Fundació HiTT

Report on the results of the survey on Health Priorities in the Catalan Health System

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Introduction

Setting health priorities is one of the main challenges facing health systems. In a context characterised by an ageing population, the increasing prevalence of chronic diseases, the emergence of new health technologies and the limitation of available resources, **decisions on resource allocation have become a key strategic issue**. Identifying the most relevant health needs makes it possible to direct public policies, biomedical research and healthcare investment towards areas with the greatest potential to improve population health and ensure the sustainability of the health system.

In this context, the **definition of priorities cannot be based exclusively on clinical, epidemiological or economic criteria**. There is a growing recognition of the need to incorporate the citizens' perspectives into health planning processes. The experiences, knowledge and expectations of patients, healthcare professionals, managers, representatives of patients associations and other relevant stakeholders provide valuable insights into perceived needs, emerging challenges and areas in which greater efforts in prevention, diagnosis, treatment, research and innovation efforts are considered necessary.

The **participation of the different stakeholders across the health ecosystem in setting priorities** also helps strengthen the legitimacy, transparency and quality of health decision-making processes. Incorporating diverse perspectives makes it possible to complement objective data on the burden of disease, health outcomes and resource efficiency with a broader understanding of the needs and expectations of affected groups. This approach is particularly relevant in a context of limited resources, where decisions regarding the funding of specific therapeutic areas, healthcare programmes or research priorities can have significant social, health and economic implications.

The HiTT Foundation, an **organisation committed to improving the sustainability of the health system through innovation**, knowledge transfer and the participation of stakeholders across the health ecosystem, promotes initiatives aimed at generating evidence to support better decision-making in healthcare.

To this end, a survey was designed and distributed to **identify which health areas and disease groups are perceived as priorities in Catalonia**. The study aims to gather stakeholders' views on the current relevance of different health problems and their opinions on whether more or fewer resources should be allocated to these areas in terms of funding, research and the development of health policies.

This report presents the results of this consultation and analyses the priorities identified by participants. **The findings can contribute to enriching the debate on health resource allocation in Catalonia** and provide a complementary perspective to the traditional sources of information used in health policy planning and evaluation. For this purpose**, Disability-Adjusted Life Years (DALYs)** data were incorporated to contextualise the priorities expressed by participants and compare them with the burden of disease associated with the different conditions. This comparison makes it possible to explore the extent to which perceived priorities align with the burden of disease, measured in terms of the loss of healthy life years. Ultimately, the aim is to

promote more informed and participatory decision-making that is aligned with the needs and expectations of Catalan society.

Objectives

This study was carried out with the aim of **collecting and analysing the perceptions of the different stakeholders across the Catalan health ecosystem regarding health priorities and funding needs** associated with different disease areas. The general and specific objectives that have guided the development of the study are presented below.

General objectives

Identify and analyse the health priorities perceived by the different agents of the Catalan health ecosystem, with the aim of generating evidence that contributes to the processes of prioritisation and allocation of health resources, Complementing this perspective with an analysis of the burden of disease using Disability-Adjusted Life Years (DALYs).

Specific objectives

- Identify which disease groups and therapeutic areas are considered the highest priorities by study participants.
- Analyse the participants' perception of the need to increase or strengthen funding for different health areas.
- Compare the priorities identified across different participant profiles.
- Explore possible differences in priorities according to the sociodemographic and professional characteristics of the participants.
- Generate useful information to support planning, research and decision-making processes in the field of health.
- Contextualise the identified priorities using DALY data and analyse the alignment between the ranking established by participants and the burden of disease associated with the different conditions.

Materials and methods

An observational and descriptive study **was conducted** based on a survey distributed among different stakeholders associated with the Catalan health system between the third and fourth quarters of 2025 (Q3-Q4 2025). The study was geographically limited to Catalonia, as it was initially conceived as a first local-level assessment, with the aim of exploring health priorities within a specific geographical area before considering a potential expansion to other territories.

The survey was aimed at **different stakeholders' groups within the health system**, with the aim of obtaining a multidisciplinary perspective on health priorities. Participants included members of the general population with no professional ties to the health sector, health professionals, health center managers, representatives of public bodies, pharmaceutical industry professionals, members of non-governmental organizations and other agents related to the field of health.

In addition to information on the professional profile, data on the years of work experience and the age group of the participants were also collected to characterize the sample.

