international Decision Support Initiative: Bellagio and beyond

A narrative summary

Prepared by NICE International

What would the world look like if the international Decision Support Initiative, iDSI, were successful? This was the core issue we explored at an event at the Rockefeller Bellagio Center in Italy on 10-12 September 2014. The event brought together 25 like-minded individuals from various organisations across the globe, ranging global health funders and development agencies, practitioners of priority-setting, as well as universities and consultancies with an important stake in global health. We share a common vision: if iDSI were successful, we would see **countries making the right choices for better health**. Our mission is thus **guiding decision makers to effective and efficient resource allocation strategies for improving people's health**.

In the following narrative summary, we provide an account of the substantive discussions that took place, highlight some of the important actions, as well as some of the work we've done and progress made since September that bring us closer to our vision. Presentations from the event and background material are available on here.

This work received funding support from Bill & Melinda Gates Foundation (BMGF), the Department for International Development (DFID, UK), and the Rockefeller Foundation.

What would success look like for iDSI?

What would our vision mean, in practical terms, say in 5, 10 , 20 years? How would we achieve our mission? How would we measure to what extent we have been successful? And how would we narrate our story to others?

> ***"What is the counterfactual? For example, is it bad if a country has no HTA agency? This message is not coming through."***

Better decisions for better health

By the end of the three days of intense discussion at Bellagio, and numerous unreadable slide schematics, it became painfully obvious that iDSI needed to articulate a simple yet meaningful theory of change that could encapsulate its new tagline: **"better decisions for better health"**.

> ***"Let's measure all of the value added by the network, the process, and the decisions. This is the value change."***

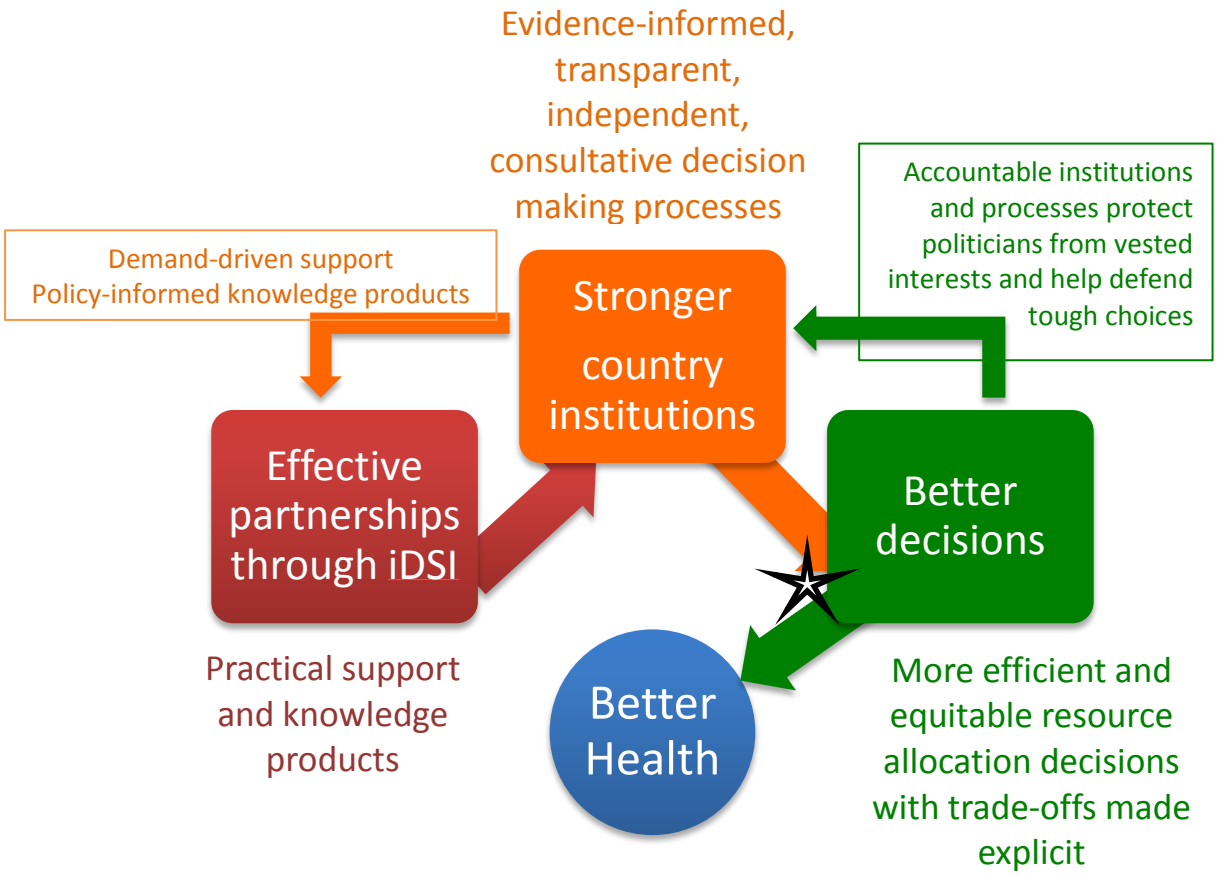
It's important to have one unified M&E framework that is results-oriented with clearly expressed causal links; that expresses the value proposition of the iDSI network; and that stakeholders (including funders) buy into.

