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The art of medicine
The art of priority setting

As Rembrandt's painting *The Wardens of the Amsterdam Drapers' Guild, Known as "The Syndics"* reminds us, evaluation is first and foremost an art done by a group of people selected because of their expert knowledge and understanding of the task to be achieved. The painting represents a discussion between drapers who were elected to assess the quality of cloth that weavers offered for sale to members of their guild. One would assume that their evaluation was made on the basis of criteria decided by the group and rooted in their objectives and values, and that their decision, after careful consideration of the characteristics of the fabric, was considered legitimate based on those premises.

Similarly, the art of evaluating health-care interventions to support health system governance, and its associated priority setting, requires setting up a group of knowledgeable people who consider criteria derived from the objectives and values rooted in each context. We consider as an example the deliberation that underpins priority setting in universal health coverage (UHC).

WHO's recommendations for countries seeking fair UHC emphasise that countries are accountable to the populations they serve and should optimise the legitimacy of coverage decisions and associated priority setting. WHO also acknowledges health technology assessment (HTA) agencies as key players in health systems governance. However useful, HTA committees can be insufficiently equipped to face a growing tension between satisfying individual needs, serving the whole population equitably, and ensuring sustainability of health systems. A key issue is that the HTA field tends to approach priority setting from a rational and technical standpoint when it is a complex and value-laden political process that takes place in an environment of often conflicting social values and interests.

The 2009 pneumococcal vaccine (PCV7) coverage case in Mexico during an outbreak of influenza A H1N1 showed how diverging values and interests that are not considered explicitly within a reasonable process may result in a decision that is not aligned with the objectives of the health-care system as a whole. Faced with the competing choice of allocating vaccine funds to universal H1N1 vaccination versus adding a booster dose to a vaccine already covered for PCV7, a vaccine committee recommended allocating funds to the latter option because they wanted Mexico not to deviate from what was then the standard of care in developed countries. No fair deliberative process that investigated the legitimacy and ethical implications of such a recommendation within the Mexican context occurred.

Legitimacy of coverage decisions is a critical aspect of fair UHC but its operationalisation is complex. Legitimacy lies in the people—the selection of those who take the decision. But it also lies in how process is applied—procedural legitimacy—and in the criteria and evidence considered to make such decisions and why these are considered relevant—substantive legitimacy. The art of priority setting requires that a selected group of individuals who represent the society they serve consider the relevant issues related to the mission of health-care systems. Indeed, in addition to identifying meaningful health-care interventions for individual patients, the group needs to bear in mind whether the decision to reimburse a given health-care intervention will improve the population's health in an equitable way, ensure financial sustainability, and meet with the expectations of professionals and the society at large. How might this be achieved?

We suggest that an ethical framework, known as accountability for reasonableness (A4R), can be combined with multicriteria approaches rooted in the common goal of UHC to support policy makers in their quest for legitimacy. Such an approach provides methods for both procedural and substantive legitimacy.

The A4R approach recognises that stakeholders often justifiably disagree about social values, and proposes that it is more likely that stakeholders will agree on a fair process to set priorities than on social values. A4R defines four main conditions that can enhance legitimacy and help stakeholders develop a mutual basis for decision making: publicity of rationales for choices; relevance of criteria agreed to by a broad range of stakeholders; revisability of the decision in light of new evidence or arguments; and enforcement that means the other conditions are met. A4R has been criticised for its over-reliance on stakeholder values and because it does not specify what evidence should be used in decision making.

Multicriteria decision analysis (MCDA) uses analytical methods to help decision makers explicitly consider the many different criteria that contribute to a decision. Traditional MCDA is generally praised for its rational pursuit, but is also criticised for being technocratic, methods-oriented rather than user-oriented, difficult to use in real-life settings, and lacking deliberation and process measures to reach fair outcomes. It is hard to see how such an algorithmic approach enhances legitimacy. But when adapted to become more reflective MCDA might just do so.

