

Criteria for priority-setting in health care in Uganda: exploration of stakeholders' values

Lydia Kapiriri¹ & Ole Frithjof Norheim²

Objective To explore stakeholders' acceptance of criteria for setting priorities for the health care system in Uganda.

Methods A self-administered questionnaire was used. It was distributed to health workers, planners and administrators working in all levels of the Ugandan health care system. It was also distributed to members of the public. Participants were asked how strongly they agreed or disagreed with 18 criteria that could be used to set priorities for allocating health care. A total of 408 people took part. Data were entered and analysed using SPSS statistical software. Predetermined cut-off points were used to rank the criteria into three different categories: high weight (>66% of respondents agreed), average weight (33–66% of respondents agreed) and low weight (<33% of respondents agreed). We also tested for associations between respondents' characteristics and their degree of agreement with the criteria.

Findings High-weight criteria included severity of disease, benefit of the intervention, cost of the intervention, cost-effectiveness of the intervention, quality of the data on effectiveness, the patients age, place of residence, lifestyle, importance of providing equity of access to health care and the community's views. The average-weight criteria included the patient's social status, mental features, physical capabilities, political views, responsibilities for others and gender. Low-weight criteria included the patient's religion, and power and influence. There were few associations between respondents' characteristics and their preferences.

Conclusion There was a high degree of acceptance for commonly used disease-related and society-related criteria. There was less agreement about the patient-related criteria. We propose that average-weight criteria should be debated in Uganda and other countries facing the challenge of distributing scarce health care resources.

Keywords Health priorities/standards; Patients; Epidemiologic factors; Health status indicators; Costs and cost analysis; Health services accessibility; Social justice; Uganda (*source: MeSH, NLM*).

Mots clés Priorités en santé/normes; Malade; Facteurs épidémiologiques; Indicateur état sanitaire; Coût et analyse coût; Accessibilité service santé; Justice sociale; Ouganda (*source: MeSH, INSERM*).

Palabras clave Prioridades en salud/normas; Pacientes; Factores epidemiológicos; Indicadores de salud; Costos y análisis de costo; Accesibilidad a los servicios de salud; Justicia social; Uganda (*fuente: DeCS, BIREME*).

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يمكن الاطلاع على الملخص بالعربية في صفحة 178.

Introduction

Priority setting is one of the most important issues in health care policy because no health system can afford to pay for every service it wishes to provide. This is especially true in developing countries (1, 2). Difficult decisions must be made as the gap increases between the need for health care services and the amount of money available to provide them (3, 4). There are no easy solutions, so it is crucial that countries develop an information set to facilitate decision-making. Priority setting requires transparent approaches and explicit debate about the principles and criteria that are used to make decisions about allocating health care resources (5–7).

Some authors use the term “priority setting” interchangeably with rationing (2). Others make a distinction: they define rationing as decisions that affect individual patients at the point of delivery (micro level) and priority setting as distribution decisions made

at the macro level, which involve clear and direct limits on access to care or, simply, a process of determining how health care resources should be allocated among competing programmes or individuals (8–11). In this paper, we focus on the macro level of priority setting.

Williams defines priority setting as who gets what at whose expense (10). The “what” can be either organs from donors, laboratory procedures or, most commonly, money for services and human resources (2, 12, 13). Priority setting is a complex interaction, and it occurs at the national level (or macro level), the regional or district level (or meso level) and the patient level (or micro level) (5, 12).

Although there is growing interest in priority setting, there is little consensus on the best way to carry it out. Different approaches have been proposed, ranging from guidelines, checklists and minimum packages to explicit criteria (4). For developing

¹ Research Fellow, Centre for International Health and Department of Public Health and Primary Health Care, University of Bergen, Ulriksdal 8c, N-5009, Bergen, Norway (email: lydia.kapiriri@student.uib.no). Correspondence should be sent to this author.

