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Review Article

Comparing Research Priority-Setting Partnerships for Older Adults Across International Health Care Systems: A Systematic Review



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A B S T R A C T

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Objectives: Priority setting partnerships (PSPs) attempt to shape the research agenda to address the needs of local populations of interest. We reviewed the PSPs for older adults, with a focus on exemplar health care systems: United Kingdom (UK; publicly funded), United States (private health insurance-based), South Korea (national health insurance-based), and Africa (out-of-pocket).

Design: Systematic review.

Setting and Participants: We searched databases and sources (January 2011–October 2021; updated in February 2023) for PSPs of older adults' health care.

Methods: Based on the British geriatric medicine curriculum, we extracted and categorized the PSP topics by areas and the research priorities by themes, and generated evidence maps depicting and comparing the research gaps across the systems. We evaluated PSP quality using the Nine Common Themes of Good Clinical Practice.

Results: We included 32 PSPs (United Kingdom: n = 25; United States: n = 7; South Korea and Africa: n = 0) and identified priorities regarding 27 conditions or service arrangements in the United Kingdom and 9 in the United States (predominantly in neurology/psychiatry). The UK priorities focused on treatments and interventions whereas the US on prognostic/predictive factors. There were notable research gaps within the existing PSPs, including common geriatric conditions like continence and frailty. The PSP quality evaluation revealed issues around lacking inclusion of ethnic minorities.

Conclusions and Implications: Research priorities for older adult health care vary internationally, but certain health care systems/countries have no available PSPs. Where PSPs are available, fundamental aspects of geriatric medicine have not been included. Future researchers should conduct prioritizations in different countries, focus on core geriatric syndromes, and ensure the inclusion of all relevant stakeholder groups.

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The world's older adult population will double between 2020 and 2050 to reach 2.1 billion.¹ Meanwhile, the population aged 80 years or older will triple to 426 million, constituting more than 20% of the total population.¹ High-quality, meaningful research relevant to the needs of ageing populations is therefore essential to address the future health care challenges that will result from population ageing. There is no shortage of research questions relevant to older adults. However, with limited funding resources, mechanisms must exist to prioritize the most important questions.

Priority setting exercises or priority setting partnerships (PSPs) are a process whereby patients and health professionals prioritize the areas that research should tackle.² They serve to focus the research agenda, improve research efficiency, and ensure findings are relevant to all stakeholders, including service users, service providers, and funders (commercial and noncommercial).³ A wide range of PSPs has been undertaken to focus on diseases, syndromes, and care settings that are likely to be relevant to the health care of older adults.^{4,5} Despite the efforts of organizations such as the James Lind Alliance (JLA) from the United Kingdom (United Kingdom)² and others, no consensus has been reached on the optimal priority setting methodologies. That said, they share a similar procedure that involves (1) defining the scope and focus of the priority setting, (2) recruiting relevant stakeholders, (3) identifying potential research questions of importance to the stakeholders, (4) prioritizing and achieving consensus on the research questions, and (5) disseminating agreed research priorities.^{6,7} Considering the heterogeneity of PSPs and the considerable variability in the quality of existing works, there is a need to robustly describe the landscape of research prioritization in the health care of older adults, as well as identify and address gaps in available PSPs. Moreover, as PSPs are supposed to generate research priorities that apply to local stakeholders and local health care infrastructures, it is worthwhile to compare the PSPs conducted in different health care systems. In terms of economic resources and infrastructure,⁸ health care systems are classified as publicly funded health care (eg, the UK National Health Service), private health insurance–based health care (eg, the United States), national private health insurance–based health care (eg, South Korea), and out-of-pocket health care (eg, countries in Africa, where there is also substantial catastrophic health expenditure).

We performed a systematic review of PSPs relevant to older adult health care, focusing on recent PSPs originating from the United Kingdom, the United States, South Korea, and countries in Africa. Our primary objectives were to produce and compare evidence maps to visually describe the PSPs relevant to older adults conducted in the 4 areas and highlight the research gaps within the existing PSPs.⁹ Our secondary objectives were to describe and compare the quality of existing PSPs across the regions and provide recommendations for future research.

Methods

We registered the systematic review protocol in PROSPERO (CRD42021286125) and reported our findings in accordance with the Preferred Reporting Items for a Systematic Review and Meta-Analysis 2020 (Supplementary Table 1).¹⁰ A Multidisciplinary Steering Committee (T.J.Q., S.D.S., S.W.P., H.J., and E.J.H.) with extensive experience in older adult clinical care and research was formed to develop the search strategy and selection criteria of literature, predefine areas for categorizing medical conditions and themes for categorizing research priorities, and supervise the study selection process.

Search Strategy and Selection Criteria

We developed the search strategy based on the expertise of the research team with a combination of MeSH and free-text terms for PSPs, ageing, and the 4 regions of interest. We conducted several

scoping exercises to map the literature to gain a broad understanding of the field and identify potential gaps and opportunities,¹¹ informing the maximization of the search strategy's sensitivity and specificity. The search terms were subsequently modified and tailored for 3 electronic bibliographic databases, including MEDLINE (Ovid), Embase (Ovid), and Cumulative Index to Nursing and Allied Health Literature (EBSCO) (Supplementary Table 2). We first limited the search to studies in the United Kingdom published between January 2011 and October 2021, then updated the search in February 2023.

Gray literature was identified by searching the following websites: British Geriatrics Society, James Lind Alliance Priority setting Partnerships, National Institute on Aging, International Association of Gerontology and Geriatrics, European Geriatric Medicine Society, United Nations Decade of Healthy Ageing, and a database for projects focusing on priority setting (<https://ois.lbg.ac.at/en/project-database>). Reference lists and citations of included studies were searched to identify additional relevant studies.

Study Selection

We used Rayyan to combine, export, and screen the results of the database searches.¹² At least 2 reviewers (L.H., K.L., M.T.-R., and S.D.) independently screened titles and abstracts and full texts against the inclusion criteria. Discrepancies were resolved through discussion or involvement of a third reviewer (H.J., T.J.Q., or S.D.S.).

We included PSPs involving Delphi, nominal group technique, JLA Priority Setting Partnerships, Cornell Institute for Translational Research on Aging (CITRA), or any other recognized PSP methods focusing on older adults (aged ≥ 65 years) within ageing research or geriatric medicine (see Supplementary Table 3 for definitions of common prioritization approaches). At inception, we intended to include all mixed-age (ie, older and younger) population studies where most participants were older adults (≥ 65 years old). However, because of poor reporting of age and population within studies, we revised our approach, and decisions on inclusion/exclusion were made based on the following.

1. Did the PSP focus on older adults?
2. Was the PSP themed around a geriatric syndrome [defined by the British Geriatrics Society (BGS) curriculum]?¹³
 - If not, is the exercise relevant and important enough to be included (decisions made by the Steering Committee on a case-by-case basis)?
3. Was the PSP on a topic of particular relevance to older adults (≥ 65 years of age)?
 - If not, is the exercise relevant and important enough to be included (decisions made by the Steering Committee on a case-by-case basis)?

Studies were also required to be conducted within the last 10 years and use a multiphased approach to priority setting. Exercises involving one-off surveys or qualitative interviews that did not provide an opportunity for participants to reflect on and change priorities were excluded. We also excluded PSPs that were restricted to establishing priorities within specific health care roles (eg, nursing, physiotherapy, and occupational therapy) as well as guidelines, systematic reviews, and opinion pieces. However, reference lists of systematic reviews were searched to identify additional studies. There was no restriction on the language of the publications so long as they were published in the United Kingdom, the United States, South Korea, or countries in Africa.

Data Extraction

A data extraction form based on previous systematic reviews was developed and tested on 2 studies and refined.^{4,5} This included the

following information: title, year of publication, health care topic or condition, setting, population included in identifying priorities along with any demographic characteristics, prioritization methodology, funding sources, and the specific priorities suggested by each study. We extracted the top 10 priorities from each PSP. When no ranking of priorities was given in an article, we extracted all priorities provided unless they were clearly unrelated to older adult health care. At least 2 reviewers (L.H., K.L., M.T.-R., and S.D.) independently extracted data from included studies.

Quality Appraisal

Quality of research prioritization assessments was undertaken at the study level via the “Nine Common Themes of Good Practice” (9CTGP) (see [Supplementary Table 4](#)).⁷ At least 2 reviewers (L.H., K.L., M.L., and S.L.) independently evaluated each study. Disagreements were resolved through discussion or involvement of a third reviewer (M.T.-R.). The checklists were trialed on 2 preselected studies. Internal validity of quality assessment was established via the extent of agreement between the 2 reviewers. Questions and criteria were refined and tailored to the review. We also highlighted the extent to which the PSPs adhered to the 9CTGP and provided information on the quality of existing studies, including the reporting standards of key participant demographics.

Data Synthesis

We synthesized and categorized our findings using a 2-level approach. The first level involved categorizing PSP topics (ie, medical conditions or service arrangements) by areas predefined by the Steering Committee based on the BGS curriculum.¹³ The second level involved grouping similar research priorities identified in the included

studies by predefined themes according to the BGS curriculum.¹³ There has yet to be an agreed definition for evidence maps or authoritative recommendations on their development.⁹ In this review, we visualized the findings (ie, areas, topics, themes, and the number of priorities across each theme) using evidence maps, where cells with no research priorities were indicative of research gaps. At least 2 review authors (L.H., K.L., M.T.-R., and S.D.) independently worked on the categorization and mapping. Disagreements were resolved via discussion or a third arbiter where necessary (H.J., T.J.Q., or S.D.S.).

