

Strategizing national health in the 21st century: a handbook
Chapter 4

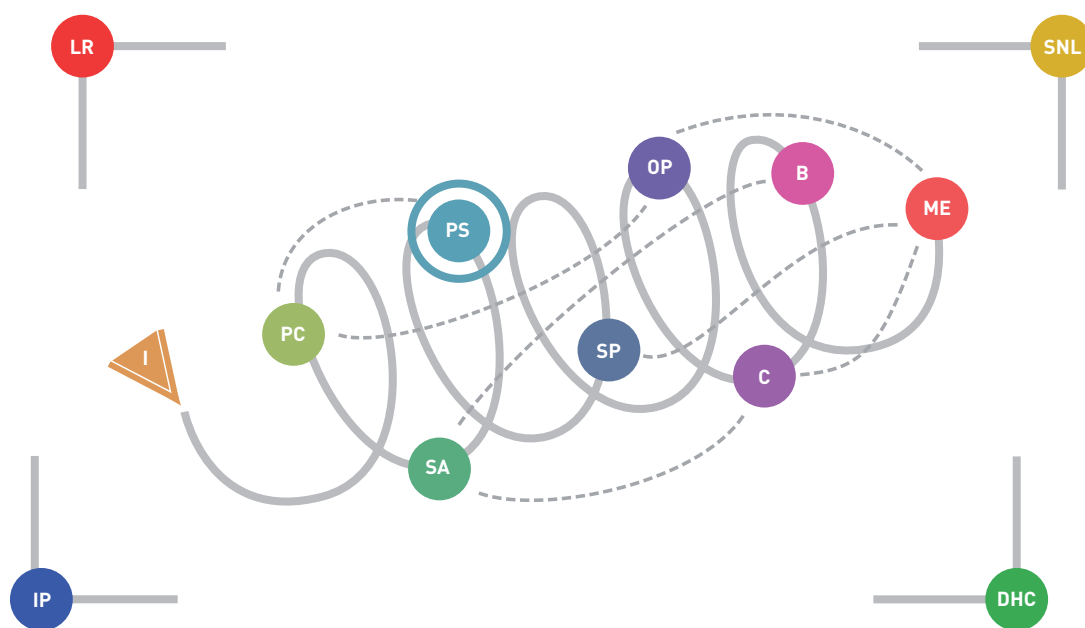
Priority-setting for national health policies, strategies and plans

Frank Terwindt

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Agnes Soucat





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The background of the page is a photograph of a public space, possibly a park or a community area. In the center, a person is seen from behind, wearing a dark jacket and light-colored pants, with a red bag slung over their shoulder. To the left, another person is partially visible, wearing a dark jacket with red and white stripes. To the right, a person is sitting on a bench, wearing a blue jacket and white pants. The entire image is overlaid with a semi-transparent blue filter.

Overview

Priority-setting determines the strategic directions of the national health plan. Led by citizens who are the principals and decision-makers, priority-setting is a shared responsibility between the ministry of health (MoH) and the entire health stakeholder community. This

chapter elaborates various criteria and approaches for priority-setting. It closes with some specificities of the priority-setting exercise in particular contexts such as the decentralized and highly centralized setting, fragile states, and an aid-dependent environment.

Summary

What is priority-setting?

The process of priority-setting is inherently political, which means that it is a process where societal values and goals are important, and resulting priorities reflect a compromise among stakeholders. That being said, the aim of the process is to select among different options for addressing the most important health needs, as highlighted in the health sector situation analysis,¹ in the best way (“best” here depends on a number of criteria, explained in the course of this chapter), given limited resources (rationing). In health, priority-setting determines the key objectives for the health sector for a given period, thus directly feeding into the content of the national health plan.

Why is it important?

Priority-setting is necessary everywhere, as resources are never unlimited. Choices must be made that reflect a society’s values and vision for the health system, and integrate reflections on explicitly chosen criteria. In addition, a priority-setting exercise is where the principal decisions are made after the situation analysis discussions; these decisions feed directly into national health plan development.

¹ See Chapter 3 “Situation analysis of the health sector” in this handbook.

When should priority-setting be done?

The priority-setting exercise generally follows a situation analysis and precedes decisions on resource allocation and planning.

Priority-setting can be done at different intervals in the policy and planning cycle of a sector, a programme or project. For this handbook, it is discussed notably in the context of national health planning in the medium-term.

Who should undertake or be engaged in priority-setting?

Actors such as government (ministries) have a formal responsibility for priority-setting. In an inclusive approach, stakeholder groups of various levels are consulted, as are the population.

How can priority-setting be done? What are the criteria and approaches?

Priority-setting is a multifaceted process that is usually informed by the situation analysis. It is based on criteria set by health sector stakeholders, where evidence is examined to feed into the formulation of the national health policy, strategy or plan (NHPSP). Possible criteria and approaches are elaborated upon in this chapter.

Anything else to consider?

- ▶ Decentralized environment;
- ▶ Highly-centralized setting;
- ▶ Fragile environment;
- ▶ Aid-dependent setting.





Fig. 4.1 Trade-offs are part of priority-setting

Damian Glez; scenario by Bruno Meessen.

4.1 What is priority-setting?

The aim of the priority-setting process is to select among different options for addressing the most important health needs, as highlighted in the health sector situation analysis,^{II} given limited resources (rationing). The process of priority-setting is inherently political; it is a process where societal values and goals are important, and resulting priorities reflect a compromise among stakeholders, including the

population. Indeed, citizens are the principals and decision-makers of the priority-setting process. In health, priority-setting determines the key objectives for the health sector for a given period, thus directly feeding into the content of the national health strategy. The priority-setting exercise generally follows a situation analysis and precedes decisions on resource allocation and planning.

The process of priority-setting is inherently political, which means that it is a process where societal values and goals are important, and resulting priorities reflect a compromise among stakeholders.

^{II} See Chapter 3 "Situation analysis of the health sector" in this handbook.

Priority-setting is closely linked to the challenges identified during the situation analysis process, and the debate around potential strategies to overcome those challenges. It helps to make the best possible choices regarding the distribution of means, since resources are scarce, and trade-offs are thus necessary. The intended consequence is to improve health system performance in an efficient and fair way.

Priority-setting is not only about making the best use of financial resources; it is also about attribution of resources in general in response to population value choices, demand and need. ^{III} For instance, it may be agreed that certain institutional reforms are a priority. The concerned reforms may necessitate a change in administrative and technical procedures, which in turn may require existing staff to use their time differently – the necessary investment is thus not predominantly monetary in nature.

Priority-setting is often about giving more importance to certain health interventions above others. It must be kept in mind that when importance and resources are attributed to one intervention over another, a reduction of resources or exclusion altogether for the other intervention is the consequence.

In the context of this chapter, the term interventions may cover programmes, sets of activities, policies, strategies, reforms, investments or implementation modalities, undertaken separately or in combination. An intervention is thus any measure whose purpose is to improve health or alter the course of disease, for example, a solution to a health problem or a health promotion activity or a new organigram for the district health management team, etc.

^{III} "Need" in the context of health is something that is necessary for humans to live a healthy life. This can be measured by, for example, self-reporting, health status indicators, biomedical markers,

geographic measures, etc. Broadly speaking, "demand" for health-related services is the expression of felt need. Demand is influenced by factors such as illness behaviour, knowledge of services, media, etc.

4.1.1 Priority-setting in the context of universal health coverage (UHC)



“I regard universal health coverage as the single most powerful concept that public health has to offer,” stated the World Health Organization’s (WHO’s) Director-General Dr

Margaret Chan at a ministerial-level meeting on UHC in February 2013.¹

UHC is a social contract, an overarching goal towards which a health system should steer. WHO Member States committed to this in the World Health Assembly resolution 64.9, with the definition anchored in the 2010 World Health Report: “UHC is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”² In addition, Sustainable Development Goal 3.8 is to achieve universal health coverage, a goal which all UN Member States subscribed to in September 2015.

There is no blueprint solution for the path towards UHC; instead, it is a process that must be pursued differently in a context-specific way in each individual setting. However, all contexts and all settings will require a health system approach to move closer towards the overarching goal of UHC – an approach that seeks to actively collaborate with other relevant sectors, and bring together all relevant health sector stakeholders to discuss potential interventions to improve the population’s health. Especially important are activities in other sectors besides health. If a priority-setting exercise would only be disease-based and only consider health care solutions, it would ignore other determinants of health, such as education, housing, labour conditions, etc.

The UHC concept takes into account the aspect of financial protection for improving coverage, geographical accessibility and availability of care. To move towards UHC, WHO thus recommends working on three dimensions (Fig. 4.2): extension of health coverage to the population not yet covered, improvement of the health service package provided (in terms of number and quality of services), and a reduction of cost sharing and out-of-pocket payments for health.

Priority-setting exercises can help address these dimensions:

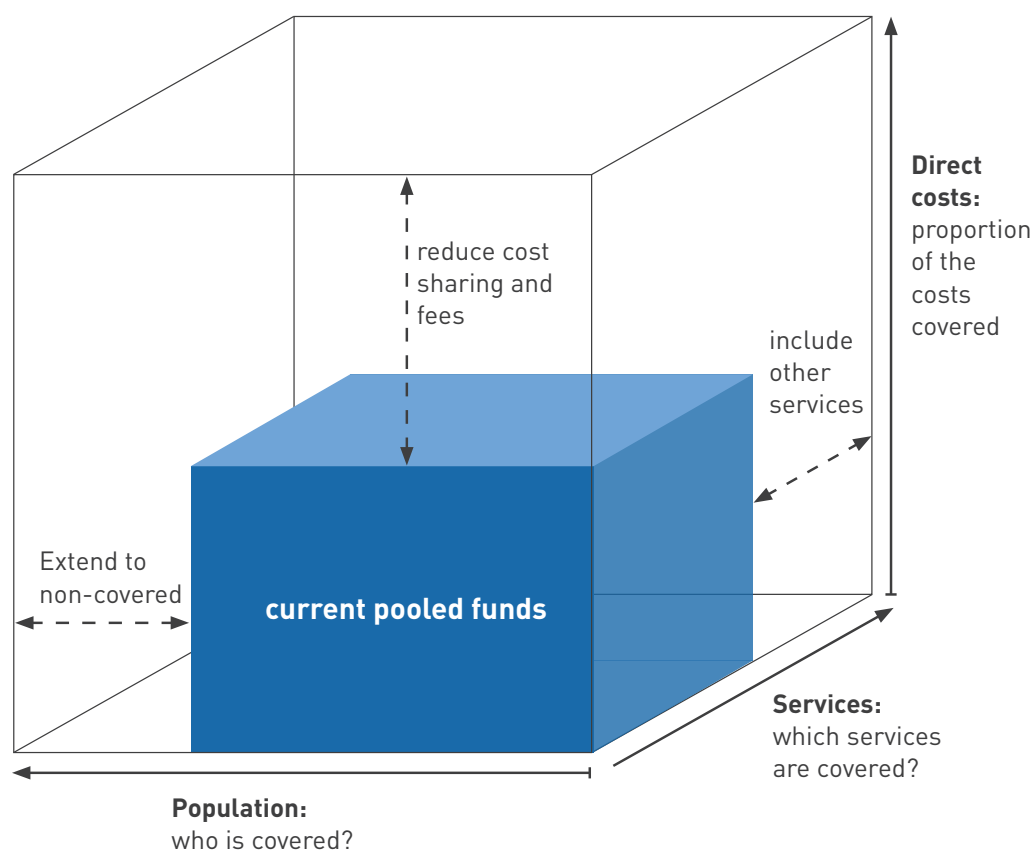
- ▶ Reaching vulnerable, marginalized and hard-to-reach populations (“width” of coverage) can be achieved by the extension of services to those segments of the population not yet covered.
- ▶ Maximizing service delivery provision (“depth” of coverage) can be achieved by improving efficiency in service package results.
- ▶ Improvements in financial risk protection (“height” of coverage) can be achieved for poor and vulnerable populations through targeted reduction of cost sharing and fees.

Moving towards UHC means that priority actions and investments along each axis are needed; for this, trade-offs are constantly necessary. These trade-offs will be influenced by imperatives that change over time as choices of citizens evolve the economy develops, the population ages, or the disease burden shifts. Hence, moving toward UHC is at the heart of the democratic debate, a political process that involves public information and negotiation between different groups in society over the contribution to and use of the public purse, allocation of health benefits and who should pay for these benefits.

UHC is a process that must be pursued differently in a context-specific way in each individual setting. However, all contexts and all settings will require a health system approach to move closer towards the overarching goal of UHC – an approach that seeks to actively collaborate with other relevant sectors, and bring together all relevant health sector stakeholders to discuss potential priority interventions to improve the population’s health.



Fig. 4.2 Three dimensions to consider when moving towards UHC³



4.1.2 Priority-setting basics

Priority-setting examines the degree to which an identified important need – generally specified in the situation analysis – can be addressed, based on criteria such as, but not limited to, the importance of the health issue at hand,

fairness the effectiveness of the intervention, the acceptability of the intervention. A society may also include other criteria that it feels are essential and reflect its culture, history and objectives.

Cost-effectiveness has been an extensively used priority-setting criterion in economic literature and discourse, in this chapter we advance the view that cost-effectiveness analysis is an important and widespread technological approach (and not a criterion), which feeds into the evidence base during the priority-setting process. However, it is only one of several technological approaches, whose results should be deliberated upon carefully during the course of the priority-setting process, along with all other available evidence. More on cost-effective analysis and its place in the priority-setting process is discussed in section 4.5.3.

We distinguish between prioritizing health problems or health sector challenges and prioritizing solutions or interventions to overcome those problems and challenges. Naturally, the two are very closely linked; however, a health problem can have several possible solutions. For example, identifying diabetes as a priority disease in a country is a separate decision from the one that examines the different preventive, promotive and curative interventions available to tackle diabetes.

The priority-setting criteria mentioned in this chapter address both priority-setting for health problems and priority-setting for possible solutions. The criterion of importance looks mainly at the health problem, while effectiveness, cost and acceptability address the proposed health intervention (solution). Fairness can address both.

Resource limitations are taken into account in a priority-setting process. However, the actual

resource allocation and budgeting decisions come after the priority-setting, because it is a process of trade-offs. Priority-setting informs the decision-making process. The priority-setting process makes explicit which health problems, challenges and solutions should be given priority based on certain criteria; the decisions then taken are based on the priority-setting process's evidence, giving more or less weight to certain issues based on a (political) debate and discussion. In the end, there might be trade-offs between the various criteria, and the weight of each of them will be a political decision.

In practice, feasibility and implementation issues will be part of the priority-setting dialogue and cannot be artificially extracted from it. Also, feasibility may be included in the priority-setting criteria in some settings. Strictly speaking, the priority-setting process should focus first on what the country's health sector priorities should be for the national health policy, strategy or plan (NHPSP); considerations of feasibility and implementation constraints will be more strongly taken into account in the actual decision-making and NHPSP formulation process.

Because priority-setting is highly coloured by politics, there may be a tendency to focus on shorter-term gains rather than looking at a longer-term strategic vision. Either way, it is useful to keep in mind that a collection of short-term priorities may not necessarily culminate in achieving a longer-term one and that special care might need to be taken to keep the longer-term priorities on the agenda.

In the context of strategizing for health, priority-setting examines the degree to which an identified important need – which is generally specified in the situation analysis – can be addressed, based on criteria such as, but not limited to, the importance of the health issue at hand, the effectiveness of the intervention, the cost of the intervention, the acceptability of the intervention and fairness.





4.2 Why do we want to prioritize?

Priority-setting is necessary, as resources are always limited. A priority-setting exercise is where the principal decisions are made, based on the results of periodic assessments of health needs and solutions.

4.2.1 Priority-setting is necessary to adapt to a changing context

Over time a population's health and its determinants change and a health sector priority-setting exercise can adequately reflect this. For instance, due to the population's increased mobility, new communicable disease threats which, in the past, may have been more geographically contained, may emerge. Or new habits and attitudes, triggered by macroeconomic changes and leading to modifications in lifestyle, may affect the health status of certain population groups (eg. the middle class in emerging economies). Changes in the country's demographic profile (larger percentage of elderly population) may explain the predominance of certain (chronic) disorders. Increased awareness or new technological solutions may cause shifts in mortality and morbidity prevalence and incidence. Fundamental changes in a country's political and or administrative system, such as decentralization, may create new opportunities for a healthier life and more effective health care.

Such trends must be monitored and changes must be detected in a timely fashion for a periodic reassessment of health needs and solutions. This is especially important in the context of public service sectors competing for insufficient government resources.

4.2.2 Priority-setting addresses challenges raised during the situation analysis

The health sector situation analysis process is where the health system's strengths, weaknesses, opportunities, and threats (SWOT) – including their root causes and effects – are analysed and debated upon amongst all relevant stakeholders. A discussion on what has worked well and less well is connected to potential solutions and recommendations to overcome health sector challenges. Thus those very suggestions, already debated upon, discussed, and sorted through by a broad stakeholder base, form the starting point for the priority-setting exercise. Priority-setting is a grand opportunity to take the recommendations and insights coming from the situation analysis work one step further according to give them a specific priority level.

Priority-setting is thus a grand opportunity to take the recommendations and insights coming from the situation analysis work one step further and examine them in view of according them a specific priority level.