² Professor, Centre for International Health and Department of Public Health and Primary Health Care, University of Bergen, Bergen, Norway.

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countries, the Burden of Disease (BOD) approach and cost-effectiveness approaches have been recommended (14, 15). The BOD measures societal preferences for future health and a healthy life lived at different ages, as well as societal perceptions of the severity of disability. It incorporates these into epidemiological data (16). Although the method is robust, some have pointed out that the approach may not account for important societal concerns, and some of the values used may not be acceptable to all (17–19).

Many have argued that societal concern for equity of access to health care and the distribution of benefit need to be included in discussions of priority setting (11, 20, 21). While others have proposed that legitimacy and fairness should be considered (22, 23). To add legitimacy to decision-making, van der Grinten (24) and Nord (25) emphasize the need for measuring people's ethical preferences, but others have pointed out the limitations of empirical ethics (22, 26).

Many criteria for priority setting have been proposed and debated. We identified some criteria from a review of the literature (27), and we updated them with criteria used in the BOD study (16). We also added criteria elicited from a Ugandan study (19, 28, 29). Some of the criteria we used are summarized in Box 1. This list is not complete, only some of the most commonly debated criteria are included.

Most of the debate on criteria for priority setting has been carried out in developed countries. These countries often use approaches and address problems that may be far different from

the realities of developing countries, where resources are extremely scarce (30). Developing countries are faced not only with a severe lack of resources but may also have cultural values and characteristics that will influence the criteria they use to set priorities (25, 30, 31).

Objective

Which criteria should be used in Uganda? We presented a list of criteria to stakeholders in Uganda to determine whether they would be acceptable.

We hoped that exploring stakeholders' values would be useful for policy-makers but we assumed that the criteria would need to be discussed further. We also assumed that having a better understanding of stakeholders' views would provide a basis for widening the scope of research on these criteria in developing countries.

Methods

We used a self-administered questionnaire to determine which criteria should be used to set priorities for health care in Uganda. We calculated that we needed a sample size of 610 people (assuming a response rate of 50% and a 95% confidence interval). Non-respondents were sent three reminders. Participants at the national level were chosen from the Ministry of Health. Participants were also chosen from four districts (Adjumani, Hoima, Kamuli and Kampala). These districts were selected to

Box 1. Some of the criteria that are most widely used and debated for priority setting

Criteria ^a	Comments
<i>Medical^b</i>	
Cost-effectiveness of intervention	Most of the medical criteria that we used are well supported by previous studies. However, there are differences in the degree of support for different criteria (for example, between cost-effectiveness and severity of illness). In some studies, respondents valued equality of access to care above the outcome of treatment.
Expected outcome of treatment	
Costs of treatment	
Effectiveness of treatment	
Severity of the condition	
Quality of evidence on effectiveness	
Urgency of need for care	
<i>Non-medical^b</i>	
Age	There is a lot of controversy over the non-medical criteria.
Gender	
Race	Most of the literature agrees that it is important to include some non-medical criteria. However, studies have failed to come to consensus about which criteria are important. Criteria vary according to who is asked.
Religion	
Social status	
Responsibilities	Some researchers have proposed that unless such criteria have a direct influence on the outcome of treatment it should not be considered.
Mental (or learning) capabilities	
Physical capabilities	However, race, age, religion, gender, social power and influence, mental features, lifestyle, genetic background and sexual orientation have been explicitly discounted as acceptable criteria.
Area of residence	
Time on waiting list	
Political views	
Community's view	
Number of people benefiting from an intervention	
Genetic background and sexual orientation	
First-time or second-time transplants	
Likely work status after transplants	
Patient's lifestyle responsible for cause of disease ^c	

^a Sources for the criteria were references 16, 19, 27.

^b Classifications used as they appear in the literature.

^c Mentioned mostly in relation to organ transplantation.

represent the different regions of Uganda. The sample included health policy planners and health workers at national, district, health sub-district and facility levels, and representatives from the general population.

