

CHAPTER 2

Prioritisation in Public Health: Aims, Methods, Problems and Practical Experiences

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Summary

Prioritisation in public health is more complex than in health services, with permanent tension between ‘purists and pragmatists.’ Two types of difficulties are encountered: first, that of unravelling and measuring the values of the society; second, the technical difficulties in determining the expected or probable consequences of different actions. The problem is not only technical, but also it requires us to address conflicts of interest between organisations, and thus to consider problems of implementation and organisational reforms. As health is not the sole aim of social welfare policies, the framework in public health prioritisation should be wide. Ultimately, the decision must be taken as to whether prioritisation should be limited to health, or rather, should address more ambitious – and more difficult – targets in the field of social welfare.

By performing prioritisation we fuel the culture of prioritisation, which is essential for its social acceptance. Just as there are orphan drugs, there are also orphan policies, the evaluation of which no organisation is willing to pay.

The two most commonly used explicit prioritisation methods are Programme Budgeting and Marginal Analysis (PBMA) and Multi-Criteria Decision Analysis (MCDA). The dimensions that are most frequently applied to health problems or programmes form a long and varied list, and the weights or values assigned to each of these dimensions are of crucial importance in the final ranking obtained.

Health plans are well-intentioned attempts at prioritisation, but they are generally unsuccessful because of the technical and political problems outlined above. In general, these initiatives tend to prioritise problems more than solutions, and have evolved towards plans based on the interdepartmental paradigm and towards ‘Health in All Policies’.

A checklist for pragmatic considerations in priority setting should include four aspects: (i) clear, well-structured objectives with a clearly-defined time horizon; (ii) an organisation equipped for change; (iii) selecting appropriate people to carry out change;

and (iv) the financial and organisational feasibility of change. From a review of practical experiences, we conclude that in many cases, public health exercises continue to be more didactic than pragmatic.

Introduction

Terms such as prioritisation, choice and trade-off are inseparable from the genome of the economy. Prioritisation in public health is more complex than in health services, and there is permanent tension between ‘purists and pragmatists’ [1], with the risk that it may be restricted to a mere academic exercise or an excessively narrow, health-focused framework may be adopted in which health is the sole objective of actions and policies, which, in fact, extend beyond the departmental barriers of healthcare.

Any prioritisation responds to a system or set of interests and values, and there are no exclusively technical solutions. Two types of difficulties are encountered in any prioritisation process: (i) unravelling and measuring the values of a social system; (ii) the technical difficulties in determining the expected or probable consequences of different actions. The more general the **prioritisation framework**, the more difficult it will be to compile evidence on causes and effects, and to obtain a common measure of social benefits: personal health versus social welfare; extending life versus improving its quality; programmes to benefit a few identifiable members of society or to benefit diffuse population groups. Moreover, the more general the prioritisation framework, the more refractory are both types of difficulties. The allocation of resources on the basis of ‘silos’; that is, reserving specific funds for certain programmes or policies, which is one way to avoid or to minimise these problems. Indeed, in practice, **narrow-frame prioritisations** tend to prevail (e.g. between different treatments for stomach cancer, according to the funds allocated from a silo). However, the public health policy makers should not resign themselves to such a narrow framework, because its fundamental goal is a generality: the population’s overall health.

In this field, there are two types of prioritisation: **health problems** and **interventions** (in order to address a given problem there may be alternative, complementary or substitutive interventions). In other words, either **problems or solutions** may be prioritised¹.

It is also useful to differentiate between formal and informal prioritisation. Prioritising helps managers make decisions about funding public programmes in a systematic, transparent way; ultimately, it responds to an ethical principle. Thus, ‘Accountability for reasonableness (A4R) is an ethics approach that focuses on ensuring fair priority-setting processes’ [2].

In public health, prioritisation is often eluded by denying the greatest priority; that is, the need to prioritise, by asserting that *everything* is important, essential and cannot be renounced [3]. But prioritisation is intrinsic to action, and when it is not performed with explicit criteria and methods, it is done implicitly. Thus, in Spain, tobacco is evidently assigned a higher level of priority than alcohol, according to the evidence available in regulations and public interventions regarding both drugs; nevertheless, no laws or public statements have been passed clearly stating such a ranking.

