NEW FRONTIERS IN PRIORITY SETTING

BIRMINGHAM, UNITED KINGDOM
7TH - 9TH SEPTEMBER 2016

@IntSocPriHC #priorities16 www.birmingham.ac.uk/priorities2016
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On behalf of the management committee for the International Society for Priorities in Health (ISPH), I’d like to express our pleasure in welcoming you to the 2016 Priorities meeting. It is fitting that two decades after the establishment of this Society, its 11th meeting, with an outstanding agenda in place, is taking place in Birmingham, the place of the ISPH’s genesis.

Priority setting grows ever more complex as the tools of medicine become more technical and more expensive, at the same time that understanding of the critical role of social and environmental factors in health grow. Where should we put our resources in order to maximize the health of communities and countries? How should we plan programs and distribute resources such that we vanquish the enormous inequities that exist across localities and across nations?

Improving the health of populations, decreasing inequities, and restraining cost growth are critical challenges at the national, local, and health delivery system levels throughout the world. The Society looks to its biennial meeting to bring together academics across a range of disciplines and decision-makers and practitioners with a range of problems to solve and experiences from differing settings, in order to build the science and practice of priority setting.

Unlike many conferences that are tailored primarily to academics or primarily to practitioners, the ISPH, from its inception has sought to be a meeting ground for work that is both practically grounded and academically rigorous. The agenda for this year’s meeting well reflects that objective. The collaboration of the University’s Health Services Management Centre with the Department of Health Economics together with the stellar international planning committee assembled by our colleagues here in Birmingham has created a vision for this meeting that you, its delegates, have responded to with the submission of topical and incisive abstracts. Outstanding thinkers and actors from across the world fill the meeting’s plenary sessions. All of this will be grist for the rich formal and informal discussions that have come to characterize the Society’s meetings.

The current management committee has been keenly interested in developing the Society’s reach as an entity that will foster collaborations and share ideas beyond biennial meetings. We urge those who are new to the meeting, as well current members to join us on Friday September 9th for the Society’s business meeting, after the conference closes. This is a setting in which ideas and directions are proposed and management committee members interested in developing this work are elected.

Marthe Gold
President of International Society for Priorities in Health Care
Welcome
from the Organising Committee

The Local Organising Group, along with the wider Organising Committee have been planning this conference for many weeks and months, and it is fantastic that the event is finally upon us. In keeping with the Society’s international reach and scope, we have sought to put together a programme that addresses themes of universal interest, and fosters learning across health systems of all types. To this end, we have secured plenary speakers from across the globe to discuss the challenges of providing efficient and equitable health coverage under conditions of resource scarcity, and also we have a dedicated plenary and conference stream on the theme of patient and public engagement.

We have also worked hard to deliver a conference programme that speaks to the immediate concerns of those working in health services, local government and other local and national bodies across the UK and elsewhere, as they seek to improve the wellbeing of their populations whilst working with constrained budgets. Finally, we have sought to maintain the reputation of this conference for academic excellence and for leading developments in research, methodology and theory on the theme of priority setting in health and care.

There are a few features of the conference that we want to make sure you are aware of. We have an excellent collection of academic posters which will be on display at various times during the meeting. We will be giving an award to the best of these as well as to the best oral presentation from a current or recent PhD researcher. For the evening reception of the conference we are delighted to have Professor Chris Ham, current CEO of the Kings Fund, London, and founder member of the Society, giving his views on the past, present and future of priority setting. On day two of the meeting we will entertain delegates at the famous Birmingham Botanical Gardens for the conference social dinner.

We would like to finish with a few thankyous. In particular we’d like to thank Mary-Lou Chatterton and the team at Deakin University Melbourne, hosts of the highly successful 2014 meeting, for their help in the transition to Birmingham 2016. We also extend our thanks to the Society for the opportunity to host the meeting and for their ongoing support and advice, and to our generous sponsors. We would like to thank all members of the Local Organising Group, the Organising Committee and the Scientific Committee. We are particularly grateful to Dr Emma Frew from the Health Economics Unit at the University of Birmingham for chairing the Scientific Committee and for her input into all aspects of the conference, and to Evelina Balandyte and Marie Greene from the Health Services Management Centre for their tireless work over the past 18 months, and for their dedication to making the conference happen.

Welcome from the Health Services Management Centre and the Health Economics Unit

The International Society on Priorities in Health Care was founded by the University of Birmingham in 1996, and priority setting remains a key area of research, education and civic engagement for both HSMC and HEU. We are therefore delighted to be able to mark the Society’s twentieth anniversary by hosting its eleventh biennial meeting on the theme of ‘New Frontiers in Priority Setting’.

Although the world has changed immeasurably in the twenty years since the Society’s inception, the central challenge of allocating limited resources to meet complex health needs remains unchanged. This conference has always taken a multidisciplinary approach to solving this challenge, and this year will be no different. Fittingly, we have been able to bring together both Medical and Dental Sciences and Social Sciences Colleges of the University as well as local and national decision makers from home and abroad in putting together the conference programme.

We extend our welcome to the international research community from disciplines including: law; ethics and philosophy; public health; political science and social policy; economics and statistics, and from the full range of methodological traditions. It is precisely this mix of approaches that is required to tackle the ongoing challenges of priority setting in health.

We would urge you to make the most of your time in Birmingham. Of course this means enjoying the excellent academic and social programme that the organising group have put together. However don’t forget the many great attractions that the University of Birmingham and the wider City has to offer. Welcome to you all!

Professor Judith Smith
Director of the Health Services Management Centre

Professor Tracy Roberts
Head of the Health Economics Unit

Iestyn Williams
Co-chair of the organising committee

Joanna Coast
Co-chair of the organising committee
Delegate Information

Meeting Venue

Medical School
University of Birmingham
Vincent Drive
Edgbaston
Birmingham
B15 2TT

Email: priorities2016@contacts.bham.ac.uk
Telephone: +44 (0)121 414 7054

Free wi-fi access is available throughout the conference: please connect to “WifiGuest” open your browser and visit service.thecloud.net, select “Get online at Edgbaston Campus”, follow the on screen instructions, create an account and log in.

TOA Taxis: +44 (0)121 427 8888

Registration

The registration desk is situated on the ground floor of the Wolfson Centre, within the Medical School and will be open throughout the meeting.

Name Badges

Please wear your name badge at all times during the conference and to the Social Functions. If you lose your badge at any time, please inform a member of the conference team situated at the registration desk and they will provide you with a replacement.
Birmingham

Welcome to Birmingham! Named one of the world’s Top 10 Cities in the Rough Guide 2015, we are host to Cadbury World, Aston Villa Football Club and the flagship Queen Elizabeth Hospital, as well as being the childhood home of JRR Tolkien. With more miles of canal than Venice, and Sutton Park National Nature Reserve, the seventh largest urban park in Europe, there is plenty of outside space to enjoy. The city’s Jewellery Quarter makes forty percent of the country’s fine jewellery, with museums and workshops to discover. We are known as the UK’s second city, but in terms of diversity, we come first. The city is famous for its historic industrial past and is now a centre of culture, commerce and entertainment with a diverse and vibrant community.

Whether you’re interested in arts or science, the University of Birmingham has something for everyone. The Barber Institute of Fine Arts, housed in a Grade II-listed Art Deco building, contains work from Van Gogh, Monet and many others. The newly-reopened Lapworth Museum of Geology holds one of the largest collections of fossils, minerals and rocks in the Midlands, and is one of the oldest specialist geological museums in the UK, dating back to the 1880s. Winterborne House and Gardens is a short five minute walk from campus, detailing the lives of the Nettleford family in the Edwardian period and showcasing seven acres of Grade II listed gardens.

Want to explore the city during your stay? You could visit the Library of Birmingham, shortlisted for the 2014 Stirling Award, situated next to Symphony Hall, hailed by the Sunday Telegraph as the best concert hall in the country. Explore our cultural history at the Birmingham Museum and Art Gallery, and find food for thought at the ThinkTank Science Museum. Finish with a tour of the BBC studios at the Mailbox and find out what goes on behind the scenes at one of the UK’s media institutions.

Birmingham has a restaurant to suit every taste. Interested in street food served in a festival atmosphere? Digbeth Dining Club might be for you! Looking for a fine-dining experience in a Michelin-starred establishment? Why not try Adam’s Restaurant on Bennett’s Hill. Fans of Indian cuisine wouldn’t want to miss the famous Balti Triangle!

We hope you’ll enjoy your stay in Birmingham and your visit to the University of Birmingham campus.
Conference Programme
**WEDNESDAY**

08.30  Registration desk open

09.45  Conference Welcome - Leonard Deacon Lecture Theatre
       **David Adams, Head of College of College of Medical and Dental Sciences and Dean of Medicine, University of Birmingham**
       **Marthe Gold, Chair of the International Society for Priorities in Health Care**
       **Iestyn Williams, Co-chair of the Organising Committee, Priorities 2016**

10.05  Plenary Session One - Leonard Deacon Lecture Theatre
       What matters to people: priorities for individuals, communities and populations
       **Angela Coulter**, Patient choice and experience: challenges for priority setting
       **Rachel Baker**, What do the public think about priority setting?
       **Sally Brearley**, Priority setting: a patient perspective
       Chair: Joanna Coast

11.20  Refreshments

11.50  Parallel Session 1

13.10  Lunch and poster display

14.00  Parallel Session 2

15.20  Refreshments

15.50  Parallel Session 3

17.10  Conference close

Evening Reception sponsored by Midlands and Lancashire Commissioning Support Unit - Bramall Music Building

17.45 - 19.30  Welcome  
       **Professor Judith Smith**, Director at Health Services Management Centre, University of Birmingham
       The challenges of priority setting 20 years after the International Society was founded  
       **Professor Chris Ham**

**THURSDAY**

08.30  Registration desk open

09.00  Parallel Session 4

10.20  Refreshments and poster display

10.50  Parallel Session 5

12.10  Lunch and poster display

13.10  Plenary Session Two - Leonard Deacon Lecture Theatre
       Priority setting at the national level: a European comparison of drug adoption decisions
       **Gillian Leng**, England and Wales
       **Eckhard Nagel**, Germany
       **Werner Brouwer**, The Netherlands
       Chair: Jacqueline Cumming
       Discussant: Norman Daniels

15.00  Refreshments

15.30  Parallel Session 6

16.50  Conference close

19.00 - 23.00  Social Dinner - Birmingham Botanical Gardens
       Coach travel leaves from City Centre at 18.45
FRIDAY

09.00  Registration desk open

09.30  Parallel Session 7

10.50  Refreshments and poster display

11.20  Parallel Session 8

12.40  Lunch

13.45  Plenary Session Three - Leonard Deacon Lecture Theatre
        Ethics, health equity and universal health coverage: perspectives from low, middle and high income countries
        Paula Braveman, Health inequalities and health equity, and their role in priority-setting
        Jeanette Vega, The path to universal health care in Chile
        Addis Woldemariam, Towards universal health care in Ethiopia
        Chair: Ole Frithjof Norheim
        Discussant: Kalipso Chalkidou

15.30  Awards for best poster and best PhD paper

16.30  General meeting of the International Society for Priorities in Health - Forum Lecture Theatre

Social Programme

Guided Tour of Queen Elizabeth Hospital Birmingham
Tuesday 6th September (30 minute tour between 16:00 – 18:00)

Located just five minutes’ walk from the Priorities Conference, the Queen Elizabeth Hospital Birmingham is the city’s first new acute hospital for 70 years. Join our expert guides to see the latest technological innovations such as the new futuristic Outpatients Department Pharmacy and the Institute of Translational Medicine (ITM), a world class clinical research facility opened in 2015.

Evening Reception at the Bramall Music Building
Wednesday 7th September 17:45 - 19:30

Join us on the beautiful University of Birmingham campus for drinks, nibbles and music provided by the acclaimed Mercian String Quartet. The Bramall Music Building is just a short walk from the Medical School.

Social Dinner at the Birmingham Botanical Gardens
Thursday 8th September 19:00 - 23:00

The Botanical Gardens, just a short journey from the city centre, is one of the most glorious summer locations in Birmingham. We’ll enjoy a drinks reception with canapés before sitting down to dinner.

For more information on the conference social programme, please contact:
priorities2016@contacts.bham.ac.uk
Wednesday 7th September

Parallel Session 1: 11.50-13.10

Organised Session
Leonard Deacon Lecture Theatre
Prioritising medical device investments under resource constraints
Chair: Tracy Roberts
Organiser: Karin Diaconu
Contributors: Caiole Cummins, University of Birmingham
Adriana Valdez Perumal, World Health Organisation
Gabrielle Jimenez Moyao, Independent Consultant
Mireille Goethetheuer, EVIDEM Collaboration

Organised Session
Forum Lecture Theatre
From priority-setting decisions to health impact: new explorations of a complex translation process
Chair: Laura Morris
Organiser: Laura Morris
Contributors: Eleanor Grieve, University of Glasgow, UK
Yot Terasawattananon, HITAP, Thailand
Emma Newbatt, ITAD, UK

Evaluating local priority setting models - CPD 6
Chair: Amanda Owen-Smith
Bridget Roe
A socio-technical approach to healthcare decision-making: How compatible are technical and social perspectives?

Organised Session
CPD 5
Applying the Oregon list in a UK setting - lessons learnt two years on
Chair: Cheryl Hardisty
Organiser: John Harvey
Contributors: Gemma Smith, North Staffordshire CCG
Paul Davies, Milliman Health Analytics

William Hall
Longitudinal evaluation of priority setting and resource allocation in a Canadian health authority

Carl Tollef Solberg
The disvalue of death and global burden of disease

Organised Session
Understanding citizen perspectives and preferences - CPD 4 Chair: Emma Frew
Mari Broqvist
How hard can it be? - assessing severity of ill health from citizen’s perspective
Sama Hurst
Solidarity and cost-effectiveness: Swiss citizens’ reasons for priorities in health care
Michael Laeuger
Age-Based priority setting: results of a mixed method approach to elicit public preferences

Organised Session
Forum Lecture Theatre
Applying the Oregon list in a UK setting - lessons learnt two years on
Chair: Cheryl Hardisty
Organiser: John Harvey
Contributors: Gemma Smith, North Staffordshire CCG
Paul Davies, Milliman Health Analytics

Wednesday 7th September

Parallel Session 2: 14.00-15.20

Economics and priority setting - Leonard Deacon Lecture Theatre
Chair: Joanna Coast

Sterling Bryan
Why do health economists promote technology adoption rather than the search for efficiency?

Ellen Rule
Resource scarcity in the English NHS: the relevance of economics for prioritisation decisions

Ryozo Matsuda
Politics of institutionalising economic appraisal in health care in Japan

Marissa Collins
Managing scarcity in integrated care: the case of health and social care partnerships in Scotland

Organised Session
Forum Lecture Theatre
Ultra-orphan drugs: establishing a fair and reasonable priority setting process
Chair: Daphne Austin
Organiser: Jonathan Howell
Contributors: Sheila Uneek, NICE
Mark Sheehan, Oxford Biomedical Research Centre

Frode Lindemark
Access to elective specialised healthcare in Norway: clinical priority guidelines, patients’ rights and politics

Judith Bell
Developing a prioritisation framework for NHS England specialised services commissioning

Barbro Knevers
Development of systematic prioritisations between different welfare sectors- and get it running

Neale Smith
Priority setting and resource allocation for social determinants of health

Organised Session
PCP 6
Medicaid expansion in Michigan: patient and practitioner priority setting
Chair: Marion Danis
Organiser: Susan Goold
Contributors: Lisa Smyecko, University of Michigan, USA
Karen Calhoun, Neighbourhood Services Organisation, Michigan

Louise Jackson
Understanding patient priorities in public health: preferences for STI screening in different settings

Harald Schmidt
Breast screening, resource allocation and individual decision making: is conflict inevitable or resolution possible?

Alec Morton
Leveraging country financing for health

May Dao Van
Trade-off between chance of success and urgency in organ allocation- a discrete choice experiment
### Wednesday 7th September

**Organised Session**
Leonard Deacon Lecture Theatre

**Beyond institutions: international experiences and trends in public and patient involvement in health priority setting**

**Chair:** Katharina Kieslich  
**Organiser:** Katharina Kieslich  
**Contributors:** Kalipso Chalkidou, NICE International  
Aviva Tugendhaft, University of the Witwatersrand  
Jennifer Whitty, University of East Anglia

**Koonal Shah**  
Does society wish to prioritise end-of-life treatments over other types of treatment?

**Neil McHugh**  
Societal preferences for provision of treatment at the end of life establishing QALY weights

**Joanna Coast**  
“The guiding principle should be need... and compassion”: choices about funding end of life care

**Koonal Shah**  
Does society wish to prioritise end-of-life treatments over other types of treatment?

**Sarah Costa**  
Disinvestment in cancer drug funding: results from a deliberative public engagement event in Vancouver, Canada

**Jenny Harlock**  
Identifying best practice for patient and public involvement in healthcare decommissioning: A Delphi study

**William Hollingsworth**  
Using geographic variation in unplanned ACSC admission rates to identify research and commissioning priorities

**Neil McHugh**  
Societal preferences for provision of treatment at the end of life establishing QALY weights

**Sarah Costa**  
Disinvestment, waste and decommissioning - CPD 6  
Chair: Neale Smith

### Thursday 8th September

**Organised Session**
Leonard Deacon Lecture Theatre

**Public health decision making within UK local government**

**Chair:** Brian Ferguson  
**Organiser:** Emma Frew  
**Sponsor:** Public Service Academy

**Contributors:** David Hunter, Durham University  
Jo Gray, University of Northumbria  
Sara McCafferty, Newcastle University  
Mark Petticrew, London School of Hygiene and Tropical Medicine

**Matthew McCoy**  
Public engagement in priority setting: experiences from countries transitioning to universal health coverage

**Valentin Schärzlein**  
Evaluation of “Priority-Cafés” as an innovative multi-stage deliberative method to promote informed preferences

**Lindsey Realmuto**  
Prioritize Health! How should a hospital contribute to the health of the community it serves?

**Susan Goold**  
Priorities of minority and underserved communities for health research: the effect of deliberation

**Kristine Bærøe**  
A moral-political concept of health for our times

**Penelope Mullen**  
Are trust and security relevant to health service priority setting?

**Mathias Barra**  
Sub-treatment balancedness is a necessary property for priority setting criteria

**Lydia Kapiriri**  
Are equity, social justice and social values considered in donor organization priority setting?
Thursday 8th September Parallel Session 5: 10.50-12.10

Organised Session
Forum Lecture Theatre

Getting the most out of your budget – a roundtable discussion on how to set priorities in the English NHS
Chair: Judith Smith
Organiser and sponsors: The Health Foundation and the Health Services Management Centre
Contributors: Sally Al-Zaidy

Outcomes for commissioning: the potential for capability wellbeing measures to support decision-making
Chair: Hugh McLeod
Organiser: Hugh McLeod
Contributors: Joanna Coast
University of Bristol
Elis Rule, Gloucestershire Clinical Commissioning Group

Developing ethical criteria for priority setting (two) - CPD 5
Chair: Carleigh Krubiner

Inger Lise Teig
Equitable healthcare: on the potential impact of politicization, bureaucratization and medical standardization of healthcare

Rashi Jhunjhunwala
Why and how should we prioritize surgery on the global path to universal health care?

Lisa Szymecko
Champions for priorities during deliberation

Trygve Ottersen
The coverage cube and its many permutations – how can it best promote universal health coverage?

Ann-Charlotte Nedlund
Puzzling priorities: the transition of healthcare and patient influence in an era of austerity

Kristine Onarheim
Selling goats to pay for medicines – family priorities and coping strategies towards universal health coverage

Colene Bentley
The patient's voice in public deliberation-reaching collective solutions on allocating resources for cancer drugs

Lydia Kapiriri
Universal health care coverage and equitable health care access in Uganda and Zambia

Thursday 8th September Parallel Session 6: 15.30-16.50

Organised Session
Leonard Deacon Lecture Theatre

Evaluating health and social care interventions to aid decision making: reablement case study
Chair: Justine Karpusheff
Organiser: Helen Weatherly
Contributors: Annette Bauer, London School of Economics and Political Science
Jennifer Francis, NICE
Collaborating Centre for Social Care, SCIE

Understanding context and its effects on priority setting - CPD 6 Chair: Marissa Collins

Paul Healy
Contextual factors influencing decisions of value in health: a systematic review and narrative synthesis
Chair: TBC
Organiser: Keith Syrett
Sponsor: Hemspons
Contributors: David Lock QC, Landmark Chambers
Jean McHale, University of Birmingham
Christopher Newdick, University of Reading

Politics and priority setting - CPD 5 Chair: Peter Littlejohns

Michele Castelli
Setting healthcare priorities as a ‘wicked problem’: insights from the policy analysis literature

Maarten Jansen
Prioritizing HIV treatment strategies in Sub-Saharan Africa: the need to incorporate health system constraints

Timiwe Mzimela
"Wait – is this really necessary health care? A realist review of priority-setting decisions

Donya Razavi
The influence of priority setting framework health intervention on policymaking

Juliana Yi
The jurisdictional and organisational context of priority-setting for health technology assessment

Carole Cummins
Assessment of medical devices for the National Institute for Health and Care Excellence (NICE)

Paul Healy
Contextual factors influencing decisions of value in health: a systematic review and narrative synthesis

Lidia Engel
Conceptualizing benefits beyond health within the quality-adjusted life year (QALY) framework: a critical interpretive synthesis

Yvonne Michel
Diverging interpretations of items in generic preference-based HRQoL instruments: the example of mobility and SCI

Michele Castelli
Setting healthcare priorities as a ‘wicked problem’: insights from the policy analysis literature

Lidia Engel
Conceptualizing benefits beyond health within the quality-adjusted life year (QALY) framework: a critical interpretive synthesis
Friday 9th September  

Parallel Session 7: 09.30-10.50

**Weighing competing commitments to disadvantaged populations within and outside national borders**  
Chair: Marthe R. Gold  
Organiser: Marion Danis  
Contributors: Matt McCoy, University of Pennsylvania; Verina Wild, Ludwig-Maximilians-University, Munich; Carl Runde, Department of Bioethics, National Institutes of Health; Councillor Waseem Zaffir, Birmingham City Council

**What are your priorities? Involving service users and adding value to health research**  
Chair: Katherine Cowan  
Joint Organisers: Sabine Best & Katherine Cowan

**Craig Mitton**  
Priority setting and resource allocation in health care: lessons learned from Canada

**Sari Koskinen**  
Health care priority setting during economic depression in Finland

**Corinne Gower**  
Does active performance management lead to health service better prioritisation and decision making?

** trygve Ottersen**  
Open and fair: a new proposal for priority setting in Norway

**Ingrid Miljeteig**  
"Protecting families from costs is my priority": Ethiopian physicians perceived roles as gatekeepers and stewards

**Lars Schwettmann**  
The chimera of WTP for a QALY: inconsistencies of stated preferences in scenario variations

**Amanda Owen-Smith**  
Priority setting at the micro level: decision-making in two different clinical contexts

Friday 9th September

Parallel Session 8: 11.20-12.40

**Neoliberal epidemics: understanding how neoliberalism threatens health, and how to fight back**  
Chair: Ted Schrecker  
Organiser: Ted Schrecker, Durham University

**Craig Mitton**  
Priority setting and non-communicable diseases - CPD 5 Chair: Louise Jackson

**Johanna Wiss**  
Priority setting and orphan drugs in five European countries

**Joanna Charles**  
Resource allocation decisions assessing respiratory care - programme budgeting marginal analysis in action

**Mieraf Taddesse Tolla**  
Out-of-pocket expenditure for cardiovascular disease care in Addis Ababa, Ethiopia: a cross-sectional study

**Vadim Dukhanin**  
Systematic review: incorporating social justice considerations into economic evaluations in healthcare and public health

**Johanna Wiss**  
Beyond the hospital bed? Including family health in economic evaluation

**Lars Schwettmann**  
The chimera of WTP for a QALY: inconsistencies of stated preferences in scenario variations

**Joseph Millum**  
Putting a number on the harm of death
Invited Speakers
Rachel Baker is Professor of Health Economics and Deputy Director of the Yunus Centre for Social Business and Health, Glasgow Caledonian University. Before moving to Glasgow in 2010, she worked at the University of Newcastle where she completed her PhD funded by the Medical Research Council (MRC) and her Postdoctoral Fellowship funded by the Economic and Social Research Council (ESRC).

Rachel’s research interests focus on societal values with respect to health care resource allocation and understanding choice. She has expertise in Q methodology and qualitative methods as well as health economic approaches to valuation and preference elicitation. With funding from the MRC Methodology Panel, from 2011-2014, Rachel led research to explore societal perspectives on the relative value of life-extending treatments for people with terminal illnesses. She is Past President of the International Q methodology Society.

Paula Braveman, MD, MPH is Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health at the University of California, San Francisco (UCSF). Her formal training is in Family and Community Medicine and in Epidemiology. For nearly 30 years, Dr. Braveman has studied and published extensively on health equity, health inequalities, and the social determinants of health, and has worked to bring attention to these issues in the U.S. and internationally. Her research has focused on measuring, documenting, understanding, and addressing socioeconomic and racial/ethnic disparities, particularly in maternal and infant health. During the 1990s she collaborated with World Health Organization staff in Geneva to develop an initiative on equity in health and health care in low and middle-income countries. Recently, she served as research director for a Robert Wood Johnson Foundation national commission on the social determinants of health in the U.S. Throughout her career, she has collaborated with local, state, federal, and international health agencies to see rigorous research translated into practice with the goal of achieving greater equity in health. She was elected to the Institute of Medicine (now the National Academy of Medicine) of the U.S. National Academy of Sciences in 2002.
Ms Sally Brearley
Kingston University

Sally Brearley is a Fellow in Patient and Public Involvement, Centre for Public Engagement, Kingston University.

