

Priority setting methods and transferability in health information

BRIDGE Health looks at priority setting and transferability of health information to policy now and in a future EU Health Information System...

In the previous issue of *Adjacent Government*, the first concepts of the EU Health Information System were explained and the current activities of BRIDGE Health within these. BRIDGE Health operates through work packages and horizontal activities (HA). In this issue, the focus will be on two of those HA, which are key topics in the field: priority setting methods in health information (HI) and the transferability of HI and data for policy.

Good practice priority setting is a must to make progress in EU health research¹ (Maria M Hofmarcher^{i, ii}, Nataša Perićⁱⁱ, Judit Simonⁱⁱ)

A key function of a useful and manageable HI infrastructure is to set priorities. We frame priority settings in HI as a systematic, explicit and transparent decision-making process to prioritise research in population health, in health services and health systems research. This broad concept of health research should yield societal benefits, including reduced research duplication and importantly enhanced collaboration across disciplines.

While a variety of methods exist, research shows that techniques involving a systematic, interactive forecasting method that relies on a panel of experts and questionnaires (Delphi method) and pre-selected groups identified by managing bodies of organisations through their scien-



tific performance with a view on the health topic of concern (CHNRI Child Health and Nutrition Research Initiative) are most common. Thus, prioritisation is a process where individuals or groups rank identified research priorities in terms of their importance or significance. Specific criteria are normally provided to support this process. At the same time, there are no uniform standards to develop priorities for health research. For example, EU research programmes e.g. Horizon 2020, 3rd Health Programme and Member States driven initiatives, e.g. Joint Programming Initiatives have been applying their own approach. Yet some initiatives have established transparent ranking methods, e.g. the European Centre of Disease prevention and Control (ECDC), or the CHNRI approach. Nonetheless, most priority setting processes lack adequate ex post evaluation.

Priority setting is a challenge at all levels and contexts in health systems because demand for health care usually exceeds available resources. At the same time priority setting differs across countries, within research and across health service areas. Equally, both taxpayers/patients and funders/payers are demanding greater accountability for how resources are spent and how research and health system goals are met. The setting of health targets is another avenue to prioritisation of health research and health care delivery. Currently, about half of all World Health Organization (WHO) Member States indicated that they have established a national or subnational process. On the basis of a BRIDGE health internal survey conducted in 2015, about half of responding project partners indicated to have been involved in priority setting activities including in developing health targets.

PROFILE

While prioritisation in health research is multi-layered the BRIDGE Health consortium in a recent communication has emphasised the importance of priority setting to take place in an envisioned European Research Infrastructure Consortium on Health Information for Research and Evidence-based Policy (HIREP-ERIC). In line with the analysed literature, we recommend that priority setting processes in an HIREP-ERIC should:

- Be inclusive by adopting a comprehensive concept of priority setting of health research;
- Be overseen by a well-managed and resourced multi-disciplinary advisory group;
- Involve broad representation of stakeholders;
- Utilise objective and clearly defined criteria for generating and ranking priorities;
- Be systematic and transparently documented; and
- Be evaluated.

Efficient transfer of health information (HI) and data to policy is crucial to move towards a healthier life (Anke Joasⁱⁱⁱ)

Evidence-based policy is considered a high priority. Policymaking needs clear messages to prioritise, whereas science is inherently associated with uncertainties. HI is scientific indicator based information, on health status of individuals or the general population, on health determinants, health systems and health system performance.

Transferability of HI to policy concerns the success to collect, process, analyse, report, and use HI and knowledge to

influence decision-making. Not only does the information need to be communicated to the policy makers, but the policy makers should be able to understand and implement the transferred information effectively. This process is closely related to impacts, communication, and data availability. Actor power, framing of issues and ideas, understanding the inherent characteristics of the issue and political context are basic elements of the scientific discussion on efficient knowledge transfer. Health problems that cause substantial damage, that can be easily measured and that have cost-efficient solutions, are likely to gain political support.

The European Commission has established legislation, indicators and databases to promote the transfer of HI to policy, as have the Organisation for Economic Cooperation and Development, and WHO, and there is clear evidence of successful HI to policy transfer in the field of obesity, smoking and alcohol abuse. However, it remains a challenge to fulfil.

In a recent report, WHO states that expertise in public HI remains fragmented and insufficiently used for health policy-making, despite monitoring and reporting of many national and international organisations². Opportunities to support and advance efforts to systematically and sustainably overcome the research-policy gap are considered weak or lacking. Accordingly improved communication between researchers and policy makers (and other stakeholders), strategic planning, tool development and data harmonisation are the key approaches in tackling challenges in transfer of health information and data to policy.

A future HIREP-ERIC should work towards these priorities, via a close cooperation with all relevant Commis-

sion services and established networks at European and international level, as well as with national policy makers, civil society and academic groups. Given the abundance of initiatives and big data, a HIREP-ERIC should focus on coordination, evaluation of existing approaches and tools, on interlinkage and condensation of available tools, and on tailoring to Member State and Commission needs. The management of a corresponding “conceptual framework” could be another important task.

¹ Further information and references can be found in Hofmarcher, M.; Perić, N.; Simon, J. (2016) Priority setting methods in health information, BRIDGE Health Technical Report 09/2016 on Recommendations of priority setting methods for a European Research Infrastructure Consortium on Health Information for Research and Evidence-based Policy (HIREP-ERIC), HS&I and Medical University of Vienna, September 2016.

² <http://www.euro.who.int/en/media-centre/sections/press-releases/2013/10/translating-evidence-into-effective-public-health-policy>

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