Prioritisation can be **explicit or tacit**. In the latter case, it is based on not questioning consolidated spending patterns and on renewing budgets only within the narrow margins

1 For a conceptualisation and typology of public services prioritisation, see Chapter 1 in this book by Callejon, Campillo and Ortun.

of available funding. Under **inertial budgeting**, priorities do not change; since last year's budgets reflected certain priorities, maintaining the same spending figures is deemed reasonable. In practice, economic evaluations are not usually conducted of consolidated programmes as they are assumed to be necessary and cost effective.

But between zero-based budgeting (starting from scratch and assigning everything afresh, according to prioritisation criteria) and the incrementalists, there is an extensive spectrum of more or less disruptive alternatives, which need to be prioritised.

The framework of prioritisation is defined by its intra- or inter-departmental nature and by the intra- or inter-level of government involved. A framework for public health prioritisation should ideally be comprehensive, also taking into account policies that are not directly related to health but which reduce the burden of preventable disease, as well as the health care organisation and management and the assessment of technologies. However, in practice, explicit prioritisation is generally limited to healthcare, without addressing wider considerations of public health, let alone inter-sectoral actions.

The following sections of this chapter set out a framework for the prioritisation of public health (Section 2); review the methods most commonly used in explicit prioritisation (Section 3); identify the technical difficulties that may be encountered (Section 4); discuss other problems (Section 5); review some interesting practical experiences of prioritisation in public health (Section 6); and finally, present the main conclusions drawn from this analysis (Section 7).

Framework: The Aims of Prioritisation in Public Health

One of the first difficulties encountered in public health prioritisation is that of defining its framework and objectives. Many of the policies and interventions conducted are inter-departmental, as are the outcomes achieved. However, economic considerations frequently fail to rise above the academic outlook by which social welfare is measured and valued. Although population health is a major component, and health is a requisite, or necessary 'capability' [4], it is not the sole aim of social welfare policies. In addition, other areas of social importance, such as economic well-being, education, security and the environment, compete with health for the attention of policymakers. Public health authorities have managed to win acceptance for the ideal of Health in All Policies (HiAP), with institutional success, at least on paper, since HiAP has become established as official European Union (EU) policy. Accordingly, perhaps the same progress could be achieved via the impulse of Education in All Policies, advocating a knowledge society as a strategic route towards people's economic well-being, happiness and health. Moreover, such a trade-off among social objectives implies a corresponding one between efficiency and fairness. Society must decide whether it prefers to maximise social achievements – in the field of health, for example, as the sum of years of life gained, or by enhancing the health of the most vulnerable, needy and abandoned. Another trade-off must be made between short- and long-term outlooks.

In academic economics, significant progress has been made in defining social welfare functions and in advances such as proposals for a healthy equivalent income (comparing the incomes of two persons in good health) [5]. A study conducted in 40 countries with a sample of 634,951 people [6] explored the determinants of life satisfaction between 1990

and 2011, and the extent to which restrictions on smoking influenced this satisfaction. The most striking result obtained is that the maximum difference between levels of life satisfaction occurs between employed and unemployed people, not between those who have better or worse health. Thus, between health and income there is a trade-off (we give up something in one respect to obtain an improvement in the other). Moreover, people are heterogeneous, and individuals, too, present changes throughout their lives. As we get older and richer, health becomes a higher priority and is assigned greater value [7].

Ultimately, the decision must be taken as to whether prioritisation should be limited to health or rather, should address more ambitious – and more difficult – targets in the field of social welfare. In the latter case, we would need an operative measure of social welfare with which to compare quality-adjusted life years (QALY) gained with health interventions and their determinants with the ‘satisfaction’ gained, for example, through increased income from pensions.

Let us focus on the (generic) target of health, setting aside for the moment others, such as education, income or happiness. By doing so, we avoid making comparisons that are, if not impossible, at least politically paralysing, such as having to decide between ‘vaccinating against pneumococcal disease or reinforcing environmental policies in order to reduce the planet’s temperature by one degree’.

