

## How did European countries set health priorities in response to the COVID-19 threat?

Williams, Iestyn; Kapiroiri, Lydia; Vélez, Claudia-Marcela; Aguilera, Bernardo; Danis, Marion; Essue, Beverley; Goold, Susan; Noorulhuda, Mariam; Nouvet, Elysee; Razavi, Donya; Sandman, Lars

DOI:

[10.1016/j.healthpol.2024.104998](https://doi.org/10.1016/j.healthpol.2024.104998)

License:

Creative Commons: Attribution (CC BY)

### Document Version

Publisher's PDF, also known as Version of record

### Citation for published version (Harvard):

Williams, I, Kapiroiri, L, Vélez, C-M, Aguilera, B, Danis, M, Essue, B, Goold, S, Noorulhuda, M, Nouvet, E, Razavi, D & Sandman, L 2024, 'How did European countries set health priorities in response to the COVID-19 threat? A comparative document analysis of 24 pandemic preparedness plans across the EURO region', *Health Policy*, vol. 141, 104998. <https://doi.org/10.1016/j.healthpol.2024.104998>

[Link to publication on Research at Birmingham portal](#)

### General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

### Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact [UBIRA@lists.bham.ac.uk](mailto:UBIRA@lists.bham.ac.uk) providing details and we will remove access to the work immediately and investigate.



## How did European countries set health priorities in response to the COVID-19 threat? A comparative document analysis of 24 pandemic preparedness plans across the EURO region

Iestyn Williams<sup>a,\*</sup>, Lydia Kapiriri<sup>b</sup>, Claudia-Marcela Vélez<sup>b</sup>, Bernardo Aguilera<sup>c</sup>, Marion Danis<sup>d</sup>, Beverley Essue<sup>e</sup>, Susan Goold<sup>f</sup>, Mariam Noorulhuda<sup>b</sup>, Elysee Nouvet<sup>g</sup>, Donya Razavi<sup>b</sup>, Lars Sandman<sup>h</sup>

<sup>a</sup> Health Services Management Centre, University of Birmingham Park house, 40 Edgbaston Park Rd Birmingham, B15 2RT, UK

<sup>b</sup> Department of Health, Aging & Society, McMaster University, 1280 Main Street West, Kenneth Taylor Hall Room 226, Hamilton, ON, L8S 4M4, Canada

<sup>c</sup> Faculty of Medicine and Science at the Universidad San Sebastian, Providencia, Santiago de Chile, Región Metropolitana, Chile

<sup>d</sup> Department of Bioethics, National Institutes of Health, 9000 Rockville Pike, Bethesda, MD 20812, USA

<sup>e</sup> Centre for Global Health Research, St. Michael's Hospital, 30 Bond St, Toronto, ON, M5B 1W8, Canada

<sup>f</sup> Center for Bioethics and Social Sciences in Medicine, University of Michigan Medical School, 2800 Plymouth Road Building 14, G016, Ann Arbor, MI 48109, USA

<sup>g</sup> School of Health Studies, Western University, 1151 Richmond Street, London, ON, N6A 3K7, Canada

<sup>h</sup> National Centre for Priorities in Health, Department of Health, Medicine and Caring Sciences, Linköping University, 581 83, Linköping, Sweden

### ARTICLE INFO

#### Keywords:

Priority setting  
COVID-19  
Europe  
Document analysis

### ABSTRACT

The COVID-19 pandemic has forced governments across the world to consider how to prioritise the allocation of scarce resources. There are many tools and frameworks that have been designed to assist with the challenges of priority setting in health care. The purpose of this study was to examine the extent to which formal priority setting was evident in the pandemic plans produced by countries in the World Health Organisation's EURO region, during the first wave of the COVID-19 pandemic. This compliments analysis of similar plans produced in other regions of the world. Twenty four pandemic preparedness plans were obtained that had been published between March and September 2020. For data extraction, we applied a framework for identifying and assessing the elements of good priority setting to each plan, before conducting comparative analysis across the sample. Our findings suggest that while some pre-requisites for effective priority setting were present in many cases – including political commitment and a recognition of the need for allocation decisions – many other hallmarks were less evident, such as explicit ethical criteria, decision making frameworks, and engagement processes. This study provides a unique insight into the role of priority setting in the European response to the onset of the COVID-19 pandemic.

### 1. Introduction

The COVID-19 pandemic has forced governments across the world to consider how to prioritise the allocation of scarce resources. After March 2020 when the virus took hold in Europe, governments introduced measures such as social distancing, restrictions on movement and closure of non-essential businesses and services. Faced with a public health crisis, governments also took decisions to increase funding for health services, and to redirect current fiscal, human and technical resources towards meeting the new threat [4]. Many produced or adapted previous formal pandemic preparedness plans (PPPs) which set out,

amongst other things, how the country's health response was to be co-ordinated and delivered. Although these were linked to wider guidance documents produced for example by the World Health Organization (WHO), they also retain some autonomy and reflect the priorities of national jurisdictions [41]. The existence of these plans presents an opportunity to compare and contrast how, and to what extent, priority setting was integrated into pandemic responses in countries across the world. In this paper, we examine and compare the PPPs of 24 WHO European region countries. The paper is part of a larger study which involves similar analyses across other WHO regions including lower income economies and the global south [12,26,36,37]. Our particular

\* Corresponding author.

E-mail address: [i.p.williams@bham.ac.uk](mailto:i.p.williams@bham.ac.uk) (I. Williams).