We wanted internal metrics around our network and partnerships. We wanted quantitative metrics – number of institutions generated, processes adopted, decisions made; metrics around capacity-strengthening; and sustainability of our impact. We also wanted qualitative narratives, for example describing the changes to the processes and institutions. Ultimately, we would like to measure (*ex ante* and *ex post*) coverage of healthcare services, lives saved, QALYs gained / DALYs averted, as well narrative descriptions of health consequences for individual, as a result of bad policy decisions.

It was clear that any off-the-shelf M&E would not suffice for the unique proposition of iDSI. Thus taking the collective insights from Bellagio, we developed our own iDSI theory of change.

The iDSI theory of change

From now on, this simple framework will underpin and inform all discussions and activities in iDSI, from making strategic decisions about whom we engage with and how, through reporting to funders and generating 'ammunition' to communicate our impact to wider stakeholders. A slide deck outlining the framework can be found here.



While we acknowledge that there is a complex translation process between "better decisions" and "better health" dependent on many assumptions about local factors and systems (including linkage between decisions and budgets, delivery, implementation, and data accuracy), we can and should also be explicit about our ambitions, of what we could realistically achieve through helping countries strengthen their institutions for better decision-making.

We have begun to develop an M&E framework, including a spreadsheet template and a set of indicators based on our theory of change. We anticipate that all iDSI partners could use this framework for documenting any iDSI activities and deliverables, retrospectively or prospectively, and evaluating their impact; we are currently completing the template using NI, HITAP and PRICELESS SA country engagements as a demonstration (see an example of the M&E activity log completed using existing NICE International engagements in India).

The following narrative report is structured around the three components of our theory of change: **Effective partnerships through iDSI**, **Stronger institutions**, and **Better decisions**.

Actions	Responsible parties	Status
Revise M&E framework; develop indicators; complete framework with existing examples from countries and projects; agree with donors on streamlined reporting	NICE International (lead)	Draft framework developed, and examples completed for India and Vietnam Ongoing discussions with BMGF, DFID and Rockefeller on streamlined reporting; and with partners (such as ITAD) on refinement and field testing of indicators

Effective partnerships through iDSI

Network and partnership: Our unique selling point

What is our comparative advantage? Why should a country or a funder come to us (iDSI) as opposed to hiring NICE International, HITAP, or individual universities or consultants?

> ***"We [funder] would like to see iDSI as the 'one stop shop' for priority-setting."***

iDSI is greater than the sum of its parts because the network adds value and bring capacity and sustainability to HITAP and NICE International's practical support offering. We need academic institutions (such as York, Imperial and LSHTM), that can produce rigorous and cutting-edge LMIC-relevant research and knowledge products, to create continuity and keep the practical support up-to-date and relevant; just as the knowledge products need to be informed by decision-maker needs through our country engagement. In short, our unique selling point goes beyond academic excellence, and is in integrating research and policy in order to generate impact through the cycle of evidence to practice (see this schematic on 'knowledge to action', by Carlos Cuello).

> ***"Information provision alone is not enough. For me, the added value is in having NICE-like institutions."***

Central in our approach is being open to new partners and building synergies. Through our work we also seek to build capacity strategically in high and middle income country institutions (health policy and professional organisations as well as academic ones) so they are able to support others. We shall also ensure that we are strategic in strengthening our network, by using tools such as social network analysis to assess our network structures and relationships systematically (see Shearer et al., 2014).

Furthermore, through our network we aim to bring together relevant disciplines such as HTA and health financing, as well as different analytical methodologies such as cost-effectiveness analysis and econometrics. Working with partners such as the WHO and the World Bank means we can enhance our impact and reach, for example as we have done at a recent awareness-raising event in Delhi as part of a forum for government-funded health insurers co-hosted with the World Bank.

Forging and leveraging South-South partnerships will be increasingly important too. We are continuing to do this through HTAsiaLink, PRICELESS SA, and bringing LMIC expertise to other in-country or regional knowledge sharing platforms (e.g. at the Delhi event, and

upcoming regional and international forums co-hosted by HITAP, NICE International and other partners, including the Prince Mahidol Award Conference 2015 and 2016).

