

Prioritization



Outline

- 1 Prioritizing a package of services
- 2 Prioritizing Health Systems reforms
- 3 Case study discussion (in country groups)
- 4 Political economy of reform

1. How to think about prioritizing a package of services

- A. Defining a package of services
- B. Review of EML or procurement decisions
- C. Addressing known cost drivers

Opportunity costs

- Spending in one area prevents spending in another
- Opportunity costs: health gains that could have been gained (or lost) from spending on an alternative intervention
- Particularly important in LMICs (high budget constraints mean high opportunity costs)
- Not making decisions at the margin!



A small example

Designing a HBP

Interventions
directed to MSM

Cervical cancer first
line treatment

A small example

Designing a HBP

Interventions
directed to MSM

\$6/DALY averted

25,591 DALYs averted

Cervical cancer first
line treatment

\$161,625/DALY averted

1 DALY averted

Getting practical

Countries have different health systems, constraints, financial capacity

Normative guidance can take you only so far

- Trastuzumab recommended by WHO for treatment of breast cancer & considered for inclusion in EML model, but modelling/review work showed it is not cost-effective in SSA (Gershon et al., 2019)
- WHO Focused Antenatal Care policy (FANC) – not implementable in Malawi (Mchenga et al., 2019) and increase in number of visits does not improve outcomes if care is poor (Benova et al., 2019).

A. Defining a package of services

- List of prioritized services financed through public pooled sources
 - Excluding direct payments
- Priorities revealed by actions and spending choices

Implicit Priority-Setting

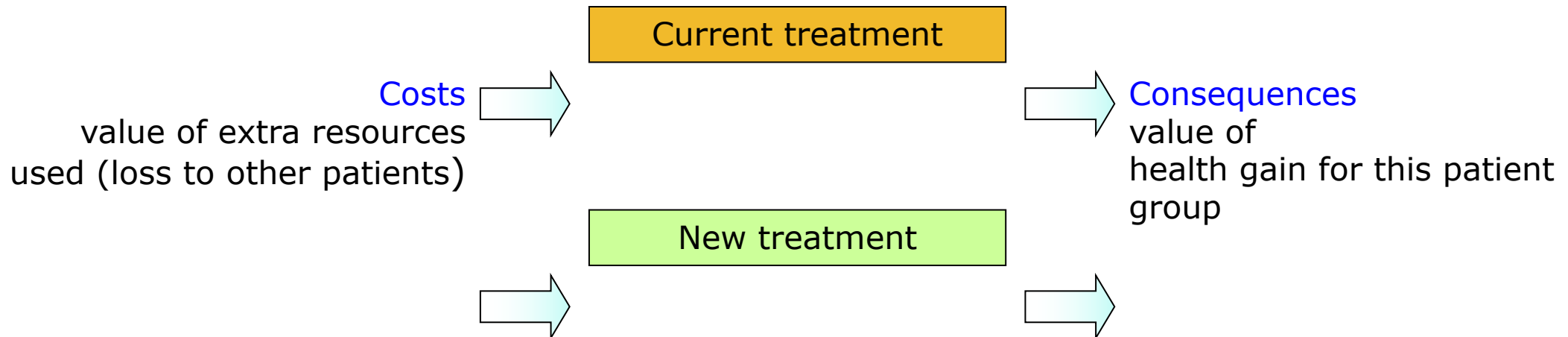
- Leads to rationing of services
- Leads to essential life-saving services not delivered

Explicit Priority-Setting

- Uses informed, transparent processes
- Openly links services to resource envelope

Using economic evaluation

Economic evaluation is the **comparative analysis** of alternative courses of action in terms of both their **costs and consequences**.