<https://doi.org/10.1016/j.healthpol.2024.104998>

Received 25 July 2022; Received in revised form 21 December 2023; Accepted 15 January 2024

Available online 19 January 2024

0168-8510/© 2024 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

focus is on the prioritisation and allocation of health-related resources such as (but not limited to) acute care beds, supplies of personal protective equipment (PPE), and ventilators [9,23]. Our paper has important implications not just for ongoing and future pandemic responses, but also for those seeking to design priority setting processes that are effective in times of extreme turbulence.

## 2. Priority setting and resource allocation

Priority setting is ‘the process of assigning precedence to certain areas or services to receive investments’ [30]. Explicit models for enacting such processes have long been advocated in health care decision making [1]. During the early stages of the COVID-19 pandemic, countries had to determine how best to set priorities to guide decision making in order to effectively and quickly control COVID-19 under severe resource constraints. Many of the countries involved had previously invested in priority setting procedures and institutions, and many methodologies and frameworks have been advanced in the priority setting literature [7].

However, priority setting methodologies and frameworks have often, and for numerous reasons, failed to become embedded into ‘real-world’ decision making [17]. This has previously been ascribed to concerns a) that priority setting tools and methodologies are overly technical, and b) that they are misaligned with both decision making contexts and wider social values [11]. The need, therefore, to attend to participative and procedural dimensions of decision making has engendered a shift of focus in priority setting frameworks, with evidence and criteria augmented by stakeholder engagement and procedural justice [40].

Whilst some scholars still retain a focus on the technical elements of achieving ‘fair’ or ‘optimal’ allocation, others highlight the intersecting roles of politics, institutions, and values [33]. The need to incorporate contextual factors when analysing and prescribing approaches to priority setting has led to calls for a ‘systems’ based approach [25], and for attention to the ‘structural and institutional factors’ shaping priority setting and how it is understood by the actors involved [19].

The continued importance of each of these dimensions of priority setting – criteria; evidence and information; values; engagement; process; politics and systems – means that no simple formula or approach is possible. Instead, researchers have sought to devise and develop integrative frameworks, such as Smith et al.’s [32] framework of ‘high performance’ in priority setting for health managers and organisations. Of perhaps most relevance to this paper is the framework developed by Kapiriri and Martin [15] specifically to inform and assess priority setting at national and international levels of government. This is an inter-disciplinary, descriptive framework informed by extensive empirical review and validated for use in a variety of contexts [6,14].

In this study, we used the Kapiriri and Martin framework to determine a) the extent to which explicit priority setting was incorporated into PPPs in countries in the EURO region during the initial Covid-19 pandemic, and b) the extent to which this priority setting reflected the quality indicators as defined by the framework

## 3. Methods

The primary method was document review involving systematic extraction and data analysis using both descriptive and analytical techniques [21]. We used Kapiriri and Martin’s [15] framework domains as our organising data extraction tool. Further detail of the methodological approach can be found in Kapiriri et al. [12] and Velez et al. [36].

### 3.1. The analytical framework

The dimensions of the framework, and translation of these to the specific context of COVID-19 responses, can be seen in Kapiriri et al. [12] and Velez et al. [36]. The many intersecting parameters contained

within the framework are categorised into five domains: priority setting context; pre-requisites of priority setting; the priority setting process; implementation of priority setting decisions; and resulting outcomes/impact. The priority setting context domain explicitly addresses the political, governance, economic and other contextual factors shaping decision making. Priority setting ‘pre-requisites’ include the presence of political will, legitimate decision making institutions, aligned incentives and available human and financial resources. The priority setting process domain assesses whether the prioritization process described included an explicit tool, method or framework, and/or drew on explicit priority setting criteria (including equity considerations), and the role of evidence and stakeholder involvement in these processes. It also assesses the extent to which procedural decision making criteria, such as publicity and appeals/revisions, are met and enforced. The implementation and outcomes domains consider post-decision stages including the extent to which priorities are actually enacted in practice and achieve intended results.

Nine of the 28 parameters within the framework could not be assessed using the PPPs and are therefore not covered in detail in this paper. In order to assess adherence to the priority setting context parameters (which are not extensively covered in the PPPs), we assembled additional sources describing, for example, burden of the disease, and wider system structures.

### 3.2. Sampling strategy

Countries from across the EURO region were sampled in order to capture variations in health and political system, economic level, experience with priority setting and disease outbreaks. To be included, countries were required to have a publicly available COVID-19 PPP. Our first step was therefore to search for these on government websites and, where they were not available, search other internet sources. In cases where these two strategies yielded no plans, the team reached out to their contacts within the selected countries and requested access to relevant documents.

To be included in the review, the PPPs must have been published between March and September 2020, as we sought to analyse early responses and this period broadly corresponded to the first pandemic wave. Where necessary, plans were translated into English before two members of the team conducted data extraction. Once validity checks were completed, extracted data were synthesised both numerically and thematically, and analysed. The analysis involved assessing the degree to which the descriptions within the plans aligned with the parameters in the Kapiriri and Martin [15] framework. We tabulated the range and number of parameters addressed in each PPP and then compared across countries within the region. Thematic analysis involved more in-depth textual analysis where this was provided in individual plans, followed by comparison across the sampled countries.

## 4. Results

The review included 24 sampled countries out of a total of 53 countries in the EURO region. We obtained a single document that constituted a national plan in 20 of the 24 sampled countries and in the remaining four we included more than one document in the analysis (Denmark, North Macedonia, Norway, and United Kingdom). Seventeen of the PPPs were published between March – May 2020, and the remainder were published by September 2020. The focus on the WHO EURO region enabled us to compare priority setting in countries that share some geographical and demographic characteristics, and that have all had relatively little recent experience of disease pandemics, prior to COVID-19. However, they also differ in multiple ways such as: income level; political system; economics; health system funding and structure; and social values. The rest of the results section is organized according to the domains of Kapiriri and Martin [15] framework.