Furthermore, by performing prioritisation we fuel the culture of prioritisation, which is essential for its social acceptance. For this reason, whenever prioritisation takes place, the active participation of the population is an essential ingredient, to provide both input and output to the process; on the one hand, to reveal values and preferences (input), and on the other, to socially assimilate the act of prioritisation, which is increasingly accepted (output). Participatory prioritisation is a resource that the EU regularly uses, even for technical issues, such as endocrine disruptors², and the Global Health Alliance (EU and World Health Organisation) has launched consultations to prioritise socially sensitive problems, such as those associated with climate change³.

Even so, the problem is complex to such a degree that the Centers for Disease Control and Prevention (CDC) provides specific courses⁴ and instruments⁵ with which to learn to prioritise public health problems. Nevertheless, wolves dressed as sheep remain wolves under the skin, and although prioritisation may take the guise of a technical exercise⁶ (in fact, the technique is quite simple), it is essentially evaluative, incorporating a predefined framework implemented via weighting criteria and based on pre-selected problems or interventions. The dimensions or criteria that are most frequently applied to health problems or interventions (programmes) in prioritisation exercises in the field of public health form a long and varied list (see Table 1), and the weights or values assigned to each of these dimensions are of crucial importance in the final ordering of the problems to be addressed and/or the order of interventions in the final ranking.

2 <http://www.usda-eu.org/wp-content/uploads/2015/01/United-States-Submission-Endocrine-Disrupters-2015-01-20.pdf>

3 <http://www.epha.org/spip.php?article5776>

4 https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/4/prioritize-problems_fg_final_09262013.pdf

5 <https://www.cdc.gov/nphpsp/documents/prioritization-section-from-apexph-in-practice.pdf>

6 <http://www.health.state.mn.us/divs/opi/qi/toolbox/prioritizationmatrix.html>

Table 1. Prioritisation dimensions or criteria in the context of public health.

Health-related problems	<ul style="list-style-type: none"> • Number of persons affected • Lethality • Degree of disability • Impact on activities of daily life • Costs of the disease • Possibility of contagion
Interventions and programmes	<ul style="list-style-type: none"> • Effectiveness • Fairness in the distribution of the benefits (with special attention to the least-advantaged) • Affordability (budget required to fund the intervention) • Cost-effectiveness • Number of beneficiaries • Appropriateness • Sustainability • System integration • Cost per QALY gained • Certainty (quality of the method and data used in the evaluation)

Source: Devised by the authors.
 QALY = quality-adjusted life years.

Methods of Prioritisation in Public Health

The two most commonly used explicit prioritisation methods are Programme Budgeting and Marginal Analysis (PBMA) and Multi-Criteria Decision Analysis (MCDA). Other methods have been proposed, although some are mere variants of the above.

In PBMA, a panel of experts is consulted to help decision makers maximise the impact of budgetary changes on the health needs of a local population. Programme budgeting is the appraisal of past resource allocation in specified programmes, while marginal analysis is the appraisal of the consequences of investments and disinvestments in specific programmes. This approach is used to determine the expected impact on one programme of spending changes in others. PBMA consists of eight steps [8]. 1. Choose a set of meaningful programmes/initiatives; 2. Identify current activity and expenditure in those programmes/initiatives; 3. Think of improvements; 4. Weigh up incremental costs and incremental benefits and prioritise a list; 5. Consult widely; 6. Decide on changes; 7. Effect the changes; 8. Evaluate progress..

MCDA is a procedure in which weighted criteria are integrated into the assessment of health problems or programmes. It consists of the following critical steps: (i) identifying interventions; (ii) identifying evaluation criteria; (iii) measuring the interventions against the criteria; and (iv) combining the criteria scores using weights to produce an overall assessment of each intervention [9]. In practice, these four steps require value judgements from experts and/or the population. Thus, stage 1 defines the framework, which, in turn, establishes the ground rules for the assessment and bears a strong influence on the results eventually obtained: will this exercise prioritise problems or solutions? Will it be narrow or wide in scope? And, above all, who will compile the list? In stage 2, which generally involves discrete choice experiments, the criteria are weighted from a

pre-selected initial list. Again, the question arises: who provides this initial list? The 'technical' part of obtaining and modelling results to obtain the weights is straightforward, and carrying out step 3 is a simple task, but the legitimacy of the exercise is based on selecting a valid sample of persons: should these be politicians, decision makers, experts, patients or the population at large? In practice, criteria weights are usually generated using discrete choice experiments based on the opinions of decision makers or of the general population.

