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## **PUBLIC PREFERENCES AND THE ALLOCATION OF HEALTH CARE: DO PROCEDURES MATTER?**

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### **Abstract**

Health economists have engaged in substantial debate on the appropriate foundations of economic evaluation but this has been conducted almost exclusively in terms of consequences. Procedures, as opposed to “process utilities”, have generally only been ascribed instrumental as opposed to inherent value. We question this viewpoint and present empirical evidence from a small scale survey. Firstly, we outline a number of reasons why procedures may legitimately generate intrinsic value for individual citizens in the context of health care rationing. Secondly, we draw on existing literature, which predominates in the fields of legal studies and social psychology, to outline procedural characteristics thought to be of importance. Thirdly, these characteristics are given practical significance by illustrating the links between them and different potential decision making groups, ranging from the general public and patient representatives, to specialist professional groups such as hospital consultants and managers. Survey questions were designed to test each of these three issues and were administered to a number of focus group participants (n=36). Questions were framed in the context of health care rationing decisions of the type faced by health authorities. Analysis shows that in general procedures matter, although there was substantial variation between the various procedural dimensions and the groups respondents would like to see involved in the decision-making process.

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## 1. Introduction

Welfare economics traditionally assesses competing states of affairs solely by reference to the outcomes each generates. In health economics this approach leads to assessing alternative technologies solely by reference to the utilities or health benefits generated. According to these consequentialist approaches it is not important how or why particular outcomes are generated, just that they are. Procedures are only of importance in terms of their instrumental value. That is, because they contribute to better outcomes. Yet other disciplines, notably Social Psychology and legal studies, have examined situations where procedures may generate inherent value to individuals (see for example Thibaut and Walker, 1975,1978; Lind et al., 1990; Leventhal, 1980).

There is considerable interest amongst economic theorists in fundamentally new approaches to welfare economics (Sen, 1992, 2001; Suzumura, 2000; Ng, 1988), with procedures one of a number of potential components of a pluralistic framework (see for example Anand and Wailoo, 2000). Yet the recognition that procedures may be of importance in addition to consequences is not new. For example, Arrow (1951) wrote

“[A]mong the variables which taken together define the social state, one is the very process by which the society makes its choice. This is especially important if the mechanism of choice itself has a value to the individuals in the society. For example, an individual may have a positive preference for achieving a given distribution through the free market mechanism over achieving the same distribution through rationing by the government. If the decision process is interpreted broadly to include the whole socio-psychological climate in which social decisions are made, the reality and importance of such preferences, as opposed to preferences about the distribution of goods, are obvious.” (pp.89-91)

Rawls (1971) too distinguished between perfect procedural justice, which corresponds to an instrumental view of procedures, and pure procedural justice, where procedural characteristics are inherently valuable. Despite this, health economists have paid scant attention to this issue. One branch of research that provides an exception to this is in the field of process utility where values are derived by patients from the process of medical care, as distinct from health outcomes. For example, Ryan (1999) included valuations of “attitudes of staff” and “continuity of contact with staff” in a conjoint analysis of in vitro fertilisation (IVF). Whilst there is some overlap with what we refer to throughout this paper as procedures, process utilitarians are concerned with preferences which exist at the level of the individual patient as a consumer. On the other hand, our concern is with preferences held by individuals as citizens operating from a societal perspective.

Coast (2001) provides an interesting example from a corresponding perspective. This qualitative study focussed on the extent to which both citizens and their potential agents felt citizens ought to be involved in health-care rationing decisions. Lowry et al. (2000) examined a similar theme in the context of water fluoridation and Fox and Swazey (1974) examined the procedural techniques used to allocate kidney transplants in the 1960's. One of the clinicians interviewed as part of the latter study stated that:

“[We] simply could not understand why everyone was much more interested in the existence and operation of the lay selection committee than in the fact that in two years we had taken a disease, end-stage kidney disease, and converted it from a one hundred percent fatal prognosis to a ninety-five per cent two year survival.”

Pure procedural preferences may exist for several reasons that we might wish to distinguish from their instrumental value, although in some cases the inherent value may have instrumental origins that are no longer recognised nor valid. Indeed, according to Ng (1988) non-instrumental procedural preferences exist *mainly* because of tradition and cultural influences.