Box 4.1

Ambitious planning requires prioritization: the case of Sierra Leone

The Sierra Leone IHP+ Compact established a voluntary agreement in 2011 between the government of Sierra Leone and its development partners⁴ to reduce inequities in health services and improve the health of vulnerable groups, especially mothers and children. Sierra Leone's National Health Sector Strategic Plan (NHSSP) 2010-2015 was developed around the same time, focusing on the following key pillars: governance and leadership, human resources for health, healthcare financing, medical products and technologies, and health information systems.^{5,6} In conjunction, the Basic Package of Essential Health Services (BPEHS) was formulated by MoH with support from stakeholders to ensure a minimum package was offered at different service delivery levels. The Joint Programme of Work and Funding (JPWF) outlined activities and investment decisions by the Government and stakeholders for the 2012-2014 years of NHSSP implementation.⁷ These overarching documents' aim was to keep the health sector's focus on reducing mortality rates and improving accessibility of care.⁸

While there was real goodwill to commit to the NHSSP through the IHP+ Compact, it is widely acknowledged that it failed to reach its full potential, as it was poorly implemented. A recent review of the NHSSP concluded that it was overambitious and disconnected with local needs, resulting in minimal improvements in the health sector as evidenced by key indicators. It further established that a

lack of priority-setting was the underlying, common misstep made in the development of all of the above documents. The review team concluded that a more participatory process, including more district consultations and input from a broader range of civil society groups, would have easily aided the MoH to identify key health sector priorities. Instead, the NHSSP and the BPEHS were comprehensive in their scope rather than selective in their priorities. Given scarce resources, both ended up being unrealistic, and therefore, poorly implemented.^{3,9}

Many of the weaknesses led to a health system which did not demonstrate the necessary resilience to contain the spread of Ebola in 2014. It has been widely documented that the Ebola-affected countries, Sierra Leone included, suffered from low-performing essential health systems functions, hampering the development of a suitable and timely response to the outbreak.¹⁰ Inadequate numbers of qualified health workers, weak basic infrastructure, logistics, health information, surveillance, governance and drug supply systems were the underlying issues which were meant to be addressed through NHSSP implementation.

Though the NHSSP initiatives aimed at strengthening systems, in practice, partners implemented individual initiatives rather than coordinating with district health management teams; more progress could have been made by working within and through

existing structures. A gap in ownership was evident in translating the NHSSP and JPWF into action; weak coordination and poor dialogue between stakeholders hindered the harmonization the documents intended to provide. The same review studied the BPEHS and analysed that, although it offered higher quality minimum services and created a more comprehensive set of guidelines for service delivery, operationalization was hindered by a lack of understanding of what the population could afford at district level.

The Sierra Leone example underlines the paramount importance of priority-setting in a situation of massive need, a sector which is struggling and insufficient resources. This illustration also demonstrates the criticality of the conditions which must be created to make it a meaningful and effective exercise: involvement of those who are on the implementing side and input from the population and/or those representing them. The Sierra Leone case also demonstrates the dire consequences of inadequate priority-setting: a weak health system which was unable to successfully face the Ebola threat.



4.2.3 Priority-setting, identifies challenges expected to be prominent in the future

When priorities are explicitly set with clear criteria, they can be a subject of dialogue and debate, i.e. they can be challenged. If it can be challenged, there is a potential for improvement.

Future challenges, such as an ageing population, climate change, or increasing health inequalities, may have emerged both during population consultations and the health sector situation analysis. During the priority-setting phase, health stakeholders need to contemplate the consequences of these expected challenges and if available, interpret specific studies for the local context, or commission new ones. The process of setting priorities is the opportunity for policy-makers and health sector stakeholders to pre-empt foreseeable health problems and ensure that their negative impact on health outcomes is mitigated.

With this in mind, priority-setting goals in the health sector are:

- ▶ to relate the most important citizens' health needs and demands, as identified in the situation analysis, to the best options for addressing those needs and demands;
- ▶ to ensure that programmes and interventions are evidence-based, cost-effective and fairly distributed, addressing health needs of all population groups, particularly the poorest segments of society;
- ▶ to inform national strategies and resource allocation of the public purse;
- ▶ to provide key reference information and evidence for policy-making, and monitoring and evaluation.

4.2.4 Implicit priority-setting happens if it is not consciously made explicit

A national health planning process always includes priorities. If this is not explicitly done, with a transparent discussion on priority-setting criteria and a joint examination of the evidence, then it will be done in an ad hoc, implicit way. The latter does not encourage accountability, is not transparent and is prone to influences and special interests that may or may not be in the best interest of population health. When priorities are explicitly set with clear criteria, they can be a subject of dialogue and debate, i.e. they can be challenged. If a priority can be challenged, there is a potential for improvement. A recent article by Chalkidou et al.¹¹ summarizes this as:

“In an explicit process it is clear who made which decisions, the criteria used, whether the criteria used were met, what evidence was considered and whether the evidence was adequately assessed, whether appropriate values were employed, who was consulted, whether those giving advice had significant conflicts of interest and how the various trade-offs were made.”

4.3 When should we conduct a priority-setting exercise?

Where does priority-setting start in the planning cycle and where does it end? In principle, priority-setting happens on a continuous basis in some shape or form throughout the policy & planning cycle. Some find that the priority-setting phase is only concerned with the preliminary steps of identifying the most important needs and opportunities, while others include the weighing of resource limitations. Some also include the decision-making process on resource allocation in priority-setting.

Once the health needs/problems and their causes have been identified in the preceding situation analysis phase, the priority-setting should then focus on ranking those identified needs and options, on the basis of a set of criteria, approaches and methods/tools (many of which are described in this chapter). In the planning phases that then follow, decisions will be taken on sequencing priority interventions and on budgeting.

4.3.1 Periodicity and scope of priority-setting

Priority-setting may be done:

- ▶ at varying intervals (annually, mid-term, etc.) and for any given time frame (short-term, medium-term, long-term, or other);
- ▶ at any level of the system (national, province/region, district, or other);
- ▶ on varying themes and system components (hospital reform, post-Ebola health system recovery, etc.);
- ▶ with any group of actors (authorities, service providers, private sector, communities, etc.).

This chapter focuses particularly on comprehensive, medium-term, health sector priority-setting. Approaching priority-setting from a whole-of-sector perspective is a complex undertaking, encompassing all its levels, types of care, actors, implementation modalities and funding flows. This approach may be at odds with the *modus operandi* in settings where programmes and projects are vertical in nature since their management timelines may not be in sync with the national governmental planning cycle. Here, there is a risk that the scope of priority-setting for these programmes is limited to the (vertical) programme objectives. In such situations, more integration and alignment with the overall sector planning cycle should be sought and vertical programme priorities should be examined in view of overall sector priorities.

Priority-setting should be a participatory and inclusive process, as part of the health policy and planning cycle. This process itself is transparent and understood by all.

Priority-setting often provides a key milestone for strategic planning. Strategic options are weighed in the priority-setting process. Decisions taken based on criteria such as importance, cost-effectiveness, affordability and fairness will shape the strategic plan, given the resources available for the health sector. Much of the priority-setting process will build on the situation analysis and population consultations phases, closely examining the evidence generated as well as analysed in those processes.

Later, the strategic medium-term choices will be translated into annual plans. Priority-setting will also be necessary for guiding this operational planning. It will contribute to budget recommendations on resource allocation for phased implementation of the medium-term

The situation analysis can be seen as the starting point of the priority-setting process.





4.3.2 Priority-setting as part of comprehensive health sector development

strategic directions. This chapter deals with medium-term priorities, while priority-setting to guide operational planning (annual implementation plans and budgets) will be covered in another chapter.^{IV}

Priority-setting may or typically come after the situation analysis and before the decision-making and policy debates on key strategic directions for the health sector. Budgeting then follows, after which NHPSP implementation takes place and results are monitored and evaluated.

A comprehensive situation analysis takes an in-depth look at factors that explain success and failure in past implementation. It is retrospective. It can be organized as a mid-term or final health sector review in the case of a medium-term strategic plan. Such a review results in a set of key recommendations (usually for each health system building block¹² and for thematic areas) and sometimes certain priorities are already identified. So the situation analysis can be seen as the starting point of the priority-setting process.

To ensure adequate priority-setting for the development of national health policies, strategies and plans, it should be assumed that:

- ▶ the situation analysis has taken into consideration population needs and demand – through a citizen consultation, by analysing secondary data on patient satisfaction, and by including community leaders meaningfully into the situation analysis process, etc.;
- ▶ there is a realistic forecast of the resources likely to become available for the period to be planned;
- ▶ criteria and formulae are likely to inform resource allocation;
- ▶ budgets will be based on a costing exercise, which in turn is based on an adopted methodology;
- ▶ plans and budgets are based on adopted implementation modalities (e.g. horizontal, vertical, decentralized).

A clear distinction is made here between priority-setting and the final decision-making. The priority-setting phase formulates the recommendations for priority areas/interventions/levels, etc., taking into consideration cost implications and assuring fairness, but without going as far as making actual decisions.

^{IV} Please see Chapter 6 “Operational planning: transforming plans into action” in this handbook.



4.4 Who should be involved in priority-setting?

Which actors should be involved in the priority-setting process needs to be considered carefully. An inclusive approach is where different stakeholder groups of various levels are consulted and where the expectations of the population are heard.

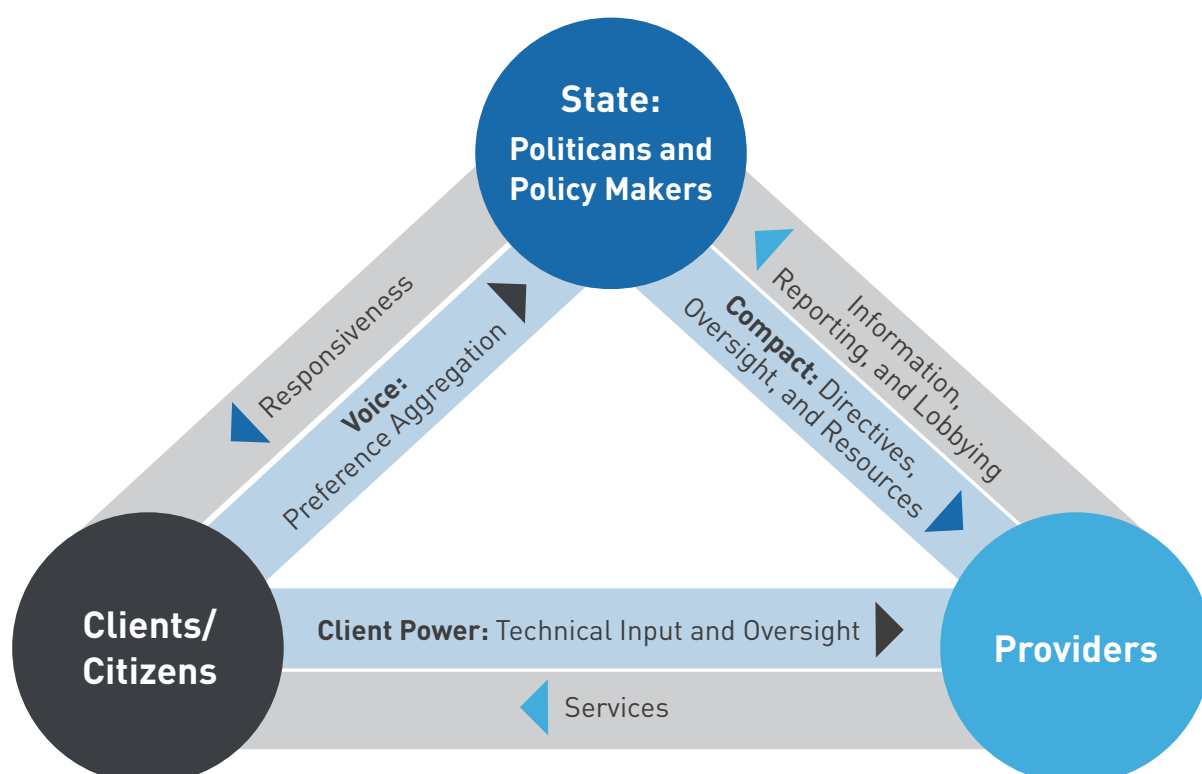
Priority-setting rests on judgements informed by evidence, and those responsible for making those judgements need to be held accountable for their decisions. So if priority-setting is to have legitimacy, citizens are to make the final choice through their parliaments.¹³

Some actors have a natural position of participation in the process:

- ▶ policy-makers and health planners: MoH, other ministries (such as ministry of finance, ministry of planning);
- ▶ administrative and health authorities at decentralized levels;
- ▶ health professionals (public and non-public sectors);
- ▶ community representatives and/or groups of patients.

Brinkerhoff and Bossert's¹⁴ [see Fig. 4.3] three categories of population groups who have a stake in health governance can be used as a lens to better understand the roles of those stakeholders who have a natural position of participation in the priority-setting process.

Fig. 4.3 Three dimensions to consider when moving towards UHC



4.4.1 Clients/citizens

Citizens are the final decision-makers on priorities through their parliaments; they thus need to be involved at each step of a priority-setting exercise (see Boxes 4.2 and 4.3).¹⁵ The priorities which are set should ultimately be owned by citizens as part of the democratic process.

Public accountability is one of the principal aims of consulting citizens on their views and needs. As much as possible, the population is to be well informed beforehand about the advantages and disadvantages of various options, and when the methodology is extensive and intensive. The need for and feasibility of an in-depth, large-scale consultation will depend on the national context.¹⁶ Context may also determine to what extent the country chooses a consultation of the population at large or a less complex consultation via appointed population representatives. For this second option, it is assumed that population representation is based on transparent and democratic means.

Consensus-based expert opinion approaches are by definition less inclusive than a large direct citizen consultation because participants are selected based on expertise. However, they are relatively easy to organize and results can be obtained quickly. The main caveat is that external experts may not necessarily be aware of important local developments.¹⁷

4.4.2 The state: politicians and policy-makers

National leadership (the state: politicians and policy-makers), in particular the MoH, needs to navigate the political complexities of working within and across stakeholders and organizations (both clients/citizens as well as providers) with differing incentives systems and cultures. The role of the MoH is to plan, initiate, coordinate and oversee the priority-setting process, where relevant through health sector coordination mechanisms.

The ministry may seek the assistance of independent technical experts for developing and preparing the methodology and tools, as well as for facilitating the process, but the overall coordination and final decision-making is likely to remain with the government side. Policy-makers must thus lead the process, ensure broad and meaningful stakeholder participation, ensure that the priorities that are set reflect stakeholder input in a balanced way, and be held accountable for the results.

In a decentralized environment, the policy-makers are the local government. They must collaborate with service providers (Brinkerhoff and Bossert's "providers"), civil society and the community (clients/citizens) for their insights and input. The process must be transparent, with clear roles and responsibilities, especially when it comes to evaluating and discussing evidence from different angles and viewpoints.

In countries that rely heavily on external funding, the active participation of development partners in the priority-setting process is necessary. In a process lead by the government, it improves their understanding of national considerations, enhances alignment with national priorities and sensitizes for integrated aid contributions.

The role of the MoH is to plan, initiate, coordinate and oversee the priority-setting process, where relevant through health sector coordination mechanisms.



Providers and the population can have differing views regarding health sector priorities – the priority-setting process provides an essential platform for making these different views explicit and discussing them in a spirit of finding a common solution.

Box 4.2

Balancing patients' demands with medical needs and cost-effectiveness¹⁸

A Swedish study in 2012 questioned nurses, general practitioners, and patients on their views on priority health problems in primary health care. The study found that for nurses and general practitioners, the severity of the health condition was the most important priority-setting criterion. Specifically for general practitioners, cost-effectiveness was an additional key criterion. Patients, on the other hand, assigned a relatively higher priority to acute/minor conditions in routine primary care also compared to preventive check-ups for chronic conditions. It was concluded that the challenge for primary care providers is to balance the patients' demands with medical needs and cost-effectiveness. Transparency in applying criteria might contribute to a greater consensus between general practitioners and nurses.

4.4.3 Providers

Service providers are the front-line organizations who are at the heart of implementing the priority actions that have been decided upon. Their experience of the health sector comes from the inside, is practical, and offers insights on feasibility. Their input into the priority-setting process is therefore crucial – they essentially translate policy-makers' resolutions into services for citizens.

As the Swedish example demonstrates (Box 4.2), providers and the population can have differing views regarding health sector priorities – the priority-setting process provides an essential platform for making these different views explicit and discussing them in a spirit of finding a common solution. Addressing these differences early on, before the NHPSP is implemented, precludes potential problems and bottlenecks later on during NHPSP implementation.

Box 4.3

More public engagement for health sector decision-making: a meta-study from low- and middle-income countries¹⁹

Citizen consultations aim to actively engage health system end users in priority-setting. A 2013 meta-study looked at different forms and current trends of such consultations in low- and middle-income countries.

In Uganda, nominated community members were recommended to represent the public on technical committees in health sector decision-making. In Kenya, local health workers developed an annual list of priority activities and targets, informed by the local community. In Indonesia, an annual, bottom-up participatory budgeting process was created specifically to replace Indonesia's former centralized system. In India, the National Rural Health Mission advocates increased stakeholder and public engagement in priority-setting at the village, sub-center, block, district, and state levels.

And a recent ordinance in the Philippines requires bottom-up planning for poverty alleviation to incorporate community and grassroots organizations' perspectives at the local government unit level.

The meta-analysis found that affordable, appropriate and effective engagement of the public remains elusive, despite many good initiatives and promising starts. To remedy this situation, it is suggested that, rather than mandating public participation, countries and donors should focus on building a policy environment that is conducive to grassroots initiatives and public involvement in decision-making processes. In addition, a stronger evidence base must be created at local level for what works and what works less well, using small pilot studies.



4.4.4 The media supports all three stakeholder groups

The media can be seen as straddling between the three stakeholder groups, as they bring information to and provide a medium to represent all three groups. The media plays an important role in informing and sensitizing the population about the importance of priority-setting, priority health needs and the consultation process. Media can also function as a forum for public debate on these issues, and act as a key partner

in follow-up feedback. Here, the policy-maker and other stakeholders must make a conscious effort to communicate more simply, with less technical jargon, with the media, as well as through the media to the populace. Producing targeted documentation on priority-setting analyses in easy to understand language for the public can be a powerful tool in making choices more transparent.



4.5 How should we do priority-setting?

4.5.1 Criteria for priority-setting

Priority-setting is a trade-off: attributing more attention and resources to a given intervention means to a large extent that less can be done in other areas. That being said, the actual trade-off must be preceded by understanding the health sector challenges (situation analysis), examining possible solutions to overcome the challenges, and then defining the priority-setting criteria explicitly. In this section, five criteria are recommended which underpin the approaches, methods and tools used to set priorities.

Since health status is to a large extent determined by other factors such as cultural, socioeconomic and environmental, it is critical to go beyond the strict remit of the MoH and to consider other sectors when prioritizing solutions for a health problem. Although this might seem obvious, there are few countries which manage to systematically bring intersectoral thinking and action into national health planning processes.^V An example priority area of focus could be waste management as a solution for lowering the incidence of diarrhoeal diseases – this would imply that the ministry of environment would take the lead, but with key input (and potentially funds) from the MoH. The point here is that some priority options for the health sector may be carried out principally by other sectors and this should be kept in mind.

