Global Experiences in Priority Setting for Primary Care

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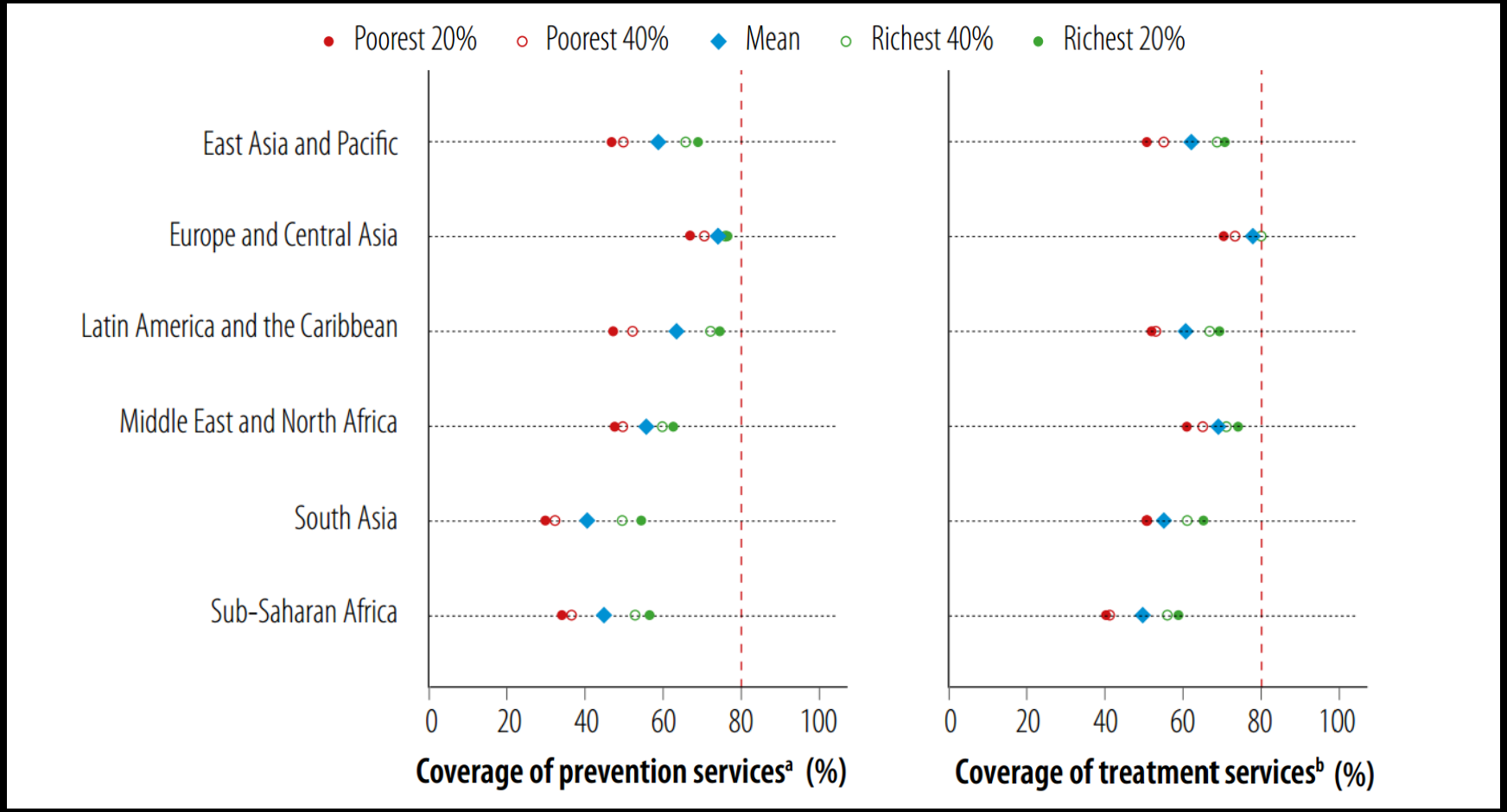
Current coverage of 13 essential services falls short in all regions

