IMPROVEMENT STRATEGIES MODEL:

ADJUSTMENT TO POPULATION HEALTH NEEDS: PRIORITY SETTING

Led by: BILL & MELINDA GATES *foundation*   THE WORLD BANK IBRD • IDA | WORLD BANK GROUP   World Health Organization   In partnership with: ARIADNE LABS   RESULTS FOR DEVELOPMENT

PRIORITY SETTING

Priority setting is the process of making decisions about how best to allocate limited resources to improve population health. Priority setting is a complex and inherently political process involving a diverse array of stakeholders, decision-makers, and actors whose motivations and actions are often imperfectly aligned. Effective priority setting addresses these differing interests and motivations through a clear process focused on the use of evidence, transparency, and participation to identify the most appropriate programs and interventions to address population health needs. (1,2) Priority setting relies on the use of diverse sources of data (including health and burden of disease information, service delivery evaluations, and cost-effectiveness assessments) as well as stakeholder input to prioritize the most appropriate programs and interventions and inform resource allocation. (3), (2,4) While priority setting for PHC is an integral part of improving population health for all, it must be supported by strong governance, political, and financial commitment as well as regulation and implementation capacities to achieve priority setting goals. (5) Effective priority setting is central to building resilient health systems that can effectively adapt and respond to changing population health needs and demands. (6–9)

Priority setting may occur at all levels of the health system. The information here is specific to national and sub-national priority setting; more information can be found in the local priority setting Information Systems module.

WHAT IT IS: WHAT IS PRIORITY SETTING AND WHY IS IT IMPORTANT?

INTEGRATING STAKEHOLDER ENGAGEMENT AND SOCIAL ACCOUNTABILITY INTO PRIORITY SETTING

Priority setting is a shared and multisectoral responsibility that relies on participatory and inclusive stakeholder engagement, including both people who will be affected by decision-making and people who can influence the implementation of the selected priorities during the priority-setting process. (2), (10) Stakeholder engagement plays an important role in priority setting because it ensures that priorities reflect population needs and that the interventions and programs selected are acceptable, appropriate, and desired. (6,11) Stakeholder engagement should be systematic, meaning the processes for identifying, communicating with, and convening stakeholders are transparent and consistent, with engagements occurring at regular, predefined intervals as well as on an ad-hoc basis, as necessary. Opportunities should be made for citizens to play an active role in shaping the priority setting agenda, including through citizen consultations and community leader involvement in decision-making processes.

The World Health Organization identifies three categories of stakeholders that should be involved in priority setting: (12), (2,13)

- **Government:** The role of the government is to plan, initiate, coordinate, and oversee the priority setting process within and across stakeholders and organizations. The way in which government stakeholders coordinate the priority setting process and who specifically will engage depends on the economic and political environment of the health system. For example, decentralized environments may need to collaborate more with local governments and providers whereas highly aid-dependent contexts may involve more collaboration with development partners. High-level actors may include policy-makers and planners in the Ministry of Health and other ministries as well as administrative and health authorities at decentralized levels.

- **Providers:** Service delivery providers are important stakeholders because they can offer insights into the feasibility of prioritized service delivery decisions, including balancing patients' needs and demands with cost-effectiveness. Provider-level actors may include health professionals in both the public and non-public sectors.

- **Clients/citizens:** To ensure stakeholders are accountable for their decisions, citizens should be involved in determining which priorities are set as a part of a democratic process. (2) Citizens should be well-informed in advance about the advantages and disadvantages of various options. Citizen-level actors may include citizens themselves, community representatives, and/or groups of patients. Particular attention should be given to ensuring a diverse and representative group of citizen-level actors in this process.

Stakeholders must be willing to continue participating in the process and accept priority setting decisions, even if they disagree with the outcomes. (4) Effective stakeholder engagement relies on robust institutional frameworks for multisectoral action and social accountability strategies. (2) More information on multi sectoral engagement and social accountability can be found in the relevant tools and resources page for priority setting.

SETTING THE CRITERIA FOR THE PRIORITY SETTING PROCESS

Criteria are a set of measures that stakeholders use to weigh and determine which health problems, challenges, and solutions should be made a priority. These criteria should be defined before starting the priority setting process and be the basis for final priority setting decisions. In order to make high-quality PHC a priority, stakeholders need to define the principles that drive high-quality PHC (such as equity, efficiency, and sustainability) and set priorities for their health system based on these principles. (5) These principles will inform how stakeholders evaluate criteria relative to each other when considering what is politically feasible, affordable, and technically possible. (2), (14) The WHO suggests a non-comprehensive list of five criteria that can be used to set priorities in the health sector. These include:

- **The burden of disease:** The burden of disease is a quantitative, time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of sub-optimal health (i.e. injury, disease).

