



## Health sector priority setting at meso-level in lower and middle income countries: Lessons learned, available options and suggested steps



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### ABSTRACT

Setting priority for health programming and budget allocation is an important issue, but there is little consensus on related processes. It is particularly relevant in low resource settings and at province- and district- or “meso-level”, where contextual influences may be greater, information scarce and capacity lower. Although recent changes in disease epidemiology and health financing suggest even greater need to allocate resources effectively, the literature is relatively silent on evidence-based priority-setting in low and middle income countries (LMICs). We conducted a comprehensive review of the peer-reviewed and grey literature on health resource priority-setting in LMICs, focussing on meso-level and the evidence-based priority-setting processes (PSPs) piloted or suggested there. Our objective was to assess PSPs according to whether they have influenced resource allocation and impacted the outcome indicators prioritised. An exhaustive search of the peer-reviewed and grey literature published in the last decade yielded 57 background articles and 75 reports related to priority-setting at meso-level in LMICs. Although proponents of certain PSPs still advocate their use, other experts instead suggest broader elements to guide priority-setting. We conclude that currently no process can be confidently recommended for such settings. We also assessed the common reasons for failure at all levels of priority-setting and concluded further that local authorities should additionally consider contextual and systems limitations likely to prevent a satisfactory process and outcomes, particularly at meso-level. Recent literature proposes a list of related attributes and warning signs, and facilitated our preparation of a simple decision-tree or roadmap to help determine whether or not health systems issues should be improved in parallel to support for needed priority-setting; what elements of the PSP need improving; monitoring, and evaluation. Health priority-setting at meso-level in LMICs can involve common processes, but will often require additional attention to local health systems.

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### Introduction

Health needs always exceed the available resources, so priority-setting is a key element in health resource allocation. It is traditionally undertaken by governments responding to market failures in health care, and to support public goods like immunisation.

However, in both developed and developing countries the process of setting priority for public spending in health has been perennially difficult, and the subject of considerable debate. Prudent governments take priority-setting seriously because the resources at their disposal – budget, staff time, equipment and facilities – are precious, and all have alternative uses inside and outside the health sector. Ideally, governments should collaborate with other stakeholders during the priority setting process (PSP), including population representatives, local interest groups and development partners, to determine how best to utilise available resources. Such inclusive priority-setting has been recommended for decades (Navarro, 1969; Paalman, Bekedam, Hawken, & Nyheim, 1998), but

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can be very difficult and affected by context, often resulting in funding choices influenced primarily by history, or “grand-fathering”. Another key issue is the difference between the macro-level priority-setting that occurs at national level and has been the subject of much research and comment, and the more program-focused priority-setting that occurs at meso-level, on which far less has been written, and which is the subject of this paper.

In decentralised systems the focus of national or macro-level priority-setting in health is usually which interventions may be financed with public money, while the difficult task of deciding the mix of programs, resources and strategies for delivering interventions is usually undertaken by meso-level authorities (e.g. provinces, states or districts). Ideally, the PSPs at each level are linked, and allocations reflect the needs and preferences of all stakeholders in a well-described, cascading and participatory process. The outcome would meet the efficiency goal of health economists, the effectiveness goal of clinicians and be legitimate and reasonable according to relevant policies and cross-sectoral inputs. Moreover, the outcome would be equitable and just, and the process itself would be accepted by all (McDonald & Ollerenshaw, 2011; Sibbald, Singer, Upshur, & Martin, 2009). In practice, priority-setting seems difficult at any level and the links between the levels have not been well described, particularly in lower- and middle-income countries (LMICs).

Effective priority-setting is probably even more important now as populations increase, expectations of good health rise, technical solutions to health problems expand and yet resources become increasingly stretched. This is particularly the case for many LMICs negotiating the epidemiologic transition and the so-called double burden of disease (Abegunde, Mathers, Adam, Ortegón, & Strong, 2007), and especially for meso-level authorities considering solutions for a new constellation of issues. Money wasted on a failed PSP or misguided allocations could have been spent on alternative processes or interventions. Indeed, the problems identified in priority-setting at macro-level are most likely accentuated at meso-level, especially in LMICs where limitations to effective priority-setting are likely to be greater. In the increasing number of LMICs with decentralised health systems, these limitations may even outweigh the benefits of greater local experience and accountability among local managers (compared to managers in centralised systems). Accordingly, LMIC authorities should benefit from a review of others' experiences and suggestions on how to proceed with health priority-setting at sub-national levels.