Coverage of Prevention and Treatment Services by Region, 2002-2003

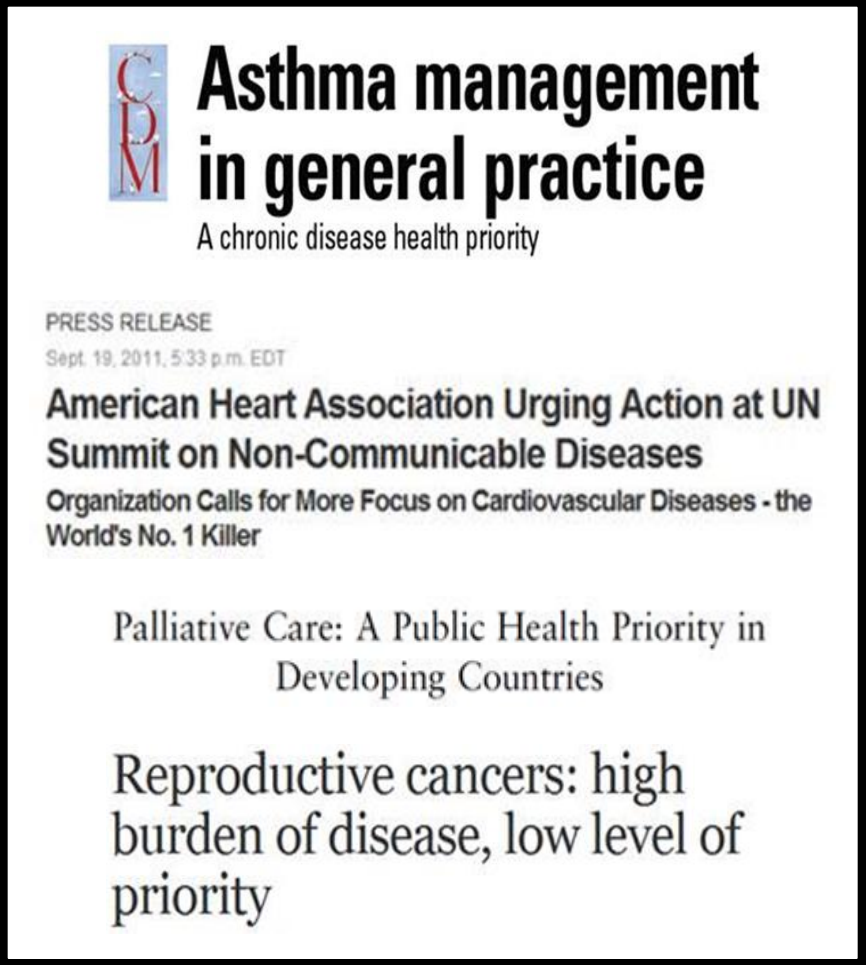


Notes: **a)** Prevention services: mammogram; Pap smear; antenatal care (more than four visits); measles vaccination; improved water source; adequate sanitation; and non-use of tobacco; **b)** Treatment services: skilled birth attendance; antiretroviral treatment; tuberculosis treatment; diabetes treatment; dental care; and eye surgery

Source: WHO & World Bank, "Monitoring progress towards UHC at country and global levels," 2014

