Deliberative methods for combining different types of evidence in the development of policy recommendations

Journées annuelles de santé publique
Montréal 12 March 2010

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Overview

- Session theme: *"Deliberating to inform decision-making"*
- Presentation title: *"Deliberative methods for combining different types of evidence in the development of policy recommendations"*
  - Key concepts
  - Systematic review

  - Prescribed aim: *"By the end of your presentation, the participants should be able to better understand how deliberative processes can be used to combine different forms of evidence"*

‘Deliberating’ and ‘deliberative methods’

Julia Abelson’s work

CHSRF definition

Casting a wide net

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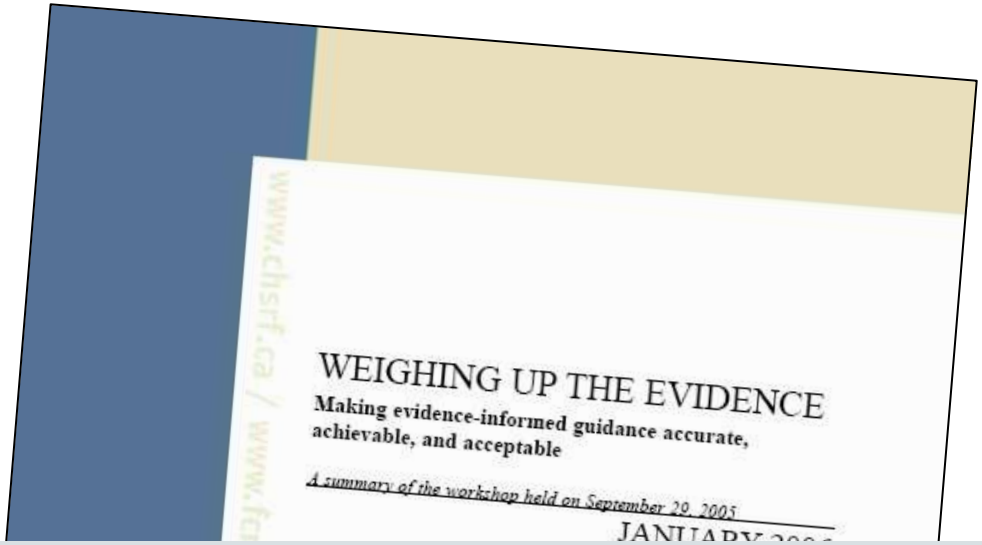


Deliberative process

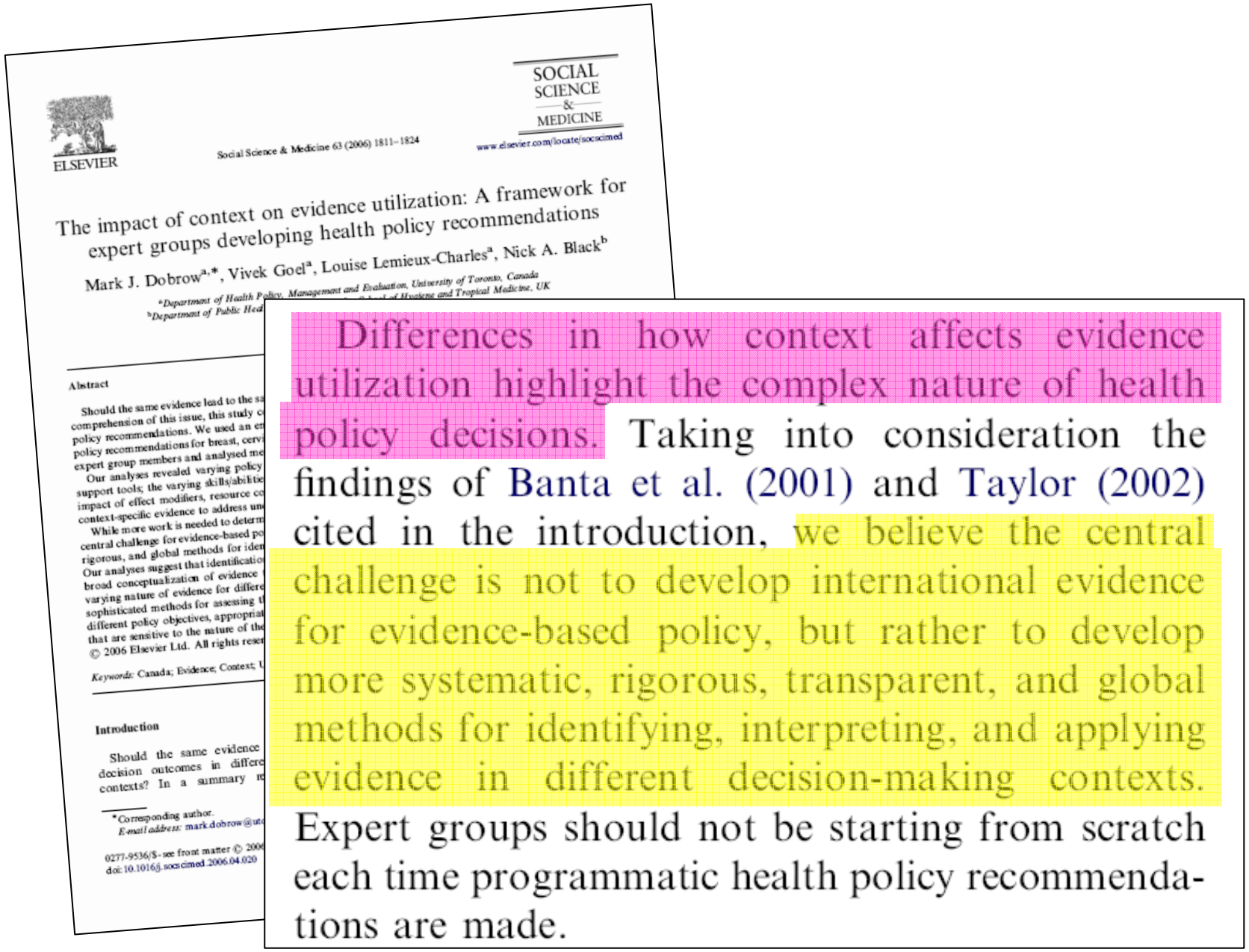
A deliberative process is a tool for producing guidance based on heterogeneous evidence. It is a participatory process that includes representation from experts and stakeholders, face-to-face interaction, criteria for the sources of scientific evidence and their weight, and a mechanism for eliciting colloquial evidence while making it subsidiary to the science.

‘Informing decision-making’ and ‘developing policy recommendations’

What types of decisions/policies?

What types of decision-making processes/contexts?

What is the aim – better decisions vs. better outcomes?



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Social Science & Medicine 63 (2006) 1811–1824

SOCIAL SCIENCE & MEDICINE

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The impact of context on evidence utilization: A framework for expert groups developing health policy recommendations

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[b]Department of Public Hea

Abstract

Should the same evidence lead to the sa
comprehension of this issue, this study c
policy recommendations. We used an en
policy recommendations for breast, cervi
expert group members and analysed me
Our analyses revealed varying policy
support tools; the varying skills/abilitie
impact of effect modifiers, resource co
context-specific evidence to address un
While more work is needed to determ
central challenge for evidence-based po
rigorous, and global methods for iden
Our analyses suggest that identificatio
broad conceptualization of evidence
varying nature of evidence for differe
sophisticated methods for assessing t
different policy objectives, appropriat
that are sensitive to the nature of the

Keywords: Canada; Evidence; Context; U

Introduction

Should the same evidence
decision outcomes in differe
contexts? In a summary r

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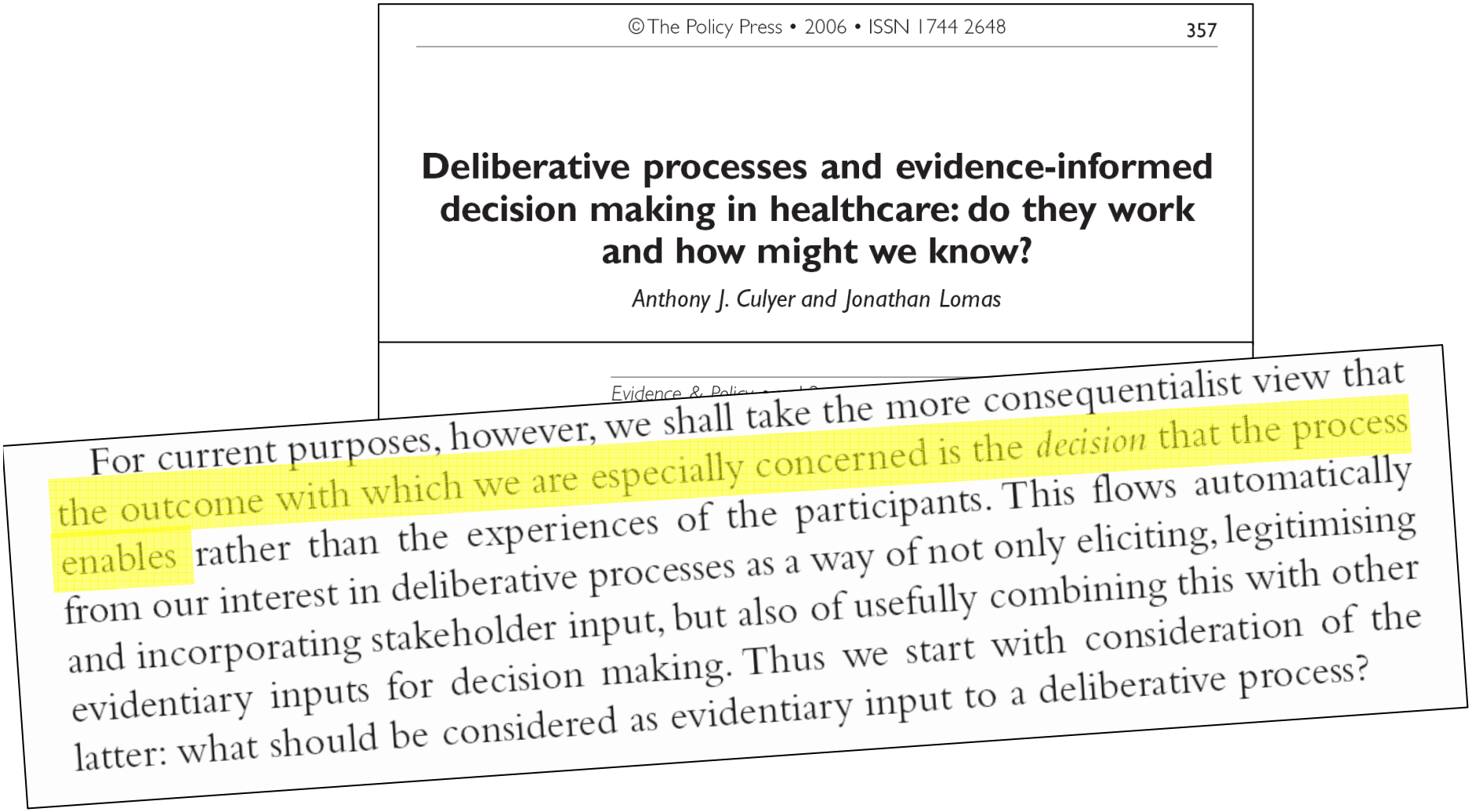
0277-9536/$ - see front matter © 200
doi:10.1016/j.socscimed.2006.04.020