Krehbiel and Cropanzano (2000) outline a cognitive model of emotional responses that suggests individuals use a two-stage appraisal technique. The first stage is primarily a judgement based on an assessment of outcomes that can trigger particular emotional responses. Procedural judgements take place as part of the secondary appraisal where different emotions can be triggered. For example, if an unfavourable outcome is paired with an unfair procedure then anger, guilt, frustration and anxiety are likely to occur. In decisions concerning health care rationing it is feasible that individuals rely on this second stage appraisal more so than in other situations since no distribution is seen as satisfactory; particularly if the concept of opportunity cost is not readily accepted. Evidence from Lenaghan (1997) supports this view; she highlights the difficulties that have been encountered in trying to establish substantive rights to health care in the UK and other countries and recommends that policy focus on procedural health care rights.

A substantial component of procedural preference is based on concerns for fairness or justice and has been shown to be of particular relevance in conflict resolution (see for example Thibaut and Walker, 1975), where opposing parties have interests that are diametrically opposed when defined in terms of consequences. The issue of health care rationing has many parallels with conflict, which might indicate that acceptable solutions can only be found by reference to procedures. Individuals may accept unfavourable outcomes if they are the result of an acceptable procedure agreed *ex ante*. Those concerned only with procedural fairness would accept *any* outcome so long as it is the consequence of fair procedures. Here, procedural fairness considerations lexicographically dominate concerns for outcomes.

In what follows, we outline a taxonomy of procedural characteristics and relate these characteristics to different professional groups, lobbyists and public representatives who could conceivably be involved in health care rationing decisions. This forms the basis of empirical investigation using survey evidence from a pilot sample of the general public. Survey methods are described in section 3. Section 4 presents the results. Section 5 concludes.

## 2. PROCEDURAL CHARACTERISTICS AND DECISION-MAKERS.

A number of commentators have discussed the types of procedures that are of importance to individuals in a range of decision making scenarios. The main contributions to this literature are from Lind and Tyler (1988) and Levanthal (1980), which provide the procedural characteristics of health-care rationing discussed below. We highlight the relationship between each of these procedural characteristics and various professional and public groups which might potentially participate in the decision-making process. We know that individual citizens are concerned about which groups make decisions on their behalf both in the context of health-care rationing (Coast, 2001) and other social choices (Pommerehne et al., 1997). By outlining these links we seek to establish clear policy relevance and go beyond simply establishing that procedures are (or are not) a relevant component of any health care rationing framework. Ultimately, quantification of the trade-offs both between procedural characteristics and between procedures and consequences may be required but at this preliminary stage our aims do not extend this far.

Six procedural characteristics are discussed below. For each of the groups, we explore possible procedural justifications for their inclusion.

The most consistent finding in all research into procedural preferences is that individuals place importance on the extent to which they are consulted within the decision-making process. Even where this procedural characteristic of *voice* has no impact on outcomes, the opportunity to express one's opinion may be valued since it implies that that opinion is worth hearing.<sup>1</sup> In public choice problems like health-care rationing it is rarely feasible to allow every individual to directly participate so sampling of the general public may be required.<sup>2</sup> Alternative possibilities are that representatives such as patient group leaders or politicians could be seen as acceptable citizen representatives, although we also hypothesise that some professional groups, such as nurses and general practitioners, might be perceived as equally preferable.

Daniels and Sabin (1997), in a discussion of health-care rationing, state that procedural fairness "requires openness or publicity, that is, *transparency* about reasons for a decision." (p.323; italics added). Transparency can be seen as a procedural tool which helps to guarantee the legitimacy of the process in general and to allow judgements regarding fairness to be made. Citizens who observe only the final outcomes of health care rationing decisions are unlikely to be in a position to make judgements about the performance of the decision-making body, for example the health authority, without reference to the methods used to generate the decision. A central part of transparency is the flow of information from the decision-making body and the public. Whilst there is no strong correlation therefore with the composition of a decision making committee we propose that transparency is at least encouraged by the inclusion of the general public and to a lesser extent, patient groups.

A third procedural characteristic of importance relates to the degree of *impartiality* of those involved in decision making. Social choices of this type are characterised by

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<sup>1</sup> Referred to as the "value expressive perspective on voice" by Tyler (1987b), quoted in Fondacaro (1995).