Increasing demands and ‘priorities’, with numerous initiatives and actions

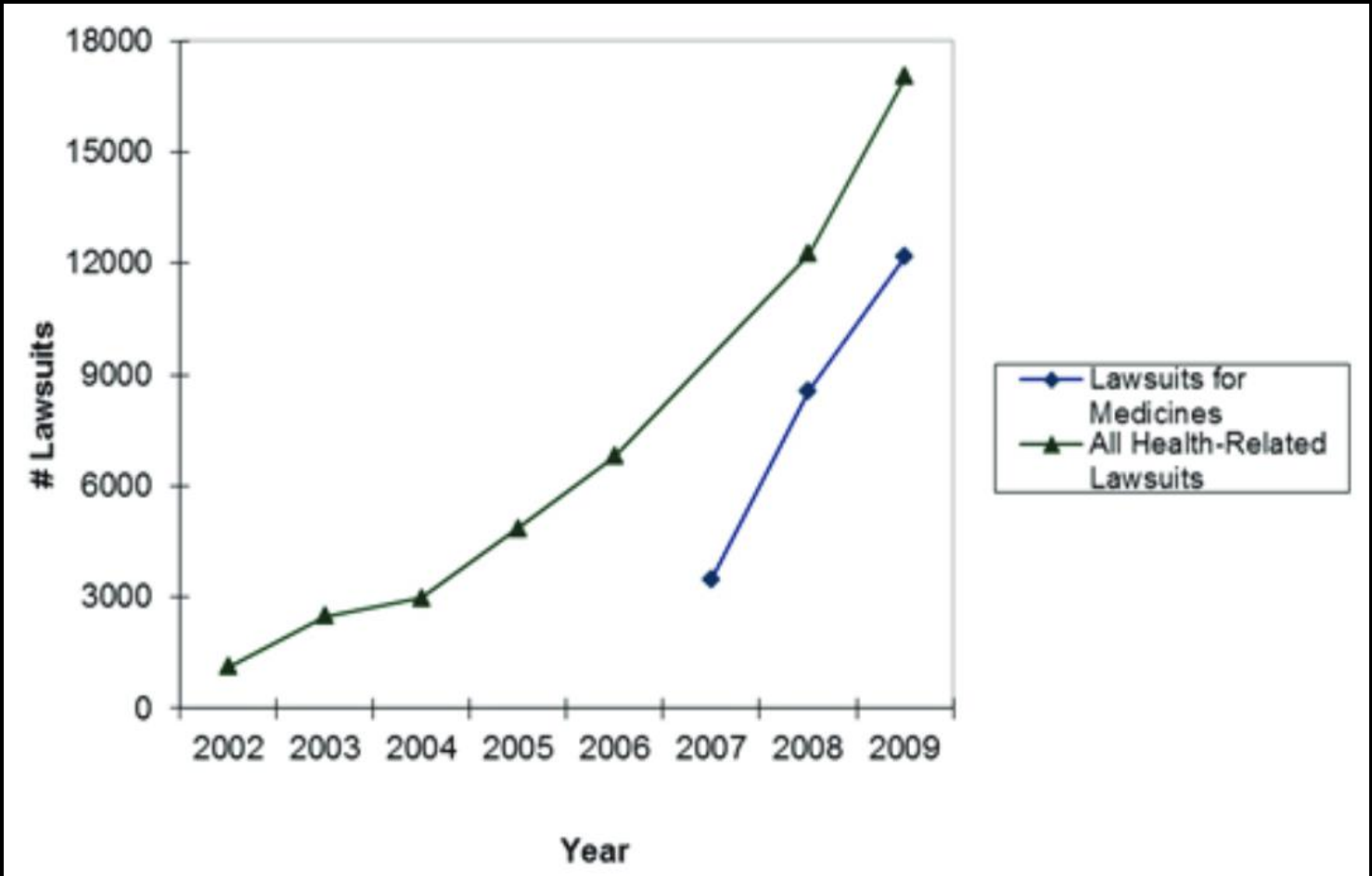
Many ‘priorities’…



…and even more initiatives

Exponential growth in right-to-health legal cases – with bankrupting potential

Rio Grande Do Sul, Brazil



João Biehl, Joseph J. Amon, Mariana P. Socal, Adriana Petryna.“ Between the court and the clinic: Lawsuits for medicines and the right to health in Brazil.” Health and Human Rights, 2012, 14(1)

How can countries develop priority setting capabilities and institutions?