Differences in how context affects evidence utilization highlight the complex nature of health policy decisions. Taking into consideration the findings of Banta et al. (2001) and Taylor (2002) cited in the introduction, we believe the central challenge is not to develop international evidence for evidence-based policy, but rather to develop more systematic, rigorous, transparent, and global methods for identifying, interpreting, and applying evidence in different decision-making contexts. Expert groups should not be starting from scratch each time programmatic health policy recommendations are made.



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Deliberative processes and evidence-informed decision making in healthcare: do they work and how might we know?

Anthony J. Culyer and Jonathan Lomas

Evidence & Policy

For current purposes, however, we shall take the more consequentialist view that the outcome with which we are especially concerned is the *decision* that the process enables rather than the experiences of the participants. This flows automatically from our interest in deliberative processes as a way of not only eliciting, legitimising and incorporating stakeholder input, but also of usefully combining this with other evidentiary inputs for decision making. Thus we start with consideration of the latter: what should be considered as evidentiary input to a deliberative process?

‘Combining different types of evidence’

What constitutes evidence?

- Broad vs. narrow definitions
- Research, knowledge, wisdom, experience, information, data
- Science vs. values
- Talking to people

What is combining evidence?

- Combining vs. using evidence (e.g., identifying, interpreting, applying)
- Explicit vs. implicit
- Combining vs. decision-making

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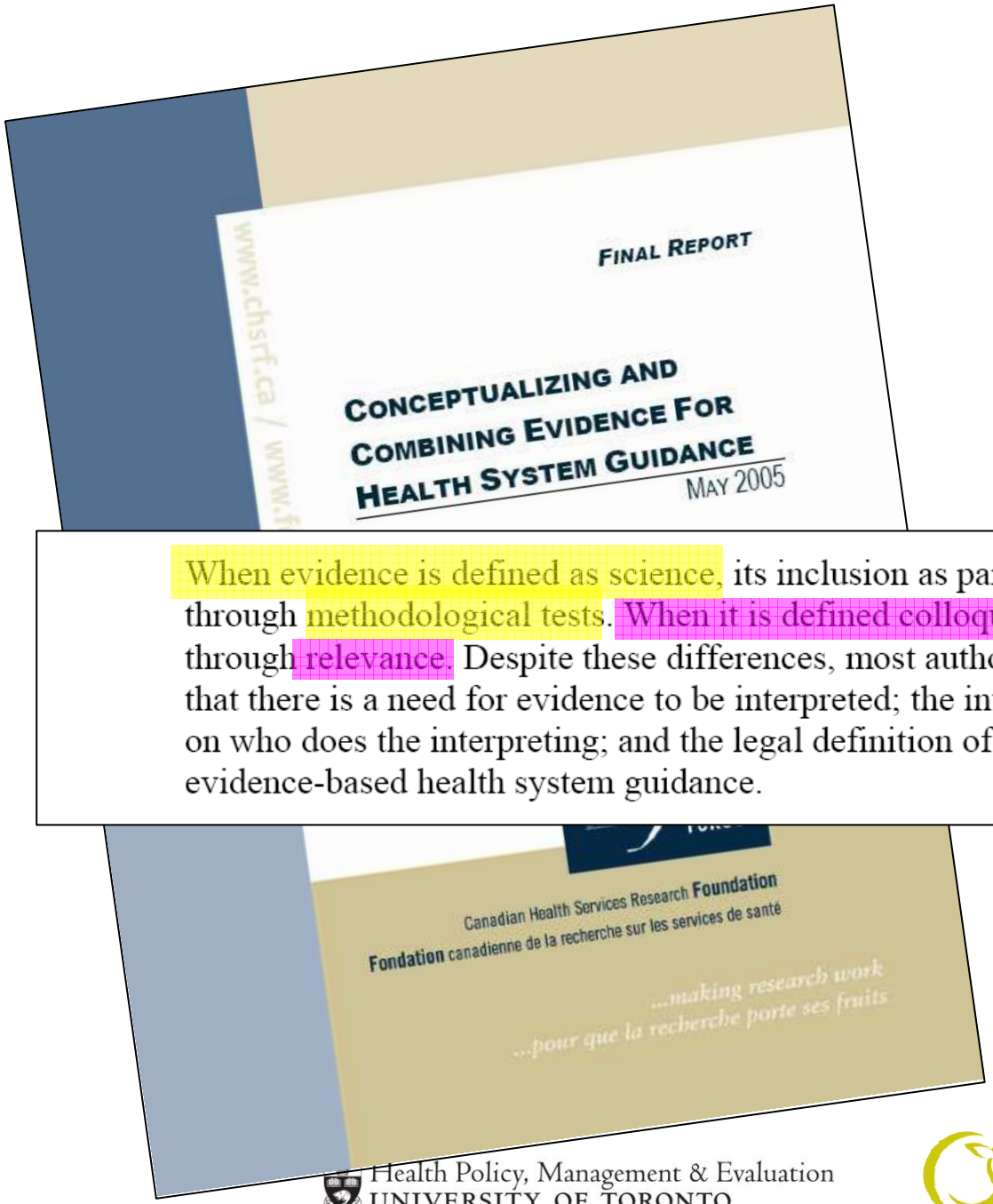
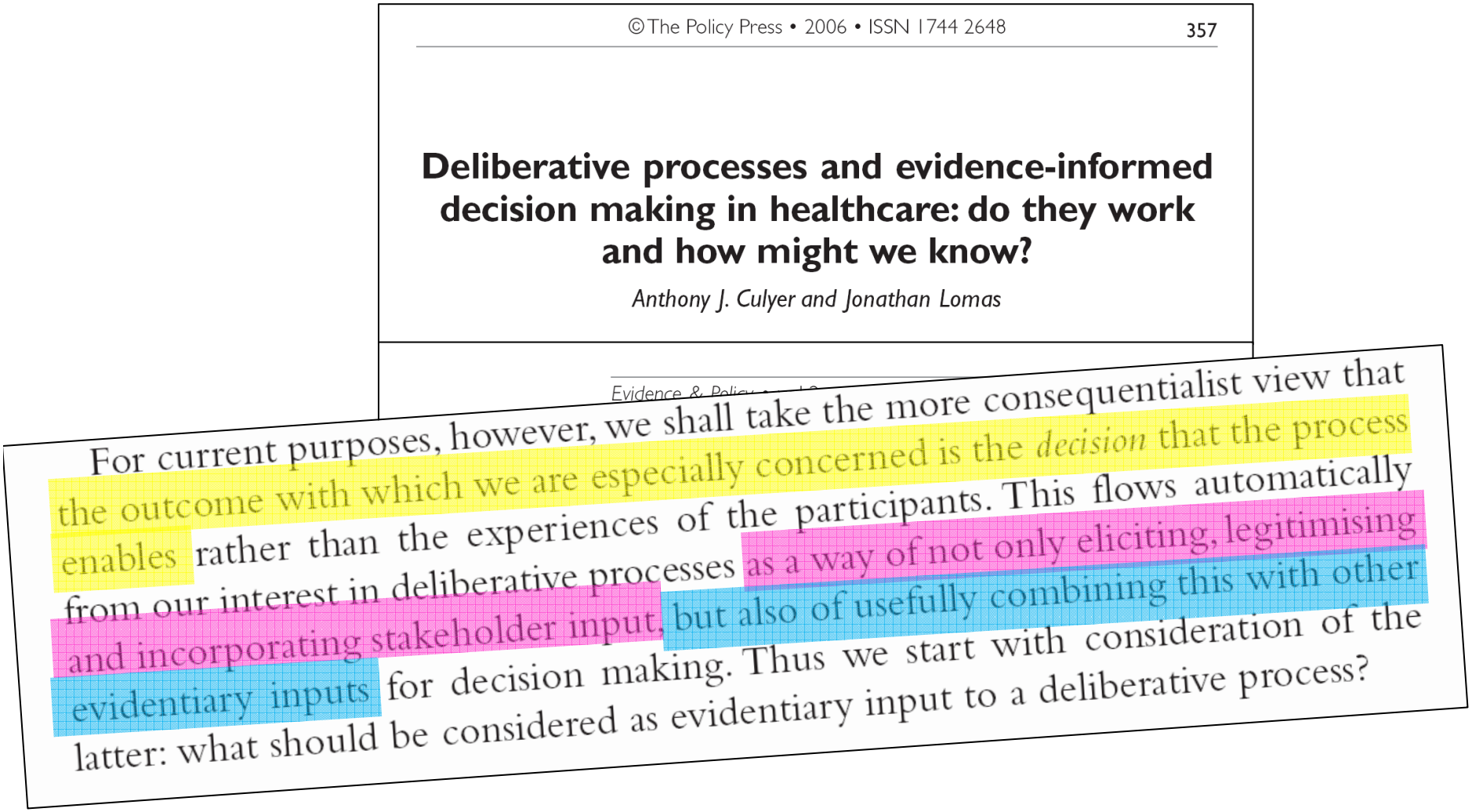


When evidence is defined as science, its inclusion as part of guidance is determined through methodological tests. When it is defined colloquially, its inclusion is determined through relevance. Despite these differences, most authors covered in the review agreed that there is a need for evidence to be interpreted; the interpretation of evidence depends on who does the interpreting; and the legal definition of evidence is not very helpful for evidence-based health system guidance.