<sup>2</sup> Anand (2001) makes the same distinction between micro and macro elements of voice.

principal-agent relationships and procedures must either exclude those who have interests **that** may differ from those of the general public or embody means of suppressing these biases. Impartiality therefore applies to those groups who have no incentive, or are perceived not to react to incentives that may impact **on** their decisions. We propose that the groups most likely to be perceived as impartial are those seen as purely scientific or analytical in their approach. Of the groups we considered it is health economists and health service managers that most closely reflect these characteristics. We suggest that these criteria might apply to a lesser extent to philosophers and legal representatives. Patient groups are single issue pressure groups; by definition their concerns are not equivalent to those of the general public.

According to Levanthal (1980), individual's value procedural consistency because it has close similarities with the notion of equality of opportunity; that no individual has special advantage. In the same way as distributive consistency is seen as one of the most important principles underlying the NHS, as evidenced by the extent of criticism of "postcode prescribing", it is proposed that procedural consistency is also relevant to health-care rationing decision-making. This characteristic does not have any direct relevance to the membership of decision-making committees but the policy implication of the requirement for procedural consistency is that the committees comprise the same types of membership both over time and across regions.

A fifth procedural dimension considered here is reversibility; the methods by which decisions can be challenged and changed if required. This condition arises because individuals recognise that there is always a potential for "incorrect" decisions to be made, either in terms of the procedure or the outcome. Furthermore, decision-making mechanisms which have clear means by which challenges and reversals of "incorrect" decisions can be made can convey a sense of confidence in the process as a whole, particularly if such reversals would be time consuming and/or expensive. In some situations where allocations are not reversible, for example where a patient is denied treatment and they subsequently die, appeals procedures may still be warranted as a means of apportioning blame or punishment. The condition is strongly allied to the requirement for transparency, which assists the identification of such mistakes, but we did not consider there to be any correlation between this characteristic and preferences regarding the composition of decision-making bodies.

Finally, it is suggested that the procedural validity of decision-making is related to the *accuracy* of the information used. There is clearly an instrumental value to this dimension of procedure; health-care rationing decisions require information on costs and benefits, *inter alia*. However, acquiring accurate information is not a costless exercise itself and consequentialists would only recommend that such information is pursued up to the point where marginal benefit equates its marginal cost. If an inherent, procedural value exists in excess of this instrumental value then it becomes desirable to pursue accurate information beyond this level. We suggest that such an inherent value may arise because the collection and use of accurate information conveys the extent to which decision makers feel a particular issue is of importance.

These six dimensions of procedures do not constitute an exhaustive list but those for which there are clear links to Rawls' conception of pure procedural justice. Instrumental values are likely to exist in conjunction with any inherent value for each of these dimensions; the viewpoint taken here is not that concerns for consequences do not matter but that they are not sufficient in themselves as a basis for social choice decisions. The purpose of the following pilot, empirical work is to examine the validity of the above procedural characteristics rather than quantify the extent of inherent versus instrumental value, as a basis for future work that seeks to develop an appropriate decision-making framework embodying both sets of concerns.

### 3. METHODS.

We devised questions which asked respondents to indicate on a five-point Likert scale the extent to which they felt each of the procedural characteristics discussed in section 2 above, were important.<sup>3</sup> We also included questions that addressed the extent to which procedural preferences arose for instrumental as opposed to inherent reasons. Finally, respondents were asked to indicate their preferences for the composition of a committee charged with making health-care rationing decisions at a health authority level. We presented a list of groups that we thought might possibly be part of such a committee. The list consisted of Patient representatives, General public representatives, Politicians, Hospital doctors, General Practitioners, Health service managers, Health economists, Nurses, Philosophers/Ethicists, Legal representatives and Religious leaders. Respondents were asked to choose five persons to form such a committee. There was no restriction on the number of times individuals from each of the groups could be selected. For example, respondents could select five health economists to form their committee. The questionnaire is reproduced in the appendix.

The survey was administered to six focus group participants after discussions based around the issue of how health authorities should act when faced either with a reduction or an increase in their funding. The authors took turns as facilitator of the discussion, with another acting as a scribe. 36 people participated in the study following invitations made firstly by email to those within our own department at the University of Sheffield and secondly by post to those registered to vote in a single Sheffield electoral ward. The first group excluded those with medical training or experience as researchers in health-related fields. We did not collect socio-economic data from respondents because a convenience sample was considered sufficient at this pilot stage.