Increasing Demand

- Health spending increasing and countries moving towards universal health coverage
- New, expensive technologies increasingly available
- Increasing use of legal court decisions, sometimes with bankrupting consequences

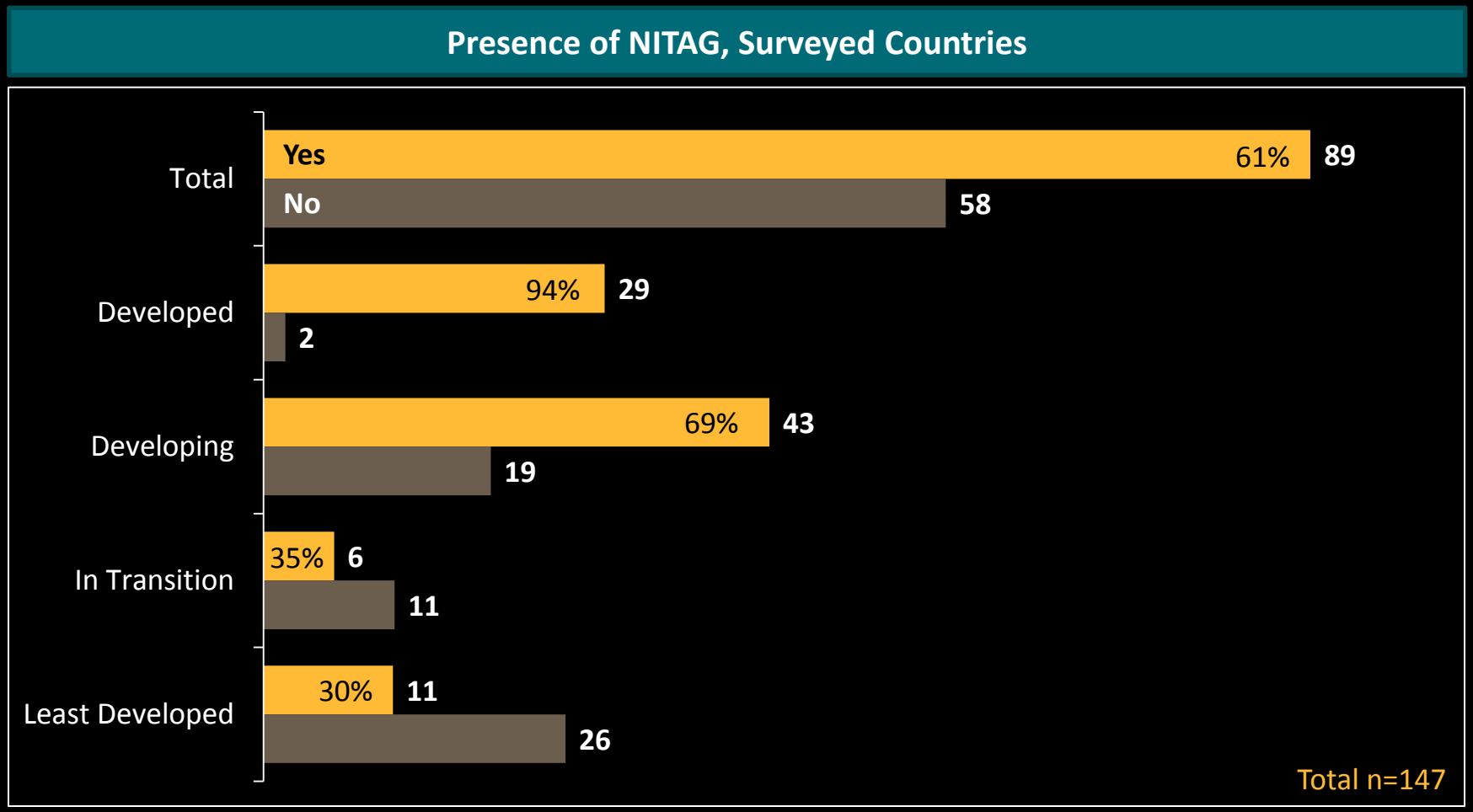
Limited Supply

- Few agencies available to provide such support for priority setting
- Often seen as one-off exercises, despite widely varying contexts and costs
- Capacity not well coordinated to tap economies of scale