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Evidence & Policy, • vol 2 • no 3 • 2006 • 357-71

The issue confronting any decision maker within a deliberative process is thus not so much how to balance the three types of evidence or to assess the weight to place on each, but rather to allow each to perform its appropriate task:

- scientific context-free evidence is evidence about general potential;
- scientific context-sensitive evidence is evidence about particular realistic scenarios;
- colloquial evidence helps to provide a context for otherwise context-free evidence and to supply the best evidence short of scientific evidence when there is neither context-free nor context-sensitive evidence.

"Evidence does not make decisions, people do"

Haynes et al., 2002

A role for deliberative methods in combining different types of evidence?

Systematic Review

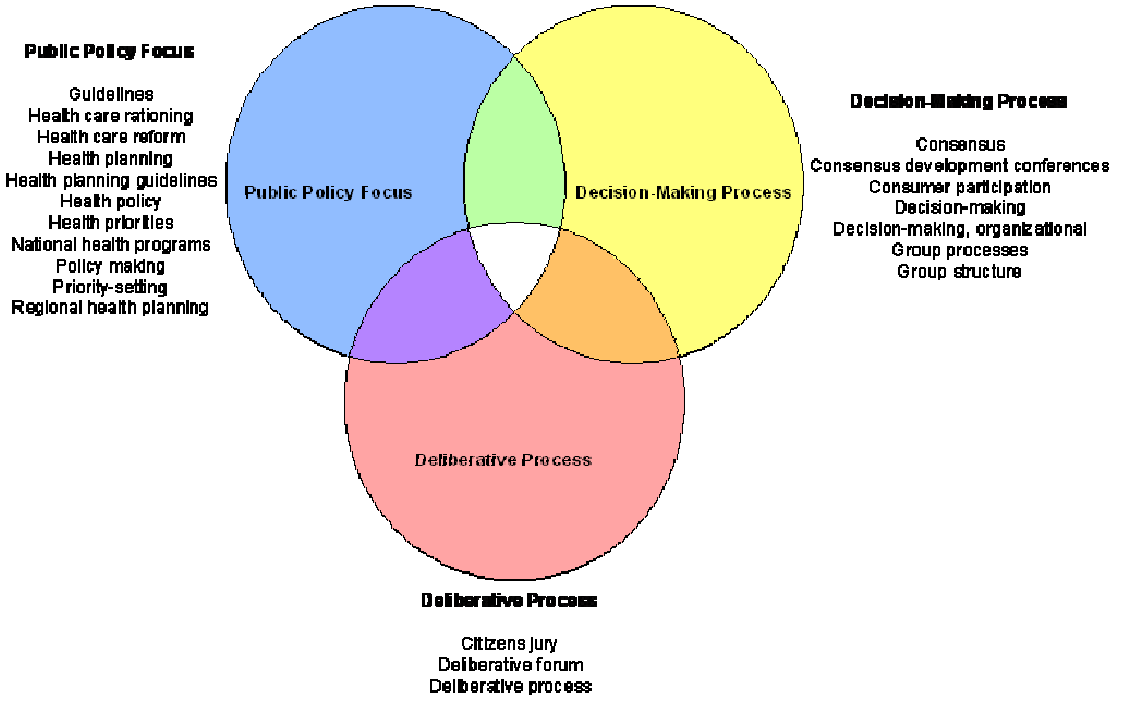
Two overarching questions:

(Q1) How/when are deliberative methods used to combine heterogeneous evidence?

(Q2) What is known about the effectiveness of deliberative methods in combining heterogeneous evidence?

Methods 1/2

- Sources
  - 4 Health databases
    - Medline, Embase, HealthStar, CINAHL
  - 14 Non-health databases
    - ERIC, TRANSPORT, Business Source Premier, InfoTrac Environmental Issues & Policy eCollection, GEOBASE, ProQuest, Scholar's Portal (IBSS, PsycINFO, SSCI, AGRICOLA, ESPM, PAIS, TOXLINE).
  - Other sources
    - Research team, expert recommendations, bibliographies, Google, Google Scholar/Books
- Search Strategy



Methods 2/2

- Articles were excluded if they:
  - were published before 1980;
  - were not written in English or French;
  - were not focused on the process of decision-making for public policy or management practice (e.g., were solely focused on individual/clinical decision making);
  - did not describe the combination of heterogeneous evidence (e.g., context-free scientific, context-sensitive scientific and/or colloquial evidence) within the decision-making process; or
  - did not collect data about how the process worked, or what participants thought about the process (i.e., were not evaluative).

Findings

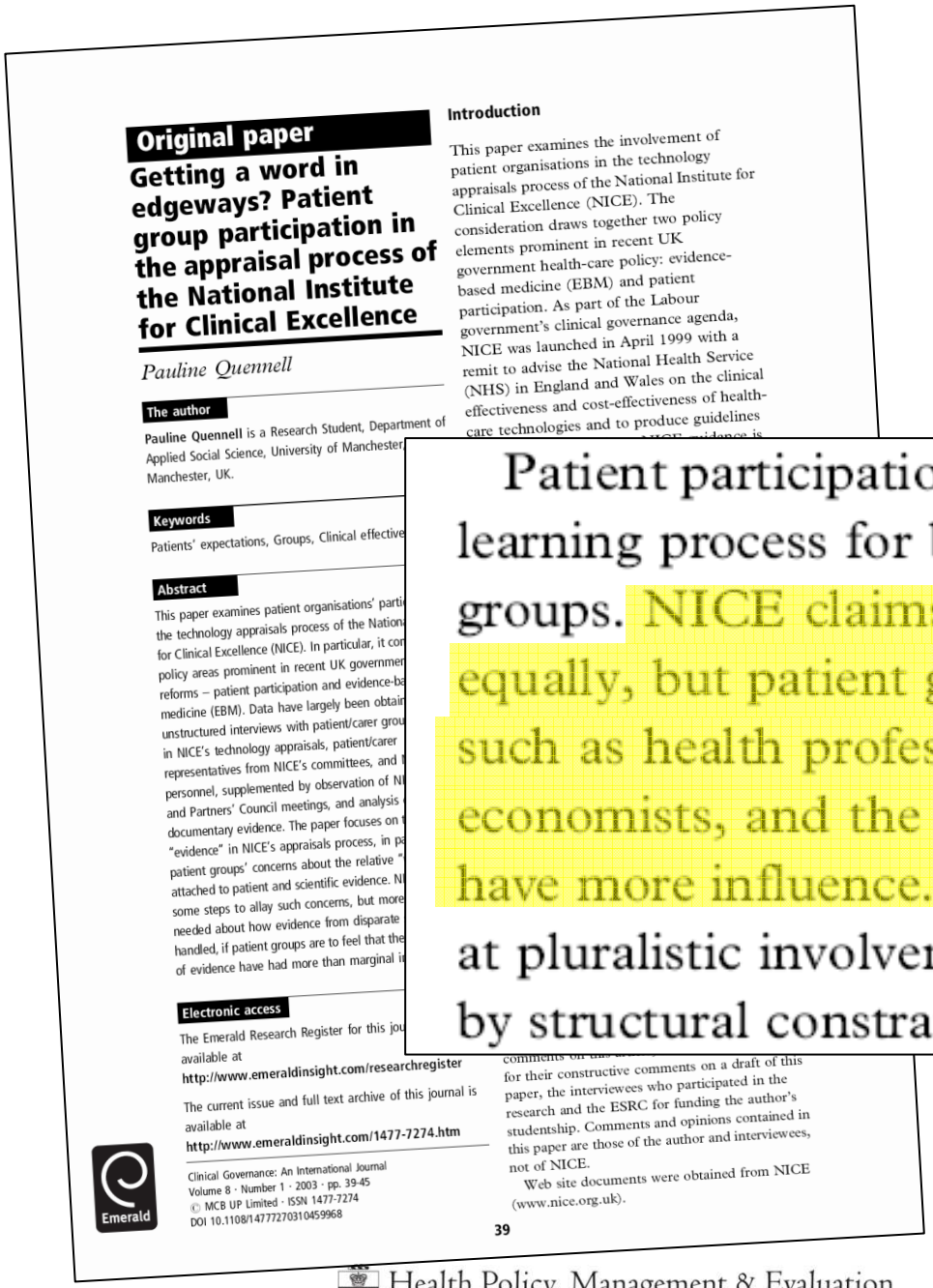
- Total unique articles (all sources): **6853**
- Total high relevance articles: **15/0***
  - Health policy-related: 11
  - Other public policy-related: 4

*15 articles that were ultimately coded as high relevance did provide insights related to question (Q1), however these articles only indirectly addressed question (Q2)

- Characteristics of deliberative processes highly variable
- Evaluative approaches typically based on case studies incorporating qualitative methods

- Three factors emphasized
  - Deliberative approach
  - Nature of evidence use
  - Decision proximity

Deliberative approach



Original paper

Getting a word in edgeways? Patient group participation in the appraisal process of the National Institute for Clinical Excellence

Pauline Quennell

The author

Pauline Quennell is a Research Student, Department of Applied Social Science, University of Manchester, Manchester, UK.