Responses from the first section using Likert scales were coded from -2 to 2 to indicate the range from strong disagreement to strong agreement with the importance of a procedural characteristic. We used Chi-squared tests to test for interactions in responses between questions relating to each of the procedural characteristics and those which asked about inherent versus instrumental procedural value. We repeated the process to

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<sup>3</sup> See Appendix 1 for exact questions.

test for interactions between responses in section 1 with the types of committee membership respondents favoured in section 2. However, due to the small sample size we were not expecting statistical tests to be of sizeable value.

The objective of the study was to explore the following:

- (1) whether procedures matter, and if this differs across alternative procedural characteristics,
- (2) the extent to which support for certain procedural characteristics is associated with support for having particular people on the decision making committee, and
- (3) whether the strength of support for procedural characteristics is associated with the extent to which the respondent thinks procedural characteristics have inherent value.

#### 4. RESULTS

Tables 1A and B summarise the responses given to the questions in sections 1 and 2 of the survey respectively.<sup>4</sup> Of interest is how the number of people choosing “neither agree or disagree” fluctuates from question to question. This seems to offer indirect evidence that these questions made sense to the respondents. For all but one of the procedural characteristics tested the location of the median voter, indicated by bold type, is either in the “agree” or “agree strongly” categories.<sup>5</sup> In the case of transparency, impartiality and accuracy of information used, the median response is strong agreement. The exception to this is question 1(5), where the median respondent does not agree with the importance of procedural consistency.

Questions 8 to 10 in this section asked respondents to indicate on the same 5-point Likert scale the extent to which they felt that procedures were of importance for inherent reasons. We found that the median response in the first two questions asked agreed that procedures are of instrumental value but the response was neutral in the third example.

Table 1B shows the distribution of nominees for a health-care rationing decision-making committee. Each respondent was asked to choose five persons to form such a committee. We report both the total number of times each group was selected and the mean score which was expressed as a proportion of five. The two most frequently selections are for hospital doctors and GPs. Interestingly, health service managers, patient group representatives, the general public, health economists and nurses all receive only slightly fewer selections. Four of the groups suggested received little or no support. These were politicians, religious groups, legal representatives and philosophers/ethicists.

In table 2, we have categorised respondents into two groups according to whether they are in agreement with the importance of each procedural category or did not explicitly

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<sup>4</sup> One person did not fill in any of the survey questions. There were three questions that had an additional missing observation which was from a different participant in each case.

<sup>5</sup> The agreement or disagreement is with respect to the procedural characteristic in question; since some questions are worded negatively, this is not always the same as agreement or disagreement with respect to the statement in the questionnaire.

agree. For both groups, the proportion of members who selected each decision maker at least once is reported and p-values indicate the level of statistical significance of observed differences.

In the case of voice, only one of the differences achieved is statistically significant at the 10% level. Perhaps not surprisingly, of those who supported this procedural dimension 60% wanted members of the general public involved in decision making compared to 20% of those who did not see voice as important. We also expected that respondents in favour of voice were also more likely to select patient representatives as committee members (64% vs. 50%). They were also less likely to select politicians, GPs or health service managers although only the latter corresponds with the hypotheses we set out in section 2.

The second category of “transparency” received such a strong level of support (34 out of 35 responses) that the difference between groups is of little use. Similarly, no comparisons were made in the category of “accuracy of information”, where all respondents agreed with the importance of this procedural dimension.

Many of the hypotheses we held regarding which groups might be seen as impartial contributors to the decision-making process are supported by the data. We suggested that health economists and health service managers were the most likely groups to be perceived as impartial. In both cases, those that believe this procedural characteristic is important are more likely to select members of these groups as preferred decision-makers. In the former case this difference is statistically significant ( $p=0.01$ ). We also found that patient group representatives are less likely to be selected by those supporting this procedure (59% vs. 80%).

Whilst we did not expect differences in preferences for either consistency or reversibility to translate into differences in preferences over committee members, the data revealed two relationships. Firstly, supporters of procedural consistency were significantly more likely to select nurses to the decision-making committee (83% vs. 43%;  $p=0.072$ ). Secondly, support for reversibility of decisions suggests a lower propensity to select health service managers (58% vs. 100%), although this finding just fails to achieve statistical significance at the 10% level.

