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ORIGINAL ARTICLE

A Strategy to Improve Priority Setting in Developing Countries

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Abstract Because the demand for health services outstrips the available resources, priority setting is one of the most difficult issues faced by health policy makers, particularly those in developing countries. Priority setting in developing countries is fraught with uncertainty due to lack of credible information, weak priority setting institutions, and unclear priority setting processes. Efforts to improve priority setting in these contexts have focused on providing information and tools. In this paper we argue that priority setting is a value laden and political process, and although important, the available information and tools are not sufficient to address the priority setting challenges in developing countries. Additional complementary efforts are required. Hence, a strategy to improve priority setting in developing countries should also include: (i) capturing current priority setting practices, (ii) improving the legitimacy and capacity of institutions that set priorities, and (iii) developing fair priority setting processes.

Keywords Developing countries · Improvement strategies · Priority setting

The Current State of Priority Setting in Developing Countries

Priority setting is one of the biggest challenges faced by health planners worldwide, because the demand for health services outstrips the resources available to finance health care [1]. It is a process that is inevitably value-laden and political [2–4], requiring credible evidence and strong and legitimate institutions and fair processes [5].

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Priority setting is arguably most important when resources are scarce, as is the case in developing countries [6] where government expenditures on health is less than USD $20 per capita per year [7]. This is further complicated by (i) the burden of underdevelopment in these countries which increases the gap between the health needs and resources available to respond to them, (ii) the many uncertainties in priority setting due to lack of dependable information, (iii) the multiple players with various agendas, (iv) few systematic processes for decision making and, (v) multiple obstacles to implementation such as political instability, inadequately developed social sectors, weak institutions, and marked social inequalities, which make the implementation of systematic priority setting processes difficult [2]. Hence, priority setting within these context tends to be ad hoc and occurring more by chance than by choice [8]. How can developing country planners improve their priority setting processes?

International experiences could inform decision makers. However, there is no systematic learning platform for capturing and sharing lessons. In reviewing the literature on international experiences in priority setting Holm & Haudemaekers [9, 10], noted that the search for “simple technical solutions” to the problem of priority setting has failed. The meager literature on priority setting in developing countries identified four major challenges: (i) lack of information [11] (ii) overcoming the disconnection between who is setting priorities in developing countries and who should be [12]; (iii) overcoming the disconnection between the values that are driving priority setting decisions in developing countries and the values that should be; [13, 14]; and (iv) the weak institutions and meager capacity available to make priority setting decisions [2, 15].

In the past decade, efforts to address priority setting challenges in developing countries have focused on the first challenge by developing information and tools to aid decision making. For example, the World Health Organization projects- The Burden of Disease and Cost-effectiveness analysis, then—CHOosing Interventions that are Cost- Effective (WHO-CHOICE) which provide evidence on the burden of disease and cost-effectiveness of selected interventions in developing countries [11]. A recent series in the British Medical Journal used this information to identify priorities for reaching the millennium development goals for child health. The authors of these series, however, noted the need to strengthen institutional capacity and the fact that factors other than cost-effectiveness do and should influence priority setting in the real world [16].

Our paper expands on this theme and argues that improvements in priority setting may not be realized unless there are corresponding efforts to: *Capture and share current priority setting practices; strengthen the legitimacy and capacity of priority setting institutions,* and *develop fair priority setting processes.*

Capturing Priority Setting Experiences

Any sustainable strategy to improve priority setting must be built on a continuous learning platform that, at the very least, captures how priority setting decisions are actually made. This requires description of the key contextual factors (such as the social, economic and political factors) of relevance to priority setting, the people or institutions involved in priority setting, the criteria or values used in decision making and how these were identified, the information or evidence used, and a description of the priority setting process.

Capturing the experiences of decision makers from multiple contexts can provide an evidence base upon which to build context sensitive improvements. Kleinman has argued that knowledge regarding complex social phenomena, such as priority setting, must be grounded

in “local worlds [17]. Fraser also further warns that any intervention intended to improve priority setting that is not empirically grounded in actual practice may be inappropriate or impractical [18]. Based on these arguments, Martin and Singer [19], developed an evidence-based strategy to improve priority setting, which is grounded in the local priority setting context. The strategy involves (i) *describing* priority setting in the context where it occurs; (ii*) evaluating* the description using an ethical framework; and (iii) *improving* priority setting based on the evaluation. Since this *describe*-*evaluate*-*improve* strategy is generalizable and has been used to improve priority setting processes in different health care institutions [20–27] the lessons learnt from using this approach can serve as exemplars for similar efforts in developing countries.

Strengthening the Legitimacy and Capacity of Priority Setting Institutions

A necessary, though insufficient, condition for effective priority setting is the presence of institutions with legitimate decision makers [27–28]. Legitimacy refers to the moral authority of the *people*/*institutions* who exercise priority setting authority and how that authority is derived. Legitimacy is relevant because priority setting is value laden and there is no consensus about the values that should influence priority setting. Priority setting reflects the local values of the people and institutions involved in the process in any specific context [29]. In addition to being legitimate, the institutions that set priorities should have the capacity to analyze evidence, clarify policy choices and promote informed debate [2]. Unless they have the capacity to use the information, providing more evidence may only lead to more confusion in priority setting [5]. Unfortunately, some of the legitimate institutions that should set priorities in developing countries are thought to be lacking in the necessary capacity.