In the priority-setting process it will usually be possible to identify “quick wins” and “low-hanging fruit” to guide the strategic planning. Some changes to the current set of health sector activities can be relatively easy to achieve and can be addressed first, because they are politically feasible, affordable and technically possible.

Five key criteria for setting priorities in the health sector are suggested here, without any pretence that this list is comprehensive; in the end, the choice of and weight given to the criteria themselves will be a product of debate and deliberation by society, stakeholders and policy-makers. They are:

- ▶ importance of the health issue;
- ▶ effectiveness of the intervention;
- ▶ cost of the intervention;
- ▶ acceptability of the intervention;
- ▶ fairness.

A country may decide to choose different, or additional, criteria according to local needs and norms. The relative weight attributed to each of these criteria may vary as a range of factors influence them. Trade-offs between the various criteria, and the weight of each of them, will be a political decision. Several methods and tools have been developed for measuring and analysing these criteria as far as possible; some are concerned with only one of the five criteria (e.g. health needs assessment), while others combine two criteria (e.g. a method for measuring cost-effectiveness, burden of disease, or several criteria (e.g. health technology assessment)).

Almost all priority-setting is a trade-off: attributing more attention and resources to a given intervention means to a large extent that less can be done in other areas.

(a) Importance of the health issue^{20,21}

Importance, or relevance, refers to the nature of the health problem or issue, and can be viewed from the perspective of the MoH, health providers, or the population. From the MoH or service provider point of view, the *magnitude*

^V For more information, please see Chapter 12 “Intersectoral planning for health and health equity” in this handbook.



Importance, or relevance, refers to the nature of the health problem or issue, and can be viewed from the perspective of the MoH, health providers, or the population.

severity and *urgency* of the matter are most pertinent. From the population perspective, it is the *responsiveness* of the health sector to their needs that is most germane. These aspects are not mutually exclusive; for example, a high burden of disease increases the magnitude/weight of the problem, but addressing this problem is responsive to population needs.

From the MoH or health provider perspective, the **importance** of a health issue can be established, for example, by analysing epidemiological trends and data such as prevalence, incidence, and survival rate (these kinds of data can give information on magnitude, severity and urgency, depending on the disease and the situation). For example, the epidemiological profile of many low- and middle-income countries is rapidly changing, with a growing burden of disease caused by non-infectious, degenerative diseases that are linked to changes in lifestyle and environmental factors. Such a situation may ask for a review of priorities in health care delivery, whereby more focus is given to preventing and treating noncommunicable diseases (because the importance of the health issue is judged as high) in terms of information campaigns to stimulate a healthy lifestyle, intersectoral action, new training for health staff, an adjustment of services provided at facility level, etc.

A cost-related aspect which is linked to the **importance** of a disease-based health issue is the cost of the burden of disease (cost of the health problem). Burden of disease is a time-based measure combining years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. It shows that some health issues, if

left unresolved, will have more of a cost impact than others (this can be due to magnitude, severity of urgency of the health problem) on the health system as well as on the society. So the cost of the disease burden (which fulfils the criterion “importance”) itself can influence how it is prioritized.

The *magnitude* of a health problem may be indicated, for example, by the proportion of the population at risk or affected in terms of mortality and morbidity. This also means identifying patient subgroups for which treatments have differential benefits and establishing whether or not interventions are effective in all healthcare settings and subpopulations. Projections and trends are essential in ranking health threats, despite the uncertainty of such a judgement. For instance, many countries experience a rapid increase in migrating populations from rural to urban settings. This phenomenon is likely to cause important shifts in the distribution of health risks and health care needs, which may subsequently need prioritizing. Another example of how the magnitude of a health problem can influence priority-setting decisions is sickle-cell disease^{VI} in tropical regions and parts of Africa where there are pockets of up to 25% population prevalence of sickle-cell disease gene carriers. In this setting, the magnitude of sickle-cell disease will likely be a deciding factor for allocation of money and resources to programmes to prevent symptomatic sickle-cell disease as well as for disease management. Prioritization of the identified target population (sickle-cell disease gene carriers) with preventive measures and early intervention are likely to have a considerable impact on the burden of this disease.²²

^{VI} Sickle-cell disease is a haemoglobin disorder that affects how oxygen is carried in the body. In this blood disease, misshapen cells lack plasticity and can block small blood vessels, impairing blood flow. The condition leads to shortened red blood cell survival, and subse-

quent anaemia, often called sickle-cell anaemia. Poor blood oxygen levels and blood vessel blockages in people with sickle-cell disease can lead to chronic acute pain syndromes, severe bacterial infections, and necrosis (tissue death).

Box 4.4

The burden of disease: obstetric fistulas and living in a state of less than full health

Obstetric fistulas remain a major maternal health issue, especially in resource-poor regions, such as some sub-Saharan African and South-East Asian countries, where maternal mortality rates are high and access to emergency obstetric care is limited.²³ The majority of obstetric fistulas result from cases of obstructed labour, one of the top five causes of maternal death and an issue linked closely with young not fully formed girls experiencing pregnancy, the developmental effects of malnutrition, delay in seeking care and poor accessibility to health services.²⁴ Most women living with the disorder experience urinary or fecal incontinence due to fluid leaking into the vaginal canal through a hole resulting from complications in delivery. The result is not only physical discomfort and constant attempts to mitigate the issue — coping strategies include wearing protective cloths to absorb leaking fluid, linked to an ongoing preoccupation with managing and cleaning the cloth, or applying scented perfumes to mask the smell, both strategies that rarely make a difference—but also shame over ensuing smells, physical isolation from families and communities, and potential divorce or abandonment which further isolates affected women.²⁵

Women living with an obstetric fistula can be considered a “state of less than full health” in which their capacities are not necessarily completely debilitated because of the health problem yet they still experience a life of less care, equality, opportunity, and treatment compared to unaffected counterparts. There are vivid descriptions of coping with the dis-

order that illustrate living in a state of less than full health.

- ▶ “In this condition producing odours is inevitable... No perfume is capable of covering up these odours. I give off a bad smell.”
- ▶ “The sores bother me terribly; I feel as though I am in prison all the time.”
- ▶ “My life is ruined; I have become like a crazy woman who must live alone cut off from the world. I live far from my parents, my village, and my husband, in order to escape the noise (insults and questions) of others and to look for a cure.”

Such recollections exhibit not only the physical consequences of the disorder but the social and cultural ramifications of fistulas. Almost 90% of obstetric fistula cases can be cured by a simple vaginal repair surgery, but transportation limitations because of the disorder, poor accessibility to care, and lack of financial resources can impede on seeking treatment.²⁶

According a priority to obstetric fistula treatment and prevention at a national level may be necessary in some settings to minimize the damaging long-term effects of such a condition. The criteria underlying such a decision could be importance (responsiveness – it responds to a demand from a specific population group), effectiveness (vaginal repair surgery is relative simple and effective), and fairness (a vulnerable group in society – women – are suffering and being marginalized due to this health problem).



Severity can be determined by the effects of the health threat: acute or chronic, disabling effects, mortality, measured in quality-adjusted life-years (QALYs) and disability-adjusted life-years (DALYs).

The **urgency** of a problem may also be a reason for declaring it a priority. The justification would in that case be, for example, the threat of an epidemic outbreak (rate of spread, infectiousness). The recent Ebola epidemic required urgent priority interventions, not only in the three most affected countries (Guinea, Liberia and Sierra Leone), but also at a global scale. Containment of the outbreak in a region with poorly-functioning health and communication systems and porous national borders required large-scale emergency measures and health system recovery investments.

Responsiveness looks at the importance of the health intervention from the patient and population perspective, giving more weight to the demand side of the health system in the priority-setting process. Essentially, this criterion seeks to answer the question “is the health sector responsive to the needs and demands of patients and the population?” (see Box 4.4). The perception of people is accorded attention here, such that those health interventions that respond to population expectations will receive priority. Hence, health sector stakeholders, in applying this criterion, look at the extent to which the demand and preferences of the public are satisfied.

Besides these principles, there are other, subjective, value-based aspects to consider, such as the population perception of the relevance of a health issue.^{VII}

(b) Effectiveness of the intervention^{27,28}

This criterion considers how well, clinically or practically, the health issue can be solved, not only in terms of output, but also in outcome and impact. In other words: what is the likelihood that the selected strategy or priority will lead to expected results? What are the risks of the identified problem in terms of available technological and organizational solutions? What are feasibility considerations under the given conditions? Other terms often used in this context are: applicability, deliverability, sustainability. What are trends and developments? Examples include emerging technologies, human resource specialization and skill-mix issues.²⁹

When determining effectiveness, the “innovation” factor needs to be taken into account: has the strategy or intervention not yet been researched and tested (evidence-based), or is there an existing knowledge base that has already established effectiveness? One must keep in mind that a new solution may have proven technological effectiveness at a global level, but its effectiveness at country level needs to be assessed as well. For instance, is telemedicine adapted to the local context? Can telemedicine be made operational within the planned period? The same applies for organizational effectiveness. Example: Is decentralized governance sufficiently robust in terms of skills, systems and practices for introducing performance-based financing? What are potential limitations and barriers in implementing healthcare strategies? This means assessing the major forces shaping the service, including technological developments, manpower trends and health policy.

^{VII} See Chapter 2 “Population consultation on needs and expectations” in this handbook.

When the effectiveness of certain solutions is to be analysed, it is useful to distinguish between two types of situations.

- (i) The evidence base has not yet been established at the global level and will have to be created through scientifically-sound testing.
- (ii) The evidence base exists at global or international level, but the applicability and (cost) effectiveness needs to be verified for the local context. Eventually, the solution/intervention may need to be adapted. Also other issues of effectiveness, indirectly related to the problem, may need to be determined, such as communication capacity and geographical accessibility. For example, while the effectiveness of schistosomiasis prevention through pest control by the application of pesticides has been established at the global level, the effectiveness of this solution needs to be verified for each environment. Also the “strategic fit” for the proposed priority solution has to be verified. For instance, while the arguments for a progressive privatization of a certain type of hospital may be convincing, it will still be necessary to verify that this option is in line with other sector strategies. Questions which need to be answered include: do consequences of an ongoing administrative decentralization have to be taken into account? Are the existing price policies for service delivery in line with such a move? Establishing the evidence base at country level may require a study, pilot project or expert appraisal. Ultimately, the decision is often based on the judgement of a mixed group, composed by experts and non-experts alike, including those who are knowledgeable of and closely linked to the policy process.

The potential of new, innovative solutions must be weighed against the effectiveness of current interventions. Hence, an evaluation of the latter is necessary. In certain cases, an in-depth health technology assessment may be necessary.

The effectiveness and applicability of a solution is also determined by the acceptability of the intervention by the target population. Moreover, the availability of resources to execute the intervention will have to be evaluated. This will allow decision-makers to prioritize health issues that have evidence-based, viable and efficient solutions.

(c) Cost of the intervention^{30,31,32}

This criterion is about cost in the sense of affordability (How much does the NHPSP cost? Is it affordable?) as well as efficiency (a value-for-money assessment, which should cover both cost minimization and cost-effectiveness). Both the affordability and efficiency of the solution to address a health problem need to be carefully considered. In other words, this criterion encompasses the issue of whether the health intervention is affordable in absolute terms as well as the relative cost to the health sector, to the community and to individuals for tackling the health problem. The cost of the intervention must be economically feasible and economically sustainable.

An example is the proposal to establish a national health insurance. While for the health sector this may seem an obvious solution for solving the problem of catastrophic health expenditure, the feasibility and sustainability of a comprehensive insurance scheme will to a large extent depend

The effectiveness criterion considers how well, clinically or practically, the health issue can be solved, not only in terms of output, but also in outcome and impact.

The cost criterion is about cost in the sense of affordability (How much does the NHPSP cost? Is it affordable?) as well as efficiency (a value-for-money assessment, which should cover both cost minimization and cost-effectiveness).



on political commitment and the country's macroeconomic perspective.

Just as for the criteria importance and effectiveness, the quality of the cost analysis depends on the quality of the data and information available. Here, we not only mean cost-related data but also information on planned implementation insofar as it has cost implications. For instance, the strength of support systems in the health sector need to be taken into consideration, as it has implications on the cost of a health intervention, in addition to more classical clinical dimensions.

(d) Acceptability of the intervention

The acceptability of a priority health intervention refers to whether a community or target population accepts the chosen health intervention that addresses a priority problem.³³ It also refers to the willingness by those who will be carrying out the intervention to do so – for example, health service providers, MoH, and subnational health authorities. Acceptability can be further declined as social acceptability or cultural acceptability; to address this criterion, context-specific priority-setting is required.³⁴ Acceptability is strongly related to the applicability or feasibility of providing a certain intervention in a local setting.³⁵ On the service provider side, risk aversion and resistance to change can effectively hinder any policy or intervention – reasons cited are often a reduction of revenues or an increased workload. From the government side, a new priority may create resistance from civil servants and administrators if it represents an additional workload with perceived little added value. It is therefore all the more essential to

ensure solid policy dialogue with all stakeholder groups from the outset to raise, discuss and clarify concerns.

If a priority health intervention naturally goes against social and cultural norms, it has a low chance of success, unless specific interventions addressing the issue of social or cultural acceptance are undertaken. Priority-setting thus requires evidence on the nuances of social and cultural acceptability, and underlying factors which may affect the success or failure of the health intervention.³⁶ In the national health planning process, community perceptions of acceptability need to be considered at every stage, and especially so during the priority-setting stage.³⁷ A district health management team member from Kenya explains exemplarily:³⁸

“We also look at specific health problems in a given area. For example, if there is a lack of pit latrines in a specific area due to cultural beliefs that a daughter and a father cannot share the same toilet, we design programmes together with the people to ensure that the programmes are relevant and acceptable to them. So we rely on data and reports from the people.”

Another eye-opening example of the influence of cultural and societal factors on the success or failure of priority health interventions is female genital mutilation (FGM) and interventions aimed at reducing or eliminating the practice. FGM, the act of partial or total removal of a female's external genitalia, is a deeply rooted societal, cultural, and religious tradition. In order for FGM to be successfully eliminated, communities themselves must decide to abandon it and adopt behavioural change.³⁹ Health education programmes must be sensitive to cultural and

Acceptability
can be further
declined as social
acceptability
or cultural
acceptability.

religious concerns of the community or run the risk that information will be taken as offensive and more deeply entrench the practice that workers are trying to dismiss. For instance, a health programme that immediately lists the reasons why FGM has no health benefits in a community that has religious leaders supporting it as an act of faith may view the health programme as a threat to their religion. The most successful interventions are those that are participatory, allowing communities to create their own solutions and involving many families in the community so that collective change is made. No matter what intervention is used, programmes that maintain a mindset of cultural and social awareness will be more successful for long-term elimination efforts of FGM.

(e) Fairness^{40,41}

The notion of fairness is defined by the quality of treating people equally or in a way that is right or reasonable.⁴² Put in other words, it is “the state, condition, or quality of being free from bias or injustice”. It is based on principles such as equality and equity. Fairness must be brought into a priority-setting discussion, as it is closely linked to the judgment and trade-off on the importance of a health need and the effectiveness of an intervention. It also influences the decision regarding how much weight to give to the cost of its solution. For instance, a health problem may mainly affect people with an income level that is too low to assure healthy living conditions and financial access to health care. A health problem may also be particularly prevalent amongst populations living in a hazardous environment. In

other circumstances, a particular segment of the population may be at risk because of their unhealthy lifestyle (dietary habits, drug abuse, etc.). In all of these cases, the fairness criteria might lead to a decision to give priority to the health problems of these population subgroups, even though their health need represents a minority of the population, and even though the treatment of this health problem is not the most cost-effective (see Box 4.5).

Another subjective element linked to fairness which has risen in prominence recently is the “rule of rescue” (RoR) concept, especially when examining the cost effectiveness evidence for intervening early in life. The RoR is a commonly and strictly felt duty to “rescue the doomed”, i.e. those with a life-threatening condition. The imperative to rescue is, undoubtedly, of great moral significance, making RoR a predominantly ethical issue linked to the sentiment that those who are “doomed” need special attention and must be “rescued” on grounds of fairness. RoR in health care is commonly invoked as a constraint on cost benefit evaluation, but quite often it may prove the opposite: for example, rescuing patients from a fatal disease prevents patients’ premature death. Restoring them to good or full health will “produce” a large number of QALYs.⁴⁸

The RoR concept highlights the ethical dilemma between the two principles “sickest-first” and “maximizing aggregate benefit” (cost benefit). Examples of RoR-principled therapies are renal dialysis and second-chance transplants. Examples of interventions that receive lower priority according to the RoR logic are prevention programmes such as diagnostic screenings.

Fairness is based on principles such as equality and equity. Fairness must be brought into a priority-setting discussion, as it is closely linked to the judgment and trade-off on the importance of a health need and the effectiveness of an intervention. It also influences the decision regarding how much weight to give to the cost of its solution.



Box 4.5

The fairness criteria applied to priority-setting: health investments to marginalized vulnerable populations: the case of the Australian indigenous population

Discernment of what is considered “fair” in priority-setting is sometimes a challenge to perceive. It is a value judgment that a government and society makes collectively. In Australia, it was recently decided to focus public health efforts and resources on the indigenous populations, for objective reasons such as their poorer health status, but also for reasons of fairness (based on principles of equality and equity) linked to decades of having less opportunities and being marginalized.

Indigenous people make up approximately 2.5% of the entire Australian population (with 90% of that group identifying as Aboriginal), in other terms over 710,000 individuals, one third of them under the age of 15.⁴³ Obvious health disparities exist between indigenous and non-indigenous populations.⁴⁴ Thirteen per cent of indigenous people report some form of cardiovascular disease, 33% are affected by respiratory disease, and communicable diseases are more prevalent in indigenous groups than non-indigenous groups. Smoking rates are twice as high for indigenous people than for non-indigenous people.³² Furthermore, a large number of indigenous groups

have poor accessibility to health services, and are often not treated with welcome and quality care in centres even when they do have access.^{33,32}

Through the national health planning process, the Australian government decided to establish a separate fund for indigenous health-care in efforts to close the gap and ensure equity, thus clearly giving indigenous health an unequivocal priority. The health sector spends 18% more per capita for indigenous than for non-indigenous people, accounting for 3% of the national expenditure on health, and the funding levels for indigenous health continue to grow.^{45,46} From 2014–2018 the Australian government plans to spend \$A 3.1 billion on indigenous-specific health care and programmes, a 16% increase from the 2009–2013 expenditure.⁴⁷ As part of the Indigenous Australians’ Health Programme, an updated funding allocation methodology was established to assure investments were directed to the areas of most need, focusing on four different areas: primary health care, child and maternal health, chronic diseases, and a stronger future in health.