Results

From database searches, we identified a total of 5131 articles, with 2422 of them from the first search and 2709 from the updated search and the supplementary search. An additional 17 relevant PSPs were identified through other sources (eg, reference lists and websites). After deduplication, 3214 titles and abstracts were screened, 188 articles were included for full-text screening and 32 studies were included in the review. See [Figure 1](#).

Characteristics of Included Studies

Characteristics of the 32 included studies are summarized in [Table 1](#). Among them, 25 were carried out in the United Kingdom, 7 in the United States, and none in South Korea or Africa. Nineteen UK PSPs were inclusive of participants across the whole of the country. The other 6 PSPs were region-specific.^{16,19,20,23,26,41} Most studies (n = 20) employed the JLA or modified JLA approach to identify priorities. Of the remaining studies, 3 used a nominal group technique^{16,23,41} and 2 used a Delphi approach.^{25,34} All 7 US PSPs were inclusive of participants across the whole of the country. Most studies (n = 4) were facilitated by the GEAR (Geriatric Emergency care Applied Research)

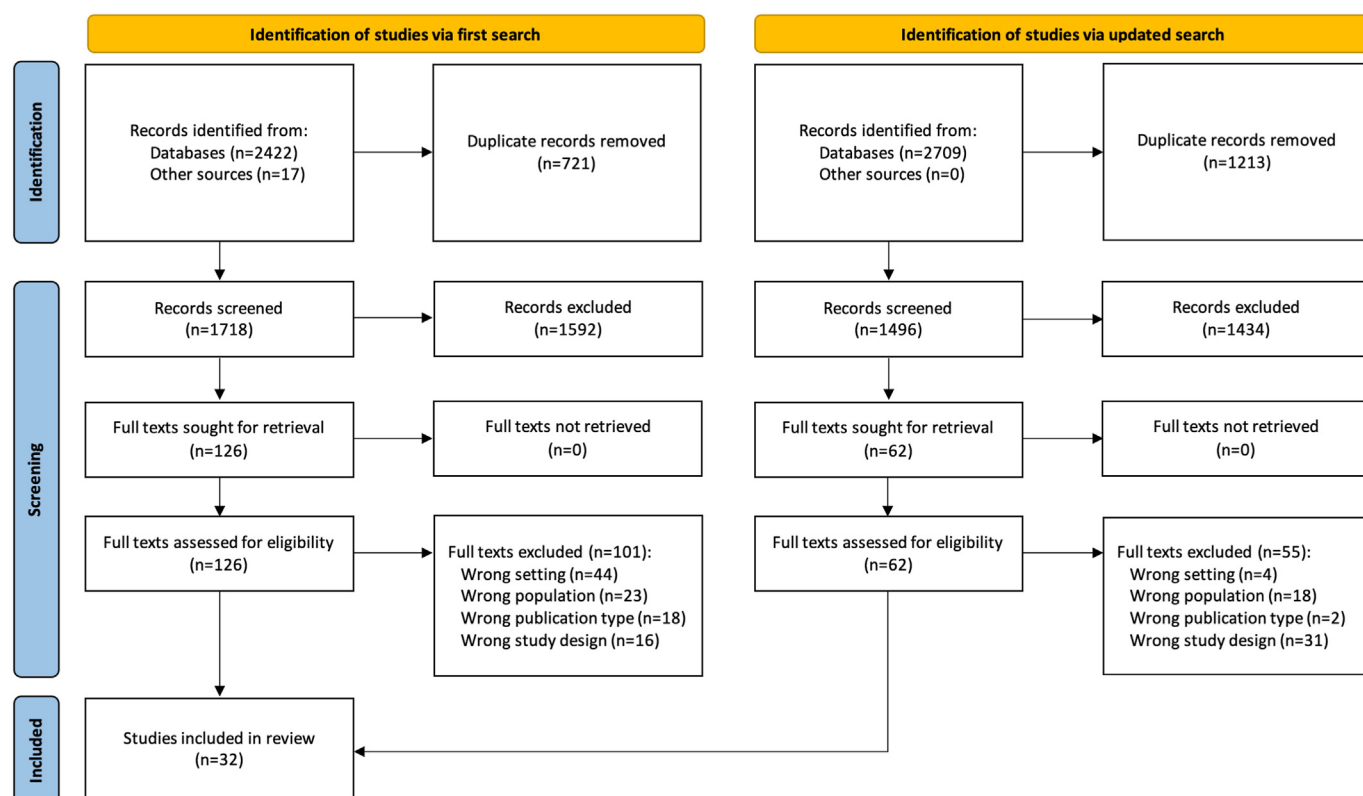


Fig. 1. Screening and selection process of studies on priority setting partnerships.

Table 1
Characteristics of Included Studies

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Cardiovascular Research priorities in advanced heart failure: James Lind alliance priority setting partnership ¹⁴	Steering group: patients (n = 4) and caregivers (n = 2) Initial survey: patients (n = 74) and caregivers (n = 17) Interim prioritization: patients (n = 17) and caregivers (n = 15) Final workshop: patients (n = 5), caregivers (n = 3), and charity representatives (n = 2)	Steering group: researchers (n = 2), nurse specialist (n = 1), palliative care nurse (n = 1), cardiologist (n = 1), geriatrician (n = 1), palliative medicine consultant (n = 1), general practitioner (n = 1) Initial survey: health and social care professionals (n = 92) Interim prioritization: health and social care professionals (n = 96) Final workshop: general practitioners (n = 6), general practice cardiologists (n = 3), nurse specialists (n = 2), cardiologist (n = 1), physiotherapist (n = 1), and cardiology research nurse (n = 1)	Gender of patients in steering group: 6 males and 12 females Gender of patients in initial survey: 34 males, 39 females, 1 not stated Gender of patients in interim prioritization: 4 males, 10 females, 3 not stated Number of patients across age groups (y) in initial survey: 6 (<40), 14 (41-50), 18 (51-60), 19 (61-70), 12 (71-80), 5 (>80) Number of patients across age groups (y) in interim prioritization: 2 (<40), 2 (41-50), 4 (51-60), 3 (61-70), 2 (71-80), 0 (>80) Ethnicity of patients in initial survey: 69 White British, 1 Black African, 2 mixed, 2 not stated Ethnicity of patients in interim prioritization: 16 White British, 0 Black African, 0 mixed, 1 not stated	JLA	UK (whole of the UK)	UK NIHR
Comorbidity Priorities for research in multiple conditions in later life (multimorbidity): findings from a James Lind Alliance priority setting partnership ¹⁵	Steering group: patients, caregivers, and patient representatives (n = NR) Initial survey: older adults and caregivers (n = 162) Interim prioritization: older adults (n = 27) and caregivers (n = 29) Final prioritization: older adults (n = 4) and caregivers (n = 5)	Steering group: health and social care professionals (n = NR) Initial survey: health and social care professionals (including geriatricians, general practitioners, nurses, physiotherapists, dentists, dietitians, social workers, occupational therapists, pharmacists, hospital practitioners, and others) (n = 192) Interim prioritization: health and social care professionals (n = 82) Final prioritization: general practitioners (n = 2), geriatricians (n = 2), dentist (n = 1), dietician (n = 1), nurse (n = 1), occupational therapist (n = 1), and physiotherapist (n = 1)	NR	JLA	UK (whole of the UK)	Newcastle University, UK NIHR
Dentistry Older people and oral health: setting a patient-centred research agenda ¹⁶	Users (older adults) of oral health services (n = 11), caregivers of older adults (n = 6), and representatives from charities and patient organizations (n = 5)	Academics interested in health services research for older adults (n = 2), community care geriatrician (n = 1), dental public health consultant (n = 1), restorative dentistry consultant with a special interest in gerodontology, dental commissioner (n = 1), and chair of local professional network (n = 1)	Users (older adults) of oral health services: 7 females, 9 aged ≥65 y, 2 aged between 60 and 65 y Caregivers of older adults: 5 females, all aged ≥65 y	Nominal group technique	UK (Greater Manchester, England)	University of Manchester, UK Economic and Social Research Council

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Table 1 (continued)

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Elder abuse Research priorities for elder abuse screening and intervention: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ¹⁷	Consensus conference: Patient advocates (n = NR)	Core group: emergency physicians (n = 3), social workers (n = 3), epidemiologist (n = 1), geriatric nurse practitioner (n = 1), and research assistant (n = 1) PICO question prioritization: health and social care professionals (n = 33) Consensus conference: health and social care professionals (including emergency physicians, researchers, educators, clinicians, students, geriatricians, nurses, social workers, pharmacists) (n = NR)	NR	CITRA	US (whole of the US)	The John A. Hartford Foundation, Gary and Mary West Health Institute, US NIH
End of life care Palliative and end of life care priority setting partnership ¹⁸	Steering group: patients, caregivers, and patient representatives (n = NR) Initial survey: bereaved caregivers, family members, or friends (n = 491), current caregivers, family members, or friends (n = 182), members of the public (n = 182), patients (n = 56), and volunteers (n = 42) Interim prioritization: bereaved caregivers, family members, or friends (n = 293), current caregivers, family members, or friends (n = 120), members of the public (n = 106), patients (n = 27), and volunteers (n = 27) Final prioritization: bereaved caregivers (n = 4), bereaved caregivers and health and social care professionals (n = 4), current caregivers (n = 2), patient representative and health and social care professionals (n = 182), patients (n = 1), and patient and current and bereaved carer (n = 1)	Steering group: health and social care professionals (n = NR) Initial survey: health and social care professionals (n = 673) Interim prioritization: health and social care professionals (n = 852) Final prioritization: health and social care professionals (n = 11)	NR	JLA	UK (whole of the UK)	Marie Curie, Cancer Research UK, Macmillan Cancer Support, Motor Neurone Disease Association, All Ireland Institute of Hospice and Palliative Care, UK NIHR, UK Chief Scientist Office, UK Department of Health, UK Medical Research Council, UK Economic and Social Research Council, Northern Ireland Public Health Agency