- **The effectiveness of the intervention:** This criteria evaluates how well the identified health issue can be addressed (clinically or practically) by the given intervention, including if the intervention is applicable and cost-effective for the local-context.

- **Cost of the intervention:** This criteria considers the cost of an intervention in terms of affordability and efficiency. It is important to consider the absolute and relative costs to the health sector, target community, and the individuals. The cost of an intervention must be both economically feasible and sustainable.

- **Acceptability of the intervention:** This criteria refers to whether the target community or population accepts the chosen health intervention, taking into account the social and cultural norms as well as the willingness of providers or other health authorities to carry out the intervention (i.e. risk aversion, resistance to change, perceived value). This criteria strongly relates to the applicability and feasibility elements of the effectiveness criteria; both require contextual knowledge to evaluate the intervention.

- **Fairness:** Fairness is a value judgment made collectively by governments and society based on the principles of equality and equity. The fairness criteria is essential to making well-informed judgements about tradeoffs on the importance of a health need and the effectiveness of an intervention. It also influences how much weight to give to the cost of a solution. For example, it might be important to prioritize the health problems of a specific at-risk or marginalized

segment of the population, even if the intervention is not particularly cost-effective. An evaluation of fairness can help direct resources to marginalized populations, even when the intervention is not the most cost-effective solution.

Often, stakeholders will have to make trade-offs between different criteria; for example, stakeholders may consider both equity and cost-effectiveness in the evaluation of a given health intervention and find that the intervention that is the most equitable might not be the most cost-effective. The weight given to different criteria is ultimately a political decision shaped by the country-context, including values, principles, and economic and political environment. (2)

While the above criteria are a strong starting point for priority setting conversations, new criteria may need to be added or adapted based on contextual factors, such as the epidemiological and demographic profile of the country, the health system structure, and political and financial capital. (2,15) Accordingly, local needs and norms will influence the relative weight attached to these different criteria. The analyses of these criteria will depend on both the quality of the data and information available - including information on the implementation of interventions.

CONDUCTING A SITUATION ANALYSIS

Effective priority-setting is based on data and evidence and priority-setting exercises should therefore start with an in-depth situation analysis of the health sector to determine existing and emerging needs.(2) A situation analysis identifies the strengths and weaknesses of the health system and is a key initial step in the development of different elements of the national health plan, including the strategic directions and identification of priority diseases and interventions. (11) The situation analysis must generate a sufficient evidence-base to ensure that stakeholders have access to quality and diverse information needed to make informed decisions consistent with the needs and values of the population (4) While the situation analysis can happen at any level of the health system and on varying themes and scopes, such as health financing or workforce, (2,11) this module focuses on an overall health sector situation analysis for system-wide priority setting.

According to the World Health Organization, a well-facilitated situation analysis should be **participatory and inclusive, analytical, relevant, comprehensive,** and **evidence-based** and is separated into three distinct streams of analysis: (11)

- **Health data -** Analyses of health data from all levels of the health system - national, regional, and local - including trends and developments over time, provide information on both the health needs of the population and the current performance of the health system in meeting those needs. Analysts involved in examining health data should include technical experts trained to analyze and interpret data and non-technical experts familiar with health sector activities. Examples of data sources include population health surveys, HMIS, CRVS, facility assessments, patient-reported outcomes, and surveillance system reports.

- **Activity and budget -** An analysis of the health sector budget and the implementation of health sector activities should assess whether the budgets allocated in the health sector and the policies, strategies, or plans adopted into the national health plan reflect the broader national health plan objectives, including whether activities are sufficiently funded and able to be implemented as per the planned activities and budget. Examples of data sources include Ministry of Health and Ministry of Finance routine financial reports, national health accounts, public expenditure data, performance reports, and facility assessments.

- **Effectiveness of national health plan activities** - This analysis should assess the strengths and weaknesses of different elements in the health system, including programs, sub-policies, and

strategies, focusing on whether those elements have achieved the expected results and what changes may need to occur in order to reach higher levels of effectiveness. While the first two streams of analysis rely heavily on technical expertise, this analysis is grounded in a participatory dialogue that considers both the opinions of experts as well as those using the health system on a daily basis - the service providers and population themselves.