Designing a benefit package is one of several policy instruments for priority setting

Strengths	Method	Weaknesses
• Allows policy-makers and immunization program managers to make evidence-based decisions	**NITAG: National Immunization Technical Advisory Group**	• Absence of outcome indicators matched to policy-making processes • Does not consider budget impact • Limited to vaccines/immunizations
• WHO Model List is frequently updated • Relatively easy to set up, given WHO Model List (150+ countries have an EML)	**EML: Essential Medicines List**	• Generally non-binding to clinicians • Process is too often ad hoc • Does not guarantee availability of medicines listed • Does not consider budget impact • Minimal dedicated staff at WHO (2 people)
• Provide guidelines to providers on best practices based on evidence	**CG: Clinical Guidelines / Do-not-do Lists**	• Generally non-binding to clinicians
• Provides a systematic appraisal of the properties, effects, or impacts of health 'technology' • Involvement of a wide range of professionals (policy-makers, care providers, academics, citizens, etc.) • Can be used successfully to inform public reimbursement/coverage	**Health Technology Assessment Agencies**	• Can be a resource consuming undertaking • Limited, but increasing, international guidance and experience • Process is too often ad hoc
• Could incorporate cost-effectiveness into funding decisions • Can be a mechanism to reform budgeting and align funding with priority technologies and populations • Explicit plans and lists reduces costs	**Health Benefits Plans**	• Process is too often ad hoc • Limited international guidance • Instances of known c/e interventions not funded at scale, while examples of not c/e interventions receiving subsidy • Incremental and baseline costs of new interventions not known

NITAG: Developed countries more likely to have one



Source: Bryson, et al., "A global look at national Immunization Technical Advisory Groups," Vaccine, 2010