Keywords

Patients' expectations, Groups, Clinical effective

Abstract

This paper examines patient organisations' parti the technology appraisals process of the Nation for Clinical Excellence (NICE). In particular, it cor policy areas prominent in recent UK governmer reforms – patient participation and evidence-ba medicine (EBM). Data have largely been obtair unstructured interviews with patient/carer grou in NICE's technology appraisals, patient/carer representatives from NICE's committees, and personnel, supplemented by observation of N and Partners' Council meetings, and analysis documentary evidence. The paper focuses on "evidence" in NICE's appraisals process, in pa patient groups' concerns about the relative attached to patient and scientific evidence. N some steps to allay such concerns, but more needed about how evidence from disparate handled, if patient groups are to feel that the of evidence have had more than marginal i

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Clinical Governance: An International Journal
Volume 8 · Number 1 · 2003 · pp. 39-45

· ISSN 1477-7274
DOI 10.1108/14777270310459968

Introduction

This paper examines the involvement of patient organisations in the technology appraisals process of the National Institute for Clinical Excellence (NICE). The consideration draws together two policy elements prominent in recent UK government health-care policy: evidence-based medicine (EBM) and patient participation. As part of the Labour government's clinical governance agenda, NICE was launched in April 1999 with a remit to advise the National Health Service (NHS) in England and Wales on the clinical effectiveness and cost-effectiveness of health-care technologies and to produce guidelines

for their constructive comments on a draft of this paper, the interviewees who participated in the research and the ESRC for funding the author's studentship. Comments and opinions contained in this paper are those of the author and interviewees, not of NICE.

Web site documents were obtained from NICE (www.nice.org.uk).

Patient participation in appraisals has been a learning process for both NICE and patient groups. NICE claims to treat all stakeholders equally, but patient groups feel that others such as health professionals, health economists, and the pharmaceutical industry have more influence. Thus attempts by NICE at pluralistic involvement may be hampered by structural constraints. By extending the

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Public Health (2001) 115, 21–29

www.nature.com/ph

Implementation and evaluation of local-level priority setting for stroke

D Chappel[1]*, J Bailey[1], R Stacy[2], H Rodgers[1,3] and R Thomson[1]

[1]*Department of Epidemiology and Public Health, School of Health Sciences, The Medical School, University of Newcastle upon Tyne, Newcastle upon Tyne, UK;* [2]*Department of Primary Health Care, School of Health Sciences, The Medical School, University of Newcastle upon Tyne, Newcastle upon Tyne, UK; and* [3]*Department of Medicine (Geriatrics), School of Clinical Medical Sciences, The Medical School, University of Newcastle upon Tyne, Newcastle upon Tyne, UK*

We aimed to develop and evaluate a prioritisation process to combine the evidence base with stakeholder involvement within a stroke programme for a Health Improvement Programme (HImP). Implementation involved: formation of a district stroke group (DSG); review of the evidence; survey of DSG members; survey of other key professionals; consensus within the DSG; consultation with local users of the service. Evaluation was through semi-structured interviews and docu… as appropriate and valuable by the majority of participants, and a d… process. However, s… setting process was … perceived lack of ov… felt that the prioritic… consultation days oc… approach that is bro… of stakeholders, cla… setting. The model …

Keywords: priority…

In…

Prioritisation and rationi… national level over the la… away from the view th… rationing by marshallin… calculating the best solu… is 'inescapably a poli… interest in defining tha… less discussion about h… level, but a view that th… and reduced scope for …

However, there will… itisation, as national pri… decisions can only be n… specific treatments,[5] u… have relatively little impact on the totality of care locally. They need to be operationalised locally. Studies of local priority setting have been limited and have, as in the national situation, focused more on evidence-based solutions[6] or on the mechanism for gaining public input[7] rather than the whole process leading to decisions. They have also

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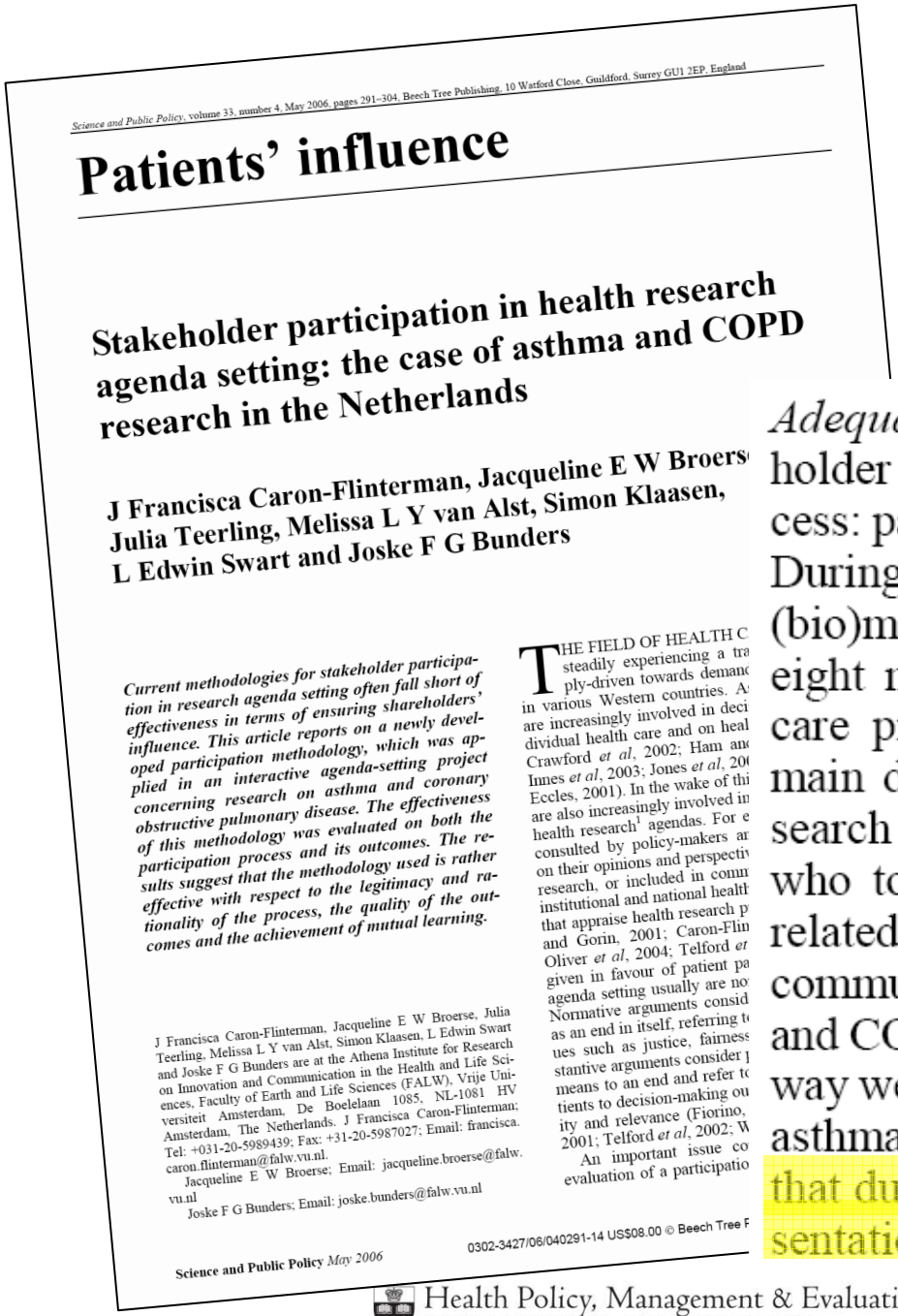
Accepted 27 September 2000

We chose stroke because it is an … morbidity and mortality locally, and a national priority in England.[4,12,13] We describe prioritisation in a single district health authority (DHA) in the North East of England. It was used to inform a chapter of the district's Health Improvement Programme—a local strategy required in all DHAs in England. We developed a process designed to balance the need for an evidence base with the need for wide stakeholder involvement. The evaluation of the process is part of a larger study evaluating a health care programme approach

No one involved (professional or manager) expressed any views that they should not have been involved or that anyone else should not have been. However, there was confusion at times as to whether people were acting as individuals or representatives of the organisations they came from—this was particularly difficult for primary care, but also occurred with people from NHS trusts, the health authority and social services.

Only two mentioned the lack of public, patient and carer input to the process.



Science and Public Policy, volume 33, number 4, May 2006, pages 291–304, Beech Tree Publishing, 10 Watford Close, Guildford, Surrey GU1 2EP, England

Patients' influence

Stakeholder participation in health research agenda setting: the case of asthma and COPD research in the Netherlands

J Francisca Caron-Flinterman, Jacqueline E W Broers Julia Teerling, Melissa L Y van Alst, Simon Klaasen, L Edwin Swart and Joske F G Bunders

Current methodologies for stakeholder participation in research agenda setting often fall short of effectiveness in terms of ensuring shareholders' influence. This article reports on a newly developed participation methodology, which was applied in an interactive agenda-setting project concerning research on asthma and coronary obstructive pulmonary disease. The effectiveness of this methodology was evaluated on both the participation process and its outcomes. The results suggest that the methodology used is rather effective with respect to the legitimacy and rationality of the process, the quality of the outcomes and the achievement of mutual learning.

J Francisca Caron-Flinterman, Jacqueline E W Broerse, Julia Teerling, Melissa L Y van Alst, Simon Klaasen, L Edwin Swart and Joske F G Bunders are at the Athena Institute for Research on Innovation and Communication in the Health and Life Sciences, Faculty of Earth and Life Sciences (FALW), Vrije Universiteit Amsterdam, De Boelelaan 1085, NL-1081 HV Amsterdam, The Netherlands. J Francisca Caron-Flinterman; Tel: +031-20-5989439; Fax: +31-20-5987027; Email: francisca.caron.flinterman@falw.vu.nl.