For the national-level sample, a list of all health workers was obtained, and the head of each directorate was included in the study. If the head was not available, the questionnaire was given to the next person in the hierarchy. At the national teaching hospital, senior house officers and student nurses were sampled. In the district hospitals, 10 questionnaires were given to health workers in each of the four major departments (medicine, paediatrics, surgery, and obstetrics and gynaecology). They were instructed to distribute them randomly between doctors and nurses. All health workers in health centres were included in the study. All members of the local council for each district and the health team were included. The rest of the questionnaires were distributed to randomly selected members of the public. Because this was a preliminary study, all of the participants had some knowledge of the subject we were exploring.

Questionnaires

The questionnaires were self-administered. They included criteria identified from the literature on priority setting and a previous study (29). The criteria were chosen because they are widely accepted, seem relevant to Uganda, are part of the BOD/cost-effectiveness approach, or have implications for equity of access to health care. To test for overt differences between our findings from Uganda and those in the literature, we also included criteria that are controversial or considered to be unacceptable (Box 1) (16, 19, 27–29). The criteria were organized to reflect issues related to patients, issues related to diseases and issues related to society.

- Patient-related criteria: these included the patient's age, place of residence, social status, gender, religion, power or influence, mental disabilities, responsibilities, physical capabilities and whether the patient's lifestyle was responsible for the illness.
- Disease-related criteria: these included the costs of treatment, benefits of interventions, the cost-effectiveness of the intervention, the severity of the condition and the quality of data on cost-effectiveness.
- Society-related criteria: these included equity of access, the community's views or preferences, and political views (high advocacy).

Participants used a six-point scale to indicate whether they agreed or disagreed with statements. They could choose to strongly agree, agree, have no opinion, disagree, strongly disagree or say that they didn't know. Each questionnaire began with the statement: "In my opinion, the following criteria should be considered when setting priorities for health in Uganda".

Data analysis

Data were analysed using SPSS statistical software. First, we calculated the percentage of respondents who agreed with each of the criteria. We defined three cut-off points:

- If 0–33% of respondents strongly agreed or agreed with a criterion, it was classified as a low-weight criterion
- If 34–66% of respondents strongly agreed or agreed, then it was classified as an average-weight criterion
- If 67–99% strongly agreed or agreed, then it was classified as high-weight criterion.

The six-point response scale was dichotomized. Respondents who strongly agreed or agreed with a criterion were re-coded as agreeing with a statement, and those who disagreed or strongly disagreed were re-coded as disagreeing with it. Because the number of responses in the other categories was quite low and would obscure significant findings, we re-coded them as missing from the system.

We also dichotomized demographic characteristics. Age was grouped as ≤ 35 years or > 35 years. Respondents were coded as a health worker or not a health worker. Respondents were also asked whether they considered priority setting to be part of their daily duties; these responses were dichotomized as yes or no. Level of work was dichotomized as district and national planning level or health facility level.

We tested for possible associations between characteristics of the respondents using the χ^2 test. To adjust for a number of factors simultaneously, multiple logistic regression analysis was used to test for associations between the respondents' characteristics and their degree of agreement with each of the different criteria (32).

Results

Altogether 408/610 (67%) of the questionnaires were returned. The lowest response rate was from the Northern Region. The majority of respondents were health workers who worked directly with patients (Table 1). The mean age of the respondents was 30.4 years. Most respondents (359/408; 88%) considered priority setting to be part of their regular work.

The majority of respondents strongly agreed that it was important to consider all of the disease-related criteria when setting priorities for health care. There was also general agreement with the societal criteria, with the exception of the criterion of

Table 1. Demographic characteristics of respondents (n= 408)^a

Characteristic	Number of respondents
Age (years)	
<25	29 (7) ^b
25–35	201 (49)
36–45	136 (33)
46–55	4 (0.9)
>55	4 (0.9)
Job title	
Medical doctor	133 (33)
Allied health worker ^c	187 (46)
Administrator	28 (7)
Other	59 (14)
Level of work	
National	38 (9)
District	26 (6)
Health facility	209 (51)
Teaching hospital	66 (16)
United Nations	12 (3)
Other	57 (14)
Is priority setting part of respondent's job?	
Yes	359 (88)
No	47 (12)

^a The total number of respondents varied; some did not complete all of the parameters of the questionnaire.