NITAG: Many countries make NITAG information readily available online

Countries with NITAG information on Resource Center dashboard

Source: NITAG Resource Center (http://bit.ly/1kMLVi1), 2014

NITAG: The NITAGS of many countries in the Americas meet multiple times per year

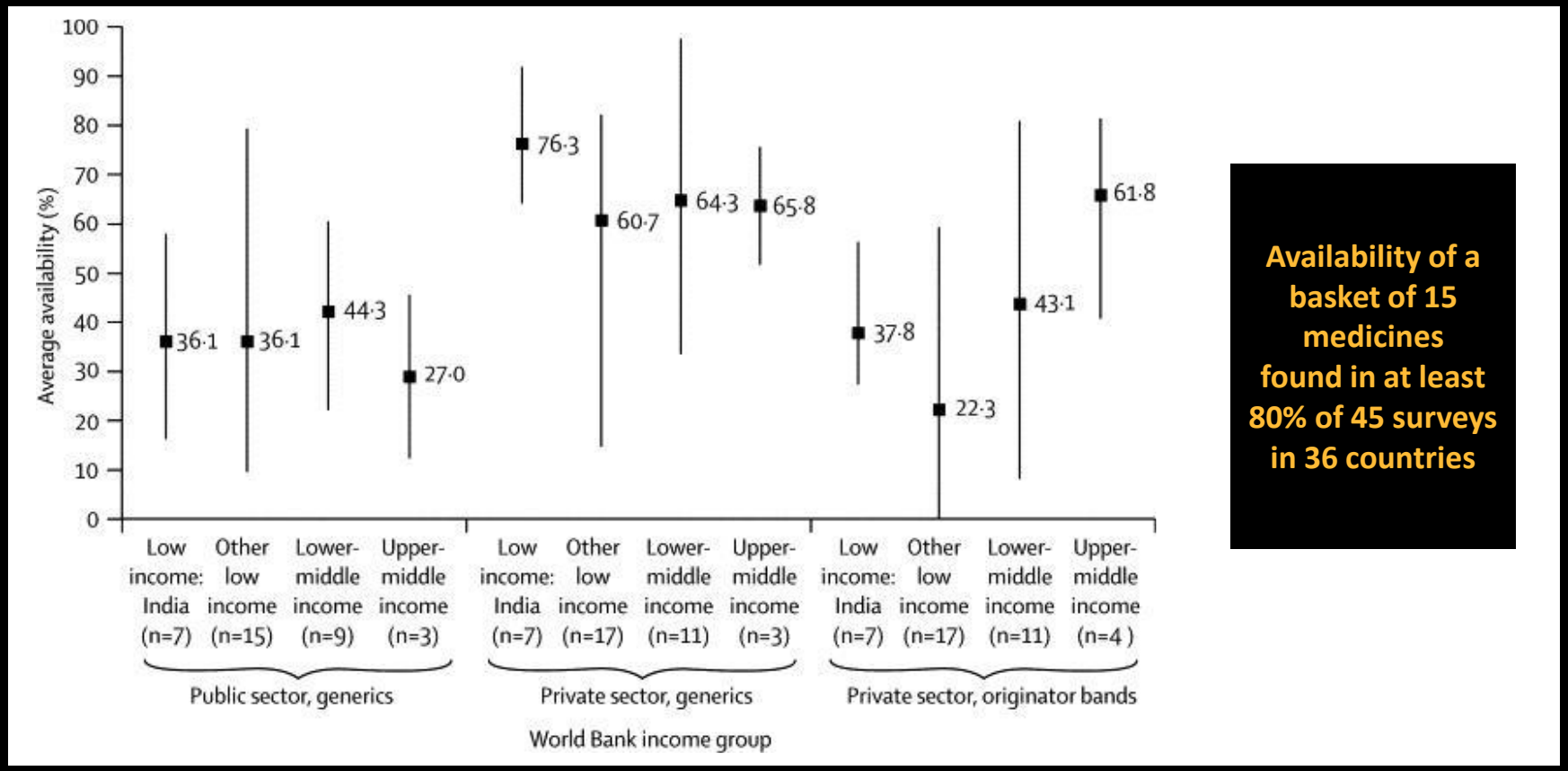
Number of NITAG meetings by country – PAHO Countries (2012)

Country	Number of NITAG Meetings
Panama	18
Peru	12
Mexico	6
Chile	6
Honduras	5
El Salvador	4
Cuba	4
Argentina	4
Colombia	3
Uruguay	3
Brazil	2

Source: PAHO, Immunization in the Americas—2013 Summary (http://bit.ly/1isVnEp), 2014

EML: Most countries have an EML, but essential medicines are often unavailable in public facilities

Average of Country-level Mean Availability of Medicines, %



Availability of a basket of 15 medicines found in at least 80% of 45 surveys in 36 countries

EMLs are widespread: Over 80% (117/139) of LMICs have a reference to an EML on the WHO website

Source: Cameron, et al., "Medicine prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis," The Lancet, 2009

HTA Agencies have been established in a number of countries in recent years.

Source: Glassman & Chalkidou, "Priority-Setting in Health: Building institutions for smarter public spending," a report of the Center for Global Development's Priority-Setting Institutions for Global Health Working Group, 2012

HTA agencies are sometimes unconnected with policies, and selected topics are ad hoc

HTA in selected middle-income countries: How and why topics are selected

Country/Entity	Prioritization process for topic selection
Brazil/ANVISA/CITEC	• No formal process • The definition of priorities has been made through an Annual Workshop on Priorities
Chile/CCA	• No formal process. Topic selection is carried out by the CCA
Colombia/CRES	• No preestablished process for topic selection • In 2011 for the first time a more systematic process was used, but this has not been institutionalized Colombian Law
Uruguay/FNR/MoH	• There is no formal process for topic selection • Both the MoH and the FNR define the topics
Thailand/HITAP	• Representatives of four groups of stakeholders (health professionals, academics, patient groups, and civil society organizations) are appointed to sit on a panel overseeing intervention prioritization • Panel introduces six agreed criteria • A scoring approach with well-defined parameters and thresholds was employed to address each criterion