Data collection

The information was collected through a **structured questionnaire comprising five sections**. The questionnaire was prepared in Catalan and Spanish to ensure the linguistic accessibility and facilitate participation among the different stakeholders involved in the health system.

The first section collected **sociodemographic and professional information from the** participants, including employment status, years of work experience, and age group.

The second section consisted of an **open-ended question in which participants were asked to identify up to three diseases or disease groups**, ranked in order of priority, that they considered should receive greater attention in terms of health system funding.

The third section asked participants to **rank five major disease groups according to the level of priority** they believed should be assigned to each: cancer, cardiovascular diseases, mental disorders, musculoskeletal disorders and neurological disorders. The classification was carried out using a five-point ordinal scale, where 1 corresponded to the highest priority and 5 to the lowest priority.

The fourth section **focused on each of the five major disease groups**. For each category, participants were required to rank specific diseases according to the priority they assigned to them. The selection of disease groups and specific conditions included in the questionnaire was based on a review of the incidence data available for Catalonia. An open-ended option ("Other") was also included to allow participants to identify diseases that had not been initially considered.

Finally, the fifth section asked participants to **select a maximum of five diseases**, among all those included in the questionnaire, which they considered should have the highest level of priority in terms of care and funding.

Procedure

The survey was implemented through an electronic platform and distributed through the HiTT Foundation's communication channels. Participation was **voluntary** and **responses were collected anonymously**. Before answering the questionnaire, participants were informed about the purpose of the study and about the confidential handling of the information provided.

Data analysis

A total of **57 responses** were received. Data were analyzed using descriptive statistical techniques. Participant characteristics were summarized by counting responses and the percentage distribution of the different profiles.

Regarding the open question on health priorities, a process of reviewing and refining the answers was carried out with the aim of standardising the information collected. The different names used by participants were grouped into common categories of diseases or groups of pathologies, with responses referring to the same clinical condition or therapeutic area being consolidated. This process facilitated the analysis and improved the comparability of the results.

A weighted scoring system was applied to the ranking questions. Each position in the ranking was assigned a score: 5 points for the first position, 4 points for the second, 3 points for the third, 2 points for the fourth and 1 point for the fifth. The scores obtained for each pathology were then added together, and the final ranking was established based on the total cumulative score.

Finally, in the last question of the questionnaire, in which participants had to select a maximum of five diseases considered a priority, the results were analysed by counting the total number of selections received for each pathology.

Results

Respondent profiles

The sample includes participants from different professional backgrounds across the Catalan health ecosystem, providing a broad perspective on health priorities.

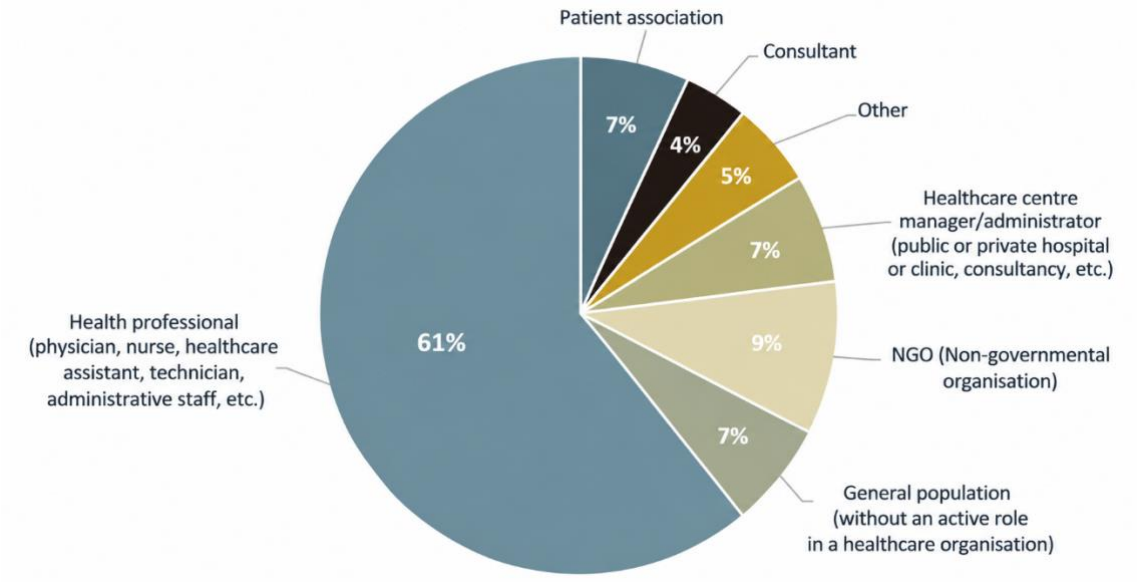

Illustration 1: Distribution of participants according to professional profile.