^b Values in parentheses are percentages.

^c Other health workers at health facility level who are not doctors.

political views (Table 2). However, there were wide variations in the responses to the patient-related criteria. Over 80% of the respondents thought a patient's age and equity of access should be considered when setting priorities, and only 24% thought a patient's religion, power and influence should be considered. From 5% to 31% of respondents said that they didn't know whether some of the patient-related criteria should be considered. From 5% to 8% said they didn't know whether some of the disease-related criteria should be considered; and from 5% to 23% said that they didn't know whether some of the criteria related to society should be considered.

Non-response rates for all criteria ranged from 11–21%. Most of the non-respondents were health workers who were younger than 35 and worked in a health facility. There were no significant differences between the characteristics of responders and non-responders.

Table 3 shows that more than 66% of respondents agreed that the following were important:

- All of the disease-related criteria (namely severity, benefit of an intervention, cost of an intervention, cost-effectiveness of an intervention, and quality of data on effectiveness)
- Most of the criteria related to society (namely equity of access and the views of the community)
- Only one of the patient-related criteria (namely the patient's age). Using a patient's religion, and amount of power and

influence to determine whether he or she received care was supported by <33% of the respondents, making these low-weight criteria. The rest of the criteria were supported by 33–66% of the respondents, making them average-weight criteria.

Table 3 shows how the criteria were weighted according to the responses. There was a significant relation between whether the respondent worked at the national or district level and their age (χ^2 test = 26.9, $P = 0.00$), between whether the respondent worked at the national or district level and their job title (χ^2 test = 30.6, $P = 0.00$), and between a respondent's job title and whether the respondent was involved in priority setting (χ^2 test = 40.8, $P = 0.00$).

Multiple regression analysis also revealed a few associations. Compared with respondents working at a health facility, respondents working at the national and district levels were five times more likely to support the idea that a community's views should be used as a criterion for priority setting ($P < 0.05$). Respondents who were involved in priority setting were nine times more likely to support considering the severity of a disease than respondents who were not involved in priority setting ($P < 0.001$). No regional differences were found. (Table 4, web version only, available at: <http://www.who.int/bulletin>.)

Table 2. Respondents' ($n = 408$) rating of importance of each criterion in setting priorities for health care in Uganda

	No. respondents ^a						
	Strongly agree	Agree	No opinion	Disagree	Strongly disagree	Don't know	No response
Patient-related criteria							
Age	246 (60) ^b	84 (21)	18 (4)	10 (3)	4 (1)	2 (0.5)	44 (11)
Place of residence	138 (34)	115 (28)	45 (11)	36 (9)	12 (3)	2 (0.5)	50 (15)
Social status	114 (28)	94 (23)	59 (14)	50 (13)	21 (5)	4 (1)	65 (16)
Responsibilities	89 (22)	128 (31)	70 (17)	38 (9)	15 (4)	4 (1)	64 (16)
Gender	106 (26)	116 (28)	86 (21)	30 (7)	10 (3)	8 (2)	52 (13)
Religion	37 (9)	61 (15)	106 (26)	84 (21)	53 (13)	6 (2)	61 (15)
Power and influence	31 (8)	67 (16)	94 (23)	85 (21)	46 (11)	13 (3)	72 (18)
Mental capabilities	81 (20)	108 (27)	61 (15)	38 (9)	17 (4)	2 (0.5)	85 (21)
Responsible for causing own illness	110 (27)	123 (30)	48 (12)	28 (7)	19 (5)	9 (2)	71 (17)
Physical capabilities	87 (21)	135 (33)	49 (12)	31 (8)	13 (3)	8 (2)	86 (21)
Disease-related criteria							
Treatment costs	222 (54)	91 (22)	27 (7)	11 (3)	8 (2)	2 (0.5)	47 (12)
Benefit of intervention	188 (46)	113 (28)	24 (6)	8 (2)	3 (1)	7 (2)	65 (16)
Quality of evidence	179 (44)	119 (29)	26 (6)	4 (1)	5 (1)	5 (3)	62 (15)
Cost-effectiveness of intervention	225 (54)	91 (22)	14 (3)	12 (3)	4 (1)	8 (2)	54 (13)
Severity of condition	222 (54)	95 (23)	16 (4)	10 (3)	6 (2)	4 (1)	55 (14)
Society-related criteria							
Equity of access	203 (50)	112 (28)	19 (5)	2 (0.5)	3 (0.7)	11 (3)	58 (14)
Political views	47 (12)	110 (27)	78 (19)	63 (15)	44 (11)	4 (1)	62 (15)
Community's view	145 (34)	141 (33)	42 (10)	12 (3)	6 (2)	1 (0.2)	61 (15)

