

4

Setting Priorities⁴

4.1 Introduction

Setting priorities can be a complex process, and it is important, especially in the early days of planning, to keep it as simple as possible. It may not be necessary or desirable to follow this process at every level. A simpler way is to set priorities at the provincial and/or district levels, and then have the lower levels use the same priorities.

4.2 Priority-setting framework

While there is no “correct” approach to setting priorities, it is necessary to have a common planning framework (*Green, 1999*). The framework needs to:

- achieve balanced participation between different groups and in particular between communities and professionals;
- encourage a multi-sectoral perspective;
- achieve a balance between the centre and the periphery;
- use clear and consistent criteria;
- result in aims and objectives that are clear and feasible; and be an open and understandable process.

4.3 Health programme priorities

Health programme priorities should be based on the health challenges shown in the annual reports and on the strategic priorities set at the provincial level. Funding constraints should not be taken into account for setting priorities, only during the development of objectives and targets and the selection of service delivery mechanisms.

The process of selecting priorities must be as objective as possible, and must therefore be well structured. A good way is to use a priority-setting matrix. (*See Table 5.*) Criteria such as severity and demand are used to rank different health problems, which are entered in order of importance for each criterion. For example, if enteric diseases affect the greatest number of people it should be entered first under “magnitude”.

⁴ These guidelines cannot give sufficient space to some of the complex issues around priority-setting and option appraisal and selection (choosing service delivery mechanisms). Further information can be obtained from other reading materials, such as Green (1999) and also Pillay (1999).

Selecting a single list of priorities from the matrix can be done by assigning a numerical ranking to the lists. For example, the first priority disease in each group can be assigned 10 points, the second 9, and so on. Each variable can also be assigned a weighting factor. For example, if magnitude is deemed to be twice as important as public demand, then it is given a weight of 2, and the first priority would have 20 points (10 x 2).

Priorities will also differ according to the group consulted. The health professionals may consider one health problem to be the most important, while the community may consider another most important. Priorities may also differ among health professionals, especially since at the district and provincial levels, there are managers for the main health programmes. The manager of each programme may consider his or her programme the most important. Equally, different community groups have different priorities. The young may not consider chronic diseases to be very important, whereas the old may not consider family planning to be a priority. If different groups are consulted, then it is best to have each one use the matrix and compare the results in a general forum. The Department of Health (DOH) would then make the final decision and should explain the reasoning where it is different from that chosen by any of the groups.

Table 5. Priority-setting matrix

Priority Ranking	Magnitude	Severity/danger	Public demand	Impact on poor and vulnerable	Social disruption	Technical feasibility	Cost/effectiveness of intervention
1	Enteric diseases	HIV/AIDS	Malaria	HIV/AIDS	HIV/AIDS	TB	Enteric diseases
2	Respiratory diseases	Tuberculosis (TB)	TB	TB		Measles	TB
3	HIV/AIDS	Mental disorders				Polio	Eye disease
4	etc						

(See Green for a description of the matrix and Green and Ministry of Health, Tanzania for more examples of criteria)

4.4 Support and management priorities

While the most important prioritisation is among health programmes, it will also be necessary to establish priorities for support and management services.

Such services can be divided into the following groups:

- Health services: clinics, CHCs, hospitals
- Resource management: drugs, laboratory, human resources, transport, etc.
- General management: health information, finance, etc.

Priorities should be set for each type of service, stating how it will contribute to the achievement of one or more of the health priorities. For example, achieving the TB priority may rely on an improvement in laboratory services, which should be reflected in the laboratory service priorities. Each of these is represented by a line item in the budget and each can be related to an individual patient. The resources referred to under resource management are all represented by the budget line items.

If contractual agreements, such as service level agreements with municipalities or public/private partnerships, are in place and cover part of the period being planned, the plan will need to take into account the goals, objectives and targets included in the agreements.

4.5 Final listing of priorities

The selected priorities should be listed in order of importance, and should be separated for strategic priorities, health programmes, general service delivery, and support services. (See Table 6.) Draft objectives and targets can be shown for each priority, since this will serve as a starting point for choosing service delivery mechanisms. The draft targets should be based on historical and current performance and on provincial norms and targets. The province should prepare a set of norms and standards, based on national figures where available, for all districts to use. The draft objectives and targets should be agreed with the health programme managers, the institutional managers, and the support service managers.

Table 6. Illustrative list of selected priorities and quantified objectives and outputs

Priorities	Quantified Objectives and Outputs
Strategic	
Improve quality of care	Implement hospital accreditation programme
Improve equitable access	Ensure that all clinics and CHCs have Essential Equipment Package in place
Etc	
Health Programmes	
Reduce spread of HIV/AIDS	Reduce infection rate from 15% to 12%. Expected to reduce clinic visits from 3.6 to 2.9 per person and hospital admissions from 12 per 1,000 to 10 per 1,000.
Treat AIDS patients more cost-effectively	Expand home-based care from 500 to 1,000 persons treated. Expected to reduce hospital admissions from 12 per 1,000 to 10 per 1,000.
TB	Increase number of TB cases cured from 50% to 70%. Expected to increase clinic visits by 2,000 per year.
Etc	
Health Services	
Reduce the average length of stay	Reduce average length of stay from 10 to 7 days.
Resource Management	
Pharmacy	Increase purchases of priority drugs
	Improve drug management system
Etc	
General Management	
Financial management	Reduce the time taken to process payments
Etc	

The objectives should be reviewed to make sure any conflicts are identified and resolved. For example, a move to shift some outpatient services from a hospital to a CHC may conflict with a move at the CHC to shift some specialist outpatient services to the hospital. In such a case, one or both objectives would have to be modified.

4.6 Emergency plans

It is not possible to plan for every eventuality; and a disease may not be priority in normal times but may become one in an emergency. An example would be cholera, which may only be a major issue if there is flooding. Emergency problems like this should be addressed in a separate emergency health plan, and special funds should be available, perhaps under another government department.