Nephrology	Identifying integrated health services and social care research priorities in kidney disease in Wales: research prioritisation exercise ¹⁹	Steering group: patients and caregivers (n = NR) Gathering uncertainties: patients and caregivers (n = NR) Interim prioritization: patients and caregivers (n = NR) Final prioritization workshop 1: patients and caregivers (n = 14), representatives from charities (n = NR), and local and government officials (n = NR)	Steering group: health and social care professionals (n = NR) Gathering uncertainties: health and social care professionals (n = NR) Interim prioritization: health and social care professionals (n = NR) Final prioritization workshop 1: health and social care professionals (n = NR) Final prioritization workshop 2: health and social care professionals (n = 8)	Gender of participants in initial survey: 62% male, 38% female	Modified JLA	UK (Wales)	Health and Care Research Wales
Neurology and psychiatry	Top 10 research priorities relating to life after stroke—consensus from stroke survivors, caregivers, and health professionals ²⁰	Steering group: survivors, caregivers, and representatives from key national stroke charities and patient organizations (n = NR) Gathering uncertainties: survivors (n = 22) and caregivers (n = 4) Interim prioritization: survivors and caregivers (n = 42) Final workshop: survivors and caregivers (n = 16)	Steering group: nurses, physicians, allied health professionals, and researchers (n = NR) Gathering uncertainties: health and social care professionals (n = 61) Interim prioritization: health and social care professionals (n = 55) Final workshop: health and social care professionals (n = 12)	NR	JLA	UK (Scotland)	Scottish Government's National Advisory Committee for Stroke, Scottish Government Health Directorate's Chief Scientist Office
Priority setting partnership to identify the top 10 research priorities for the management of Parkinson's disease ²¹	Steering group: patients (n = 2), carer (n = 2), and patient representatives (n = 9) Consultation survey: patients (n = 600), caregivers (n = 136), and patients' family and friends (n = 86) Final workshop: patients (n = 10) and caregivers and family (n = 5)	Steering group: clinical consultants (n = 2) and nurse specialist (n = 1) Consultation survey: health and social care professionals (including consultants, nurse specialists, nurses, care assistants, allied health professionals, social workers, and others) (n = 140) Final workshop: consultants (n = 5), nurse specialists (n = 4), and allied health professionals (n = 3)	Mean age of participants in consultation survey: 65-74 (patients), 65-74 (caregivers), 55-64 (patients' family and friends) Ethnicity (%) of patients in consultation survey: 86 White, 5 Black or Asian, 2 others, 7 not stated Ethnicity (%) of caregivers in consultation survey: 90 White, 1 Black or Asian, 1 other, 8 not stated Ethnicity (%) of patients' family and friends in consultation survey: 90 White, 7 Black or Asian, 2 others, 1 not stated	JLA	UK (whole of the UK)	Parkinson's UK	

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Table 1 (continued)

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Dementia priority setting partnership with the James Lind Alliance: using patient and public involvement and the evidence base to inform the research agenda ²²	Steering group: patients and caregivers (n = 5) Gathering uncertainties: patients (n = 64) and caregivers (n = 1188) Interim prioritization: patients and caregivers (n = NR) Final workshop: patients (n = 2) and caregivers (n = 5)	Steering group: health and social care professionals and researchers (n = 7) Gathering uncertainties: care workers (n = 16), geriatricians (n = 6), general practitioners (n = 5), nurses (n = 61), psychiatrists (n = 14), physiotherapists (n = 4), occupational therapist (n = 20), and social workers (n = 8) Interim prioritization: health and social care professionals (n = NR) Final workshop: clinicians (n = 6) and nurses/nursing managers (n = 5)	Ethnicity (%) of caregivers in gathering uncertainties: 78.6 White, 2 Black or Asian, 0.2 others, 23.2 not stated	JLA	UK (whole of the UK)	Alzheimer's Society UK, UK NIHR
Establishing research priorities relating to the long-term impact of TIA and minor stroke through stakeholder-centred consensus ²³	Gathering research priorities: patients (n = 3) and patient advocate (n = 1) Interim prioritization: patients (n = 3) and patient advocate (n = 1) Final priority setting: patients (n = 3) and patient advocate (n = 1)	Gathering research priorities: nurses (n = 3), consultant (n = 1), general practitioner (n = 1), psychologist (n = 1), and researcher (n = 1) Interim prioritization: nurses (n = 3), consultant (n = 1), general practitioner (n = 1), psychologist (n = 1), and researcher (n = 1) Final priority setting: nurses (n = 3), consultant (n = 1), general practitioner (n = 1), psychologist (n = 1), and researcher (n = 1)	Number of participants across age groups (y): 1 (25-34), 3 (35-44), 2 (45-54), 3 (55-64), 1 (65-74), 1 (75-84) Gender of participants: 6 males, 5 females	Nominal group technique	UK (Birmingham, England)	Wellcome Trust
Top 10 research priorities relating to aphasia following stroke ²⁴	Steering group: patients (n = 2) Gathering uncertainties: patients (n = 22), caregivers (n = 21), and patient advocates (n = 15) Interim prioritization survey: patients (n = 21) and caregivers (n = 7) Consensus meeting: patients (n = 10) and caregivers (n = 3)	Steering group: researchers (n = 5) Gathering uncertainties: health and social care professionals (n = 65) and researchers (n = 3) Selecting uncertainties: researchers (n = 3) Interim prioritization survey: speech and language therapists (n = 18) Consensus meeting: speech and language therapists (n = 9)	NR	JLA	UK (whole of the UK)	Funding source(s) not reported
Prioritising target non-pharmacological interventions for research in Parkinson's disease: achieving consensus from key stakeholders ²⁵	Survey round 1: patients (n = 9) Panel discussion: patients (n = 8) Survey round 2: patients (n = 13)	Survey round 1: health and social care professionals (n = 10) Panel discussion: health and social care professionals (n = 8) Survey round 2: patients (n = 13)	NR	Delphi process	UK (whole of the UK)	Parkinson's UK
Identifying research priorities for older people's mental health services ²⁶	Steering group: patients, caregivers, and patient advocates (n = NR) Research interests survey: patients (n = 9) and caregivers (n = 21) Research prioritization survey: patients (n = 6) and caregivers (n = 23) Consensus workshop: patients (n = 3) and caregivers (n = 4)	Steering group: health and social care professionals and researchers (n = NR) Research interests survey: health and social care professionals (n = 95) Research prioritization survey: health and social care professionals (n = 29) Consensus workshop: clinical psychologist (n = 1), clinical nurse (n = 1), research nurse (n = 1), and deputy service manager (n = 1)	NR	JLA	UK (Norfolk and Suffolk, England)	Norfolk and Suffolk National Health Service Foundation Trust

Shaping stroke research to rebuild lives ²⁷	Steering group: survivors, caregivers, and representatives from key national stroke charities and patient organizations (n = NR) Gathering uncertainties: patients (n = 552) and caregivers (n = 202) Interim prioritization: patients and caregivers (n = 475) Final workshop 1: patients and caregivers (n = 13) Final workshop 2: patients and caregivers (n = 12)	Steering group: nurses, physicians, allied health professionals, and researchers (n = NR) Gathering uncertainties: health and social care professionals (n = 615) Interim prioritization: health and social care professionals (n = 677) Final workshop 1: health and social care professionals (n = 14) Final workshop 2: health and social care professionals (n = 14)	Ethnicity of patient and health and social care professionals in gathering uncertainties: 4 White, 1 Black or African, 5 Asian, <1 mixed Ethnicity of patient and health and social care professionals in final workshops: 6 White, 0.5 Black or African, 5 Asian, <1% mixed	JLA	UK (whole of the UK)	Stroke Association
Delirium prevention, detection, and treatment in emergency medicine settings: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ²⁸	Consensus conference: patient advocates (n = NR)	Core group: emergency physicians (n = 4), social geriatricians (n = 3), research assistants (n = 3), doctoral researcher (n = 1) PICO question prioritization: health and social care professionals (n = 33) Consensus conference: health and social care professionals (including emergency physicians, researchers, educators, clinicians, students, geriatricians, nurses, social workers, pharmacists) (n = NR)	NR	CITRA	US (whole of the US)	The John A. Hartford Foundation, Gary and Mary West Health Institute, US NIH
A research agenda for the assessment and management of acute behavioral changes in elderly emergency department patients ²⁹	Steering committee: patients and patient advocates (n = NR) Working group: patient advocate (n = 1) and representative from the industry (n = 1) Consensus conference: patients and patient advocates (n = NR)	Steering committee: social workers, emergency physicians, psychiatrists, nursing, and clinical researchers (n = NR) Working group: emergency physicians (n = 2), psychiatrists (n = 2), emergency clinician-researcher (n = 2), and nonphysician student (n = 1) Consensus conference: social workers, emergency physicians, psychiatrists, nursing, and clinical researchers (n = NR)	NR	Nominal group technique	US (whole of the US)	University of Arkansas
Orthogeriatrics Generating research questions from research priorities in early osteoarthritis of hip and knee ³⁰	Steering Group: patients and caregivers (n = NR) Gathering uncertainties: patients and caregivers (n = NR) Interim prioritization: patients and caregivers (n = NR) Final workshop: patients and caregivers (n = 10)	Steering Group: surgeons, rheumatologists, general practitioners, physiotherapists, extended nurse practitioners, and acupuncturists (n = NR) Gathering uncertainties: health and social care professionals (n = NR) Interim prioritization: health and social care professionals (n = NR) Final workshop: health and social care professionals (n = 10) and researchers (n = 10)	NR	JLA	UK (whole of the UK)	British Orthopedic Association, British Association of Surgeons of the Knee, British Hip Society, UK NIHR