The situation analysis should be conducted by a core team of working groups comprised of relevant experts and stakeholders who have sufficient understanding of the issue and are representative of all the categories of the population. (11) More information on establishing working groups, identifying the expertise required for situation analysis, and sequencing of work can be found in the WHO chapter on situation analysis of the health sector.

CONDUCTING THE PRIORITY SETTING EXERCISE

The World Health Organization summarizes the recommended steps for the priority setting process as: (2)

1. Adopt a clear mandate for the priority setting exercise
2. Define the scope of the priority setting exercise 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 for priority setting and assure the availability of the necessary resources
6. Develop an effective communication strategy
7. Inform the public about priority setting and engage internal/external stakeholders
8. Organize the data collection, analysis, and consultation/deliberation processes
9. Identify or develop a scoring system
10. Adopt a plan for monitoring and evaluating the priority setting exercise
11. Collate and analyze 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

This process should result in a set of priorities, ranked by what is considered to be the most important based on the established criteria, discussed in "establishing the criteria" above. More information on methods and tools for priority setting such as cost-effective analysis, health needs assessments, and burden of disease analysis is available in Annex 4.1 of the World Health Organization's chapter on priority setting for national health policies, strategies, and plans. Additional methods and tools for value-based approaches to priority setting, such as accountability for reasonableness, multi-voting technique, nominal group technique, and multi-criteria decision-making are available in Annex 4.2 of the World Health Organization's chapter on priority setting for national health policies, strategies, and plans.

In addition, stakeholders can explore the Disease Control Priorities Review (third edition), managed by

the University of Washington's Department of Global and the Institute for Health Metrics and Evaluation, which includes a review of global evidence about the most cost-effective ways to address the burden of disease in low-resource areas and existing and emerging policies and platforms that support universal health coverage. (16) Actionable recommendations for building smart and ethical decision-making systems for priority setting are also found in the Center for Global Development's report on Priority Setting in Health: Building Institutions for smarter public spending.

TRANSLATING PRIORITIES INTO ACTION

After the priority setting process, relevant stakeholders will need to translate priorities into the strategic and operational plans for the health sector, followed by costing and budgeting, implementation, and finally, monitoring and evaluation. (2) Multiple tools exist to assist with the planning and implementation of health interventions set as a part of the priority process, including Partners in Health's UHC Monitoring and Planning tool. (17,18) More information on resources allocation and planning can be found in the World Health Organization's chapters on estimating cost implications of a NHPSP, budgeting for health, monitoring, evaluation and review of NHPSP, and strategizing for health at sub-national level.

WHAT OTHERS HAVE DONE: WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE PRIORITY SETTING?

INDIA: A DECENTRALIZED APPROACH TO IMPROVING COMMUNITY-ENGAGEMENT IN PRIORITY SETTING

The National Rural Health Mission (NRHM), now named the National Health Mission was launched in 2005 in India to improve the availability, access, and quality of high-quality health services for all. The NRHM focuses on 18 states with weak public health infrastructure and outcomes to improve care for poor women and children living in rural areas. (19) The launch of the NRHM required significant collaboration among a diverse set of stakeholders from different sectors and political parties to improve various deficiencies in the health system such as a lack of community ownership and accountability, infrastructure and human resource shortages, and a lack of integration among disease control programs. (20)

The Government of India is actively promoting a decentralized approach to develop and maintain more participatory and accountable processes for decision-making and to provide more efficient opportunities for community involvement. The NRHM has leveraged this decentralization to increase stakeholder and public engagement in priority setting at the village, sub-center, block, district, and state levels. (2,19,21) To better tailor resources and services to local community needs, there are specific guidelines for the allocation and management of funds and roles and responsibilities related to service delivery at different levels of the health system. Elected representatives are involved in the institutional structures at all levels of the health system to provide an efficient avenue for communities to express their voice. Additionally, various committees are in place at the district and village level to ensure decentralized planning, efficient allocation of funds, and the integration of community voices - including district health committees, village health sanitation and nutrition committees, and facility-based committees.(22)

Despite the roll-out of these institutional structures for participatory decision-making, studies have shown mixed-results.(2,20,22) This is in part due to a poorly-defined planning process and low levels of awareness of the role and functions of the different communities. However, states in India that have a stronger state and local institutional capacity to support civil society organizations and mobilize partnerships between different stakeholders have had more success in implementing the NRHM initiatives, including decentralized health planning.(22,23) These studies underscore that mandating public participation is not sufficient and success relies on the presence of support structures such as well-defined policies and guidelines and sustained capacity-building efforts at lower levels of health system. (2)