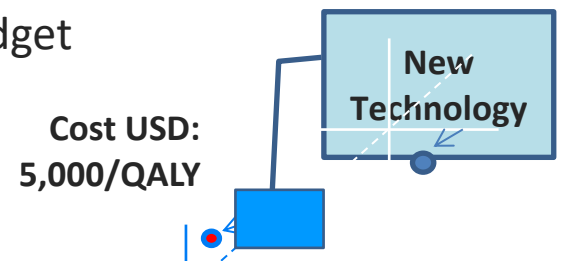
Analysis should be conducted separately for each subgroup of patients.

League table approach

Intervention	Cost-effectiveness US \$ of 2012/DALY
Blood pressure management, UMIC	Cost-saving
Polypill for high absolute risk CVD, UMIC	Cost-saving
ACE inhibitor vs no medication, heart failure, with access to treatment	Cost-saving
Give female condom to sex workers, South Africa	Cost-saving
Preventive chemotherapy for onchocerciasis	9
Treat severe malaria with artesunate vs quinine	5
Salt reduction policy in food	Cost-saving to 45
Voluntary male circumcision	10
Add syphilis screen to HIV screen/treat, LIC	9
Emergency obstetric care	15
Pre-hospital ECG vs none, MIC	16
Screen/treat syphilis, LIC	17

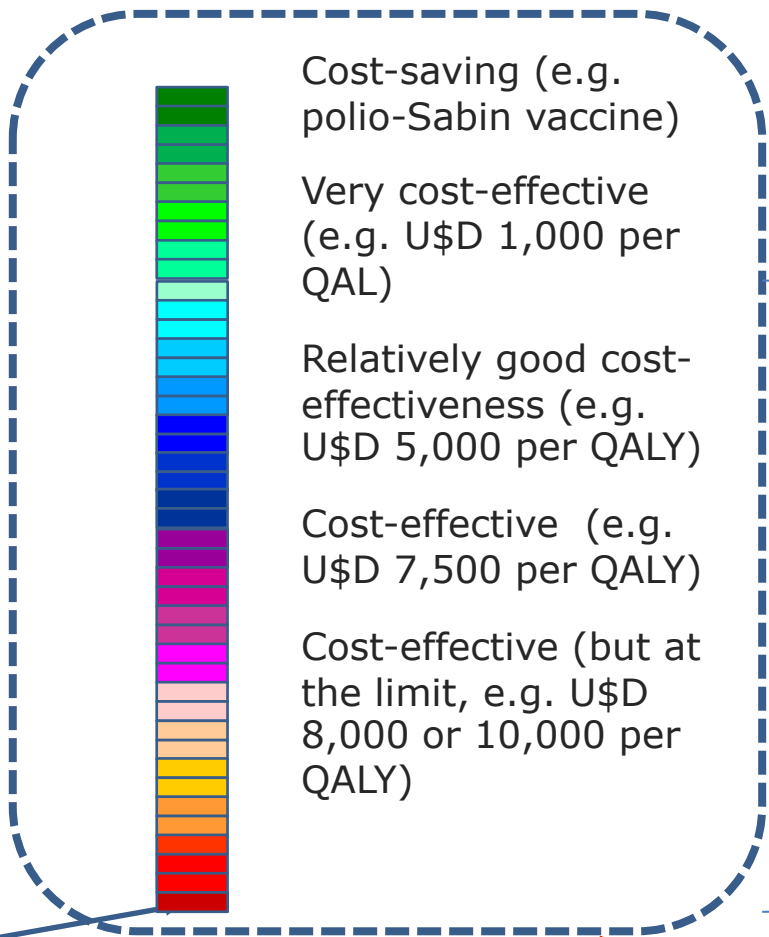
Intervention	Cost-effectiveness US \$ of 2012/DALY
Detect and treat human African trypanosomiasis	22–83
Treatment smear positive TB with first-line drugs, LIC	6–49
Cataract surgery	6–70
Detect and treat visceral leishmaniasis	18
Treat malaria with ACT, Africa	18–34
EMTCT Option B HIV versus no treatment, Africa	26
ACE inhibitor versus no medication, heart failure, no access to treatment	28
Cleft lip and palate repair	9–108
Hernia repair	11–101
Intermittent preventive treatment malaria in infants, Africa	4–422
Preventive chemotherapy for trachoma	22–83
Intermittent preventive treatment malaria in pregnancy, Africa	4–591