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Table 1 (continued)

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Research priorities in fragility fractures of the lower limb and pelvis ³¹	Steering group: patients, caregivers, and patient advocates (n = NR) Gathering uncertainties: patients and caregivers (n = 179) Interim prioritization: patients and caregivers (n = 111) Final workshop: patients and public members (n = 12)	Steering group: health and social care professionals (n = NR) Gathering uncertainties: health and social care professionals (n = 186) Interim prioritization: health and social care professionals (n = 98) Final workshop: surgeons, general practitioners, nurses, and allied health professionals (n = 12)	NR	JLA	UK (whole of the UK)	British Orthopaedic Association, Orthopaedic Trauma Society, UK NIHR
Research priorities for the management of broken bones of the upper limb in people over 50: a UK priority setting partnership with the James Lind Alliance ³²	Steering group: patients and patient advocates (n = NR) Initial survey: patients and public members (n = 174) Interim prioritization: patients and public members (n = 107) Final workshop: patients and public members (n = 13)	Steering group: health and social care professionals (n = NR) Initial survey: health and social care professionals (n = 138) Interim prioritization: health and social care professionals (n = 102) Final workshop: surgeons, general practitioners, nurses, and allied health professionals (n = 7)	Gender of participants in initial survey: 103 males, 202 females Ethnicity of participants in gathering uncertainties: 268 White, 34 minority ethnic, 26 prefer not to say Ethnicity of participants in interim prioritization: 187 White, 17 minority ethnic, 4 prefer not to say	JLA	UK (whole of the UK)	Orthopaedic Trauma Society, British Orthopaedic Association, UK NIHR
Top ten research priorities for problematic knee arthroplasty ³³	Steering group: patients and caregivers (n = NR) Gathering uncertainties: patients and caregivers (n = 227) Interim prioritization: patients and caregivers (n = 139) Final workshop: patients and caregivers (n = 12)	Steering group: health and social care professionals (n = NR) Gathering uncertainties: surgeon (n = 59), physiotherapists (n = 26), anesthetists (n = 7), nurses (n = 6), general practitioners (n = 6), surgical care practitioners (n = 3), pain specialist (n = 2), medical manager (n = 1), operating department practitioner (n = 1), and occupational therapist (n = 1) Interim prioritization: surgeon (n = 59), physiotherapists (n = 41), anesthetists (n = 3), nurses (n = 3), general practitioners (n = 4), surgical care practitioners (n = 2), pain specialist (n = 1), researchers (n = 10), operating department practitioner (n = 1), and occupational therapists (n = 2) Final workshop: health and social care professionals (n = 12)	Gender of participants in gathering uncertainties: 146 males, 121 females Gender of participants in interim prioritization: 98 males, 103 females Mean age of participants in gathering uncertainties: 68.9 y Mean age of participants in interim prioritization: 54.5 y Ethnicity of participants in gathering uncertainties: 119 White British, 3 White Irish, 4 Black, 7 Asian, 3 other Ethnicity of participants in interim prioritization: 156 White British, 4 White Irish, 6 Black, 12 Asian, 4 mixed, 19 other	JLA	UK (whole of the UK)	Funding source(s) not reported

Use of a modified Delphi process to develop research priorities in major trauma ³⁴	Steering committee: public representatives (n = NR) Phase 1 (question submission): patients (n = 2) Phase 2 (initial prioritization): patients (n = NR)	Steering committee: field experts (n = NR) Phase 1 (question submission): health and social care professionals and researchers (n = 63) Phase 2 (initial prioritization): health and social care professionals and researchers (n = NR) Phase 3 (final prioritization): paramedics (n = 16), surgeons (n = 12), anesthetists (n = 8), emergency physicians (n = 6), and elderly care physicians (n = 4)	NR	Modified Delphi process	UK (whole of the UK)	Funding source(s) not reported
RE-CODE DCM (REsearch Objectives and Common Data Elements for Degenerative Cervical Myelopathy): A consensus process to improve research efficiency in DCM, through establishment of a standardized dataset for clinical research and the definition of the research priorities ³⁵	Steering group: patients and caregivers (n = NR) Gathering uncertainties: patients and caregivers (n = 99) Interim prioritization: patients and caregivers (n = 107) Final workshop: patients and caregivers (n = 12)	Steering group: health and social care professionals (n = NR) Gathering uncertainties: health and social care professionals (n = 330) Interim prioritization: health and social care professionals (n = 310) Final workshop: health and social care professionals (n = 13)	NR	JLA	UK (whole of the UK)	University Hospitals Bristol National Health Service Foundation Trust, University of Bristol, Wellcome Trust, UK NIHR, UK Medical Research Council
Moving the needle on fall prevention: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ³⁶	Consensus conference: patient advocates (n = NR)	Core group: emergency physician scientists (n = 6), nursing scientists (n = 2), epidemiologist (n = 1), health services researcher (n = 1), and doctoral researcher (n = 1) PICO question prioritization: health and social care professionals (n = 33) Consensus conference: health and social care professionals (including emergency physicians, researchers, educators, clinicians, students, geriatricians, nurses, social workers, pharmacists) (n = NR)	NR	CITRA	US (whole of US)	The John A. Hartford Foundation, Gary and Mary West Health Institute
Injury due to mechanical falls: future directions in gender-specific surveillance, screening, and interventions in emergency department patients ³⁷	Workgroup: patients, representatives of federal agencies, and policy makers (n = NR) Consensus conference and final agenda revision: patients, representatives of federal and funding agencies, and representatives of regulatory bodies (n = NR)	Steering committee: researchers (n = 6) Workgroup: researchers, clinicians, nurses, and prehospital providers (n = NR) Consensus conference and final agenda revision after conference: junior faculty (n = 43), trainees (students, residents, or fellows) (n = 33), associate professors (n = 25), full professors (n = 17), doctoral researchers (n = NR), nurses (n = NR), and paramedics (n = NR)	Consensus conference and final agenda revision: female (71%), White (79%), aged 31-50 y (57%)	Modified nominal group technique	US (whole of US)	US NIH

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Table 1 (continued)

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Oncology						
The James Lind Alliance approach to priority setting for prostate cancer research: an integrative methodology based on patient and clinician participation ³⁸	Steering group: patients and patient advocates (n = NR) Gathering uncertainties: patients (n = 32) Ranking exercise: patients and patient advocates (n = NR) Final prioritization: patients and patient advocates (n = NR)	Affiliated partners: health and social care professionals (n = NR) Gathering uncertainties: clinicians (n = 6) and researchers (n = 2) Ranking exercise: health and social care professionals (n = NR) Final prioritization: health and social care professionals (n = NR)	NR	JLA	UK (whole of the UK)	Prostate Cancer Research Foundation, Prostate Cancer Support Federation
Research priorities in mesothelioma: a James Lind Alliance priority setting partnership ³⁹	Steering group: patients (n = 2), bereaved carer (n = 1), and representatives of patient and family support groups (n = 4) Initial survey: patients (n = 103) Interim prioritization survey: patients (n = 38) Final consensus meeting: patients (n = 6)	Steering group: health and social care professionals (including nurses, surgeons, oncologists, chest physicians, and palliative care experts) (n = 9) Initial survey: health and social care professionals (n = 82) Interim prioritization survey: health and social care professionals (n = 50) Final consensus meeting: health and social care professionals (n = 16)	79% of the patients were male; 86% of the caregivers were female	JLA	UK (whole of the UK)	UK NIHR
Living with and beyond cancer ⁴⁰	Steering group: patients and caregivers (n = 12) Gathering uncertainties: patients and caregivers (n = 952) Interim prioritization: patients and caregivers (n = 1347) Final workshop: patients and caregivers (n = 13)	Steering group: health and social care professionals (n = 9) Gathering uncertainties: health and social care professionals (n = 375) Interim prioritization: health and social care professionals (n = 345) Final workshop: health and social care professionals (n = 14)	NR	JLA	UK (whole of the UK)	UK National Cancer Research Institute
Prescribing						
A multi-stakeholder approach to the co-production of the research agenda for medicines optimisation ⁴¹	Stage 1 (research question generation): patient and public representatives (n = 2) Stage 2 (research question refinement): patient and public representatives (n = 11) Stage 3 (prioritization workshop): patient and public representatives (n = 7)	Stage 1 (research question generation): academic pharmacists (n = 8), nonpharmacist academics (n = 7), and general practitioners (n = 2) Stage 2 (research question refinement): pharmacists (n = 12), academic pharmacists (n = 7), nonpharmacist academics (n = 6), general practitioners (n = 2), and medical consultant (n = 2) Stage 3 (prioritization workshop): pharmacists (n = 9), academic pharmacists (n = 9), nonpharmacist academics (n = 5), and general practitioners (n = 2)	NR	Modified nominal group technique	UK (Bath, Bristol, Cardiff, and Exeter, England)	GW4 Alliance (Consortium of the Universities of Bath, Bristol, Cardiff, and Exeter)

