



**Global Forum
for Health Research**
HELPING CORRECT THE 10|90 GAP



Health Research for Policy, Action and Practice

Resource Modules

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Module II Setting priorities for health research

Unit 1 Introduction

We welcome readers' comments to enable us to continually update and improve this material.

THE COLLABORATIVE TRAINING PROGRAMME

Alliance for Health Policy and Systems Research
Council on Health Research for Development
Global Forum for Health Research
INCLIN Trust

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Acronyms

ACHR	Ad Hoc Committee on Health Research Relating to Future Intervention Options
CHRD	Commission on Health Research for Development
ENHR	Essential national health research
GFHR	Global Forum for Health Research

Module II. Setting priorities for health research

Unit 1. Introduction

Evolution of priority-setting initiatives

One of the roles of health research is to ensure that the measures proposed to break the vicious circle of ill-health and poverty are based, as far as possible, on evidence, so that the resources available to finance these measures are used in the most efficient and effective way possible. “Too often priorities for public sector health research and development investments are determined with little concern for the magnitude of the problem to be addressed, for the extent to which scientific judgement supports the possibility of new products and initiatives will be more cost-effective than available alternatives. Or on the ongoing efforts elsewhere” (Ad Hoc Committee, 1996).

The Commission on Health Research for Development (CHRD) was established in 1987 out of the concern that important health needs in the developing world were not being addressed adequately. The specific mandate of the Commission was to produce an independent expert evaluation of the state of health research relevant to developing countries.

In 1990, the Commission publication entitled *Health research: essential link to equity in development* found that there was a “gross mismatch between the burden of illness, which is overwhelmingly in the Third World, and investment in health research, which is overwhelmingly focused on the health problems of the industrialized countries” (CHRD, 1990). To address this issue, the Commission proposed the development of an “essential national health research” (ENHR) strategy in each country. ENHR would have seven elements for strengthening national health research systems, and priority-setting was one of the elements – “each developing country will need ... to set national priorities for research, for using both domestic and external resources” (CHRD, 1990).

The successor of the Commission – the Council on Health Research for Development (COHRED), established in 1993, facilitated a number of country experiments and experiences in health research priority-setting. These approaches were embedded within the other elements of ENHR which included, for example, capacity-building and networking. The focus of the ENHR initiatives has been on the process of priority-setting at national level. The analysis of these country initiatives led to the production of a manual for research priority-setting using the ENHR strategy (Okello et al., 2000).

Ten years later, the Commission’s view was reaffirmed at the International Conference on Health Research for Development (Bangkok, 2000), which stated that one of the key features of a revitalized health research system would be that “(the) research agenda has to be driven by country needs and priorities within an interactive regional and global framework. This requires countries to develop and retain the capacity to set the research priorities, and for research and development

agencies, funding bodies and other international players to respect these priorities” (IOC, 2001).

The need for global prioritization in health research had been recognized by the Commission on Health Research for Development in 1990. This was echoed in the *World development report 1993: Investing in health* (World Bank, 1993). It was noted that less than 10% of global spending on health research was devoted to 90% of the world’s health problems – a misallocation that has come to be known as the “10/90 gap” (GFHR, 2000).

In response to this concern, the Ad Hoc Committee on Health Research Relating to Future Intervention Options (Ad Hoc Committee) was formed under the auspices of WHO in 1994. The 1996 report of the Committee stated that its intention was “to contribute to an agenda for international action in which individual nations’ agendas inform global priorities and global needs and experience influence national agendas” (Ad Hoc Committee, 1996). Urging a systematic approach to the allocation of health research funds, the report outlined a five-step strategy for prioritizing research. Applying this strategy, four “best buys” or key investments were identified representing “the unfinished agenda”:

- maternal and child health
- continually changing microbial threats
- noncommunicable illnesses and injuries
- health policy and systems.

The issue was taken up also by the WHO Advisory Committee on Health Research which introduced and promoted The Visual Health Information Profile (VHIP) (ACHR, 1997) as a tool for priority-setting.

One of the 17 recommendations of the Ad Hoc Committee was the establishment of the Global Forum for Health Research (GFHR) to help correct the 10/90 gap. Since its creation in 1997, one of the Global Forum’s major activities has been the development of tools to facilitate the processing of information that would support priority-setting. The Global Forum has developed a Combined Approach Matrix (CAM) which builds on the five-step strategy of the Ad Hoc Committee, the ENHR strategy and the VHIP.