4.5.2 Contextual factors

Priority-setting will depend on a number of contextual factors, including political processes and influences, at both national and international levels.

(a) A comprehensive whole-of-government approach

When strategizing for health, including when priority-setting, a sector-wide comprehensive approach has many advantages. First of all, it assures comprehensive and integrated planning for the whole health sector. This means that priority-setting is done for all sector aspects, levels and interventions together. In this way, comparative importance and opportunities are taken into account. Secondly, various stakeholder groups are involved in the priority-setting. This ensures that those who are directly concerned (programme and facility managers, supporting organizations and health system users) contribute in the selection of priorities. Thirdly, a comprehensive sector-wide approach reinforces national (MoH) leadership which, in the context of a priority-setting exercise, enhances country ownership of the priority-setting results. In short, priority-setting in a comprehensive sector-wide approach can lead to improved effectiveness, efficiency, broad commitment and acceptability, and therefore sustainability.

Many countries have stated their adherence to the principles of a comprehensive planning approach and of the Paris Declaration. Many also signed the IHP+ Global Compact and have developed a national Compact.⁴⁹ Still, even if concrete commitments in a country's health policy and strategic framework reflect adherence, this does not guarantee that the scope, approach and methodology of medium-term

priority-setting for the health sector will be genuinely sector-wide and based on broad stakeholder inclusiveness. For this to become reality, effective stakeholder consultation and coordination mechanisms must be in place with clear principles and procedures for joint decision-making. Secondly, comprehensive sector information, analysed and synthesized, must be shared. This demands clear and strong MoH communication. Last but not least, strong national leadership is required to lead the priority-setting, with MoH proactively managing the process. Here, challenges may include avoiding a politicized environment in priority-setting and withstanding undue pressure from powerful and potentially generous external partners.

(b) Politics and political climate at national level

Priority-setting is inherently a political process. The need to invest in getting all relevant stakeholders on board and ensuring political buy-in cannot be emphasized enough. In addition, the general political climate and political party programmes are an important underlying aspect which needs to be taken into consideration.

In the end, citizens, through their governments will determine which health issues are addressed in policy and the allocation of resources within the health system. Political opportunities such as elections or a change in government can greatly impact the nature and methods used on setting priorities within the health sector. Also, the influence of various types of lobbies (including pharmaceuticals, donors, and civil society) is not to be underestimated. In countries where national level governance has been weakened due to political turmoil, special care must be taken to ensure that the population's health

The time and resources necessary to invest in getting all relevant stakeholders on board and ensuring political buy-in cannot be emphasized enough.





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4.5.3 Approaches, methods and tools

remains the strong focus. Even though politics will certainly be omnipresent in priority-setting, health sector stakeholders should ensure that evidence and hard facts are at the centre of the political debate.

(c) International policy relevance

Issues of international policy relevance – whether as a debate, an agenda or a firm national commitment – need to be considered. For example, environmental protection is a key theme in the global debate. The consequences of air/water/soil pollution and of climate change include threats for the health of the concerned populations. Ideally, this would mean that an environmental goal such as the reduction of carbon monoxide levels should also be reflected in priority-setting for health. Similarly, international commitments with regard to the protection of human rights could be reflected in the explicit protection of marginalized groups against discrimination and further marginalization with regard to the accessibility of health care. Regional disturbances and warfare may lead to a sudden massive migration/exodus which would unexpectedly affect health care in neighbouring countries. Another aspect that needs to be taken into account is the pressure of industrial and trade policies on global health policy-making.

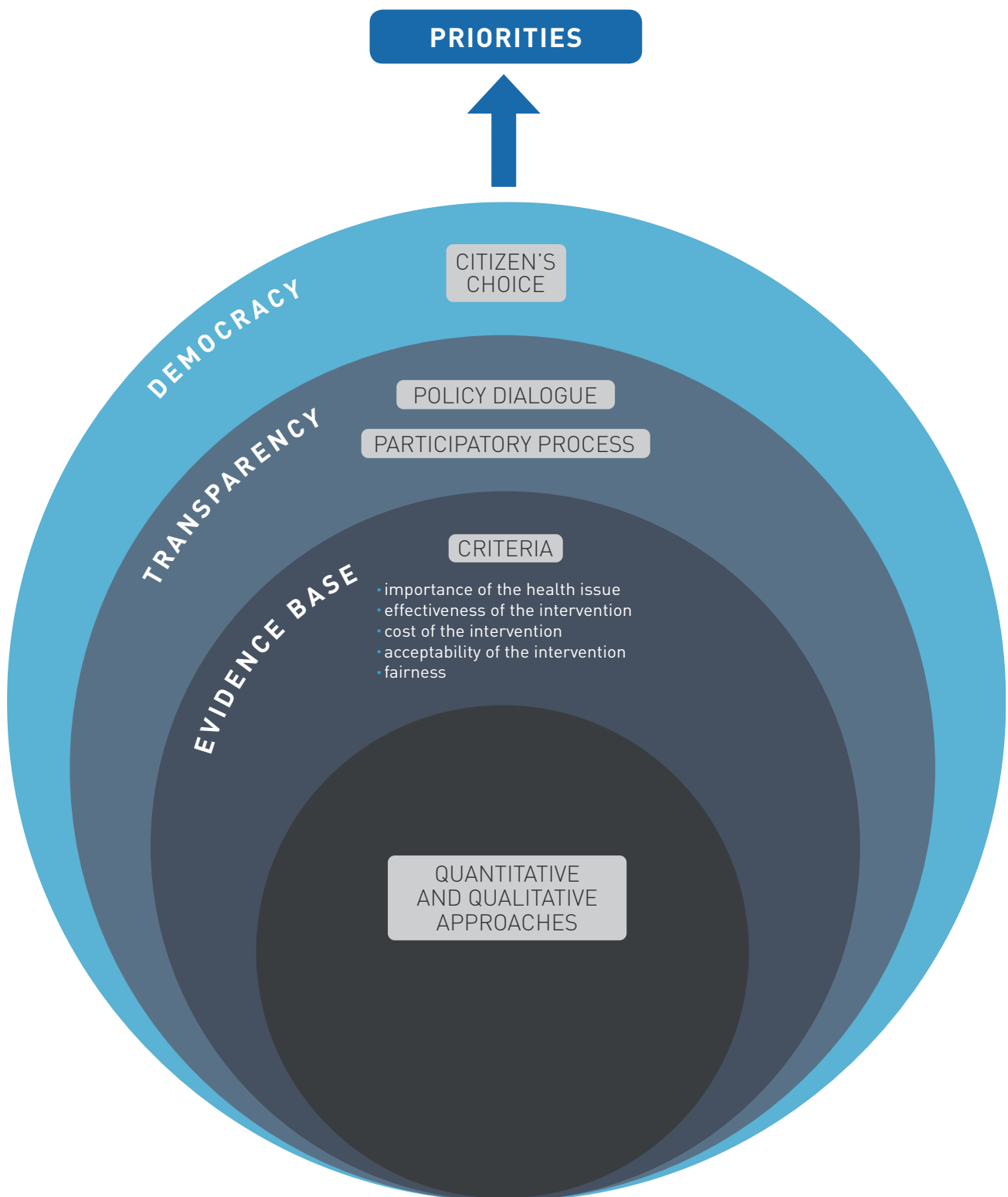
The literature describes a variety of approaches and hybrids of approaches and models, all of which figure on a continuum that goes from technical to value-based (see Fig. 4.3). A technical approach attempts to analyse the available data and evidence to provide a rational basis for a priority-setting decision. A value-based approach has a strong subjective element, with the foundation for the priority-setting decision based on a judgment of the rightness or wrongness of a certain principle (examples of such principles are “equity”, or “health as a human right”). Please note that many priority-setting methods are a mix of both a technical and value-based approach.

A recent comprehensive literature review discusses a long list of existing approaches, mostly for the technical side of the continuum: Accountability for Reasonableness, multi-criteria, decision analysis, public budgeting and marginal analysis, multidisciplinary approach, business case approach, saved lives, investment case approach, balance sheet combined normative-empirical approach, public participation approach, mixes of qualitative and quantitative approaches, the local level diamond model. The review concluded that no particular approach could be confidently recommended, suggesting that the advantages and limitations of each of these approaches should be weighed in relation to the local situation and context.⁵⁰

Technical approaches such as burden of disease and mortality analyses would be situated at the rational end of the continuum because they are evidence-based and because the methodologies have been tried and tested. Economic evaluation techniques, such as cost-effectiveness analysis (CEA) and published clinical trials are also situated at the rational end. Tools such as the



Fig. 4.4 Citizens must be empowered through democracy, transparency, a real policy dialogue and participatory process, supported by evidence



Basic Priority Rating System and the 2x2 grid (see Annex 4.1 for more information on all of the mentioned tools and approaches) are also technical approaches. The future projections approach or risk factor approaches already move somewhat to the centre of the spectrum because certain assumptions may be used that already bring in a subjective element. The social solidarity approach finds itself at the value-based end, because priority-setting is based on ethical and moral aspects, judged by the society or country that is setting priorities. Approaches that are seen as quite strongly value-based are population consultation and the multivoting technique.

That being said, ethics and moral values are never completely absent from a priority-setting process. They are often invoked to mobilize support for various health initiatives, and theories of social justice are often applied to assure fair and equitable treatment of people.⁵¹ A priority-setting process will always involve both a theoretical, rational approach and a value-based approach in some way, shape, or form.

Value-based approaches are sometimes also referred to as deliberative approaches, because values are weighed and judged by selected stakeholders who “deliberate” on the priorities.

In this chapter, at several places, the argument is made for choosing a combination of several approaches and tools. The reason is clear: used in isolation, none of the approaches is able to examine priority options from different angles, while parallel analyses, with different

methods, used by different actors, provide a more comprehensive perspective on questions of the relative importance of a health need, on the potential of a particular solution and on the fairness of a strategy. Also, since the priorities in this context are being ultimately set by the public sector (even if input from private sector and others is actively solicited), it is important to note that the principles, objectives and issues are multiple from the public sector perspective. This calls for putting different arguments and views in balance with one another, which is best done when evidence from a combination of approaches and tools are examined.

In the literature, the distinction between approaches, models, methods and tools used in priority-setting is not always uniform. We use “approach” to mean a particular way of thinking about or dealing with something or someone in space, time, quality or amount, or, more simply: direction and ways of getting to a common goal.

In this handbook, the term “method” stands for a procedure, technique, or way of doing something, especially in accordance with a definite plan. A “tool” is defined as an item or implement used for a specific purpose. The criteria for priority-setting put forth in this handbook should be part of and feed into the decision of which approach(es) is/are chosen.

This section will start with a brief reminder of the key elements and goals of UHC (see Box 4.6), after which several aspects of both technical and value-based approaches are discussed.

Used in isolation, no single approach is able to examine priority options from different angles, while parallel analyses, with different methods, used by different actors, provide a more comprehensive perspective on questions of the relative importance of a health need, on the potential of a particular solution and on the fairness of a strategy.

Box 4.6

Examples of policy priorities in line with the three UHC dimensions

For the technical approach

- ▶ *Maximizing service delivery:* strengthening the gate-keeper function in hospitals.
- ▶ *Reaching vulnerable, marginalized and hard-to-reach populations:* establishing mobile primary health care (PHC) services for hard-to-reach communities.
- ▶ *Improvements in financial risk protection:* adopting a pro-poor price policy and preference for generic drugs.

For the value-based approach

- ▶ *Maximizing service delivery:* focus efforts on the prevention of neglected infectious diseases.
- ▶ *Reaching vulnerable, marginalized and hard-to-reach populations:* prioritize extension of the facility network in rural, remote areas.
- ▶ *Improvements in financial risk protection:* introducing free of charge care for vulnerable high risk populations.

In the following sections, various priority-setting approaches are discussed. All of them help assess the potential for solutions to health problems and health sector bottlenecks against the key criteria for prioritization, mentioned earlier.

Technical approaches are used for assessment and ranking of:

- (i) health needs;
- (ii) health technology effectiveness; and
- (iii) cost-effectiveness and affordability.

Fairness is judged through value-based approaches.

Technical approaches

The technical approaches most widely used are described briefly here, with a short mention of the advantages and disadvantages. More detailed information on each of the methods is in Annex 4.1.

Health needs

Identification and ranking of health needs (problems and threats) should be based on an approach that analyses both the importance of diseases and the importance of their determinants. This is notably important because the combined approach gives more insight into the vulnerability of a health problem/threat, and subsequently guides the weighing of options to address it. For example, if under-five children frequently suffer from diarrhoea, an assessment

of socioeconomic health determinants may link this problem to poverty and to poor water and sanitation infrastructure. The solutions for these determinants exist but are not the mandate of the health sector. Nevertheless, priority-setting should include strategies and interventions to collaborate with other sectors as well.

Three analyses often used to look more carefully at health needs are burden of disease analysis, health needs assessment, and the 2x2 grid.

(a) Burden of disease analysis (BoD)

The burden of disease analysis encompasses a broad range of assessments from multiple data sources to determine health loss from diseases, and its attribution to specific risk factors. Even though this analysis is specific to disease-related health issues, it can also help inform priority-setting in health system related issues. The advantages of using BoD are that, with consistent methods, it critically analyses available information on each health condition, makes this information comparable and systematic, and produces results using standardized metrics.

(b) Health Needs Assessments (HNA)

A HNA involves epidemiological, qualitative, and comparative methods to describe health problems of a population. It may be undertaken as part of the situation analysis phase when routine data and existing information are insufficient for purposes of ranking health needs. For

individual practices and health professionals, HNA provides the opportunity for describing the patterns of disease in the local population, differences between districts, regions and national disease patterns, while highlighting the areas of unmet need. It also allows for learning more about the needs and priorities of the local population. It provides a clear set of objectives to work towards to meet these needs and helps to decide rationally how to use resources to improve their local population's health in the most effective and efficient way.

(c) 2x2 grid

The 2x2 or strategy grid uses need and feasibility criteria to determine which health priorities yield the greatest results. The grid organizes health problems using two dimensions, need and feasibility, to form a quadrant. The combination of a health problem and its solution can be classified either as of

- (i) low need/high feasibility,
- (ii) high need/high feasibility,
- (iii) high need/low feasibility, or
- (iv) low need/low feasibility.

An example can be found in Annex 4.1. This grid helps to refocus efforts by shifting emphasis towards addressing problems in a manner that will yield the greatest results. This simple tool may assist in transitioning from brainstorming with a large number of options to a more focused plan of action and can be used also by stakeholder groups with limited capacity.





Health technology assessment (HTA)

HTA is a multidisciplinary form of research used to generate evidence about the performance of health technologies. One of the main pieces of analysis undertaken in HTA is the cost-effectiveness analysis; in addition, it looks at identifying new technologies for health problems. HTA works under an explicit legal and

institutional framework, aiming to channel and manage political, commercial, advocacy and donor interests fairly and ethically.

More recently, HTAs have focused more attention to the assessment of weaknesses and inefficiencies in existing interventions. In the

same way, HTAs increasingly take into account the country's broader development context, visions, and goals; for instance, the quest to move towards UHC. A comprehensive HTA thus may be the technical approach which provides the most comprehensive set of evidence for priority-setting.

When doing a comprehensive HTA of a programme, one may be tempted to expect that all the technologies of that programme have a high score on cost-effectiveness. This is not always the case. For example, while the strategy for screening may be cost-effective, certain palliative technologies may not be. Therefore, when prioritizing between programmes, it is recommended to do a HTA separately for each individual health technology. Within a programme HTA may be done, for example, for devices, drugs, procedures and/or systems. Similarly, a cancer-control programme usually includes a variety of technologies, for prevention interventions, screening, early-detection, diagnostics, therapies and palliative treatment.

Cost-effectiveness and affordability

Maximizing health is usually the goal of health policy-makers. Economic considerations in priority-setting are important for furthering such goals. Economic models and their measurements offer the decision-maker a rational approach to making policy choices to maximize health.

Cost effectiveness analysis

The main type of economic evaluation is the CEA, which compares the cost of a potential health intervention with the expected (or in some cases, known) health gain. CEA is a powerful tool for priority-setting; from an economic perspective,

it looks at the problem of choosing the optimal portfolio of programmes that can be afforded from a limited national healthcare budget. It forces the decision-maker to define explicitly the objectives of the priority-setting process, even if these cannot be easily measured. CEA promotes value for money in health in order to allocate available resources. CEA can be a central factor for decision-makers when choosing health issues to prioritize. An economic perspective recognizes that the priority-setting process will often involve a series of conflicts, but instead of obscuring such conflicts, it provides a framework for their exploration, and trade-offs can be made explicit.

CEAs are popular with the public health community because the method offers a coherent measure of benefit while avoiding the difficulties involved with the valuation of health. The value of health can be seen as the "price" of health multiplied by its quantity. However, this "price tag" is based on the most obvious health benefit, i.e. those that can be easily expressed in mortality, disability avoided, etc. The caveat here is that it may lead to a narrow focus on benefits related to health care only, rather than broader health-related development goals. It is more difficult to attach a value to some of the broad development goals which influence health.

It is important to keep in mind that despite many decades of advancement in addressing the technical and methodological issues, it is widely recognized that economic models such as this one should be put in context and combined with other approaches in order to paint a more complete picture of health sector priorities.

The traditional economic approach proposes maximizing health gain (however measured) subject to a budget constraint, which implies ranking

Cost-effectiveness analysis is a powerful tool for priority-setting; from an economic perspective, it looks at the problem of choosing the optimal portfolio of programmes that can be afforded from a limited national healthcare budget.



programmes according to their cost-effectiveness ratio. The traditional approach generally ignores the numerous practical constraints arising from the political, institutional, and environmental context in which priority-setting takes place. A few such limitations to keep in mind when undertaking CEA are listed below.⁵²

Methodological concerns include identifying whose perspective to adopt, the generalizability of results to multiple settings, the treatment of uncertainty and timing, and the treatment of interactions between programmes.