We sought to assess the evidence on processes available to guide meso-level LMIC health authorities considering strategies for scale-up of accepted health interventions. We therefore conducted a comprehensive review of studies describing meso-level PSPs, their impact on resource allocation and related lessons from the field. Given the dearth of reports from meso-level, we also included review articles on macro-level PSPs. We first report our review of the literature here. Drawing on this review of processes and experiences and additionally on the perspectives of experts, particularly those related to what is feasible in LMICs, a roadmap for approaching meso-level health priority-setting in such contexts is proposed.

## Method

This research was undertaken during 2012 in the context of work to develop evidence-based recommendations on how to develop and use investment scenarios to take forward the United Nations Secretary General's *Global Strategy for Women's and Children's Health* in LMICs of the Asia-Pacific region (Jimenez-Soto, Alderman, Hipgrave, Firth, & Anderson, 2012). Our objective was thus to critically review formal processes for priority-setting in LMICs from a policy perspective.

## Search for relevant literature

The first step in our review of the evidence involved brainstorming on key resources and the establishment of limitations. This yielded a list of resources, mostly grey literature, and was followed by a series of searches in formal literature. Since the focus was on investment scenarios, we agreed that the review should be restricted to evidence for resource allocation and PSPs, and thus excluded studies related to broader areas such as evidence-based planning or policy-setting not specifically related to resource allocation. This decision was reinforced by the fact that when we initially searched for recent literature using broad terms such as (“planning” OR “budgeting” AND “health care”) we found over 128,000 references. Even when narrowed down by relevant categories (e.g. health care sciences services), over 35,000 studies were found and very few of the first 300 appeared relevant. We accordingly restricted our search to articles published in the last decade using the following key words: “resource allocation” AND “health care” AND “policy” OR “priority-setting” AND “health care” AND “policy”. We did not restrict the search to LMICs. Web of Science and Econlit databases were searched for relevant peer-reviewed articles. The Web of Science search was narrowed down by categories (“health policy services” or “economics” or “planning development” or “public administration”) and subject areas (“health care sciences services” or “public administration” or “mathematical methods in social sciences”). The search yielded 239 references, many of which were relevant. Upon further discussion the key word ‘policy’ was dropped to expand the search, yielding 874 references. The Econlit database search produced 351 references, most of which overlapped those from the Web of Science or were deemed irrelevant. The Cochrane database was searched for systematic reviews on the subject but none were found. Finally the key search terms were also entered into the Google search engine; no relevant new articles were identified. The literature search was conducted during February–March, 2012. Ethics approval was not required for this research, which did not involve human subjects.

## Selection of papers for inclusion

All identified titles and/or abstracts were reviewed by two of the authors (KA and EJ) using pre-determined inclusion criteria. Articles not specifically related to priority-setting and resource allocation in the health sector were excluded (e.g. those only describing processes of planning or development of clinical services). In reviewing the abstracts it became apparent that in addition to articles describing individual approaches to priority-setting for health, there were others describing common elements of that process. The former “approaches” articles, were included if they described in detail or reviewed a systematic approach to evidence-based health priority-setting. Because there were few reports focussing specifically on sub-national priority-setting, we also included articles that reviewed approaches to priority-setting at macro-level in several countries. However, we excluded individual country studies of macro-level approaches (such as health technology assessments). We also excluded papers which focused only on the statistical techniques underlying some of the approaches, such as the use of cost-effectiveness analysis (CEA). The latter “common elements” or “background” articles were included only if their focus was on the policy implications of a particular element of priority-setting.

Using the above strategy a list of 75 “approaches” articles and 57 “background” articles was compiled. All 132 articles were read in full and abstracted using one of two templates prepared by the authors (available upon request). The “approaches” abstraction template included categories such as its objectives; content areas;

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