As shown in the ***Illustration 1***, the sample was mainly composed of health professionals, who represented the **61%** of all participants. The rest of the sample was distributed among members of NGOs (9%), managers or administrators of health centers (7%), patient associations (7%), general population without professional ties to the health sector (7%), other profiles (5%) and consulting professionals (4%). This distribution reflects a predominance of participants with direct experience in the field of care, while incorporating the perspective of other relevant agents in the health system.

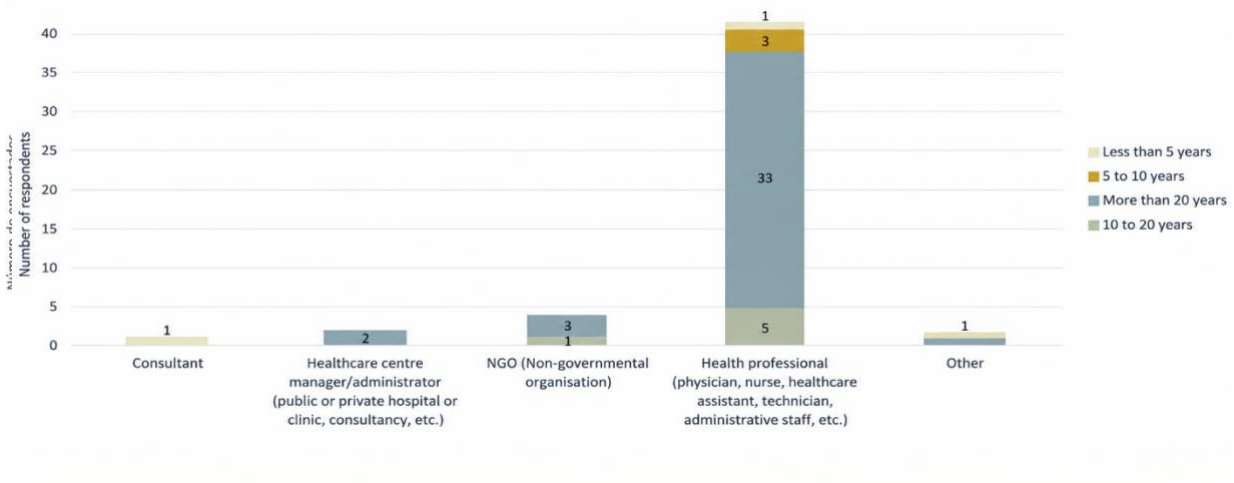

Illustration 2: Distribution of participants according to professional profile and years of work experience.

Regarding professional experience (***Illustration 2***), most of the participants had substantial work experience. Among the health professionals, the largest group corresponded to people with more than twenty years of experience, while the rest were mainly distributed between 10 and 20 years and 5 to 10 years. Participants in the other professional groups also tended to have extensive work experience.

Order of Priority by Disease Group (OPEN QUESTION)

To obtain an initial unrestricted assessment, participants were asked to identify, through an open-ended question, the three disease groups they considered to be priorities. This approach allows for the spontaneous collection of perceived priorities, without limiting responses to a predefined set of categories.