Pulmonary and respiratory Research priorities for exacerbations of COPD ⁴²	Steering group: patients (n = 3) Initial survey: patients (n = 418) and caregivers (n = 39) Interim prioritization survey: patients (n = 74) and caregivers (n = 9) Final priority setting workshop: patients (n = 7)	Steering group: health and social care professionals (including doctors, nurses, and physiotherapists) (n = 9) Initial survey: health and social care professionals (n = 110) Interim prioritization survey: health and social care professionals (n = 101) Final priority setting workshop: health and social care professionals (n = 7)	Gender of patients in initial survey: JLA 138 males; 430 females; 3 prefer not to say Gender of patients in interim prioritization survey: 124 males, 64 females, 3 prefer not to say Number of patients across age groups (y) in initial survey: 16 (18-29), 97 (30-49), 269 (50-69), 165 (70-79), 23 (≥80), 1 prefer not to say Number of patients across age groups (y) in interim prioritization survey: 5 (18-29), 67 (30-49), 70 (50-69), 42 (70- 79), 6 (≥80), 1 prefer not to say Ethnicity of patients in initial survey: 548 White, 13 Asian, 1 Black, 1 Arab, 6 mixed, 2 prefer not to say Ethnicity of patients in interim prioritization survey: 164 White, 13 Asian, 2 Black, 3 Arab, 5 mixed, 4 prefer not to say	UK (whole of the UK)	British Lung Foundation
Vision The Sight Loss and Vision Priority setting Partnership (SLV-PSP): overview and results of the research prioritisation survey process ⁴³	Steering committee: patients and eye health service users (n = NR) Initial survey: patients (n = 1420), caregivers, partners, or relatives (n = 266), patient advocates (n = 133), and parents (n = 44) Interim prioritization survey: patients, caregivers, or relatives (n = 446) Final prioritization workshops: patients, caregivers, or relatives (n = 78)	Steering group: professionals from ophthalmology, optometry, orthoptics, ophthalmic nursing and social care (n = NR) Initial survey: eye health professionals (n = 355) Interim prioritization survey: eye health professionals (n = 218) Final prioritization workshops: eye health professionals (n = 77)	Age of participants in initial survey: JLA 65.7 y (mean), 16 mo (youngest), 105 y (oldest) Gender of participants in initial survey: 38% male, 62% female	UK (whole of the UK)	Fight for Sight, UK Vision Strategy, Royal National Institute of Blind People, Royal College of Ophthalmologists, UK College of Optometrists, UK NIHR

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Table 1 (continued)

Area and Study Title	Stakeholder(s)	Health and Social Care professional(s)	Demographics of Participants	Method(s)	Country (Regions Involved)	Funding source(s)
Other						
Care transitions and social needs: a Geriatric Emergency care Applied Research (GEAR) Network scoping review and consensus statement ⁴⁴	Consensus conference: Patient advocates (n = NR)	Core group: emergency physician (n = 6), nursing scientists (n = 2), geriatrician (n = 1), social psychologist (n = 1), public health professional (n = 1), research assistant (n = 1), and social welfare scientist (n = 1)	NR	CITRA	US (whole of US)	The John A. Hartford Foundation, Gary and Mary West Health Institute, US NIH
A patient-centered research agenda for the care of the acutely ill older patient ⁴⁵	Consultation: patients, caregivers, and patient advocates (n = 151) Prioritization: patients, caregivers, and patient advocates (n = NR)	PICO question prioritization: health and social care professionals (n = 33) Consensus conference: health and social care professionals (including emergency physicians, researchers, educators, clinicians, students, geriatricians, nurses, social workers, pharmacists) (n = NR) Steering committee: researchers (n = 5) Consultation: health and social care professionals (n = 522) Prioritization: health and social care professionals (n = NR)	All respondents in consultation: female (77%), white (85%), aged 45–65 y (65%)	Modified JLA with nominal group technique	US (whole of US)	The John A. Hartford Foundation, Association of Specialty Professors, American Society of Internal Medicine

CITRA, Cornell Institute for Translational Research on Aging; COPD, chronic obstructive pulmonary disease; JLA, James Lind Alliance; NIH, National Institutes of Health; NIHR, National Institute for Health and Care Research; NR, not reported; TIA, transient ischemic attack.

Network,⁴⁶ concerning the caring of older adults in emergency care settings, and adopted the CITRA approach for their priority setting exercise.^{17,28,36,44} The remaining 3 either used a nominal group technique (n = 2),^{29,37} or the modified JLA approach (n = 1).⁴⁵ Of the 22 UK PSPs reporting their source(s) of funding, all were financially supported by British government funders (eg, National Institute for Health and Care Research), professional bodies (eg, British Orthopaedic Association), registered charities (eg, Parkinson's UK), charitable foundations (eg, Wellcome Trust), and/or universities. The 7 US PSPs were funded by the US National Institutes of Health, private philanthropies (eg, John A. Hartford Foundation), professional bodies (eg, Association of Specialty Professors), and/or universities. None of the included PSPs reported the involvement of pharmaceutical companies in any research activities.

The 25 UK PSPs were conducted for 27 distinct medical conditions or service arrangements common in older adults. Eight of them focused on neurology or psychiatry, including stroke or transient ischemic attack (n = 4),^{20,23,24,27} Parkinson disease (n = 2),^{21,25} dementia (n = 1),²² and mental health services (n = 1).²⁶ Six were on orthogeriatrics, including fractures (n = 2),^{31,32} osteoarthritis (n = 1),³⁰ knee surgery (n = 1),³³ degenerative cervical myelopathy (n = 1),³⁵ and major trauma (n = 1).³⁴ Three focused on oncology, including prostate cancer (n = 1),³⁸ mesothelioma (n = 1),³⁹ and living with cancer (n = 1).⁴⁰ One study each concentrated on cardiovascular (heart failure),¹⁴ comorbidity (multimorbidity),¹⁵ dentistry (oral health),¹⁶ end of life care (palliative care),¹⁸ prescribing (medicine optimization),⁴¹ nephrology,¹⁹ pulmonary or respiratory (chronic obstructive pulmonary disease),⁴² and vision (age-related macular degeneration, cataracts glaucoma, corneal and external diseases, neuro-ophthalmology, ocular cancer, ocular inflammatory diseases, and retinal vascular diseases).⁴³ There was no PSP conducted in the United Kingdom for topics regarding continence, elder abuse, frailty, hematology, hearing loss, nutrition, or sarcopenia. See Table 2.

The 7 US PSPs were conducted for 9 distinct medical conditions or service arrangements and 2 care planning topics. Most of them (n = 6) discussed the research priorities for patient management in emergency care settings.^{17,28,29,36,37,44} Five studies concentrated on neurology or psychiatry, including delirium (n = 2),^{28,29} dementia (n = 2),^{29,45} and depression (n = 1).⁴⁵ Three focused on orthogeriatrics, including falls (n = 2)^{36,37} and orthopedic surgery (n = 1).⁴⁵ One study each targeted acute inpatient care,⁴⁵ care transitions and social needs,⁴⁴ elder abuse,¹⁷ end of life care (palliative care),⁴⁵ and prescribing (medicine optimization).⁴⁵ Like the United Kingdom, there was no PSP conducted in the United States for topics on continence, frailty, hematology, hearing loss, or nutrition. Apart from those, the topics on cardiovascular, comorbidity, dentistry, nephrology, oncology, pulmonary or respiratory, sarcopenia, and vision were also not covered by the US PSPs. See Table 3.

Themes of Research Priorities

The research priorities were grouped into a total of 9 themes (see Supplementary Table 5 for definitions of themes).

1. Diagnosis and recognition
2. Treatment and intervention
3. Prevention
4. Prognostic and predictive factors
5. Etiology
6. Caregivers and support
7. Service development
8. Patient knowledge, experience, education, and engagement
9. Other (priorities that could not fit within the preceding themes)

Table 2
Summary of Existing Research Prioritization Topics in the United Kingdom Relevant to Health Care in Older Adults