^a The total number of respondents varied; some did not complete all of the parameters of the questionnaire.

^b Values in parentheses are percentages.

Table 3. Weighting of criteria for priority setting according to number of respondents who agreed criterion was important

Weighting	Disease-related criteria ^{a, b}	Patient-related criteria	Society-related criteria
High weight (>66% agree)	Benefit of intervention (301; 74%) Quality of available evidence on benefit ^a (398; 98%) Cost-effectiveness of intervention (316; 78%) Severity of disease (317; 78%) Treatment costs (313; 77%)	Age (330; 81%)	Equity of access (315; 77%) Community's views (286; 70%)
Average weight (33–66% agree)	None	Social status ^a (208; 51%) Responsibilities (217; 53%) Gender (222; 54%) Mental features (189; 46%) Physical capabilities (221; 54%) Area of residence (253; 62%) Lifestyle responsible for disease (233; 57%)	Political views (157; 38%)
Low weight (<33% agree)	None	Religion (98; 24%) Power and influence (98; 24%)	None

^a Denominators for all criteria are 408 except quality of available evidence ($n=406$) and social status ($n=407$).

^b Values in parentheses are numerators; percentages.

Discussion

We found that high-weight criteria (those which were accepted by >66% of respondents) included all of the disease-related criteria, as well as the patient's age, place of residence, lifestyle, equity of access and views of the community. Average-weight criteria included the patient's social status, responsibilities, mental and physical features, and political views. Low-weight criteria (which were accepted by <33% of respondents) included the patient's religion, power and influence.

Our findings should, however, be interpreted with caution. Since we used strategic sampling methods, the results are not generalizable. Our sample included only people who could read and write and who were familiar with priority setting. We also had an over-representation of health workers. However, several studies exploring public values in priority setting found that the public regards health workers as legitimate representatives (8, 31, 33, 34). Given the weakness of civil society in Uganda, we used the health workers' preferences as a proxy for gaining a better understanding of stakeholders' values.

There are other limitations. Because the questionnaire was self-administered, we cannot be sure that questions were interpreted correctly. The sources of the criteria may also pose a difficulty since the criteria in the literature came from a different social, economic and cultural context. However, they were supplemented with some locally obtained criteria (19, 28, 29), so we believe that the findings, although exploratory, can help understand the values held by people living in a developing country). These criteria should be tested for ethical appropriateness since not all empirically elicited preferences are always ethically acceptable (22, 26).

A patient's age was given high weight; however, this criterion has been debated in the literature (7, 16, 35, 36). In several settings, age is not considered to be a good criterion to use for setting priorities unless it affects the outcome of treatment (35, 36).