Priority #1

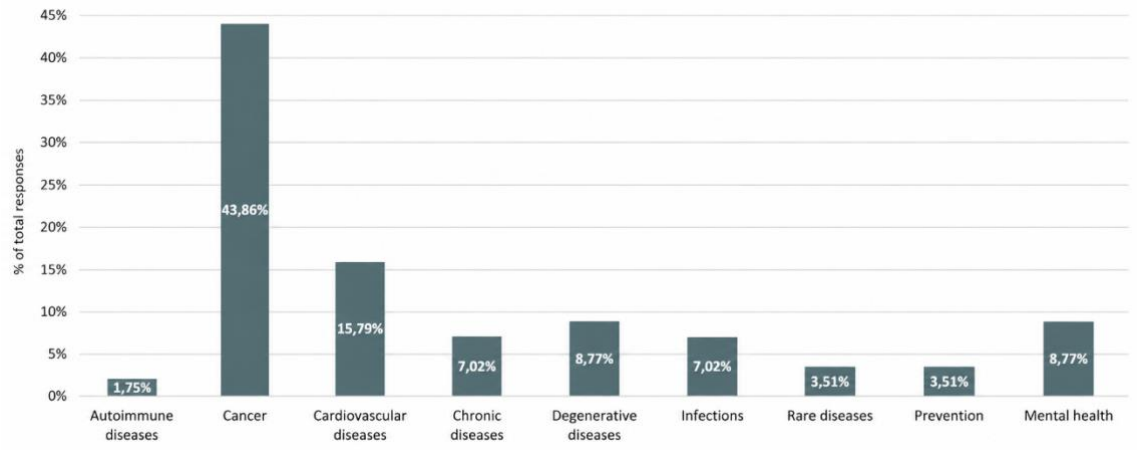

Illustration 3: Disease groups identified as the first priority in the open question.

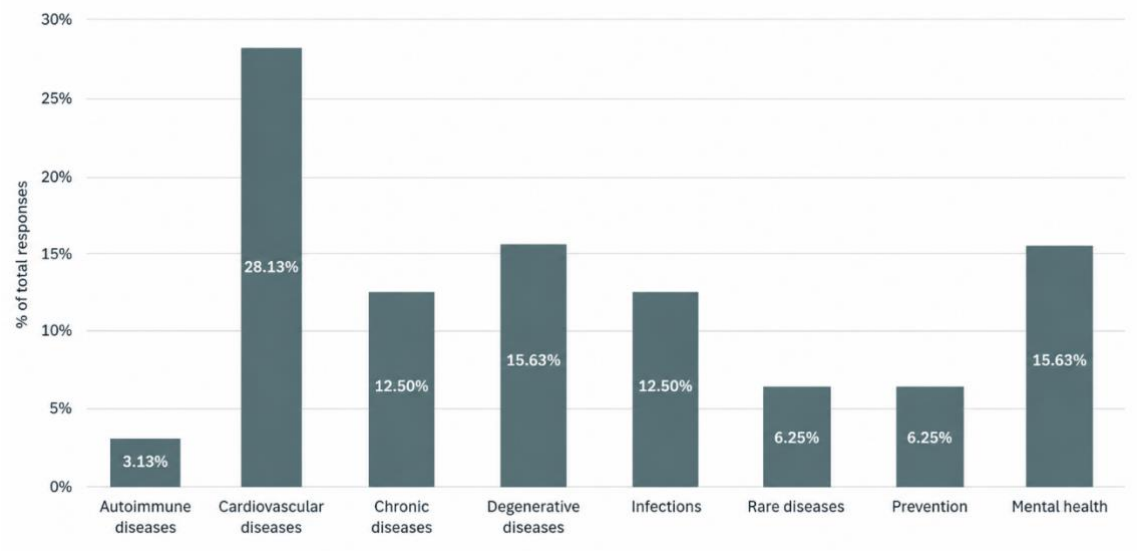

Illustration 4: Group of diseases identified as first priority in the open question, excluding the category "Cancer".

Priority #2

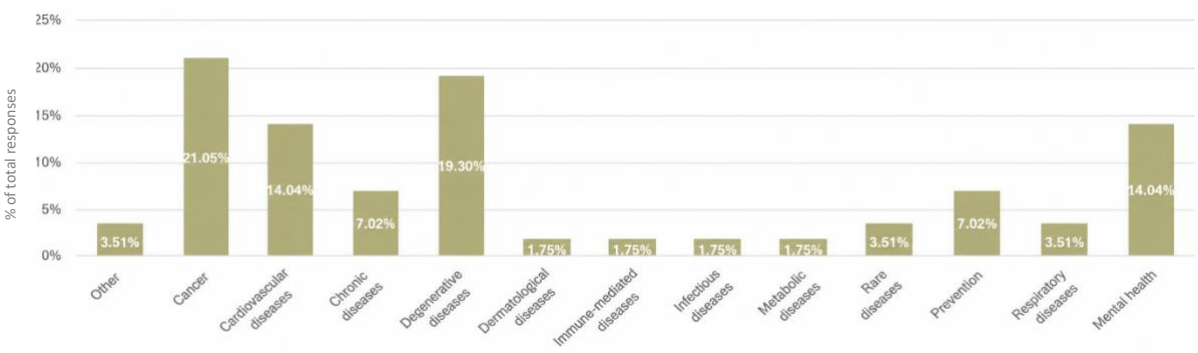

Illustration 5: Disease groups identified as second priority in the open question.