#### 4.1. Priority setting contexts

The 24 sampled countries represented variations along the key dimensions that were relevant to the study and to priority setting (summarized in Table 1, drawing on [22,34] and political stability rankings from TheGlobalEconomy.com).

According to the World Bank, all of the included countries provide universal health care to their citizens, with a range of 65 to 87 on the Universal Health Coverage continuum [22]. Table 1 includes

information on each sampled country's economic, political and health system, UHC Service Coverage index, health expenditure, relationship between private and public healthcare funding, political stability and number of hosted refugees. Countries within the sample that are 'major destinations' for asylum seekers in the period 2010–2019 include France and Turkey (0.6 million), Italy, Russia and Sweden (0.5) and the UK (0.3) [34]. This is important as there are acknowledged gaps in health care coverage across the region for such groups [24].

**Table 1**  
Country contexts.

	Country	Economic System	Political System	UHC Service Coverage Index	GINI Index (2018)	Health expenditure per capita 2018 (current USD)	% of private insurance coverage	% of public insurance coverage	Political stability index (–2.5 weak; 2.5 strong)	Number of refugees hosted
Central Asia	<b>Kazakhstan</b>	Upper-middle	Presidential republic	76	27.8	\$ 275.85	NI	NI	–0.26	524
	<b>Tajikistan</b>	Low	Presidential republic	68	34.0**	\$ 59.84	NI	NI	–0.52	3791
	<b>Uzbekistan</b>	Lower-middle	Presidential republic, authoritarian	73	35.3*	\$ 82.27	NI	NI	–0.44	8242
Eastern Europe	<b>Moldova</b>	Lower-middle	Parliamentary republic	69	25.7	\$ 212.97	NI	NI	–0.42	423
	<b>Russia</b>	Upper-middle	Semi-presidential federation	75	37.5	\$ 609.01	NI	NI	–0.73	42,433
	<b>Slovak</b>	High	Parliamentary republic	77	25.0	\$ 1299.91	NI	NI	0.64	977
	<b>Ukraine</b>	Lower-middle	Semi-presidential republic	68	26.6 <sup>§§</sup>	\$ 228.39	NI	NI	–1.16	2172
	<b>Denmark</b>	High	Parliamentary constitutional monarchy	81	28.2	\$ 6216.77	33	94	0.94	37,540
Northern Europe	<b>Ireland</b>	High	Parliamentary republic	76	31.4 <sup>§</sup>	\$ 5489.07	45	100	0.98	7800
	<b>Norway</b>	High	Parliamentary constitutional monarchy	87	27.6	\$ 8239.10	0	100	1.25	53,888
	<b>Sweden</b>	High	Parliamentary constitutional monarchy	86	30.0	\$ 5981.71	0	100	1.02	253,794
	<b>United Kingdom</b>	High	Parliamentary constitutional monarchy	87	35.1 <sup>§</sup>	\$ 4315.43	11	100	0.47	133,094
	<b>Italy</b>	High	Parliamentary republic	82	35.9 <sup>§</sup>	\$ 2989.00	0	100	0.44	207,619
	<b>North Macedonia</b>	Upper-middle	Parliamentary republic	72	33.0	\$ 399.10	NI	NI	0.1	208
	<b>Portugal</b>	High	Semi-presidential republic	82	33.5	\$ 2215.17	28	100	1.03	2387
Southern Europe	<b>Serbia</b>	Upper-middle	Parliamentary republic	65	36.2 <sup>§</sup>	\$ 617.09	NI	NI	–0.09	26,433
	<b>Slovenia</b>	High	Parliamentary republic	79	24.6	\$ 2169.58	86	100	0.71	751
	<b>Spain</b>	High	Parliamentary constitutional monarchy	83	34.7	\$ 2736.32	18	99	0.4	57,761
	<b>Georgia</b>	Upper-middle	Parliamentary republic	66	35.9 <sup>§§</sup>	\$ 312.75	NI	NI	–0.43	1360
	<b>Turkey</b>	Upper-middle	Presidential republic	74	41.9 <sup>§§</sup>	\$ 389.87	NI	NI	–1.19	3597,531
	<b>France</b>	High	Semi-presidential republic	78	32.4	\$ 4690.07	0	100	0.31	407,923
Western Europe	<b>Germany</b>	High	Federal parliamentary republic	83	31.9***	\$ 5472.20	34	89	0.67	1146,685
	<b>Luxembourg</b>	High	Constitutional monarchy	83	35.4	\$ 6227.08	NI	NI	1.23	2572
	<b>Switzerland</b>	High	Federal republic	83	33.1	\$ 9870.66	28	100	1.19	110,168

\*2003, \*\*2015, \*\*\*2016, §2017, §§2019, other countries 2018.

#### 4.2. Priority setting pre-requisites

**Political will:** We sought to assess the extent to which the plans demonstrate an explicit political commitment and support for priority setting and resource allocation. We can infer at least some base level political will from the existence of the plans, and the statements of ownership/involvement they contain from various governmental and associated bodies. All of the PPPs were produced by national/federal government departments or ministries, apart from a small number that were prepared either by international bodies such as the World Bank (North Macedonia) and the United Nations (Ukraine), or by arms-length national organisations such as the Swiss Academy of Medical Sciences, and the National Board of Health and Welfare in Sweden. The internal chain of command and responsibility for the response is clearly articulated in nearly all documents, again indicating political will, (Table 2).

