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SUPPORT Tools for evidence-informed health Policymaking (STP)

2. Setting priorities

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Abstract

Background: This article is number 2 in a series of 21 articles on tools for evidence-informed health policymaking. Policymakers and other stakeholders have limited resources to develop (or support the development of) evidence-informed policies and programmes that improve health or reduce health inequities. These resources need to be used wisely judiciously in order to maximise their impacts.

Objective: In this article we suggest four questions that can guide those who use priority-setting approaches in which the focus is on identifying which issues require more attention.

Key messages:

- The following questions can guide how to decide which issues require more attention:
  1. Does the approach to prioritisation make clear the timelines that have been set for addressing high-priority issues?
  2. Does the approach incorporate explicit criteria for determining priorities?
  3. Does the approach incorporate an explicit process for determining priorities?
  4. Does the approach incorporate a communications strategy and a monitoring and evaluation plan?
- Three possible criteria can be used for prioritising a given issue:
  1. The underlying problem(s), if properly addressed, could lead to health benefits or to improvements in health equity
  2. Viable policy and programme options, if properly implemented, could affect the underlying problem(s), and hence lead to health benefits or to improvements in health equity, or could lead to reductions in harms, cost savings or better value for money, and
  3. Political events could foreseeably open (or political events may already have opened) 'windows of opportunity' for change
- Four possible features of a priority-setting approach include:
  1. It is informed by a pre-circulated summary of available data and evidence and by a discussion about the application of explicit criteria to issues that are considered for prioritisation
  2. It ensures fair representation of those involved in, or affected by, future decisions about the issues that are considered for prioritisation
  3. A facilitator is engaged who uses well-constructed questions to elicit views about the priority that should be accorded to issues as well as the rationale for their prioritisation, and
  4. An experienced team of policymakers and researchers is engaged to turn high-priority issues into clearly defined problem(s) and viable policy or programme options that will be the focus of more detailed assessments

Background

This article is number 2 in a series of 21 articles on tools for evidence-informed health policymaking. It is also the 1st of 2 articles in this series about prioritising and defining problems. Its purpose is to suggest questions that can be used by those involved in deciding which issues warrant more attention in the policymaking process.

Policymakers and other stakeholders have limited resources to develop – or support the development of – evidence-informed policies and programmes either to improve health or reduce health inequities. There are constraints, both in terms of numbers and capacity, of those who support policymakers, and these constraints mean that only a limited number of issues can be comprehensively assessed and put forward for prioritisation within any period of time. Limitations in financial resources also mean that work contracted out to others may only focus on a very restricted number of issues. Such resources need to be used wisely in order to maximise their impacts. The actual *implementation* of policies and programmes is also necessarily shaped by the limited resources of policymakers and other stakeholders and this is the focus of Article 4 of this series [1].

The tools and resources available to support priority setting in the health sector can be divided into three key types:

- Many tools and resources address how to prioritise illnesses and injuries. These tend to focus on the use of available data on their prevalence or incidence [2-5]
- Most tools and resources focus on how to prioritise programmes, services and drugs that are targeted at illnesses and injuries, or at ill health more generally. Many of these tools and resources focus both on data on prevalence or incidence and on research evidence about the effectiveness or cost-effectiveness of prevention and treatment options [6-8]. Only a few deal with a broader set of criteria and have a more holistic approach to setting priorities [9, 10]
- Almost no tools and resources address the issue of how to prioritise health system arrangements (or changes to health system arrangements) that support the provision of cost-effective programmes, services and drugs [11]

Tools and resources are also available to support priority setting for both primary research and systematic reviews in the research sector [12-16], as well as for recommendations for the health sector (e.g. clinical practice guidelines) [17].

This article examines priority setting for those issues that will be the focus of evidence-informed policymaking. Policymakers deciding which issues require more attention have difficult challenges.