This limit is imposed by the constrained health care budget



New health technology with a cost-effectiveness ratio of U\$D 25,000/QALY

Technologies that will be displaced offered less “value for money”. The benefit gain from the new treatment is greater than the benefit foregone



Is the benefit gain from the new treatment greater than the benefit foregone through displacement?
No. Displaced technologies offered better “value for money” (the healthcare system loses “health” and efficiency)

HBP of an imaginary country where the Ministry of Health (many years ago) defined a cost-effectiveness threshold of U\$D 10,000 per QALY in order to consider a technology as cost-effective and allow its incorporation into the benefit plan.

B. Review of EML or procurement decisions



Rapid review of spending decisions for drugs and commodities, identification of outliers or quick wins



Drugs and commodities make up for a large share of healthcare spending in all countries



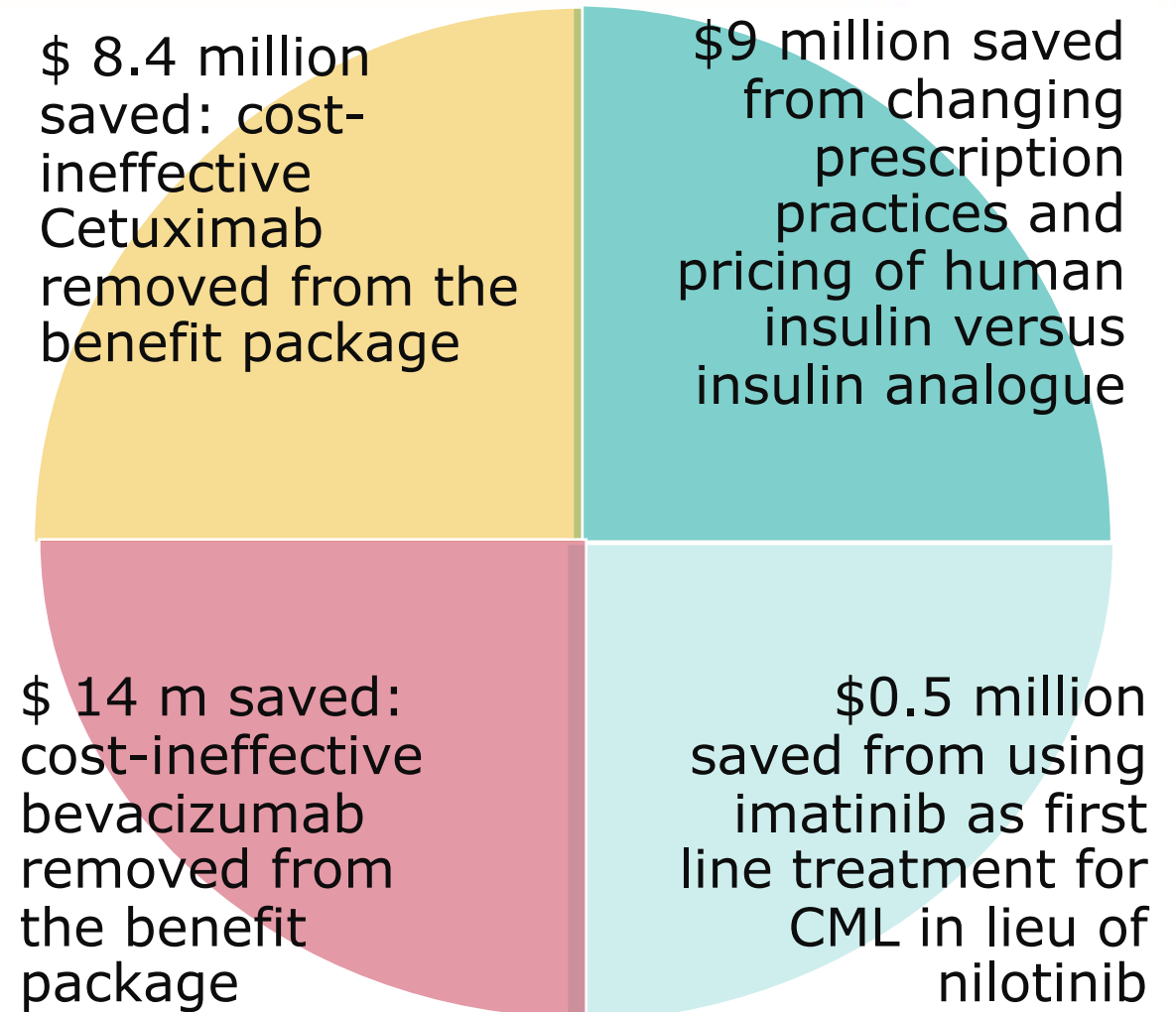
Recent review of procurement: spending on drugs in a couple of countries amounted to \$50 billion yearly, one of the fastest growing expenditure category in many countries (Turkey, Egypt, Pakistan)