**Resources:** We extracted data on the extent to which the plans explicitly address the matter of resources. For example, do they a) indicate how the proposed plans will be funded and resourced and b) identify which resources (e.g., material, human or otherwise) are likely to be scarce and therefore subject to prioritisation? We found that the majority of plans did not specify the overall resources available to fund or implement the response plan and, in this respect, they fall short of what is required for explicit priority setting which assumes a clear understanding of available resources. The majority, however, itemise the resources that are anticipated to become stretched during the pandemic (see Table 3). In order of prevalence, these are: human resources and deficits in relevant skills (i.e., training gaps) (identified in 18 plans); COVID-19 testing kits (17); PPE and the materials required for their production (15); health care facilities (15); laboratory equipment (13); essential medicines (11); acute care beds (10); medical equipment and supplies (9); ambulances (8); vaccines (6), and life support equipment (6). Our analysis suggests that a small number of plans refrain from explicitly itemising areas of resource shortage. For example, the PPPs of Ireland and the UK make reference to the need to increase capacity in core roles and facilities but do not indicate a) what current resource levels are b) how these deficits will be addressed or c) what consequences this will have in other areas.

**Legitimacy:** The majority of plans do not include substantive information on the level of stakeholder support for the plans or the bodies responsible for enacting them. For example, no citizen consultation or involvement is described in any of the plans. It is therefore difficult to assess levels and extent of trust in the validity and authority of the decision making institutions, based on the documents included for analysis.

**Incentives for compliance:** the reviewed plans did not include reference to any type of (dis)incentives for implementers to comply with the priority setting plans.

#### 4.3. Priority setting processes

**Prioritising across service areas:** Eight of the 24 plans (France, Ireland, Italy, Kazakhstan, Norway, Portugal, Slovenia, Spain) include a strategy for ensuring continuity of other health services during the pandemic, including routine vaccinations, critical and urgent care, community care for vulnerable groups, mental health and substance abuse services. Whilst most of these plans indicate priority areas to *maintain*, almost none identifying parallel services and/or patient groups for de-prioritisation. The exception to this is the French plan which contains a commitment to maintain provision to 'fragile' patients such as oncology, haematology, geriatrics, cardiology, and acknowledges the need to 'de-programme' non-urgent surgical or medical activity, in order to 'prioritize' the management of COVID-19 patients.

**Stakeholder involvement:** Eleven of 24 plans include a list of stakeholders involved in their development (France, Georgia, Ireland, Italy, North Macedonia, Portugal, Slovenia, Spain, Sweden, Tajikistan, Ukraine). However, in all cases these stakeholders are dominated by

government and expert bodies/learned societies at regional, national and international levels. As noted earlier, no direct involvement of citizen, community or patient groups is recorded in any of the plans.

**Use of priority setting tools and criteria:** Only two of the 24 included plans - Sweden and Tajikistan - make explicit reference to priority setting processes and/or methodologies. The Swedish plan presents a 'model' for prioritisation of areas of care, acknowledging the opportunity cost of prioritising COVID-19 vis a vis 'healthcare outside of intensive care, which may need to be postponed or not performed at all.' The Tajikistan plan provides a detailed description of a three-day simulation and prioritisation exercise, resulting in 10 key areas ('pillars') and associated resource needs. The Ireland plan refers to the use of mathematical modelling, but does not connect this specifically to resource allocation.

Half of the plans (France, Denmark, Germany, Ireland, North Macedonia, Norway, Portugal, Slovenia, Sweden, Switzerland, Tajikistan, United Kingdom) refer to priority setting criteria, albeit these descriptions vary in terms of comprehensiveness (i.e. the range of decision points they cover) and the extent to which they are conceptualised as decision criteria. Some plans, such as those of Norway, Sweden and Switzerland, cite well-established ethical concepts such as dignity, fairness, and solidarity, alongside cost-effectiveness and severity. In other plans, underlying principles can be inferred from the identification of priority population groups, such as older and clinically vulnerable groups (France, Denmark), and health care professionals (Denmark, Switzerland) (see Table 4). That said, none of the plans note an intention to promote equity among marginalised and/or disadvantaged groups on grounds of, for example, sex, ethnicity, socio-economic status or immigration status.

Two plans (North Macedonia and Portugal) make explicit reference to social and economic factors as being relevant to decision making, and the Tajikistan plan makes reference to 'trust and confidence of response organizations and people/society at large'. The Swiss plan is unique in listing the criteria *excluded* from the prioritisation process. These latter include: age; chance (i.e. via lotteries); 'first come, first served' and 'social usefulness.'

**Use of evidence:** The use of evidence – broadly defined – in the development of the plans is cited in 16 of 24 documents, and in almost all cases, this includes guidelines/guidance from national and/or international bodies such as the WHO and the European Centre for Disease Prevention and Control. These citations vary from cursory references to a pre-existing document (France, Luxembourg, Moldova, North Macedonia, Russia, Ukraine) to more in-depth descriptions of, for example, previous pandemic plans, published studies and ongoing data collection (Denmark, Germany, Ireland, Italy, Portugal, Slovenia, Spain, Sweden, Tajikistan, UK).

**Reflecting public values:** The role of, and extent of compatibility with, wider public values is not directly covered in any of the plans, with the partial exception of Sweden which asserts its adherence to principles legally established in the Swedish parliament. Whilst the Ireland, Slovenia, Tajikistan, United Kingdom and Ukraine plans devote some space to discussing public communication strategies, this is generally unidirectional and primarily concerned with minimising the risk of 'misinformation'.

**Publicity of priorities and criteria:** Four plans include brief statements of how they are intended to be disseminated and accessed, including via government websites (France, Slovakia, Spain, Switzerland). Eight plans contain more active strategies for dissemination and revision, including, for example, via social media (Germany, Ireland, Moldova, North Macedonia, Portugal, Slovenia, Tajikistan, United Kingdom). The remaining 12 plans do not directly address this parameter.