- Policymakers have to combine a *proactive* approach to priority setting (e.g. what priority should an issue be given in a national strategic plan for the health sector?) together with a *reactive* approach that can respond to the pressing issues of the day (e.g. what priority should an issue receive when it appears on the front page of a newspaper or was just discussed in the legislature?). A priority-setting approach needs to contribute to future plans while responding to existing potentially difficult circumstances
- Policymakers have to balance *a disease or illness orientation* (e.g. what priority should be given to HIV/AIDS or diabetes?), *a programme, service and drug orientation* (e.g. what priority should be given to a screening programme, a counselling service or a new class of drugs), and *a health system arrangements orientation* (e.g. what priority should be given to a regulatory change in scope of practice of nurses, to a change in the financial arrangements that determine how doctors are paid or to a change in the delivery

- Policymakers have to balance shorter-term confidentiality issues with a longer-term commitment to transparency and public accountability. Policymakers rely heavily on civil servants to assess issues for them. Strict confidentiality provisions are often set to ensure that issues are not discussed before they have been vetted by the policymakers. This is important given that policymakers are accountable in a very public way (through periodic elections) for the decisions they make. A priority-setting approach needs to accommodate a mix of confidentiality and transparency provisions.

Box 1 provides examples of current approaches to priority setting in three countries.

The tools and resources outlined above, help to shape the process of priority setting for those issues considered in evidence-informed policymaking. For example, burden-of-disease data may be used to inform assessments of the contribution of a particular disease to the overall burden of ill health. Research evidence about the effectiveness of programmes, services and drugs needs, can help to inform assessments of policy and programme options to address ill health, too. Similarly, approaches to priority setting for basic research (which may use a 5-25 year time horizon), applied primary research (which may use a 2-5 year time horizon) and for systematic reviews (which may use a 6-18 month time horizon) can all provide insights into priority setting for policy briefs. (Article 17 of this series contains a review of policy briefs and the tools available to prepare and use them. Policy briefs may have a time horizon ranging from weeks to months) [18]. Approaches to priority setting for recommendations can also give insights into priorities for evidence-informed policymaking. However, a recent review of priority setting for recommendations concluded that there was "little empirical evidence to guide the choice of criteria and processes for establishing priorities" [17].

Box 2 provides examples of organisations in which a priority-setting approach can be beneficial.

Questions to consider

The following questions can guide how to decide which issues require more attention:
1. Does the approach to prioritisation make clear the timelines that have been set for addressing high-priority issues?
2. Does the approach incorporate explicit criteria for determining priorities?
3. Does the approach incorporate an explicit process for determining priorities?
4. Does the approach incorporate a communications strategy and a monitoring and evaluation plan?

1. Does the approach to prioritisation make clear the timelines that have been set for addressing high-priority issues?

Policymaking processes may play out over days, weeks, or even years. Explicit priority-setting processes aren't typically appropriate for very short timelines because the priority-setting process could take longer than the time available to make a decision. However, explicit criteria can still help to inform judgements about which issues require an all–hands-

on-deck approach (e.g. for those moments when the Minister says “We need it now!”). Conversely, they also help to identify which issues could be dealt with over a longer time period, or should be put aside entirely, and which issues fall somewhere in between.

For policymaking processes that play out over weeks or months, explicit priority setting criteria and explicit priority-setting processes can offer value. This is particularly true if there is a receptivity on the part of policymakers or other stakeholders to seeking an independent assessment of the research evidence (such as a policy brief) (see Article 17 for further discussion of preparing and using policy briefs) or to seeking the input of stakeholders through a policy dialogue (see Article 18 of this series for a discussion of how to organise and use dialogues in the process of evidence-informed health policymaking) [18, 19]. Such a priority-setting process should be dynamic and have revisions done every few weeks or months, if it is to provide a meaningful balance of proactive and reactive approaches.

For ‘perennial’ policy issues, and those policymaking processes that play out over many months or even years, policymakers and other stakeholders can embrace a more strategic approach to priority setting. This could include commissioning researchers to conduct a systematic review of the research literature on a specific policy or programme question, or conducting an impact evaluation of a policy or programme (this topic is the focus of Article 15 in this series) [20].