She has worked in or with the NHS for all her working life, firstly as a physiotherapist, then a nurse, but for the last 20 years as facilitator of patient and public involvement, and a lay representative on a wide range of groups and committees.

She is interested in priority setting because it is vital to the sustainability of the NHS and a nettle that we have continually failed to grasp.

Professor Werner Brouwer
Erasmus University Rotterdam

Werner Brouwer is a Professor of Health Economics at and Dean of the Institute of Health Policy and Management (iBMG) of the Erasmus University Rotterdam, The Netherlands. He obtained an MSc in Economics (1996) and a PhD in Health Economics (1999) at the same university. Werner is also affiliated with the Institute for Medical Technology Assessment and the Erasmus School of Economics. Moreover, he is an Honorary University Professor at the Corvinus University in Budapest, Hungary.

His research focuses on the methodology of welfare economic evaluations in health care, directly related to the issue of priority setting. His work has covered topics like optimal decision rules, normative foundations of economic evaluations in health, discounting, measurement and valuation of informal care and productivity costs, incorporating equity considerations in economic evaluations, outcome measurement as well as the monetary value of health gains. In addition, he has performed work on the link between economic evaluation and health policy, behavioral economics and public health economics. He has published extensively on these topics (with some 200 international publications) in journals like Health Economics, Journal of Health Economics, Medical Decision Making, British Medical Journal and PLoS Medicine.

Werner is an Associate Editor of Health Economics and a member of the Editorial Boards of the European Journal of Health Economics, PharmacoEconomics and Cost-Effectiveness and Resource Allocation. He is a member of the Scientific Advisory Board (WAR) of the Dutch Health Care Institute (ZINL), which advises the priority setting process of health care interventions in the Netherlands. Moreover, he is a member of subsidy-committees of the Netherlands Organization for Health Research and Development (ZonMW) and of the European Union Expert Panel on Effective Ways of Investing in Health. He also is the independent chairman of the Foundation for Top Clinical Mental Health Care.
Dr Kalipso Chalkidou

Kalipso Chalkidou is the founding director of NICE’s international programme, helping governments build technical and institutional capacity for using evidence to inform health policy. She is interested in how local information, local expertise and local institutions can drive scientific and legitimate healthcare resource allocation decisions. She has been involved in the Chinese rural health reform and also in national health reform projects in Colombia, Turkey and the Middle East, working with the World Bank, PAHO, DFID and the Inter-American Development Bank as well as national governments.

She holds a doctorate on the molecular biology of prostate cancer from the University of Newcastle (UK), an MD (Hons) from the University of Athens and is a visiting Professor at King’s College London, a senior advisor on international policy at the Center for Medical Technology Policy (USA) and visiting faculty at the Johns Hopkins Berman Institute for Bioethics. Between 2007 and 2008, she spent a year at the Johns Hopkins School of Public Health, as a Harkness fellow in Health Policy and Practice, studying how comparative effectiveness research can inform policy and US government drug pricing policies.

Kalipso is interested in priority setting processes, especially in emerging economies transitioning towards universal healthcare coverage, and in particular, in the political economy as well as the informational and capacity challenges faced by budget holders when making decisions about resource allocation.

Dr Angela Coulter

Angela Coulter is a health policy analyst and researcher who specialises in patient and public involvement in healthcare. She is Director of Global Initiatives at the Informed Medical Decisions Foundation, Boston, and Senior Research Scientist in the Nuffield Department of Population Health, University of Oxford. A social scientist by training, Angela has a doctorate in health services research from the University of London. From 2000 to 2008 she was Chief Executive of Picker Institute Europe. Previous roles included Director of Policy and Development at the King’s Fund, and Director of the Health Services Research Unit at the University of Oxford. She is Adjunct Professor at the University of Southern Denmark, a Senior Visiting Fellow at the King’s Fund in London, holds Honorary Fellowships at the UK Faculty of Public Health and the Royal College of General Practitioners and is a Trustee of National Voices.

Angela has published more than 300 research papers and reports and several books including The Autonomous Patient, The European Patient of the Future (winner of the 2004 Baxter Award), The Global Challenge of Healthcare Rationing, Hospital Referrals, Engaging Patients in Healthcare and Understanding and Using Health Experiences. She was the founding editor of Health Expectations, an international peer-reviewed journal on patient and public involvement in health care and health policy. She has won awards for her work from the Donabedian Foundation of Barcelona in 2012 and the International Shared Decision Making Conference in 2013.

While working at the King’s Fund Angela played a leading role in the Rationing Agenda Action Group. Since then she has sat on numerous national policy bodies and has published extensively on patient and public engagement and priority-setting in healthcare, including a book on the topic co-edited with Chris Ham.
Professor Jacqueline Cumming

University of Wellington

Professor Cumming has extensive public policy experience, having worked for a number of New Zealand government policy organisations, including the Ministry of Health, prior to joining the HSRC. She has over 20 years’ experience working on and leading a large number of health services and health policy-related research projects in New Zealand, including national evaluations of New Zealand’s elective services policy and its Primary Health Care Strategy. Her current research interests are in priority setting, access to health services, primary health care and health systems reform, and evaluation. She also co-ordinates courses at Victoria University’s School of Government on Health Policy; and Monitoring and Evaluation; and she supervises a number of PhD students in health services research and health policy. She is immediate past president of the Health Services Research Association of Australia and New Zealand and recently became a Fellow of the Australasian College of Health Service Management.

Jacqueline has had a long standing interest in issues relating to priority setting. It was the much missed health economist Prof Gavin Mooney who first piqued her interest in the topic. She worked for the New Zealand Core Services Committee, whose role emphasised priority setting; and she completed her PhD on the topic of how an explicit core of services might (or might not) work in health care. Her research work has included exploring New Zealand’s elective services priority setting processes and she has written on the work of New Zealand’s Pharmaceutical Management Company (PHARMAC). She is currently supervising a PhD student who is examining the elective services system at district health board level. She hopes that future work will explore the role of patient-reported outcomes measures (PROMs) in priority setting in New Zealand.

Professor Normal Daniels

Harvard School of Public Health

Norman Daniels is Mary B. Saltonstall Professor and Professor of Ethics and Population Health at Harvard School of Public Health. Formerly Goldthwaite Professor, Chair of the Tufts Philosophy Department, and Professor of Medical Ethics at Tufts Medical School, where he taught from 1969 until 2002, he has degrees from Wesleyan (B.A. Summa, 1964), Balliol College, Oxford (B.A., First Honors, 1966), and Harvard (Ph.D., Plympton Dissertation Prize, 1971). He has written widely in the philosophy of science ethics, political and social philosophy and medical ethics. He has published 200 articles in anthologies and journals as well as authoring and editing multiple books on themes such as ethics, justice and fairness in health and health care.

His current research focuses on adapting the “benchmarks of fairness” for use in less developed countries, on developing fair process for priority and limit setting decisions about resource allocation in various settings, including the new Mexican health insurance plan, and on issues of global justice. A member of the Institute of Medicine, a Fellow of the Hastings Center, a Founding Member of the National Academy of Social Insurance and of the International Society for Equity in Health, he has consulted with organizations, commissions, and governments in the U.S. and abroad on issues of justice and health policy, including for the United Nations, WHO, and the President’s Commission for the Study of Ethical Problems in Medicine.

He served as a member of the Ethics Working Group of the Clinton White House Health Care Task Force (Spring 1993), as a member of the Public Health Service Expert Panel on Cost Effectiveness and Clinical Preventive Medicine, as a member of a National Academy of Social Insurance study panel on the social role of Medicare, and as a member of a Century Fund task force on Medicare reform. He has held Fellowships and Grants from the National Endowment for the Humanities, the National Science Foundation, the National Institutes of Health, the National Library of Medicine, the Robert Wood Johnson Foundation, the Retirement Research Foundation, the Greenwall Foundation, and others. He held a Robert Wood Johnson Investigator’s Award for the period 1998-2001, as well as a Rockefeller Foundation grant for the international adaptation of the benchmarks. In 2010, he received the Harvard Graduate Student Association Everett Mendelsohn Award for mentoring graduate students.
**Professor Chris Ham**

The King’s Fund

Chris Ham took up his post as Chief Executive of The King’s Fund in April 2010. He was professor of health policy and management at the University of Birmingham between 1992 and 2014 and director of the Health Services Management Centre at the university between 1993 and 2000. From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform. Chris has advised the World Health Organization (WHO) and the World Bank and has served as a consultant on health care reform to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, and a companion of the Institute of Healthcare Management. He is a founder fellow of the Academy of Medical Sciences.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and The Health Foundation, and as a member of the advisory board of the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

Chris is the author of 20 books and numerous articles in academic and professional journals about health policy and management. He is currently emeritus professor at the University of Birmingham and an honorary professor at the London School of Hygiene & Tropical Medicine. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012. He was appointed Deputy Lieutenant of the West Midlands in 2013.

Chris has been involved in researching and writing about priority setting for almost thirty years, and was involved in the early days of the International Society. He is particularly interested in international comparisons and what countries can learn from each other. He is also interested in using this learning to inform policy makers and decision makers about which approaches to priority setting work.

**Professor Gillian Leng**

NICE

Gillian Leng is the Deputy Chief Executive at NICE, the National Institute for Health and Care Excellence, and a visiting professor at King’s College London.

Gillian trained in medicine at Leeds, and then spent several years researching the epidemiology of peripheral vascular disease at Edinburgh University. She was involved in the Cochrane Collaboration as it first became established, and still contributes as an editor to the EPOC Group (Effective Practice and Organisation of Care). She specialised in public health medicine, and worked as a consultant before moving to NICE in 2001.

At NICE, Gillian has been responsible for the initial set up and running of the clinical guidelines programme, for establishing the NICE implementation function, and for setting up NHS Evidence. More recently she has been responsible for establishing the NICE accreditation programme, for new work on Quality Standards and for setting up NICE’s programme on safe staffing.

Gillian is also Director of the Health and Social Care Programme and since January 2015 is leading the public health team at NICE.

Gillian is interested in priority setting from a range of perspectives, including determining NICE’s work programme of guidance, in using economic analysis to prioritise healthcare spend, and in prioritising local services and access to treatments. Cutting across all of these is an over-riding interest in the processes used to set priorities that are explicit and fair.
Professor Eckhard Nagel
University of Bayreuth

Professor Dr. med. Dr. phil. Dr. theol. h. c. Eckhard Nagel is Executive Director of the Institute of Medical Management and Health Sciences (IMG) at the University of Bayreuth. Until April 2016 he was member of the German Ethics Council and 2010 - 2015 Chief Executive and Medical Director of the University Hospital Essen.

As a physician and philosopher, Eckhard Nagel has always been interested in superior structures of healthcare beyond his practical work as transplant surgeon. These structures play a decisive role in his current work environments. Priority setting is one of the research emphases at the IMG. In this field, Eckhard Nagel has established several interdisciplinary projects within an international context as well as within the context of the German statutory health insurance. He has brought together theoretical analysis focusing on normative as well as on economic themes and empirical analysis focusing on stakeholder preferences concerning priority setting.

Professor Ole Frithjof Norheim
University of Bergen

Ole Frithjof Norheim is a past president/chair of the ISPSH and a physician and professor in medical ethics, Department of Global Public Health and Primary Care, University of Bergen, and adjunct Professor at the Department of Global Health and Population, Harvard TH Chan School of Public Health. Norheim’s wide-ranging research interests include theories of justice, inequality in health, the ethics of priority setting in health systems and how to achieve Universal Health Coverage and the Sustainable Development Goal for health.

He is currently heading the research project Priority Setting in Global Health (2012-2016, funded by a grant from the Norwegian Research Council/NORAD). Norheim has chaired the 2009 revision of Norwegian Guidelines for Primary Prevention of Cardiovascular Disease, the World Health Organization’s Consultative Group on Equity and Universal Health Coverage (2012-2014), and the third Norwegian National Committee on Priority Setting in Health Care (2013-2014).
Dr Addis Tamire Woldemariam is currently working as a senior advisor to McKinsey and Company based in Addis Ababa. He is a medical doctor, with MPH from the University of South Africa. He has more than a decade experience in both clinical and public health practice across Ethiopia and the globe.

Dr Addis has served as the Director General of the Office of the Minister (Chief-of–Staff) at the Ministry of Health in Ethiopia for three years. As a chief of staff, Dr Addis ran a very complex ministerial office that continuously interacts with all development actors inside and outside the government, represented the minister in local and international fora, ran the Minster’s Delivery Unit established to bring significant impact on the six selected minister’s priorities, led and oversaw the critical processes, including the development of the 5-year Health Sector Transformation Plan (HSTP), the 20-year-Health Sector Envisioning, revision of National Health Policy, and the revision of the long term Healthcare Financing Strategy.

Before joining the Ministry, Dr. Addis worked as a public health researcher for local and international organizations and as a physician, in different public and private institutions. Dr Addis has authored and co-authored a number of articles in prestigious journals, including The Lancet.

Dr Addis believes that setting priorities based on evidence has been critical to making the most important decisions both globally and at a country level. Now, as resources get more constrained and meagre, it becomes even more important. Therefore, building the capability and capacity of countries to use evidence to set priorities is the most sustainable way of driving impact in countries.
Plenary Abstracts
What matters to people: priorities for individuals, communities and populations

Professor Angela Coulter (University of Oxford), Professor Rachel Baker (Glasgow Caledonian University), Ms Sally Brearley (Fellow in Patient and Public Involvement, Kingston University)

There has been an increasing focus on the role of the public in priority setting and this has pervaded both the academic literature and the development of policies by national and local bodies making decisions over the allocation of public resources. However, the views and preferences of citizens and communities can sometimes be at odds with the individual values and preferences of patients and services users, and many health systems are grappling with the challenge of increasing responsiveness to, and empowerment of, the individual patient consumer. This plenary session explores these tensions through keynote presentations and facilitated discussion amongst leading international experts.

Dr Angela Coulter: Personal value and its place in priority setting

Nowadays policy makers strive to achieve value-based healthcare, including technical value, allocative value and personal value. Much emphasis is placed on technical value – ensuring that practice is evidence-based, effective and efficient, and on allocative value – aiming to ensure fair and efficient distribution of resources according to need. The goal of personal value - ensuring that individuals’ goals and preferences shape the care they receive – can appear to be in conflict with these other values. This presentation will describe ways in which personal value can be achieved, with practical examples, reviewing evidence on its likely impact on health and equity. We will then examine the extent to which fears about the incompatibility of these different approaches to value-based healthcare are justified, and discuss the policy consequences of a focus on personal value.

Professor Rachel Baker: Perspectives, priorities and plurality: what matters?

There are clear and legitimate arguments for public involvement in health care priority setting. One approach is to elicit societal perspectives on the principles or practices of priority setting but there is little consensus on how societal perspectives can or should be integrated into actual decisions. Drawing on a body of empirical research and focussing specifically on work funded by the UK Medical Research Council’s Methodology Panel to investigate societal viewpoints on the subject of NHS provision of life-extending technologies for terminally ill patients, Rachel will illustrate and discuss plurality in societal perspectives. Assuming that ‘the public’ will almost always present a number of competing perspectives – both in terms of allegiances with different high-level principles and with respect to specific priority setting questions – how should researchers and policy makers respond? Rachel will draw on work using Q methodology to consider ways in which plurality might be addressed by subjecting societal viewpoints to i) critical analysis, based on identifying areas of consistency and consensus between viewpoints ii) theorising and ethical analyses iii) majoritarian approaches to measuring the degree of support in a wider population and iv) deliberative methods.

Sally Brearley will provide a response to these presentations and the session will be chaired by Joanna Coast, Professor of Health Economics, University of Bristol. It will involve questions and answers with the audience, supported by a live twitter feed to relay audience questions.
Priority setting at the national level: a European comparison of drug adoption decisions

Professor Gillian Leng, NICE; Professor Eckhard Nagel, University of Bayreuth, Germany and Professor Werner Brouwer, Erasmus University Rotterdam

Many OECD countries now delegate responsibility to independent national bodies to make recommendations for investment decisions in health care. In England and Wales the National Institute for Health and Care Excellence (NICE) continues to occupy a central role in managing the entry of new drugs into the NHS. Arrangements in other European health systems vary. For example in Germany the Institute for Quality and Efficiency in Health Care (IQWiG) developed special evaluation methods as a basis for value based pricing and in the Netherlands also in light of negative reimbursement recommendations of the Dutch National Health Care Institute, the debate on expensive drugs is sharpening.

This plenary discussion focuses on the ongoing challenges of prioritising drugs and pharmaceuticals at national policy levels in health care. It compares the assessment of a single cancer drug (Bevacizumab for colorectal cancer) in three jurisdictions – England and Wales, Germany, and the Netherlands. This cross-country case study is used to explore common and unique features of the three systems and to identify good practice in the cost effective management of new drugs and technologies at the national level.

The session will be chaired by Professor Jacqueline Cumming (Victoria University of Wellington) and will feature presentations from Professor Gillian Leng (NICE), Professor Eckhard Nagel (University of Bayreuth, Germany) and Professor Werner Brouwer (Erasmus University Rotterdam). A response to these presentations will be provided by Professor Norman Daniels (Harvard University).

The session will then involve questions and answers with the audience, supported by a live twitter feed to relay audience questions.

Ethics, health equity and universal health coverage: perspectives from low, middle and high income countries

Professor Paula Braveman, University of California, USA; Mr Addis Woldemariam, former Director General, Ministry of Health, Ethiopia; Ms Jeanette Vega, Director of Fonasa, the National Chilean Public Health Insurance Agency

There is a global drive towards universal access to health care and reductions in health disparities within and between health populations. However, finding effective strategies for achieving these goals requires sensitivity to context, and there is a need for systematic cross-country learning. This plenary session draws together experts from research and policy and focusses on the challenges of achieving equitable health coverage in low, middle and high income countries. Professor Paula Braveman (University of California, San Francisco) will focus on the terms health inequalities and health equity, which have become familiar in public health and medical circles in most high-income countries and in many low- and middle-income countries over the past three decades. However, their meaning is often not explicit, and their implications for setting policy priorities are unclear. Paula will describe a conceptual basis for these concepts in ethical and human rights principles, and explain how different definitions can be used to justify very different approaches to setting resource allocation priorities with implications for health.

Following this presentation Dr Jeanette Vega (Director of Fonasa, the National Chilean Public Health Insurance Agency) will discuss her experience and analysis of the path to universal health care in Chile. This will be followed by Dr Addis Woldemariam (former Director General, Ministry of Health, Ethiopia) who will present work underway in Ethiopia to re-define the essential healthcare package and its financing mechanisms, towards universal health care.

The session is chaired by Professor Ole Frithjof Norheim (University of Bergen) and a response to these presentations will be provided by Dr Kalipso Chalkidou, Director of NICE International. This will be followed by questions from the audience, supported by a live twitter feed.
Getting the most out of your budget – a roundtable discussion on how to set priorities in the English NHS

A Special Parallel Session sponsored by the Health Foundation

The difficult financial climate in health and care means there are increasing demands on local budgets. In England, the £22bn per annum efficiency savings required from the NHS by 2020/21, combined with Local Government budget constraints and the requirement to produce Sustainability and Transformation Plans, have all intensified the need to take difficult decisions over spending. This appears likely to be further exacerbated by the EU referendum decision and subsequent economic turmoil and implications for public spending. However, placing limits on what is provided in health and care, often leads to challenge from both within and outside of the system.

The combined challenge for the NHS at a national and local level of staying in budget, whilst negotiating these political risks and hazards is the subject of this special parallel session. The discussion will be structured to include key perspectives from research, policy, practice and other stakeholders, and will include insights from international experience. It will be of particular interest to decision makers and leaders in health and care organisations at all levels of the NHS, as well as Local Government partner agencies. The session will have interesting parallels for colleagues from other health systems, and we therefore welcome their input and sharing of experience.

Join us for a structured and highly interactive roundtable discussion in which practical, evidence-based strategies for setting priorities and implementing service changes will be presented and discussed.

Participants will include:

- Professor Judith Smith, Health Services Management Centre (Chair)
- Ms Sally Al-Zaidy, Senior Policy Fellow at The Health Foundation
- Professor David Haslam, Chair of the National Institute for Health and Care Excellence
- Dr Jenny Harlock, Research Fellow, Health Services Management Centre
- Dr Tim Moorhead, NHS Clinical Commissioners / NHS Sheffield Clinical Commissioning Group
- Professor Cam Donaldson, Glasgow Caledonian University
- Professor Craig Mitton, University of British Columbia
- Sir Muir Gray, NHS Right Care
MCDA for setting priorities in health care – introduction, opportunities and challenges

Dr Rob Baltussen, Radboud University Medical Center; Martina Garau; Dr. Mireille Goetghebeure, University of Montreal; Norman Daniels, Harvard School of Public Health

Priority setting decisions are complex and involve confronting trade-offs between multiple, often conflicting, objectives. Using structured, explicit approaches to decisions involving multiple criteria can lead to better quality, more transparent and more systematic priority setting in health care. A set of techniques, known under the collective heading multiple criteria decision analysis (MCDA), are useful for this purpose. MCDA methods are widely used in other sectors, and recently there has been an sharp increase in applications in health care priority setting.

Yet, a challenge for users of MCDA is that there are many MCDA methods available. These differ not just in how MCDA is put into practice but also in terms of the fundamental theories and beliefs underpinning them. One question, for example, is whether MCDA is not just another mathematical solution for what really is an ethical problem, or whether it can indeed reconcile fact and values in health care priority setting?

The panel address these controversies by sharing content from a 2-day workshop attended by MCDA experts from around the world. The debate will explore whether MCDA can be a useful approach to set priorities in health care, and will be structured as follows: 1) an introduction to MCDA, based on recently published good practice guidelines for conducting MCDA, as authored by the panellists, including examples; 2) opportunities of MCDA to support the paradigm change needed by decision makers to explicitly address the broad range of criteria in priority setting including ethical issues – a presentation of real world applications through the use of EVIDEM; 3) an exploration on how reflective MCDA can support deliberative fair processes in priority setting.

These points will be debated during an interactive session with the audience to explore whether or not MCDA can contribute to better quality, more transparent and more systematic priority setting in health care.

What are your priorities? Involving service users and adding value to health research

Dr Sabine Best, Head of Research, Marie Curie; Katherine Cowan, James Lind Alliance Senior Adviser; Professor Sandy Oliver, Professor of Public Policy, Social Science Research Unit, UCL Institute of Education, London; Sally Crowe, Co-convenor of the Cochrane Priority Setting Methods Group; Dr Angela McCullagh, Service User Representative; Dr Matt Westmore, Director of Finance and Strategy, NIHR Evaluation, Trials and Studies Coordinating Centre

The aim of this session is to introduce the audience to an innovative approach of involving patients and clinicians in setting priorities for health research, a sector where the end users of research are far less likely to influence the agenda than researchers, funders and the pharmaceutical industry.

The session will provide some background to introduce the importance of prioritisation in health research avoiding waste and adding value [1]. It will present work that highlights mismatches that exist between the research that researchers carry out and the research patients and clinicians feel would be of value to them [2]. The session will introduce the rationale and methods of the James Lind Alliance (JLA), a not-for-profit initiative established in 2004 and now hosted by the National Institute for Health Research (NIHR) [3]. The JLA method has been used internationally to identify patients’ and clinicians’ priorities in over 50 areas of health research.

The session will present an example of the JLA approach, the Palliative and end of life care Priority Setting Partnership (PeolcPSP) led by Marie Curie. Palliative and end of life care to date, attracts little research funding and yet decision-makers from policy to patients and carers all need better information in order to make evidence-informed decisions about interventions, services and their own treatment. It is therefore especially important to ensure research that is funded has the potential to make a difference to patients living with a terminal illness and their families and friends. We will describe the results of the PeolcPSP, in which over 1400 people in the last years of life, current and former carers, and health and social care professionals participated, producing a prioritised list of 83 questions for research [4]. We will explore the challenges faced by the PeolcPSP and the lessons learned, as well as the impact it has had on the profile and funding of research in this area to date.

We will then hear from one of the largest public funders of health research in the UK, the National Institute for Health Research (NIHR) about how it is using the results of Priority Setting Partnerships with the James Lind Alliance to prioritise research funding to add value and avoid research waste.