In the present study, although no clarifying questions were asked to determine which age should be given priority, an earlier study in Uganda showed respondents had a preference for interventions in childhood (28). Hence, our results may reflect concern for vulnerable people and for intergenerational equity (37), especially given the high morbidity and mortality among infants and children (38). The concern for equity may also explain the support for the criterion of place of residence. In Uganda, there are inequities that are related to where a person lives (for example, urban versus rural), and these may have a direct impact on a person's health (39). It is not surprising that equity of access was supported by most of the respondents.

We did not expect that >50% of respondents would support considering a patient's lifestyle as a criterion when in the literature it is considered unacceptable unless it affects treatment outcome (35). This illustrates the limitations of using empirical values in decision-making and why it is necessary to test such results for ethical appropriateness and general acceptance (22). Social status and gender are important determinants of health (40, 41); but our respondents did not consider these to be particularly important. While gender, physical capabilities and social status may not be important in more equitable societies, in societies such as Uganda, where these influence the burden of disease and access to health services, it may be important to consider them for affirmative action (21, 41). The criteria that were given low weight in our study may not be ethically justifiable, and are not widely accepted because they may lead to discrimination (27).

There is substantial overlap among most of the high-weight criteria in Table 3 with criteria in the literature (42–48). In the literature, we found some additional unacceptable criteria (namely, race or ethnicity, sexual orientation and genetic background) (29). While the last two may not be relevant in Uganda,

race or ethnicity, which we did not include, has been found to be an important determinant of health (39).

There were few significant differences between the respondents' characteristics and how willing they were to accept a given criterion. This could mean there is a high degree of consensus within the selected sample. However, sampling bias could be another explanation. The list of criteria that we used is not exhaustive, and there are additional important criteria that we did not include. These criteria and locally elicited criteria need to be tested on a more representative sample before our findings can be generalized to Uganda and similar contexts.

Conclusion

Because this was an exploratory study, we propose that the findings presented in Table 3 could be used to aid further research and debate on criteria and values in developing countries. Further discussion about the criteria that were given average weighting would be needed. This would help policy-makers develop an appropriate information set for setting priorities in health and other relevant sectors in Uganda.

Given the differences in preference for the various criteria, wide participation of relevant stakeholders, including the general public, should be encouraged. Furthermore, other strategies, such as qualitative studies, would be useful in identifying values not elicited through surveys.

This study sheds some light on the acceptability of criteria by stakeholders in Uganda. There is, however, need for similar studies in other developing countries. ■

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Résumé

Critères de fixation des priorités en matière de soins de santé en Ouganda : échelle de valeurs

Objectif Evaluer auprès des intéressés le degré d'accord sur les critères de fixation des priorités concernant le système de soins de santé en Ouganda.

Méthodes Un questionnaire autoadministré a été distribué aux agents de santé, aux planificateurs et aux administrateurs sanitaires occupant des fonctions à tous les niveaux du système de soins de santé ougandais. Le questionnaire a été également distribué au grand public. Il a été demandé aux participants d'indiquer dans quelle mesure ils étaient d'accord ou non sur les 18 critères qui pourraient être utilisés pour fixer les priorités concernant la répartition des soins de santé. Au total, 408 personnes ont participé à l'étude. Les données ont été saisies et analysées en utilisant le logiciel statistique SPSS. On a préalablement déterminé des seuils pour classer les critères en trois catégories différentes : très importants (critères sur lesquels plus de 66 % des répondants étaient d'accord), moyennement importants (critères sur lesquels 33 à 66 % des répondants étaient d'accord) et peu importants (critères sur lesquels moins de 33 % des répondants étaient d'accord). On a également tenté d'établir des corrélations entre les caractéristiques des répondants et le degré d'accord sur les critères.