**Mechanisms for appeal and enforcement:** These are largely absent from the plans, with only Kazakhstan, Slovenia and Spain discussing either mechanisms of appeal, or enforcement.

**Table 2**  
Priority setting parameters included in the plans.

	Regions	Central Asia			Eastern Europe				Northern Europe				Southern Europe					Western Asia		Western Europe				All (%)		
	Country	Kazakhstan	Tajikistan	Uzbekistan	Moldova	Russia	Slovak	Ukraine	Denmark	Ireland	Norway	Sweden	UK	Italy	North Macedonia	Portugal	Serbian	Slovenia	Spain	Georgia	Turkey	France	Germany		Luxembourg	Switzerland
Aspects of priority setting	Resources	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	21 (88)
	Degree of scarcity	N	N	N	N	N	N	N	N	Y	N	N	N	N	Y	Y	N	Y	N	N	N	N	N	N	Y	5 (21)
	Populations	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	Y	N	Y	N	16 (67)
	Geographic regions	Y	N	N	Y	N	N	Y	N	Y		N	N	N	N	N	N	N	Y	N	N	N	N	N	N	5 (21)
	Healthcare settings	Y	Y	Y	Y		Y	N	N	Y	Y	N	N	Y	Y	Y	N	Y	Y	N	N	Y	Y	N	N	14 (58)
	Interventions	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	Y	Y	N	Y	Y	Y	N	Y	Y	N	N	17 (70)
	Research	N	N	N	N	N	N	N	N	Y	N	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	3 (13)
	Priority areas	N	Y	N	Y	N	N	N	N	Y	Y	N	Y	Y	N	N	N	Y	Y	Y	N	Y	Y	N	N	11 (46)
Pre-requisites	Political will	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	24 (100)
	Resources	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	22 (92)
	Legitimate institutions	N	N	N	N	N	N	Y	Y	Y	N	Y	Y	N	N	N	N	N	Y	N	N	Y	N	N	N	7 (29)
	Incentives for compliance	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
The priority setting process	Plan for continuity	Y	N	N	N	N	N	N	N	Y	Y	N	N	Y	N	Y	N	Y	Y	N	N	Y	N	N	N	8 (33)
	Stakeholder participation	N	Y	N	N	N	N	Y	N	Y	N	Y	N	Y	Y	Y	N	Y	Y	Y	N	Y	N	N	N	11 (46)
	Priority setting process/tools	N	Y	N	N	N	N	N	N	Y	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	3 (13)
	Priority setting criteria	N	Y	N	N	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	N	Y	N	N	N	Y	Y	N	Y	12 (50)
	Use of evidence	N	Y	N	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N	N	Y	Y	Y	N	16 (67)

(continued on next page)

Table 2 (continued)

	Reflection of public values	N	Y	N	N	N	N	Y	Y	Y	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	6 (25)
	Publicity of priorities	N	Y	N	Y	N	Y	N	N	Y	N	N	Y	N	Y	Y	N	Y	Y	N	N	Y	Y	N	Y	N	Y	12 (50)
	Mechanisms for appealing the decision	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	2 (8)
	Mechanisms for enforcement decisions	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	2 (8)
Implement ation of the set priorities	Allocation of resources	N	Y	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	4 (17)
	Improved accountability	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	Y	Y	N	N	N	N	N	4 (17)
Priority Setting Impact	Impact on swiftness	N	N	N	Y	N	N	N	N	N	N	N	N	Y	N	N	N	Y	Y	N	N	Y	Y	N	N	N	N	6 (25)
	Impact on population health	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0
	Impact on reducing inequalities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0
	Fair financial contribution	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0
	Increased public confidence in the health sector	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	1 (4)
	Total (out of 28)	9	14	4	13	5	7	10	9	16	9	9	12	11	11	11	3	16	19	6	1	15	11	5	6			
	%	32	50	14	46	18	25	36	32	57	32	32	43	39	39	39	11	57	68	21	4	54	39	18	21			

4.4. Implementation and impact

These two domains were largely lacking from the plans, with little by way of formal mechanisms for ensuring decisions are put into practice to ensure the implementation of priorities. The plans also did not describe the expected outcomes and impact of the proposed priority setting plans.

5. Discussion

The existence of these pandemic preparedness plans presents an opportunity to compare the initial responses of governments in the EURO region as the enormity of the COVID-19 pandemic became clear, and in particular to assess the extent to which they reflect good practice in the application of priority setting and resource allocation. Although the included plans vary both in content and in the timing of their introduction, they nevertheless provide a rich source of information on how the challenges posed by COVID-19 were understood, and how the plans for decision making concerning the allocation of limited resources were developed. Despite some commonalities across these plans, each one reflects the unique context in which it was developed, for example with respect to available resources, systems and structures of government, and wider political and civic cultures and values.

Our study suggests, perhaps unsurprisingly, that there was a clear political commitment evident in the plans, to an extent that often isn't observed in 'normal' times [8]. Many governments were also willing to explicitly acknowledge resource scarcity and the implications of this for meeting health needs. In a small number of cases, they went further to itemise the 'pinch-points' and deprioritised services and groups. This level of explicit rationing can be problematic - a social media study of the Swedish priority guidelines for intensive care documented both understanding and distrust among the public, suggesting that such transparency may be both welcomed by some and rejected as unnecessarily distressing by others [3].