The session will conclude with a question and answer opportunity with all speakers available in a panel discussion. The ultimate aim of health research is to improve health and well-being. The session will be of interest to any audience of health researchers, policy makers and practitioners as well as patients and carers by showing ways to increase the value and impact of research by consulting the end users of research when developing research questions.
Weighing competing commitments to disadvantaged populations within and outside national borders

Dr Marion Danis, National Institutes of Health; Matt McCoy, PhD, Postdoctoral Fellow, Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania; Verina Wild, PhD Post Doctoral Researcher, Faculty of Philosophy, Ludwig-Maximilians-University, Munich; Carl Runge, Research Associate, Department of Bioethics, National Institutes of Health

Aim:
To propose an approach that governmental entities might consider for prioritizing the competing needs of refugees and disadvantaged domestic populations

Theme: Decision Making in Difficult Times

Format: Symposium

Topics covered in the session:
- The argument in favor of collective responsibility for addressing a refugee crisis
- Arguments for reducing health disparities among disadvantaged populations
- An approach to reconciling these obligations
- Examples of one national government’s response and one municipal government’s response to the refugees currently fleeing war-torn countries

Structure:
- The first presentation, by Marion Danis, will focus on a proposal for weighing competing commitments to refugees and disadvantaged domestic populations as outlined in the abstract below.
- The second presentation, by Verina Wild, PhD, will examine the legal and practical situation in Germany where a large number of Syrian refugees are currently residing.
- The third presentation by Birmingham City Councillor Waseem Zaffir, will focus on his service as the cabinet member for social cohesion and community safety and the city’s response to the refugee crisis in Syria.
- The final portion of the session will involve dialogue between the speakers and the audience

Responding to the growing number of displaced people in Europe and the Middle East, a number of scholars have argued that wealthy countries bear collective responsibility for accepting refugees and meeting their basic health and welfare needs. It is also widely agreed that countries bear responsibility for meeting the basic needs of disadvantaged persons already living within their own borders. Based on considerations of global and domestic justice, respectively, these responsibilities can make competing demands on host countries’ resources.

Despite this tension, insufficient attention has been paid to the question of how these responsibilities should be reconciled. In this paper, we develop a three-step approach to priority setting for health and welfare spending that integrates countries’ responsibilities to refugees and disadvantaged residents living within their own borders. First, in cooperation with the international community, countries should agree to accept their fair share of the global responsibility for resettling refugees. Second, once refugees are admitted to a country, they and disadvantaged residents already living within that country should be assessed regarding their relative needs using equivalent metrics. Third, to the extent that incoming refugees add to the number of disadvantaged persons living within a country, policy makers must plan for the available pool of resources for poverty alleviation and health to be expanded or more thinly spread. If it is practically or politically impossible to expand the pool of available resources, any reduction in benefits and services should be guided by the principle of minimizing harm to the worst off.
Prioritizing Medical Device Investments under Resource Constraints

Ms Karin Diaconu, University of Birmingham; Presenters: Dr. Carole Cummins, Senior Lecturer, Institute of Applied Health Research, University of Birmingham; Ms Adriana Velazquez Berumen, Senior Advisor and Focal Point for Medical Devices, World Health Organization; Ms. Gabriela Jimenez Moyao, Independent Consultant; Dr. Mireille Goetghebeur, University of Montreal; Prof. Tracy Roberts, Institute of Applied Health Research, University of Birmingham

Medical devices and equipment are core components of health systems. Research suggests, however, that between 40-70% of such technologies deployed in resource constrained settings are broken, unused or unfit for purpose. This symposium brings together presentations on current research and World Health Organization initiatives aimed at exploring and tackling this issue. Speakers will address the diverse challenges resource-constrained settings encounter in procuring and managing medical devices and critically discuss the role of health economic evaluations for informing improved resource allocation. Stakeholders from the World Health Organization will further reflect on the prioritization of health technologies using a multi-criteria analysis framework and present the resulting List of Priority Medical Devices for Cancer Care.

The session aims to introduce international policy and decision-makers, as well as health system and health technology assessment researchers, to original up-to-date research in this area and thus promote improved health service delivery planning and resource allocation.

Please see the below for brief presentation outlines:

• Presentation 1: Medical device procurement under resource constraint: views from The Gambia, Romania, expert community and literature.
Findings from a qualitative study exploring medical device procurement decision processes and dynamics in contrasting low- and middle-income country settings will be presented. We present recommendations on best procurement practices crystallized from a systematic review of the international literature.

• Presentation 2: Reflections on the feasibility of undertaking economic evaluations of medical devices for resource constrained settings
The presentation reflects on the feasibility of carrying out health economic evaluations for resource-constrained settings. We present the background, methods and findings of an orthopaedic femur-fracture care case study and discuss challenges encountered in the use of generalized cost-effectiveness analyses methods.

• Presentation 3: Prioritization of Health Technologies: Developing the WHO List of Priority Medical Devices using MCDA

A current initiative on the use of multi-criteria decision-analysis (MCDA) for the development of the World Health Organization’s (WHO) List of Priority Medical Devices is presented. In a first phase, the list focuses specifically on devices for cancer management. The project, its intent and rationale behind engaging different stakeholders via the use of MCDA will be presented. Challenges and opportunities for decision makers and end-users of resulting medical device lists will be discussed.
Public Health Decision Making Within UK Local Government

Dr Emma Frew, University of Birmingham; David Hunter, Professor of Health Policy and Management, Centre for Public Policy and Health, Durham University; Jo Gray, Senior Lecturer in Health Economics, Faculty of Health & Life Sciences, University of Northumbria; Sara McCafferty, Health Economics Group, Institute of Health & Society, Newcastle University; Mark Petticrew, Professor of Public Health Evaluation, London School of Hygiene & Tropical Medicine

Session Sponsor: the Public Service Academy, University of Birmingham

In 2013 public health responsibilities in England shifted from the National Health Service (NHS) and returned to local government. While broadly welcome, the move occurred at a time of unprecedented financial pressure on public services and decision makers have been faced with making difficult resource allocation decisions.

This organised session will present research from different parts of England aimed at gaining a deeper understanding of the architecture of decision making within local government; recognising the political and cultural contexts; identifying the information needs of decision makers; and understanding what the main barriers and obstacles are to using decision support tools to aid prioritisation, investment and disinvestment.

Presentations:

1. “Shifting the Gravity of Spending?” Priority-setting for local authority public health commissioners.  
Presenter: Professor David Hunter

The research had two aims: (1) develop support for local authority-based public health commissioners and other stakeholders in prioritising investment in health and addressing health inequalities, and in deciding on disinvestment; and (2) evaluate the use of evidence in the prioritisation process in order to develop broader insights for knowledge exchange. The presentation reports on the four main influences on priorities for investment: an organisational context where health was less likely to be associated with health care and where accountability was to a local electorate; a commissioning and priority-setting context (plan, do, study, act) located within broader local authority priority-setting processes; different views of what counts as evidence and, in particular, the role of local knowledge; and debates over what constitutes a public health intervention, triggered by the transfer of a public health budget from the NHS to local authorities. We conclude that the relocation of public health into local authorities exposes questions over prioritizing public health investment, including the balance across lifestyle interventions and broader action on social determinants of health and the extent to which the public health evidence base influences local democratic decision-making.

2. Use of economic evidence to facilitate public health decision making within Birmingham Local Authority.  
Presenter: Dr Emma Frew

Recently, a 4-year programme of research has been funded to understand how health economics can facilitate public health decision making within Birmingham. This presentation will report on the findings of the first work package that is designed to understand what and how economic evidence is currently used within decision making, and to identify the information needs from the perspective of the decision makers. Qualitative research methods comprising observations of meetings and one-to-one interviews will be reported. Results will provide an understanding of the decision types, whether the decisions are for whole or parts of services, and overall a better understanding of context to help identify how and where economic evaluation can be most useful to decision making.

Presenters: Jo Gray & Sara McCafferty

This presentation will provide an overview of economic approaches and methodologies that can be utilised to help inform decision making in Public Health priority setting. These range from ‘light touch’ scorecard style to more intensive multi criterion decision analysis (MCDA) techniques. Furthermore, we will report on findings from practical case studies from various local authorities in the North East of England to demonstrate how the uptake and application of these methods have gained momentum over the past couple of years and the impact they have had. Finally, we reflect on the work to date and consider the role and responsibility of health economists to develop robust, but pragmatic and practical tools which can be readily adopted by practice partners.

4. “Cultures of evidence” beyond the health sector. 
Presenter: Mark Petticrew

It is important to understand how “evidence” is understood, used and created in sectors outside the health sector. This presentation will use recent findings from several studies conducted to explore how information and evidence are defined, assessed and utilised by local professionals who are situated beyond the health sector. A qualitative study of practitioners working in design, planning and maintenance of the built environment found that decision-makers value empirical evidence, but also prioritised evidence on the acceptability, deliverability and sustainability of interventions over evidence of longer term outcomes (including many health outcomes). The findings are consistent with a systematic review which found that the evidence use is often constrained by its applicability to practice, considerations of political support, and legislative considerations. The implications of these various findings for “evidence based public health” will be discussed.
Medicaid Expansion in Michigan: Patient and Practitioner Priority Setting

Dr Susan Goold, University of Michigan; Lisa Szymecko, University of Michigan Department of Internal Medicine; Karen Calhoun, Neighbourhood Services Organisation, Detroit, USA

In 2014 Michigan expanded eligibility for Medicaid health insurance to residents up to 138% of the federal poverty level. The Healthy Michigan Plan (HMP) was approved by the federal government contingent on evaluation of unique features, including:

1. Copayments and premiums for those with higher incomes
2. Financial incentives for completing a Health Risk Assessment (HRA) and committing to healthy behaviors
3. Enrollment in managed care plans
4. Required primary care visit within 90 days of enrollment

This session will:

1. Provide brief background about the Affordable Care Act and states’ options for expanding Medicaid.
2. Describe Michigan’s Medicaid expansion (HMP) and its unique features
3. Describe the evaluation plan for HMP and the rationale and methods for emphasizing the voices and perspectives of enrollees.

Evaluating the impact of the Healthy Michigan Plan requires understanding the experience of those who enroll:

Do they understand their cost-sharing parameters and the incentives they have for particular behaviors? Do they establish primary care? Does their health improve? Understanding the overall health and economic impact of the Healthy Michigan Plan at a personal level requires learning about the experiences of participant beneficiaries. Our evaluation plan includes:

1) Interviews with enrollees, providers and organizations serving low-income residents in 5 diverse communities in the state.

2) A survey of all primary care providers (PCPs) serving at least 12 HMP enrollees (n=4322) to obtain empirically valid and timely data about experiences caring for HMP beneficiaries, new practice approaches and innovations adopted or planned in response to the HMP, and future plans regarding care of HMP patients.

3) The Healthy Michigan Voices Survey of 4000 enrollees, randomly selected within geographic regions and income strata, to describe

- Consumer behaviors and health insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.
- Self-reported changes in health status, health behaviors, and facilitators and barriers to healthy behaviors, and strategies that facilitate or challenge improvements in health behaviors.
- Decisions about when, where and how to seek care, including decisions about emergency department utilization.

4. Describe primary care providers’ (PCPs) decision-making on whether to accept HMP patients

Background: An adequate primary care workforce to care for newly insured HMP patients is of critical importance. Despite concerns for insufficient primary care capacity, our previous work found increasing availability of appointments for new HMP patients. What factors influence PCPs’ decisions to accept new HMP patients?

Methods: We surveyed 4322 PCPs caring for HMP enrollees in 2015, and conducted 20 in-depth interviews with PCPs from diverse communities and practice settings.

Results: The response rate was 56%. We will describe the proportion of PCPs currently accepting new HMP patients and PCPs’ rating of factors considered important to the decision to accept new HMP patients, such as reimbursement, the capacity to accept new patients with any type of insurance, the availability of specialists who see Medicaid patients, and illness burden or psychosocial needs of Medicaid patients. We will also describe themes about accepting HMP patients that emerged from analysis of interviews using a grounded theory approach.

Conclusions & Implications: During expansion of public insurance programs in the U.S. and elsewhere, understanding how health care professionals make decisions to care for low-income individuals is increasingly relevant. We will discuss how PCPs in Michigan face this decision after insurance expansion in the U.S.

5. Present results from a study of enrollee views/experiences of cost-sharing and financial incentives:

Methods: We conducted in-depth interviews with 32 HMP enrollees, selected for geographic, racial and ethnic diversity, and a range of income and cost-sharing requirements. Interviews were recorded and transcribed verbatim. Thematic analysis used a grounded theory approach.

Results: Many perceived their cost-sharing to be fair, affordable and reasonable, particularly for the benefits received. Most were relieved that payments were small. Some felt responsibility for paying part of the cost of care. Most enrollees did not understand the financial incentives for healthy behaviors and completing the HRA. Many expressed a desire to be healthy or to get needed health care as reasons for those activities.

Conclusions: Asking low-income individuals to pay a portion of their costs confronts competing priorities for their limited resources. We found, however, that Medicaid enrollees perceived modest payments as fair, reasonable and (usually) affordable. Our findings suggest that financial incentives may not add to the inherent motivation for healthy behavior. Importantly, for any such incentives to be effective, potential recipients need to be aware of and understand them.

6. Discussion.
Applying the Oregon list in a UK setting – lessons learnt two years on

**Dr John Harvey**, North Staffordshire Clinical Commissioning Group; Gemma Smith, Senior Commissioning Manager, North Staffordshire Clinical Commissioning Group; Cheryl Hardisty – Chair, North Staffordshire Clinical Commissioning Group; Dr Paul Davies, Milliman Health Analytics UK

North Staffordshire Clinical Commissioning Group (CCG) is working in partnership with the other five CCGs and the Local Authorities in Stoke and Staffordshire to maximise the value of commissioned services for the population of Staffordshire (a county in England) through a Prioritisation Programme. The aim is to ensure the available resources are used wisely and fairly to achieve sustainable improvement in health and well being for all of the communities and residents of Staffordshire County.

Building on a 5 year continual programme of prioritisation using a MCDA (modified Portsmouth scorecard) which has ranked more than 250 interventions, the programme was broadened to produce a local Staffordshire Prioritised List (SPL) of healthcare services collating the local ranking with the Oregon Prioritised List of Health Services. This session will examine the barriers encountered by the programme and the opportunities which it has created, whilst describing the processes and the progress in implementation.

**Aims:**

i. Describe the logic involved in creating the SPL
ii. Examine the strengths and weaknesses of the programme
iii. Present the impact on commissioning intentions and policies
iv. Analyse the potential benefits or harms to population health

The session will address these themes:

- The challenges of local health and social care decision making
- Disinvestment, decommissioning and low value care
- The role of health professionals as gatekeepers and resource stewards

**Structure:** Four presentations with time for a plenary discussion

1. Creating the SPL
   This presentation will define the rationale for creating the SPL with reference to The Triple Aim of care, health and cost. The process will be described with emphasis on the experience of prioritisation locally. Two of the major barriers to success will be analysed: the distractions of ‘business as usual’ and the differences in commissioning philosophy of the different parties. The efforts to secure public and clinical engagement will be reviewed critically.

2. Better use of data
   This presentation will describe the limitations on securing timely relevant data to allow each line in the SPL to be analysed for activity (eg which procedures and how many) and costs. The opportunities presented by better use of data and the commission tools which have been created will be discussed, with reference to the aim of controlling costs. This better understanding of the resource utilisation brings options to derive benefit from risk-based contracts. The pros and cons of this approach in the local context will be summarised.

3. Issues in implementation
   The progress in implementation will be described with emphasis on improving technical efficiency in the high volume high cost lines, reducing activity by setting eligibility criteria, and expanding and reinforcing the policy on procedures of low clinical value. This is aimed at improving the individual experience of care. Steps taken on to move towards a well managed health care system in the county will be discussed. The key role of the gatekeeper in implementation has been recognised and the gains from use of local versions of Map of Medicine in primary care will be presented.

4. The impact on population health
   This presentation will challenge the assumptions about the impact of the use of a prioritised list on the overall health and wellbeing of the population. Two issues will be addressed in relation to the local context. Does the use of a prioritised list of healthcare services or interventions result in reduced access for certain population groups e.g. those with mental health conditions? Does healthcare priority setting negatively impact on health inequalities for socially disadvantaged groups?

This presentation will describe the progress in developing and implementing a local prioritised list (Staffordshire Prioritised List, SPL) as a tool for commissioners in the context of the English NHS. The prioritisation programme in Staffordshire has the potential to impact the Triple Aim of care, health and cost. The efforts to secure public and clinical engagement will be reviewed critically.

The key barriers to successful implementation will be analysed with attention to the effectiveness of the chosen solutions. These barriers are:

- the limitations on securing timely relevant data to allow each line in the SPL to be analysed for activity (eg which procedures and how many) and costs.
- the limitations on improving technical efficiency in the high volume high cost lines, reducing activity by setting eligibility criteria, and expanding and reinforcing the policy on procedures of low clinical value.
- the key role of the gatekeeper, the primary care physician, in implementation and the gains from use of local versions of Map of Medicine in primary care.

In addition the assumptions about the impact of the use of a prioritised list on the overall health and wellbeing of the population will be discussed. Two issues will be addressed in relation to the local context. Does the use of a prioritised list of healthcare services or interventions result in reduced access for certain population groups e.g. those with mental health conditions? Does healthcare priority setting negatively impact on health inequalities for socially disadvantaged groups?
Ultra-orphan drugs: establishing a fair and reasonable priority setting process at the extreme end of decision making when considering new health care interventions

Jonathan Howell, Consultant in Public Health; Sheela Upadhyaya, The NICE Associate Director for the HST Committee; Dr Mark Sheehan, Oxford Biomedical Research Centre (BRC) Ethics Fellow at the Ethox Centre

This session focuses on the new NICE committee that considers the funding of the very expensive orphan drugs on behalf of the NHS. The aim is to explore some of the issues in looking at the processes and the evidence used in making the complex decisions on these new drugs.

The NHS in England has struggled over the last 10 to 20 years to find a reasonable process to make decisions on the funding of the new drugs for the rare diseases that have very small patient numbers. These diseases have been termed “orphan diseases” and orphan drug legislation in many developed countries has allowed the introduction of expensive drugs targeted at patients with some of these rare diseases. With possible costs reaching £250,000 per patient per year or above, decision making in the context of other health service priorities has been pushed to the extreme in trying to balance giving these patients a fair chance of treatment without undermining other treatments of more reasonable value for patients with common diseases.

Since 2014 the English NHS has asked for these funding decisions to be made on the recommendation of a new committee at the National Institute for Health and Care Excellence (NICE). The NICE Highly Specialised Technologies Committee (http://www.nice.org.uk/About/What-we-do/Our-Programmes/NICE-guidance/NICE-highly-specialised-technologies-guidance) has started to develop a specific methodology and process to consider how to balance the issues around these complex decisions. This process needs to take into account difficult evidence on clinical effectiveness and the associated health economic modelling along with patient preferences and the need for the pharmaceutical industry to have sufficient incentive to develop innovative new treatments. NICE Committees are expected to follow explicit principles that in turn are based to some extent on the principles in Accountability for Reasonableness (Daniels and Sabin).

Three presentations are:

• The methodology for the working of the committee and the problems in developing a fair and reasonable process that meets the requirements of a single national payer with a fixed budget for a much wider range of health services than orphan drugs alone.

• The evidence used in the process and the issues with uncertainties in the evidence that make clear judgements more difficult. This will particularly focus on the clinical and cost effectiveness evidence that is core to any decision and that the evidence requirements for the market authorisation of a new drug are substantially less that the evidence needed to make a funding decision.

• Part of the methodology of the Committee is to take into account the evidence from patient and public representatives on any particular drug. This part of the process is important but clearly has the potential to be less objective than other published evidence on the effectiveness of a new drug. NICE has sponsored research into this aspect and this will be presented along with a view on how this part of the process works to help the Committee to make a decision.

The intended audience is anybody interested in priority setting principles and the implementation of those principles in complex health care funding decisions. Also those people particularly interested in making decisions on very expensive orphan drugs, which may be perceived to have poor cost effectiveness.
Beyond institutions: international experiences and trends in public and patient involvement in health priority setting

**Dr Katharina Kieslich**, King’s College London;** Dr Kalipso Chalkidou**, NICE International; **Aviva Tugendhaft**, PRICELESS South Africa, University of the Witwatersrand; **Professor Jennifer Whitty**, University of East Anglia

This organised session will present and discuss key findings from an international workshop on patient and public involvement (PPI) in health priority setting, which reveal that PPI takes place outside as well as inside institutionalised PPI structures. The workshop was held at the Brocher Foundation in Geneva in November 2015 and brought together global representatives of multiple disciplines including political science, bioethics, medicine, law and philosophy.

Health care systems are facing increasing demands against the background of limited resources. Most countries are introducing systems to assess “value for money” that offer approaches to prioritising health services that seek to gain legitimacy with those on whose behalf they function. These emerging processes face legal, political, methodological, philosophical and ethical challenges. Most approaches consider PPI as central to acceptability and legitimacy but struggle to gain meaningful interaction or impact. Given that the literature on PPI in health priority setting continues to grapple with the question of the impact of PPI, the workshop proceedings gave rise to a unique set of empirical material on different country experiences. The most illuminating finding was that in countries where little to no institutionalised PPI structures exist, the public and patients are finding other ways to get involved and influence the outcome of prioritisation decisions, for example through litigation in Latin America and through advocacy in South Africa. Especially in the context of the National Health Service (NHS), PPI is commonly conceptualised as part of the official decision-making process, e.g. in the context of the National Institute for Health and Care Excellence, but the experience in low and middle income countries suggests that this conceptualisation might be too narrow.

The organised session will consist of three presentations on some of the themes that emerged from the workshop in Geneva. The first presentation will be given by Professor Jennifer Whitty. Professor Whitty will discuss the patterns of PPI in health priority setting that are emerging in different countries. This will highlight that PPI does not just take place in institutionalised forums, but also in more informal ways that may, in some cases, have a bigger effect on the decisions in health prioritisation than institutionalised PPI. Case study examples from middle and high income countries will be used to illustrate the patterns of PPI that are emerging.

Dr Kalipso Chalkidou will give the second presentation. This presentation will discuss whether cost effective, but very expensive, interventions such as the new direct-acting antiviral hepatitis C medicines call for a wider form of PPI that includes the public beyond the established PPI structures. Again, the focus is on country experiences of involving the public and patients when making reimbursement decisions on new hepatitis C medicines. Dr Chalkidou will explore whether the involvement of the public has helped decision-makers address the challenges that emerge and whether a case can/should be made for different modes of PPI when the treatments in question exhibit certain characteristics.

Finally, Aviva Tugendhaft will present the developments of PPI in health priority setting in South Africa, with an emphasis on what has been labelled ‘contestatory politics’. Aviva Tugendhaft will show that public engagement is a key feature in South African policies, guided by an overarching Constitution and Bill of Rights, but has often not translated into implementation. This has resulted in citizens increasingly articulating concerns outside of formal structures through advocacy, protests and litigation, with an impact on the priority setting agenda. Aviva will consider the case of the Treatment Action Campaign as an example, highlighting lessons learned and the need for more effective models of public engagement.

Dr Katharina Kieslich will chair the session. The presentations will be followed by questions from the audience with the aim of instigating a discussion on the findings that were presented.

The unique feature of the proposed organised session is that its focus is on cross-national country comparisons of patterns and modes of PPI in priority setting. We hope that this session will be of interest to both researchers working on PPI in health priority setting as well as practitioners and decision-makers who are looking to learn from other countries as they develop their PPI processes.
Outcomes for commissioning: the potential for capability wellbeing measures to support decision-making

Dr Hugh McLeod, University of Birmingham; Professor Joanna Coast, University of Bristol; Ellen Rule, Gloucestershire Clinical Commissioning Group; Dr Graham Mennie, GP and Clinical Programme Group Clinical Lead, Gloucestershire CCG; Barbara Stevens, Clinical Programme Lay Champion, Gloucestershire CCG

Aims
Capability wellbeing measures have been designed for assessing outcomes in the economic evaluation of interventions across the health and social care system. While health economists have started to use these measures in conventional economic evaluations, capability measures can also be used directly by commissioners. This session highlights the considerable potential of capability measures to support local decision-making about resource allocation. The work is informed by early experience at Gloucestershire Clinical Commissioning Group.

Intended audience
All those involved with local decision-making about resource allocation in commissioning organisations, such as Clinical Commissioning Groups in England. Staff in health and social care provider organisations engaged with the commissioning process.

Structure
Session chair: Dr Hugh McLeod, Research Fellow, University of Birmingham.

The organised session will comprise two presentations, followed by a panel discussion with questions from delegates, and concluding remarks.

First presentation: Capability measures?
Joanna Coast, Professor in the Economics of Health and Care, University of Bristol

Outline
• Introduce the capability measures and highlight how:
  - Defining outcomes in terms of capability offers an important new focus for priority setting;
  - Measuring capability wellbeing facilitates a holistic approach to quantifying outcomes which is appropriate for assessing interventions that cross the health and social care system;
  - The capability measures can focus attention on the ‘health inequality’ agenda, in part, by recasting it in terms of a focus on achieving ‘sufficient capability’.

Second presentation: A Commissioner’s perspective on the potential of the Capability measures to inform outcome-based commissioning
Ellen Rule, Director of transformation and service redesign, Gloucestershire Clinical Commissioning Group (CCG).

Outline
• Drawing on experience at Gloucestershire CCG highlight how:
  - by instigating collection of capability data from patients before and after a wide range of service interventions, commissioners could promote and facilitate dialogue with providers about the impact of services, and inform strategic priority setting;
  - by adopting the capability measures, commissioners could demonstrate system leadership. At one level, this is linked to building a consensus for a shared approach to valuing outcomes both between their executive team and their counterparts in health and social care provider organisations. At another level, a focus on improving capability wellbeing has the potential to influence how frontline staff view their role and interact with patients.
  - Capability measures could be used to inform outcome-based commissioning, but promoting a better understanding of outcomes is only one very important step towards developing outcome-based commissioning.