In the last few years, some groups have drawn attention to the importance of fairness and procedural justice in setting priorities. This emphasis underlines the principle that the process of priority-setting is as important as the product. Careful attention to consensus-building increases the likelihood of compliance and legitimacy of the results.

Why set health research priorities?

At one level, thinking about priorities should make us pause simply to ask the question “What is really important in my work – or in the work of my institution/programme/network?”. For those of us involved in health research in the

context of human development, the question then might be “how is my work, as a health researcher, contributing to human development?”.

Several other reasons for setting priorities may be offered.

- To ensure that the best use is made of available resources. This is particularly important in the light of the commitment to address the needs of the most vulnerable groups in any society, in other words, a health research system based on the “value” of equity needs to employ a systematic approach to setting priorities.
- To identify the human and financial resources required to meet competing and overwhelming demands. The term “10/90 gap” illustrates the immense need for global health research.
- To reinforce and strengthen the links between research, action, policy and practice, so that health policy, practice and action is firmly based on the best available scientific evidence.

Engaging in a priority-setting process has a number of “spin-off” benefits.

- It encourages “systems thinking” within an institutional or national health research system.
- It disciplines the system and the actors in it to: monitor the contribution of research to the health of populations and the performance of the health system; evaluate programmes and interventions; be explicit about values and the criteria by which decisions are made; be more accountable to stakeholders.

Contexts for priority-setting

Health research priority-setting can be undertaken at several levels.

Global

The major rationale for priority-setting at the global level is the need to address the “10/90 gap in health research”.

National

The major rationale for priority-setting at national and subnational levels is the need to work for equity in health and make research an active part of development.

Subnational

Subnational levels include provinces or states. The experience with health research priority-setting at this level is more limited. It has been suggested that local management levels could be involved through municipal forums, development association meetings, health committees and boards, since these could provide a suitable environment for dialogue and negotiation

Institutional

Various kinds of health research institutions engage, either systematically or more informally, in the process of setting health research priorities. These institutions include university-based departments or other entities (units, centres, institutes),

free-standing research institutes, and other organizational entities. In fact, priority-setting becomes a basic tool in the larger process of strategic planning.

Agencies

Most bilateral agencies engage in priority-setting exercises from time to time. These include the health sector, and sometimes health research per se. Some health research agencies in high-income countries have undertaken systematic priority-setting reviews. Similarly, large foundations that support global health research (e.g. the Bill and Melinda Gates Foundation, the Wellcome Trust and the Rockefeller Foundation), review their priorities from time to time.

Disciplines

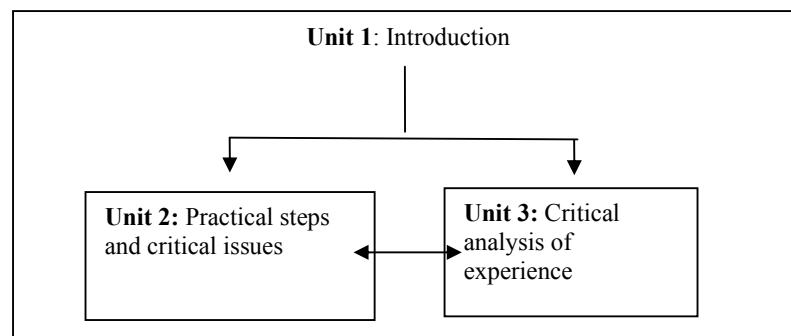
Researchers within a given discipline sometimes engage in priority-setting.

Problems

There are some examples where research groups focused on a specific problem area have attempted to set priorities for their work. The UNDP/UNFPA/WHO/World Bank Special Programme on Tropical Diseases Research and Special Programme of Research, Development and Research Training in Human Reproduction (HRP) are such examples.

A road map for users of this module

Although a great deal of information on, and experience in, techniques and processes for priority-setting for health research has accumulated during the past decade, the field could be regarded as “work in progress”. While awaiting further refinement of tools and processes, several countries, institutions and health programmes have realized the benefits of priority-setting, and embark on priority-setting exercises. Unit 2 of this module provides guidance for those who wish to initiate, facilitate or support a process of priority-setting. Unit 3 of this module provides a summary description and analysis of these major initiatives in priority-setting. Users of this module are encouraged to read both units 2 and 3, and modify and adapt the guidance provided in unit 2 on the basis of their own context, as related to the experiences and lessons provided in unit 3.



References and further reading

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