Jacqueline E W Broerse; Email: jacqueline.broerse@falw.vu.nl

Joske F G Bunders; Email: joske.bunders@falw.vu.nl

THE FIELD OF HEALTH C
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dividual health care and on heal
Crawford *et al*, 2002; Ham and
Innes *et al*, 2003; Jones *et al*, 20
Eccles, 2001). In the wake of thi
are also increasingly involved in
health research[1] agendas. For e
consulted by policy-makers ar
on their opinions and perspectiv
research, or included in comm
institutional and national health
that appraise health research p
and Gorin, 2001; Caron-Flin
Oliver *et al*, 2004; Telford *et*
given in favour of patient pa
agenda setting usually are no
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as an end in itself, referring t
ues such as justice, fairness
stantive arguments consider p
means to an end and refer to
tients to decision-making ou
ity and relevance (Fiorino,
2001; Telford *et al*, 2002; W
An important issue co
evaluation of a participatio

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Adequate representation of stakeholders Three stakeholder groups participated in the agenda-setting process: patients, health care professionals and scientists. During the consultation phase, respectively 13 (bio)medical scientists, six socio-cultural scientists, eight medical specialists/researchers, and 12 health care professionals were involved, representing the main disciplines involved in asthma and COPD research or care. In addition, more than 300 patients, who together reflect the demographic and disease-related characteristics of the entire NAF member community as well as the Dutch population of asthma and COPD patients in general, were consulted. In this way we achieved an adequate representation of Dutch asthma and COPD patients. We thus can conclude that during the consultation phase an adequate representation of stakeholders had been achieved.

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Risk Analysis, Vol. 18, No. 5, 1998

Deliberation: Integrating Analytical Results into Environmental Decisions Involving Multiple Stakeholders

George E. Apostolakis[1] and Susan E. Pickett[1]

The National Research Council has recommended the use of an analytic/deliberative decision-making process in environmental restoration decisions that involve multiple stakeholders. This work investigates the use of the results of risk assessment and multiattribute utility analysis (the "analysis") in guiding the deliberation. These results include the ranking of proposed remedial according to each stakeholder's preferences, as well as the identification of the holder preferences are over a number of performance individual worker risk, as well

A concern in utilizing deliberation in order to smooth out the differences among the stakeholders is that the technical issues often fall to the wayside, or

1. INTRODUCTION

Risk management has gained a significant amount of attention from both policymakers and the public over the past 30 years, as the interaction of technology and policy choices has become more predominant in the evaluation of trade-offs in a democratic society. This is particularly so in environmental decisions regarding the cleanup of contaminated sites. Risk assessments are often used to aid the decision maker; however, due to the multidimensionality of risk and the fact that only its dimensions that refer to health and safety effects are usually analyzed, many decisions have been controversial. While balancing the multitude of objectives in order to meet social needs, policymakers and the responsible agencies are faced with difficult choices. Trade-offs among incompatible measures, such as environmental sources and

In order to address these challenges, the National Research Council[1] has recommended that the decision maker (government agency) incorporate all relevant stakeholders in the decision-making process from the start. They recommend an analytical/deliberative process for dealing with decisions that involve substantial risk assessment. Risk assessments used to understand and quantify risk need to be utilized in conjunction with input from the affected parties so that assumptions underlying the evaluation are clarified, understood, and validated.[2–4] The basic premise is that, by involving the stakeholders in the risk assessments (the analytical part of the process) and by including deliberation, the decision-making process will be enhanced and the previous failings and causes for mistrust will be overcome.[5]

Our main objective in this paper is to structure the deliberation among the stakeholders in such a way that the most useful results and insights derived from anal-

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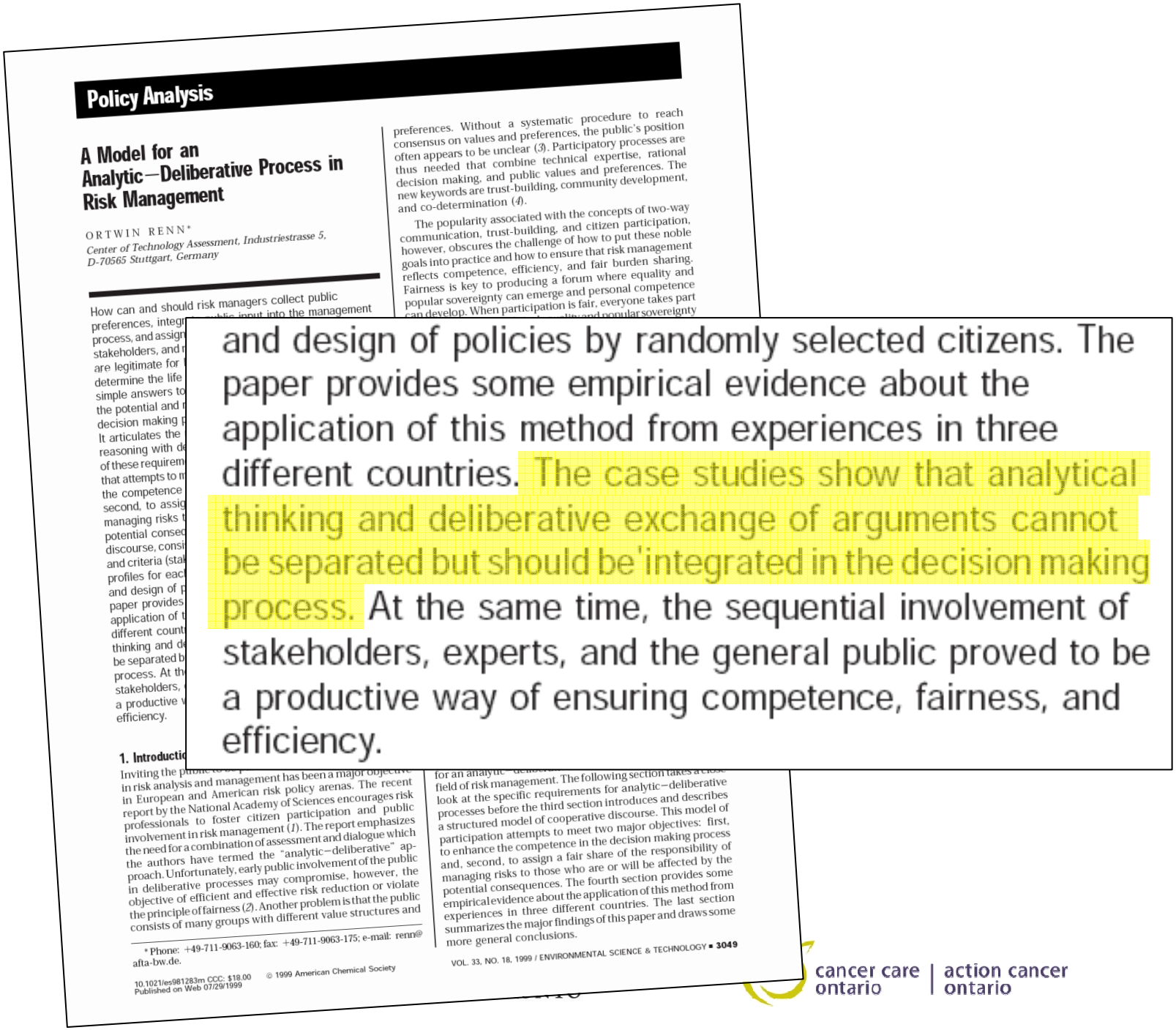

Policy Analysis

A Model for an Analytic–Deliberative Process in Risk Management

ORTWIN RENN*
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How can and should risk managers collect public preferences, integr… public input into the management process, and assign… stakeholders, and … are legitimate for … determine the life … simple answers to … the potential and … decision making … It articulates the … reasoning with … of these requirem… that attempts to … the competence … second, to assig… managing risks … potential conseq… discourse, consi… and criteria (stak… profiles for eac… and design of … paper provides … application of … different count… thinking and … be separated b… process. At th… stakeholders, … a productive … efficiency.

and design of policies by randomly selected citizens. The paper provides some empirical evidence about the application of this method from experiences in three different countries. The case studies show that analytical thinking and deliberative exchange of arguments cannot be separated but should be integrated in the decision making process. At the same time, the sequential involvement of stakeholders, experts, and the general public proved to be a productive way of ensuring competence, fairness, and efficiency.

1. Introductio…

Inviting the … in risk analysis and management has been a major objective in European and American risk policy arenas. The recent report by the National Academy of Sciences encourages risk professionals to foster citizen participation and public involvement in risk management (*1*). The report emphasizes the need for a combination of assessment and dialogue which the authors have termed the "analytic–deliberative" approach. Unfortunately, early public involvement of the public in deliberative processes may compromise, however, the objective of efficient and effective risk reduction or violate the principle of fairness (*2*). Another problem is that the public consists of many groups with different value structures and preferences. Without a systematic procedure to reach consensus on values and preferences, the public's position often appears to be unclear (*3*). Participatory processes are thus needed that combine technical expertise, rational decision making, and public values and preferences. The new keywords are trust-building, community development, and co-determination (*4*).

The popularity associated with the concepts of two-way communication, trust-building, and citizen participation, however, obscures the challenge of how to put these noble goals into practice and how to ensure that risk management reflects competence, efficiency, and fair burden sharing. Fairness is key to producing a forum where equality and popular sovereignty can emerge and personal competence can develop. When participation is fair, everyone takes part … and popular sovereignty … for an analytic–deliberative … field of risk management. The following section takes a close look at the specific requirements for analytic–deliberative processes before the third section introduces and describes a structured model of cooperative discourse. This model of participation attempts to meet two major objectives: first, to enhance the competence in the decision making process and, second, to assign a fair share of the responsibility of managing risks to those who are or will be affected by the potential consequences. The fourth section provides some empirical evidence about the application of this method from experiences in three different countries. The last section summarizes the major findings of this paper and draws some more general conclusions.