While there might be actual lack of capacity, it is also important to recognize that most institutions that set priorities in developing countries operate within very complex contexts which may make it difficult for these institutions to function as they should. For example, in addition to the lack of credible tools and evidence on which to base their decisions, many developing countries have to comply with the macro- economic policies- such as the Structural Adjustment Policies (SAPs), which have not always favored the health sector [30]. In addition, most of the health sectors in low income countries heavily rely on donor support for their health budgets, yet in contexts such as Bangladesh, donors (may be through their experiences) have been known to perceive government institutions to be weak, and lacking in accountability and integrity [4]. Leading to lack of confidence in government institutions and high external influence either directly or through provision of strict policies and guidelines. The strict guidelines that accompany some of these policies and funding make local in-put to decision making almost impossible and may distort local priority setting [31]. Under these circumstances, the local institutions lack the necessary capacity and leverage to influence priority setting decisions; leading to predominant influence of a few powerful people- mostly donors/developmental partners [12, 31].

While they may influence priority setting, their legitimacy in making these decisions has been questioned in some contexts. For example, in a study carried out by Kapiriri et al. [12], health planners and practitioners in Uganda were asked to indicate, (by ranking), the people who (they thought) currently influenced and those who should- ideally influence priority setting. The findings indicated that while the actors taking the lead in priority setting included, among others politicians and donors, the respondents ranked these lower when asked to indicate who they thought should ideally be playing the main role in priority setting. (see Box 1).

Box 1 The mismatch between actual and ideal decision makers in the Ugandan health system.

Actual	Ideal
1. Health professionals	1. Health professionals
2. Donors	2 Patients
3. Politicians	3 General Public
4. NGOs	4 NGOs
5. General public	5 Politicians
6. Patients	6 Donors
7. Consumer organizations	7.Consumer Organizations
8. Insurance companies	8.Insurane companies
9. Judiciary	9. Judiciary
10. Other sectors	10. Other Sectors

(Source: Kapiriri et al, 2004)

Given the people's preferences and the legitimacy of involving the people affected by the priority setting decisions in the process, influences of a few "powerful" people should be mitigated. This can be facilitated through identifying and empowering the legitimate people/institutions by augmenting their capacity to set priorities through training, ensuring that they have access to credible evidence and tools, and the legal and moral mandate, to enable them to make priority setting decisions. *Effective* implementation of Sector Wide Approaches (whereby donors support the budget of the health sector through basket funding (as opposed to vertical projects), and governments take the lead in identifying their own priorities), may be useful in mitigating these external power influences [32].

Developing a Fair Priority Setting Process

There is no consensus about overarching and universal criteria to guide priority setting. For example, although relevant and important, efficiency, embodied by cost-effectiveness analyses, is not the only value important for priority setting in developing countries [33–35]. Given the lack of consensus about universal criteria, priority setting decisions must be worked out locally, and the goal of priority setting should be fairness [23]. Fairness pertains to the *process* of making priority setting decisions.

Legitimacy and fairness are interrelated in that, over time, a fair priority setting process tends to convey legitimacy upon the decision makers involved. However, they are also discrete – legitimate authorities may make decisions unfairly; illegitimate authorities may make decisions fairly. "Accountability for Reasonableness" is an ethical framework which articulates the characteristics of a legitimate and fair priority setting process [6].

Box 2 The mismatch between actual and ideal decision makers in the Ugandan health system.

Relevance: Rationales for priority setting decisions must rest on reasons (evidence and principles) that 'fair-minded' people can agree are relevant in the context.
Publicity: Priority setting decisions and their rationales must be publicly accessible – justice cannot abide secrets where people's well being is concerned.
Revisions/Appeals: There must be a mechanism for challenge, including the opportunity for revising decisions in light of considerations that stakeholders may raise.
Enforcement: There is either voluntary or public regulation of the process to ensure that the first three conditions are met.

(*Source: Daniels and Sabin, 2002*)

'Accountability for reasonableness' framework has been identified as one of the most important advances in priority setting in recent years [1], because it helps to operationalize fair priority setting in specific priority setting contexts, enhancing democratic deliberation regarding priority setting.· It is theoretically grounded in justice theories emphasizing democratic deliberation [36]. It was developed in the context of real-world priority setting processes, and is therefore able to give practical guidance to decision makers. 'Accountability for Reasonableness' has emerged over the past five years as a leading framework for priority setting research [1, 19–20]. According to 'accountability for reasonableness', a fair priority setting process meets four conditions: *relevance*, *publicity*, *revisions,* and *enforcement*. (See text Box 2).