2. Does the process incorporate explicit criteria for determining priorities?

Explicit criteria can help to guide those involved in a priority-setting process *and*, if confidentiality restrictions permit, to communicate the rationale for decisions about priorities to stakeholders. Three possible criteria for prioritising a given issue include:

- The underlying problem(s), if properly addressed, could lead to health benefits or to improvements in health equity, now or in the future
- Viable policy and programme options, if properly implemented, could affect the underlying problem(s), and hence lead to health benefits or to improvements in health equity, or could lead to reductions in harms, cost savings or increased value for money, and
- Political events could open (or political events may already have opened) ‘windows of opportunity’ for change

The application of these criteria requires readily available data and research evidence, and collective judgement (based on these and other considerations) about whether an issue warrants prioritisation. A thorough assessment would only be needed for a limited range of issues considered to be of higher priority.

The first criterion listed above relates, in part, to concerns such as the burden of illness and the likely severity of new or emerging illnesses. But it also relates to judgements about how likely it is that the underlying problem(s) can be addressed. These underlying problem(s) may vary in scope, ranging from a narrow focus on the specific characteristics of the illnesses and injuries, through to the programmes, services and drugs used to prevent or treat these illnesses and injuries, and/or the health system arrangements that support the provision of programmes, services or drugs. Given that data and research evidence about underlying problem(s) may not be readily available or may be lacking entirely, other considerations may need to be

introduced. (Article 3 in this series provides an overview of the processes involved in identifying and defining underlying problems) [21].

The second criterion requires judgements about how likely it is that policy and programme options will have acceptable costs and desired consequences (i.e. how likely it is that they would be considered viable). Framing options to address a problem, which is the focus of Article 4 in this series, requires systematic reviews of studies to examine the benefits and harms of options, as well as data or research evidence about costs and relative cost-effectiveness [1]. Two recent developments, namely the growth of databases containing systematic reviews and the growing availability of policymaker-friendly summaries of systematic reviews that can be linked to from these databases (which are the focus of Article 5), have made preliminary assessments of this type increasingly feasible [22]. However, where research evidence about the viability of policy and programme options is not readily available, other considerations will need to be introduced.

The third criterion requires judgements about whether a window of opportunity for action could open, or has opened [23]. As we review in more detail in Article 3, such opportunities can occur because of attention given to a problem at particular moments [21]. Significant media coverage, for example, may be given to documented cases of significant gaps in quality and access in cancer care delivery. However, these windows can close equally fast given that media attention tends to move on quickly. A window of opportunity may also be opened by political events, such as, for example, the formation of a coalition of stakeholders who have chosen to take action on a particular issue, or when a politician with a personal interest in an issue is appointed as Minister of Health. Some events related to problems or politics can be predicted, such as the publication of periodic reports by national statistical agencies and elections, but often the specific *nature* of the opportunity can't.

3. Does the process incorporate an explicit process for determining priorities?

Explicit criteria do not make decisions – people do. And an explicit process can help them to make decisions in a systematic and transparent way. Four possible features of a priority-setting process include:

- It is informed by a pre-circulated summary of available data and evidence and by a discussion about the application of explicit criteria to issues that are considered for prioritisation
- It ensures fair representation of those involved in, or affected by, future decisions about the issues that are considered for prioritisation
- A facilitator is engaged who uses well-constructed questions to elicit views about the priority that should be accorded to issues as well as the rationale for their prioritisation, and
- An experienced team of policymakers and researchers is engaged to turn high-priority issues into clearly defined problem(s) and viable policy or programme options, that will be the focus of more detailed assessments.

The preparation of a pre-circulated summary of available data and evidence about possible priority issues is a highly efficient way of preparing participants for a priority-setting process. Gaps in the data and research evidence can be as important to describe as what is available. Such summaries can provide common ground from which discussions can start.