Round-table panel. Panel discussants:
Dr Hugh McLeod, University of Birmingham (chair)
Professor Joanna Coast, University of Bristol
Dr Graham Mennie, GP and Clinical Programme Group Clinical Lead, Gloucestershire CCG
Ellen Rule, Gloucestershire CCG
Barbara Stevens, Clinical Programme Lay Champion, Gloucestershire CCG

Concluding remarks: Next steps for knowledge mobilisation – applying theoretical advances in practice – and learning from experience
Dr Hugh McLeod, University of Birmingham

Outline
• Despite policy rhetoric on the merits of outcome-based commissioning, there has typically been little discussion about outcomes between commissioners of health and social care and service providers;
• Promoting the capability approach at Gloucestershire CCG generated considerable enthusiasm for adopting the holistic approach to measuring outcomes that it entails;
• Piloting the use of capability measures across a range of services will raise awareness among stakeholders, while a collaborative approach is vital to address any apprehension associated with drawing attention to outcomes.
From priority-setting decisions to health impact: new explorations of a complex translation process

Ms Laura Morris, National Institute for Health and Care Excellence; Ms Eleanor Grieve, University of Glasgow (UK); Yot Teerawattananon, Health Intervention and Technology Assessment Program (HITAP, Thailand); Ms Emma Newbatt, Itad (UK)

This organised session will be a panel discussion on defining the impact of priority-setting decisions and health technology assessment (HTA) in low- and middle-income countries.

Background:

Institutionalisation of HTA is moving forward in many countries making the journey towards universal health coverage. This has been bolstered by commitments at a global level, such as the World Health Assembly resolution in 2014 which recognised the role HTA and robust priority-setting processes can play in making fair resource allocation decisions and sustaining health systems’ performance. However, even in countries where HTA programmes are well-established, research identifying their outcomes and impact in terms of health gains is limited.

Past evaluations and studies from the UK and international literature mainly focus on the effect HTA has on policy processes and decision-making, rather than outcomes. In the UK, recent evaluations of the NIHR’s HTA programme confirmed that impact on knowledge generation is more easily quantified than that on policy outputs or especially health gain. For countries with greater capacity constraints, how decision-making interacts with ‘context’ leading to health outcomes is even less explored and arguably of critical importance. Measuring health in terms of health gains necessarily requires implementation to be addressed, however, it is also evident that this is the least researched area of HTA.

Aims of the session:

The session will stimulate rich discussion on the expected benefits of HTA for priority-setting, and on what is needed to realise these benefits beyond the existence of evidence and policy will. Panelists will discuss key findings from work by members of the International Decision Support Initiative (iDSI), a global partnership of HTA institutes, universities, and think-tanks. iDSI’s vision of “better decisions for better health” recognises that there is a complex translation process between decisions and health outcomes, dependent on local features including links between decisions and budgets, delivery, implementation, and data accuracy.

We anticipate that this session will be of interest to UK and international practitioners in priority-setting initiatives, in addition to researchers. This include programme leaders and health service managers who are at early stages of introducing evidence-based thinking into routine practice, and wish to discuss the range of contextual factors which can affect implementation and impact.
Priorities on the path to universal health coverage: integrating fairness with cost-effectiveness

Professor Ole Frithjof Norheim, University of Bergen; Tessa Tan-Torres, World Health Organization; Richard Cookson, University of York; Trygve Ottersen, University of Oslo, University of Bergen, and Norwegian Institute of Public Health; Dr Addis Woldemariam, Ministry of Health, Ethiopia

The aim of the session is to discuss priority setting on the path to universal health coverage (UHC) and how fairness and cost-effectiveness best can be integrated when selecting services. This fits very well with conference theme A, which pertains to equity as well as global health and universal health coverage. The target audience include researchers, policy makers, and health planners seeking to strengthen health systems and promote universal health coverage, and particularly those who are involved with the evaluation and choice of interventions to be funded.

To this end, the session will present ongoing work directly addressing this issue, as well as look forward and discuss other planned WHO initiatives.

The session will include five prepared presentations and will seek to be highly participatory. The structure of the session is planned as follows:

1) Welcome and introduction to three criteria for making fair choices (Prof. Ole Frithjof Norheim, University of Bergen): The chair of the session, Ole Frithjof Norheim, will welcome all participants, set the stage, and outline the structure of the session. Dr. Norheim will then introduce three overarching criteria for priority setting on the path to UHC. This will be based on recent and ongoing work, including some of the material to be presented later in the session.

2) Revising the essential health services package in Ethiopia (Dr. Addis Woldemariam, former Chief of Staff, Ministry of Health in Ethiopia): Dr. Woldemariam will share his experiences with setting priorities among interventions when seeking to strengthen the Ethiopian health system.

3) The audience will be invited to share their experiences with designing health service packages, and especially experiences related to the relationship between cost-effectiveness and fairness.

4) Case studies on making fair choices on the path to UHC (Ms. Tessa Tan-Torres, World Health Organization): Ms. Tan-Torres will briefly describe the recent work of the WHO-CHOICE project and main findings of the WHO Consultative Group on Equity and Universal Health Coverage, which published their report in 2014. She will then present the WHO casebook, which builds on that report and is to be published in 2016. The cases in this book are designed to invite users to reflect on the cases before solutions are suggested. Ms. Tan-Torres will present one of the cases in this way and invite deliberation among the audience.

5) Quantitative integration of distributive concerns (Prof. Richard Cookson, University of York): Dr. Cookson will present recent and ongoing work on the quantitative integration of distributive concerns in priority setting for UHC. He will describe methods of “extended” and “distributional” cost-effectiveness analysis, recently developed by the DCP3 project and the Centre for Health Economics at the University of York, respectively, and discuss how they can fruitfully be applied to achieve fairer decisions and better health for all in low, middle and high income country contexts.

6) Merging ethics and economics into a common framework for evaluating health interventions (Dr. Trygve Ottersen, University of Bergen): Dr. Ottersen will present key findings and recommendations from an ongoing book project that seeks to merge perspectives in ethics and economics in a common framework for evaluating health interventions. Dr. Ottersen is co-editor of the book, which is expected to be published early 2017.

7) The chair will invite comments and suggestions and facilitate discussions pertaining to one or more of the presentations.

8) The session will conclude with closing remarks by the chair.
Neoliberal epidemics: Understanding how neoliberalism threatens health, and how to fight back

Professor Ted Schrecker, Durham University; Dr. Lisa Garnham, Glasgow Centre for Population Health; Prof. Kate Pickett, Department of Health Sciences, University of York and Equality Trust; Prof. Jennie Popay, Institute for Health Research and Health R&D North West, Lancaster University; Dr. Katherine Smith, Global Public Health Unit, School of Social & Political Science, University of Edinburgh

Neoliberalism has been the ascendant political ideology in the UK and much of the rest of the world for the past few decades. In 2015, Schrecker and Bambra coined the term ‘neoliberal epidemics’ to describe the health consequences of neoliberalism and the social impacts and policies that lead to those consequences. Consideration of the ethics and politics of priority-setting often neglects both ‘upstream’ social determinants of health and the macro-scale policy choices that influence these and create the context for priority-setting. These dimensions have acquired added urgency in the context of post-2008 (selective) austerity measures.

This panel builds on the concept of neoliberal epidemics and demonstrates its usefulness by considering case studies; seeking to explain the penetration of neoliberal ideas into the policy process; and proposing directions for change.

Kate Pickett summarises recent evidence for a causal relation between the inequalities that are magnified by neoliberal policies and a range of adverse health outcomes, and describes the Equality Trust’s innovative efforts to place inequality higher on the political agenda. Based on extensive ethnographic study, Lisa Garnham explores how the erosion of welfare state policies in the areas of housing, subsistence, social services and healthcare, along with labour market policies that tolerate and even encourage the spread of precarious employment, have played out in practice and impressed themselves upon the lived experience in a formerly industrial part of west central Scotland since the 1970s. In particular, she focusses on how these impacts have accumulated across the life course, by considering the impacts upon three birth cohorts: those born around 1930; those born around 1950; and those born around 1980.

Katherine Smith uses interviews and an analysis of two large policy consultations to identify the types of organisations that are trying to influence contemporary policy responses to health inequalities in the UK and European Union, examining both the ideas about health inequalities that each type of actor seems to be promoting and the ways in which they are interpreting and employing available evidence. This analysis demonstrates that a wide range of actors, beyond researchers, are trying to influence policy responses to health inequalities, supporting calls for researchers to take the politics of health policy more seriously and highlighting the lack of any clear advocacy coalitions within health inequalities policy debates. In addition, the findings add further weight to concerns about ‘lifestyle drift’.

Jennie Popay argues that the evolution of community involvement in public sector decision-making illustrates another dimension of the neoliberal epidemic: as the dominant narrative around involvement in the design and delivery of services moves from ‘choice’ to ‘voice’, the reality is essentially ‘do it yourself’ welfare. This shift is encapsulated in the multitude of initiatives apparently aimed at promoting individual and collective ‘resilience’ and ‘empowerment’. In the context of a shrinking state and hollowed out public services these initiatives seek neoliberal ‘voluntarism’ supported by private sector philanthropy.

Finally, Ted Schrecker sets out seven principles for fighting neoliberal epidemics: ‘First, do no harm’; treat public finance as a public health issue; think critically about standards of proof with respect to the use of research evidence, working towards a precautionary principle in public health; understand the depth of disparities in the ‘epidemiological worlds’ that people inhabit; beware lifestyle drift; interrogate assertions of resource scarcity; and speak truth about power.
Perspectives on the legal regulation of priority-setting

Professor Keith Syrett, Cardiff University; Dawn Brathwaite, Partner, Mills and Reeve Solicitor; David Lock QC, Barrister, Landmark Chambers; Jean McHale, Professor of Health Care Law, University of Birmingham; Christopher Newdick, Professor, University of Reading

Although frequently regarded as an irritant by decision-makers, law plays a central role in regulating the process of priority-setting in health care, in the National Health Service as in other health systems. There is now broad acceptance of its value in articulating procedural standards, compliance with which will assist in legitimising difficult allocative choices.

Nonetheless, the scope and reach of law’s role remain controversial. For example, critical interrogation in the courtroom of the evidence which underpins priority-setting decisions raises concerns as to whether legal actors possess the requisite expertise to undertake their task. Further, the framing of legal claims in terms of “rights” (whether to access care, as in the case of individual patients, or the commercial interests of “big pharma”), may cast doubt upon the capacity of legal processes to uphold public over private interests in the context of priority-setting. And particularly difficult questions of lawfulness may arise in respect of short and long-term socio-economic pressures placed upon health systems. Consider, for example, the warning issued by a UK minister of health in 2015 that “inappropriate rationing of care” carried out as a response to central government demands to make savings on NHS expenditure might amount to breach of the legal responsibility to provide services to meet the needs of local populations; or the possibility that measures taken to secure systemic sustainability in light of demographic change might violate legal norms and statutory obligations in respect of equality.

This organised session seeks to provide a critical exploration of law’s engagement with contemporary priority-setting in health care. Drawing upon both academic and practitioner perspectives, it will present an accessible, yet conceptually rich, analysis of the functions and limitations of law as a framework within which priorities are established. The five panelists will each present short papers addressing discrete topics in the theory and practice of legal regulation of priority-setting. The papers will be followed by a roundtable discussion of the issues raised, with audience engagement facilitated by the panel chair. While there will be a particular focus on the UK NHS, the topics presented will be of wide applicability across differing health systems. The session will therefore be of interest both to those researching priority-setting and those who are tasked with making such decisions in practice.

Evaluating health and social care interventions to aid decision making: Reablement case study

Ms Helen Weatherly, University of York; Helen Weatherly (Centre for Health Economics, University of York); Annette Bauer (PSSRU, London School of Economics and Political Science); Jennifer Francis (NICE Collaborating Centre for Social Care, SCIE); Contact in NICE (TBC Justine Karpusheff)

Over time, increasing amounts of research are being undertaken to evaluate what health and social care interventions work and at what cost. Such evaluations are undertaken to assist decision makers in deciding which interventions represent the best value for money and therefore which they should invest in. Also, they highlight the uncertainty associated with the investment, and provide clarity on factors which might enhance the use of the intervention in practice.

Reablement is a time limited, multi-disciplinary intervention to help individuals retain or regain the ability to live independently after an illness or injury. It is hailed as an effective and cost-effective intervention. Within the UK and internationally there is a growing drive to invest in reablement. The expectation is that reablement can help to reduce the pressure on public budgets, in an ageing society, by improving people’s wellbeing and health and in reducing the use of ongoing home care.

There have been a number of evaluations, in particular in the UK, New Zealand and Australia, however, there remain many unanswered questions. For example, whilst a large retrospective longitudinal study by Glendinning et al (2010) carried out in the UK found that health and social care-related quality of life improved, it did not identify cost savings in the first year. Studies that applied a more robust, randomised design found no significant improvements in health and wellbeing but significantly lower health and social care costs in the intervention group (Lewin et al 2013; 2014). Reablement interventions vary in terms of the population they target, their duration and intensity, and skill mix of staff. Faced with budgetary pressures, there have been many attempts in practice to make reablement more affordable, by e.g. reducing length or intensity of provision or in using less expensive staff. The impact of these adaptations in terms of outcomes and costs is far from clear.

This session brings together three researchers who work with the National Institute for Health and Care Excellence (NICE) They come from different disciplines and sectors including academia and the third sector. Together they represent a broad range of knowledge from a policy, systematic review and economic evaluative perspective. All contributors have an interest in understanding the value of investing in reablement. Their different and often complementary perspectives are explored in this session. Reablement is used as a focus to discuss the issues and challenges faced in making sense of the health and social care evidence from the various perspectives, and in creating new evidence to fill the gaps. The aim is that the session is useful in informing decision makers with an interest in reablement, as well as those who are undertaking evaluations in this area, or similar areas where interventions are multi sector, relying on health and social care input and possibly other sectors too, such as the third sector.

The Chair of the session will introduce the 3 contributors, manage discussion and debate on the issues raised and summarise the key themes and messages at the end of the session. The first presentation will offer a brief overview of research on reablement (Francis et al, 2011), highlighting key issues including disseminating evidence for specific audiences and plugging research gaps with practice expertise. The first presenter will also discuss some of the challenges of using evidence in the development of NICE social care guidelines and the options available to guideline committees when research to support decision making is lacking. The second presentation will summarise the plans for an ongoing cost-effectiveness evaluation of reablement. It will explore the methods, issues in evaluating reablement, and social care interventions more generally based on a systematic review of relevant empirical literature, and how this is used to inform the methods used in the ongoing study. The third presentation explores the challenges faced by policy and decision makers in interpreting the available economic evidence and for practitioners and researchers to produce evidence that demonstrates short-term gains. This will refer to the challenges of evaluating complex social care interventions that have important impacts on other sectors and budgets, and the way that costs and outcomes are often determined by system level factors such as eligibility criteria. The impact of including unpaid care in decision making will be illustrated; and how evaluating this contribution can change the decision.
Priority setting in health: on the integration of facts and values

Professor Gert Jan van der Wilt, Radboud University Nijmegen Center; Prof Norman Daniels, Harvard School of Public Health; Prof Bjorn Hofmann; University of Oslo; Dr Rob Baltussen, Radboud University Nijmegen Center.

This panel presents and discusses various approaches to integrating facts and values in priority setting, and explicitly aims to debate this with the audience in an interactive session.

Methods for priority setting in health has traditionally been skewed towards the use of quantitative analyses, such as cost-effectiveness analyses. Yet, in recent years, HTA agencies and researchers are becoming increasingly aware that they should also consider the legal, societal and ethical aspects of technologies. This reflects the aim to increase the relevance and applicability of the assessments. However, the various aspects differ in their nature in whether they are quantitative or qualitative, and whether there is agreement on the norms and values underlying them – and thereby constitute a mix of facts and values. This poses challenges for HTA researchers on how to adequately assess these criteria, and to HTA agencies on how to appraise and trade-off the multiple criteria in a meaningful way.

The debate will be structured as follows:

i) a brief introduction to the challenge (chair: Prof van der Wilt);

ii) a brief overview of the results of the recently completed INTEGRATE project on how to adequately perform an integrated assessment of multiple aspects of health technologies (Prof. Hofmann)

iii) a brief theoretical exploration on how deliberative processes can be an answer to the challenge (Prof Daniels);

iv) putting theory in practice: a brief discussion on how facts and values can be integrated in practice, using a combined framework of deliberative processes and multi criteria decision analysis – this is presented with examples from EVIDEM and HIV control in Indonesia (Dr Baltussen).

v) an interactive session with the audience.
Beyond the hospital bed? Including family health in economic evaluation

Context: Economic evaluation is used to set healthcare priorities in a way that ostensibly maximises total health benefits. However, current practice focuses on the patient – ignoring the knock-on impact of interventions on family members’ health. The inclusion of family health raises challenges for economic evaluation in relation to how the family ‘spillover’ could be measured and how – if at all - the cost-effectiveness threshold should be adapted.

Aim: To test techniques to measure, predict, and include family health in economic evaluation, using a case study of a serious, preventable illness.

Methods: Data were collected on health outcomes of 1,218 family networks, where one family member was affected by meningitis. Comparison group and regression-based methods were used to measure family spillovers. Algorithms based on patient health were used to predict family spillovers. A framework for including family spillovers in economic evaluation, using ‘multiplier effects’, was developed.

Results: Different measurement approaches indicated a sizeable health spillover from meningitis on the family. This spillover extended beyond a single close family member. Predictive models were unable to estimate family spillovers with accuracy in this context.

Conclusion: To pursue a goal of health maximisation, economic evaluations need to incorporate health spillovers in addition to patient health benefits. Different methods can be feasibly used to measure spillovers, with the choice of method likely to depend on data availability. The findings suggest, however, that family health spillovers are best measured directly rather than ‘predicted’ based on patient outcomes.
A moral-political concept of health for our times

Aim and context: The World Health Organization defines health as "... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The definition has been criticized for various reasons. It does not reflect that people can adapt to their conditions and feel healthy despite chronic disease or disability; it cannot be operationalized; it is limitless and may therefore contribute to unjustified medicalization; and the definition is insensitive to distinctions between the severity of health deficiencies and correlating distinctions in claims for health care. Has time come to revise WHO's definition?

Method: The discussion is based on epidemiology, moral theory and reflection.

Result: We argue that we need a concept that allows for subjective experience of health and must reflect all the concerns mentioned above. Moreover, given the epidemiological knowledge of social health inequalities across and within nations, we contend that time has come to modify the individual-centred definition of health with a moral-political understanding of health.

We suggest a moral-political concept of health that incorporates all of the mentioned concerns while revolving around a specified threshold of human functionality and that cannot reasonably, or logically, be rejected by anyone who believes in giving people equal opportunities in life: "Health is the physical and mental capacity required to freely realize individual and social rights and duties and to participate in individual and social activities correlating with absence of diseases and infirmity and long lifetime expectancy.

Sub-treatment balancedness is a necessary property for priority criteria

The Norwegian government recently put in place a priority commission tasked with suggesting a set of explicit criteria for priority setting in the health care sector. The commission suggested three criteria, the first two of which equate to cost-effectiveness (in terms QALYs.) The third criteria specifies that the number of QALYs be multiplied by a factor depending on the total health loss – also measured in QALYs – without the treatment in question.

In this paper, we will show that the suggested weighting scheme creates contradictory situations in which the priority of treatment programmes will change based on arbitrary bundling or sub-divisions. We show that these types of problems can be ameliorated if the weighting scheme satisfies a property called sub-treatment balanced so that the total weighted QALY-gain is preserved when treatments are bundled or sub-divided.

We demonstrate that sub-treatment balance can easily be achieved in general, and in particular we show how to adapt the weighting scheme suggested by the Norwegian priority commission in order to satisfy this sub-treatment balance. Finally, we argue that any weighting scheme used in health care priority setting should be sub-treatment balanced with respect to any other attribute of a treatment which policy makers would want to take into account when making their decisions.

Sub-treatment balance should be required of any weighing scheme, and is crucial given that (i) the criterion results in weighting QALYs, and (ii) if the selected measure of severity is affected by the administered treatment.
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Developing a prioritisation framework for NHS England Specialised Services commissioning

The AIM of this work is to devise a sustainable means by which NHS England can make annual prioritisation decisions on new investments in Specialised Services.

The CONTEXT is that NHS England was created under the Health and Social Care Act 2012 with Public Health England as its public health advisor. NHS England in addition to overall strategic leadership for the English NHS also has responsibility itself for directly commissioning those services which are designated as Specialised by virtue of being high cost or low volume or for rare conditions. They account for around 14% of total NHS spend and because of their nature, seeking to innovate, in major centres, they excite interest and attention from many quarters. Formerly these services were the responsibility of local commissioners who had shared arrangements at regional level. Moving to a national operating model for the entire population of England meant, among other things, devising a sustainable model for relative prioritisation. This offers opportunities and challenges in equal measure in December 2013 PHE was asked for advice on the way forward.

The METHODS have been a combination of engagement through workshops, formal public consultation, expert seminars and feasibility testing.

In terms of RESULTS then this is an evolving methodology and we will present key findings particularly in relation to appropriateness of different approaches for Specialised Services commissioning.

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The patient’s voice in public deliberation-reaching collective solutions on allocating resources for cancer drugs

Aim: To show that patients at a deliberative public engagement in Vancouver, Canada, actively contributed to collective solutions to policy challenges and were not essentialized by their health status.

Context: HTAs commonly incorporate social preferences for allocation decisions. However, since patients and the public assign different values to the same hypothetical health states, deciding which preferences should be incorporated—patients’ or the public’s—remains a contested question. A deliberative public engagement event was held in Vancouver, British Columbia (BC) to determine what values British Columbians felt should underpin drug funding decisions.

Methods: A stratified sample of 24 individuals were recruited based on 2011 BC census data. Screening questions on i) experience with chronic disease and ii) advocacy were used to identify patients and mitigate sectarian interests, respectively. The event’s overall objective was to create a “mini public” through recruitment strategies and structured deliberation enabled by independent facilitation. All sessions were recorded and transcribed. Qualitative methods were used for transcript analysis.

Results: Participants made 30 recommendations for cancer drug policy. Several spoke openly about their experiences with illness; some identified as cancer patients. Participants accepted the need for trade-offs and limit-setting, including the need to rule out some benefits as too costly. Key themes informing the recommendations were fairness, patient choice, and the “grandfather clause.”

Conclusion: Deliberative public engagement methods can mitigate the dichotomization of patient and public perspectives through specific recruitment methods and supporting informed, respectful dialogue to encourage participants to reach civic-minded recommendations for allocating scarce health resources.
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How hard can it be? Assessing severity of ill health from citizen’s perspective

Context: Severity is a widespread criterion for priority setting within health care, highly valued by citizens, but the meaning and methods for assessment vary. Most studies of citizens’ views relate to health improvement and cost-effectiveness rather than severity per se. In order to receive more transparency and consistency a framework for assessing severity has been derived from the Swedish Parliament’s guidelines for priority setting, and tested by health care professionals in national and regional priority settings. Despite the fact that method development concerning priority setting cannot lean entirely on professional competence when it comes to values, citizens are seldom involved in these processes.

Aim: We wanted to see if the citizens’ reasoning about severity was in line with the framework used by professionals. Methods. An interview study with 15 Swedish citizens, using open-ended questions and pairwise ranking of descriptions derived from the framework. We used purposeful sampling based on demographic criteria, health experiences and attitudes towards priority setting. Directed content analysis was applied.

Results/Conclusion: Preliminary results showed that the respondents’ view corresponded with aspects of the severity framework (including functional impairment, activity limitations, participation restrictions, duration, intensity and future risks), but they also incorporated aspects that are ethically disputed. The results showed how they weighed the severity aspects against each other, giving psychological and social aspects great importance. These kinds of results need to be compared

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Why do health economists promote technology adoption rather than the search for efficiency?

Context: Practitioners of economic evaluation have largely focused narrowly on new technologies, with less emphasis on broader efficiency questions relating to technologies already in widespread use. This ‘adoption addiction’ has contributed to the unabated rise in health care expenditures over recent years. At a time of intense pressure on health care budgets, the search is for efficiency gains delivered in part through disinvestment in low-value in-use technologies.

Aim: This paper explores how health economists might begin to adopt a broader efficiency lens. The argument is not against evaluating new technologies but in favour of the ‘search for efficiency’, where the ultimate objective is to identify reallocations that improve population health in the face of resource scarcity.

Methods and Results: Drawing on an extensive literature review, we first explore why in-use technologies may be of low value and consider how economic evaluation analysts might embrace a broader efficiency lens. A conceptual model is developed, starting with ‘technology management’ (a process of analysis and evidence-informed decision making throughout a technology’s life-cycle) and progressing through ‘pathway management’ (the search for efficiency gains across entire clinical care pathways). A number of model-based case studies are used to illustrate the approaches: diabetic retinopathy screening and treatment pathways for prostate cancer.

Conclusion: We encourage the health economics community to embrace the role of ‘searchers for efficiency’, rejecting the current, almost exclusive, emphasis on technology adoption. This broadening of the analytic scope offers the possibility of fundamentally changing the nature of resource allocation decision making.
Agile health systems - aligning financial, operating and prioritization processes in real time to drive performance

Background:
In times of economic uncertainty, and constraint more agile performance management is needed. Annual budgets and month end review processes are generally too late to course correct. Siloes and special interests keep the health system “stuck” and makes it difficult to operate effectively.