Cost-savings in the world's largest UHC scheme

\$31m health budget could be saved annually if the government implements the HTA Committee recommendations, produced with iDSI assistance

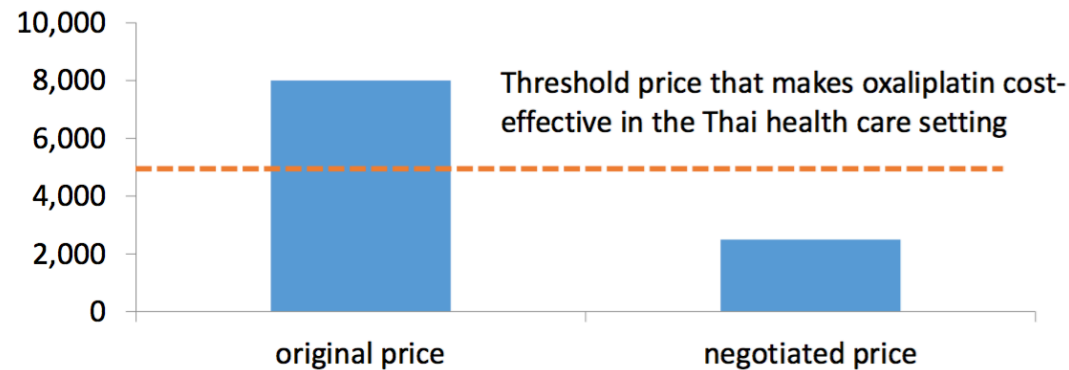
In Oct 2018, Indonesia's social health insurer decided to remove cetuximab and bevacizumab (source: Sida/iDSI/CHAI Health Financing meeting at the HSR 2018 Conference, Liverpool)

\$31m reinvested into the health system could avert over 44,787 DALYs in the Indonesian population



Smarter procurement: price negotiation

Threshold analysis for price of oxaliplatin



Use of HITA information in price negotiation

Medicine	Original price (THB)	Reduced price (THB)	Potential saving (THB per year)
Tenofovir	43	12	375 million
Pegylate interferon alpha-2a (180 mcg)	9,241	3,150	600 million
Oxaliplatin (injection 50 mg/25 ml)	8,000	2,500	152 million



Journal of Evidence, Training and Quality in Health Care

Volume 108, Issue 7, 2014, pages 397-404

What is the contribution of health-related evaluations to decision-making in healthcare? Experiences from 7 selected countries



main emphasis

The use of economic evaluation for the pharmaceutical industry in Thailand

Cost-benefit assessments as an instrument for establishing the list of medicines to be reimbursed in Thailand