Résultats Parmi les critères importants figurent la gravité de la maladie, les avantages de l'intervention, le coût de l'intervention, le rapport coût/efficacité de l'intervention, la qualité des données sur l'efficacité, l'âge du patient, le lieu de résidence, le mode de vie, l'égalité des chances d'accès aux soins de santé et l'opinion de la communauté. Les critères moyennement importants comprennent le sexe, le statut social du patient, ses capacités mentales, ses capacités physiques, ses opinions politiques et ses responsabilités à l'égard d'autrui. La religion du patient, son pouvoir et l'influence qu'il peut exercer sont des critères peu importants. Les corrélations entre les caractéristiques des répondants et leurs préférences sont peu nombreuses.

Conclusion On a noté un très fort degré d'accord sur les critères les plus utilisés en rapport avec la maladie et la société. En revanche, il l'est moins pour les critères applicables aux patients. Nous proposons que les critères moyennement importants fassent l'objet d'un débat en Ouganda et dans d'autres pays confrontés au problème de la répartition des soins de santé lorsque ceux-ci sont insuffisants pour répondre à tous les besoins.

Resumen

Criterios para el establecimiento de prioridades en la atención de salud en Uganda: estudio de los valores de los interesados directos

Objetivo Estudiar la aceptación por parte de los interesados directos de los criterios de establecimiento de prioridades para el sistema de atención sanitaria de Uganda.

Métodos Se distribuyó un autocuestionario entre los trabajadores de salud, planificadores y administradores que trabajaban en todos los niveles del sistema de atención sanitaria de Uganda. El cuestionario se distribuyó también entre el público. Se preguntó a los participantes en qué medida estaban de acuerdo con 18 criterios de establecimiento de prioridades para distribuir la atención de salud. Participaron en total 408 personas. Los datos fueron introducidos y analizados mediante el software

estadístico SPSS, y se usaron puntos críticos predeterminados para clasificar los criterios en tres categorías diferentes: ponderación alta (estaban de acuerdo más del 66% de los encuestados), ponderación media (estaba de acuerdo un 33%–66% de los encuestados) y ponderación baja (estaban de acuerdo menos del 33% de los encuestados). También analizamos la existencia de relaciones entre las características de los encuestados y su grado de coincidencia con los criterios.

Resultados Consiguieron una ponderación alta los siguientes criterios: gravedad de las enfermedades, beneficios de la intervención, costo de la intervención, costoeficacia de la intervención, calidad

de los datos de eficacia, edad del paciente, lugar de residencia, estilo de vida, importancia de asegurar la equidad del acceso a la atención de salud, y opiniones de la comunidad. Los criterios que consiguieron una ponderación media incluyeron el estatus social del paciente, su condición mental, su capacidad física, las opiniones políticas, sus responsabilidades para con otros, y el sexo. Los criterios con baja ponderación fueron la religión del paciente, y su poder e influencia. Se observó una escasa relación

entre las características de los entrevistados y sus preferencias. **Conclusión** Se detectó un alto grado de aceptación para los criterios de uso común relacionados con las enfermedades y con la sociedad. Hubo menos acuerdo en cambio por lo que se refiere a los criterios relacionados con el paciente. Proponemos que los criterios de ponderación media sean objeto de debate en Uganda y en otros países que afrontan hoy el reto de distribuir unos recursos sanitarios escasos.

ملخص

معايير تحديد الأولويات في مجال الرعاية الصحية في أوغندا: استطلاع قيم أصحاب المصالح المؤثرين في القرار