Equity considerations are either related to some concept of need or related to access to services. However, it has been reported that many contributions to the debate on equity concepts are theoretical and remote from practical implementation issues.

Practical constraints arise from the political, institutional, and environmental context in which priority-setting takes place. These include the influence of interest groups, the transaction costs associated with policy changes, and the interactions between the provision and financing of health services.

The following tools look at either cost or effectiveness or cost-effectiveness; they do not explicitly put effectiveness/feasibility in relation to the local context. Especially in settings of weak, poorly-managed institutions and insufficient capacities, context should be taken into account in other ways within the priority-setting process.

(a) Lives Saved Tool (LiST)

LiST is a software tool used to model the impact of scaling-up health interventions aimed to reduce mortality and morbidity in mothers, newborns, and children under five years of age. It allows users to set up and run multiple scenarios, called projections, in order to estimate the impact of different health intervention packages based upon coverage at the national or subnational (e.g. region, state, or district) level.

(b) Basic Priority Rating System (BPRS)

The BPRS, also known as the Hanlon method, helps to quantify public health problems. It proposes a priority rating, based on attributing scores from 1 to 10 for three sets of variables on

- (i) weight;
- (ii) severity, urgency, economic consequences, and willingness/involvement of others);
- (iii) the effectiveness of the intervention. The tool is used by health administrators and decision-makers and uses various data in order to quantify public health problems and set reasonable priorities.⁵³ Though a complex method, the Hanlon method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

(c) Propriety, Economics, Acceptability, Resources and Legality component (PEARL)

The PEARL⁵⁴ rates preselected priorities on five factors of feasibility. These factors are not directly related to the health problems; how-

ever, they contribute greatly to deciding which priorities should be addressed. PEARL can be used in combination with BPRS. The PEARL component requires sufficient data about both the characteristics of the health problem and the target population.

(d) Programme budgeting and marginal analysis (PBMA)

This economic framework can be used to set priorities in health by examining how resources are currently spent and subsequently linking those expenditures to possible marginal health gains. PBMA relies on an advisory panel, which is charged with identifying areas of health service growth (for a given budget cycle) and resource distribution (to fund proposed growth). It is usually carried out within or across interventions for comparison.

Value-based approaches

Value-based approaches are used for the assessment and ranking of the fairness criterion. Fairness is the principle that all members of society should have guaranteed access to adequate health care.

Social value judgements are an important element in any public justification of how priorities are set. Some key ethical values underpinning priority-setting exercises are listed below.

Equity through solidarity: solidarity is both a shared moral sentiment and norm, arising from the sense of belonging. It is expressed in the union or fellowship of a community that

shares feelings, purposes, or responsibilities and interest. Solidarity implies that, on a voluntary basis, the community helps the disadvantaged (equity).

Rights, societal obligation, and self-interest: this argument asserts that basic human needs (such as food, shelter, education, justice) create an obligation on society to provide some level of common access to these fundamental goods. The obligation is acceptable because of the self-interest of the society members. Access to health care is an element of the common good.⁵⁵ **Social wisdom:** directs us to shape our systems of health care so that we accomplish what we value. Social wisdom is the society's implicit recognition of how it perceives health and what it values in health care. Such a foundation of common understanding and consensus guides national policy-making and planning. In its absence, a narrow focus, for example, on medical care access, would prevent society from focusing on social and economic factors that lead to major public health problems.

Social value judgements are an important element in any public justification of how priorities are set.

In addition to the above, the following can also be seen as formal values which play a role in priority-setting in specific contexts: legality, faithfulness to constitutional provisions and respect for international obligations.⁵⁶ Expressed in trust and accountability, these can be easily formalized.⁵⁷

Furthermore, there exist some classical ideologies coming from the economics field that are essentially linked to the above-mentioned values of equity through solidarity and fairness. Priority-setting exercises in some countries may be rooted in one of these ideologies, albeit not necessarily explicitly.⁵⁸



While the research and analysis for technical/rational approaches can be left to professionals, value-based approaches subjectively weigh formally adopted as well as perceived values.

Libertarianism considers personal responsibility for achievement as very important and that this is weakened when others are offered unearned rewards.⁵⁹ This would be the case for instance, when certain risk groups are entitled to specific privileges in health care in terms of access or price.

Utilitarianism claims that pleasure promotion and pain avoidance could be measured and that interpersonal comparisons of utility could be made. Utilitarians are often criticized for ignoring individual freedom. Indeed, when only consequences matter, methods used can be questionable.⁶⁰ The utilitarian approach is not considered fair, because it is solely based on the framework that “greatest good is for the greatest number”. Critics argue that preferences used for valuing health outcomes should be representative of the entire at-risk population, with due regard for the sentiments of minority disadvantaged groups such as the disabled. Therefore, valid scientific evidence on differential outcomes must exist.

Egalitarianism calls for the most equal distribution of available goods. Economic failure is not equated with moral depravity or social worthlessness. The destitute are not to be punished for alleged economic failure by limiting their access to goods. A “difference principle” calls for every arrangement to be evaluated in terms of the interest of the least advantaged. Alternative arrangements are compared first from the interest of the least advantaged only. If the least advantaged are equally badly off in two different health intervention options, then it is the situation for the second least advantaged that matters, etc.

While the research and analysis for technical/rational approaches can be left to professionals, value-based approaches subjectively weigh formally adopted as well as perceived values. They therefore seek representative working groups and/or public engagement. The latter is captured in the literature under the term “deliberative approaches”.

Deliberative approaches in weighing ethical values for priority-setting is about public involvement. It can be defined as an approach that seeks to actively involve citizens in the process of formulation, passage, and implementation of public policies through action aimed at influencing decisions. It is acknowledged that, in most cases, policy decisions are ultimately taken by public representatives and officials so the focus is on the interaction between citizens and those making health care decisions.⁶¹

A literature review on public participation in health care priority-setting found that there is a growing interest in deliberative approaches. However, formal evaluation efforts of deliberative approaches are rare. Also, it is unclear how public views might be integrated with other decision inputs when allocating social resources.⁶²

A process for deliberative priority-setting must meet four necessary conditions:⁶³

- ▶ it must be relevant to the local context as determined by accepted criteria;
- ▶ its eventual decisions – and the reasons behind them – must be publicized;
- ▶ it must include appeal mechanisms for challenging, revising, and reversing decisions its leaders must be able to enforce the above three conditions.

Examples of deliberative approaches are:

(a) Citizen consultation processes

Citizen consultation can capture a population's demands, opinion and expectation on health-related matters in order to improve the transparency and relevance of the priority-setting process. Please refer to Chapter 2 on population consultation for more detail.

(b) Accountability for Reasonableness (AFR)

Accountability for Reasonableness (AFR) is an ethics-based approach to a legitimate and fair priority-setting process that builds upon key conditions that must be fulfilled to gain support for their implementation.

Multi-stakeholder finalization and validation

Validation means the formal adoption of the priority agenda and this is the final stage of priority-setting. Decision-making on how to translate priority choices into planning and resource allocation will be discussed in the following chapters.

(a) Multivoting technique (MVT)

The multivoting technique (MVT, also known as nominal group technique, NGT), is notably used to make collaborative decisions when the list of propositions is long and team members have differing opinions. Based on a more or

less exhaustive list of options (ideas, problems, issues or solutions) produced in a brainstorming session, it seeks to ensure a good and common understanding of the items in the list. Each idea is then jointly defined by the team members in clear terms, so as to ensure that all participants have a fair idea of what each item means. Ideas are grouped or merged and a few new, related ideas may be added. The team then reduces the total number of items that can be voted for to about one third of the initial number. The last step of voting should result in a consensus. This method is also useful in the early stages of priority-setting and works best for smaller group processes.⁶⁴

(b) The Delphi technique

Just as the MVT, the Delphi method is a type of consensus method. Through questionnaires, a panel of independent experts is consulted over two or more rounds. Whereas focus groups purposely use group dynamics to generate debate on a topic, Delphi methods maintain anonymity of the participants, even after the study. The most important advantages of this technique are:

- (i) a rapid consensus can be achieved,
- (ii) participants do not have to be in the same room together to reach agreement,
- (iii) individuals are able to express their own opinions as opposed to "Group think",
- (iv) consultation can include a wide range of expertise, and
- (v) relatively low cost to administer and analyse.⁶⁵



(c) Multi-criteria decision-making (MCDM)

MCDM is a quantitative decision analysis model that captures preferences of decision-makers and discovers the most desired solution to the problem (see Box 4.7). It is a hybrid method in that it incorporates both technical and value-based approaches.⁶⁶ It is based on a performance matrix where each row describes an option and each column describes the performance of the options against each criterion. To do so, five criteria are applied: maximization of general population health, the distribution of health in the population, specific societal preferences, budgetary and practical constraints, and political considerations.

All the above tools, and others not mentioned here, have a variety of purposes and objectives. They can be used at various stages of the priority-setting process in health. Each of them has advantages and disadvantages. The majority can be used as a stand-alone tool, but they can also be used in conjunction with one another. Traditional methods, such as evidence-based medicine, burden of disease analyses, cost-effectiveness analyses (classical method) and equity analyses concentrate on a single criterion, whereas in reality, policy-makers need to make choices taking into account multiple criteria simultaneously. Advantages and disadvantages of various methods and tools are summarized in a table in Annex 4.2 together with a list of limitations of traditional single criteria methods.



Box 4.7

Economic justification for public funding targeted at the whole population or the poor only⁶⁷

Governments often attempt to provide free services to the whole population, and often spend resources on low-impact services. A study proposed a rational approach to targeting and prioritization of public spending in Ghana in order to better balance equity and efficiency in the country. It employed the priority-setting approach MCDA analysis on the following criteria: number of potential beneficiaries, severity of disease, cost-effectiveness, poverty reduction and vulnerable population. The study considered a selection of interventions related to childhood diseases, communicable diseases, noncommunicable diseases, reproductive health and injuries.

First, interventions were tested against the economic justification for public funding to define to whom spending should be targeted. Second, resulting interventions were prioritized on the basis of medical and non-medical criteria. A rank ordering emerged of interventions with a specification on whether public spending should be targeted at the whole population or the poor only. For example, whereas improved complementary feeding in childhood would be given low priority on the basis of cost-effectiveness alone, it would receive much higher priority when severity of disease, its number of potential beneficiaries, the vulnerability of children,

and its potential for poverty reduction would be taken into account as well.

The MCDA resulted in the following disease control priorities: prevention of mother-to-child HIV/AIDS transmission, and oral rehydration therapy to treat diarrhoea in childhood. Therefore, public funding of these interventions was warranted for the whole population. However, case-management of pneumonia in childhood was also considered a priority, but public funding was to be targeted at the poor only.

The study concluded that the application of MCDA in the priority-setting process of health interventions can help health systems to move towards a more equitable and efficient use of resources and that, in Ghana, it was a step forward to transparency and accountability in policy-making. However, it was recommended that policy-makers should not only use such a formulaic approach to prioritize interventions, because here only criteria that were amenable to quantification were analysed. It was stressed that addressing also non-quantitative concerns through a deliberative process to reach consensus (when possible) by different stakeholders was also warranted.



4.5.4 Process

The success of the priority-setting process depends on an honest debate to forge a common understanding of the criteria and approaches to use for priority-setting.

Priority-setting is one of the crucial stages of the national health planning process because it links the results of a health sector situation analysis with the strategic orientations of a national health strategy. Its success depends on an honest debate to forge a common understanding of the criteria and approaches to use for priority-setting. Decision-makers must agree on the interpretation of key concepts and make those interpretations transparent. It is important to ensure that all stakeholder groups understand what they will gain through their active participation in a medium-term sector priority-setting exercise for it to be successful.

Different interpretations of key notions like health, health risk, disease, quality of life or necessary care can lead to different decisions regarding the health sector interventions to prioritize (see Box 4.8). Decision-makers must agree on the interpretation of key concepts and reference standards used. A choice must be taken whether a narrow (biological) or a broad (bio-psychosocial) interpretation of health and disease is to be applied, and which standards of normality and abnormality (minimum, average or optimum) will be applied with regard to the (expected) quality of life.

Box 4.8

Differences in attitudes between national health workers and donors in weighing cost-effectiveness and severity of disease in Uganda?⁶⁸

In Uganda, the relative preference of key players in priority-setting was studied with regard to two criteria: cost-effectiveness of interventions and severity of disease. Respondents of the questionnaires were health actors at national, district, and health subdistrict and facility levels: health workers, development partners or donors and politicians. Above 90% of the respondents recognized the importance of both severity of disease and cost-effectiveness of intervention. In the three scenarios where they were to choose between the two, a majority of the survey respondents assigned highest weight to treating the most severely ill patient with a less cost-effective intervention. However, in in-depth interviews, international development partners preferred the consideration of cost-effectiveness of intervention. The study recommends that discrepancies in attitudes between national health workers and representatives from the donors should be openly debated to ensure legitimate decisions.

Steps

The following steps are suggested for the priority-setting process.⁶⁹

1. Adopt a clear mandate for the priority-setting exercise.
2. Define the scope of the priority-setting and who will play what role.
3. Establish a steering body and a process management group.
4. Decide on approach, methods and tools.
5. Develop a work plan/roadmap and assure availability of the necessary resources.
6. Develop an effective communication strategy.
7. Inform the public about the priority-setting and engage internal/external stakeholders.
8. Organize the data collection, analysis and consultation/deliberation processes.
9. Develop or adopt a scoring system.
10. Adopt a plan for monitoring and evaluating the priority-setting exercise.
11. Collate and analyse the scores.
12. Present the provisional results for discussion; adjust if necessary.
13. Distribute the priority list to stakeholders.
14. Assure the formal validation of recommendations of the priority-setting outcome.
15. Plan and organize the follow-up of the priority-setting, i.e. the decision-making steps.
16. Evaluate the priority-setting exercise.



B. Nội dung

1. Anh/chị cảm nhận những thiếu hụt nhóm kiến thức gì cho công việc so với chức năng thể phân tuyến mà anh/chị phải thực hiện

Chuyên môn

Tư vấn, truyền thông giáo dục sức khỏe

Thực hiện chương trình y tế quốc gia

☐ Khác (ghi cụ thể)

khẩn, thách thức về lĩnh vực chuyên môn mà anh chị hay gặp (có thể có nhiều)

sắp xếp theo thứ tự ưu tiên giảm dần như cấp cứu ban đầu, tư vấn, chăm sóc ...)

3. Anh chị có thường xuyên cập nhật kiến thức chuyên môn không?

~~8~~ C6

☐ Không

4. Anh/chị thường cập nhật kiến thức chuyên môn bằng cách nào

☐ Tham gia các khóa học ngắn hạn

☒ Tham gia các buổi tập huấn chuyên môn

☐ Tham gia giao ban chuyên môn

☐ Đọc sách chuyên ngành

☐ Tra cứu tài liệu trên mạng

☐ Khác (ghi cụ thể)..

5. Anh chị có nhu cầu tham gia các khóa tập huấn, đào tạo lại, cập nhật kiến thức một lựa chọn phù hợp)

Ca

Đ. Các chương trình dạy và học khác nhau

Đã thông báo bằng văn bản cho các đơn vị liên quan thực hiện.

Đến tháng 12 năm 1960, Đảng bộ và nhân dân tỉnh đã hoàn thành kế hoạch năm, vượt mức 10,5% so với kế hoạch năm.

Đường thẳng phân biệt hai đường thẳng song song

2. 1000000

4.6 Common challenges and factors of success

4.6.1 Constraints and challenges

Several constraints have been observed in priority-setting. Some of these are rooted in a given country's overall political, institutional or legal context, while others are health system related. There are also process-related constraints.⁷⁰

Context constraints

- ▶ Weaknesses in the country's legal frameworks may hamper implementation and monitoring and evaluation (M&E) of national policies, as well as adequate leadership and governance, notably in terms of transparency and accountability.
- ▶ Insufficient intersectoral coordination and collaboration, due to weak institutional frameworks, may cause inadequate priority-setting and may result in incompatible decision-making on public and donor budgets.

Health system constraints

- ▶ A poorly functioning health sector information system, marked by incomplete and flawed data, may lead to erroneous conclusions regarding the relative importance of health problems and the effectiveness of strategies. If the health system lacks the necessary entrepreneurial spirit and learning culture, the priority-setting exercise may become a formality that will not effectively provide guidance for further sector development.
- ▶ Incomplete legal frameworks for the health sector and unclear decision-making procedures may hamper programme evaluation. As a result, the evidence base for priority-setting may become biased.

- ▶ In a strongly centralized health system there is a risk that representatives of service providers and civil society are not sufficiently on board.
- ▶ If the panel for advising on health sector priorities lacks health economic knowledge and/or allocation experience, there may be insufficient capacity to translate analysis results into revised and updated plans.

Process constraints

- ▶ In a health system that is facing too many administrative demands, priority-setting and/or its follow-up may end up as an activity of low priority.
- ▶ Absence of strong MoH leadership and of effective two-way communication between the various stakeholders may lead to a poorly accepted outcome of the priority-setting and, ultimately, to uncertainty about the availability of the necessary future resources (national and external).
- ▶ Another challenge is the natural inclination of those who are involved in priority-setting to focus on the continuation of existing strategies and modalities, with slight modifications. However, ongoing interventions and programmes are usually the product of a multitude of driving forces, motivations and compromises. Understanding those driving forces can help prevent undue influences from playing a role in reviewing sector priorities, thereby better customizing existing strategies and modalities.



4.6.2 Factors of success

One major success factor is having, prior to priority-setting, an in-depth sector review or situation analysis that has examined aspects such as effectiveness, efficiency, and cost-effectiveness on the basis of not only a quantitative data analysis but also on qualitative information on cross-cutting factors that influence health system performance and potential.