Yot Teerawattananon ¹, Nattha tritasavitol ¹, Netnapis Suchonwanich ², Pritaporn Kingkaew ¹

With in 5 years implementation
Saving 768.01 million USD

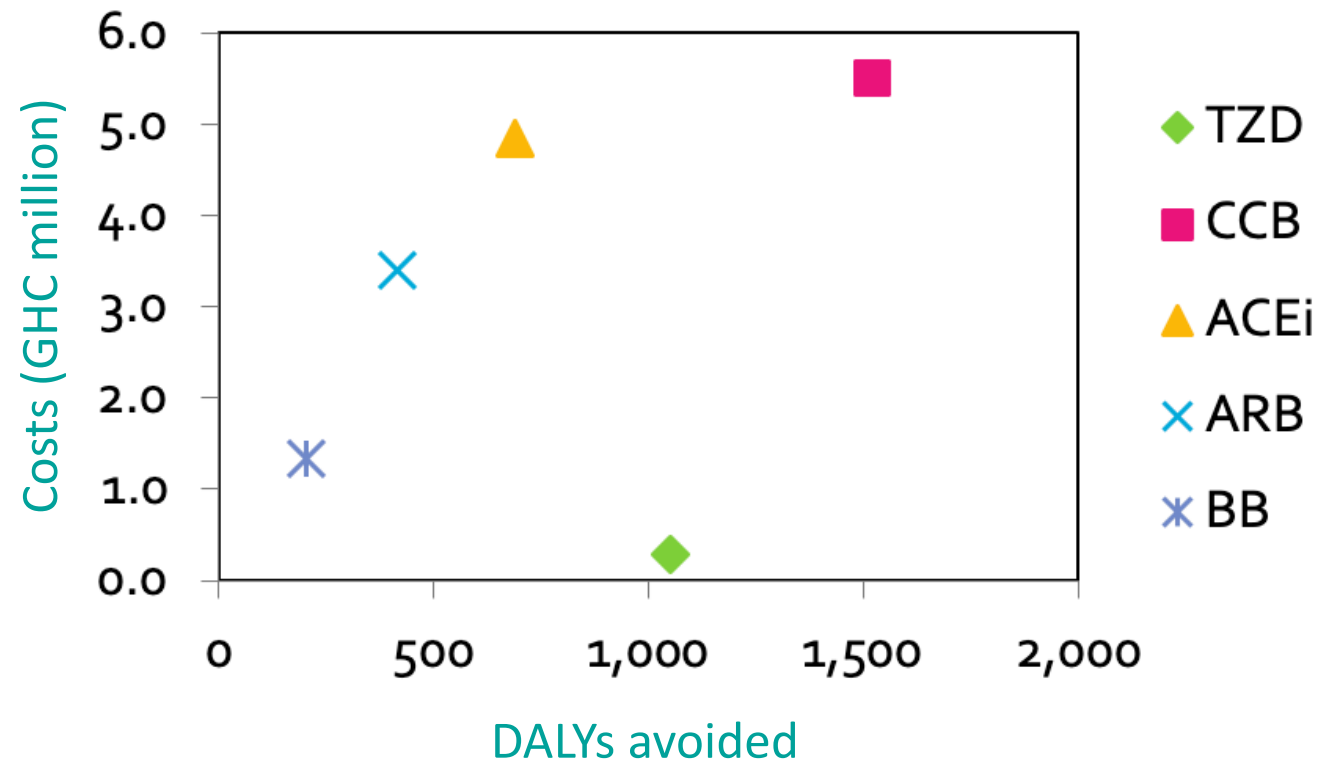
C. Addressing known cost-drivers

Situation analysis might help identify areas of inefficiencies or cost drivers in your country.

Ghana example:

- CVD: morbidity, mortality, prevention and treatment costs
- Even a small shift in prescribing could save 18% of the antihypertensive expenditure

Costs & DALYs per 1,000 people treated compared with no intervention
Mean discounted over lifetime horizon



Beyond the technical...