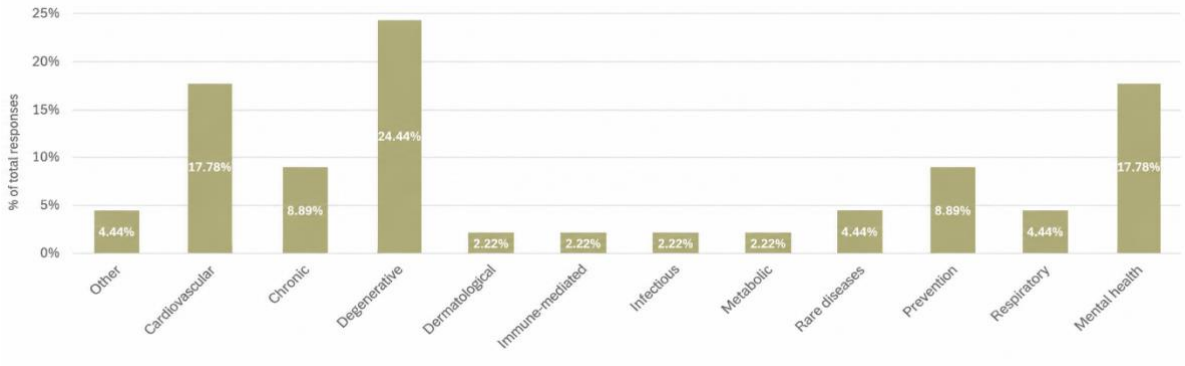

Illustration 6: Group of diseases identified as second priority in the open question, excluding the category "Cancer".

Priority #3

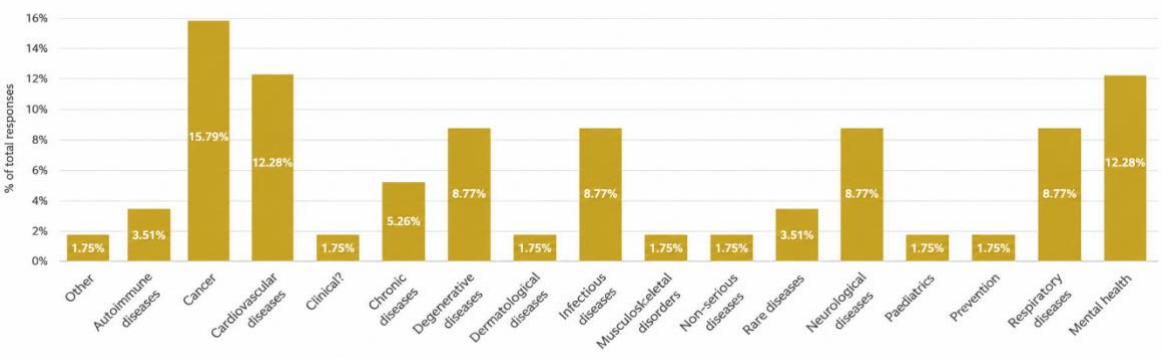

Illustration 7: Disease groups identified as third priority in the open question.

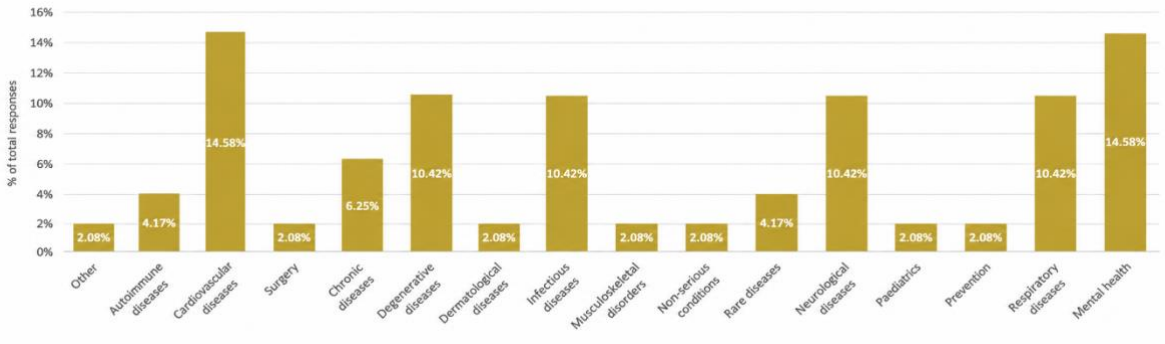

Illustration 8: Group of diseases identified as the third priority in the open question, excluding the category "Cancer".