A priority-setting process should ideally bring together the many parties involved in, or affected by, any future decisions related to the issues that are under consideration as possible priorities. Doing this requires careful mapping of the full range of stakeholders and then selecting appropriate individuals from different stakeholder groups of. Confidentiality provisions may be particularly challenging in this process if they preclude the involvement of those who will be affected by any future decisions related to the issues concerned. Civil servants, and especially politicians, may then be required to participate on their behalf.

A skilled, knowledgeable and neutral facilitator is required to ensure that a priority-setting process runs well. In Article 18 of this series, we describe the rationale for this combination of attributes [19]. For a priority-setting process that is entirely internal to government, it may be ideal if the facilitator is drawn from a strategic policy unit, rather than from units in charge of narrower policy concerns (e.g. human resources policy) or particular programmes (e.g. diabetes care).

An experienced team of policymakers and researchers is required to turn high-priority issues into clearly defined problem(s) as well as viable policy or programme options that will form the focus of more detailed assessments. The team would ideally establish clear timelines for each policy issue that will need to be addressed. The team could also provide guidance about which issues could be addressed in-house, and which could be contracted out. If certain issues are deemed confidential, these too could either be dealt with in-house or contracted out with clearly stated confidentiality clauses in the work contracts.

4. Does the process incorporate a communications strategy and a monitoring and evaluation plan?

A communications strategy is needed to ensure that policymakers and other stakeholders are informed of the high-priority issues so that they can prepare to inform the further definition of the problems, the characterisation of policy and programme options, and the identification of key implementation considerations. Ideally a range of materials, fine-tuned for different stakeholders, would be produced as part of the communications strategy. However, in some contexts or for some issues, confidentiality provisions may not permit communication with certain stakeholders.

Even the best communications strategy will not reach everyone and it may not elicit the desired commitment to address the high-priority issues. A monitoring plan can help to address this by identifying when high-priority issues are not being addressed within the established timeframe. An accompanying evaluation plan can be used to examine particular issues in a more systematic way, such as the impacts of the priority-setting process on the policymaking process, and how and why stakeholders respond to the priorities identified.

Resources

Useful documents and further reading

- Healy J, Maxwell J, Hong PK, Lin V: *Responding to Requests for Information on Health Systems from Policy Makers in Asian Countries*. Geneva, Switzerland: Alliance for Health Policy and Systems Research, World Health Organization; 2007 [24]. – Source of lessons learned about organisations that support evidence-informed policymaking (http://www.who.int/alliance-hpsr/tr1healy.pdf)
- Nolte E, Ettelt S, Thomson S, Mays N: Learning from other countries: An on-call facility for health care policy. *Journal of Health Services Research and Policy* 2008, 13: 58-64 [25]. – Source of lessons learned about a specific organisation that supports evidence-informed policymaking (http://jhsrp.rsmjournals.com/cgi/content/abstract/13/suppl_2/58)

Links to websites

- Global burden of disease – Source of data and research evidence about the global burden of disease
  http://www.who.int/topics/global_burden_of_disease/en/
- Disease Control Priorities Project – Source of research evidence and recommendations about the interventions (i.e. programmes, services and drugs) that should be prioritised in different types of countries
  http://www.dcp2.org/main/Home.html
- CHOosing Interventions that are Cost-Effective (CHOICE) – Source of data, research evidence and a tool about the interventions (i.e. programmes, services and drugs) that should be prioritised in different regions and countries
  http://www.who.int/choice/en/
- Canadian Priority Setting Research Network – Source of published articles about priority-setting in healthcare
- http://www.canadianprioritysetting.ca/
- IHC: An 'On-call Facility for International Healthcare Comparisons
  http://www.lshtm.ac.uk/ihc/about.html

Box 1: Examples of current approaches to priority setting in three countries

A qualitative study of priority settings in Ontario (Canada), Norway and Uganda focused on resource allocation decisions at three levels within health systems. At the macro level, attention was given to the intersection between programmes, services and drugs and the health system arrangements that support their provision [11]. The cases at this level all involved resource allocation to hospitals and included:

- Central funding for priority services (e.g. selected cancer services) and wait-times services (e.g. total hip and knee replacements), as well as regular hospital funding for routine hospital services in Ontario, which appeared to be influenced by the governing party's platform and a funding formula, respectively
- Central funding for action plans (i.e. priority programmes) in neglected service domains (e.g. geriatrics) and hospital priorities in Norway, both of which appeared to be influenced by a funding formula, an explicit national priority-setting guideline, and pressure groups, and
- Central funding for districts and hospitals, which appeared to be influenced by (but due to resource constraints, not *fully* determined by) the National Essential Health Care Package, and the national Health Sector Strategic Plan, but which were ultimately negotiated at the level of individual districts and hospitals

The cases above involved decisions to implement policies and programmes. They were not undertaken to support an evidence-informed policymaking process *regardless* of whether a decision was made to proceed to implementation. Nevertheless, the cases suggest that an approach to setting priorities determining which issues warrant further attention would have to take a mix of the following as a starting point:

- Timelines (e.g. post-election action on the governing party's platforms versus periodic development of a national Health Sector Strategic Plan)
- Criteria (e.g. implicit criteria such as local needs, and explicit criteria such as the magnitude of the expected benefit required in accordance with national priority-setting guidelines), and
- Processes (e.g. local negotiations versus annual budget-setting processes)

Box 2: Examples of organisations in which a priority-setting approach can be beneficial

A number of different types of organisations have emerged to support evidence-informed policymaking. For example:

- The Strategic Policy Unit, based within the United Kingdom's Department of Health, was set up to examine high-priority issues that need to be addressed within a timeline of weeks to months
- The Canadian Agency for Drugs and Therapeutics in Healthcare (http://www.cadth.ca/), a national government-funded agency, provides a rapid-response function (called the Health Technology Inquiry Service) to Provincial Ministries of Health seeking input about which health technologies to introduce, cover or fund. Timelines range from 1-30 days
- An Evidence-Informed Policy Network (http://www.evipnet.org/) in Vietnam has obtained funding to produce two policy briefs and convene two policy dialogues in the coming year to respond to the priorities of policymakers' and other stakeholders
- The European Observatory on Health Systems and Policies (http://www.euro.who.int/observatory) convenes a range policy dialogues, including 'rapid reaction seminars' which can be organised at very short notice
- The On-call Facility for International Healthcare Comparisons (http://www.lshtm.ac.uk/ihc/index.html), located within the London School of Hygiene and Tropical Medicine, responds to direct requests from the United Kingdom's Department of Health about how health systems in other high-income countries are addressing particular issues [25]

Each of these organisations must, implicitly or explicitly, have timelines within which they are prepared to work. They also need criteria to decide which issues warrant significant periods of their time and which issues warrant less, or even none at all. Processes to make these decisions are also required.

References

1. Lavis JN, Wilson M, Oxman A, Grimshaw J, Lewin S, Fretheim A. SUPPORT Tools for evidence-informed health policymaking (STP). 4. Framing options to address a problem. Health Res Policy Syst, In Press

2. Kapiriri L, Norheim OF, Heggenhougen K: **Using burden of disease information for health planning in developing countries: the experience from Uganda.** *Soc Sci Med* 2003, **56:** 2433-2441.

3. Rudan I, Lawn J, Cousens S, Rowe AK, Boschi-Pinto C, Tomaskovic L *et al*.: **Gaps in policy-relevant information on burden of disease in children: a systematic review.** *Lancet* 2005, **365:** 2031-2040.

4. Abegunde DO, Mathers CD, Adam T, Ortegon M, Strong K: **The burden and costs of chronic diseases in low-income and middle-income countries.** *Lancet* 2007, **370:** 1929-1938.

5. Stuckler D, King L, Robinson H, McKee M: **WHO's budgetary allocations and burden of disease: a comparative analysis.** *Lancet* 2008, **372:** 1563-1569.