Analytics and evidence is only part of the picture.

Consider:

- Feasibility in your local health care system
- Social acceptability
- Political economy pressures



2. Prioritizing Health Systems Reforms

Possible
Reforms



Impact



Technical



Affordability



Innovations



Political



Possible reforms

Possible
Reforms

Impact

Technical

Affordability

Innovations

Political

- Decentralization of hiring of staff
- Effectively exempting the poor from user fees
- Improving referral and transportation system
- Increasing operational budget at the facility/decentralized level



Possible Reforms

What is the likely impact?

Possible
Reforms

Impact

Technical

Affordability

Innovations

Political

- Health impact can be modeled (under certain –often strong!- assumptions)
- Also consider the cost savings (cfr. Indonesia, Ghana examples). Money can be used elsewhere.



Likely Impact

What are examples of modeling tools that can help with prioritization?

Possible Reforms

Impact

Technical

Affordability

Innovations

Political

Tool	Developers	Purpose	Strengths	Limitations
Lives Saved Tool (LiST)	Johns Hopkins, Avenir Health	Models health impact (i.e. deaths averted) of changes in MNCH+N intervention coverage	<ul style="list-style-type: none"> Integrated RMCH+N impact estimation tool Can be standalone or built into other more complex models 	<ul style="list-style-type: none"> Limited to RMNCH+N interventions No cost-effectiveness/efficiency analysis No health systems modeling
OneHealth Tool (OHT)	Avenir Health, overseen by UN IAWG/WHO	Comprehensive model estimating cost and impact of health interventions and health system strengthening programs. Incorporates existing tools: MBB, LiST, FamPlan, AIM/GOALS/Reource Needs Model, WHO Stop TB, etc.	<ul style="list-style-type: none"> Good for costing and modeling impact of sector-wide health strategies, with links between health interventions and health systems investments 	<ul style="list-style-type: none"> Less useful for single program/issue
EQUIST 2.0	UNICEF	Analyzes bottlenecks for RMNH interventions, identifies strategies to overcome bottlenecks, and develops scenarios and cost-comparisons. Best for comparing costs of alternative strategies added into existing health systems.	<ul style="list-style-type: none"> Explicit equity focus Integrates cost and impact 	<ul style="list-style-type: none"> Not intended for costing entire health programs

Important considerations when using tools

Possible Reforms

Impact

Technical

Affordability

Innovations

Political

- Sustainability
 - Developer – documentation, updating over time, etc.
 - User (government) – training, ownership and institutionalization
- Transparency of underlying assumptions
- Data quality and availability
- Tool = Panacea...?



Likely Impact

Can you technically implement?

Possible Reforms

Impact

Technical

Affordability

Innovations

Political

- Results Based Financing: link payments to results (quantity and quality) at the facility level to help make the user fee removal scheme effective
- Impact sometimes limited because
 - payment delays
 - too many facilities to manage/verify
 - little capacity of central level to manage payments
 - little capacity at the decentralized level to manage funds
 - payment function too complex for providers to understand link between payment and results



Technical Feasibility

Is it affordable at the scale required to achieve impact?

Possible Reforms

Impact

Technical

Affordability

Innovations

Political

- Cost-effective ≠ affordable !
- Investment + operational cost
 - Buildings require staff and operational budget
 - Additional HR remains on the payroll for a very long time and reduces flexibility in budget
- Can externally financed programs (e.g. incentive payments for CHWs) be taken over by the government?



Affordability

Are there innovations/alternatives that are cheaper/easier?

Possible Reforms

Impact

Technical

Affordability

Innovations

Political

- E-health platforms for specialist consultations (vs trying to decentralize specialists)
- E-procure system to facilitate large tenders with pharmaceutical companies (vs having every facility/district procure drugs)
- Maternity waiting homes (vs trying to provide emergency transportation) or using community taxis rather than investing in more ambulances



Innovations/Alternatives

Is it politically feasible?