Source: Glassman & Chalkidou, "Priority-Setting in Health: Building institutions for smarter public spending," a report of the Center for Global Development's Priority-Setting Institutions for Global Health Working Group, 2012

Health Benefits Plans: A Closer Look

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This limit is imposed by the constrained health care budget

Cost-saving (e.g. polio-sabin vaccination)

Very cost-effective (e.g. U$D 1,000 per QAL)

Relatively good cost-effectiveness (e.g. U$D 5,000 per QALY)

Cost-effective (e.g. U$D 7,500 per QALY)

Cost-effective (but at the limit, e.g. U$D 8,000 or 10,000 per QALY)

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

Health benefit plan (basket of services) 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.

New Technology

Cost USD: 5,000/QALY

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

Source: Andrés Pichon-Riviere , 2013. La aplicación de la evaluación de Tecnologías de Salud y las evaluaciones económicas en la definición de los Planes de Beneficios en Latinoamérica

Many LMICs have explicit health benefits plans in different settings

Low- and Middle-Income Countries with Health Benefit Plans

World Bank developing country group	Countries
Central and Eastern Europe	**Health insurance schemes:** Azerbaijan, Bulgaria, Croatia, Estonia, Georgia, Hungary, Kyrgyz Republic, Lithuania, Macedonia, Moldova, Poland, Romania, Russian Federation, and Slovenia **Tax-funded systems**: Armenia, Kazakhstan, Slovak Republic, and Tajikistan
Latin America and Caribbean	**Health insurance schemes:** Argentina, Chile, Colombia, Dominican Republic, Nicaragua and Uruguay **Tax-funded systems:** Argentina, Bolivia, Brazil, Honduras,Nicaragua, Peru
Asia	**Health insurance schemes:** Lao PDR, Philippines, and Vietnam **Tax-funded systems:** Cambodia, China, India, Malaysia, and Thailand
Middle East and North Africa	**Health insurance schemes:** Egypt, Israel, Lebanon, Malta, Syria, Tunisia, United Arab Emirates, West Bank and Gaza, and Yemen **Tax-funded systems:** Bahrain, Djibouti, Jordan, Morocco, Oman, Qatar, and Saudi Arabia
Sub-Saharan Africa	**Health insurance schemes**: Ghana, Kenya, Namibia, Nigeria, Senegal, South Africa, Tanzania, and Uganda **Tax-funded systems:** Uganda and Zambia