Given the fundamental, and largely anticipated, problem of resource shortages to meet the challenges presented by COVID-19, it is telling that so few plans refer to formal priority setting tools and frameworks. This would appear to underline the relative failure of priority setting as a

normative discipline to become embedded in governmental decision making processes. This echoes previous literature suggesting that formal priority setting is often a marginal activity in the context of policy decision making [17]. It is therefore not entirely clear how well aligned pre-existing tools (such as economic evaluation; programme budgeting and marginal analysis, and multi-criteria decision analysis) are for priority setting under these conditions, and therefore what the reasons might be for their relative absence from the PPPs. This chimes with criticisms of other disciplines, such as health economics, for being largely absent from the initial planning for the pandemic response [29].

While efforts at formal priority setting do occur to a variable degree across countries in Europe under normal circumstances [5], perhaps pre-existing tools, developed for normal conditions, require adaptation to the turbulence resulting from emergencies such as the COVID-19 pandemic. A key difference is the intensified requirement for *de-prioritisation* of current services (albeit temporarily), in order to accommodate the extraordinary demands posed by the pandemic. Few if any established priority setting methodologies are designed with this scenario in mind, and de-prioritisation in general has proven to be something of a weak link in resource allocation [39]. As well as this, the literature suggests that priority setting itself can be resource intensive as it requires evidence, deliberation, analysis and so on, all of which can be in short supply in times of emergency.

Despite the absence of formal priority setting tools and frameworks, many of the plans cite explicit criteria intended to inform resource allocation. This would appear to represent progress when compared to results from a similar study published in 2006 which concluded that 'plans seldom mentioned ethics in the context of resource allocation' ([35]; 1725). However, ethical criteria can often be viewed as abstract and ambiguous, and many plans express these values in concrete decision making criteria. That countries like Norway and Sweden make explicit references to ethical criteria is likely due to the fact that in these countries, healthcare legislation requires priority setting to follow such criteria [10]. In general, the presence of value-laden or ethical criteria in plans might reflect the extent to which such values are part of the public discourse on healthcare priority setting also under normal conditions in the chosen countries. To adopt such criteria as explicit decision guides

**Table 3**  
Resources identified for prioritisation in the plans.

Country	Human resources and training	PPE and other IPC materials	Lab equipment	Testing kits	Healthcare facilities	Medical equipment/supplies	Essential medicines	Vaccines	Ambulances	ICU beds	Life support equipment	Financial resources	Blood services	Telehealth
France	x	x		x	x	x	x			x	x		x	x
Denmark		x		x	x		x			x				
Georgia	x			x										
Germany	x	x	X	x	x			x						
Ireland														
Italy	x				x					x				
Kazakhstan		x	X	x	x				x					
Luxembourg	x	x	X	x	x									
Moldova	x	x		x	x	x	x			x	x			
North Macedonia	x	x	X	x	x					x				
Norway	x		X							x	x			
Portugal	x	x		x	x	x	x		x					
Russia	x	x	X	x	x	x	x		x					
Serbian	x		X	x										
Slovak	x	x	X	x	x	x	x	x	x					
Slovenia	x	x	X	x	x	x	x	x	x					
Spain	x	x	X	x	x	x	x	x	x	x	x		x	
Sweden	x					x								
Switzerland							x			x	x			
Tajikistan	x	x	X	x	x	x	x		x	x	x			
Turkey														
United Kingdom								x						
Ukraine	x	x	X	x				x						
Uzbekistan	x	x	X	x	x		x		x	x				
<b>Total</b>	<b>17</b>	<b>15</b>	<b>13</b>	<b>17</b>	<b>15</b>	<b>9</b>	<b>11</b>	<b>6</b>	<b>8</b>	<b>10</b>	<b>6</b>	<b>0</b>	<b>2</b>	<b>1</b>



**Table 4**  
Patient populations prioritised in the plans.

		France	Denmark	Georgia	Germany	Ireland	Italy	Kazakhstan	Luxembourg	Moldova	North Macedonia	Norway	Portugal	Russia	Serbian	Slovak	Slovenia	Spain	Sweden	Switzerland	Tajikistan	Turkey	United Kingdom	Ukraine	Uzbekistan	Total
<b>Prioritized in WHO documents</b>	Elderly	x	x			x				x	x	x				x					x					8
	Immune-compromised											x				x										2
	With comorbidities or predisposing conditions	x					x			x	x	x				x					x					7
	Healthcare workers		x			x										x										3
	Travellers																									0
	Living in institutions	x																								1
<b>Prioritized for continuity of services</b>	Pregnant women									x	x	x				x		x								5
	Young infants							x				x				x		x								4
	In need of sexual and reproductive services																									0
	With pre-existing illnesses	x				x																				2
	People living with HIV																									0
	'Fragile' patients (oncology, hematology, geriatrics, cardiology)	x										x														2

(continued on next page)



context, others suggest significant areas for potential improvement in future pandemic preparedness planning and in the integration of priority setting into these processes.

## Funding

This study was funded by McMaster University COVID-19 research fund.

## CRediT authorship contribution statement

**Iestyn Williams:** Conceptualization, Formal analysis, Methodology, Writing – original draft. **Lydia Kapiriri:** Conceptualization, Funding acquisition, Investigation, Methodology, Writing – review & editing. **Claudia-Marcela Vélez:** Data curation, Formal analysis, Project administration, Writing – review & editing. **Bernardo Aguilera:** Investigation, Writing – review & editing. **Marion Danis:** Conceptualization, Investigation, Methodology, Writing – review & editing. **Beverley Essue:** Conceptualization, Investigation, Methodology, Writing – review & editing. **Susan Goold:** Conceptualization, Investigation, Methodology, Writing – review & editing. **Mariam Noorhuda:** Data curation, Investigation, Writing – review & editing. **Elysee Nouvet:** Investigation, Writing – review & editing. **Donya Razavi:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – review & editing. **Lars Sandman:** Investigation, Methodology, Writing – review & editing.