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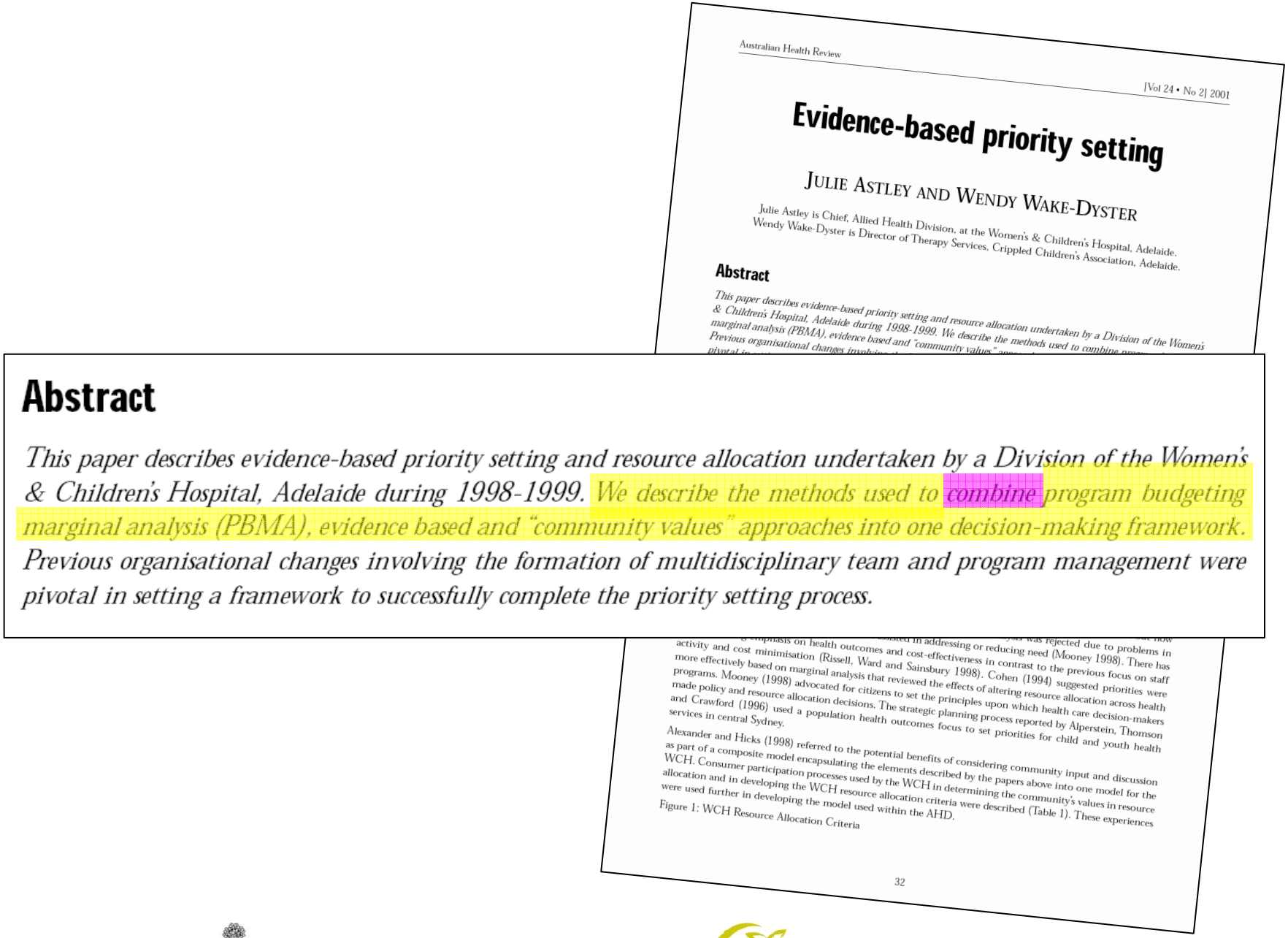
10.1021/es981283m CCC: $18.00
Published on Web 07/29/1999

Deliberative Approach

Democratic-Deliberative	Analytic-Deliberative
▪ Participatory process ▪ Seeks input from stakeholder/public representatives regarding values and preferences ▪ Aim to encourage discussion and consideration of the evidence ▪ Recommendations are evidence-influenced	▪ Technical/participatory process ▪ Seeks to combine technical knowledge/expertise with stakeholder/public values and preferences ▪ Aim to improve understanding and comprehension of the evidence ▪ Recommendations are evidence-informed

Nature of evidence use



Australian Health Review [Vol 24 • No 2] 2001

Evidence-based priority setting

JULIE ASTLEY AND WENDY WAKE-DYSTER

Julie Astley is Chief, Allied Health Division, at the Women's & Children's Hospital, Adelaide.
Wendy Wake-Dyster is Director of Therapy Services, Crippled Children's Association, Adelaide.

Abstract

This paper describes evidence-based priority setting and resource allocation undertaken by a Division of the Women's & Children's Hospital, Adelaide during 1998-1999. We describe the methods used to combine program budgeting marginal analysis (PBMA), evidence based and "community values" approaches into one decision-making framework. Previous organisational changes involving the formation of multidisciplinary team and program management were pivotal in setting a framework to successfully complete the priority setting process.

activity and cost minimisation (Rissell, Ward and Sainsbury 1998). Cohen (1994) suggested priorities were more effectively based on marginal analysis that reviewed the effects of altering resource allocation across health programs. Mooney (1998) advocated for citizens to set the principles upon which health care decision-makers made policy and resource allocation decisions. The strategic planning process reported by Alperstein, Thomson and Crawford (1996) used a population health outcomes focus to set priorities for child and youth health services in central Sydney.

Alexander and Hicks (1998) referred to the potential benefits of considering community input and discussion as part of a composite model encapsulating the elements described by the papers above into one model for the WCH. Consumer participation processes used by the WCH in determining the community's values in resource allocation and in developing the WCH resource allocation criteria were described (Table 1). These experiences were used further in developing the model used within the AHD.

Figure 1: WCH Resource Allocation Criteria

32

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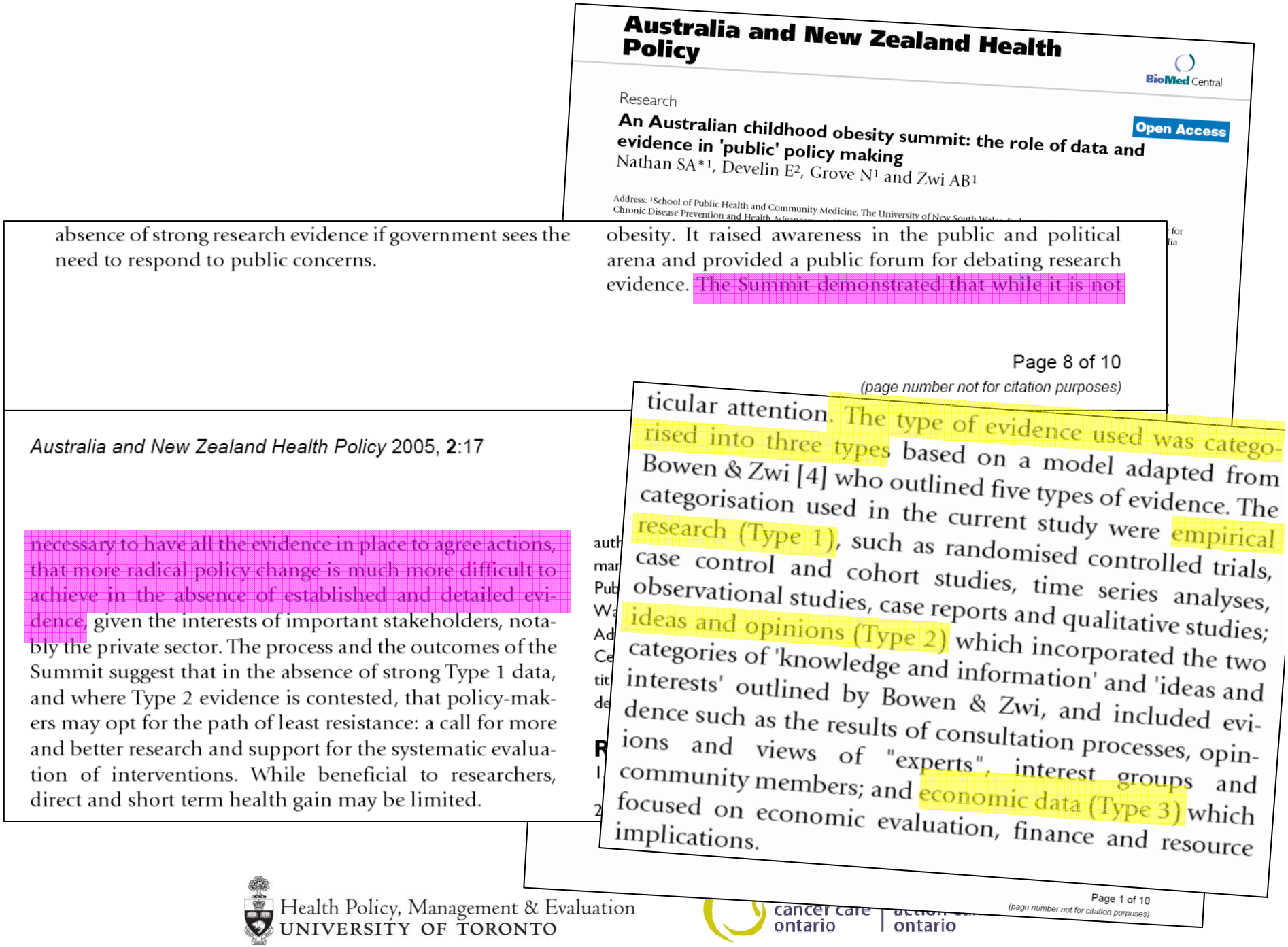

Australia and New Zealand Health Policy

BioMed Central

Research

An Australian childhood obesity summit: the role of data and evidence in 'public' policy making

Open Access

Nathan SA*[1], Develin E[2], Grove N[1] and Zwi AB[1]

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absence of strong research evidence if government sees the need to respond to public concerns.

obesity. It raised awareness in the public and political arena and provided a public forum for debating research evidence. The Summit demonstrated that while it is not

Page 8 of 10

(page number not for citation purposes)

Australia and New Zealand Health Policy 2005, **2**:17

necessary to have all the evidence in place to agree actions, that more radical policy change is much more difficult to achieve in the absence of established and detailed evidence, given the interests of important stakeholders, notably the private sector. The process and the outcomes of the Summit suggest that in the absence of strong Type 1 data, and where Type 2 evidence is contested, that policy-makers may opt for the path of least resistance: a call for more and better research and support for the systematic evaluation of interventions. While beneficial to researchers, direct and short term health gain may be limited.

ticular attention. The type of evidence used was categorised into three types based on a model adapted from Bowen & Zwi [4] who outlined five types of evidence. The categorisation used in the current study were empirical research (Type 1), such as randomised controlled trials, case control and cohort studies, time series analyses, observational studies, case reports and qualitative studies; ideas and opinions (Type 2) which incorporated the two categories of 'knowledge and information' and 'ideas and interests' outlined by Bowen & Zwi, and included evidence such as the results of consultation processes, opinions and views of "experts", interest groups and community members; and economic data (Type 3) which focused on economic evaluation, finance and resource implications.