Area	Topic of PSP	Themes									
		Diagnosis and Recognition	Treatment and Intervention	Prevention	Prognostic/ Predictive Factors	Etiology	Caregivers and Support	Service Development	Patient Knowledge, Experience, Education, and Engagement	Other	
Cardiovascular	Heart failure	0	4	0	0	0	1	1	4	0	
Comorbidity	Multimorbidity	1	3	1	0	0	1	3	0	1	
Continence	No PSP identified	0	0	0	0	0	0	0	0	0	
Dentistry	Oral health	0	1	0	0	0	1	4	1	0	
Elder abuse	No PSP identified	0	0	0	0	0	0	0	0	0	
End of life care	Palliative care	0	2	0	0	0	1	7	0	0	
Frailty	No PSP identified	0	0	0	0	0	0	0	0	0	
Hematology	No PSP identified	0	0	0	0	0	0	0	0	0	
Hearing loss	No PSP identified	0	0	0	0	0	0	0	0	0	
Nephrology	Kidney disease	2	8	1	0	0	0	11	12	6	
Neurology and psychiatry	Dementia	1	7	0	0	0	3	3	0	6	
	Parkinson's	1	8	0	0	0	0	0	0	0	
	Stroke or transient ischemic attack	3	22	4	2	1	4	6	3	5	
	Mental health services	0	0	0	1	0	0	2	0	1	
Nutrition	No PSP identified	0	0	0	0	0	0	0	0	0	
Orthogeriatrics	Fractures	0	11	3	1	0	0	0	4	1	
	Osteoarthritis	2	16	0	6	0	0	2	0	2	
	Knee surgery	1	3	2	1	0	0	1	0	2	
	Degenerative cervical myelopathy	3	2	0	0	1	0	1	0	2	
	Major trauma	0	3	0	4	0	0	0	0	3	
Oncology	Mesothelioma	2	7	0	1	0	0	0	0	0	
	Prostate cancer	2	2	4	0	0	0	1	0	1	
	Living with cancer (general)	0	3	0	1	2	0	1	1	1	
Prescribing	Medicine optimization	0	0	0	0	0	0	10	4	1	
Pulmonary and respiratory	Chronic obstructive pulmonary disease	2	2	3	2	0	0	0	0	1	
Sarcopenia	No PSP identified	0	0	0	0	0	0	0	0	0	
Vision	Age-related macular degeneration	1	2	3	2	1	0	0	1	0	
	Cataracts	1	6	2	0	1	0	0	0	0	
	Glaucoma	2	4	1	0	2	0	0	0	1	
	Corneal and external diseases	0	6	1	0	2	0	0	0	0	
	Neuro-ophthalmology	2	6	1	0	1	0	0	0	0	
	Ocular cancer	1	5	0	0	2	0	0	0	2	
	Ocular inflammatory diseases	1	0	3	1	4	0	0	0	0	
	Retinal vascular diseases	0	4	2	1	0	0	0	1	0	
	Total number of priorities		24	111	23	20	17	11	52	26	28

PSP, priority setting partnership.
Values are number of priorities.

Table 3
Summary of Existing Research Prioritization Topics in the United States Relevant to Health Care in Older Adults

Area	Topic of PSP	Themes								
		Diagnosis and Recognition	Treatment and Intervention	Prevention	Prognostic/ Predictive Factors	Etiology	Caregivers and Support	Service Development	Patient Knowledge, Experience, Education, and Engagement	Other
Cardiovascular	No PSP identified	0	0	0	0	0	0	0	0	0
Comorbidity	No PSP identified	0	0	0	0	0	0	0	0	0
Continence	No PSP identified	0	0	0	0	0	0	0	0	0
Dentistry	No PSP identified	0	0	0	0	0	0	0	0	0
Elder abuse	Elder abuse	3	2	0	0	0	0	0	0	0
End of life care	Palliative care	0	0	0	0	0	0	1	0	0
Frailty	No PSP identified	0	0	0	0	0	0	0	0	0
Hematology	No PSP identified	0	0	0	0	0	0	0	0	0
Hearing loss	No PSP identified	0	0	0	0	0	0	0	0	0
Nephrology	No PSP identified	0	0	0	0	0	0	0	0	0
Neurology/ Psychiatry	Delirium	4	6	1	4	2	0	3	0	1
	Dementia	0	0	0	1	0	1	0	0	0
	Depression	0	0	0	1	0	0	0	0	0
Nutrition	No PSP identified	0	0	0	0	0	0	0	0	0
Orthogeriatrics	Falls	4	0	6	8	0	3	1	1	3
	Orthopedic surgery	0	0	0	1	0	0	0	0	0
Oncology	No PSP identified	0	0	0	0	0	0	0	0	0
Prescribing	Medicine optimization	0	0	0	0	0	0	1	0	0
Pulmonary/ Respiratory	No PSP identified	0	0	0	0	0	0	0	0	0
Sarcopenia	No PSP identified	0	0	0	0	0	0	0	0	0
Vision	No PSP identified	0	0	0	0	0	0	0	0	0
Other	Acute inpatient care	0	1	0	1	0	0	0	0	0
	Care transitions and social needs	0	1	0	0	0	1	2	0	2
Total number of priorities		11	10	7	16	2	5	8	1	6

PSP, priority setting partnership.
Values are number of priorities.

Table 4
 Prioritization Exercises' Adherence to the 9 Common Themes of Good Practice

Country and Study Title	Context	Use of a Comprehensive Approach	Inclusiveness	Information Gathering	Planning for Implementation	Criteria	Methods for Deciding on Priorities	Evaluation	ransparency
United Kingdom									
Research priorities in advanced heart failure: James Lind alliance priority setting partnership ¹⁴	*	†	*	†	†	†	†	†	†
Priorities for research in multiple conditions in later life (multi-morbidity): findings from a James Lind Alliance priority setting partnership ¹⁵	*	†	‡	†	†	†	†	†	†
Older people and oral health: setting a patient-centred research agenda ¹⁶	*	†	‡	‡	†	†	†	†	†
Palliative and end of life care priority setting partnership ¹⁸	*	†	‡	†	†	†	†	†	†
Identifying integrated health services and social care research priorities in kidney disease in Wales: research prioritization exercise ¹⁹	*	†	‡	†	†	†	†	†	†
Top 10 research priorities relating to life after stroke—consensus from stroke survivors, caregivers, and health professionals ²⁰	†	†	‡	†	†	†	†	†	†
Priority setting partnership to identify the top 10 research priorities for the management of Parkinson disease ²¹	*	†	‡	†	†	†	†	†	†
Dementia priority setting partnership with the James Lind Alliance: using patient and public involvement and the evidence base to inform the research agenda ²²	*	†	‡	†	†	†	†	†	†
Establishing research priorities relating to the long-term impact of TIA and minor stroke through stakeholder-centred consensus ²³	†	†	‡	†	†	†	†	‡	†
Top 10 research priorities relating to aphasia following stroke ²⁴	†	†	‡	†	†	†	†	†	†
Prioritising target non-pharmacological interventions for research in Parkinson's disease: achieving consensus from key stakeholders ²⁵	*	‡	‡	†	*	†	†	‡	†
Identifying research priorities for older people's mental health services ²⁶	*	†	‡	†	†	†	†	†	†
Shaping stroke research to rebuild lives ²⁷	†	†	‡	†	†	†	†	†	†
Generating research questions from research priorities in early osteoarthritis of hip and knee ³⁰	†	†	‡	†	†	†	†	†	†
Research priorities in fragility fractures of the lower limb and pelvis ³¹	*	†	‡	†	†	†	†	†	†
Research priorities for the management of broken bones of the upper limb in people over 50: a UK priority setting partnership with the James Lind Alliance ³²	*	†	*	†	†	†	†	†	†
Top ten research priorities for problematic knee arthroplasty ³³	*	†	*	†	†	†	†	†	†
Use of a modified Delphi process to develop research priorities in major trauma ³⁴	*	†	‡	†	†	†	†	†	†
RE-CODE DCM (REsearch Objectives and Common Data Elements for Degenerative Cervical Myelopathy): A consensus process to improve research efficiency in DCM, through establishment of a standardized dataset for clinical research and the definition of the research priorities ³⁵	*	†	‡	†	†	†	†	†	†
The James Lind Alliance approach to priority setting for prostate cancer research: an integrative methodology based on patient and clinician participation ³⁸	†	†	‡	†	†	†	†	†	†
Research priorities in mesothelioma: a James Lind Alliance priority setting partnership ³⁹	†	†	‡	†	†	†	†	†	†

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Table 4 (continued)

Country and Study Title	Context	Use of a Comprehensive Approach	Inclusiveness	Information Gathering	Planning for Implementation	Criteria	Methods for Deciding on Priorities	Evaluation	ransparency
Living with and beyond cancer ⁴⁰	†	†	‡	†	†	†	†	†	†
A multi-stakeholder approach to the co-production of the research agenda for medicines optimisation ⁴¹	*	†	‡	†	†	†	†	‡	†
Research priorities for exacerbations of COPD ⁴²	†	†	*	†	†	†	†	†	†
The Sight Loss and Vision Priority setting Partnership (SLV-PSP): overview and results of the research prioritisation survey process ⁴³	*	†	‡	†	†	†	†	†	†
United States		†	‡	†	†	†	†	†	†
Research priorities for elder abuse screening and intervention: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ¹⁷	*	†	‡	†	†	†	†	†	†
Delirium prevention, detection, and treatment in emergency medicine settings: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ²⁸	*	†	‡	†	†	†	†	†	†
A research agenda for the assessment and management of acute behavioral changes in elderly emergency department patients ²⁹	*	†	‡	†	†	†	†	‡	†
Moving the needle on fall prevention: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement ³⁶	*	†	‡	†	†	†	†	†	†
Injury due to mechanical falls: future directions in gender-specific surveillance, screening, and interventions in emergency department patients ³⁷	*	†	‡	†	†	†	†	†	†
Care transitions and social needs: a Geriatric Emergency care Applied Research (GEAR) Network scoping review and consensus statement ⁴⁴	*	†	‡	†	†	†	†	†	†
A patient-centered research agenda for the care of the acutely ill older patient ⁴⁵	*	†	*	†	†	†	†	†	†

COPD, chronic obstructive pulmonary disease; TIA, transient ischemic attack.

*Study partially adhered to good practice design.

†Study fully adhered to good practice design.

‡Study did not adhere to good practice design at all.