Aim of Study:
In 2015 The Canadian Institute for Health Information and Alberta Health Services commissioned a project to test an integrated agile performance model covering:
- Predictive real-time analytics
- Real-time prioritization and decision support
- Funding approaches, and commissioning
- Financial processes – budgeting and month end close

Methods:
- Developed a hypothetical performance model
- Conduct desktop research to capture funding best practices and lessons learned from Canadian and international health systems, including input from CIHI and other stakeholders
- Tested with interviews and filed visits in Canada, New Zealand, Australia and Israel
- Conducted webinars to solicit feedback

Results:
Agile Financial Performance Model provides a significant opportunity for Canada - $1.1bn to $1.9bn
- Returns on investment high (10:1+ payback observed)
- Predictive and real-time analytics are the cornerstone for agile performance management
- Ethical prioritization process needed to make real-time disinvest and reinvest decisions (PBMA) is the leading approach used
- Integrated Operations Centre’s are key enablers to break down siloes
- Funding reform is the most effective way break down siloes, and incentivize the right behaviour
- Funding reform coupled with behavioral economics is the fuel for effective change

Themes:
- Duncan Campbell to present the study findings and how health systems in Canada are using the results of the study to improve performance in light of constrained health funding
- Craig Mitton to present prioritization processes and software is being used in context of the real-time performance model.

Setting healthcare priorities as a ‘wicked problem’: Insights from the policy analysis literature

In 1973, Rittel & Webber published a definition of what they described as ‘wicked problems’ in the context of urban and regional planning. The category has since been applied to a number of health policy and public health problems - arguably in some cases misapplied, since highly complicated or challenging problems are not necessarily wicked ones. We argue that how to allocate resources and set priorities for healthcare appropriately is a quintessential wicked problem. In this paper we elaborate that argument with respect to the ten criteria set out by Rittel & Webber, with the addition of two more that reflect specific characteristics of the health policy context. The point is not only to inform directions for the design of priority-setting institutions, but also – with reference to Calabresi and Bobbitt’s discussion of Tragic Choices – to suggest caution about the extent to which disputations about priority-setting can ever be regarded as ‘settled’.

Finally, again drawing from Tragic Choices, we suggest the need for attention to the macro-scale choices, exemplified by current policies of selective austerity, that give rise to some of the most intractable challenges for setting healthcare priorities. The National Institute for Health and Care Excellence (NICE), in particular the role of its Citizens’ Council set up to address the moral and ethical issues arising from the guidance NICE produces in an age of scarce resources, will serve as a case study illustrating that the questions involved cannot be reduced to technical issues of health economics.
Resource allocation decisions assessing respiratory care - programme budgeting marginal analysis in action

Health Boards face increasing pressure to deliver services that are considered good use of resources against a backdrop of limited budgets. A Programme Budgeting Marginal Analysis (PBMA) was undertaken collaboratively by Betsi Cadwaladr University Health Board (BCUHB), Public Health Wales and Bangor University. PBMA is a framework for making resource allocation decisions.

A PBMA panel was established with representation from managers of medicines’ management, therapies, finance, planning, and health care professionals from across BCUHB. Thirteen candidates for resource reallocation were selected, based on clinician suggestions and guidelines. Each was presented to the panel in an evidence booklet. The PBMA panel were charged with making resource reallocation recommendations based upon the evidence. Criteria for decision-making were decided and rated by the panel (including cost effectiveness and patients views). Individuals who oversaw the PBMA exercise had experience conducting PBMA and expertise in health economics, clinical, NHS finance and pharmacy prescribing.

The PBMA exercise found BCUHB spent £86.9 million on respiratory care in 2012-13. The panel recommended encouraging prescribers no longer to use mucolytics and seek savings in reducing medicines waste, while investing resources in pulmonary rehabilitation and pharmacy based smoking cessation services. The exercise demonstrated that against a backdrop of constrained health care budgets, PBMA offers an evidence based, transparent framework to make resource reallocation decisions.

“The guiding principle should be need... and compassion”: choices about funding end of life care

Aim/context: Resources for end of life care are provided by health services, social care and charities. There is little explicit exploration of decision rules for allocating these resources within or across sectors; this research explores these issues with policy makers and citizens in the UK.

Methods: Focus groups with randomly sampled citizens and policy makers included discussion on value-based rules for decision making and the realities of current provision. Subsequent in-depth interviews were conducted with individuals purposively sampled by views expressed in focus groups. Focus groups and interviews were audio-recorded and fully transcribed. Analysis used constant comparison.

Results: Seven focus groups were held with citizens (38 participants) and five with policy makers from the NHS, hospices and national organisations, as well as local hospice volunteers (36 participants). Eleven citizens and 16 policy makers were interviewed individually. Preliminary analytic themes include: the complexity of weighing different needs for end of life patients and those who can achieve health gain, whilst still giving sufficient resource to end of life care; equality of treatment for those at end of life alongside concerns about varying regional provision; the importance of compassion and flexible provision in the context of duty of care. Although these data are exploratory and relate to the UK context, they suggest the need for different decision-making rules for end of life, in line with one participant’s view that: “end of life care’s different from everything else... you’re not making a person better, you’re just making a person comfortable and happy”
Managing scarcity in integrated care: the case of Health and Social Care Partnerships in Scotland

Background: The move towards integration between health and social care challenges local delivery organisations to consider the cost, quality and value of services provided. Integration, especially with public sector austerity, requires robust, effective frameworks for decision making.

One such framework is Programme Budgeting and Marginal Analysis (PBMA). PBMA offers an analytical approach for assessing costs and benefits of alternative courses of action, which could assist with identification of the effects of resource shifts and areas for disinvestment among programmes.

Three pilot sites in Scotland were selected to test out the feasibility of using PBMA in newly formed Health and Social Care Partnerships (H&SCPs). The focus will be our work in two localities within one site, each using PBMA.

Methods: Before and after interviews were conducted. Workshops outlining the economic principles and theory of PBMA were held. The process was led by an Advisory Group with the research team leading and facilitating meetings.

Results: One locality completed the process and agreed a list of four options to take forward for implementation; two are being funded. The other focused on restructuring one area of community care.

The PBMA process provided the pilot sites with a transparent, inclusive and structured approach to prioritisation. A strength was the role of including other stakeholders in the process - such as service users - alongside statutory providers. PBMA promoted debate and critical appraisal of options and a prioritisation process based on PBMA has been included in statutory guidance for H&SCP’s in developing Strategic Commissioning Plans.

Disinvestment in cancer drug funding: Results from a deliberative public engagement event in Vancouver, Canada

Aim: Twenty-four participants took part in a public deliberation event in Vancouver, Canada, on the topic of cancer drug funding. While participants collectively recognized the need for trade-offs in drug funding and disinvestment decisions, certain factors – such as patient choice – were found to be more important than a gain of cost savings.

Context: Drug funding decisions are challenged by rising costs and availability of new treatments. Within a publicly funded healthcare system, there is increasing recognition that investments in health treatments must be considered alongside decisions about disinvestment from comparatively less effective treatments. Genuine public input into this priority-setting process can help increase engagement and trust in these decisions.

Methods: Participants were tasked with making collective recommendations about the principles that should guide funding decisions in BC. Deliberative questions and decision aids were used to elicit participants’ preferences as they made trade-offs between health outcomes, including increased quantity and quality of life, and cost savings.

Results: Through qualitative thematic analysis, we found that participants demonstrated a strong capacity to engage in the decision tasks and recognize budgetary constraints. When tasked with a decision between two drugs with comparable effectiveness, participants prioritized patient choice, fairness and equity above a gain of cost savings. In short, they demanded significant ‘value for money’ in order to support the trade-off.

Conclusion: Decision-making frameworks can include consideration of these factors, in addition to clinical- and cost-effectiveness evidence, to help ensure that disinvestment decisions are acceptable to British Columbians and healthcare organizations alike.
Assessment of medical devices for the National Institute for Health and Care Excellence (NICE)

Background: The Medical Technologies Evaluation Panel of the National Institute for Health and Care Excellence (NICE) requires that medical devices should be cost saving or resource releasing to be recommended for use in the NHS. The evaluation of a medical device can be impeded by inappropriate evidence and faulty understanding of its place in the care pathway.

Methods: Evidence underpinning MedTech Innovation Briefings (MIBs) and published NICE guidance will be reviewed to characterise limitations. Additional insights gained from the process of MIB development will be reported.

Results: Clinical evidence available on medical devices may not align with their value to the health service. Examples illustrating key evidence gaps collated from NICE guidance and advice will be collated and categorised. For example, in the case of HumiGard, a humidification system to reduce the incidence of peri-operative hypothermia in laparoscopic or open surgery, evidence failed to address a key outcome, hypothermia. Economic models suggesting that HumiGard is cost saving or cost neutral were limited by the robustness of the clinical evidence. The process of developing a MIB on the i-STAT point-of-care blood analyser revealed a mismatch between value and evidence. Rapid test results in the emergency department will reduce patient stay only in conjunction with service redesign: high quality evidence was lacking.

Conclusion: Methods to develop NICE advice and guidance are robust but depend on the evidence available. A shared understanding between industry and commissioners of the evidence needed to support medical device value propositions is required.

Trade-off between chance of success and urgency in organ allocation - a discrete choice experiment

Aim/context: Weighting of conflicting prioritization criteria in organ allocation: Donor organs must be allocated with particular regard to chance of success and urgency according to the German Transplantation Act. Current allocation guidelines balance these conflicting criteria differently depending on the type of organ. This is only justified in parts by medical reasons. Hence a general discussion on the stated trade-off is indispensable. This also contains considering public preferences.

Methods: In this pilot study, preferences of 250 participants were assessed using a Discrete Choice Experiment. Choice-sets for the allocation of a donor organ comprised two patients, characterized by three success- and two urgency-based attributes. Data analysis was performed by Counting Analysis and Hierarchical Bayes estimation as well as Student’s t-tests for subgroup analysis.

Results: All attributes influenced allocation decisions significantly (p<0.01). In total, chance of success and urgency were equally important for the allocation of organs (53% and 47% respectively). The importance of single success- and urgency-based attributes was quantified as follows: The post-TX 5-year probability of survival was weighted with 31%, the expected post-TX quality of life and the surgery survival with 11% each, the pre-TX 3-month mortality with 35% and pre-TX quality of life with 12%. Subgroup analysis revealed significant differences.

Conclusions: Such results could help decision makers to develop organ-specific guidelines taking public preferences into account. Stronger involvement of citizens in decision making could (re)gain confidence in transplantation medicine (after scandals in Germany), increase the willingness to donate and thereby counteract the tragedy of distributional conflicts.
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Systematic review: incorporating social justice considerations into economic evaluations in healthcare and public health

Background: Despite a widely acknowledged need to incorporate social justice considerations into economic evaluations in healthcare and public health, few methodological strategies exist.

Methods: We performed a systematic review to describe both challenges and solutions (existing or theorized) for incorporating social justice into economic analysis in priority-setting. Relevant studies were identified using an electronic search strategy in EMBASE, PubMed, EconLit, PsycInfo, Philosophers Index and Scopus. The search included articles published in English from 1995 to 2015. Additional publications were identified through article bibliographies and grey literature review. We included only those social justice considerations that are experiential and applicable to a subpopulation level. Two reviewers independently appraised candidate studies to determine inclusion. Extracted data were collaboratively synthesized in narrative form.

Results: Out of 2388 papers reviewed, 26 were retained for inclusion. Solutions sought either to incorporate social justice considerations directly into cost-effectiveness measures by imposing weights or constraints; or to report social justice units alongside cost-effectiveness measures, allowing for comparison. Solutions adopting the first approach experienced difficulties with selection of criteria and their measurement and combination. Similarly, solutions adopting the latter approach struggled with the identification of legitimate normative values and their quantification or ranking. Moreover, both approaches required external input in determining weights, constraints or criteria, and lacked decision support regarding acceptable trade-offs.

Conclusions: Current strategies to support justice-enhanced decision-making face significant challenges at both the methodological and normative levels. Our findings invite inquiry about how to deploy substantive ethical frameworks and operationalize empirical input from relevant stakeholders.

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Conceptualizing benefits beyond health within the quality-adjusted life year (QALY) framework: a critical interpretive synthesis

Background: There is a growing interest in broadening the evaluative space of the quality-adjusted life year (QALY) framework. The objectives of this work were to synthesize critically evidence regarding ‘benefits beyond health’ within the context of QALYs, and to develop a conceptual map that displays the relationship between concepts.

Methods: A critical interpretive synthesis was undertaken. Papers were searched in Web of Science using the citation pearl growing method. Peer-reviewed journal articles that discussed the notion of benefits beyond health within the context of QALYs were included. A synthetic argument was developed that integrated evidence across studies and own interpretations into a thematic framework, and then organized into a concept map (not presented here).

Results: The synthesis was constructed around four themes: (i) benefits derived from the process (process utility); (ii) benefits affecting wellbeing (psychological wellbeing, subjective wellbeing, empowerment, and capability wellbeing); (iii) benefits beyond the treated individual (option value, externalities, spillover effects, and equity); and (iv) benefits beyond the health care sector. The synthesis showed that exclusion of benefits beyond health does not appear to be problematic for the QALY metric per se; instead, this is a broader issue for decision-making (i.e., identifying an appropriate maximand). Typically, QALYs are defined by what they measure rather than their conceptual origin; the choice of preference instrument and/or elicitation technique determines the evaluative space.

Conclusion: Future studies should provide further justification for the evaluative space of the QALY and investigate whether individuals are willing to sacrifice health for benefits beyond health.
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Same, same-same or different? Exploring overlap between the ICECAP-A and six preference-based HRQoL instruments

Background: The ICECAP-A is a measure of capability wellbeing, suitable for use in economic evaluation. It was designed to overcome limitations associated with existing preference-based instruments that focus explicitly on health. However, it remains unclear whether or not preference-based health-related quality of life (HRQoL) instruments are also able to capture aspects of capability wellbeing.

Methods: Using data from the Multi Instrument Comparison (MIC) project, pairwise exploratory factor analyses were conducted comparing the ICECAP-A with six preference-based HRQoL instruments (15D, AQoL-8D, EQ-5D-5L, HUI-3, SF-6D, and QWB-SA). Applying an oblique rotation, the underlying structures of the instruments were explored and the numbers of unique underlying latent factors were ascertained.

Results: Data from 6,756 individuals were used in the analyses. Throughout all pairwise comparisons, four ICECAP-A attributes (stability, attachment, achievement, and enjoyment) loaded on the same underlying latent factor (F1), whereas autonomy represented a distinct concept (F2). Factor loadings varied across different factor solutions for items of the respective HRQoL instruments. Overall, anxiety/depression (EQ-5D-5L), energy (SF-6D), emotion & cognition (HUI-3), depression & distress (15D), six QWB-SA items, and 17 AQoL-8D items were associated with F1. F2 (autonomy) was not adequately covered by other instruments, except for the AQoL-8D (14 items), 15D (9 items), and the SF-6D (5 items).

Conclusion: Despite some overlap, the ICECAP-A provides information over-and-above that garnered from several commonly used preference-based HRQoL instruments. Further investigations are needed to explore the extent and implications of ‘double counting’ when applying the ICECAP-A alongside the AQoL-8D.

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Restricting access to new cancer treatment: Oncologists’ perceptions of legitimate limit-setting

Aim: To better understand oncologists’ perceptions of the legitimacy of restricting access to new and expensive cancer drugs.

Background: All societies must make decisions about what healthcare interventions to provide to their population. Decisions about which cancer drugs to fund within a public healthcare system affect different stakeholders in different ways, and governmental decision-makers recognize the importance of perceived legitimacy of their funding processes. We wanted to explore how Norwegian clinicians experience governmental decisions to deny cancer patients treatment because effectiveness and cost-effectiveness of the drugs has not been demonstrated.

Methods: Semi-structured qualitative in-depth elite interviews with 12 Norwegian oncologists were carried out. Deductive thematic analysis was used. A theoretical framework inspired Daniels’ and Sabin’s notion of Accountability for Reasonableness aided data gathering and interpretation.

Results: The oncologists interviewed emphasized that escalating healthcare costs make it necessary to make priority-setting decisions. However, the participants advocated for increased access to new cancer drugs and for equity between individual patients. Resource allocation processes was found be acceptable if the process was in accordance with a system perceived as transparent, evidence-based and fair. Fairness included notions of equity and severity.

Conclusion: There was a tension between oncologists’ aspiration to offer their patients promising treatment options and government’s need to make choices as to which expensive cancer drugs are subsidized. The oncologists found the Norwegian system lacking legitimacy because concerns about equity and severity were perceived as to be insufficiently taken into consideration.
Goold, Susan¹

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What is the added value of deliberation about priority-setting?

Gathering members of the public to learn and deliberate about priority setting, and form a policy recommendation, has been justified by appeals to develop a more informed public, create decisional legitimacy, and/or claim that deliberators and their constituents have consented to decisions. While public deliberation can be justified philosophically, critical questions remain about the value of deliberative procedures.

In a deliberative project about Medicaid spending priorities, we randomly assign low-income participants to informed deliberation (n=220) or education (n=220) alone, and compare the impact of the interventions on their knowledge and attitudes. We measure participants’ preferences, perceived need for and beliefs about the affordability of health insurance, and the acceptability of strategies for cost containment, including value-based cost-sharing. Knowledge and attitudes about Medicaid, and understanding of limited resources, are measured at baseline and after review of educational materials (Controls) or at the close of deliberations (Deliberators). We also collect data on individuals’ priorities before and after deliberation or education alone.

We will use linear mixed-effects models with knowledge and attitude scores as response variables and a dummy variable indicating Deliberation (vs. Control) as the primary predictor, and will adjust for potential clustering within the same block (session) and pre-intervention values of the response variable as covariates. The model will give estimates of the relative impact of public deliberation compared to education and the impact of each.

To date, we have completed data collection for 23 deliberators and 21 controls, with data collection to be completed by 30 April 2016.

Priorities of minority and underserved communities for health research: the effect of deliberation

Informed deliberations should influence the policy recommendations of deliberators, and not merely aggregate preexisting opinions.

Methods: Academic-community partnerships adapted the simulation exercise CHAT (CHoosing All Together) to engage 47 groups (n=519) from minority and underserved communities in informed deliberations about health research priorities. Priorities selected by individuals before and after deliberation, and by groups, are collected during the exercise. Within-participant changes in priorities from pre to post-deliberation used a mixed-effect logistic regression model.

Results: Participants ranged from 18 to 88 years old, about 2/3 were women, and most reported incomes <US$35,000.

Before deliberation, individuals commonly prioritized research about Mental Health (90.6%), Child Health (89.3%), Causes of Disease (85.6%), Promote Health (82.7%), Healthcare Quality (82.7%), Aging (81.1%), and Environment (81.1%).

Nearly all groups selected Child Health and Mental Health research (93.6% and 95.7%, respectively) and a majority chose the highest possible investment for those categories. Causes of Disease, Environment, Aging, Access, Promoting Health and were the next most likely to be selected by groups.

Access was the only type of research more often selected by individuals after than before group deliberation (77.2 vs. 84.0%, OR 1.63, p=.005). Improving Research, Policy Research and Culture and Belief research were less often selected after group deliberations (all, p<.001).

Conclusions: Members of underserved communities, in informed deliberations, prioritized research in mental health and child health. Group deliberations seem to influence modestly individuals’ priorities for research.
Gower, Corinne
Victoria University of Wellington

Does active performance management lead to health service better prioritisation and decision making?

New Zealand is internationally recognised for its use of demand-side nationally consistent clinical assessment tools to prioritise elective service delivery. Yet the use of clinical assessment tools is one of seven strategies discussed in a Government Electives Strategy (2000) that aims to reduce waiting times and achieve nationally equitable access to services. Other strategies include increase elective service supply, give patients certainty, improve public hospital capability, improve primary and secondary care liaison, actively manage sector performance and build confidence.

This aim of the presentation is to present the findings of PhD research on the use of active performance management as a government strategy, which has led to increased reporting and monitoring of DHB decision making at key points in the patient’s healthcare journey.

The research examines how District Health Board’s (DHBs), government agencies accountable for optimising the arrangement of publicly funded elective health service delivery, have been influenced by active performance management.

The research has used sequential mixed methods, analysing actual government published performance data since 2006 to select DHBs for case studies, undertaking interviews, analysing documents. The research has used the theoretical lens of neo-institutional theory (Di Maggio and Powell, 1977) to explore influence and relationships.

Research results indicate the current mechanism to increase elective supply is creating pressure and can lead to unintended service delivery consequences and primary and secondary liaison is much improved through health pathways. It is unclear that continuous reporting of DHB priorities and decision making to government leads to sustainable service improvement.

Gustavsson, Erik
The Swedish Center for Priority Setting in Health Care

Patients with multiple diseases and priority to the worse off

In priority setting it is common practice for decision-makers to rank treatments targeting a specific disease according to (amongst other things) the degree of patient need associated with this particular disease. Whereas this practice is often unproblematic it may be a disadvantage to patients with multiple diseases, in particular older patients who may experience a higher degree of comorbidity. Such a patient may have several minor needs for health care which, when considered one by one, do not seem to make her particularly badly off. That is, her need-based claim on health care resources is quite weak. However, a patient who experiences a large number of such small needs may, intuitively, be quite badly off. This is not captured by ranking a treatment targeting a specific disease.

In this talk I shall explore if this intuition can be accounted for in terms of intrapersonal aggregation of needs. If small needs could be aggregated into a whole the patient sketched in this abstract would turn out to be quite badly off and would, accordingly, have a quite strong need-based claim on health care resources. Whereas there may be several practical reasons to employ the ranking of single treatments targeting specific diseases there may be ethical reasons to employ intrapersonal aggregation of needs. Ethical reasons rooted in the importance of taking suffering seriously, independent of whether it is caused by one or several diseases.
Longitudinal evaluation of priority setting and resource allocation in a Canadian health authority

Introduction: In order to meet the challenges presented by increasing demand and scarcity of resources, healthcare organizations are faced with difficult decisions related to resource allocation. Tools to facilitate evaluation and improvement of these processes could enable greater transparency and more optimal distribution of resources.

Methods: An evaluation tool for assessing the performance of priority setting and resource allocation (PSRA) was implemented in a healthcare organization in British Columbia, Canada. Recommendations for improvement were delivered, and a follow up evaluation exercise was conducted two years post to assess the trajectory of the organization’s PSRA process.

Results: Implementation of the tool identified strengths and weaknesses of the organization’s PSRA at the time of the original evaluation. Strengths included their use of criteria and evidence, their ability to re-allocate resources, and their involvement of frontline staff in the process. Weaknesses included training, communication, and lack of program budgeting. Although the follow up revealed a regression from more formal PSRA, a legacy of explicit resource allocation was reported to be providing ongoing benefit for the organization.

Conclusion: To the investigators’ knowledge, this is the first longitudinal evaluation of an organization’s PSRA process. By including the strengths, weaknesses, and evolution of one organization’s journey with PSRA, the investigators’ intent is that the content presented will assist other healthcare leaders in meeting the challenges of allocating scarce resources.

Identifying best practice for patient and public engagement in healthcare decommissioning: a Delphi study

Context and Aim: Decisions to decommission healthcare services and interventions have the potential to affect a high proportion of the population both directly as patients/service users or carers, and indirectly as citizens of a local health economy. However the highly emotive, political and complex nature of decommissioning, combined with the often lengthy timescales involved, raises particular challenges for engagement of patients/service users and the public, and there is a relative dearth of published evidence on their involvement in decommissioning processes (e.g. Bunt and Leadbeater 2012; Robinson et al. 2013). In this context, this paper explores patient and public opinion regarding, first, the factors and processes that should shape decisions to decommission (that is, remove, reduce or replace) healthcare services and, second, consensus as to best practice for the engagement of patients and the public in decommissioning decisions, planning and implementation in the English NHS.

Methods: The paper reports findings from deliberative focus group discussions and a three-round, online Delphi survey designed and conducted nationally with patients/service users, carers and third sector organisations. Responses to each round of the Delphi survey were analysed using measures of the degree of consensus, and results were presented back to participants at each stage. Open comments provided during the focus group discussions and Delphi study were analysed thematically.

Results: Findings focus on the attitudes and perspectives of these groups towards decommissioning, and compare these with results from prior research into the perspectives of decision makers and professionals.
**Healy, Paul²**

Co-authors: H Brown¹ - I Williams¹

#1University of Birmingham #2NHS Confederation

**Contextual factors influencing decisions of value in health: a systematic review and narrative synthesis**

This paper presents a synthesis of the empirical evidence on the contextual factors that influence decisions of value in health and care. ‘Decisions of value’ are defined as those with a significant and demonstrable impact on both quality and resources. The paper reports on both allocative and technical decision making and finds that the evidence base is increasingly substantial in relation to the former but still disparate and exploratory in relation to the latter. The authors use Pettigrew’s (1985) distinction between inner and outer context to structure analysis of the range of factors reported as being influential.

The review is the first of its kind to consider the full range of resource/quality decisions and to synthesise knowledge on the contextual drivers of these. The paper confirms the limits to narrow notions of instrumental rationality as applied to decisions of value in health and care, and argues that in future research greater attention should be paid to relatively under-explored area of technical, as opposed to allocative, decision making.