Cancer was by far the group of diseases most frequently identified as the **first priority**, accumulating a much higher number of responses than the rest of the categories. Cardiovascular diseases, mental health and degenerative diseases stood out as the next most frequently mentioned priorities, while other groups, such as chronic, infectious or prevention-related, were less represented.

Regarding the **second** and **third priorities**, the responses showed a more heterogeneous distribution. Although cancer remained one of the most mentioned groups of diseases, the relative weight of **degenerative diseases, mental health and cardiovascular diseases**, as well as other less frequently mentioned categories, increased. This greater dispersion suggests that, beyond a clear consensus on the priority of cancer, there is a diversity of perceptions regarding the financing needs of other health areas.

Order of priorities by disease group

After spontaneously identifying the main health priorities, the participants were asked to order five major groups of diseases according to the level of priority that, in their opinion, they should have within the health system. This question enabled direct comparisons between the different categories and an assessment of the degree of consensus regarding their prioritisation.

In addition, data on Disability-Adjusted Life Year (DALY) from the Global Burden of Disease (GBD) of the Institute for Health Metrics and Evaluation (IHME) were incorporated. DALYs represent the total number of healthy years of life lost due to a specific disease or health condition, accounting for both premature mortality and disability. Data were extracted for Spain (2023), considering the entire population, both sexes, all ages, the metric in absolute number and the classification by cause These data were used to compare the priorities expressed by participants with the burden of disability associated with the different disease groups. Based on the data available for Spain, the necessary calculations were performed to extrapolate the results and obtain estimates for Catalonia.

General

Table 1: Classification of major disease groups according to the priority level assigned by participants.

Disease group	Position
Cancer	#1
Cardiovascular diseases	#2
Mental disorders	#3
Neurological disorders	#4
Musculoskeletal disorders	#5

Cancer was established as the disease group considered **the highest priority** by participants. Most responses placed it in first position, making it the category with the greatest consensus regarding the need for prioritisation. Cardiovascular diseases ranked second, followed by mental disorders, neurological disorders and, finally, musculoskeletal disorders.

Cancer

Table 2: Prioritization of the different types of cancer according to the level of priority assigned by the participants.

Disease group	Position	DALY ES	DALY Cat
Breast cancer	#1	191.706	31.606
Colon and rectal cancer	#2	363.217	59.883
Lung cancer	#3	557.637	91.937
Prostate cancer	#4	121.185	19.980
Urinary bladder cancer	#5	100.247	16.528

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

Breast cancer was ranked as the highest-priority cancer type, followed by **colorectal cancer** and **lung cancer**. By contrast, **prostate cancer** and **urinary bladder cancer** occupied the lowest positions in the ranking established by participants.

Cardiovascular diseases

Table 3: Prioritization of cardiovascular diseases according to the level of priority assigned by the participants.

Disease group	Position	DALY ES	DALY Cat
Ischemic heart disease	#1	717.273	118.256
Stroke	#2	540.503	89.112
Peripheral vascular disease	#3	32.787	5.406
Atrial fibrillation	#4	147.254	24.278
Valve diseases	#5	95.285	15.709

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

Ischaemic heart disease was identified as the highest-priority cardiovascular condition, followed by **stroke**. **Peripheral vascular disease** occupied an intermediate position, while **atrial fibrillation** and **valvular heart disease** ranked fourth and fifth, respectively.

Mental disorders

Table 4: Prioritization of mental disorders according to the level of priority assigned by the participants.

Disease group	Position	DALY ES	DALY Cat
Depression	#1	382.852	63.120
Anxiety	#2	475.313	78.364
Bipolar disorder	#3	70.326	11.595
Attention deficit hyperactivity disorder (ADHD)	#4	33.364	5.501
Autism Spectrum Disorder (ASD)*	#5	75.752	12.489

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

***** ASD obtained the same weighted score as ADHD. Once ADHD was assigned fourth place according to the tie-breaking criterion, ASD occupied fifth position.