6. DeSavigny D, Kasale H, Mbuya C, Reid G. In Focus: Fixing Health Systems. 2004. Ottawa, Canada, International Development Research Centre.

7. Laxminarayan R, Mills AJ, Breman JG, Measham AR, Alleyne G, Claeson M *et al*.: **Advancement of global health: key messages from the Disease Control Priorities Project.** *Lancet* 2006, **367:** 1193-1208.

8. Hutubessy R, Chisholm D, Edejer TT: **Generalized cost-effectiveness analysis for national-level priority-setting in the health sector.** *Cost Eff Resour Alloc* 2003, **1:** 8.

9. Mitton C, Donaldson C: **Health care priority setting: principles, practice and challenges.** *Cost Eff Resour Alloc* 2004, **2:** 3.

10. Gibson JL, Martin DK, Singer PA: **Evidence, economics and ethics: resource allocation in health services organizations.** *Healthc Q* 2005, **8:** 50-9, 4.

11. Kapiriri L, Norheim OF, Martin DK: **Priority setting at the micro-, meso- and macro-levels in Canada, Norway and Uganda.** *Health Policy* 2007, **82:** 78-94.

12. Gross CP, Anderson GF, Powe NR: **The relation between funding by the National Institutes of Health and the burden of disease.** *N Engl J Med* 1999, **340:** 1881-1887.

13. The Working Group on Priority Setting: **Priority setting for health research: lessons from developing countries. The Working Group on Priority Setting.** *Health Policy Plan* 2000, **15:** 130-136.

14. Lomas J, Fulop N, Gagnon D, Allen P: **On being a good listener: setting priorities for applied health services research.** *Milbank Q* 2003, **81:** 363-388.

15. Ali N, Bhutta ZA, Bruce N, de Francisco A, Ghaffar A, Gulbinat W *et al*.. The Combined Approach Matrix: A Priority-Setting Tool for Health Research. 2004. Geneva, Global Forum for Health Research.

16. Nuyens Y: **Setting priorities for health research: lessons from low- and middle-income countries.** *Bull World Health Organ* 2007, **85:** 319-321.

17. Oxman AD, Schunemann HJ, Fretheim A: **Improving the use of research evidence in guideline development: 2. Setting priorities.** *Health Res Policy Syst* 2006, **4:** 14

18. Lavis JN, Permanand G, Oxman AD, Lewin SA, Fretheim A. **SUPPORT Tools for evidence-informed health policymaking (STP). 17. Preparing and using policy briefs**. Health Res Policy Syst, In Press

19. Lavis JN, Boyko JA, Oxman AD, Lewin SA, Fretheim A. **SUPPORT Tools for evidence-informed health policymaking (STP). 18. Organizing and using policy dialogues**. Health Res Policy Syst, In Press

20. Fretheim A, Oxman A, Lavis JN, Lewin S. **SUPPORT Tools for evidence-informed health policymaking (STP). 15. Monitoring and evaluating policies and programmes**. Health Res Policy Syst, In Press

21. Lavis JN, Wilson MG, Oxman AD, Lewin SA, Fretheim A. **SUPPORT Tools for evidence-informed health policymaking (STP). 3. Defining the problem**. Res Policy Syst, In Press

22. Lavis JN, Oxman AD, Grimshaw JM, Johansen M, Boyko JA, Lewin SA *et al*.. **SUPPORT Tools for evidence-informed health policymaking (STP). 5. Finding systematic reviews**. Health Res Policy Syst, In Press

23. Kingdon JW: *Agendas, Alternatives, and Public Policies*, 2nd edn. New York: Longman; 2003.

24. Healy J, Maxwell J, Hong PK, Lin V. Responding to Requests for Information on Health Systems from Policy Makers in Asian Countries. 2007. Geneva, Alliance for Health Policy and Systems Research, World Health Organization.

25. Nolte E, Ettelt S, Thomson S, Mays N: **Learning from other countries: an on-call facility for health care policy.** *J Health Serv Res Policy* 2008, **13 Suppl 2:** 58-64.