that committee *leadership* also contributed to perceptions of fairness. Committee chairs usually participate in the selection of members and guide the flow of discussion. According to the participants, a commitment to fairness requires that the leader ensure that all committee members, especially where experts and non-experts are members, can participate and all issues and perspectives are considered.

“It was fair because I think [the chair] did a very good job in making sure pros and cons were brought to the table. Although he is at the forefront of the use of [technology], he was also cautious and he wasn’t overzealous in his approach. So I think that the way that he was able to give enough airtime to all of the issues ensured that the process was fair.”

They also argued that the committee members’ participation should reflect a high level of *understanding* regarding pertinent information. In order to ensure that members have opportunity to achieve sufficient understanding, the chair may have to intervene to ask for repetition or clarification.
“I think part of [the chair’s] job is to make sure that everybody understands a reasonable amount of the content of the discussion. The specialists can drift off … it’s sometimes important for [the chair] to back people back a little bit and ensure that the statements made about a specific drug or specific condition are rephrased in terms that everyone understands, and also, but probably more importantly, that they’re phrasing in the same kind of terminology that was used when we discussed the previous drug or the previous condition.”

According to the decision-makers in our study, to achieve fairness, all members should have an opportunity to express views and be listened to with respect.

“You don’t want the person who has the most expertise to shut up. And yet, you don’t want the committee to be overinfluenced by, quote, an expert, who happens to be on the committee.”

They also thought that agenda setting (presentations, topics, and decisions that are formally scheduled for committee meetings) should be undertaken with the same commitment to fairness as all the chair’s duties. Moreover, all members should have the opportunity to influence agenda setting.

“But I think it’s really critical that the committee not be seen to favor any particular group or that access be better for any set of people—and I guess that’s another role for the chair.”

“There was ample time for members of the panel to take exception or to change the course or to add new things to the agenda.”

4. Comparing decision makers views with accountability for reasonableness

In this section we will compare the description of fair priority setting derived from decision-makers with the conditions of accountability for reasonableness. We will identify aspects of the decision makers description that helps to refine accountability for reasonableness’ four conditions. (Publicity, Relevance, Appeals, Enforcement—described below). (see Table 1).

4.1. Publicity

According to the publicity condition of accountability for reasonableness, making priority-setting decisions and their rationales publicly accessible enables wider public deliberation regarding the principles upon which limit setting decisions are
made. Engaging stakeholders in public deliberation about tough limit setting decisions demonstrates respect for the moral diversity of those affected[15]. In addition, as each successive decision and its rationales are submitted for public scrutiny, a type of ‘case law’ begins to develop which helps to ensure decision-making consistency.

The decision-makers we interviewed supported this idea by arguing that fairness is not an ‘all-or-nothing’ concept, but that fairness is relative and, therefore, could be improved. In addition, they proposed a concept they called transparency, which had two parts: internal and external. Internal refers to transparency within the committee, among committee members. External refers to transparency outside the committee, meaning publicly. Their concept of external transparency is the same as the publicity condition of accountability for reasonableness. Distinguishing between the concepts of external and internal transparency is a refinement to accountability for reasonableness.

4.2. Relevance

According to the relevance condition of accountability for reasonableness, rationales for priority setting decisions should be ‘reasonable’, that is they should appeal to values and principles that ‘fair-minded’ people can agree are relevant to limit setting in each context. People are fair-minded if they are committed to co-operating and considering the common good.

The decision-makers we interviewed considered that having a wide range of individuals involved was the key to fairness. In their view, which closely corresponds to the relevance condition, including multiple perspectives ensures that a wide range of relevant values and principles are considered in decision-making. Similarly, when one or more relevant perspectives appear to be missing, seeking external consultation fills that void. They also provided two refinements to the relevance condition. First, they expanded on the concepts of mutual Cupertino and agreement by indicating that the ‘method’ of fair decision making should be consensus and not majority or elite rule. They also sharpened the notion of ‘fair-minded’ people by suggesting that decision-makers in fair priority setting should participate honestly and should identify any potential conflicts of interest. These may be thought of as ‘tests’ or ‘checks’ on fair-mindedness.

4.3. Appeals

According to the appeals condition of accountability for reasonableness, an appeals mechanism is necessary for two reasons. First, it shows respect for those who disagree with a particular decision and provides them with a way of engaging with decision makers in a dispute resolution procedure designed to prevent or de-escalate conflict. Second, it contributes to the public deliberation and, therefore, to the growing case law of priority setting decisions.