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**Hollingworth, William**

Co-authors: J Busby - S Purdy

University of Bristol

**Using geographic variation in unplanned ACSC admission rates to identify research and commissioning priorities**

Objectives: To use geographic variation in unplanned ambulatory care sensitive condition (ACSC) admission rates to identify the clinical areas and patient subgroups where the greatest opportunities exist to improve the efficiency of care through highly-targeted admission avoidance programs.

Methods: We used random-effect Poisson models and data from the 2011/12 English Hospital Episode Statistics to estimate geographic variation in unplanned admission rates after adjusting for differences in need (e.g. age, deprivation). We contrasted geographic variation across admissions with different length of stay, which we used as a proxy for clinical severity.

Results: There were 1.8 million ACSC admissions during 2011/12. Substantial geographic variation in ACSC admission rates was commonplace: schizophrenia and peripheral vascular disease admission rates were more than three times greater in high use PCTs compared to low use PCTs. Conversely the difference was less than 25% for hip fracture and stroke. Short-stay admissions were consistently more variable than longer stays. Reducing rates in the highest use areas could lead to savings of up to 2.8 million bed days annually.

Conclusions: Widespread geographic variations in admission rates for conditions where admission is potentially avoidable should concern commissioners and could be symptomatic of inefficient care. Further work is required to explore the causes of these differences and should initially focus on the clinical areas (e.g. schizophrenia, short-stay admissions) where the greatest variation exists. Careful analysis of geographic variations could provide a sustainable method to identify opportunities for efficiency gains in other parts of the healthcare system.
Jackson, Louise
University of Birmingham

Co-authors: H Al-Janabi - J Ross - T Roberts

Understanding patient priorities in public health: preferences for STI screening in different settings

Background. Growing pressures on public health budgets and increases in diagnoses of Sexually Transmitted Infections (STIs) suggest a need for new strategies to improve sexual health in England. STI screening is now being provided in a wider range of settings such as GP surgeries and pharmacies, with screening kits also provided online. Priority setting in service development needs to consider new but cost-effective approaches to ensure the engagement of those most at risk (e.g. young people) and prevent further spread of disease.

Aims. To explore the value that young people place on STI screening and examine their preferences for screening in different settings.

Methods. The project involves a series of seven focus groups supplemented by one-to-one interviews with young people in community, primary care and specialist settings. The groups were designed to include young people from a variety of socio-demographic and cultural backgrounds. The themes explored relate to the ‘trade-offs’ people are willing to make between services in different settings and priorities for service provision.

Results. The results of the analysis will be finalised by the end of May. It is anticipated that preferences and priorities for screening provision will vary by gender, ethnicity and age group, with some young people likely to express negative values for screening in some contexts.

Discussion. This study examines the complexities of young people’s preferences for STI screening in different settings. The challenges faced by providers and commissioners in addressing these preferences within a framework of diminishing resources are explored.

Hurst, Samia¹

¹University of Geneva ²National Institutes of Health

Solidarity and cost-effectiveness: Swiss citizen’s reasons for priorities in health care

Context: Approaches to priority setting in scarcity have shifted to public deliberation as the trade-offs become more difficult. We report results of deliberation in Switzerland, a country with high health care costs, an individual mandate for health insurance, and a strong tradition of direct democracy with frequent votes related to health care.

Methods: We adapted the Choosing Healthplans All Together (CHAT) tool, an exercise developed to transform complex health care allocation decisions into easily understandable choices, for use in Switzerland. We conducted focus groups in twelve Swiss cities, recruiting from a range of socio-economic backgrounds in the three language regions.

Findings: A majority of 175 participants accepted greater gatekeeping (93%), exclusion of invasive life-sustaining measures in dying patients (80%), longer waiting times for non-urgent episodic care (77%), greater adherence to cost-effectiveness guidelines in chronic care (60%), and lower premium subsidies (51%). Most chose greater coverage for dental (59%) and long-term care (89%). Reasons to cover health services included protection of vulnerable groups and arguments based on collective interests. Participants grappled with integration of personal responsibility and solidarity into coverage decisions. They disagreed on coverage of dental and vision care, and on whether sexual health ought to be covered. They prioritized protection for families, chronic illness, and limited burdensome care at the end of life.

Conclusion: Public deliberation about health care priorities, assisted by the CHAT tool in a country with a long tradition of democracy and solidarity, yields thoughtful trade-offs different from current coverage and from participants’ personal interests.
Jhunjhunwala, Rashi
King's College London

Why and how should we prioritize surgery on the global path to universal health care?

In the rapidly developing landscape of global health concerns, principles of distributive justice are instrumental in assessing the value of healthcare delivery platforms to conduct fair and equitable priority-setting in a non-ideal world. Recently, surgical healthcare interventions have received increased attention in the global sphere. This has been fuelled by an expansion of data-driven evidence about the surgical disease burden, emergence of surgical advocacy and governing organizations, and a political context that is amenable to horizontal growth and development in a post-2015 MDG development framework. Nonetheless, global surgery has still not achieved high-priority status in terms of funding or resource allocation. Crucially, it is necessary to construct a cohesive argument for prioritization of surgery that appeals both to reason-based claims of high disease burden and cost-effective interventions as well as inspiring passion and emotional investment to secure global support.

I discuss the issues specific to prioritizing surgery rather than other types of healthcare as well as the most prominent justifications that have been proposed for prioritizing surgical care and where they fall short. I then propose an alternative framework within which to approach decisions of priority setting that provides solutions to the challenges that emerged from the previous frameworks. I further consider applications of this theory and trade-offs in prioritization between surgical procedures as a coherent argument for the application of this framework in surgical and nonsurgical interventions. This project has been conducted to satisfy the core dissertation requirement of my MA Bioethics & Society at King’s College London.

Jansen, Maarten¹
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Prioritizing HIV treatment strategies in Sub-Saharan Africa: The need to incorporate health system constraints

Aim
We call for a policy relevant, integrated approach to cost-effectiveness analysis that incorporates health system constraints in prioritising HIV treatment strategies.

Context
Evidence for resource allocation of HIV treatment strategies – e.g. on eligibility for treatment initiation and alternative treatment delivery models – has so far largely been based on considerations of cost-effectiveness. Cost-effectiveness analysis, not evaluated in the context of health system constraints, may however result in recommendations that are theoretically optimal, but practically infeasible to implement.

Methods
By performing a systematic literature review of the extensive literature evaluating cost-effectiveness of ART eligibility criteria and delivery strategies in Sub-Saharan Africa we found that these are almost invariably based on the implicit premise of a well-functioning health system with unlimited financial, infrastructural and human resources that would automatically ensure immediate implementation and sustainable provision of care. Yet in reality, most health systems experience constraints that may hamper successful implementation.

Results
We argue that health system constraints should be better integrated into cost-effectiveness analysis – facilitated by a dialogue between researchers and policy makers on the nature of constraints, and by accounting for such constraints in the use of mathematical models. This will result in recommendations for HIV treatment strategies that are more policy relevant, and will allow countries to make choices on optimal resource allocation for strategies that are practically feasible to implement.
Are equity, social justice and social values considered in donor organization priority setting?

There is increasing recognition that social values such as equity and fairness are considered when setting healthcare priorities. Since most LIC health care systems are supported by development assistance partners (DAPs), their health priorities are inevitably influenced by the priorities set by these organizations. There is limited literature on the degree to which equity, social justice and social values influence the DAPs priority setting (PS). The objective of this paper is to discuss the values that reportedly guide PS within these organizations, and the degree to which equity, fairness and other social values are considered.

Methods: 35 in-depth interviews with stakeholders from the main DAP organizations that support LIC health systems and a review of relevant related information from DAP organization Websites. The interviews and website analysis revealed the values that respondents identified as relevant for guiding PS and the ones they deemed most important.

Discussion and conclusions: The degree to which equity, social justice and social values are explicitly identified and incorporated in the DAP PS processes will be discussed and comparisons between the different organizations will be made. The values that influence PS in DAP organizations influence what programs are implemented in LICs. Explicit lack of consideration of equity, social justice and social values can have serious implications with regard to which programs are implemented with potential impact on either propagating or reducing existing inequities in health. There is a need for more dialogue on the values that should influence priority setting within DAP organizations.

Universal health care coverage and equitable health care access in Uganda and Zambia

Universal health care (UHC) is thought to be one of the most important concepts public health has to offer, providing an avenue through which people can, “lift themselves from poverty, so that they may lead healthy, productive lives—lives with dignity, equity and opportunity” (World Bank, 2014). However, it remains unclear whether it is sufficient to achieve effective equity in access to health care. The aim of this paper is to review the strategies employed by low income country governments to ensure equitable UHC, and the degree to which these strategies have contributed to achieving effective equitable access to health care.

In-depth qualitative interviews were conducted with health system stakeholders in Uganda (n=22) and Zambia (n=32) and these were triangulated with policy documents.

Countries have focused on health service delivery; decentralizing health service delivery and re-orienting services to primary care, and the essential health package. Services are provided free of charge. However, the quality of care in some of these units remains poor. Even if the quality is improved the most vulnerable populations still experience barriers that prevent them from accessing the services. The barriers identified in this study, if not addressed, will undermine the effectiveness of UHC in improving equity of access to care in these settings. The drive towards UHC should not overshadow the key determinants of health and access to care. These should equally be considered if UHC is to facilitate effective and equitable access to health care.
Krevers, Barbro¹

#1Linköping University #2Motala Municipality

Development of systematic prioritizations between different welfare sectors - and get it running

Context. In Sweden systematic priority setting in health care has been an issue for several years; different stages of development has been reached using the Parliament’s guidelines and a National model for priority setting in health care. As the first municipality, Motala has started a long term work to achieve a transparent systematic resource allocation process for all different budget areas and sectors, and that involve all decision-levels from operational managers to politicians.

Aim. To describe a systematic procedure for priority setting between different welfare sectors, which combine current ethical principles for priority setting in health care with overall political goals and strategic plans in a municipality.

Method. An action research and development project in collaboration with clerks from the municipality. It was an iterative process during 2 years to go from idea to put into practice. The National model was a starting point in that process. Data: field notes from development activities; related documents, and questionnaires.

Results. A new systematic procedure was developed and tested in an investment procedure cross sectors. The procedure included a description of each priority object (condition/problem plus intervention) concerning: citizen/municipality benefit related to set goals; effectiveness; costs, and suggested ranking. Operational managers provided needed information and suggested ranking, discussed in cross-sector meetings. Politicians took the final budget decision of investments. The procedure was experienced as useful, enhancing transparency and systematics.

Conclusion. It is possible to combine national guidelines for priority-setting with political goals, in a transparent and systematic cross-sectors priority-setting procedure.

Koskinen, Sari¹

Council for Choices in Health Care in Finland / COHERE, Finland

Health care priority setting during economic depression in Finland

Aim and Context: There has been a period of economic depression in Finland during the past 8 years. Simultaneously, an extensive social and healthcare reform has been prepared. The Council for Choices in Health Care in Finland was nominated in 2014 to develop definitions, principles and criteria for the range of public health services. The Council recommendations are based on three main principles: effectiveness, safety and ethical acceptability, which includes financial sustainability.

For the implementation of the principles, a strong commitment of health care organizers and clinical decision makers is needed. The principles will act as a mechanism steering which services will be provided for the inhabitants by public funding. Social welfare and health care reform requires strong steering by the government and joint collaboration of all actors involved. While people’s wellbeing and health need to be improved, there should also be consciousness of the limits of public finance available. This means that in the future according to the reform, the government will steer the autonomous regions to use new, uniform and cost-effective range of services.

Methods, Results: This is a non-scientific description of the development work that is currently going on.
Age-Based Priority Setting: Results of a mixed method approach to elicit public preferences

Objectives: Age as criterion for prioritization is a very controversial issue. Assuming that the allocation discussion profits from evidence concerning the public opinion, we elicited preferences of laymen. To analyze whether the assessment of age is context-sensitive, we used different scopes of priority setting: (i) generally, (ii) reimbursement of dentures, (iii) organ allocation.

Methods: Qualitative content analysis of group interviews combined with frequency analysis and inferential statistical analyses: We conducted two focus groups with participants aged 18-63 and two focus groups with older persons (>63). We used qualitative content analysis (MAXQDA 10) to design a system of categories, identified the most important arguments for and against age-based priority setting by frequency analysis and conducted subgroup analyses (Chi2; SPSS).

Results: (extract). Age-based priority setting is predominantly rejected when discussed (i) generally: Arguments e.g. cast doubt on the significance of chronological age and emphasize the equality of life. This tendency applies in accordance for the (ii) specific context of the reimbursement of dentures: Age is e.g. rejected on the basis that adequate masticatory function is essentially important. But age is mainly accepted in the (iii) context of organ allocation: One important argument is that less remaining life years justify subordination. Overall, preferences are context sensitive. Furthermore, we identified differences between younger and older participants.

Implications: Laymen weigh up arguments for and against age-based priority setting and thereby consider the prioritization context. The approach discloses the structure of preferences that could be considered in the expert discussion on prioritization decisions.

Access to elective specialised healthcare in Norway: Clinical priority guidelines, patients’ rights and politics

Background: Norway has 33 clinical priority-setting guidelines organised by specialty that help hospitals evaluate whether individual patients have a right to necessary elective specialised healthcare. This analysis presents recent legislative changes of priority-setting criteria and ensuing guideline revisions, and describes attempts to achieve harmonisation of the guideline recommendations across specialties.

Methods: The Norwegian Directorate of Health, national specialist groups, patient representatives and general practitioners worked systematically over a two-year period to revise the priority-setting guidelines. Condition-intervention pairs were defined (n=556) within each specialty and scored according to severity, effectiveness and cost-effectiveness in order to justify clinical need. All patients with a need for specialist healthcare services are assigned a right to these services, so long as interventions satisfy effectiveness and cost-effectiveness criteria, regardless of the degree of need. Severity only determines the maximum waiting time.

Main findings: 93% (n=516) of the conditions are granted a right to necessary specialist healthcare services compared to 77% (n=368) under the original guidelines. The low-priority category ‘need, no right’ (n=111) was removed. A new ‘don’t do’ list of 40 conditions may prevent unnecessary specialist treatment, but indicates a very low threshold for getting a right to specialist healthcare. The revised Patient Rights’ Act and guidelines may improve access to low-priority elective services. The strong emphasis on patients’ rights may have weakened the case for setting explicit priorities in access to elective specialised healthcare, as there are no mechanisms for saying no to patients with low levels of need.
Matsuda, Ryozo
Ritsumeikan University

Politics of institutionalizing economic appraisal in health care in Japan

Since 2012 a committee of the Japanese government has been discussing ways of using cost-effectiveness analysis in deciding lists of services, pharmaceuticals and medical devices covered by the Statutory Health Insurance System (SHIS). With the recommendation of the committee the government decided to introduce economic appraisals on a trial basis from the fiscal year 2016. To understand politics of institutionalizing economic appraisal in health care in Japan, this interpretative and qualitative paper analyses policy documents, minuets of concerned government organizations, statement of actors and other documents.

First, it gives descriptions on critical institutions in the Japanese statutory health insurance system. Because the government uses positive lists and prices of services and goods covered by the system with traditional fee-for-services payments, those lists have direct impacts on clinical decision making. For example, in order to use an unlisted drug in the existing system, patients need to pay from their pockets not only for the drug but also for all other relevant services and drugs. The lists decide what services and goods are legitimate in the SHIS.

Discussion: Norwegian CECs are involved in priority-setting decisions, and seem to be useful in advising and raising awareness on ethical aspects in resource allocations as well as bridging clinical practice with higher-level decisions.
Public engagement in priority setting: experiences from countries transitioning to universal health coverage

As countries transition to universal health coverage (UHC), they face difficult decisions about which services to expand first, whom to cover first, and how to shift from out-of-pocket to pooled payment for health care. These priority setting decisions are controversial, and much thought has been given to the question of how they can be made fairly. The World Health Organization, among others, has affirmed the notion that robust public engagement can enhance the fairness of priority setting processes. However, despite growing support for public engagement in priority setting, there have been no systematic attempts to study how and on what grounds countries transitioning to UHC engage the public in priority setting processes.

To inform ongoing policy developments in this area, we conducted a series of semi-structured interviews with senior-level policy makers with leadership roles in the implementation of UHC in their respective countries. Our questions were clustered in three groups examining: (1) which decisions and processes involve public engagement; (2) which populations are involved in public engagement exercises; and (3) what are the main rationales for engaging the public? Our preliminary data show that while some commitment to public engagement is common, the rationales, methods, and extent of public engagement in priority setting vary widely across countries.

Societal preferences for provision of treatment at the end of life: establishing QALY weights

In the UK, the National Institute for Health and Care Excellence (NICE) and the Scottish Medicines Consortium (SMC) assess end of life (EoL) technologies using criteria that can result in provision of these treatments when the cost per quality-adjusted life year (QALY) is relatively high. However, empirical evidence of public preferences for EoL treatments is equivocal and there is limited evidence of public preferences regarding different types of health benefits – quality of life (QoL) improvement and life extension (LE) – at the EoL. This study aims to provide more definitive evidence of societal preferences in relation to the value of QALYs gained at the EoL relative to QALYs gained from non-terminal health problems and on the relative value of different types of QALYs (improvements in QoL compared to improvements in LE) gained at the EoL.

Eight health scenarios have been designed depicting i) QoL improvements for non-terminal temporary and chronic health problems and ii) QoL and LE improvements for terminal health problems. Preferences are elicited for these health scenarios using three techniques: Willingness to Pay (WTP), Person Trade-Off (PTO) and Benefit Trade-Off (BTO). These techniques allow values to be elicited from an individual (self-interested) perspective (WTP) and a citizen’s perspective (PTO & BTO).

The survey will be administered via Computer Assisted Personal Interview (CAPI) to a quota sample of 900 nationally representative individuals in Scotland. Data collection begins in March 2016 with data delivered early June 2016 for analysis and write up; initial results will be presented.
Diverging interpretations of items in generic preference-based HRQoL instruments: the example of mobility and SCI

Background: Health-related quality of life (HRQoL) is often measured with generic, preference-based HRQoL instruments for resource allocation purposes. Such instruments have mostly few items per dimension, which may be interpreted differently by specific groups that experience challenges in describing their health status.

Methods: To explore diverging interpretations of items, we applied a thematic framework approach to focus group transcripts and analyzed how individuals with spinal cord injury (SCI) made sense of HRQoL items. Fifteen individuals living with SCI discussed their perceptions towards the following six instruments: 15D, Assessment of Quality of Life 8-dimension (AQoL-8D), EQ-5D-5L, Health Utilities Index, Quality of Well-Being Scale Self-Administered (QWB-SA), and the 36-item Short Form Health Survey (SF-36v2). Analyses focused exclusively on the perception and interpretation of mobility-related items.

Results: Four themes emerged: wording of mobility, reference to aids and appliances, search for suitable response options, and reframing of items. The first category of themes reflected features that respondents perceived as relevant in enabling them to describe their mobility (as a component of describing their overall health status). Reframing of items was identified as a response strategy that respondents used when facing inaccessible items where mobility was equated with ‘walking’.

Conclusions: The identified features are possible sources of variation in responses to items of generic preference-based HRQoL instruments and provide analysts with a better understanding of their quantitative data. The use of reframing as a response strategy poses significant challenges to the interpretation of HRQoL data and requires further investigation.

"Protecting families from costs is my priority" Ethiopian physicians’ perceived roles as gatekeepers and stewards

Background: Studies show how health workers ration scarce resources to save institutional costs. Less is known on how they consider family welfare in medical decisions implying expenses for patients. We assess physicians’ concerns regarding financial welfare of patients and their experiences in reducing catastrophic health expenditure for patients in Ethiopia.

Method: A national survey among physicians from 49 public hospitals in six regions was conducted. All physicians in the selected hospitals were invited to respond to a self-administered questionnaire, which also included an open-ended question asking for descriptions on self-experienced ethical dilemma.

Results: Totally 583 physicians responded (91%). Among them, 87% agreed to the quote: “Costs for the patient is important for me when I decide to use or not to use an intervention”.

Physicians view themselves as gatekeepers of public resources as well as patient advocates and stewards (financial protector) of patients and their families. These roles are challenging and often incompatible, and must be acknowledged by authorities and policymakers.
Millum, Joseph
National Institutes of Health

Putting a number on the harm of death

Aim & Context: Principled ways to make decisions about the allocation of scarce health care funds all make some use of summary measures of health—like QALYs and DALYs—which provide a common measure of the value (or disvalue) of morbidity and mortality. They thereby allow comparisons between health interventions with different effects on the patterns of death and ill health within a population. The construction of a summary measure of health requires that a number be assigned to the harm of death. But the harm of death is currently debated. In particular, there is substantial disagreement over the relative importance of the loss experienced by young children who die compared with adults. Some theorists think that the loss to infants is much less than the loss to young adults. Others, including those who currently construct summary measures of health, take the opposite view. In the context of global health spending this has the potential to make a huge difference to priority-setting decisions because young deaths constitute a large proportion of the global burden of disease.

This paper considers how we should assign numbers to the harm of deaths at different ages in the face of uncertainty and disagreement.

Methods: Literature review and conceptual analysis.

Results: In the face of disagreement and uncertainty we must still assign numerical values to the prevention of deaths. This paper presents a function relating age and the disvalue of death that is argued to be the best reconciliation of current plausible views.

Mitchell, Paul¹
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Capabilities as an appropriate evaluative space for renal care? A proof of concept study

There is increasing interest among health economists and policy makers in measuring individual capabilities to assess patient interventions. A person’s capability, that is their ability to do the things in life that matter, was developed by Amartya Sen as an alternative evaluative space to traditional welfare economic assessment of utility. Research in health economics has, to date, primarily focused on patient reported outcome measures of capability, typically focusing on people requiring forms of integrated care, such as mental health, public health and social care. Less attention has been given to traditional health care and the appropriateness of adopting a broader assessment of wellbeing in areas typically considered to primarily focus on health gains.

Focusing on patients receiving different forms of renal replacement therapy as a case study, we conceptually explore the potential trade-offs in health and capability that patients experience. Patients with end-stage renal disease are faced by the choice of receiving dialysis on site or at home, kidney transplantation or conservative care. Dialysis can be in various forms: haemodialysis, a blood cleaning treatment carried out on site or at home, and peritoneal dialysis, a treatment that flushes fluid through a tube in the abdomen during sleep (automatic) or throughout the day (continuous ambulatory) and is usually performed at home. Each option has differing implications for health gain and capability gain; this paper considers the implications for priority setting in renal care according to whether the objective is health maximisation, capability maximisation or sufficient capability.
Leveraging country financing for health

In this talk we discuss the problem faced by a donor who wishes to give money to a country to support its healthcare programmes. The two parties have overlapping but not identical objectives – the donor only cares about healthcare, while the country cares about other things as well. The structure of the game is that the donor decides to subsidise some projects and then the country chooses which projects to fund. We show how the donor can calculate an optimal subsidy regime which maximises the contribution the country makes to its healthcare sector. We demonstrate our model with a worked example based on HIV treatment and conclude by discussing political and moral aspects of this model.

Co-authors: A Arulselvan
Are trust and security relevant to health service priority setting?

There is widespread recognition that there is no single ‘correct’ approach to priority setting in healthcare. Nevertheless, cost-effectiveness, with the aim of maximising health gain, remains central to many approaches. This is based on the assumption, implicit or explicit, that health is the primary, or even sole, objective of healthcare systems. However, health-gain maximisation (QALY maximisation) can have a number of undesirable consequences, including reinforcement of inequalities and discrimination against those with rare diseases, those with pre-existing disabilities and those needing more costly interventions. As a result, modifications have been proposed, for example, weighting QALYs or adjusting funding thresholds, but without questioning the underlying assumptions of the pursuit of health-gain maximisation.

After critically examining those approaches, this paper proposes that there should be a clearer distinction between the objectives of health-related interventions and the objectives of healthcare systems. In particular, in the case of healthcare systems, it is argued that trust and security are under-recognised as important, and possibly primary, objectives. The implications of this for healthcare priority setting, at all levels, are explored.

Puzzling priorities: the transition of healthcare and patient influence in an era of austerity

Context: The future of the needs-based publicly funded healthcare is far from sustainable and the fair distribution of resources is a constant challenge. National healthcare systems, like in the UK and the Nordic countries, were renowned for paternalistic producer sovereignty with expert-determined healthcare need. In latter decades patients have got a more active role to participate and to make choices about the services they receive. In Sweden, the new ‘Patient Act’ (2015) has extended the patient’s right from choosing among healthcare providers to receive information on diagnostics and treatments and, where possible, choose between alternatives. The current health service, and its professionals, represent neither ‘church’ nor ‘garage’ – to use Klein’s metaphor – but is struggling to balance between political initiatives, highly varied needs and expectations among patients.

Aim: The aim is to explore how actors within the healthcare system understand the changing patient role, how this change influence the meeting between patients and professionals and how this shift can be understood in a priority-setting context.

Method: Semi-structured interviews with 20 healthcare politicians, senior administrators, clinical unit managers and business developers in one Swedish regional health authority.