## Declaration of competing interest

We have no conflicts of interest to report.

## Acknowledgements

We are grateful to the GPSet collaboration who have been involved in the wider project that this paper stems from.

## References

- Baltussen R, Mitton C, Danis M, Williams I, Gold M. Global developments in priority setting in health. *Int J Health Policy Manag* 2017;6(3):127. <https://doi.org/10.15171/ijhpm.2017.10>.
- Bollyky TJ, Hulland EN, Barber RM, Collins JK, Kiernan S, Moses M, Pigott DM, Reiner Jr RC, Sorensen RJ, Abbafati C, Adolph C. Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021. *Lancet* 2022. [https://doi.org/10.1016/S0140-6736\(22\)00172-6](https://doi.org/10.1016/S0140-6736(22)00172-6).
- Broqvist M, Sandman L. Reaktionen på nätet: ett axplock av reaktioner på riktlinjer för prioriteringar av intensivvård under covid-19 pandemin. Linköping University Electronic Press; 2021.
- Colfer Barry. Public policy responses to COVID-19 in Europe. *Eur Policy Anal* 2020; 6(2):126–37. <https://doi.org/10.1002/epa2.1097>.
- Di Costanzo C. Healthcare resource allocation and priority-setting. A European challenge. *Eur J Health Law* 2020;27(2):93–114. <https://doi.org/10.1163/15718093-12271448>.
- Essue BM, Kapiriri L. The unfunded priorities: an evaluation of priority setting for noncommunicable disease control in Uganda. *Glob Health* 2018;14(1):1–14. <https://doi.org/10.1186/s12992-018-0324-2>.
- Glassman A, Chalkidou K, Giedion U, Teerawattananon Y, Tunis S, Bump JB, Pichon-Riviere A. Priority-setting institutions in health: recommendations from a center for global development working group. *Glob Heart* 2012;7(1):13–34. <https://doi.org/10.1016/j.ghheart.2012.01.007>.
- Hall W, Williams I, Smith N, Gold M, Coast J, Kapiriri L, Danis M, Mitton C. Past, present and future challenges in health care priority setting: findings from an international expert survey. *J Health Organ Manag* 2018. <https://doi.org/10.1108/JHOM-01-2018-0005>.
- Hantrais L. Policy learning from COVID-19 in Europe. *Emerald Open Res* 2021;3.
- Hofmann B. Priority setting in health care: trends and models from Scandinavian experiences. *Med, Health Care Philos* 2013;16(3):349–56. <https://doi.org/10.1007/s11019-012-9414-8>.
- Hunter DJ, Kieslich K, Littlejohns P, Staniszevska S, Tumilty E, Weale A, Williams I. Public involvement in health priority setting: future challenges for policy, research and society. *J Health Organ Manag* 2016. <https://doi.org/10.1108/JHOM-04-2016-0057>.
- Kapiriri L, Kiwanuka S, Biemba G, Velez C, Razavi SD, Abelson J, Williams I. Priority setting and equity in COVID-19 pandemic plans: a comparative analysis of 18 African countries. *Health Policy Plan* 2021.
- Kapiriri L, Essue B, Bwire G, Nouvet E, Kiwanuka S, Sengooba F, Reeleder D. A framework to support the integration of priority setting in the preparedness, alert, control and evaluation stages of a disease pandemic. *Glob Public Health* 2021;1–13. <https://doi.org/10.1080/17441692.2021.1931402>.
- Kapiriri L, Schuster-Wallace C, Chanda-Kapata P. Evaluating health research priority-setting in low-income countries: a case study of health research priority-setting in Zambia. *Health Res Policy Syst* 2018;16(1):1–12. <https://doi.org/10.1038/sj.jp.7211402>.
- Kapiriri L, Martin DK. Successful priority setting in low and middle income countries: a framework for evaluation. *Health Care Anal* 2010;18(2):129–47. <https://doi.org/10.1007/s10728-009-0115-2>.
- Kapiriri L, Razavi SD. Salient stakeholders: using the salience stakeholder model to assess stakeholders' influence in healthcare priority setting. *Health Policy Open* 2021;2:100048. <https://doi.org/10.1016/j.hjopen.2021.100048>.
- Kapiriri L, Razavi D. How have systematic priority setting approaches influenced policy making? A synthesis of the current literature. *Health Policy* 2017;121(9): 937–46. <https://doi.org/10.1016/j.healthpol.2017.07.003>.
- Islam N, Sharp SJ, Chowell G, Shabnam S, Kawachi I, Lacey B, Massaro JM, D'Agostino RB, White M. Physical distancing interventions and incidence of coronavirus disease 2019: natural experiment in 149 countries. *BMJ* 2020;370: m2743. <https://doi.org/10.1136/bmj.m2743>.
- Kislov R, Checkland K, Wilson PM, Howard SJ. Real-world priority setting for service improvement in English primary care: a decentred approach. *Public Manage Rev* 2021;1–25. <https://doi.org/10.1080/14719037.2021.1942534>.
- Mitton C, Smith N, Peacock S, Evoy B, Abelson J. Integrating public input into healthcare priority-setting decisions. *Evid Policy: J Res, Debate Pract* 2011;7(3): 327–43. <https://doi.org/10.1332/174426411x591762>.
- Mogalakwe M. The use of documentary research methods in social research. *Afr Sociol Rev/Revue Africaine De Sociologie* 2006;10(1):221–30.
- Montagu D. The provision of private healthcare services in European countries: recent data and lessons for universal health coverage in other settings. *Front Public Health* 2021;9:171. <https://doi.org/10.3389/fpubh.2021.636750>.