One major success factor is having, prior to priority-setting, an in-depth sector review or situation analysis that has examined aspects such as effectiveness, efficiency, and cost-effectiveness on the basis of not only a quantitative data analysis but also on qualitative information on cross-cutting factors that influence health system performance and potential. We must know what worked and what did not work in the past, but above all we must find out why interventions of the past period were effective or not. A classic example is health information, an area that in many countries was diagnosed again and again as suffering from serious systemic weaknesses, in spite of repeated strategic (medium-term) decisions to strengthen it. In many cases this was to no avail, because the root causes were not addressed in subsequent new plans. In other words, the “why” question was not adequately addressed. If, once again, the insufficiencies of the health information system are seen as a key problem to be addressed in the coming years, it is only useful to select this area as a priority when the proposed renewed efforts and investments are based on a clear understanding of the root causes of dysfunction.

The priority-setting can be considered successful when a number of criteria have been met.⁷¹

- ▶ The priority-setting process is based on a clearly defined scope, approach and methodology.
- ▶ The process of priority-setting has evolved in a transparent manner, with adequate information management, whereby communication

and feedback were ensured, the organizers were accountable and opportunity existed for a decision review (appeals mechanism).

- ▶ The analysis has taken into consideration values and local context.
- ▶ If undue driving forces have co-determined the previous priority agenda, there is space for “alternative agenda setting”.
- ▶ The next (stage of the) plan and budget show a more balanced and rational resource distribution, based on needs, cost-effective interventions and values.
- ▶ It transpires clearly from the next (stage of the) plan and budget that the most important health threats are adequately addressed.
- ▶ Resources are allocated for interventions that benefit the population groups and regions most affected and at risk.
- ▶ The implementation of the plan/budget shows better cost-effectiveness because strategies and implementation modalities have been adapted to evidence-based technologies, whereby the local context was taken into account.
- ▶ The next (stage of the) plan and budget show that priority needs of disadvantaged population groups are explicitly addressed.
- ▶ The adopted priorities and following resource allocation and plans have taken into account the views of various stakeholder groups through an explicit process that has resulted in their engagement (buy-in) and the priority-setting outcomes are socio-culturally acceptable to the population. As a result, stakeholders have shifted priorities and/or reallocated resources changes in strategic directions.

Factors that facilitate the priority setting:⁷²

- ▶ senior-level managerial and clinical championship;
- ▶ strong leadership in coordination and oversight;
- ▶ culture to learn and change integrated management of budgets;
- ▶ resources earmarked for the process itself and for follow-up on recommendations.



4.7 What if ...?

4.7.1 What if your country is highly centralized?

In a highly centralized setting, those who are responsible for the priority-setting exercise must be aware of four risks.

- ▶ If communication (two-way) between central level and intermediate and operational levels is insufficient, the MoH may not have all the necessary information about the situation “in the field”, for identifying and adopting priorities. For instance, the ministry may not have a complete picture of different situations and needs between regions and may not have full insight in the perceptions, opinions and demands of local stakeholders.
- ▶ If MoH’s communication strategies, mechanisms and means are insufficient, there is a risk that various groups of actors and beneficiaries of the health system are not adequately informed and sensitized for the priority-setting exercise in a timely manner.
- ▶ The existing institutional and organizational framework may not provide the necessary platform function for consulting various stakeholder groups and for facilitating their participation in the priority-setting process (including repeal mechanism).
- ▶ If decision-making in the health sector is highly centralized, the translation of the results of the priority-setting (i.e. the recommendations for prioritizing specific needs, interventions and for resource allocation) in planning and budgeting may be unduly influenced by political influences, thereby weakening its legitimacy.

The following case (Box 4.9) describes some of the potential threats experienced in a highly-centralized system:

Box 4.9

Influences in priority-setting at the meso and micro levels in a highly-centralized system⁷³

A study in Kerman province in Iran sought to understand how the national priority-setting programme worked. What factors influenced the implementation process, at the meso and micro levels, in this centralized health system? The analysis showed that the process of priority-setting was non-systematic, that there was little transparency, and the priority decisions were made independently from their implementation. This was found to be due to the highly centralized system: priorities are set at the macro level without involving meso or micro local levels or any representative of the public. The two main benefit packages are under the responsibility of different ministries and there was no coordination between them. The process was also heavily influenced by political pressure exerted by various groups, mostly medical professionals. The weaknesses were exacerbated by a growing gap between rural and urban areas in terms of access to health services.

In order to avoid the above-mentioned risks, it is useful for central level authorities to think about its existing health sector policy cycle to ensure improved communication and participation. This is only of benefit to the central authorities as more input from and better communication with the sub-national levels will lead to better adherence and more meaningful contribution to new plans and budgets.

4.7.2 What if your country is decentralized?

In many countries, decentralization of the health sector involves decision-making and resource management being delegated to regional and district health managers. In a situation of comprehensive political/administrative decentralization, there is even devolution of powers and responsibilities to local government. Consultation in health sector priority-setting will take place in line with the type and degree of decentralizing. The main challenges will be to:

- ▶ organize, coordinate and guide the consultation at all levels, and to adequately synthesize the results of all phases;
- ▶ allow for sufficient flexibility in setting priorities, respectful of mandates at decentralized levels, while also keeping in mind national guidelines, targets and norms for the whole country.

Especially in a situation where health sector responsibilities and powers have been devolved to local government, it is important that local administrators are well prepared for the task at hand. This means that

- (i) they must have a good understanding of public health issues;
- (ii) their mandate is clear and that coordination and collaboration with local health authorities is adequate;
- (iii) they receive clear guidelines and instructions regarding any norms, priority areas, resource allocation decisions etc, that have been defined at national level. Hence, central-level MoH and the ministry of local government jointly have a key role to play in preparing local government for priority-setting in the local health system (see Box 4.10).



Box 4.10

Challenges in participatory planning and priority-setting in Uganda's decentralized health system⁷⁴

In Uganda, participatory planning is fairly established; many decentralized district leaders involve the public in local health priority-setting processes. In an attempt to draw lessons from Uganda's experience, one study conducted in-depth interviews with health planners at the national, district and community levels, and organized five group discussions at community level. Participants revealed a number of challenges.

District level respondents reported to have gained decision-making powers, but were concerned about the degree of financial independence they had to implement decisions. The national level respondents were concerned about the capacity of the districts to absorb their new roles. Meaningful involvement of the public in priority-setting, and poor communication between the different levels of the decentralization system, despite the existing structures, were additional concerns.

To address these challenges, the authors proposed several potential solutions. Regarding district health planning capacity, the authors suggested providing stronger technical assistance and supporting districts to hire qualified technical personnel. In addition, they recommended that the national level ensure true financial decentralization so that districts actually have more control over the decisions and plans they make. The authors also encouraged mapping of resources allocated to districts so that resource distribution can be better visualized and understood at the national level. This would have positive spillover effects on the level of financial independence granted to districts. Finally, to address the issue of poor public participation, the authors advocate for more resources to facilitate continuous discussion and dialogue between the public and leaders.

4.7.3 What if fragmentation and/or fragility is an issue in your country?

Determinants of fragility include conflicts, weak institutions, external shocks, poverty, disease and regional instability. It is the interplay of these determinants that determines the outcome. Drivers of dysfunctional governance are often self- and mutually-reinforcing. In this environment, short-term gains may outweigh an uncertain long-term vision, and any priority-setting exercise will certainly reflect this.

In a fragmented and/or fragile environment, health needs are likely to be very diverse and extreme, varying from rampant infectious diseases to malnourishment, injuries caused by violence and chronic effects from failed primary-level care. On the other hand, effectiveness and efficiency of available solutions/interventions may be very low, due to local implementation constraints such as insufficient service providers, poor maintenance, interrupted access due to insecurity and corruption. Meanwhile, the situation on the ground may evolve rapidly and in an unplanned way. In combination with poor communication lines, it makes it difficult for central government to keep a good overview of the situation and trends for the whole country. The problem is often compounded by incomplete and possibly flawed data/information, which is to provide the basis for the sector analysis. This makes the assessment of health needs, feasibility of solutions and cost implications difficult.

A weak public sector is one of the common characteristics of a fragmented and/or fragile environment. The MoH may have insufficient human resource capacity (in numbers and in expertise). The institutional framework may be

suboptimal as well as the internal organization, leading to ineffective communication and coordination. Weak leadership by the MoH and insufficiencies in the coordination of stakeholders and actors make it difficult to organize a comprehensive and inclusive approach for the priority-setting.

Before formulating recovery strategies as per sector priorities, stakeholders should consider what the main characteristics of the crisis are, and what the future country context might look like. Important questions to be answered are, for instance: Is the present turmoil structural or transient? What are the chances that a legitimate government will eventually emerge from the protracted crisis? What are the economic prospects (recovery of livelihoods, resettlement of displaced people and refugees)?

The supranational landscape needs to be understood as well. Will external actors remain involved in domestic affairs, and if so for how long? Will donors support transition and health system development? What will be the role of neighbouring countries?

In addition, priority-setting must take into account the role of the national government and the MoH in a situation of fragmentation and/or fragility. Is the national government politically legitimate and technically capable? Is the MoH willing to lead healthcare developments, disinterested or resource-less? Are health authorities able to play a leading role in the healthcare field? Are there no contested regions? Is there no opposition by powerful donors on political or human-rights grounds?



A medium-term priority-setting exercise for the health sector in such an environment will probably need an adapted and simplified approach in various areas.

1. Data/information collection and analysis

If the health information system is poorly organized, turning out incomplete and unreliable data, the usefulness of (the analysis of) certain data for priority-setting may be doubtful. One might be tempted then to immediately invest in repairing/completing the entire database and to start strengthening the health information system. However, this is a comprehensive, complex and sizeable undertaking, even under more favourable circumstances. Therefore, instead, some “quick and dirty” assessments could be organized that would provide a “good enough” understanding of the essential issues

2. Consultative approach, scope and time horizon

When communication with certain parts of the country is disturbed due to insecurity or failing logistics, or when partner organizations from the non-public sector have started operating more or less independently due to failing coordination mechanisms, a comprehensive consultation process will be difficult to organize and is likely to become a costly exercise. Moreover, due to the disturbed environment, those to be consulted may not have been adequately informed in advance on the health sector

issues at stake. In such circumstances, the concessions may be necessary with regard to the scope of the consultation, the methods to be used and the degree of representativeness of various stakeholder groups.

3. Flexibility of the resulting recommendations

While the recommendations that result from the consultation may be relevant and fair, their feasibility may become questionable due to rapidly changing circumstances in a volatile environment. Therefore, it may be useful to formulate these recommendations in such a way that they can be used in different situations. A few scenarios may be considered, for example, with regard to the likelihood of achieving in the near future a planned government reform and implementation of measures towards governance strengthening. Because of this need to allow for flexibility in the recommendations, it is preferable that their total number be limited.

If there are indications of serious health threats, specific for a certain population group or region, or of paralysed service provision in certain service areas (types, levels or geographical), efforts must be made to establish a clear picture of the current situation and trends. Such problems need to be quantified and their likely consequences are to be documented. This will allow for situation- or area-specific priority-setting recommendations.

In a fragile state context, a “quick and dirty” assessment could be organized that would provide a “good enough” understanding of the essential issues.

4.7.4 What if your country is highly dependent on aid?

As we move from Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), the fragmented priorities seen in global health for decades are being counterbalanced with more sustainable, system-focused solutions. The SDGs are applicable to all countries, and go well beyond the MDGs.⁷⁵

Accordingly, the role of donors and global health initiatives is evolving greatly over the last decade. The Millennium Development Goals (MDGs) adopted by the United Nations in 2000 had set the tone for much of the international agenda for health and directed the nature of health as priorities at national level. Looking back 15 years at the trends and positive forces during the MDG era, several limitations have also become apparent. These are, a limited focus, resulting in verticalization of health and disease programmes, a lack of attention to strengthening health systems, the emphasis on a “one-size-fits-all” development planning approach, and a focus on aggregate targets rather than equity. The MDGs is perceived by some as a typical case of bypassing the will of developing countries’ citizens.

The MDGs spurred large global health initiatives to donate millions to national governments for very specific health issues; this has shifted the perspective of national governments when deciding on resource allocation for health. It may be the case, as is seen with HIV in Malawi (see Box 4.11), that certain diseases take prominence because of the available financial resources from large donors and not initially because of the prevalence or burden of disease.

The importance of high aid dependency for the priority-setting process depends on several factors.

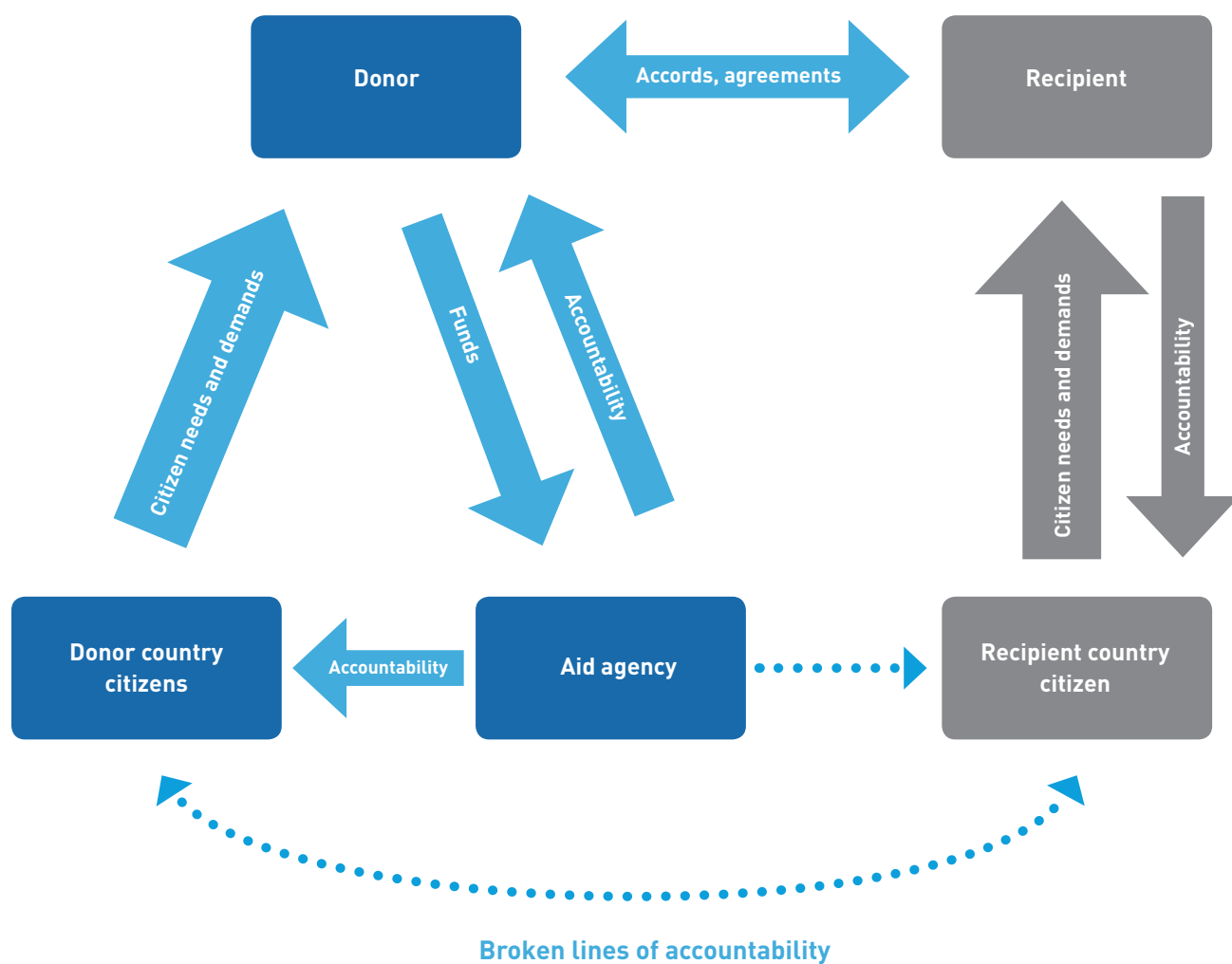
(a) The extent to which the external aid and donors are integrated in the overall health sector development, in terms of coordination, alignment, etc.

In aid-dependent settings, it is especially crucial to keep striving for better collaboration and coordination in planning, especially for joint sector analysis, comprehensive needs assessment, resource allocation, budgeting, predictability of resource flows, resource utilization and management. Stronger national leadership and formal arrangements for harmonized sector development by the entire stakeholder community are important goals to work towards and keep working towards.

While structural high dependency on external aid itself is a barrier for establishing a sustainable national health system, the consequences of scattered and poorly coordinated aid probably have an even more negative impact on the planning process, especially on priority-setting. Medium-term and comprehensive health sector priority-setting in an environment of poorly integrated and coordinated aid is undermined by parallel steering and decision-making, which is often guided by different agendas and based on different criteria and decision-making processes. Even when in such a situation, development partners express support for national leadership and adhere to the adopted sector plan and priorities, this does not guarantee that their financial and technical resources can be harnessed towards the implementation of the adopted sector priorities. These constraints have been extensively documented and have led to initiatives such as the Paris Declaration, the Accra Agenda and IHP+. Experience to date with countries where a National IHP+ Compact was signed indicates that important gains could



Fig. 4.5 Inexistent lines of accountability between donor agencies, their citizens and recipient citizens



Adapted from the World Development Report 2004:
Making services work for poor people, World Bank, 2004

be made in assuring that external aid is used adequately.

(b) The opportunities and prospects for reducing aid dependency

The options may be limited, when

- (i) solutions for solving the country's health problems are costly;
- (ii) the country's economic basis is weak;
- (iii) extensive efforts have already been made to reduce costs through efficiency gains by introducing reforms, adapted strategies and implementation modalities.

In such a case, national government and development partners should jointly develop ideas and plans for efficiency gains and review resource redistribution. This may require institutional reforms or adaptation of standard strategies and care systems for improving efficiency. New strategies and implementation modalities will have to be tested in a pilot before they are implemented. In addition, it may be necessary to review the economic sustainability of certain care solutions. Such a review may lead to a decision to disinvest in a certain area/service in order to increase resource availability for more crucial health needs.

Integration of priority (disease-based) programmes in comprehensive health system development is often an uphill battle. The vertical nature of some of these programmes in terms of planning, implementation modalities, funding flows, allocation criteria and M&E is usually seen as a condition for obtaining rapid and significant results, especially in an environment of weak public-sector leadership and governance. The risks that come with well-funded vertical programmes are also well documented.⁷⁶ They are related to the multiplication of implementation systems, norms and standards, misbalanced sector funding, conflicting interests and ownership issues. It is, therefore, important to carefully manage the role of such vertical programmes and their funders in a sectorwide priority-setting process. National IHP+ Compacts should help to avoid that pressure from powerful, sometimes semi-autonomous disease programmes and the temptation of their lavish funding that can distort the processes of ranking priorities and subsequent decision-making in resource allocation and planning.