Results/Conclusion: A shared view can be found among the actors that the conditions for patients to influence the services they receive vary a lot and that the gap in this respect between patient groups is widening. However, the views among the actors differ with regard to implications for the distribution of resources, priority setting and the responsibility among politicians, professionals and patients.
Integration isn’t a competition, collaborate for success

Commissioning integrated care may improve the quality and efficiency of health and social services for long-term conditions such as stroke. Variation in commissioning arrangements across multiple provider organisations may make commissioning integrated services challenging. New commissioning models may improve integration but are untested.

This study aims to understand how new commissioning models are being used in practice. Three comparative case studies of stroke service reorganisation were explored over one year. Over sixty semi-structured interviews with commissioners, providers (acute, community, social care, third sector), patient representatives and advisory bodies were completed, commissioning meetings were observed and strategic documentation for each organisation was collected. Thematic analysis identified key themes. All three sites adopted different approaches through collaboration and competition to commission new models of integrated care. Site A commissioners attempted to force a lead provider model through procurement but providers did not collaborate as commissioners expected and reorganisation failed. Site B commissioners facilitated provider engagement and collaboration, allowing co-design and commissioning of a lead provider model. This resulted in a partially integrated stroke pathway. Site C commissioners passively relied on the provider’s initiative to generate change, led predominantly by the acute provider. This achieved improved provider relationships but limited integration and no changes to commissioning arrangements.

Findings suggest competition inhibits collaboration and is not compatible with integration, and acute providers may dominate change when passively managed. When commissioners actively facilitate engagement and collaboration between providers, new commissioning models like lead provider are accepted and lead to improved integration across healthcare providers.

Selling goats to pay for medicines – family priorities and coping strategies in the context of universal health coverage

Aim
Health expenses can be catastrophic for poor families in societies without financial risk protection. In many low-income countries neonatal mortality is still high, partly due to lack of care-seeking or adherence to medical advice. Ethiopia is currently moving towards universal health coverage, and we aim to study the costs families experience when seeking care for sick newborns. Further, we aim to explore how they deal with these costs and the trade-offs they face during newborn illness.

Context and methods
A qualitative study was conducted in Butajira in 2015, comprising observation in hospital, 40 semi-structured interviews and 7 focus group discussions with family members, health workers, and community members. Data were collected on costs of care at hospital, health center and pharmacy.

Results
When newborns fall ill, families commonly do not have money at hand to handle the costs of care. They worry about unpredictable expenses when using health care services, and experience that paying for hospital services, medicines, transportation, or food strain family welfare. Families cope with the expenses by using savings, working more or using networks to borrow money and sell their possessions. The very poor families have limited opportunity to mobilize resources, and struggle to balance concerns to the health of the newborn and family welfare. When the financial burden is too high, families may delay health care seeking or may not go to the hospital or health center at all.

While delivery care is provided free of charge, families struggle with high expenses related to care for the newborns. Families must be ensured financial risk protection as Ethiopia moves towards universal health coverage, a first step is to provide newborn health care services free of charge.
Open and fair: a new proposal for priority setting in Norway

Health systems worldwide struggle to meet increasing demands for health care, and Norway is no exception. This paper discusses the new, comprehensive framework for priority setting recently laid out by the third Norwegian Committee on Priority Setting in the Health Sector.

The framework posits that priority setting should pursue the goal of “the greatest number of healthy life years for all, fairly distributed” and centres on three criteria: 1) The health-benefit criterion: The priority of an intervention increases with the expected health benefit (and other relevant welfare benefits) from the intervention; 2) The resource criterion: The priority of an intervention increases, the less resources it requires; and 3) The health-loss criterion: The priority of an intervention increases with the expected lifetime health loss of the beneficiary in the absence of such an intervention. Cost-effectiveness plays a central role in this framework, but only alongside the health-loss criterion which incorporates a special concern for the worse off and promotes fairness. In line with this, cost-effectiveness thresholds are differentiated according to health loss. Concrete implementation tools and open processes with user participation complement the three criteria.

Informed by the proposal, the Ministry of Health and Care Services is preparing a report to the Parliament, with the aim of reaching political consensus on a new priority-setting framework for Norway.

The coverage cube and its many permutations—how can it best promote universal health coverage?

Bolstered by its inclusion among the recently adopted Sustainable Development Goals (SDGs), universal health coverage (UHC) is firmly topping the global health agenda. As policy makers around the world chart paths and make difficult choices towards UHC in the next 15 years and beyond, they will likely reflect on what has become one of the most powerful memes in health policy: the so-called coverage cube, popularized by the World Health Organization (WHO). However, since the cube figured prominently in the World Health Report 2010, more than a dozen versions have been set out, differing profoundly. Which cube should policy makers use? How should they use it? And does the plethora of designs weaken or strengthen the cube’s relevance and utility?

We conduct a systematic review of coverage cubes, identify crucial shortcomings in extant designs, and propose a practical way forward to maximize utility of using the cube in working towards UHC.
Priority setting at the micro level: decision-making in two different clinical contexts

Setting priorities is widely recognised as one of the most important dilemmas facing healthcare professionals in the 21st century. Decision-making at the micro level is a key aspect of resource allocation but is often overlooked in research and policy making. In this study we analysed decision-making in two different priority-setting contexts relating to the allocation of bariatric surgery and suitability for kidney transplantation.

Selected clinic consultations were recorded and in-depth interviews were conducted with clinicians in both specialties. A qualitative approach was taken to research and sampling was undertaken purposively and theoretically. Analysis was based on constant comparison, integrating aspects of targeted Conversation Analysis where appropriate.

87 consultations were recorded and 22 interviews were conducted. Clinicians in both groups struggled to manage conflicting concerns around individual patient advocacy and utilitarian concerns about making the best use of available resources. Both clinical and lifestyle issues were important in decision-making, but these were rarely made explicit to patients and implicit decision-making prevailed. Renal clinicians were reassured that a ‘second tier’ of prioritisation existed at the national level and occasionally used inside knowledge of these criteria to de-prioritise patients without having to say ‘no’ to them in clinic.

Similar tensions between maximising patient engagement and being realistic about external limitations on care existed in both specialties. Clinicians felt exposed and uncomfortable when discussing prioritisation between individual patients, which often resulted in one-sided decision-making and potentially inequitable access to care.

The influence of priority setting frameworks for health intervention on policymaking

Background: Priority setting in health systems is a major challenge for policy-makers globally. Frameworks can provide a structured guide when setting health system priorities.

Objectives: This study aims to establish the degree to which some of the most commonly documented priority setting frameworks for health interventions have been used to influence policymaking.

Methods: A scoping review of priority setting frameworks for health interventions was conducted for the period of January 2000 to March 2015. The literature was synthesized to identify documentation of instances where frameworks were adopted by policy-makers as a tool to guide their routine priority setting processes.

Findings: Of the four frameworks examined herein—accountability for reasonableness (A4R), program budgeting and marginal analysis (PBMA), multi-criteria decision analysis (MCDA), and burden of disease & cost-effectiveness analysis (BoD/CEA)—few studies reported cases where the framework was adopted by the jurisdiction as the standard to guide future priority setting. Cases including uptake of the framework by jurisdictional authorities were most commonly found in high-income countries. PBMA was the most widely adopted document framework, whereas MCDA was least commonly adopted. BoD/CEA has been reported to influence development of National Essential Health Packages in low income countries. A4R was commonly applied to evaluate fairness of priority setting processes after they had been carried out.

Implications: There is a need for sustained knowledge exchange between researchers and policy-makers to ensure that these frameworks are more applicable, accessible, useful and sustainable for informing policy—especially in low and middle-income countries.
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A socio-technical approach to healthcare decision-making: how compatible are technical and social perspectives?

A persistent challenge for healthcare policymakers and commissioners is the need to allocate scarce financial and specialist resources, ensuring high quality care whilst simultaneously reducing health inequalities (Ham, 2008; McCafferty, 2012). This has prompted new approaches in healthcare prioritization and decision-making that move beyond traditional ‘technical’ approaches (such as cost effectiveness analysis) to more ‘socio-technical’ approaches that combine elements of health economics with stakeholder engagement and deliberation. This aims to produce decisions that are transparent, evidence based and meaningful to a range of stakeholders (Airoldi et al., 2011; 2014).

In this paper we focus on the implementation of one socio-technical approach, focusing in particular on the challenges of blending the ‘technical’ with the ‘social’ elements of decision-making through a highly structured facilitated process. Through a qualitative study of the implementation process we seek to develop a practice-based understanding, examining the experiences of different stakeholders and the facilitators.

Our findings explore the potential barriers to ‘bridging the gap’ between the technical and the social. In considering the compatibility of the social and technical approaches we highlight a number of enduring challenges. These include: epistemological differences (between the social and the technical), power and status differences amongst stakeholders; and the potential for a de-coupling of the social and technical perspectives. We suggest that the key to successful implementation lies with strong facilitation that prevents a de-coupling of the methodology.

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Prioritize Health! How should a hospital contribute to the health of the community it serves?

Aim: To assess the impact of public deliberation on knowledge gains and attitude changes among participants in deliberations held to inform an urban hospital on resident priorities for health promotion.

Context: U.S. federal and New York State mandates require that not-for-profit hospitals undertake assessments of community health needs and engagement of community members in order to develop programs that improve the health of individuals living within their service area. Maimonides Hospital, an institution serving a diverse New York City community engaged The New York Academy of Medicine to implement public deliberations to inform hospital decision makers as to public priorities for health initiatives.

Methods: Sixty six individuals, diverse with respect to age, race, ethnicity, neighborhood, and educational attainment were recruited from 285 interested residents to participate in three 2-day deliberative sessions that included interactions with experts and discussions of case studies of evidence-based interventions. Surveys were administered pre- and post-deliberation to assess change in participant knowledge, attitudes and priorities. A qualitative analysis of the deliberations was also completed.

Results: There were statistically significant increases in knowledge regarding health information (p<0.001) and health research (p<0.001). Increases in participant’s knowledge regarding social determinants of health, particularly the impact of educational attainment, was significantly associated with a higher prioritization of a health intervention aimed at improving high school graduation rates. A significant majority of participants prioritized community level interventions versus individualized clinic-based prevention approaches and recommended that the hospital focus prevention efforts on populations at highest risk of disease due to socioeconomic status.

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Resource scarcity in the English NHS: the relevance of economics for prioritisation decisions

The reality of healthcare provision today is an ever increasing demand for healthcare against a backdrop of limited resources. ‘Economics as a discipline explicitly addresses (this) reality by acknowledging resource scarcity, however, the extent to which economics actually influences such prioritising decisions in healthcare is unclear.’ (Bate and Mitton 2006). Health economists have devised a number of tools and techniques to support rationing decisions, but as described by Bate and Mitton (2006) and Eddama and Coast (2009) it’s a moot point how embedded any of these techniques are in the realities of the day to day prioritisation decisions that occur across the NHS.

The aim of the study was to explore actual decision making in the context of commissioning in the English NHS by using qualitative techniques to compare day to day realities of decision making with the theoretical framework Programme Budgeting and Marginal Analysis. A series of in depth semi-structured interviews were held between the ‘practitioner researcher’ (themselves a senior NHS decision maker) and decision makers selected using purposive sampling methods. The findings were then analysed and compared to the evidence from the literature.

The conclusions of this study were that to best support decision makers the prioritisation framework should be ‘light touch’ on technical detail whilst focusing on strategic vision, decision making principles, communications strategy and wide engagement of stakeholders across the health community. Resource prioritisation decisions in difficult times is much more likely to be successful when responsibility for healthcare resources is everyone’s business.

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Should we take from the more needy to cover care for the less needy?

Within health-care, priority-setting exercises often result in ranking lists over interventions. There are a number of different suggestions and methods for how these ranking lists should be established. Whatever approach is used, the basic rationale is that these lists should reflect some form of ethical values and norms guiding priority setting. Hence, a ranking list implies that the interventions getting the highest ranking are more important to implement than lower ranked ones. However, this is not necessarily how these ranking lists are interpreted when it comes to actual resource allocation. In the talk, two common implementation suggestions found within the practice of priority setting are explored: the idea about rationing from the bottom of such a list and the idea that the higher the ranking, the higher the relative degree of coverage should be.

It is argued that following common ethical aspects guiding priority setting, e.g. patient need and/or cost-effectiveness, they will only support rationing from the bottom. Therefore, relative degree of coverage must be supported by more pragmatic arguments - like generating enough resources for the health-care system to distribute and getting public acceptance for priority setting. At the same time, these pragmatic reasons risk flying in the face of established and explicit ethical values within the health-care system.
Schätzlein, Valentin
University of Bayreuth

Evaluation of “Priority-Cafés” as an innovative multi-stage deliberative method to promote informed preferences

Objectives: Public participation has attained a competent part in many societal decision-making processes nowadays. However, there is a lack of knowledge about adequate participatory methods in the context of health. This study evaluates whether World-Cafés as a multi-stage deliberative method can lead to consolidated knowledge in laymen groups about complex (allocation) questions like prioritization in medicine.

Methods: We conducted three “Priority-Cafés” – one for each priority criteria (i) age, (ii) self-responsibility and (iii) evidence-based. In those 15-16 laymen discussed one criteria in different contexts (organ allocation and reimbursement of dentures). Following the World-Café approach, participants were split in small groups facilitated by experts (Physician, Jurist, Economist, or Philosopher). After a certain time of discussion participants regrouped until all participants visited all experts.

For the evaluation of the “Priority-Cafés” we performed a mixed-method: We analysed questionnaires to evaluate participants’ preferences on the topic of interests before and after the “Priority-Café”. Moreover, we conducted detailed discourse analysis following the documentary method by Bohnsack and focussing on the line of arguments respectively the opinion formation processes.

Findings: Findings show that opinions are rather strengthening through “Priority-Cafés” than changing. But more differentiated opinions regarding the three priority criteria have been established. Participants consider themselves as more adequately informed through the deliberative process. Our findings support the view that the method is adequate to reveal more informed preferences and consolidated knowledge about complex questions.

Schmidt, Harald
University of Pennsylvania

Breast screening, resource allocation and individual decision making: is conflict inevitable or resolution possible?

Aims: To review international approaches to breast-screening and identify best practice. Context: Breast-screening clearly saves lives. The more women get screened, the more lives are saved. But while some women will experience direct benefit, a far larger number of women also experiences harms. For example, the US Preventive Service Task Force’s recently updated guidelines estimate that screening 1,000 women age 50+ biennially for 20 years will avert 7 breast cancer deaths. But there will also be 953 false positive findings with associated worry and anxiety, and 146 unnecessary biopsies. In addition, there will be 19 over-diagnosed tumors, meaning that women will have needless breast removal, and chemo- or radiation therapy. In view of these data, and in the context of increasing efforts to reduce the economic, physical and emotional harms associated with overdiagnosis and overtreatment, what is the right policy response?

Methods: Combining a systematic review of OECD member country’s policy and conceptual analysis, I describe and critically discuss approaches ranging from leaving the screening decision to the individual, to national invitation systems with/without default appointments, to commonly used financial or other rewarding incentives for getting mammograms, to tax-based and more severe penalties for not getting screened.

Results: It is argued that the ethically most defensible policy is to offer financial rewards for using evidence-based decision aids on mammograms. While clearly not uncontroversial, arguments based in the ethics of personal responsibility for health, behavioral economics, clinical medicine and public health are identified that can provide robust support.
The International Society on Priorities in Health Care

11th Biennial Conference, 7-9 September, Birmingham, UK

The International Society on Priorities in Health Care
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Does society wish to prioritise end-of-life treatments over other types of treatment?

Context: The debate on whether health gains should be weighted differently for different patient groups has focused recently on the relative value of treatments for patients with short life expectancy. It is unclear whether society is prepared to fund end-of-life treatments that would not meet the reimbursement criteria used for other treatments.

Aim: To review the empirical evidence in the published literature relevant to the research question: Do members of the general public wish to place greater weight on a unit of health gain for end-of-life patients than on that for other types of patients?

Methods: A systematic approach was used to identify and select data for the review. We conducted a keyword search of the Social Sciences Citation Index (aided by an innovative approach to ‘searching for search terms’), with follow-up of references to obtain additional data. Hierarchical criteria were applied to select empirical studies reporting stated preferences relating to hypothetical health care priority-setting contexts.

Results: Seventeen studies met the inclusion criteria and were included in the review. Choice exercises were the most common method; other approaches included willingness-to-pay, budget pie and person trade-off. Some studies found that the observed preferences regarding end-of-life patients are influenced by information about the patients’ ages. Overall, the evidence is mixed, with an equal split between the number of studies that report evidence consistent with an end-of-life ‘premium’ and the number that do not. We identify and discuss methodological and design aspects that appear to influence the findings of priority-setting preference studies.

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Schwettmann, Lars
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The Chimera of WTP for a QALY: Inconsistencies of Stated Preferences in Scenario Variations

Aim and context: To measure their willingness-to-pay (WTP) for a quality-adjusted life year (QALY) survey participants face hypothetical scenarios in which they can avoid health losses by paying money for a medical treatment. Scenarios are characterized and varied with respect to five attributes, viz. extent, duration and point in time of the health loss, (un-)certainty of the illness and payment method. We investigate whether individual reactions to ceteris paribus variations of single attributes are consistent with common assumptions of economic theory.

Methods: The dataset was collected within the GermanVaQ (German Value of a QALY) project with four representative samples of the German population in 2012 and 2014 including about 5000 respondents. We formulate hypotheses regarding WTP reactions to ceteris paribus variations and test them in a within-subject design. Three reaction types are distinguished: Type 1 reacts in accordance to our hypotheses (e.g. states a higher WTP for larger health gains); Type 2 states the same WTP in both scenarios and, thus, ignores the change; Type 3 reacts inversely to the corresponding hypothesis.

Results: Proportions of types vary between different pairs of scenarios. Type 1-shares are remarkably low (39% to 55%). The same amounts (Type 2) are stated by 23% to 47%, the proportions of Type 3 vary between 11% and 22%. Influences of socioeconomic variables on individual’s types are analysed, too. The observed reactions of Types 2 and 3 nourish existing doubts about established methods to determine WTP for health gains.

Co-authors: M Ahlert

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**The disvalue of death and global burden of disease**

Aim: To investigate the relevance of the two most promising theories on the badness of death, the Deprivation Account (DA) and the Time-Relative Interest Account (TRIA), for the Global Burden of Disease study (GBD).

Context: The GBD is a comprehensive regional and global research program that assesses mortality and disability from major diseases, injuries, and risk factors. The GBD project was first commissioned in 1990, followed by subsequent studies. In all versions of the GBD, we count the death of newborns as enormous losses, whereas we do not count stillbirths at all.

Methods: Inevitably, a study like the GBD comes with certain normative presuppositions. However, the treatment of birth as morally significant is problematic and in need of defense. When is the worst time to die? The crucial point for DA is the amount of good life lost after an individual has started to exist. Few argue that we begin to exist at birth. For TRIA, the level of cognitive development when an individual dies is what matters, in addition to the amount of good life lost.

Results: It seems to be the case that for DALYs to be coherent, death must be a loss for those who die. Accordingly, GBD needs to rely on some theory about the badness of death. And the best theories, DA, and TRIA, both imply that we should, to some degree, include stillbirths in the GBD.

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**Smith, Neale¹**

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**Priority setting and resource allocation for social determinants of health**

Priority setting can take place at the micro-, meso-, or macro-system level. One of the biggest challenges at the macro-level is to allocate resources between healthcare and other sectors. These sectors are typically known as social determinants of health. Since health, at the population level, is the product of the interactions among individual factors (e.g., genetic endowment) and lifestyle and other choices made within social, cultural, economic and political contexts, some of the best gains in population and individual health might be achieved by reallocation. Money might be disinvested from healthcare services to invest in programs and policies for poverty reduction, housing affordability, early childhood education, or other initiatives. This has come to be known as a Health-in-all-Policies approach.

Enacting Health-in-all-Policies draws upon the theory and practice of network governance, in which responsibility for policy making and delivery is shared across Departmental, organizational, and/or jurisdictional boundaries. This presentation reviews the literature and summarizes lessons and guidance from such experiences in a variety of countries. Increased complexity of governance arrangements has implications for resource stewardship, accountability, evaluation, public engagement and other subjects prominently of concern in priority setting research. Drawing upon such lessons can inform efforts to adapt our established approaches to macro-level priority setting into such networked and cross-sectoral settings. This will bring the benefit of our established formal models and tools for healthcare priority setting, rooted in economic and ethical principles, into debates upon resource reallocation for social determinants of health.
Champions for priorities during deliberation

Priorities set through deliberative processes are the product of not just the values of deliberators, but also the discussions that precede priority setting. This presentation explores one aspect of that discussion that may be particularly influential: the presence or absence of a champion who advocates for a particular priority. DECIDERS (Deliberately Engaging Communities in DEcisions about Research Spending) engaged minority and underserved communities in deliberations about health research funding priorities and found overwhelming support for mental health and child health research. We explore what might account for these dominant findings by analyzing the deliberations preceding their decisions, and the impact of individuals who may have "championed" specific priorities.

Methods: Using the simulation exercise CHAT (CHoosing All Together), 47 groups (n=519) deliberated about health research priorities. Pre and post-deliberation surveys measured participants' characteristics and views of deliberations. Priorities selected by individuals before and after deliberation, and by groups, were collected during the exercise. Deliberations were audiorecorded, transcribed and thematically analyzed to identify the reasons underlying the priorities selected. Unique codes for the "champion role" were developed inductively.

Results: Nearly all groups selected Child Health and Mental Health research (93.6% and 95.7%, respectively), and most groups chose the highest possible investment for those two categories. Thematic analysis of reason-giving and the "champion" role is in progress.

Conclusions: The in-depth qualitative analysis of a large body of deliberation transcripts provides a unique opportunity to examine the role of deliberators as champions for particular causes in a research priority setting exercise.

Out-of-pocket expenditure for cardiovascular disease care in Addis Ababa, Ethiopia: a cross-sectional study

About one-third of total health expenditure in Ethiopia comes from out-of-pocket (OOP) payment.

Aims: To quantify the magnitude and intensity financial catastrophe and impoverishment related to OOP expenditure for cardiovascular disease (CVD) and risk factors in Addis Ababa, Ethiopia.

Methods: A cross-sectional survey was carried out among patients in seven hospitals (four public and three private hospitals) in Addis Ababa. Out-patient and in-patient care cost for ischemic heart disease, stroke, hypertension and dyslipidemia was collected between February to March, 2015.

Results: The response rate was 95% for an estimated 684 sample size. STATA was used for the analysis. The magnitude and intensity of financial catastrophe and impoverishment was assessed. With a age 56 years, 55% of participants had a CVD event. The mean annual total OOP expenditure is about US$ 139 in public and US$ 674 in the private hospitals. The richer spend more in absolute terms. Direct medical costs constitute about two-thirds, while transportation accounts for 20-30% of OOP expenditures. Households use current income (53%), get support from family (34%) and use savings (8%) to cover OOP for out-patient care. At a 10% of total household income threshold, 22% in Q1 and 17% in Q4 experienced financial catastrophe, with a mean overshoot of 2, 66% points. About 1% households were impoverished after OOP expenditure as defined by daily income of < US$ 1.25.

Conclusions: Poorer households face high rate of financial catastrophe for CVD care. A targeted approach is required to ensure financial risk protection on the way to universal health coverage.
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Equitable healthcare: On the potential impact of politicization, bureaucratization and medical standardization of healthcare

Aim: Our aim is to increase the awareness of how governing instruments may maintain or even reinforce health inequity at the point of care. We discuss the potential impact governing instruments that are shaping healthcare systems may have on socioeconomic disadvantaged patients' access to healthcare in the contexts of publicly funded and universally accessible healthcare.

Argument: An analysis of potential barriers to access must disclose characteristics of healthcare systems that might pose challenges to equal access given unequally distributed capacities to fully take entitled advantages of the services. Such barriers could be: 1) outside the healthcare system, i.e. in income, education and environment, 2) within the healthcare system itself, i.e. lack of education on the social determinants of health, how health inequity may occur and could be tackled, and cultural discrepancies between healthcare providers and receivers, 3) governing instruments that require skills and resources certain patient groups typically lack, such as money and education, in order to fully benefit from its services. Our main argument is that these latter, formative barriers are vastly ignored in the literature and that we need to establish such knowledge in order to bring about healthcare systems that actually promote equitable access to its services.

Method: The analysis is based on normative theories and social science theories about the dynamics of formative barriers within a social system.

Results: We propose a theoretical analysis of how the implementations of a limited set of political, administrative and standardizing instruments influence socioeconomic disadvantaged patients' access to healthcare.

Addressing ‘waste’ in health systems: a critical interpretive synthesis

Objective: To understand: 1) whether, how and under what conditions health systems address ‘waste’; 2) how health systems have chosen to address the issue; and 3) how health systems have implemented approaches.

Approach: We conducted a critical interpretive synthesis and searched 15 databases to identify all empirical and non-empirical articles focused on disinvestment at a system level. Two reviewers independently screened records, assessed for inclusion and conceptually mapped included articles. We selected a purposive sample of articles, and created structured summaries of key findings using frameworks related to government agendas, policy development and implementation, and health system arrangements. We used the structured summaries to thematically synthesize the results across our domains of interest.