- Norman R, Robinson S, Dickinson H, Williams I, Meshcheriakova E, Manpis K, Anstey M. Public preferences for allocating ventilators in an intensive care unit: a discrete choice experiment. *Patient-Patient-Center Outcomes Res* 2021;14(3): 319–30. <https://doi.org/10.1037/amp0000709>.
- Palm W, Webb E, Hernández-Quevedo C, Scarpetti G, Lessof S, Siciliani L, van Ginneken E. Gaps in coverage and access in the European Union. *Health Policy* 2021;125(3):341–50. <https://doi.org/10.1016/j.healthpol.2020.12.011>.
- Petricca K, Bekele A, Berta W, Gibson J, Pain C. Advancing methods for health priority setting practice through the contribution of systems theory: lessons from a case study in Ethiopia. *Soc Sci Med* 2018;198:165–74. <https://doi.org/10.1016/j.socscimed.2017.12.009>.
- Razavi SD, Noorhuda M, Velez CM, Kapiriri L, Dreyse BA, Danis M, Essue B, Goold SD, Nouvet E, Williams I. Priority setting for pandemic preparedness and response: a comparative analysis of COVID-19 pandemic plans in 12 countries in the Eastern Mediterranean Region. *Health Policy Open* 2022;100084.
- Razavi SD, Kapiriri L, Wilson M, Abelson J. Applying priority-setting frameworks: a review of public and vulnerable populations' participation in health-system priority setting. *Health Policy* 2020;124(2):133–42. <https://doi.org/10.1016/j.healthpol.2019.12.005>.
- Schmidt AE, Merkur S, Haindl A, Gerkens S, Gandré C, Or Z, Groenewegen P, Kroneman M, De Jong J, Albrecht T, Vracko P. Tackling the COVID-19 pandemic: initial responses in 2020 in selected social health insurance countries in Europe. *Health Policy* 2021. <https://doi.org/10.1016/j.healthpol.2021.09.011>.
- Schulenburg J. COVID-19: not the time for health economists? A plea for more proactive health economic involvement. *Eur J Health Econ* 2021;22(7):1001–4. [https://doi.org/10.1016/S1473-3099\(21\)00079-7](https://doi.org/10.1016/S1473-3099(21)00079-7).
- Seixas BV, Regier DA, Bryan S, Mitton C. Describing practices of priority setting and resource allocation in publicly funded health care systems of high-income countries. *BMC Health Serv Res* 2021;21(1):1–15. <https://doi.org/10.1186/s12913-021-06078-z>.
- Siciliani L, Wild C, McKee M, Kringos D, Barry MM, Barros PP, De Maeseneer J, Murauskienė L, Ricciardi W. Strengthening vaccination programmes and health systems in the European Union: a framework for action. *Health Policy* 2020;124(5):511–8. <https://doi.org/10.1016/j.healthpol.2020.02.015>.
- Smith N, Mitton C, Hall W, Bryan S, Donaldson C, Peacock S, Gibson JL, Urquhart B. High performance in healthcare priority setting and resource allocation: a literature-and case study-based framework in the Canadian context. *Soc Sci Med* 2016;162:185–92. <https://doi.org/10.1016/j.socscimed.2016.06.027>.
- Smith N, Mitton C, Davidson A, Williams I. A politics of priority setting: ideas, interests and institutions in healthcare resource allocation. *Public Policy Adm* 2014;29(4):331–47. <https://doi.org/10.1177/0952076714529141>.
- UNHCR (2020) Global trends forced displacement in 2019 [www.unhcr.org/5ee200e37.pdf](http://www.unhcr.org/5ee200e37.pdf).
- Uscher-Pines L, Omer SB, Barnett DJ, Burke TA, Balicer RD. Priority setting for pandemic influenza: an analysis of national preparedness plans. *PLoS Med* 2006;3(10):e436. <https://doi.org/10.1371/journal.pmed.0030436>.
- Vélez CM, Aguilera B, Kapiriri L, Essue BM, Nouvet E, Sandman L, Williams I. An analysis of how health systems integrated priority-setting in the pandemic planning in a sample of Latin America and the Caribbean countries. *Health Res Policy Syst* 2022;20(1):1–16. <https://doi.org/10.1186/s12961-022-00861-y>.

- [37] Vélez CM, Kapiriri L, Nouvet E, Gool S, Aguilera B, Williams I, Danis M, Essue BM. Examining priority setting in the National COVID-19 pandemic plans: a case study from countries in the WHO-South-East Asia Region (WHO-SEARO). *Health Policy Open* 2022;3:100086.
- [38] Wang D, Mao Z. A comparative study of public health and social measures of COVID-19 advocated in different countries. *Health Policy* 2021;125(8):957–71. <https://doi.org/10.1016/j.healthpol.2021.05.016>. August 2021.
- [39] Williams I, Harlock J, Robert G, Kimberly J, Mannion R. Is the end in sight? A study of how and why services are decommissioned in the English National Health Service. *Sociol Health Illn* 2021;43(2):441–58. <https://doi.org/10.1111/1467-9566.13234>.
- [40] Williams I, Dickinson H, Robinson S. Rationing in health care: the theory and practice of priority setting. Policy Press; 2012.
- [41] World Health Organization. COVID-19: operational guidance for maintaining essential health services during an outbreak: interim guidance, 25 March 2020 (No. WHO/2019-nCoV/essential\_health\_services/2020.1). World Health Organization; 2020.