Page 1 of 10

(page number not for citation purposes)

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Nature of Evidence Use

Informal-Implicit	Formal-Explicit
▪ Introduction of evidence often through informal channels (e.g., through general discussion) ▪ Interpretation of evidence based on expert assessment/evaluation ▪ Combination of evidence through unstructured deliberation ▪ The recommendation rather than the evidence is the main focus of the process	▪ Introduction of evidence primarily through formal processes resulting in broad/diverse evidence base ▪ Interpretation of evidence based on formal assessment tools (e.g., GRADE, evidence hierarchies) ▪ Combination of evidence based on formal weighting criteria ▪ The evidence rather than the recommendation is the main focus of the process

Decision proximity

HEALTH ECONOMICS
Health Econ. **16**: 179–193 (2007)
Published online 7 September 2006 in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/hec.1133

SEEING THE NICE SIDE OF COST-EFFECTIVENESS ANALYSIS: A QUALITATIVE INVESTIGATION OF THE USE OF CEA IN NICE TECHNOLOGY APPRAISALS

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SUMMARY

Resource scarcity is the *raison d'être* for the discipline of economics. Thus, the primary purpose of economic analysis is to help decision-makers when addressing problems arising due to the scarcity problem. The research reported here was concerned with how cost-effectiveness information is used by the National Institute for Health & Clinical Excellence (NICE) in national technology coverage decisions in the UK, and how its impact might be increased. The research followed a qualitative case study methodology with semi-structured interviews, observation and analysis of secondary sources. Our research highlights that NICE represents an important progression

Thus, our data suggest that for analyses to be viewed as acceptable, it is necessary that they provide information: (1) that end-users see as relevant (i.e. providing data on parameters that are likely to influence the decision of the policy-maker), (2) that is appropriate to the decisions being faced, taking into account relevant contextual factors (e.g. budgetary arrangements commonly seen in the NHS), and (3) that can inform implementation of decisions in a complex decision-making environment.

INTRODUCTION

Resource scarcity is the *raison d'être* for the discipline of economics. In one sense or another, all economists are working on issues that have some connection to scarcity and limits on our ability to do all we would like. Thus, the primary purpose of economic analysis, and cost-benefit and cost-effectiveness analysis (CEA) in particular, is to help decision-makers when addressing problems arising due to the scarcity problem. Therefore, such information is generated with the direct intention of influencing policy – but is that objective achieved? Over recent years in the health care literature there have been repeated expressions of concern about the usefulness of CEAs (Ross, 1995; Drummond *et al.*, 1997; Sloan *et al.*, 1997; Walley *et al.*, 1997; Bryan and Brown, 1998; Duthie *et al.*, 1999; Drummond and Weatherly, 2000; Kernick, 2000; von der Schulenburg, 2000; McDonald, 2002). Responses to this concern have tended to centre on questions of how evaluation research by health economists can be made more useful and accessible to policy-makers (for example, see (Pelc, 1994; Schechter, 1993)).

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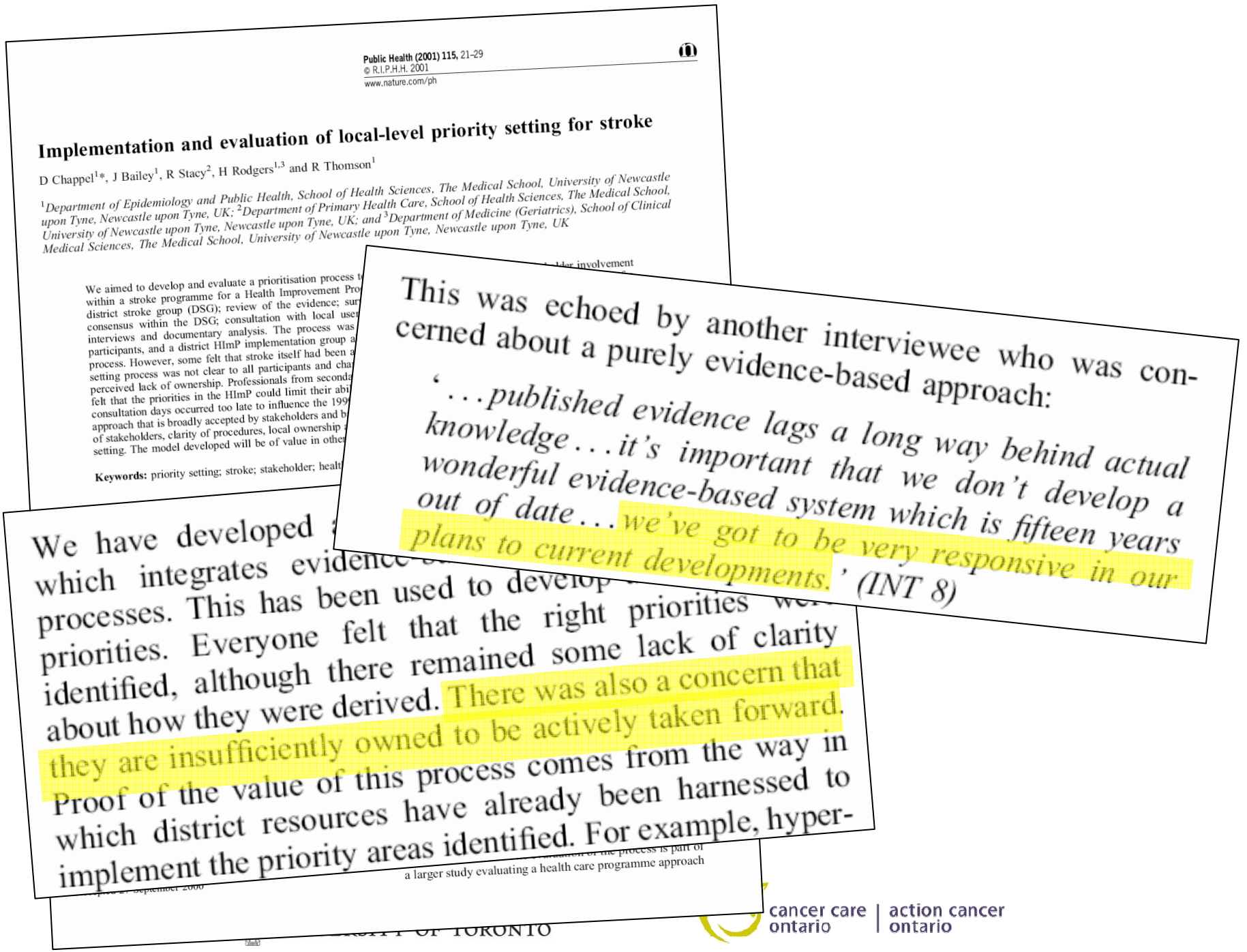

Public Health (2001) 115, 21–29
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Implementation and evaluation of local-level priority setting for stroke

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We aimed to develop and evaluate a prioritisation process t
within a stroke programme for a Health Improvement Pro
district stroke group (DSG); review of the evidence; sur
consensus within the DSG; consultation with local user
interviews and documentary analysis. The process was
participants, and a district HImP implementation group a
process. However, some felt that stroke itself had been a
setting process was not clear to all participants and cha
perceived lack of ownership. Professionals from seconda
felt that the priorities in the HImP could limit their abi
consultation days occurred too late to influence the 199
approach that is broadly accepted by stakeholders and b
of stakeholders, clarity of procedures, local ownership
setting. The model developed will be of value in othe

Keywords: priority setting; stroke; stakeholder; healt

...lder involvement

This was echoed by another interviewee who was concerned about a purely evidence-based approach:

'...*published evidence lags a long way behind actual knowledge...it's important that we don't develop a wonderful evidence-based system which is fifteen years out of date...we've got to be very responsive in our plans to current developments.*' *(INT 8)*

We have developed
which integrates evidence
processes. This has been used to develop
priorities. Everyone felt that the right priorities
identified, although there remained some lack of clarity
about how they were derived. There was also a concern that
they are insufficiently owned to be actively taken forward.
Proof of the value of this process comes from the way in
which district resources have already been harnessed to
implement the priority areas identified. For example, hyper-

...evaluation of the process is part of
a larger study evaluating a health care programme approach