Depression was identified as the highest-priority mental health condition. **Anxiety** and **bipolar disorder** followed, while **attention-deficit/hyperactivity disorder (ADHD)** and **autism spectrum disorder (ASD)** ranked fourth and fifth, respectively.

Musculoskeletal disorders

Table 5: Prioritization of musculoskeletal disorders according to the level of priority assigned by the participants.

Disease group	Position	DALY ES	DALY Cat
Rheumatoid arthritis	#1	28.591	4.714
Osteoarthritis	#2	236.580	39.005
Neck pain	#3	156.877	25.864
Low back pain	#4	562.684	92.769
Gout	#5	17.506	2.886

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

Rheumatoid arthritis was considered the musculoskeletal pathology with the highest priority, followed by **osteoarthritis**. In the intermediate positions are **neck pain** and **low back pain**, while **gout** occupies the fifth position in order of priority.

Neurological disorders

Table 6: Prioritization of neurological disorders according to the level of priority assigned by the participants.

Disease group	Position	DALY ES	DALY Cat
Alzheimer's disease	#1	550.524	90.764
Parkinson's disease	#2	116.250	19.166
Multiple sclerosis	#3	22.156	3.653
Epilepsy	#4	49.543	8.168
Headache	#5	375.022	61.829

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

Alzheimer's disease was identified as the neurological disorder with the highest priority, followed by **Parkinson's disease**. In third place is **multiple sclerosis**, while **epilepsy** and **headache** occupy the fourth and fifth positions, respectively.

Order of priorities by disease

As a final prioritisation exercise, participants were asked to select a maximum of five diseases that, in their opinion, should receive the highest priority in terms of care and funding within the health system. Unlike the previous sections, this question included all the diseases listed in the questionnaire, allowing the identification of those perceived as the highest priorities, regardless of the disease group to which they belonged.

Table 7: Selection of the five diseases considered to be of highest priority by the participants.

	List of diseases	Score	The 5 most repeated diseases
1)	**Breast cancer**	**38**	**X**
2)	**Colon and rectal cancer**	**34**	**X**
3)	**Ischemic heart disease**	**33**	**X**
4)	**Lung cancer**	**30**	**X**
5)	**Stroke**	**19**	**X**
6)	Depression	17	
7)	Multiple sclerosis	10	
8)	Osteoarthritis	8	
9)	Autism Spectrum Disorder (ASD)	7	
10)	Anxiety	6	
11)	Prostate cancer	5	
12)	Rheumatoid arthritis	4	
13)	Bipolar disorder	4	
14)	Low back pain	3	
15)	Attention deficit hyperactivity disorder (ADHD)	2	
16)	Others	2	
17)	Urinary bladder cancer	1	
18)	Neck pain	1	
19)	Headache	0	
20)	Alzheimer's disease	0	
21)	Parkinson's disease	0	
22)	Valve diseases	0	
23)	Peripheral vascular disease	0	
24)	Epilepsy	0	
25)	Osteoarthritis	0	
26)	Gout	0	

Breast cancer was the most frequently selected disease, followed by **colorectal cancer**, **ischaemic heart disease**, **lung cancer** and **stroke**, which together make up the group of the five diseases most frequently prioritised by the participants.

Table 8: Comparison of the five highest-prioritised diseases and their burden of disease measured in DALYs.

Disease group	Position	DALY ES	DALY Cat
Breast cancer	#1	191.706	31.606
Colon and rectal cancer	#2	363.217	59.883
Ischaemic heart disease	#3	717.273	118.256
Lung cancer	#4	557.637	91.937
Stroke	#5	540.503	89.112

Abbreviations: Disability-Adjusted Life Year (DALY); Cat, Catalonia; ES, Spain.

The comparison between the five conditions most highly prioritised by participants and their burden of disease, expressed in terms of DALYs, highlights some differences between perceived prioritisation and the impact measured in terms of healthy life years lost. In particular, breast cancer stands out as the top-ranked condition in participants' prioritisation, despite having the lowest number of DALYs among the five selected conditions. Conversely, ischaemic heart disease, which has the highest disease burden within this group, ranks third in the prioritisation ranking.