Possible
Reforms

Impact

Technical

Affordability

Innovations

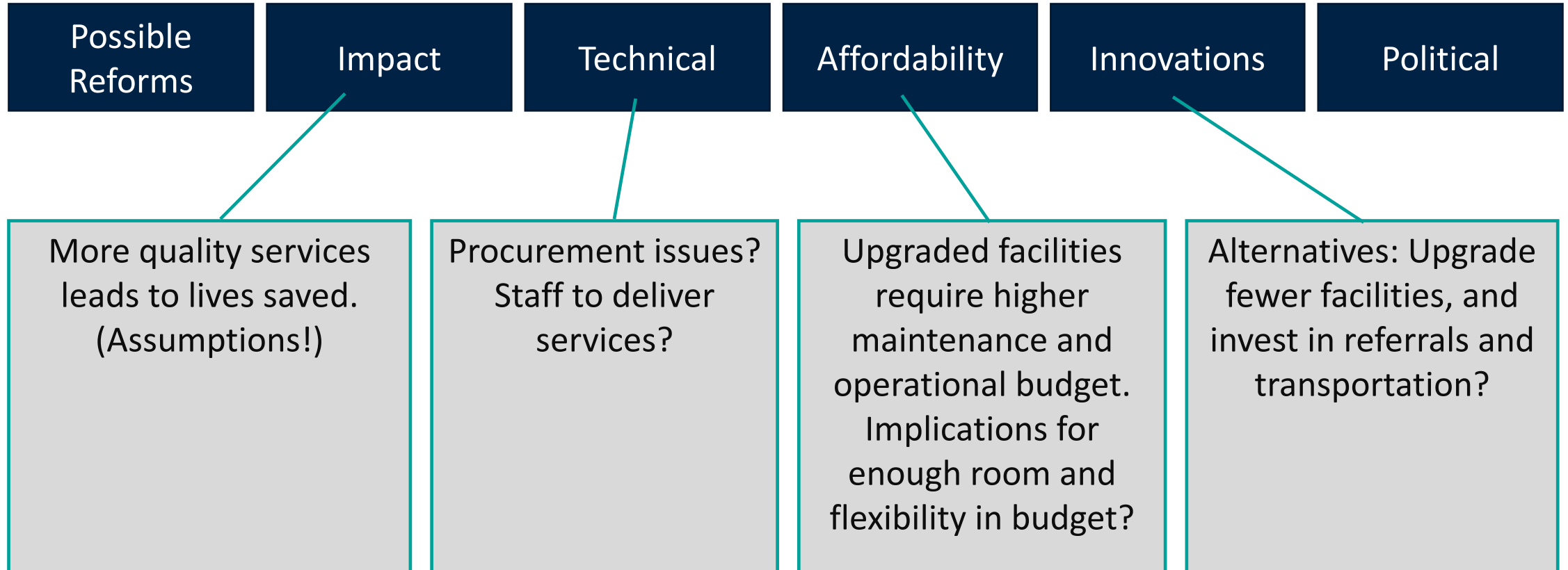
Political

- Is there someone willing to champion the reform?
- What is political cycle? Does this win votes?
- Is there likely push back from specific interest groups?