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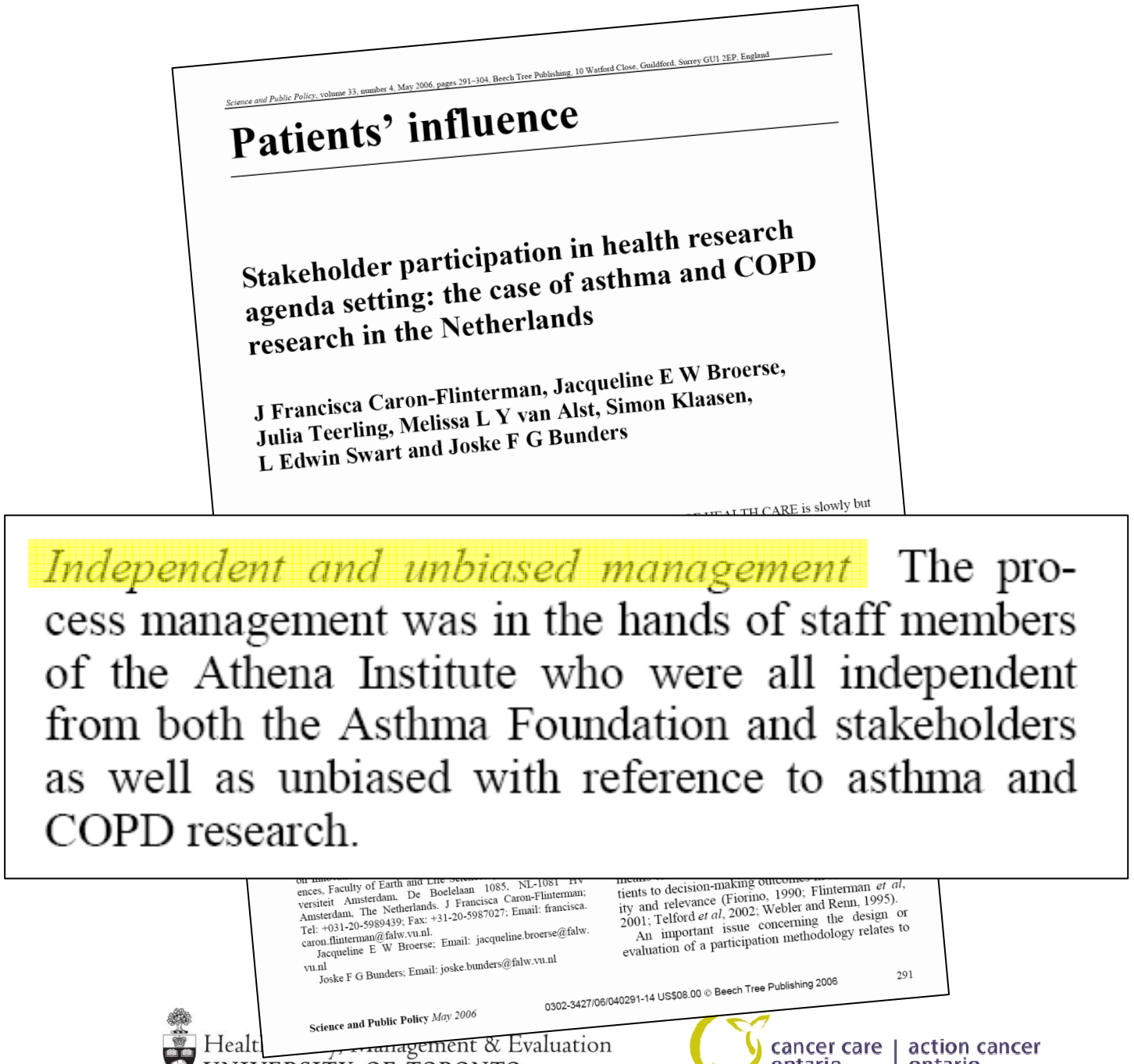

Science and Public Policy, volume 33, number 4, May 2006, pages 291–304, Beech Tree Publishing, 10 Watford Close, Guildford, Surrey GU1 2EP, England

Patients' influence

Stakeholder participation in health research agenda setting: the case of asthma and COPD research in the Netherlands

J Francisca Caron-Flinterman, Jacqueline E W Broerse, Julia Teerling, Melissa L Y van Alst, Simon Klaasen, L Edwin Swart and Joske F G Bunders

HEALTH CARE is slowly but

Independent and unbiased management The process management was in the hands of staff members of the Athena Institute who were all independent from both the Asthma Foundation and stakeholders as well as unbiased with reference to asthma and COPD research.

ences, Faculty of Earth and Life Sciences, Vrije Universiteit Amsterdam, De Boelelaan 1085, NL-1081 HV Amsterdam, The Netherlands. J Francisca Caron-Flinterman; Tel: +031-20-5989439; Fax: +31-20-5987027; Email: francisca.caron.flinterman@falw.vu.nl.

Jacqueline E W Broerse; Email: jacqueline.broerse@falw.vu.nl

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tients to decision-making outcomes ity and relevance (Fiorino, 1990; Flinterman *et al*, 2001; Telford *et al*, 2002; Webler and Renn, 1995).

An important issue concerning the design or evaluation of a participation methodology relates to

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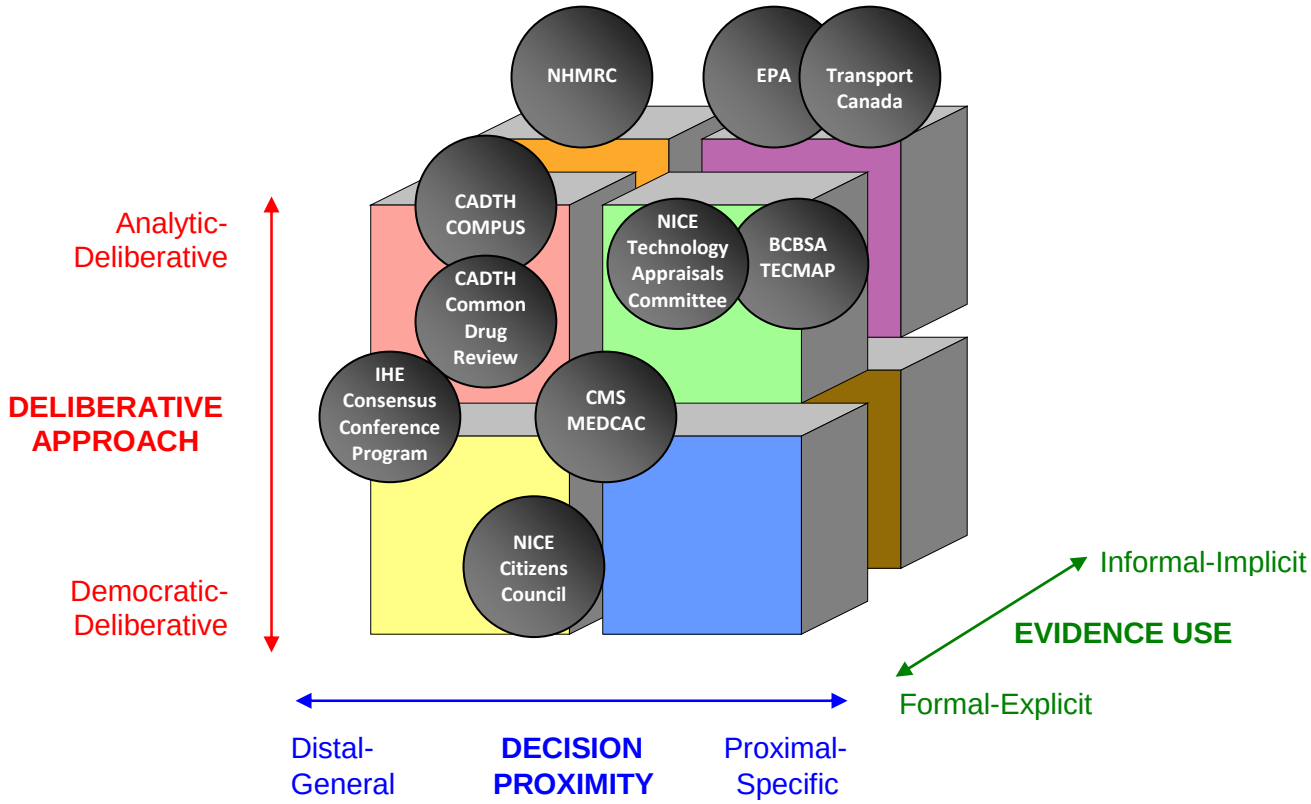
Decision proximity

Distal-General	Proximal-Specific
▪ Decision context is general, theoretical ▪ Key decision-maker audiences not always clearly identifiable ▪ Relevant decision-making contexts are heterogeneous ▪ External to decision-making process ▪ Unlikely to be linked to a specific decision outcome ▪ Addresses 'global' issues including values and preferences ▪ Context-specific evidence not sought ▪ Generates/combines evidence	▪ Decision context is specific, operational ▪ Key decision-maker audiences clearly identifiable ▪ Relevant decision-making contexts are homogenous ▪ Linked to, or embedded within, decision-making process ▪ Likely to be linked to a specific decision outcome ▪ Addresses 'local' issues including effectiveness, feasibility and implementation ▪ Context-specific evidence sought ▪ Combines evidence


NHMRC
EPA
Transport Canada
CADTH COMPUS
NICE Technology Appraisals Committee
BCBSA TECMAP
CADTH Common Drug Review
IHE Consensus Conference Program
CMS MEDCAC
NICE Citizens Council
Analytic-Deliberative
DELIBERATIVE APPROACH
Democratic-Deliberative
Informal-Implicit
EVIDENCE USE
Formal-Explicit
Distal-General
DECISION PROXIMITY
Proximal-Specific

Conclusions

- What do we know about the effectiveness of deliberative methods for combining different types of evidence?
  - Identified numerous examples where deliberative methods are used in policy guidance processes.
  - However, there were only a handful of examples explicitly using deliberative methods to combine heterogeneous evidence, with a paucity of empirical work directly assessing their effectiveness.
  - The health sector has more established deliberative processes than other sectors, however work in the field of environmental policy provided important insights on the role of deliberative methods for combining heterogeneous evidence.

- Ultimately, we identified 3 key factors that influence how deliberative methods contribute to the combining of different types of evidence:
  - **Deliberative approach**: democratic vs. analytic
  - **Nature of evidence use**: formal /explicit vs. informal/implicit
  - **Decision proximity**: proximal-specific vs. distal-general

Acknowledgements

- Co-Investigators:
  - Helen Burchett, Roger Chafe, Tony Culyer, Louise Lemieux-Charles
- Funding:
  - Canadian Health Services Research Foundation

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