الموجودات: اشتملت معايير فئة المستوى المرتفع على وخامة المرض، وفائدة التدخلات، وتكلفة التدخلات، ومردودية التدخلات، وتأثير جودة المعطيات على الفعالية، وعمر المريض، ومحل إقامته، ونمط حياته، وأهمية العدالة في الحصول على الرعاية الصحية ووجهة نظر أعضاء المجتمع. أما معايير فئة المستوى المتوسط فشملت الحالة الاجتماعية للمريض، وسماته النفسية، وقدراته الجسمانية، وآرائه السياسية، ومسؤولياته عن الآخرين، وجنس المريض. وأما فئة معايير المستوى المنخفض فشملت ديانة المريض، ومدى سلطته وتأثيره. وقد لوحظت ارتباطات قليلة بين خصائص المُستجوبين وبين تفضيلاتهم. **النتيجة:** تبين الدراسة درجة قبول عالية للمعايير الشائعة الاستخدام المتعلقة بالمرض وبالمجتمع. وكانت درجة الموافقة على المعايير المتعلقة بالمريض أقل. وتقرح الدراسة فتح نقاش حول معايير المستوى المتوسط، في أوغندا وفي غيرها من البلدان التي تواجه تحديات في توزيع موارد الرعاية الصحية الشحيحة.

الهدف: استكشاف مدى قبول أصحاب المصالح لمعايير تحديد الأولويات في نظام الرعاية الصحية في أوغندا. **الطريقة:** تم توزيع استبيان ذاتي الاستكمال على العاملين الصحيين والمخططين والإداريين العاملين في جميع مستويات نظام الرعاية الصحية في أوغندا، وعلى أفراد من الجمهور. وقد سُئل المشاركون في الاستبيان عن مدى موافقتهم أو عدم موافقتهم على ١٨ معياراً يمكن أن تستخدم لتحديد أولويات تخصيص موارد الرعاية الصحية. وشارك في الاستبيان ٤٠٨ أشخاص، واستخدم البرنامج الإحصائي الحاسوبي SPSS في إدخال وتحليل المعطيات. واستخدمت حدود قصوى محددة سلفاً لترتيب المعايير في ثلاث فئات مختلفة، هي: فئة المستوى المرتفع (للمعايير التي تحظى بموافقة أكثر من ٦٦٪ من المُستجوبين)، وفئة المستوى المتوسط (للمعايير التي تحظى بموافقة ٣٣٪ إلى ٦٦٪ من المستجوبين)، وفئة المستوى المنخفض (للمعايير التي تحظى بموافقة أقل من ٣٣٪ من المستجوبين). كما تم اختبار الارتباط بين خصائص المُستجوبين وبين درجة موافقتهم على المعايير.

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Table 4. Association between respondent's characteristics and degree of agreement with importance of a given criterion for priority setting (analysis done using multivariate logistic regression)

Criteria	Respondents' characteristics			
	Adjusted odds ratios ^a			
	Age (<35 years)	Job title (Health worker)	Respondent considers priority setting as part of his or her duty	Level of work (National and district)
Patient-related criteria				
Age	— ^b	—	—	—
Place of residence	—	—	—	—
Social status	—	—	—	0.5(0.3–0.9) ^{c, d}
Responsibilities	—	—	—	—
Gender	0.5(0.3–0.8) ^d	—	—	—
Religion	—	—	—	0.5 (0.2–1.0) ^e
Power and influence	—	—	—	—
Mental features	—	—	—	—
Responsible for causing own condition	—	0.4(0.2–1.0) ^e	—	0.5 (0.3–0.9) ^e
Physical capabilities	—	—	—	—
Disease-related criteria				
Treatment costs	—	—	—	—
Benefit of intervention	—	—	—	—
Quality of evidence	0.4(0.2–0.9) ^e	—	—	—
Cost-effectiveness	—	—	—	—
Severity of condition	—	—	8.9(3.0–29.0) ^f	—
Society-related criteria				
Equity of access	—	—	—	—
Political views	—	—	—	—
Community's views	—	—	—	5.0(1.0–16.0) ^e

^a The following reference categories were used: Age = 35 years; Job title = Not a health worker; Respondent does not consider priority setting as part of their duty; Level of work = Respondent works at Facility/ Service delivery level.

^b Cells with dashes indicate that results were not significant at $P = 0.05$.

^c Figures in parentheses are 95% confidence intervals.

^d Significant at $P = 0.01$

^e Significant at $P = 0.05$.

^f Significant at $P = 0.001$.