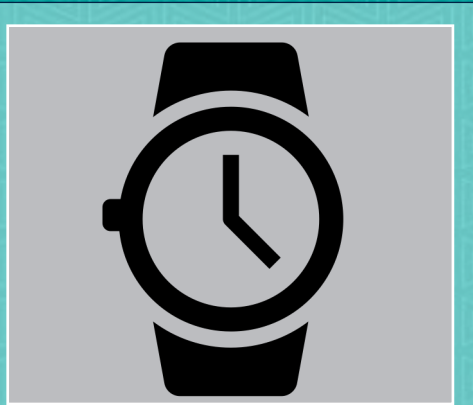


Political Feasibility

Example: upgrade the number of facilities



Case Study Activity



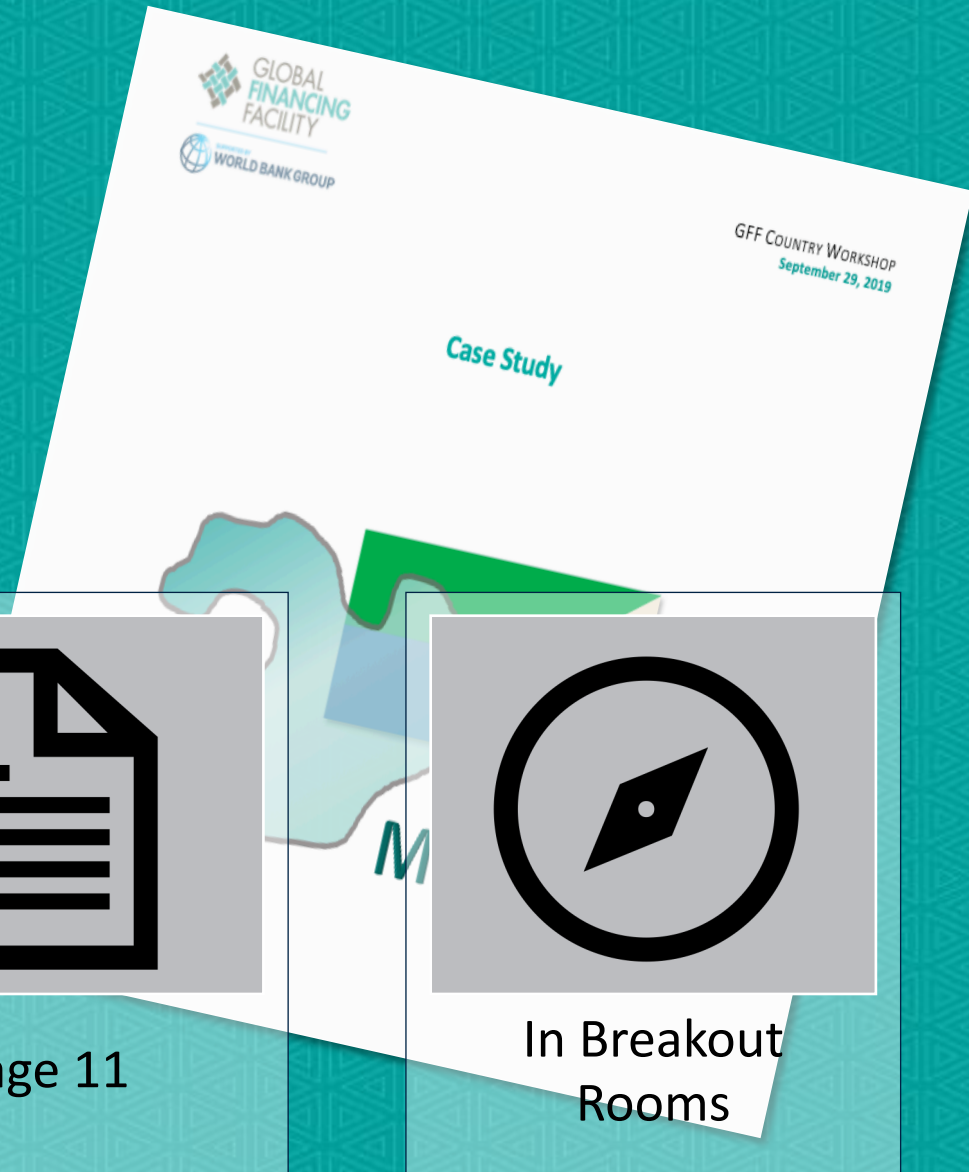
45 minutes



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In Breakout
Rooms



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