MCDA is increasingly used because it incorporates both health and non-health economic outcomes into the prioritisation of public health interventions, and because it overcomes the limitation of QALY as a single homogeneous measure of results. Furthermore, it incorporates a broader spectrum of values, and addresses them more systematically than under economic evaluation [9].

Among other proposals (less widely accepted than PBMA and MCDA) is macro-marginal analysis, described as an 'explicit process for setting priorities across major service areas within a regional health authority, based on both evidence and local expert opinion' [1]. Its proponents claim it overcomes limitations of non-comparability of rankings for different health problems and patient groups, and that it provides a zero-sum means of identifying 'margins for change', such as investing in certain problems and areas with resources derived from others. A budgetary experiment [10] has also been proposed and used in a participatory health system priority setting.

Technical Problems in the Procedures and Methods of Prioritisation in Public Health

The problematic incorporation of values into interdepartmental and intersectoral actions

Transversal prioritisation within a context of intersectoral collaboration can make a major contribution to health improvements, but the problem of accurately measuring and evaluating outcomes may be irresolvable and paralysing, with each department involved valuing achievements in terms of its own perspective and interest. How can a common measure of value in healthcare be used to compare activities as disparate as agricultural production, industrial externalities, trade controls and incentives or rates of taxation? [3]. Furthermore, the problem is not only technical, but also it requires us to address conflicts of interest between organisations, and thus to consider problems of implementation and organisational reforms.

The inadequacy of the methods

As observed above, prioritisation in public health requires a broader framework than in health care services. Additional problems must be overcome in order to determine society's willingness to pay, which is an essential input, when there exist externalities and public goods: the two fundamental characteristics that define public health. The lack of a market that could relate costs and benefits is a much more disturbing handicap in public health than in health services. The QALY approach is clearly inadequate, but there is a dearth of measures of social welfare that are sufficiently generic and inclusive, but at the

same time reliable, with which to assess the consequences of interdepartmental policies in wide-ranging prioritisation exercises. In short, traditional prioritisation methods fall short of requirements.

Uncertainty about cause-and-effect relations

Knowledge can only be provisional. It is continually subject to revision, and sometimes prior beliefs must be discarded. Scant evidence is available on the effectiveness of public health policies compared to that concerning medicines. In the absence of evidence, managers must fall back on guidelines citing the desirability of certain strategies or programmes, although they may never have been rigorously evaluated, or if they have, with surprising results. Thus, the 'walking bus' programme to prevent childhood obesity has proved ineffective, as have many health education programmes in Australia [11].

Nevertheless, methods to perform policy evaluation and health impact assessment are essential in the prioritisation of public health, and any progress in this regard is welcome.

Moreover, there is a need to identify knowledge gaps regarding health-related cause-and-effect relationships; therefore, research efforts regarding effectiveness, cost-effectiveness and policy impact must also be prioritised [12,13].

Beyond Technical Difficulties

Unlike uncertainty, which refers to a lack of knowledge because science has not yet advanced sufficiently, **ignorance** consists in disregarding the evidence due to limitations of the person and/or of the organisation. Kahneman [14] proposes an example from the field of public health to illustrate heuristics and bias in decision making (to which politicians and decision-makers, among others, are also subject). When a public health programme is formulated positively, by presenting the gains to be achieved (lives saved), it is much more likely to be preferred and chosen than if the same programme were presented in negative terms (the number or rate of deaths).

The bias of immediacy is also strongly present in political decisions, and is often supplied by the media, which remind society of the (fashionable) issues that opinion makers wish to highlight, implicitly imposing their own agendas and priorities. Accordingly, it is essential for good public health data to be provided, so that tainted sources may be avoided.