Table 3 presents the results of similar correlations between the responses to questions on specific procedural characteristics and responses to questions about the inherent value of procedures in general. The analysis aims to differentiate between those procedural characteristics valued due to pure procedural preferences as opposed to those that are instrumentally important. Once again, p-values are of limited value with such small numbers and in only one of the scenarios tested is the difference statistically significant. Those for whom voice was considered important were more likely to feel that procedures were of inherent value (92%) than those who did not (50%,  $p=0.006$ ).

Interestingly, those who valued impartiality in decision-making were less likely to hold pure procedural preferences than those who did not value this characteristic. This was



seen in each of the three scenarios tested and was strongest in question 1(9). We also observed this pattern of response in correlations with questions about the importance of reversibility. The largest difference observed between those who supported this dimension and those who did not occurred in the first scenario (Q1(8)). No other differences were considered significant in either sense.

## 5. CONCLUSIONS.

We have found preliminary evidence that procedures are important to members of the general public in the context of health-care rationing decisions. There are several reasons why preferences may in part be based on procedures rather than purely consequential considerations and there is tentative support from the data to suggest that these preferences are not solely due to the instrumental value procedures inevitably embody.

However, our results suggest that certain procedural characteristics, namely impartiality and reversibility, may not be intrinsically valuable. At a policy level, there are correlations between the types of procedures individual's value and preferences relating to the composition of decision-making bodies, although the pilot nature of this study inevitably means that these correlations are statistically weak.

We recognise that these results are likely to be sensitive to question framing effects and this should be investigated further in larger scale studies.

[The authors have recently been awarded funding by the AHRB to undertake such a study and we would therefore be particularly interested in suggestions about survey or other design issues.]

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Table 1A: Distribution of responses: whether they agree to the importance of the procedure in question (%)

	agree strongly	agree to some extent	neither agree nor disagree	disagree to some extent	disagree strongly	Total (n)
Q1(2) voice	29	43	9	20	0	35
Q1(3) transparency	74	23	0	3	0	35
Q1(4) impartiality	65	21	9	3	3	34
Q1(5) consistency	9	9	15	56	12	34
Q1(6) reversibility	37	51	3	6	3	35
Q1(7) accuracy	91	9	0	0	0	35
Q1(8) inherent value of procedure	24	56	0	18	3	34
Q1(9) inherent value of procedure	31	43	6	11	9	35
Q1(10) inherent value of procedure	6	31	29	23	11	35

NB. The replies to the questions with negative wording are transformed, so that the agreement/disagreement is not with reference to the question itself, but with reference to the procedural characteristic addressed in the question. The cells in bold indicate median preference.

Table 1B: Distribution of nominees for the committee

	Sum	Mean
General public	19	0.54
Patient groups	21	0.60
GPs	26	0.74
Hospital doctors/consultants	27	0.77
Nurses	17	0.49
Health service managers	24	0.69
Politicians	4	0.11
Religious groups	0	0.00
Legal representatives	2	0.06
Philosophers/ethicists	5	0.14
Health economists	20	0.57
Others	10	0.29
Total (35 × 5)	175	5.00

Table 2: Correlation between attitude to procedural categories and type of decision-maker.

		n	Hospital Doctors / Consultants	GP	Health Service Managers	Patient Groups	Health Economists	General Public	Nurses	Philosophers /ethicists	Politicians	Legal Representativ es	Religious Groups	Others
Voice Q1(2)	those agreeing	23	68%	68%	56%	64%	64%	60%	48%	16%	8%	4%	-	32%
	those disagreeing	12	90%	90%	80%	50%	30%	20%	50%	40%	20%	10%	-	10%
	p value		0.179	0.179	0.184	0.445	0.068	0.032	0.915	0.647	0.313	0.49	-	0.179
Transparency Q1(3)	those agreeing	25	74%	74%	65%	59%	56%	50%	50%	15%	12%	6%	-	24%
	those disagreeing	10	100%	100%	0%	100%	0%	0%	0%	0%	0%	0%	-	100%
	p value		0.551	0.551	0.187	0.407	0.269	0.324	0.324	0.679	0.716	0.803	-	0.085
Impartiality Q1(4)	those agreeing	29	72%	72%	69%	59%	62%	41%	52%	17%	10%	3%	-	24%
	those disagreeing	5	80%	80%	40%	80%	0%	80%	40%	15%	20%	3%	-	40%
	p value		0.723	0.723	0.211	0.364	0.010	0.110	0.628	0.315	0.536	0.673	-	0.458
Consistency Q1(5)	those agreeing	6	83%	67%	50%	33%	50%	50%	83%	33%	0%	0%	-	33%
	those disagreeing	28	71%	75%	68%	64%	57%	46%	43%	11%	11%	7%	-	25%
	p value		0.549	0.675	0.406	0.162	0.749	0.874	0.072	0.156	0.401	0.500	-	0.675
Reversibility Q1(6)	those agreeing	31	71%	77%	58%	61%	58%	52%	45%	13%	13%	7%	-	23%
	those disagreeing	4	100%	50%	100%	50%	25%	25%	75%	25%	0%	0%	-	50%
	p value		0.211	0.238	0.102	0.664	0.212	0.316	0.261	0.515	0.445	0.601	-	0.238
Accuracy Q1(7)	those agreeing	35	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	100%
	those disagreeing	0	-	-	-	-	-	-	-	-	-	-	-	-
	p value		-	-	-	-	-	-	-	-	-	-	-	-
Average selection of member			74%	74%	63%	60%	54%	49%	49%	14%	11%	6%	0%	26%