Multicriteria approaches designed with the pursuit of legitimacy in mind can help create a culture of reasonable decision making and provide guidance to fulfil the relevance condition of the A4R framework. Substantive legitimacy may be derived by defining UHC as a main goal and by identifying the underlying motivations of UHC (eg, providing access to meaningful health-care interventions to individual patients, serving the population equitably, and ensuring sustainability). These imperatives can be transformed into

criteria (eg, meaningful health care can be transformed into generic criteria such as effective, safe, addressing patients' needs) and organised into a framework that ensures their systematic consideration for each appraisal. This framework, if constructed to stimulate reflection on these criteria and their relative importance, creates an interpretive grid that can be used to elicit individual values and facilitate sharing diverse perspectives during deliberation. The reflective grid should be generic enough to allow further specification of subcriteria to reflect therapeutic areas and relevant available evidence for each criterion and subcriterion. This provides a common structure for decision makers to express their interpretation of the evidence on a given intervention for each criterion and share their reasoning. These interpretations might be expressed at the individual and group level in a narrative and qualitative way, or quantitatively with interpretive scales with predefined options that capture judgement on the meaning of the data available.

There have been attempts to implement such reflective MCDA approaches to support managed deliberation, avoid the way predominant group members can take over decision making, and increase legitimacy and acceptability through considerations relevant to the goal of UHC and a fair process.

In Italy, for example, the Lombardy health directorate has used a reflective multicriteria approach combined with the EUnetHTA core model to appraise health technologies and make coverage decisions since 2012. The reasoning of the committee members is shared publicly with stakeholders in a format that combines visual representations with narratives. In this way, interaction with stakeholders is largely facilitated by a transparent process and demonstration of reasonableness. The process is evolving to further increase legitimacy by involving a wider array of stakeholders such as citizens or patients. Another example is in Indonesia where AIDS Commission in West Java province used an evidence-informed deliberative MCDA approach to develop its strategic plan for 2014–2018. A project team did a situational analysis; established a consultation panel including 23 stakeholders; identified various criteria including their relative importance, identified 50 candidate interventions; assessed the interventions' performance; deliberated to decide on priorities; and identified the organisations that are best placed to implement and fund the prioritised activities. This evidence-informed deliberative process improved both stakeholders' involvement and the evidence base of the strategic planning process. In Colombia, the Ministry of Health and Social Protection, as part of its exploration of methods for making decisions about health coverage, did a consultation to adapt criteria of a generic reflective multicriteria approach to the Colombian situation. This process elicited criteria weights through participation of more than 200 stakeholders, including experts and citizens. A pilot testing of the framework suggested that this approach helped to structure and clarify the reasoning and deliberation of committee members. Further developments are ongoing to implement participative decision making rooted in A4R with multicriteria approaches in this setting.

The Wardens of the Amsterdam Drapers' Guild, Known as 'The Syndics', 1662 (oil on canvas); Rembrandt Harmensz. van Rijn (1606-69)/Rijksmuseum, Amsterdam, The Netherlands/Bridgeman Images
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Rembrandt Harmensz van Rijn, *The Wardens of the Amsterdam Drapers' Guild, Known as "The Syndics"* (1662)

What would have happened in Mexico if the objectives of the Mexican health-care system had been an integral part of the decision-making criteria? What if the committee had access to the available evidence for each criterion and a deliberation process took place during which various interpretive frames could be expressed to reach a group decision? Suppose further that there was clear communication of such reasoning to all stakeholders. With those drivers of legitimacy in place, a decision more aligned with the objectives of the health-care system might have been reached.

The current context of advancing the UHC agenda calls for a deep reflection on how to design (or redesign) pragmatic ethical frameworks to enhance the legitimacy of HTA and governance processes. Research in action programmes are needed to show how and whether A4R combined with multicriteria approaches can provide an answer to the quest of HTA to contribute to the governance of health systems by prioritising health-care interventions that are the most beneficial towards the goal of UHC.

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Further reading

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