Of the 25 studies and 27 medical conditions or service arrangements examined, the most identified priorities in the United Kingdom concerned the evaluation of treatments and interventions ($n = 11$ priorities) for respective conditions. Patients, health and social care professionals, and other relevant stakeholders expressed their particular interest in the management of conditions that may bring significant and long-term impacts on quality of life, namely, stroke or transient ischemic attack ($n = 22$), osteoarthritis ($n = 16$), and fractures ($n = 11$). Service development ($n = 52$) was also a popular theme for future research in this country, with particular attention paid to kidney disease ($n = 11$) and medicine optimization ($n = 10$). The stakeholders agreed upon a significant number of research priorities for improving patient knowledge, experience, education, and engagement in kidney disease management ($n = 12$).

In contrast, of the 7 PSPs conducted in the United States, the most agreed priorities were the investigation of prognostic and predictive factors ($n = 16$) for geriatric conditions and care planning. Patients, health and social care professionals, and other relevant stakeholders were particularly exploring prognostic and predictive factors of falls among older adults. Although diagnosis and recognition ($n = 11$) and treatment and intervention ($n = 10$) also drew some attention from the stakeholders, there was no specific focus on any single condition. It is also noteworthy that 6 of the 7 research priorities in prevention focused on falls.

Adherence to the 9CTGP

Studies' adherence to the 9CTGP is described in Table 4. A significant number (66%) of prioritization exercises (United Kingdom: $n = 20$; United States: $n = 1$) were conducted in collaboration with the JLA or using the JLA approach, and as such adhered, at least partially, to the majority of the 9CTGP. However, 21 of the 25 studies (84%) in the United Kingdom^{15,16,18–27,30,31,34,35,38–41,43} and 6 of the 7 studies (86%) in the United States^{17,28,29,36,37,44} did not adhere at all to at least 1 domain. Among them, 5 (20%) in the United Kingdom^{16,23,25,29,41} and 1 (14%) in the United States²⁹ did not adhere at all to more than 1 domain. The most prominent issue with study quality was related to inclusivity. Regardless of the presence of balanced participation across different age groups, gender groups, and ethnic groups, relevant demographic information was reported in just 3 (12%) studies in the United Kingdom^{14,33,42} and 2 (29%) in the United States.^{37,45} Moreover, these studies only reported the demographics of the participants who took part in selected rather than all stage(s) of the prioritization exercises. All studies in the United Kingdom, except the one that adopted the modified Delphi process,³⁴ involved patients in their steering committees (if available) and all aspects of the prioritization process. In contrast, only 1 priority setting exercise in the United States included patients and patient advocates in their steering committee, working group, and consensus conference.²⁹ Patients and patient advocates in studies with the CITRA approach could only participate in the consensus conferences for final prioritization.^{17,28,36,44}

Discussion

Summary of Findings

We identified and synthesized 32 recent PSPs regarding older adult health care, with 25 conducted in the United Kingdom and 7 in the United States. No relevant PSPs were found for South Korea or countries in Africa. Most exercises conducted in the United Kingdom and the United States focused on neurology or psychiatry and orthogeriatrics. Oncology was also a popular topic area for PSPs in the United Kingdom. There are notable research gaps for increasingly prevalent health care problems, with no priority-setting exercises on

fundamental topic areas for older adults such as continence, frailty, hearing loss, and nutrition.

In the United Kingdom, there is a clear imbalance in the focus of prioritized research: questions related to treatments and interventions dominated, with few relating to caregivers and support. This is arguably unsurprising as identifying effective treatments is likely to positively impact patient care, and many of these exercises invited participants with a health care background. Yet, in conditions that cause long-term functional impairment (eg, dementia and stroke), there were surprisingly few research priorities themed around the needs of caregivers or longer-term support given to the people living with the condition. In the United States, the prioritization of research questions focused on prognostic and predictive factors with fewer exercises examined patient knowledge, experience, education, and engagement. This may be influenced by the US insurance-based system of health care whereby stakeholders sought to minimize health care burden and cost through prevention and slowing of disease progression.

Most PSPs have been conducted using a robust methodology and adhere well to general standards of best practice. Nevertheless, there are consistent issues around inclusivity across almost all medical conditions investigated. Only a small number of studies provided ethnicity-level data, making it difficult to infer the extent to which (if at all) people from racial and ethnic minority groups were included in priority setting. Current research priorities may therefore be overly biased toward the health care needs of the white population. Racial and ethnic minority groups' experiences of health care often differ from those of the Caucasian majority⁴⁷; hence, the proportional representation of racial and ethnic minority populations in future PSPs may alter some of the currently identified health care priorities for older adults. Several PSPs reported actively attempting to boost the participation of racial and ethnic minority groups but were ultimately unsuccessful, and the reasons for this were not stated in the respective studies.^{14,42}

The absence of PSPs relevant to older adults conducted in Africa and South Korea is an important finding. The paucity of PSPs in African countries has been identified in other research areas,⁴⁸ whereas that of South Korea has not been described. Different health care systems, cultural perspectives, health-seeking behaviors, access to resources, and disease burden could mean priorities may be distinct from those described here from the United Kingdom and the United States, such as the impact of scarce resources⁴⁹ or health care delivery via South Korea's nationwide comprehensive compulsory health care system. There is a particular need for future PSPs with communities or representatives from underserved health care systems including countries in Africa. Global PSPs, which rarely include these groups and therefore may not be relevant or generalizable, are not suitable surrogates.⁴⁹ Priority-setting exercises that do take place in low-income settings remain driven by researchers and policymakers with input from third-party stakeholders all of whom may have significant cultural and economic differences from the population.^{48,50}

Implications for Practice and Research

Our review highlights some common issues with PSPs conducted in the United Kingdom and the United States, as well as the complete absence of South Korean- and African-based studies. The priority-setting exercises included came from a variety of groups, including national organizations, professional societies, academic groups, and others. A degree of diversity in the provenance of priority setting is welcome, but too many groups working in the same space risks duplication of effort and possible conflicting results. Greater collaboration between stakeholders is needed to facilitate truly cross-institute, cross-disciplinary, cross-sectoral consensus. Although most exercises are inclusive of stakeholders, they are not always reported to

be involved in all stages of the process. We recommend future researchers adopt the JLA approach,² which sees patient and public involvement as the core component in the priority setting process. Specifically, it aims to engage patients, caregivers, patient advocates, and other relevant members of the public in action plan formulation, research question generation, and interim and final prioritizations, ensuring that both the providers' and end users' comments and suggestions are well-considered in the "Top 10" list of research questions.²

Moreover, the issues with limited data on ethnicity and other protected characteristics highlight a broader problem around comprehensive and transparent reporting of PSPs. We would therefore encourage qualitative work to identify barriers to their participation in prioritization exercises. Reporting guidance with checklists are available, and their use should be advocated. For the specific issue around describing the stakeholders, those undertaking prioritization work may consider using the PROGRESS PLUS⁵¹ or the INCLUDE Ethnicity Framework⁵² to consider equity-related issues and their impact on PSPs. Doing such may ensure that the sample population included in the PSPs reflects the diversity of the study population. We would also support the future involvement of patients and communities in PSPs in low-income countries to better understand local priorities considering cultural and economic differences.

The use of formal research priority setting exercises is a relatively new development. There remain many questions around the validity of the process and whether identifying priority topics actually changes research activities. Our aim here was not to assess the impact of priority setting but to describe the topics identified in priority-setting exercises that have been performed in relation to older adults. Future research looking at these other questions relating to research priority setting is warranted.

Strengths and Limitations

We presented a comprehensive synthesis of recent older adult health care PSPs conducted across exemplars of global health care systems. We used the BGS curriculum as the framework for evidence mapping because of its robust structure and high relevance to geriatrics. Our steering committee was made up of a diverse, highly experienced team of health care professionals who specialize in the care of older adults. It ensured that the PSPs included in this review were relevant to older adults. This review will enable clinicians and researchers to easily gauge and compare the quality and extent of research priorities relevant to the health care of older adults across 4 distinct health care systems, identify the need for further PSPs in specific areas of health care, and provide guidance for improving the standards of future studies.

There are several limitations that must be considered. Although guidance from our study steering committee ensured a general relevance of a PSP to older adult health care, it remained challenging to determine how relevant individual priorities reported within respective studies were to older adults, specifically. Many of the priorities extracted from the included studies likely represent a mix of priorities relevant to middle-aged and older adults. Moreover, disease-specific PSPs that were not older adult-specific and we therefore did not include (eg, myocardial infarction and diabetes) may still be relevant to older adult health care. Secondly, we did not include prioritization exercises related to specific professions involved in the care of older adults (eg, nurses, physiotherapists, and occupational therapists) and these PSPs may have included older adult-specific content. Third, this review is relatively UK- and US-centric because we limited the study scope to exemplars of 4 health care systems and failed to identify studies from South Korea and countries in Africa. Therefore, we are unable to determine whether the priorities that we have described above reflect global priorities. A more global perspective of older adult research

priorities may find priorities not covered in this review. Future work could repeat this exercise to include the whole international literature and adopt our framework to identify commonalities and gaps. Lastly, some prioritization exercises are almost a decade old and therefore the findings may not now be relevant.

Conclusions and Implications

Research PSPs conducted in the United Kingdom and the United States over the last decade have investigated a broad range of medical issues relevant to older adults. Despite this, the key areas that have not received attention would likely benefit from well-designed PSPs that in turn inform the research agenda to improve the health care of older adults. These future studies should strive to be more inclusive with full engagement of patients and reporting of demographics at each prioritization stage.

Disclosure

All authors declare no conflicts of interest.

Supplementary Data

Supplementary data related to this article can be found online at <https://doi.org/10.1016/j.jamda.2023.09.003>.