Within the context of a legitimate institution (described above), the *relevance* condition would be satisfied if priority setting decisions are based on rationales that are relevant to the legitimate stakeholders within the priority setting context. This would necessitate eliciting of values and criteria for priority setting from a representative group. Here, special attention should be given to the selection of the group, the methods used in eliciting the values and the amount of information given to the participants [37]. Once elicited, the values should be tested for their ethical appropriateness, before establishing their relevance to the legitimate stakeholders [13, 21]. However, since fair processes may not resolve all disagreements with regards to the reasons, decision-makers may need to identify a set of agreed upon core set of relevant reasons- to ensure consistence in decision making- and also decide on how conflicting reasons are to be balanced- a priori [38]. The *publicity* condition would be satisfied if the priority setting decisions and the reasons are made publicly available so as to stimulate public debate on priority setting. While there may be risks to publicity [39], consistent publicity of the rationales and decisions would lead to more efficient, coherent and fairer decisions [27]. The *revisions* condition would be satisfied if there are mechanisms for challenging and revising decisions in view of new evidence. Dispute resolution in priority setting would (i) provide stakeholders with an opportunity to voice their opinions, and (ii) contribute to a wider social learning curve- these would eventually contribute to improving priority setting [1, 19, 23]. The *enforcement* condition would be satisfied if there is public or legal leadership, to ensure that the first three conditions (of relevance, publicity and revisions) are met [27]. Efforts to describe, evaluate and improve priority setting in developed countries have been beneficial to decision makers both in hospitals [22, 27], and in regional health authorities [26]. These experiences can serve as exemplars for similar efforts in developing countries.

Table 1 A strategy to improve priority setting in developing countries

Strategic focus	Issues to be addressed	Action points
Capturing current practices	Describing: - the priority setting contexts - the people involved and existing external influences - the tools used - the values and evidence that guide the decisions - the priority process	Identify the good practices and opportunities for improvement in the current actual practices
Strengthening the legitimacy and capacity of institutions	*How legitimate are the people/institution that set priorities?* What mandate do they have (appointed or elected)? Who is represented? How do they ensure that all voices are heard? *Do they have the required capacity?* What training and skills do they have? What resources (information) do they have? What is the status of the institution's information technology system?	If legitimate institutions exist, train them to ensure they have the necessary analytical capacity to use the available evidence to set priorities and to promote informed debate Mitigate the impact of the external (powerful) influences Strengthen the capacity of the institutions to use the available Information Technology to synthesize and use credible evidence in priority setting.
Developing fair priority setting processes	*Is the current priority setting process fair*? Are legitimate stakeholders involved? What rationales are considered? Do they publicize the decisions and rationales? Is there provision for appeals and revision? Are there mechanisms to ensure that the priority setting process is fair?	Ensure that the priority setting process conforms to the four conditions of 'Accountability for—Reasonableness' Enhance the knowledge and capacity of context-specific leaders to implement fair processes.

Next Steps

Table 1 lists the 3 strategic foci outlined above, the issues to be addressed within each foci, and the relevant action points that flow from each.

(i) *Capturing current practices* would necessitate descriptive studies of the priority setting contexts including the social, political and economic contexts, the people involved- and also the people that SHOULD be involved, any existing power influences, the tools that are used to set priorities, the rationales/reasons/criteria that guides the decisions and a detailed description of the priority setting process. This would facilitate the identification of good practices and opportunities for improvement- more so if they are evaluated

against a recognized framework such as the ethical framework of "Accountability for Reasonableness"

(ii) *Strengthening the legitimacy and capacity* of priority setting institutions would require to; first identify and characterize the people who are participating and evaluate their mandate. In addition, determine their skills, and the resources available to them with regards to information for decision making. Legitimate institutions can be facilitated to make credible and fair decisions; while illegitimate institutions may be facilitated in making fair decisions- which may improve their legitimacy. The external power influences- where they exist- should be mitigated and effective developmental support through Sector Wide Approaches may facilitate this process.

(iii) *Developing fair priority setting processes* requires that the current practices are well aligned with the four conditions of 'Accountability for Reasonableness" by ensuring that priority setting involves legitimate stakeholders, eliciting and defining a core set of values to guide priority setting, publicizing the decisions and reasons behind the priority setting decisions, and that some stakeholders ensure adherence to the three conditions. If not aligned- context-specific legitimate leaders would need training in order to enhance their capacity to implement fair priority setting processes. Where external illegitimate influences exist, these should be mitigated.

Conclusion

The meager literature on priority setting in developing countries identify four key challenges- lack of information, the legitimacy of the people setting priorities, the values/criteria used in priority setting and the capacity of the institutions that should set priorities. However, current strategies to improve priority setting in developing countries have mainly focused on providing information and tools. The three strategies proposed in this paper—capturing priority setting experiences; strengthening the legitimacy and capacity of priority setting institutions; and developing a fair priority setting processes – are complementary to approaches that focus on information and tools. These strategies ensure that improvements in priority setting are evidence based and grounded in the local contexts. When decision making is grounded in the local context, is evidence-based, legitimate, and fair, it is much *more* likely that allocation decisions will be made to ameliorate inequities which should, arguably, be one of the main outcomes of a fair priority setting process in developing countries.

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