When there is ignorance about the expected effects of causes, this may be due not only to technical problems, but also to the presence of bias in publications and scientific studies.

In addition to technical problems, there may be a lack of incentives to obtain evidence on the effect of health policies, as opposed to that of medicines and medical devices (behind which there are always sellers seeking a favourable evaluation), and of finance for studies of cost-effectiveness. Just as there are orphan drugs, there are also **orphan policies**, the evaluation of which no organisation is willing to pay.

Many public policies belong to various areas of decision, from global or multinational down to the local, and (in Spain, for example) passing through the EU, the State and the Autonomous Community (region). Decisions and actions frequently correspond to

one level of government while their consequences affect others. For example, measures against pollution and climate change are taken locally but their effects are global. The same problem that may arise with interdepartmental plans can also appear between levels of government. In other words, there are **political externalities** that are difficult to internalise. In this respect, consider taxes on health-damaging products; for example, on the sugar added to drinks. Real success in this area would be if such taxes brought in very little revenue (i.e. if consumption were diverted towards healthy substitutes). For this reason, tax-raising departments do not find them attractive, because administration and management costs would be incurred without producing corresponding economic benefits. Thus, it is the health authorities that must lead the way and convince society of the worth of this tax for social well-being.

Difficulties in resolving intragovernmental conflicts and, especially, the formidable influence of corporations are serious obstacles to the implementation of public health policies. But failures also provide lessons for the future. Accounts of flawed attempts in this field, such as alcohol restrictions in Spain, the taxation of fatty foods in Denmark and sugary drinks in Mexico, are all valuable sources of knowledge.

Social, cultural and economic globalisation imposes restrictions on local public health policies. For example, patterns of human nutrition and obesity respond to cultural globalisation rather than international free trade [15], while economic globalisation, through structures such as the Transatlantic Trade and Investment Partnership (TTIP) can impose restraints on government action⁷.

Another question, partly related to the above observations, is that of who should assess and perform the prioritisation exercise. Following the principle of 'he who pays the piper calls the tune', international development cooperation agencies, in practice, define the health priorities of developing countries. In developed countries, the question is whether government or society should pull the strings of prioritisation, and how government can turn social values into policies without their becoming 'lost in translation'. The sensitivity of governments to corporations that have private interests and often exercise undue influence, and the mechanisms by which these corporations interfere and define political agendas, are real problems [16] and institutional architecture is a factor of crucial importance. In this book, the chapter by Ana Garcia addresses these questions in detail. Another problem is that gaps in institutional coordination (e.g. between public health, occupational health and environmental health) in turn generate gaps in citizen participation in processes of health prioritisation [17].

Practical Experiences of Prioritisation in Public Health

Health plans are well-intentioned attempts at prioritisation, but they are generally unsuccessful because of the technical and political problems outlined above. In general, these initiatives tend to prioritise problems more than solutions, and have evolved towards plans based on the interdepartmental paradigm and towards 'Health in All Policies', such as the Interdepartmental and Intersectoral Plan for Public Health (PINSAP) devised in Catalonia. In Spain, some health plans include the participative exercise of prioritising

⁷ <http://sespas.es/2015/11/20/posicionamiento-sespas-ttip-y-salud/>

problems with explicit criteria, for example the Asturias Health Plan 2004–2007 (2003) was based on an evaluation conducted with the participation of experts, healthcare professionals and the general public, in which the prioritisation criteria adopted were those of the foreseeable benefits to health, the effectiveness of the intervention, citizens’ opinions and the social burden of the problem⁸. The 4th Andalusian Health Plan decentralised prioritisation towards the provinces, and referred the final coordination to a central technical committee⁹. Until the mid-2000s, the health plans issued in Spain made little mention of social inequalities in health [18], with just a few exceptions, such as the Basque Country Health Plan.

Prioritisation in public health is a matter of concern to academics, and has been the subject of reports by scientific societies, such as the Spanish Public Health Service Administration (SESPAS) [19-21].