Box 4.11

The impact of earmarked aid contributions on national health priority-setting mechanisms in Malawi⁷⁷

This case study in Malawi on external influence in priority-setting looked at the involvement of the international community in the campaign to tackle the HIV/AIDS epidemic, and found that it had an unprecedented impact on national health priority-setting mechanisms in Malawi. The example shows how, despite the country's commitment to comprehensive sector development based on national leadership and strengthened coordination, massive earmarked external funding interfered with rational and just priority-setting.

Malawi has a high prevalence of HIV (12%). In response to the MDG goal No. 6 several Global Health Initiatives (GHIs) provided increased financial assistance to Malawi for addressing HIV/AIDS within the health sector. Among them were the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), United States Agency for International Development (USAID), UN Development Programme (UNDP), the World Bank, UK Department for International Development and the African Development Bank, among others. In 2002, donor contribution to the total HIV/AIDS resource envelope held by the National AIDS Commission was 46%, but rose to 73% by 2005. In addition, the majority of the aid contributions for health were also earmarked for HIV/AIDS. Due to this shift

in the overall sector budget, attention was diverted away from other important health priorities. GFATM became the largest donor, with US\$ 300 million in aid since 2002, of which around 80% was earmarked for HIV/AIDS programmes. Not surprisingly, GFATM's role in national priority-setting and planning grew and complications arose. Concerns were reported about the poor integration of its activities into the Malawi's health sector SWAp (Sector-Wide Approach). For instance, there were parallel planning structures for the Malawi National AIDS Committee Integrated National Working Plan. These developments were not in line with Malawi's earlier efforts to better coordinate the different GHIs and development agencies even before the SWAp. Vertical funding towards HIV/AIDS has compromised the distribution of human resources for health. There has been a noticeable task-shifting impact on the health system as health workers leave other services, such as antenatal care and reproductive health, to work for HIV/AIDS programmes funded by international donors. Although there have been improvements in HIV/AIDS incidence rates in Malawi, it is important to consider the gravity of the impact of these external influences on priority-setting in the wider health sector.



4.8 Conclusion

Priority-setting is an indispensable step in the health sector development process because it guides medium-term sector development. It is important to choose approach, methods and tools carefully, taking into account the national setting with regard to important contextual developments and overall development trends, availability of key data and evaluations on performance, the role of citizens and various stakeholder groups, the organizational and leadership capacity of the public sector, and – last but not least – the resources that are available.

Priority-setting requires detailed and timely preparation as well as a formal follow-up of the results especially with regard to enabling and empowering citizens to make an informed choice through their parliaments. The analysis of the sector (see Chapter 3 on situation analysis) provides the basis for priority-setting. For follow-up, once the recommendations of the priority-setting have been formally adopted, they are used to guide the strategic planning.

Priority-setting starts with a reflection on the criteria to be used to set priorities, followed by a series of analyses where value-based and technical approaches may be used. This chapter argues in favour of a combination of approaches in priority-setting, in which technical considerations are weighed against value considerations. This means that analysis on the basis of explicit criteria (such as, but not limited to: importance of the health issue, effectiveness of the intervention, cost of the intervention, acceptability of the intervention, and fairness) is done with contributions from experts (for technical aspects) as well as from population representatives (deliberation, notably on weighing values). The latter is crucial as, in

the end, citizens should have the final say in decision-making through democratic processes.

There is not one single set of methods and tools that is considered appropriate in all settings. All those presented in this chapter have advantages and disadvantages or limitations (see Annex 4.2).

From priority-setting to planning

In priority-setting, the ranking exercise will result in a set of recommended interventions that are considered most important, most effective and least costly. The ranking must take into account preliminary cost implications in order to determine cost-effectiveness, but does not go into detailed operational costing.

The decision-making about how to apply the ranked priorities with regard to the existing resource allocation criteria and formulae is done in a following phase. This decision-making will require compromises and trade-offs. The national criteria and formulae will be applied by the ministry of finance and the MoH, taking into account the expected total volume of resources (fiscal space), after which the planning, detailed costing and budgeting will follow.

Predictability of all types of external financial resources is paramount, since these may determine to a large extent how realistic the scenarios of a Medium Term Expenditure Framework (MTEF) are.

The sector policy and planning cycle then proceeds with the strategic planning, costing and budgeting, after which follow the implementation stage and M&E.

Priority-setting starts with a reflection on the criteria to be used to set priorities, followed by a series of analyses where value-based and technical approaches may be used. Technical considerations are then weighed against value considerations. This means that an analysis on the basis of explicit criteria is done with contributions from experts as well as from population representatives.

References

- 1 The place of health in the post-2015 development agenda: opening remarks at an informal Member State consultation on health in the post-2015 development agenda. Geneva, 14 September 2012 (http://www.who.int/dg/speeches/2012/mdgs_post2015/en/, accessed 20 September 2016).
- 2 Health systems financing: the path to universal coverage. world health report 2010. Geneva: World Health Organization; 2010 (<http://www.who.int/whr/2010/en/>, accessed 20 September 2016). Green A. An introduction to health planning for developing health systems, 3rd edition. Oxford: Oxford University Press; 2007, 18–20.
- 3 Idem.
- 4 Government of Sierra Leone. Health compact. 2011 (http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/Government%20of%20S.%20Leone%20Health%20Compact.pdf, accessed 12 September 2016).
- 5 Government of Sierra Leone. National health sector strategic plan 2010–2015. [Freetown]: Ministry of Health and Sanitation; 2009 (http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/National-HealthSectorStrategicPlan_2010-15.pdf, accessed 12 September 2016).
- 6 The Government of Sierra Leone. Review of the implementation of the national health sector strategic plan (2010–2015). [Freetown]: Ministry of Health and Sanitation; 2015 (http://uhcpartnership.net/wp-content/uploads/2014/03/Sierra-Leone-NHSSP-Final-Report_FINAL.pdf, accessed 12 September 2016).
- 7 Government of Sierra Leone. National health sector strategic plan 2010–2015: joint programme of work and funding (JPWF) 2012–2014. [Freetown]: Ministry of Health and Sanitation; 2012 (http://www.nationalplanningcycles.org/sites/default/files/country_docs/Sierra%20Leone/jpwf_final.pdf, accessed 12 September 2016).
- 8 Government of Sierra Leone. Basic package of essential health services for Sierra Leone. [Freetown]: Ministry of Health and Sanitation; 2010 (http://www.unicef.org/wcaro/wcaro_SL_basic_package_health2010.pdf, accessed 12 September 2016).
- 9 The Government of Sierra Leone. Review of the implementation of the national health sector strategic plan (2010–2015). [Freetown]: Ministry of Health and Sanitation; 2015 (http://uhcpartnership.net/wp-content/uploads/2014/03/Sierra-Leone-NHSSP-Final-Report_FINAL.pdf, accessed 12 September 2016).
- 10 Kienny MP, Evans DB, Schmets G, and Kadandale S. Health-system resilience: reflections on the Ebola crisis in western Africa. *Bull World Health Organ*. 2014; 92: 850
- 11 Chalkidou K, Glassman A, Marten R, Vega J, Teerawattananon Y, Tritasavit N, et al. Priority-setting for achieving universal health coverage. *Bull World Health Organ*. 2016;94(6):462–75 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4890204/>, accessed 13 September 2016).
- 12 Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 13 September 2016).
- 13 Ham C. Priority-setting in health care: learning from international experience. *Health Policy*. 1997;42: 49–66. pmid:10173493.
- 14 Brinkerhoff DW, Bossert TJ. Health governance: concepts, experience, and programming options. Washington (DC): U.S. Agency for International Development; 2008 (Health Systems 20/20, Policy Brief; <https://www.hfgproject.org/health-governance-concepts-experience-programming-options/>, accessed 13 September 2016).
- 15 Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Public participation in health care priority setting: a scoping review. *Health Policy*. 2009;91(3):219–28. doi:10.1016/j.healthpol.2009.01.005.
- 16 Mitton C, Donaldson C. Health care priority setting: principles, practice and challenges. *Cost Eff Resour Alloc*. 2004;2(3) (<http://www.resource-allocation.com/content/2/1/3>, accessed 13 September 2016).
- 17 Robinson S, Williams I, Dickinson H, Freeman T, Rumbold B. Priority-setting and rationing in healthcare: evidence from the English experience. *Soc Sci Med*. 2012;75(12):2386–93. doi:10.1016/j.socscimed.2012.09.014.
- 18 Arvidsson E, André M, Borgquist L, Andersson D, Carlsson P. Setting priorities in primary health care – on whose conditions? A questionnaire study. *BMC Fam Pract*. 2012;13:114 (<http://bmcfampract.biomed-central.com/articles/10.1186/1471-2296-13-114>, accessed 13 September 2016)
- 19 Bolsewicz Alderman K, Hipgrave D, Jimenez-Soto E. Public engagement in health priority-setting in low- and middle-income countries: current trends and considerations for policy. (*PLoS Med*. 2013; 10(8) (<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001495>, accessed 13 September 2016).
- 20 Mitton C, Donaldson C. Health care priority setting: principles, practice and challenges. *Cost Eff Resour Alloc*. 2004;2(3) (<http://www.resource-allocation.com/content/2/1/3>, accessed 13 September 2016).
- 21 Arvidsson E, André M, Borgquist L, Andersson D, Carlsson P. Setting priorities in primary health care – on whose conditions? A questionnaire study. *BMC Fam Pract*. 2012;13:114 (<http://bmcfampract.biomed-central.com/articles/10.1186/1471-2296-13-114>, accessed 13 September 2016)
- 22 Sickle-cell disease and other haemoglobin disorders. Geneva: World Health Organization; 2011 (Fact sheet N308; <http://www.who.int/mediacentre/factsheets/fs308/en/>, accessed 13 September 2016).
- 23 Living with obstetric fistula: qualitative research findings from Bangladesh and the Democratic Republic of Congo. USAID. (<https://www.engenderhealth.org/files/pubs/fistula-care-digital-archive/1/1.2/living-with-obstetric-qualitative-brief-english.pdf>, accessed 13 September 2016).
- 24 Wall LL, Arrowsmith SD, Briggs ND, Lassey A. Urinary incontinence in the developing world: the obstetric fistula. In: Abrams P, Cardozo L, Khoury S, Wein A, editors. *Incontinence*. 2nd international consultation on incontinence, Paris, July 1–3, 2001. 2nd edition. London: Health Publications Ltd.; 2002: 893–935 (http://www.ics.org/publications/ici_2/chapters/chap12.pdf, accessed 14 September 2016).
- 25 Luwam Semere L, Nour NM. Obstetric fistula: living with incontinence and shame. *Rev Obstet Gynecol*. 2008 1(4):193–7 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2621054/>, accessed 14 September 2016).
- 26 Goh JTW, Krause H, Tessema AB, Abraha G. Urinary symptoms and urodynamics following obstetric genitourinary fistula repair. *Int Urogynecol J*. 2012;24(6):947–51 (<http://worldwidefistulafund.org/wp-content/uploads/2011/06/Goh-Urodynamics-after-VVF-repair-2013.pdf>, accessed 14 September 2016).
- 27 Robinson S, Williams I, Dickinson H, Freeman T, Rumbold B. Priority-setting and rationing in healthcare: evidence from the English experience.



- Soc Sci Med. 2012;75(12):2386–93. doi:10.1016/j.socscimed.2012.09.014.
- 28 Tromp N, Baltussen R. Mapping of multiple criteria for priority setting of health interventions: an aid for decision makers. *BMC Health Serv Res.* 2012;12:454 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3565954/>, accessed 14 September 2016).
 - 29 Primary Care Trust Network. Priority-setting: strategic planning. London: The NHS Confederation; 2008 (<http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Priority%20setting%20strategic%20planning>, accessed 14 September 2016).
 - 30 Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Public participation in health care priority setting: a scoping review. *Health Policy.* 2009;91(3):219–28. doi:10.1016/j.healthpol.2009.01.005.
 - 31 Tromp N, Baltussen R. Mapping of multiple criteria for priority setting of health interventions: an aid for decision makers. *BMC Health Serv Res.* 2012;12:454 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3565954/>, accessed 14 September 2016).
 - 32 Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Eff Resour Alloc.* 2006;4:14 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/>, accessed 15 September 2016).
 - 33 Guide for establishing public health priorities. Course notes, modified from CDC case study: Translating science into practice. 2004.
 - 34 Tromp N, Baltussen R. Mapping of multiple criteria for priority setting of health interventions: an aid for decision makers. *BMC Health Serv Res.* 2012;12:454 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3565954/>, accessed 14 September 2016).
 - 35 Buffett C, Ciliska D, Thomas H. Can I use this evidence in my program decision? Assessing applicability and transferability of evidence. Hamilton (ON): National Collaborating Centre for Methods and Tools; 2007 (<http://www.nccmt.ca/uploads/media/media/0001/01/110008a2754f35048bb7e8ff-446117133b81ab13.pdf>, accessed 14 September 2016).
 - 36 Public Health Science Team. Priority-setting in public health. Los Angeles: County of Los Angeles Public Health; 2010. [Quality Improvement Brief; <http://publichealth.lacounty.gov/qi/docs/qibrief-prioritysettinginpublichealth.pdf>, accessed 14 September 2016].
 - 37 Mendenhall E, De Silva MJ, Hanlon C, Petersen I, Shidhaye R, Jordans M, et al. Acceptability and feasibility of using non-specialist health workers to deliver mental health care: stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Soc Sci & Med.* 2014;118:33–42 (<http://www.sciencedirect.com/science/article/pii/S0277953614004973>, accessed 14 September 2016).
 - 38 Bukachi SA, Onyango-Ouma W, Siso JM, Nyamongo IK, Mutai JK, Hurtig AK, et al. Healthcare priority setting in Kenya: a gap analysis applying the accountability for reasonableness framework. *Int J Health Plann Mgmt.* 2013. (https://profiles.uonbi.ac.ke/onyangooma/files/publication_2013.pdf, accessed 14 September 2016).
 - 39 Eliminating female genital mutilation: an interagency statement: UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization; 2008. (http://apps.who.int/iris/bitstream/10665/43839/1/9789241596442_eng.pdf, accessed 14 September 2016).
 - 40 Mitton C, Donaldson C. Health care priority setting: principles, practice and challenges. *Cost Eff Resour Alloc.* 2004;2(3) (<http://www.resource-allocation.com/content/2/1/3>, accessed 13 September 2016).
 - 41 Tromp N, Baltussen R. Mapping of multiple criteria for priority setting of health interventions: an aid for decision makers. *BMC Health Serv Res.* 2012;12:454 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3565954/>, accessed 14 September 2016).
 - 42 Cambridge Dictionary. Fairness. (<http://dictionary.cambridge.org/dictionary/english/fairness>, accessed 14 September 2016).
 - 43 Australian Indigenous HealthInfoNet (2016) Summary of Aboriginal and Torres Strait Islander health status, 2015 Perth (WA): (<http://www.healthinfonet.ecu.edu.au/health-facts/summary>, accessed 14 September 2016).
 - 44 Why does the health gap exist? Melbourne: Oxfam Australia. (<https://www.oxfam.org.au/what-we-do/indigenous-australia/close-the-gap/australias-indigenous-health-crisis-in-depth/>, accessed 14 September 2016). [website]
 - 45 Australia's disturbing health disparities set Aboriginals apart. *Bull World Health Organ.* 2008;86(4):241–320 (<http://www.who.int/bulletin/volumes/86/4/08-020408/en/>, accessed 15 September 2016).
 - 46 The health and welfare of Australia's Aboriginal and Torres Strait Islander people 2011. The Australian Institute of Health and Welfare. (<http://www.aihw.gov.au/indigenous-observatory/health-and-welfare/>, accessed 15 September 2016).
 - 47 Indigenous health: 2014–2015 budget outcomes. Canberra: Australian Government Department of Health. 2016. (<https://www.health.gov.au/Indigenous>, accessed 15 September 2016).
 - 48 Schöne-Seifert B. The 'rule of rescue' in medical priority-setting: ethical plausibilities and implausibilities. In: Baumann M, Lahno, editors. *Perspectives in Moral Science. Rationality, Markets and Morals.* 2009;0:421–30 (http://www.rmm-journal.de/downloads/030_schoene_seifert.pdf, accessed 15 September 2016).
 - 49 The International Health Partnership. (<http://www.internationalhealthpartnership.net/>, accessed 15 September 2016).
 - 50 Hipgrave DB, Alderman KB, Anderson I, Soto EJ. Health sector priority-setting at meso-level in lower and middle income countries: lessons learned, available options and suggested steps. *Soc Sci & Med.* 2014;102:190–200.
 - 51 Kaplan W. Approaches to priority setting. Geneva: World Health Organization; update of 2004 version of article [Priority Medicines for Europe and the World, Background Paper 3; http://www.who.int/medicines/areas/priority_medicines/BP3_Approaches.pdf, accessed 15 September 2016).
 - 52 Hauck K, Smith PC, Goddard M. The economics of priority setting for health care: a literature review. Washington (DC): World Bank, Human Development Network; 2004 (Health, Nutrition and Population Discussion Paper; <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/>