Conclusions

The study has made it possible to obtain **a comprehensive overview of the health priorities perceived by the different agents of the Catalan health ecosystem**, providing an approach based on the participation of professionals, managers, representatives of entities and other actors linked to the health system. The results constitute a relevant source of information to understand which areas are considered priorities from the perspective of the different groups involved.

The results show a high degree of consensus in considering **cancer** as the main group of diseases to which more efforts and resources should be dedicated. This prioritization is consistently observed across the different sections of the questionnaire, including the open answers, ranking exercises and the final selection of the five highest-priority diseases. Within this group, breast cancer, colorectal cancer and lung cancer emerge as the highest-priority conditions.

Cardiovascular diseases are the second major priority identified by the participants. In particular, ischaemic heart disease and stroke stand out as cardiovascular pathologies that require greater attention, reinforcing the perception of their high clinical and care burden.

As for the other groups of diseases, participants place **mental disorders** in third position, especially depression and anxiety. Although these disorders are not among the five highest-priority diseases in the global ranking, the results highlight the recognition of the importance of mental health and the need to continue strengthening actions in this area.

In relation to **neurological** and **musculoskeletal** disorders, the participants establish a clear hierarchy between the different pathologies analysed. Alzheimer's disease and Parkinson's disease stand out within the group of neurological disorders, while rheumatoid arthritis and osteoarthritis are the musculoskeletal pathologies considered to be of the highest priority. These results suggest that perceived priority is influenced not only by disease prevalence but also by the impact on quality of life.

One of the most relevant aspects of the study is the **consistency observed** between the different questions in the questionnaire. Despite using different methodologies (open-ended questions, disease ranking and selection), the **main priorities identified remain stable** throughout the survey. This coherence supports the consistency of the findings and suggests the existence of a broad consensus among the participants regarding the main health financing needs.

Furthermore, the comparison between the five diseases most frequently selected by participants and their burden of disease, measured using DALYs, highlights relevant differences between perceived priorities and the impact measured in terms of healthy life years lost. In particular, breast cancer stands out as the highest-ranked condition in participants' prioritisation, despite having the lowest DALY burden among the five selected conditions. Conversely, ischaemic heart disease, which has the highest number of DALYs, ranks third in the prioritisation ranking.

These differences highlight that **the prioritisation of health needs does not necessarily reflect the magnitude of the burden of disease**. Other factors, such as public perception of diseases,

their impact on quality of life, healthcare needs and unmet needs, may also influence the priorities expressed by different stakeholders. In this regard, the incorporation of DALYs provides a complementary perspective that helps contextualise the survey findings and identify potential discrepancies between perceived priorities and the burden of disease.

Finally, this study highlights the value **of incorporating the perspective of the different agents of the health ecosystem in the processes of defining priorities**. The information collected complements other sources of evidence commonly used in health planning and can help guide decision-making, the definition of research priorities and the allocation of resources. Combining the priorities expressed by participants with objective indicators of disease burden, such as DALYs, provides a broader understanding of health needs and represents a useful approach to informing and strengthening healthcare planning and prioritisation processes. In this sense, the results obtained constitute a first step towards the consolidation of a periodic monitoring mechanism that allows the evolution of health priorities to be analysed and health policies to be adapted to the changing needs of the population and the health system.

Follow-up and next actions

The results obtained in this first edition constitute a valuable source of information on the health priorities perceived. The information collected provides an initial overview to the needs and preferences in terms of financing and prioritization of diseases, providing a complementary perspective that can contribute to strategic planning and decision-making processes in the health field.

Beyond the results presented in this report, the HiTT Foundation understands **this initiative as a project with a vocation for continuity**. The aim is to consolidate this consultation as a **periodic exercise** that monitoring the evolution of health priorities over time, identifying possible changes in the perceptions of the different agents and generating an increasingly solid evidence base.

In this sense, the Foundation's intention is to carry out this survey annually, progressively expanding the number of participants and promoting increasingly diverse representation of the different groups linked to the health system. This growth will allow us to obtain more consistent, representative and comparable results between editions, reinforcing the value of the study as a support tool for the definition of priorities, research planning and the orientation of health policies.

In the long term, this initiative aims to become a **benchmark observatory of health priorities**, providing **up-to-date information** based on the participation of the different agents of the health ecosystem, in order **to contribute to more informed and participatory decision-making aligned with the real needs of society.**