Peacock et al. [22] published a checklist for pragmatic considerations in priority setting (Table 2), in which four types of aspects were distinguished: (i) clear, well-structured objectives with a clearly-defined time horizon; (ii) an organisation equipped for change; (iii) selecting appropriate people to carry out change; and (iv) the financial and organisational feasibility of change.

Table 2. Checklist for pragmatic considerations in priority setting.

1. Establish the organisational objectives
<ul style="list-style-type: none"> • Multiple objectives (effectiveness, equity etc.; trade-offs between objectives) • Hierarchical objectives (provider, local, regional and national levels) • Inter-temporal objectives (short and long term)
2. Ensure the organisation is ready for change
<ul style="list-style-type: none"> • Develop leadership and ownership (managers, providers, consumers, community) • Consider timing and stability (organisational reforms) • Identify institutional boundaries (budgetary, service fragmentation or integration) • Establish incentive and sanction mechanisms (financial, managerial)
3. Establish an appropriate advisory panel structure
<ul style="list-style-type: none"> • Recruit members representing all stakeholders (service managers, providers, consumers, community) • Identify roles and responsibilities (values, decision-making criteria, evaluation of services) • Train key stakeholders • Community participation (community values, specific needs)
4. Ensure that implementation of results is feasible
<ul style="list-style-type: none"> • Is there a desire to reallocate resources? (ownership) • Will institutional boundaries allow reallocation? • How well are funding and priority setting mechanisms integrated?

Source: Peacock et al. [22]. Reproduced with permission.

Although there have been many experiences of prioritisation in public health, in health policies and in healthcare in general, most of these have been informal, without explicit criteria being established. Traditional consensus techniques, such as nominal groups or

8 http://tematico.asturias.es/salud/plan/plan/documento/plan_salud.pdf

9 http://www.andaluciasana.es/PAS/links/IV_PAS_v9.pdf

Delphi techniques, are often used. But in very few cases have explicit prioritisation criteria been employed, leading to reassignments in real-life situations. According to a recent literature review [23], the most commonly-used relational-life methods (sometimes in combination) are PBMA and MCDA. It is noteworthy that these authors, who are well versed in the field of prioritisation worldwide, in compiling real-life experiences of prioritisation published between 2000 and 2013 (including grey literature), only managed to locate 33 such prioritisation exercises. However, what is most striking is that although ‘Health Priorities’ and ‘Community Health Planning’ were included in the search terms, broad-scope terms were notably absent. Very few studies extended their research focus beyond health services, and some even restricted their attention to a specific health problem, such as diabetes, respiratory disease, growth hormone or HIV. There have also been specific exercises examining the service rather than the health problem (in areas such as spending on medicines, or health services for chronic diseases). A considerable number of studies have addressed investment/divestment/reinvestment decisions, but examinations of the use of budget increases for decisions at the leading edge of allocations are less commonly observed. According to this review, the most frequently used criteria are effectiveness, fairness, affordability, cost effectiveness and the number of beneficiaries.

An interesting pragmatic case is that of the Calgary (Canada) healthcare region [1], where Macro Marginal Analysis identified redundant activities, accounting for 3% of the total budget (over CAN\$40 m), which could be redeployed to other areas.

Another instructive experience is that of the prioritisation carried out in primary healthcare trusts in the UK [24]. The ground rules for this prioritisation are made apparent in the scoring tool, which establishes the maximum weight (from 0 to 100) to be assigned, a priori, to each of the different criteria: National priorities (maximum 20 points), local priorities (maximum 10 points), risk assessment (maximum 20 points), local needs (maximum 20 points), effectiveness (maximum 10 points), and cost considerations (maximum 20 points) [24]. The end result of the exercise, obviously, is strongly influenced by the design of this scoring tool. Over 100 initial proposals were made, with a total cost of £44 m. Of these, 66 (valued at £26 m) were evaluated. The budget available was £5 m. The top-scoring programmes resulting from this exercise were clinical ones aimed at individual patients, while community health and disease prevention programmes were assigned low priorities. In practice, it seems that ‘funding of the locally driven priorities took precedence over some of the nationally driven priorities, such as funding of specific NICE guidance in the primary care setting in the UK’ [24].