Table 3: Correlation between attitude to specific procedural categories and overall procedural attitude.

		n	Proportion agreeing that procedures in general are important		
			Q1(8)	Q1(9)	Q1(10)
Voice Q1(2)	those agreeing	23	92%	76%	40%
	those disagreeing	12	50%	70%	30%
	p value		0.006	0.714	0.580
Transparency Q1(3)	those agreeing	25	79%	74%	35%
	those disagreeing	10	100%	100%	100%
	p value		0.605	0.551	0.187
Impartiality Q1(4)	those agreeing	29	75%	69%	38%
	those disagreeing	5	100%	100%	40%
	p value		0.208	0.146	0.930
Consistency Q1(5)	those agreeing	6	83%	83%	33%
	those disagreeing	28	78%	71%	39%
	p value		0.763	0.549	0.785
Reversibility Q1(6)	those agreeing	31	77%	74%	36%
	those disagreeing	4	100%	75%	50%
	p value		0.278	0.972	0.572
Accuracy Q1(7)	those agreeing	35	100%	100%	100%
	those disagreeing	0	-	-	-
	p value		-	-	-
Average agreement with procedure			79%	74%	37%

Appendix: Questionnaire on health care resource allocation

QUESTION 1

The following statements have been mentioned in similar exercises to this one. Some of them may have come up in today's session, while others might not have.

Please indicate how strongly you agree or disagree with each statement, by circling one option for each statement.

There are no right or wrong answers – we want to find out what you think.

In situations such as those we have discussed today, ...	agree strongly	agree to some extent	neither agree nor disagree	disagree to some extent	disagree strongly
(1) Decisions should be made only after the relevant groups of health professionals have reached agreement.	a.	b.	c.	d.	e.
(2) Decisions can be made without the health authority consulting with the general public.	a.	b.	c.	d.	e.
(3) The proceedings of the decision-making body should be made available to the public.	a.	b.	c.	d.	e.
(4) The decisions should be made in an impartial way.	a.	b.	c.	d.	e.
(5) The same kinds of decisions could use different kinds of criteria.	a.	b.	c.	d.	e.
(6) There should be a mechanism for people to challenge the decisions once they have been made, so that they can be reversed if necessary.	a.	b.	c.	d.	e.
(7) Decisions should be made using accurate and up-to-date information.	a.	b.	c.	d.	e.
(8) If the decisions made are seen to be acceptable, then the ways in which those decisions were made do not matter very much.	a.	b.	c.	d.	e.
(9) If the final decisions made are going to be the same, it doesn't matter very much how these decisions were reached.	a.	b.	c.	d.	e.
(10) So long as the rules for making decisions are fair, then the resulting decisions are bound to be fair.	a.	b.	c.	d.	e.

## QUESTION 2

Imagine that decisions about how to spend money in your local health authority were to be made by a committee of five members. There are a number of groups from which these members could be drawn, as shown in the table below.

Please select five members by placing ONE tick in each column. You can select more than one member from each group if you wish.

Group:	Committee member:				
	1	2	3	4	5
General public					
Patient groups					
GPs					
Hospital doctors/consultants					
Nurses					
Health service managers					
Politicians					
Religious groups					
Legal representatives					
Philosophers / ethicists					
Health economists					
Others (state who ...)					

Thank you for coming to our session today.