References

- World Health Organization. *Ageing and health*. World Health Organization. Accessed March 13, 2023. <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>
- James Lind Alliance. *History*. James Lind Alliance. Accessed March 13, 2023. <https://www.jla.nihr.ac.uk/about-the-james-lind-alliance/history.htm>
- El-Harakeh A, Morsi RZ, Fadlallah R, Bou-Karroum L, Lotfi T, Akl EA. Prioritization approaches in the development of health practice guidelines: a systematic review. *BMC Health Serv Res*. 2019;19:692.
- Logan M, Leitch S, Bosakh Z, Beishon L, Quinn TJ. Comparing international dementia research priorities-Systematic review. *Int J Geriatr Psychiatry*. 2022;37:10.1002/gps.5836.
- Leitch S, Logan M, Beishon L, Quinn TJ. International research priority setting exercises in stroke: a systematic review. *Int J Stroke*. 2023;18:133–143.
- Tong A, Synnot A, Crowe S, et al. Reporting guideline for priority setting of health research (REPRISE). *BMC Med Res Methodol*. 2019;19:243.
- Viergever RF, Olifson S, Ghaffar A, Terry RF. A checklist for health research priority setting: nine common themes of good practice. *Health Res Policy Syst*. 2010;8:36.
- Böhm K, Schmid A, Götze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. *Health Policy*. 2013;113:258–269.
- Miake-Lye IM, Hempel S, Shanman R, Shekelle PG. What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Syst Rev*. 2016;5:28.
- Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71.
- Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implement Sci*. 2010;5:69.
- Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan-a web and mobile app for systematic reviews. *Syst Rev*. 2016;5:210.
- Joint Royal Colleges of Physicians Training Board. *Geriatric Medicine 2022 Curriculum*. Joint Royal Colleges of Physicians Training Board; 2022.
- Taylor CJ, Huntley AL, Burden J, et al. Research priorities in advanced heart failure: James Lind alliance priority setting partnership. *Open Heart*. 2020;7:e001258.
- Parker SG, Corner L, Laing K, et al. Priorities for research in multiple conditions in later life (multi-morbidity): findings from a James Lind Alliance Priority Setting Partnership. *Age Ageing*. 2019;48:401–406.
- Brocklehurst PR, Mackay L, Goldthorpe J, Pretty IA. Older people and oral health: setting a patient-centred research agenda. *Gerodontology*. 2015;32:222–228.
- Kayser J, Morrow-Howell N, Rosen TE, et al. Research priorities for elder abuse screening and intervention: a Geriatric Emergency Care Applied Research (GEAR) network scoping review and consensus statement. *J Elder Abuse Negl*. 2021;33:123–144.
- Best S, Tate T, Noble B, et al. Research priority setting in palliative and end of life care: the James Lind Alliance approach consulting patients, carers and clinicians. *BMJ Support Palliat Care*. 2015;5:102.

19. McLaughlin L, Spence S, Noyes J. Identifying integrated health services and social care research priorities in kidney disease in Wales: research prioritisation exercise. *BMJ Open*. 2020;10:e036872.
20. Pollock A, St George B, Fenton M, Firkins L. Top 10 research priorities relating to life after stroke – consensus from stroke survivors, caregivers, and health professionals. *Int J Stroke*. 2014;9:313–320.
21. Deane KH, Flaherty H, Daley DJ, et al. Priority setting partnership to identify the top 10 research priorities for the management of Parkinson's disease. *BMJ Open*. 2014;4:e006434.
22. Kelly S, Lafortune L, Hart N, Cowan K, Fenton M, Brayne C. Dementia priority setting partnership with the James Lind Alliance: using patient and public involvement and the evidence base to inform the research agenda. *Age Ageing*. 2015;44:985–993.
23. Turner GM, Backman R, McMullan C, Mathers J, Marshall T, Calvert M. Establishing research priorities relating to the long-term impact of TIA and minor stroke through stakeholder-centred consensus. *Res Involv Engagem*. 2018;4:2.
24. Franklin S, Harhen D, Hayes M, Demos MC, Manus S, Pollock A. Top 10 research priorities relating to aphasia following stroke. *Aphasiology*. 2018;32:1388–1395.
25. Bogosian A, Rixon L, Hurt CS. Prioritising target non-pharmacological interventions for research in Parkinson's disease: achieving consensus from key stakeholders. *Res Involv Engagem*. 2020;6:35.
26. Emrich-Mills L, Hammond LL, Rivett E, Rhodes T, Richmond P, West J. Identifying research priorities for older people's mental health services. *Ment Health Soc Inclusion*. 2019;23:89–100.
27. Stroke Association. *Stroke Priority Setting Partnership: Shaping stroke research to rebuild lives*. Northampton. Stroke Association; 2021.
28. Carpenter CR, Hammouda N, Linton EA, et al. Delirium prevention, detection, and treatment in emergency medicine settings: a geriatric emergency care applied research (GEAR) network scoping review and consensus statement. *Acad Emerg Med*. 2021;28:19–35.
29. Shenvi C, Wilson MP, Aldai A, Pepper D, Gerardi M. A research agenda for the assessment and management of acute behavioral changes in elderly emergency department patients. *West J Emerg Med*. 2019;20:393–402.
30. NIHR Oxford Biomedical Research Centre. *Generating research questions from research priorities in early osteoarthritis of hip and knee*. NIHR Oxford Biomedical Research Centre; 2016.
31. Fernandez MA, Arnel L, Gould J, et al. Research priorities in fragility fractures of the lower limb and pelvis: a UK priority setting partnership with the James Lind Alliance. *BMJ Open*. 2018;8:e023301.
32. Sheehan WJ, Williams MA, Paskins Z, et al. Research priorities for the management of broken bones of the upper limb in people over 50: a UK priority setting partnership with the James Lind Alliance. *BMJ Open*. 2019;9:e030028.
33. Mathews JA, Kalson NS, Tarrant PM, Toms AD. Top ten research priorities for problematic knee arthroplasty. *Bone Joint Lett J*. 2020;102-b:1176–1182.
34. McElroy L, Robinson L, Battle C, et al. Use of a modified Delphi process to develop research priorities in major trauma. *Eur J Trauma Emerg Surg*. 2022;48:1453–1461.
35. Davies BM, Khan DZ, Mowforth OD, et al. RE-CODE DCM (REsearch objectives and common data elements for degenerative cervical myelopathy): a consensus process to improve research efficiency in DCM, through establishment of a standardized dataset for clinical research and the definition of the research priorities. *Global Spine J*. 2019;9(1 Suppl):65s–76s.
36. Hammouda N, Carpenter CR, Hung WW, et al. Moving the needle on fall prevention: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement. *Acad Emerg Med*. 2021;28:1214–1227.
37. Greenberg MR, Kane BG, Totten VY, et al. Injury due to mechanical falls: future directions in gender-specific surveillance, screening, and interventions in emergency department patients. *Acad Emerg Med*. 2014;21:1380–1385.
38. Lophatananon A, Tyndale-Biscoe S, Malcolm E, et al. The James Lind Alliance approach to priority setting for prostate cancer research: an integrative methodology based on patient and clinician participation. *BJU Int*. 2011;108:1040–1043.
39. Stephens RJ, Whiting C, Cowan K. Research priorities in mesothelioma: a James Lind alliance priority setting partnership. *Lung Cancer*. 2015;89:175–180.
40. National Cancer Research Institute. *Living With and Beyond Cancer*. National Cancer Research Institute; 2016.
41. Fellenor J, Britten N, Courtenay M, et al. A multi-stakeholder approach to the co-production of the research agenda for medicines optimisation. *BMC Health Serv Res*. 2021;21:64.
42. Alqahtani JS, Aquilina J, Bafadhel M, et al. Research priorities for exacerbations of COPD. *Lancet Respir Med*. 2021;9:824–826.
43. Rowe F, Wormald R, Cable R, et al. The Sight Loss and Vision Priority Setting Partnership (SLV-PSP): overview and results of the research prioritisation survey process. *BMJ Open*. 2014;4:e004905.
44. Gettel CJ, Voils CI, Bristol AA, et al. Care transitions and social needs: a Geriatric Emergency care Applied Research (GEAR) Network scoping review and consensus statement. *Acad Emerg Med*. 2021;28:1430–1439.
45. Wald HL, Leykum LK, Mattison ML, Vasilevskis EE, Meltzer DO. A patient-centered research agenda for the care of the acutely ill older patient. *J Hosp Med*. 2015;10:318–327.
46. GEAR Network. *GEAR network*. GEAR network. Accessed March 13, 2023. <https://gearnetwork.org/>
47. Raleigh V, Holmes J. *The health of people from ethnic minority groups in England*. The King's Fund. Accessed March 13, 2023. <https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england>
48. Ditai J, Nakyazze M, Namutebi DA, et al. Maternal and newborn health priority setting partnership in rural Uganda in association with the James Lind Alliance: a study protocol. *Res Involv Engagem*. 2020;6:57.
49. 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.
50. Kafiriri L. Priority setting in low income countries: the roles and Legitimacy of development assistance partners. *Publ Health Ethics*. 2012;5:67–80.
51. O'Neill J, Tabish H, Welch V, et al. Applying an equity lens to interventions: using PROGRESS ensures consideration of socially stratifying factors to illuminate inequities in health. *J Clin Epidemiol*. 2014;67:56–64.
52. Treweek S, Banister K, Bower P, et al. Developing the INCLUDE Ethnicity Framework—a tool to help trialists design trials that better reflect the communities they serve. *Trials*. 2021;22:337.