A prioritisation exercise that was noteworthy for addressing both public health and population health was carried out in Ghana [25]. Among the 10 activities prioritised were the regulation of tobacco advertising and the obligatory use of safety belts in vehicles.

However, in many cases, public health exercises continue to be more didactic than pragmatic. Thus, one such exercise was intended to ‘demonstrate the feasibility of developing and applying a method for prioritising preventive health interventions in the UK’ [9]. A multi-criteria decision analysis was employed to prioritise 14 public health interventions, using weighted criteria in a discrete-choice experiment. Taxation was ranked at the highest priority; mass-media campaigns and brief interventions were ranked in the top half of the scale; and schools-based educational interventions, statins and interventions to address mental health problems were placed at the bottom of the list. The aim of this exercise was to establish a benchmark for public health prioritisation, by including five

major areas of health-related problems (alcohol, mental health, obesity, tobacco and sexually transmitted infections) and a wide spectrum of health interventions and non-health-related prevention, ranging from taxation to screening and pharmacological treatments. The list of interventions assessed by Marsh et al. in their public health prioritisation exercise in the United Kingdom includes interventions in the areas of alcohol, mental health, obesity, smoking and sexual transmitted infections.

In this exercise, five criteria were applied to determine incremental cost effectiveness: (i) cost per QALY gained; (ii) proportion of the population eligible for the intervention; (iii) fairness in the distribution of benefits to the most disadvantaged 20% of the eligible population; (iv) affordability (budget required to fund the intervention); and (v) certainty (based on the quality of the method and the data used in the evaluation). Feasibility and acceptability criteria were excluded due to lack of means with which to measure them.

Conclusion

Canada is a good source of experiences in health prioritisation. In an article based on three empirical exercises with international participation [26], 10 key aspects, associated with both the process and the results obtained, are proposed as fundamental to the success of a health prioritisation exercise: (i) stakeholder understanding; (ii) shifted priorities/reallocation of resources; (iii) decision-making quality; (iv) stakeholder acceptance and satisfaction; (v) positive externalities; (vi) stakeholder engagement; (vii) use of explicit process; (viii) information management; (ix) consideration of values and context; and (x) revision or appeals mechanism.

Despite lip service being paid to the ideal, few institutions actually listen to what the population has to say. This 'attention gap' remains to be addressed, although in line with '*sauve qui peut*' ad hoc solutions are often proposed; for example, via reviews of healthcare plans. Citizen participation is an essential component of public health, which the Spanish Public Health Act defines as 'the set of activities organised by public administrations, **with the participation of society**, to prevent disease and to protect, promote and recover personal health, both individually and collectively, through health service, sectoral and cross-cutting actions'.

It is important not to allow the potential for change to be worn down – and acting inappropriately or ineffectively is worse than doing nothing. Raising false hopes and proclaiming tired slogans will eventually erode, disrupt, destroy and distort ideas that are fundamentally good. Planners must learn from the mistakes of the past and reconsider traditional health plans. Why weren't options prioritised? Were these plans just examples of wishful thinking? Obviously, resources are limited and there are no superheroes around with powers to grant our every wish. Did planners count on the input of others, but without them knowing? Plans drafted in health department offices set out measures to be adopted by other branches of government, but these other offices may not be made aware of them. Did they seek to ignore the quantification of funding and its sources? Did they define measurable indicators to determine the degree of compliance? How many health plans in Spain have ultimately resulted in a transparent, well-weighted evaluation?

Health plans in Spain are all too often simulations of prioritisation, which ultimately come to nothing, but which ensure that all problems, sectors and population subgroups

are given their turn in the spotlight. It is like a family photo, with something for everyone, which fails to prioritise but rather legitimises the politician who is willing to tackle anything and everything. Prioritising, in contrast, means making a decision, selecting, concentrating on the essential and setting the rest aside.

Finally, let us remember that prioritising, in itself, is not enough. Measures must then be implemented. When the prioritisation exercise ends, the real work of putting proposals into practice begins.

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