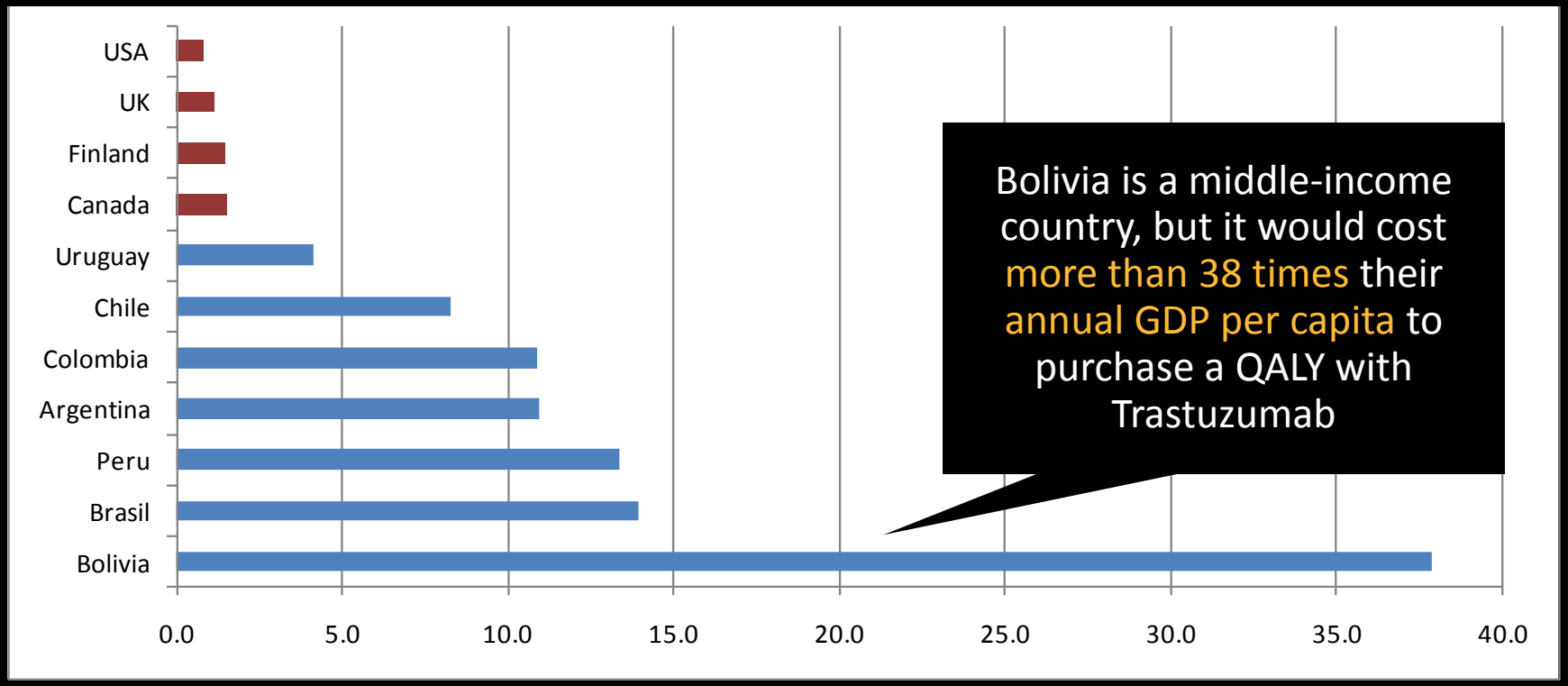
Source: Glassman & Chalkidou, "Priority-Setting in Health: Building institutions for smarter public spending," a report of the Center for Global Development's Priority-Setting Institutions for Global Health Working Group, 2012

Many issues related to explicit plans and lists

- Plans with limited connection to budgets and beneficiaries
- Known cost-effective interventions not funded at scale, yet not cost-effective interventions receiving subsidy
- International guidance limited, mostly cost-effective information from other contexts, lack of attention to affordability
- Limited comparability between existing cost-effective studies
- Incremental costs of introduction of new interventions and technologies not known, baseline costs and effectiveness not known
- Decentralized, fragmented purchasing means unexplained variations in the standard and costs of care
- Procedural fairness problematic (Culyer & Lomas 2006)

Whereas efficacy is global, cost-effectiveness and affordability (and preferences/values) are local

Cost-utility of Trastuzumab expressed as number of GDP per QALY



Source: Andrés Pichon-Riviere , 2013. La aplicación de la evaluación de Tecnologías de Salud y las evaluaciones económicas en la definición de los Planes de Beneficios en Latinoamérica

Recommendations

- Better, more transparent data, methods and processes urgently needed
  - Compliance with better practices in economic evaluation
  - Adding, modifying or eliminating technologies or benefits necessarily means adjusting budgets and payments
  - Process that is defensible in courts, and assures that people only get care that works to improve health
  - Assuring fiscal sustainability

- Link priority-setting instruments –whether EML, HBP or HTA- to incentives for effectiveness in their delivery (the cornerstone)
  - Systems have limited focus on outcomes of care, few incentives to make connections

THANK YOU!

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- MORE RESOURCES:
  - Priority-setting in health: building institutions for smarter public spending
    - http://www.cgdev.org/publication/priority-setting-health-building-institutions-smarter-public-spending
  - International Decision Support Initiative @ NICE International
    - http://idsihealth.wordpress.com/