The decision-makers we interviewed supported this condition but provided no substantial refinements.
4.4. Enforcement

According to the enforcement condition of accountability for reasonableness, enforcement is necessary to ensure that the first three conditions (publicity, relevance, appeals), which are process-oriented conditions, are met. Enforcement may be either voluntary or, if voluntary enforcement fails to ensure that the three process conditions are met, regulatory.

The decision-makers we interviewed supported the necessity of enforcement by emphasizing that fairness requires fair processes. They also provided refinements to the concept of voluntary enforcement by proposing several elements of fairness that contribute to ensuring that fair process is followed. These elements include: leadership that helps to ensure that everyone has an opportunity to express their views, that everyone understands the nature of the decision and the considerations under discussion, and that the process is transparent to all the decision makers (this is the internal part of transparency mentioned above), including ensuring transparent and accessible agenda setting. These may be thought of a ‘check’ on voluntary enforcement. The decision-makers in our study did not comment on regulatory enforcement.

5. Implications

Fairness is a goal of priority setting. It has been recognized that health care institutions wishing to achieve fair priority setting must follow a fair process [7–9,16–19]. Moreover, by focusing explicitly on fair process, health care institutions can enhance public confidence in particular priority setting decisions [20]. Accountability for reasonableness has emerged as an important model of fair process. However, it has not previously been examined from the standpoint of decision-makers engaged in priority setting.

The decision-makers in our study confirmed the idea that fairness entails fair process. They also identified two general—fairness equals fair process, and fairness not all or none, but relative—and 11 specific elements of fairness in priority setting, some of which have been described previously—seeking multiple perspectives [21], establishing leadership [22], creating an opportunity to express views [23], ensuring honesty, seeking external consultation, establishing understanding [24], ensuring transparency [25,26], achieving consensus [18,20], identifying potential conflicts of interest, agenda setting, and creating an appeals mechanism [15]. Issues related to potential conflicts of interest have been described, but not with regard to priority setting [27]. Elements that are new include honesty, external consultation, and agenda setting. We integrate these elements of fairness in priority setting in an evidence-based framework that reflects the decision-makers’ perspective.

Accountability for reasonableness is a process-oriented framework that specifies four conditions (publicity, relevance, appeals, enforcement) for fair priority setting. Each condition is familiar and acceptable to the participants—and, all four conditions can be inferred by at least one element of fairness described by the
decision-makers. In particular, the decision-makers in our study highlighted the involvement of multiple perspectives as the key specific element of fairness in priority setting. Accountability for reasonableness encourages broad stakeholder involvement. An important next step is to find creative ways of making that work to achieve the goal of fairness. In addition, the elements of fairness described by decision-makers provide more details that help to refine the four conditions of accountability for reasonableness. The refinements include: distinguishing between the concepts of internal and external transparency; external consultation to supplement committee membership; consensus as method of agreement; honesty and identifying potential conflicts of interest as ‘tests’ of ‘fair-mindedness; and five elements that flesh out the concept of voluntary enforcement (leadership, internal transparency, understanding, opportunity to express views, agenda setting). The decision-makers in our study did not identify any elements of fairness that conflict with or are missing from accountability for reasonableness. Moreover, the decision-makers in our study were operating within a primarily publicly funded health care system (i.e. Canada). This provides evidence that the conditions of accountability for reasonableness are familiar and acceptable within that context.

Our study had two main limitations. First, this description of fairness, and the focus on fair process, was developed in the context of two provincial disease management organizations making decisions regarding new technologies in cancer and cardiac care. It may not be fully generalizable to priority setting in other contexts such as governments, regional health authorities, hospitals, or hospital programs. However, since fairness is a common goal across contexts and since all contexts must deal with priority setting for new technologies, it is likely that some of the concepts will be generalizable. Second, what participants said they did (or ought to have done) may not be what they really did; there is a difference between portraying and conducting a fair process.

In conclusion, accountability for reasonableness is a framework for fair priority setting that is familiar and acceptable to decision makers in the study context. In addition, the perspective of decision-makers in our study provides refinements to accountability for reasonableness’ four condition. Moreover, our study was conducted in a primarily publicly funded health care system (i.e. Canada) and, therefore, provides evidence that it is applicable here as well as in a primarily privately funded system. Future intervention research should attempt to apply the conditions of accountability for reasonableness in health care institutions in order to improve (i.e. make fair) priority setting priority setting in health care.

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