AFGHANISTAN: PRIORITY SETTING FOR UNIVERSAL HEALTH COVERAGE IN A CONFLICT SETTING

Despite periods of intense conflict, economic insecurity, and significant resource-constraints, Afghanistan has achieved gains in population health over the last two decades. Since 2001, Afghanistan's ministry of health has made ongoing efforts to rebuild the fragmented health system and revise its package of health services to better address population health needs and health challenges. Considering 80% of Afghanistan's health system is funded by donors (16) and the global trend toward reductions in donor spending, it is an especially important moment for the ministry to invest in priority setting mechanisms that promote sustainable and cost-effective strategies for health services funding.(24) Most recently, (2017 - 2018), the ministry collaborated with national working groups from different levels of the health

system to revise both the basic and essential package of health services in response to the global agenda for universal health coverage (UHC) and changing population health needs and health threats, including noncommunicable diseases and injuries due to road incidents and conflict. This new package of health services launched in January 2019 with the hope to make the Afghan health system more sustainable and more resilient to changes in population health needs and crises. (16)

The ministry and working groups used the third edition of the national disease control priorities (DCP3) series to translate international evidence on cost-effectiveness of interventions, health and disease estimates, and cross-sectoral policy interventions for UHC to the Afghan context. To facilitate a fair and transparent priority-setting process, the Ministry of Health adopted a multicriteria approach based on five principles: translating international evidence to the local context, creating consensus among all stakeholders on a well-defined selection criteria, conducting a transparent and documented process, and agreement by all health system actors on priority decisions made during the priority setting exercise. The process was guided by two key questions: 1) Which interventions are no longer justified as a top priority and which additional health interventions are needed? And 2) How will the new package of health services be accessible to the most vulnerable and geographic isolated groups of the population?

The process also had five selection criteria: effectiveness, local feasibility, affordability, and equity.(16) The Afghan exercise offers an important example of setting priorities to achieve population health gains and UHC by adapting international evidence to the local context through a clear and transparent multilevel and multisectoral decision-making process.

TANZANIA: PARTICIPATORY DECISION-MAKING IN PRIORITY SETTING

Achieving the goals of priority setting is a shared and multisectoral responsibility that relies on participatory and inclusive stakeholder engagement across all levels of the health system. (2) Diverse stakeholder involvement can help to improve stakeholder accountability (25), restore public trust in the health system, and aid in the selection of cost-effective and contextually-relevant programs and interventions for achieving population health gains. (1,2), (26,27) Globally, countries have increased efforts to involve communities through decentralization strategies such as the formation of health committees or boards including community representatives. (28) However, full community participation in the priority setting process continues to be a challenge in resource-constrained settings with weak organizations and fragile democratic institutions. (27) (28)

In Tanzania, decentralization and health sector reforms have placed an emphasis on community participation in priority setting. (29) This is largely in response to Response to Accountable Priority Setting for Trust in Health Systems (REACT), a 5-year project carried out in 2006 in Kenya, Zambia, and Tanzania by researchers from institutions in Tanzania and Europe. The REACT project aimed to test the application and effects of the Accountability for Reasonableness (AFR) approach for improving fairness in priority setting in resource-constrained settings. The AFR approach provides stakeholders with a framework to establish priorities for their specific contexts by way of four conditions: relevance, publicity, appeals and revision, and enforcement/leadership and public regulation. (27,30) Tanzanian decentralization policy is written in service of a bottom-up approach to decision making, by which community and facility-level health committees and boards set priorities at the local level and relay this upward to higher level decision makers. (29,31). Despite the presence of these community-involvement platforms and decentralization policy, studies carried out in the Mbarali district in southwestern Tanzania have shown extension limitations of fair and active participation of communities in the decision-making process. Several groups, including women, low-income and less educated individuals, and minority groups, were found to be discriminated against in the decision-making process related to biased perceptions about these individuals' capacities for decision making. (29) While the decisions that were made were

publicized through communication mechanisms such as circulars and notice boards, there were no formal mechanisms to share this information with the public nor a process for the public to share feedback and hold stakeholders accountable to fair and equitable decisions, underscoring the need for increased community awareness, consideration of contextual barriers, and external validation of the priority setting process. (27,31) Despite these gaps, the Tanzanian government is aware of the need for a more inclusive priority-setting process (31). Users can find more information on the AFR framework here, and Tanzania's participatory approach to priority setting here and here.