- Resources/281627-1095698140167/Chapter3Final.pdf, accessed 15 September 2016).
- 53 Isell LM. Health program planning and evaluation: a practical, systematic approach for community health. Sudbury (MA): Jones & Bartlett Learning; 2004.
 - 54 Guide for establishing public health priorities. Course notes, modified from CDC case study: Translating science into practice. 2004
 - 55 Garland M, Stull J. Public health and health system reform: access, priority-setting, and allocation of resources. In Jennings B, Kahn J, Mastroianni A, Parker L, editors. Ethics and public health: model curriculum. Washington (DC): Association of Schools of Public Health; 2003.
 - 56 Clark S, Weale A. Social values in health priority setting: a conceptual framework. *J Health Organ Manag.* 2012;26(3):293–316 (http://www.ucl.ac.uk/socialvalues/downloads/files/Social_Values_and_Priority_Setting_in_Health_-_Background_paper.pdf, accessed 16 September 2016).
 - 57 Daniels N. Four unsolved rationing problems: a challenge. *Hastings Cent Rep.* 1994;24(4):27–9. pmid:7960702.
 - 58 Olsen JA. Theories of justice and their implications for priority setting in health care. *J Health Econ.* 1997;16(6): 625–39. pmid:10176776.
 - 59 Williams A. Priority setting in public and private health care: a guide through the ideological jungle. University of York Centre for Health Economics, 1988 (Health Economics Consortium Discussion paper 36; <http://www.york.ac.uk/che/pdf/dp36.pdf>, accessed 15 September 2016)
 - Hadorn DC. The problem of discrimination in health care priority setting. *JAMA.* 1992;268(11):1454–9. pmid:1387422.
 - 61 Williams I, Phillips D, Nicholson C, Shearer H. Evaluation of a deliberative approach to citizen involvement in health care priority setting. *Leadership in Health Services.* 2014;27(1):5–19. doi: 10.1108/LHS-01-2013-0002..
 - 62 Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Public participation in health care priority setting: a scoping review. *Health Policy.* 2009;91(3):219–28. doi:10.1016/j.healthpol.2009.01.005.
 - 63 Campbell S. Deliberative priority-setting. CIHR KT module. Ottawa: Canadian Institutes of Health Research; 2010 (<http://www.cihr-irsc.gc.ca/e/43533.html>, accessed 15 September 2016).
 - 64 National Association of County and City Health Officials (NACCHO). Guide to prioritization techniques. (<http://www.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples-2.pdf>, accessed 15 September 2014).
 - 65 Blackwood R. The use of Delphi methods. 2009. (<http://www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/use-delphi-methods>, accessed 15 September 2016).
 - 66 Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Eff Resour Alloc.* 2006;4:14 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/>, accessed 15 September 2016).
 - 67 Baltussen R. Priority-setting of public spending in developing countries: do not try to do everything for everybody. *Health Policy.* 2006;78:149–56 (http://www.who.int/choice/publications/p_2006_priority_setting.pdf, accessed 20 September 2016).
 - 68 Kapiriri L, Arnesen T, Norheim OF. Is cost-effectiveness analysis preferred to severity of disease as the main guiding principle in priority setting in resource poor settings? The case of Uganda. *Cost Eff Resour Alloc.* 2004;2:1 (<https://resource-allocation.biomedcentral.com/articles/10.1186/1478-7547-2-1>, accessed 15 September 2016).
 - 69 Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Eff Resour Alloc.* 2006;4:14 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560167/>, accessed 15 September 2016).
 - 70 Glassman A, Chalkidou K. Priority-setting in health: building institutions for smarter public spending. Washington (DC): Center for Global Development; 2012 (<http://apps.who.int/medicinedocs/documents/s19985en/s19985en.pdf>, accessed 16 September 2016).
 - 71 Hipgrave DB, Alderman KB, Anderson I, Soto EJ. Health sector priority-setting at meso-level in lower and middle income countries: lessons learned, available options and suggested steps. *Soc Sci & Med.* 2014;102:190–200.
 - 72 Health System Intelligence Project. The Health Planner's Toolkit. Health System Intelligence Project. Ontario: 2008. (<http://www.hclinkontario.ca/resources/14-hclink/resources/45-resources-planning.html>, accessed 16 September 2016).
 - 73 Khayatzaadeh-Mahani A, Fotaki M, Harvey G. Priority setting and implementation in a centralized health system: a case study of Kerman province in Iran. *Health Policy Plan.* 2013;28:480–94 (<http://heapol.oxfordjournals.org/content/28/5/480.full.pdf>, accessed 16 September 2016).
 - 74 Kapiriri L, Norheim OF, Heggenhougen K. Public participation in health planning and priority setting at the district level in Uganda. *Health Policy Plan.* 2003;18(2):205–13 (<http://heapol.oxfordjournals.org/content/18/2/205.long>, accessed 16 September 2016).
 - 75 Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2015 (<http://www.who.int/gho/publications/mdgs-sdgs/en/>, accessed 16 September 2016).
 - 76 De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M. Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Knowledge Network. Witwatersrand: Health Systems Knowledge Network; 2007. http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf, accessed 16 September 2016).
 - 77 Adjei S, Nazzar A, Seddoh A, Blok L, Plummer D. The impact of HIV and AIDS funding and programming on health system strengthening in Malawi. KIT, University of Malawi; 2011 (Health System Research Series No. 4; https://www.kit.nl/health/wp-content/uploads/publications/1919_111114_KIT_Ghana.pdf, accessed 16 September 2016).



Annex 4.1

Methods and tools for technical approaches

Health Technology Assessment

The health technology assessment system defines the following 7 steps.

1. **Registration** assures safety and efficacy of new products and provides a gateway for considering a technology for public or donor funding.
2. **Scoping** identifies and selects technologies (broadly defined as policies, interventions, drugs, diagnostics, and other products) for evaluation depending on country or donor priority-setting goals.
3. **Cost-effectiveness** analysis uses widely-accepted economic evaluation methods, tools, and systematic evidence reviews, building on defined priority-setting criteria, such as health impact, equity, and financial protection, as relevant.
4. **Budget impact analysis** examines and projects the potential financial and fiscal impact of adopting and diffusing a technology.
5. **Deliberative process** considers the results of cost-effectiveness analysis and budget impact analysis as well as more subjective decision-making criteria dependent on national values and context to recommend public or donor funding.
6. **Decision** assesses recommendations and makes decisions to include a technology in public or donor budgets.
7. **Appeals, tracking, and evaluation** allows for the appeal of recommendations and associated analysis, as well as the tracking and evaluation of the impact of decisions.

Cost-effectiveness analysis (CEA) compares the relative costs and effects (outcomes) of two or more courses of action.

- (a) **Marginal cost-effectiveness analysis (MCEA)**, also called incremental cost-effectiveness analysis, is only concerned with spending the marginal (i.e. the “next”) dollar on the most cost-effective option. It is exclusively based on an assessment of existing interventions, regardless of any explicit constraints. MCEA relies on a threshold as a simple decision rule for choosing whether or not to do something: if the cost-effectiveness of that activity is under the threshold, the activity should be implemented, but not otherwise. The threshold can represent some notion of social benefit but in practice it is usually defined by precedent. Such marginal decision-making on new priorities is likely to allow only for marginal improvements. The difference between the optimal position and the current position will tend to grow if marginal decision-making with respect to such criteria is repeated over many periods.
- (b) **Generalized cost-effectiveness analysis (GCEA)** does not assume that current practice is economically worthwhile. It estimates the cost-effectiveness of both the new and existing technology compared with a hypothetical “null” comparator. In GCEA, this null position is estimated by simulating the effects of “stopping” activities relevant to the domain of analysis. It does not mean removing all the effects that may persist after such activities are stopped -- the effects will usually wane as the population ages. In the WHO GCEA toolbox, known as CHOICE (<http://www.who.int/choice/en/>), the null reference scenario does not demand that they be artificially removed. Instead, the WHO CHOICE approach

assumes that priority-setting seeks to maximize benefit in a real-world setting. Therefore, CHOICE takes into account an explicit budget constraint (e.g. the current health expenditure) and realizable health gains are analysed with respect to this constraint. WHO CHOICE produces a set of interventions (activities, policies or projects) which, for a given budget, yields the highest achievable health gain. GCEA may identify opportunities for disinvestment or for increased investment in existing activities. In MCEA, such opportunities will be systematically missed.

- (c) Extended cost-effectiveness analysis (ECEA) “extends” GCEA by estimating, in addition to the health gains of an intervention, the benefits in financial risk protection and fairness (i.e. equity). These benefits can be assessed independently and reported in a “benefits dashboard”.

Program Budgeting and Marginal Analysis (PBMA) is used to determine the optimal mix of a particular set of services for a given amount of resources. While programme budgeting was originally conceived as a tool for tabulating expenditure of different programmes within an organization, marginal analysis was required as an evaluative technique to examine the reallocation of resources in order to improve benefit to the defined population. Based on the underlying economic principle of opportunity cost, use of marginal analysis can aid decision-makers in identifying potential changes in the mix of services provided which may lead to maximizing the health gains.

Limitations of PBMA mentioned in literature are:

- (i) the method is exclusively based on current programmes/priority areas and allocation criteria, and
- (ii) it is both time and data-intensive.

Burden of disease analysis (BoD)

Burden of disease analysis aims to quantify the gap between the ideal of living to old age in good health, and the current situation where healthy life is shortened by illness, injury, disability and premature death. BoD analysis can include epidemiological measures such as incidence, prevalence and mortality rates. The impact of a health problem is measured by financial cost, mortality, morbidity, or other indicators. Morbidity can be quantified in terms of quality-adjusted life-years (QALYs) or disability-adjusted life-years (DALYs), both of which quantify the number of years lost due to disease. Since DALYs/QALYs measure for loss of quality and productivity in life, these indicators are notably interesting in a setting where chronic conditions due to non-communicable diseases (such as diabetes type 2) are gaining importance over life-threatening communicable diseases (e.g. malaria).

The following examples illustrate models for BoD analysis that can also be considered in addition to the traditional BoD means of analysis.

- The Patient Generated Index (PGI) is self-administered, and aims to quantify (via questionnaire) the effect of a medical condition on a patient’s quality of life in a way that has meaning and relevance in the context of the individual’s daily life.



- ▶ The Lives Saved Tool (LiST) is a decision-making computer software that enables the estimation of intervention impact on mortality at national, regional and global levels. It contains an expansive evidence base of context-specific intervention effectiveness. A possible disadvantage of the tool is that it could encourage a vertical approach in health care strengthening, and does not take into account contextual factors that influence feasibility and effectiveness.

Health Needs Assessments (HNA)

Health Needs Assessments can include various epidemiological measurements on patterns of disease within a community or population. Examining these patterns can help to identify inequalities in health. The assessment outcome may, however, not be entirely in line with economic evaluations that focus on health problems with cost-effective solutions, because the emphasis with HNA is on high-mortality health problems (which may not be cost-effective). Despite this, HNAs provide a foundational basis for evaluating fundamental health problems.

2x2 grid

The 2x2 grid helps to evaluate priorities according to certain criteria. The grid consists of four quadrants; one broad criterion is assigned to each axis (e.g. “importance/urgency”, “cost/impact”, “need/feasibility”, etc.). Arrows on the

axes indicate “high” or “low”. Each quadrant is labelled as either “high need/high feasibility”, “high need/low feasibility”, “low need/high feasibility”, “low need/low feasibility”. Competing activities, projects, or programmes are evaluated against how well this set of criteria is met. They are then categorized and prioritized.

- ▶ **High need/high feasibility** – With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.
- ▶ **Low need/high feasibility** – Often politically important and difficult to eliminate, these items may need to be redesigned to reduce investment while maintaining impact.
- ▶ **High need/low feasibility** – These are long-term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.
- ▶ **Low need/low feasibility** – With minimal return on investment, these are the lowest priority items and should be phased out, allowing for resources to be reallocated to higher priority items.

Box A.4.1 shows a hypothetical 2x2 grid assessment of priorities in an Ebola outbreak situation. The need and feasibility parameters evolve over time, demonstrating that this sort of exercise can be done at regular intervals.

Box A.4.1

Priority-setting at national level after an Ebola outbreak

Emergency phase:

should stopping the outbreak be a priority?

High need/low feasibility

Need: Risk of outbreak further spreading, possibly becoming a pandemic.

Feasibility: No cure readily available; isolation of cases and prevention difficult.

Health system recovery:

should short-term investments be a priority?

High need/high feasibility

Need: Due to system breakdown (e.g. shortage of human and other resources), care in the affected areas is increasingly insufficient.

Feasibility: Emergency funding allows for rapid investments (e.g. by recruitment of new staff and by adding laboratory services) and for strengthening of key services (e.g. improvement of surveillance practices).

Resilient health system building:

medium-term strategies

Low need/high feasibility

Need: Parallel to the system recovery investments, an in-depth analysis of structural health system flaws (including those related to socioeconomic health determinants, and therefore multisectoral) can be thoroughly planned and implemented. Based on the results of this analysis, medium-term strategies can be developed for tackling deeply-rooted system weaknesses.

Feasibility: Firm political commitment at national and international level allows for strengthening the overall health system so that it can better prevent similar outbreaks and their spreading, as well as improve service readiness for the care of affected populations.



Basic Priority Rating System (BPRS)

The BPRS (Hanlon method) prioritizes health problems based on the nature of the problem and the effectiveness of the solution. The nature of the problem is defined by key variables, including the weight, severity, urgency, economic consequences, willingness and involvement of others and the effectiveness of the intervention. Each variable is given a rating on a scale of 1–10 (low to high). The method uses the steps outlined below.

Step 1: Rating against specified criteria – Once a list of health problems has been identified, on a scale from one through ten, each health problem is rated on the following criteria: size of health problem, magnitude of health problem, and effectiveness of potential interventions.

Step 2: The PEARL test is applied (see below).

Step 3: Priority scores are calculated, based on the three criteria.

Step 4: The health problems are ranked, based on the priority scores calculated in Step 3 of the Hanlon method, the highest priority score receiving a rank of “1”, the next highest priority score receiving a rank of “2”, and so on.

Propriety, Economics, Acceptability, Resources and Legality component (PEARL)

Once health problems have been rated by criteria, PEARL is used to eliminate any health problems which receive an answer of “No” to any of the questions below on aspects of feasibility. Alternatively, corrective action is planned to ensure that potential health priorities meet all five feasibility factors.

- ▶ Propriety – Is a programme for the health problem suitable?
- ▶ Economics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not addressed?
- ▶ Acceptability – Will a community accept the programme? Is it wanted?
- ▶ Resources – Is funding available or potentially available for a programme?
- ▶ Legality – Do current laws allow programme activities to be implemented?

Annex 4.2

Methods and tools for value-based approaches

Accountability for Reasonableness (AFR)

AFR is a decision-making approach that builds upon four conditions:

- (i) relevance to the local setting, decided by agreed criteria;
- (ii) publicizing priority-setting decisions and the reasons behind them;
- (iii) the establishment of revisions/appeal mechanisms for challenging and revising decisions;
- (iv) the provision of leadership to ensure that the first three conditions are met.

Citizen consultation processes

Citizen consultations can capture a population's demands, opinion and expectation on health-related matters in order to improve the transparency and relevance of the priority-setting process. Please refer to Chapter 2 "Population consultation on needs and expectations" in this handbook for more detail.

Multivoting technique (MVT)

1. Round-one vote: on a note card, all participants anonymously vote for as many priority focus areas as desired.
2. Update list: all votes are tallied and a small number of focus areas receiving most votes are posted for the group to view.
3. Round-two vote: all participants vote up to three times for the remaining focus areas.
4. Update list: all votes are re-tallied and the three focus areas receiving three or more votes are posted for the group to view.

5. Round-three vote: all participants vote up to two times and the only item with three or more votes is the chosen focus area.

Nominal group technique (NGT)

The technique involves a facilitator to direct a round-robin series of voting whereby an issue or problem is brought forward by each participant in the group. This is done "silently" with no group discussion and produces a lengthy list of areas that are recommended by the group for prioritization; this is also known as silent brainstorming. The items are then grouped together and categorized by nature of the issue and a discussion is facilitated to determine if the items measure up to the criteria decided upon prior to the NGT process. Participants are then asked to individually rank the various health problems identified on a scale of 1–10 (or most appropriate scaling measure). Responses are then collected, and calculated by the facilitator, who reports the scores back to the group. This process is then repeated, either by group consensus or individual ranking until the results are narrowed down further.

Delphi technique

The Delphi technique facilitates decision-making based on the results of questionnaires sent to a group of experts. Several rounds of questionnaires are sent out, and the anonymous responses are aggregated and shared with the group after each round. The experts are allowed to adjust their answers in subsequent rounds. Since multiple rounds of questions are asked and the panel is told what the group thinks as a whole, the Delphi technique seeks to reach the correct response through consensus.



Table A.4.1 Example Delphi questionnaire

In your view, which of the following clinical areas should be high priority for development of an improved evidence base on minority ethnic groups and their health needs?

CLINICAL AREA	PRIORITY LEVEL FOR DEVELOPMENT OF AN IMPROVED EVIDENCE BASE	COMMENTS – INCLUDING ANY PARTICULARLY IMPORTANT TOPICS FOR ACTION
Mental Health	Low 1 2 3 4 5 High 0 (don't know)	
Cancer	Low 1 2 3 4 5 High 0 (don't know)	
Immunization	Low 1 2 3 4 5 High 0 (don't know)	

The questionnaire provides space for respondents to raise any other issues relating to the topic. The first round of the questionnaire aims to

categorize opinions under common headings. Based on an analysis of round 1 responses, a second questionnaire is then prepared.

Table A.4.2 Example Delphi questionnaire

Cancer has been identified as a high priority for developing an evidence base relating to minority ethnic groups. Within this clinical area, what aspects should research focus on?

RESEARCH AREA	PRIORITY FOR DEVELOPMENT OF AN IMPROVED EVIDENCE BASE	COMMENTS, IMPORTANT TOPICS FOR ACTION
Identifying risk factors of disease	Low 1 2 3 4 5 High 0 (don't know)	
Identifying barriers to access to services	Low 1 2 3 4 5 High 0 (don't know)	
Improving the patient experience for minority ethnic groups	Low 1 2 3 4 5 High 0 (don't know)	

After analysis of the round 2 responses, a third round questionnaire may be designed. Here, the second round questionnaire is repeated but incorporates scores from the second questionnaire results. This gives participants a chance to see how the rest of the group prioritized the areas. If the participant then wants to change his/her opinion on the basis of the group consensus, he/she has the opportunity to do so.

Finally, the results of the third round questionnaire are analysed for agreement and degree of consensus and the findings are reported.

Multi-criteria decision-making (MCDM)

MCDM is a quantitative decision analysis model that captures preferences of decision-makers and discovers the most desired solution to the problem. It is a hybrid method in that it incorporates both technical and value-based approaches. It is based on a performance matrix where each row describes an option and each column describes the performance of the options against each criterion. To do so, five criteria are applied: maximization of general population health, the distribution of health in the population, specific societal preferences, budgetary and practical constraints, and political considerations.