Results: Our search strategy identified 3537 references, from which we included 254 papers that were classified as relevant to agenda setting/prioritization (n=65), policy development (n=46) and implementation (n=60). The focus on addressing ‘waste’ emerges from the need to ensure value for money and to prevent patient harm. Approaches for addressing ‘waste’ include: 1) processes to identify and diagnose the types of overused or misused health services; 2) stakeholder- or patient-led approaches; and 3) government-led initiatives. Implementation considerations include the need to develop ‘buy in’ from key stakeholders.

Conclusion: Ensuring the use of high-value health services to keep citizens healthy and avoid harm is a priority across health systems. Our synthesis can be used to support decision making and understand how the issue has been prioritized, approaches that have been used to address it and implementation considerations.
“Wait – is this really necessary care?” A realist review of health care priority-setting decisions

Context – National and local health authorities, health services and insurance agencies use explicit criteria, such as effectiveness, when deciding on coverage of a certain medicine or medical aid. Decision makers also examine the ‘necessity’ of provision, but as this is usually an implicit, non-standardised criterion, little is known about how it works in priority-setting decisions.

Aim – To investigate necessity-based argumentations used in hypothetical and actual priority-setting decisions.

Methods – This study is designed as a realist review, adhering to the RAMESES quality standards. Embase, Medline and Web of Science were searched for articles describing hypothetical or actual priority-setting decisions. Articles were included if they detailed macro- or meso-level decision making containing necessity-based arguments for the decision. 75 articles divided into seven data subsets (cancer therapies, orphan drugs, cosmetic surgery, obesity treatments, Viagra, smoking cessation therapy and in vitro fertilisation) were included.

Results – Seventeen types of argumentation were elicited from the data. The majority of the arguments are employed either in positive or in negative decisions; only four types are in use both in favour of and against coverage. Meso- or macro-level priority-setting decisions that specify indication criteria require a doctor to make the final individual decision. When a patient (organisation) or the public puts a treatment or therapy on the decision agenda, the final decision and argumentations used are significantly impacted.

Conclusion – Different argumentations that heighten or lower the necessity of coverage of a certain therapy or treatment are in use in priority-setting decisions, with varying degrees of explicitness.

Priority setting and orphan drugs in five European countries

New and expensive drugs are challenging for health systems in all countries. Frequently failing to qualify as cost-effective are treatments aimed at patients with rare diseases (often referred to as “orphan drugs”). Although a success for many individual patients’ previously lacking treatment alternatives, decision-makers face a challenging task of balancing different criteria such as e.g. cost-effectiveness, severity, efficacy and equal access to care, when deciding if these treatments should be provided within the publicly funded health care system.

Countries have addressed the issue of orphan drug reimbursement differently. The objective of this study is to compare of the priority setting process of orphan drugs in five European countries—England, France, the Netherlands, Norway and Sweden. Focus is on similarities and differences in the process of making reimbursement decisions regarding orphan drugs, and in the values used when making these decisions.

Interviews (n=25) were performed with relevant stakeholders with knowledge about orphan drugs and their reimbursement (i.e. representatives from reimbursement agencies, pharmaceutical companies and patient groups). A semi-structured question guide was used with questions focusing on the actual process for reimbursement decisions regarding orphan drugs but also on strengths and weaknesses with the current approach.

Results show that different countries have created different solutions for managing orphan drug reimbursement, e.g. alternative routes for assessment and appraisal, individual reimbursement, price negotiations, conditional reimbursement and interpretation of ethical principles has been employed in order to justify paying premium prices for orphan drugs.
The jurisdictional and organisational context of priority-setting for health technology assessment

In Canada and internationally, priority-setting for health technology assessment (HTA) is a practical challenge as the recommended processes for HTA priority-setting are often not aligned with the current context of HTA and health care decision-making. Evidence suggests that the way in which HTA agencies set priorities and allocate resources for assessment varies across countries. To redress these variations, current literature emphasizes the benefits of rational, systematic and explicit priority-setting processes. But knowledge about how technologies are actually prioritised for assessment and whether current processes work is limited.

Informed by literature in organizational behaviour and policy studies, we sought to understand the influence of multiple contextual factors on HTA priority-setting through a comparative case study of HTA systems in Canada (Alberta, Ontario) and the United Kingdom (England, Scotland) drawing on documentary sources and semi-structured interviews with representatives of HTA organisations and health system decision-makers of the four jurisdictions (n=13).

We find that HTA priority-setting is situated within two contextual dimensions. The first is the institutional and jurisdictional context of HTA systems. Although there are formal institutions and seemingly rational HTA processes and structures across the four jurisdictions, they are challenged by jurisdictional pressures and dynamics related to health care decision-making. The second dimension is the internal functioning of HTA organisations. This encompasses the internal decision-making structures of HTA organisations and decisions regarding the internal allocation of resources with respect to the types of technologies reviews and the types of review produce that inform health care decision-making.
Co-designing improvement priorities in dementia care

Aim: The study aims to identify improvement priorities in dementia care across County Durham (UK).

Context: Despite evidence on effective and cost-effective interventions in dementia care and a comprehensive dementia national strategy for England, research has highlighted the weaknesses of current dementia services and practice variations across the County.

Methods: The study builds on the principles of co-design. Local stakeholders (people with dementia and their informal carers, providers, commissioners and health professionals) are involved in a participatory process aiming to identify improvement priorities. This participatory process entails both quantitative and qualitative methods for data collection, including:

- A workshop to understand how dementia care is currently provided across the County and where the problems are
- In-depth interviews with people with dementia and informal carers to explore their care journeys and whether and how their needs are met by the services currently offered
- Focus groups with people with dementia and their informal carers to provide breadth on variation in their care journeys
- Focus groups with health professionals and professional carers to collect their expert view on areas needing improvement and facilitators and barriers to improvement
- A workshop to collate insights generated by the interviews and focus groups and to identify possible areas for improvement
- A workshop where the implementability and the Value-for-Money of each area for improvement is assessed using the Socio-technical approach to resource allocation (Star) approach, an MCDA-based priority setting tool.

Results: The participatory process is expected to inform commissioning decisions in the area of dementia care in County Durham.

Co-authors: M Airoldi² - J Oyebode³

University of Birmingham

Allergy- a health care priority or a distraction?

Aim: To estimate the NHS costs of managing childhood allergies in the West Midlands as an initial step for proposing a re-organisation of regional services.

Context: Allergy is an area of ‘unmet need’ in the UK. While incidence and prevalence of allergy are increasing, services have not kept up with increases in demand. Consequently allergy patients, especially children, face difficulties accessing competent primary and secondary care. Previous attempts at improving services in some parts of the UK were only partially successful, partly due to apathy of commissioners. Yet allergies are estimated to cost the NHS up to a billion pounds a year, and a considerable amount more if the costs of lost days at work, poor performance at school examinations and over the counter medications were taken into account.

Methods: Using a primary (THIN) and secondary (HES) care databases, we will estimate costs based on General Practitioner (GP) consultation numbers, prescription drug usage, and cost of anaphylactic reactions. We will estimate trends in incidence and prevalence of these conditions and consultation rates over the last 10 years to predict changes to demand on services and associated costs. Initial analysis suggests that the prevalence of allergy and consultation rates are rising and costs are quite considerable.

Conclusion: Demand for allergy services is increasing. Allergy appears not to be a priority area for commissioning since it is ‘not considered important’. But the high costs associated with allergies and the pressure they place on GPs should not be disregarded by commissioners.
**POSTER 003**

**Eden, Martin**

University of Manchester

**Valuing economic benefits of genomic-based diagnoses: qualitative meta-synthesis to inform design of best-worst scaling study**

**Aim:** Synthesise existent qualitative research to inform design of a best-worst scaling discrete choice experiment (BWDCE) looking at how people value health and non-health outcomes of genomic testing

**Context:** People can value genomic-based diagnostic information even if it doesn’t alter treatment. In healthcare systems using Quality-Adjusted Life Years (QALYs) as an outcome metric in economic evaluation it is challenging to determine the relative value-for-money of diagnostic interventions producing outcomes which ‘go beyond’ health. New genomic technologies are providing increasing opportunities for benefits from diagnostic information to be realised in ever expanding areas of healthcare. There is a need to integrate genomic diagnoses into mainstream medicine. BWDCEs can be used to quantify how people trade-off between health and non-health outcomes of complex interventions and, consequently, inform adaptation of QALY-based approaches to aid allocative decision-making. An important first step in DCE design is to identify useful attributes and levels; qualitative research is a means of doing so. A wealth of qualitative work has sought to understand how and why people value diagnostic information.

**Methods:** A systematic search identified qualitative evidence describing relevant outcomes that may be utilised to value a genomic diagnosis. Synthesis of qualitative data was facilitated using meta-ethnography: an iterative ‘translation’ of study findings.

**Results:** Relevant studies were identified and key papers included in the meta-ethnography. Data were consolidated into key overarching concepts including notions of autonomy, informed decision-making, cognitive capability and empowerment. The next step for this project is to utilise meta-ethnography findings in the design of a BWDCE.

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**POSTER 004**

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**Equity in long lasting insecticidal nets and indoor residual spraying for malaria prevention in a rural South Central Ethiopia**

**Background:** While recognizing the recent achievement in the global fight against malaria, the disease remains a grand challenge to health systems in low income countries. Beyond widespread consensuses about prioritizing malaria prevention, little is known about the prevailing status of long lasting insecticidal nets (LLINs) and indoor residual spraying (IRS) across different levels of wealth strata. The aim of this study was to evaluate the socioeconomic related dimension of inequalities in malaria prevention interventions.

**Methods:** We conduct this study in July-August 2014 in Adami Tullu district in the South-central Ethiopia, among 6,069 households. A cross-sectional data were collected on household characteristics, LLIN ownership and IRS coverage. We used principal component analysis technique for ranking households based on socioeconomic position. The inequality was measured using concentration indices and concentration curve. Decomposition method was employed in order to quantify the percentage contribution of each socioeconomic related variable on the overall inequality.

**Results:** We found that the proportion of households with at least one LLIN was 11.6% and IRS coverage was 72.5%. The Erreygers normalised concentration index was 0.0627 for LLIN and - 0.0383 for IRS. The main contributors for the inequality in LLIN ownership were difference in housing situation, household size and access to mass-media and telecommunication service.

**Conclusion:** Coverage of LLIN was low and significant more likely to be owned by the rich households, whereas houses were sprayed equitably. The current mass free distribution of LLINs should be followed by periodic refill based on continuous monitoring data.
Trends and modeling of Canadian home care delivery

Concerns related to caring for the elderly remain top of mind for healthcare leaders, decision makers, and the general public. In particular, providing high quality home care services that are sustainable presents an ongoing challenge for health systems globally. Understanding historical trends in care delivery and patient demographics as well as the relationships between different types of care and desired outcomes are key to creating comprehensive models to address issues proactively.

In this project, administrative data from a Canadian health authority will be used to observe demographic trends in patients receiving home care between 2009-2014. Regression analysis will then be applied to determine which aspects of home care (e.g. case management, cleaning, rehabilitation, physician visits) are associated with lesser levels of acute usage adjusting for demographic factors. In this way, investigators hope to illuminate past trends and current performance of home care delivery.

To project into the future, a Markov Model will be created using transition and cost data of patients from home to hospital to residential care to death. Ultimately this model will be used to forecast costs in 2036 where an anticipated 25% of the Canadian population will be over the age of 65. It will also be used to simulate various systems implementations as well - including increasing home care investment and expansions in palliative care.

This research project represents a novel development in modeling and analysis that is relevant to researchers and decision makers interested in addressing upcoming demographic challenges in health systems.

Improving and evaluating priority setting and resource allocation internationally

In Sweden, resource allocation takes place in a regionalized public system with regional government providers – the county councils. The County Council of Dalarna is responsible for all health care, primary care as well as six hospitals. In 2016, one of their objectives is to improve their PSRA, and they are planning to use an evaluation tool developed in Canada to do so.

Items from the original tool were edited and likert scales were added to facilitate an online medium of distribution. The evaluation tool will be administered to both middle and senior manager in the county at baseline, and post-implementation of an initiative to improve PSRA. The respondents will also assess the value of using the tool itself as an input for improving their PSRA process.

This application of the evaluation tool is novel in the following ways:
- It is the first international implementation of a tool that has been developed in two different health-care systems – Canada and Sweden
- It is the first time it has been used in a program evaluation capacity

The investigators hope that this presentation will demonstrate the applicability of the PSRA evaluation tool in multiple contexts, and expose decision makers to opportunities to improve their own processes.
Being accountable for the not provided healthcare: the ethics of Limit-setting Framework

Aim: The aim of this paper is two-folded. One aim is to provide an ethical framework that allows users to evaluate and compare healthcare systems in terms of how well their current priority setting processes are arranged to provide people who are adversely affected by priority- or limit setting decisions with well-justified reasons for conferring legitimacy to the decision that they do not get the wanted care. The second aim is to provide a guiding framework for decision makers/countries who want to improve their decision making practices on this aspect.

Context: The literature on priority setting offers decision makers a wide variety of principles and rationales which can be used to guide decision making in practice. Regardless of the principles used, making a limit setting decision inevitably results in some people ending up adversely affected. We argue there is a strong ethical demand to arrange the decision making process in such a way that it aims to provide people who are adversely affected by priority- or limit setting decisions with well-justified reasons for conferring legitimacy to the decision that they do not get the wanted care.

Methods: The discussion is based on normative theory and philosophical reflection.

Results: An ethical framework is proposed that can be used to evaluate and compare healthcare systems in terms of how well they provide people who are adversely affected by priority- or limit setting decisions with well-justified reasons. The framework will be presented in the form of reflective questions.

Priority setting for task-shift in primary healthcare: implications for Lady Health Workers’ program in Pakistan

Background: World Health Organization recommends task-shift as a pragmatic response to workforce shortage in primary healthcare. There is paucity of scientific information on the formal priority setting process for task-shift to Lady Health Workers (LHWs) in Pakistan. This study aimed to assess priority-setting needs and strategies for LHWs’ program.

Methods: Literature review of scientific studies, program implementation guidelines, and independent project reports related to LHWs’ task-shift was conducted. The framework for priority setting in health care was determined from literature review. Authors searched Pub-Med database and Google for published literature in English language between 2005 and 2015. Key findings were synthesized in thematic areas.

Results: Five thematic areas were drawn including i) expanding scope of work from preventive to curative programs in maternal, newborn, and child health; ii) rapid technological innovations mainly use of mobile health applications for antenatal, postnatal and newborn care; iii) unstable political climate causing frequent changes in the leadership; iv) cuts in federal health funding; and v) feelings of task overload. Program budgeting and marginal analysis (PBMA) framework is applicable to task-shift in healthcare. PBMA can be institutionalized in LHWs’ program through scoping exercise of current/future services, rationalizing alternatives, appraisal of available resources, partnership with all stakeholders, weighing decisions of investment and disinvestment, and process evaluation.

Conclusions: Priority setting for task-shift has potentials to maximize LHWs’ efficiency in Pakistan. PBMA framework is suitable to the needs of LHWs’ program; however, feasibility of program level implementation and long-term benefits should be determined through future research.
Priority setting and personal responsibility: elicitation of public preference in Germany

Social Code V (SGB V) is the essential policy for the German statutory health insurance, which covers 70 million people. §1 lifts out solidarity on the one hand and personal responsibility on the other hand as constitutional elements of this system. However, personal responsibility does not play an important role in (allocation) decisions. This contribution elicits public preferences to attach weight to personal responsibility in several contexts: (i) generally, (ii) reimbursing dentures, (iii) organ allocation.

Method: We conducted two focus groups covering participants with an unhealthy life-style and two focus groups covering persons with a healthy life-style. To disclose the structure of preferences we combined qualitative content analysis (MAXQDA 10) with frequency analysis and subgroup analysis (Chi2; SPSS).

Results: (insights). The main result is a categories system that covers arguments for and against personal responsibility as prioritization criteria. It shows, that preferences are context-sensitive. E.g., drastic consequences of withholding on the basis of personal negligence is a counter-argument in the context of organ allocation and minor consequences is a pro-argument in dental care. Differences apply for substance of reasoning as well as for weighting of pro and counter arguments. Subgroup analysis cuts across our assumptions regarding differences between participants with and without unhealthy life-style.

Implications: The chances to implement personal responsibility (as intended by SGB V) depend on public acceptance. Results show, that preferences are context sensitive. This must be taken into account when it comes to concrete proposals to use personal responsibility in specific allocation decisions.

Co-authors: E Nagel - V Schätzlein

A practical example from Sweden – from an ordinary caregivers view

Lessebo municipality has about 8400 inhabitants, and in Sweden most municipalities conduct home care. The main tasks for the rehab unit comprise of rehabilitation and home care for individuals over the age of 18, the main patient group being the elderly. Equal care is a corner-stone in Sweden, due to heavy workload we saw a risk of inequality due to differences in priorities within the unit.

The aim is to find a systematic and practical way to prioritize clinical work to obtain a more equal rehabilitation in Lessebo municipality. One of the goals is an increased consensus within the rehab unit to focus our interventions to gain the most cost-effective patient benefit.

We have been working with this project alongside our regular work. Three month’s data was collected from each member of the staff regarding the number of patients, main diagnosis and interventions carried out. From the data 42 prioritization objects were formulated, processed and ranked according to the Swedish national model for transparent prioritization. During the work we participated in a tutorial group, regularly offered to groups working with priority processes in Sweden by the National Center for Priority Setting at Linköping University.

The project lead to a register with all 42 items, implemented through regular meetings with mutual discussions and exercises in the rehab unit. As the one’s that should carry out priorities in practical health care we want to share our experiences of making equal and well-considered priorities to become a self-evident part of clinical work.

Co-authors: S Stefánsdóttir
Protecting scarce resources in healthcare: what is the true value of blood?

The aim of this paper is to estimate the true value of a unit of blood in the United Kingdom (UK).

Context: Blood is a valuable, scarce resource. In the UK, approximately 2.1 million units of blood components are transfused each year, but donor numbers are falling. The National Institute for Health and Care Excellence (NICE) have expressed the need for efforts to reduce the inappropriate use of blood, and increase the use of alternatives to transfusion (NICE, 2015). Valuing blood correctly is paramount in evaluating the cost effectiveness of alternatives to transfusion.

A unit of blood is currently valued by the National Health Service Blood and Transplant Authority (NHSBTA) at £121.85. However, there is significant uncertainty surrounding this figure with many suggesting it is an under representation of the true cost (Varney and Guest, 2003; Guest et al, 1998).

Methods: This paper will dissect the price of blood in the UK, identifying the elements that are contributing to the current price and exploring elements that may be unaccounted for, such as shrinking donor availability, restrictions on blood donor eligibility, managing periodic or enduring shortages of blood, and adverse events as a result of donor blood transfusion.

By incorporating these elements into the cost of a unit of blood we aim to develop a comprehensive and practical model that will allow us to quantify the true value of a unit of blood. This value will allow for more robust economic evaluation of alternatives to donor blood transfusion.

Determinants of enrolment of informal sector workers in cooperative based health scheme in Bangladesh

Background: Providing access to affordable health care for the informal sector remains a considerable challenge for many developing countries including Bangladesh striving to make progress towards universal health coverage. Occupational associations and cooperative can be a base for engaging such workers for healthcare financing as well as making healthcare affordable to them. The objective of the study is to identify the factors shaping the decision to enrol in a cooperative based health scheme for informal workers in Bangladesh.

Methods: Data were derived from a cross-sectional in-house survey within the catchment area of a cooperative based health scheme in Bangladesh during April –June 2014, covering a total of 784 households (458 members and 326 non-members). Multivariate logistic regression model was used to identify factors associated with cooperative based health scheme and explanatory variables.

Findings. This study found that a number of factors were significant determinants of health scheme participation including sex of household head, household composition, occupational category as well as involvement social financial safety net programs.

Conclusion: Findings from this study can be suggestive for policy-makers interested in scaling up health insurance for informal workers in Bangladesh. Shared funding from this large informal sector can generate new resources for healthcare, which is in line with the healthcare financing strategy of Bangladesh as well as the recommendation of the World Health Organization for developing social health insurance as part of the path to Universal Health Coverage. Evaluative space of the QALY and investigate whether individuals are willing to sacrifice health for benefits beyond health.
Geographic inequality in age-specific mortality and life expectancy in Norway over 35 years

Aim
This study aims at quantifying the level and changes over time of inequality in age-specific mortality and life expectancy between the 19 Norwegian counties from 1980 to 2014.

Methods
Data on population and mortality by county was obtained from Statistics Norway for 1980-2014. Life expectancy and age-specific mortality rates (0-4, 5-49 and 50-69 age groups) were estimated by year and county. Geographic inequality in these estimates was described by relative and absolute Gini indices annually. The expected number of years it would take for each county to catch up with the best performing county was estimated by using county specific annual rates of change for the period 2005-2014.

Results
Life expectancy in Norway has increased from 75.6 to 82.0 years, and the risk of death before the age of 70 has decreased from 26% to 14% from 1980 to 2014. Both relative and absolute Gini indices between counties have low values, and are decreasing for life expectancy. For age-specific mortality, the absolute Gini index decreased, whereas the relative Gini index increased for most age groups. It will take between 2 and 32 years (national average 7 years) until the counties catch up with the life expectancy in the best performing county if their annual rates of increase remain unchanged.

Conclusion
Life expectancy has become more equally distributed across Norwegian counties. Assessing whether the situation is becoming more equal for age-specific mortality rates depends on whether one is concerned with relative or absolute inequality.

Achieving high performance for priority setting in Canadian health care organizations

Aim:
The authors undertook a multi-year study to identify elements which would characterize ‘high performance’ in health care priority setting, and to develop a tool for assessing management practices in this area. Context: Setting priorities is a core task of health service delivery managers. Unfortunately, as shown in a Canada-wide online survey conducted by the authors, few health regions have established formal processes for this and even fewer evaluate the effectiveness of their efforts.

Methods:
As a follow-up to this survey, we undertook detailed case studies of six organizations identified as potential high performers in priority setting and qualitatively identified structures, processes, attitudes and behaviours to which successful outcomes were attributed. These were confirmed through comparison with existing literature and a national expert advisory committee.

Results:
The elements of High Performance comprise a comprehensive Framework for priority setting. The framework has been empirically tested in three ways. First, we conducted a retrospective evaluation of priority setting with a health organization in eastern Canada. Second, we developed and tested an evaluative tool based on the framework with two health organizations in western Canada, the first such multisite implementation. Third, we did additional follow-up research with one of these regions to reflect upon how the framework and evaluative tool guided efforts to strengthen priority setting practice over time.

The High Performance framework has been successfully employed by Canadian healthcare decision makers. Such structured approaches to priority setting should lead to better use of limited resources and increased organizational capacity and accountability.
Patient and nurse preferences for bedside handover: do they agree?

Aim/Context: This study compares patient and nurse preferences for bedside handover in hospitals.

Methods: A discrete choice experiment was undertaken by adult medical patients (n=401) and nurses (n=200) in two Australian hospitals. Handover choices were described using 6 attributes: whether the patient is invited to participate; whether a family member/carer/friend is invited; the number of nurses present; the level of patient involvement; the information content; and privacy. Data were analysed using mixed logit regression.

Results: Both patient and nurse participants preferred handover at the bedside rather than elsewhere (p<0.05); this was more strongly the case for patients. Being invited to participate (preference score 100); supporting strong two-way communication (73.4, 95%CI 51.8-94.9); having a family member/carer/friend present (58.1 points; 95%CI 46.0-70.2); and having only two nurses present (37.2, 95%CI 27.5-46.9); were most important for patients. In contrast, nurses did not consider having a family member/carer/friend present to be of importance. Further, while patients expressed a weak preference to have sensitive information handed over quietly at the bedside, nurses expressed a relatively strong preference for handover of sensitive information away from the bedside.

Conclusion: Patients strongly support handover at the bedside and want to be invited to be involved. Patient and nurse preferences for implementation of bedside handover differ. An understanding of these preferences can support recommendations for improving the patient hospital experience and consistent implementation of bedside handover as a safety initiative.
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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people’s lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people’s skills and knowledge, we aim to make a difference and contribute to a healthier population.
HEMPSONS is a leading national health and social care law firm. Our clients are public and private healthcare organisations, charities and social enterprises who plan, commission, regulate or provide health and social care services, or operate within the supply chain. Our strong NHS client base includes Foundation Trusts, NHS Trusts, CCGs and CSUs, the NHS Trust Development Authority, NHS England and other health related bodies. Hempsons is a member of every health and social care legal service panel across England, and continues to develop a reputation for advising on highly complex and innovative projects and cases. These include high profile inquiries, health service reconfigurations, major outsourcing, HR dispute resolutions, mergers and acquisitions, and joint ventures.

Commissioning is changing and we can help

With new models of care, co-commissioning, and Sustainability and Transformation Plans on the agenda, it’s a challenging yet exciting time for Clinical Commissioning Groups.

This changing landscape brings with it the opportunity to deliver great things, like improved services for patients, and healthier communities.

These are important aims, and ones we share as a CSU. We have years of NHS experience, along with the skills and expertise needed to support both everyday tasks and your biggest and boldest plans.

We’re available whenever you need help. Whether it’s a one-off project, or a long-term partnership, you can rely on us to deliver results. As one of the suppliers on the Lead Provider Framework, we’ve been given the NHS England seal of approval.

We’re already working with CCG, healthcare and public sector colleagues across the country to help them achieve their targets. Why not get in touch to see what we can do for you?

Derek Kitchen
Managing Director