WHAT TO ASK: WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for assessing priority setting in your context and determining whether it is an appropriate area of focus and how one might begin to plan and enact reforms.

HOW RELIABLY AND CONSISTENTLY ARE DATA USED TO INFORM PRIORITY SETTING?

The following types of data should be systematically used to set priorities at the national and sub-national level:

- User needs and preferences
- Service delivery evaluations
- Health and burden of disease
- Cost-effectiveness

To understand the degree to which data are used to set service delivery priorities, you might consider looking at the types of data, variation in data availability, and the use of these data. Are data available, presented, discussed and applied through consistent processes for nearly all of priority setting exercises? If not, are gaps due to problems with information systems, decision-making processes, policies, or other factors?

HOW ARE STAKEHOLDERS ENGAGED IN THE PRIORITY SETTING PROCESS?

Stakeholders should be systematically engaged in all priority setting exercises. It is important to engage a diverse array of stakeholders, with systems in place for facilitating a transparent and inclusive decision making processes and managing feedback and demands from stakeholders at national and sub-national levels. If stakeholder engagement does not occur or is not occuring for all priority setting exercises, you might consider looking at recent examples of priority setting in your country. Are processes for identifying, communicating with, and convening stakeholders in place? Are these transparent, inclusive, and consistent? Are engagements occurring at regular, predefinied intervals and when necessary, on an ad-hoc basis? If not, are gaps due to problems with social accountability mechanisms, communication networks, policies, or other factors?

HOW OFTEN AND RELIABLY ARE THE RESULTS OF THE PRIORITY SETTING EXERCISE USED TO INFORM RESOURCE ALLOCATION?

The results of the priority setting exercise (the most appropriate programs and interventions) should determine the allocation of resources all or nearly all of the time to improve population health. If resources are not being appropriately allocated, or current programs and interventions are not improving population health needs, you might look to the effectiveness of past priority-setting exercises and consider factors such as:

- Are existing and emerging health needs being assessed?
- Are stakeholders being engaged and held accountable to decisions?

- Is an explicit process for setting priorities being used?

- Are the values and context being appropriately considered?

- Are any decisions made being communicated to the relevant stakeholders, with systems in place for managing feedback and demands as a result of these decisions?

- If not, are gaps due to problems with governance, political and financial commitment, regulatory and legal structures, or other factors?

HOW TO SUCCEED: WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

HEALTH FINANCING, PRIMARY HEALTH CARE POLICIES, AND HIGH-QUALITY PHC

Priority setting, strong policies, and financing exist in virtuous circles - each can strengthen the other and ideally all exist in a mutually reinforcing manner. For example, strong governance structures, such as PHC policies and dedicated budgets, help to inform the appropriate allocation of resources and translate priorities into action. Resources and interventions for improving PHC should be periodically reassessed to align with population health needs. (5) To ensure priority setting for PHC, the process must be aligned with primary health care policies and guided by the core principles of high-quality PHC (care that is continuous, coordinated, comprehensive, and person-centered with PHC as the first point of contact).

Find more information in the *health financing, primary health care policies,* and high quality PHC Improvement Strategies modules.

SOCIAL ACCOUNTABILITY AND COMMUNITY ENGAGEMENT

Achieving the goals of priority setting is a shared and multisectoral responsibility that relies on participatory and inclusive stakeholder engagement and accountability across all levels of the health system. (2) Priority setting exercises should draw upon and strengthen existing community engagement and social accountability mechanisms and to ensure that decision-makers select priorities that align with population health needs and demands and are sensitive to local values and context.

Find more information in the access, proactive population outreach, and community engagement Improvement Strategies modules.

INFORMATION SYSTEMS AND INNOVATION AND LEARNING

Priority setting relies on the use of diverse sources of data (including health and burden of disease information, service delivery evaluations, and cost-effectiveness assessments and surveillance data) as well as stakeholder input to prioritize the most appropriate programs and interventions to improve population health for all. (3),(2,4) Throughout the process of setting priorities, it is important to have mechanisms for innovation and learning in place to ensure that priorities are set through an inclusive and transparent process and priority recommendations are consistent with the best global evidence and population health needs. This requires routine incorporation of new evidence from research or data and routine reviews and discussion of progress and challenges so that lessons from past events are identified and can be used to predict and/or improve response to future threats or changing health needs.

Find more information in the *information systems* and *innovation and learning* Improvement Strategies modules.

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