Action	Responsible parties	Status
Convene Steering Group meeting for December 2014	NICE International (Derek Cutler)	Confirmed for Wednesday 10 December and invitations sent
Schedule regular conference calls involving the core partners (CGD, HITAP, Imperial, NI, York) and Tony Culyer	NICE International (Derek Cutler)	Completed
Share iDSI email distribution lists and Google Calendar details	NICE International (Derek Cutler)	Completed – see Appendix 2. Mailing lists for iDSI partners
Commission preliminary scoping piece on social network analysis to inform baseline analysis of iDSI network	NICE International	Expert (Jessica Shearer) identified and terms of reference agreed

Coordinated research

As partners presented the various lists of theoretical and empirical research topics planned for iDSI (the big issues of thresholds and constraints, and a shortlist of other methodological issues, being explored by University of York and Imperial College London; the survey of policymaker priorities led by HITAP and NICE International; the long list of issues arising from the CGD Health Benefits Package roundtable…), the need for coherence, convergence and coordination became apparent.

How can the different parts of iDSI work together to achieve its vision and mission, ensure minimal duplication, efficient use of research capacity among the network, and that the research is relevant and accessible for policymakers?

The existing lists of research seemed technical or methodology focused, and we recognised a critical need for iDSI also to help decision makers overcome the political, ethical and other barriers to using research.

"I have never heard a policymaker agonise over the discount rate."

Qualitative research or narratives could be very useful, e.g.:

- Examples of good and bad governance in different countries
- Oral histories and anecdotes (e.g. from Sir Mike Rawlins on the three years leading up to the foundation of NICE)
- Lessons learned from previous initiatives such as World Development Report 1993
- 'Cultural assessment' of what systems are likely to work in given countries
- Our own experiences of engaging with policymakers and invariably with politics in the countries we work.

Ideally, more of the research topics should come from the country level, primarily the practical support project countries (Indonesia and South Africa). iDSI should also respond to the needs of the Global Fund, GAVI, and the funders. The Reference Case can serve an as overarching framework for research related to economic evaluation. Prioritisation is critical,

and research should be coherently linked to our theory of change and activities in the workplan.

For LICs in particular, iDSI needs to play an advocacy role to motivate the demand for research, drawing on our practical experiences working with countries to articulate what research is needed. We can use the upcoming iDSI website, and to host an online "Agora for HTA", akin to a 'matchmaking' service where decision makers can articulate their research needs, and researchers can make the case for research funding. We shall also use opportunities such as a workshop in Seattle (scheduled for September 2015) to raise awareness of knowledge transfer and exchange (KTE) among BMGF and other funders of research in LMICs.

Action	Responsible parties	Status
Finalise respective lists of theoretical, empirical and applied research topics for the short term, with a view to converging the various lists under a meaningful taxonomy in the longer term	University of York; HITAP (Yot); CGD (Amanda Glassman)	In progress
Develop criteria for prioritising topics of research to be conducted	Technical Decision Support Unit (led by York)	In progress
Explore web-based platforms for "HTAgora" research matchmaking	NICE International and BMGF (Damian Walker)	

Communication: Simple, not simpler

iDSI is complex, and we need to reduce the unnecessary detail in all documents. This is important to ensure that our outputs are relevant and accessible to policymakers and wider stakeholders, and to be able to make a strong case to the funders that our story fits in with their strategic priorities.

> ***"Lots of documents, long names that don't mean anything to others, such as the 'Gates Reference Case'! Our challenge is to balance the technical work with packaging, messaging, simplifying – let's hear more about 'How do we get this onto the ground?' "***

Our new theory of change has demonstrated itself as a simple yet effective tool for communication; we have already begun using the new tagline in the Better Decisions for Better Health event in Delhi to great success, and experimenting with the use of the #BetterDecisions hashtag for livetweeting the event. We should also explore using different media to communicate the ideas of priority-setting to different audiences, for example as HITAP have done through this YouTube animation *The Power of HTA*, and ensure that major products such as the Guide to Health Benefits Plans are not delivered at the end of the grant period as a book, but as timely, standalone sections in various formats (e.g. Web chapters, blogs, policy briefs) as they are completed throughout 2015.

We have now begun developing a communications strategy, which will establish iDSI's outreach and communication objectives, key messages and audiences, with a plan for promoting specific iDSI activities and deliverables based on those objectives and messages. We are planning to focus upcoming communication efforts, built around the iDSI website to be launched at PMAC 2015, on six core workstreams:

1. The Reference Case
2. Health benefits plans for UHC
3. Cost-effectiveness thresholds
4. Country case studies
5. Stakeholder (industry/advocacy organisations) engagement platform
6. Ethics of priority-setting

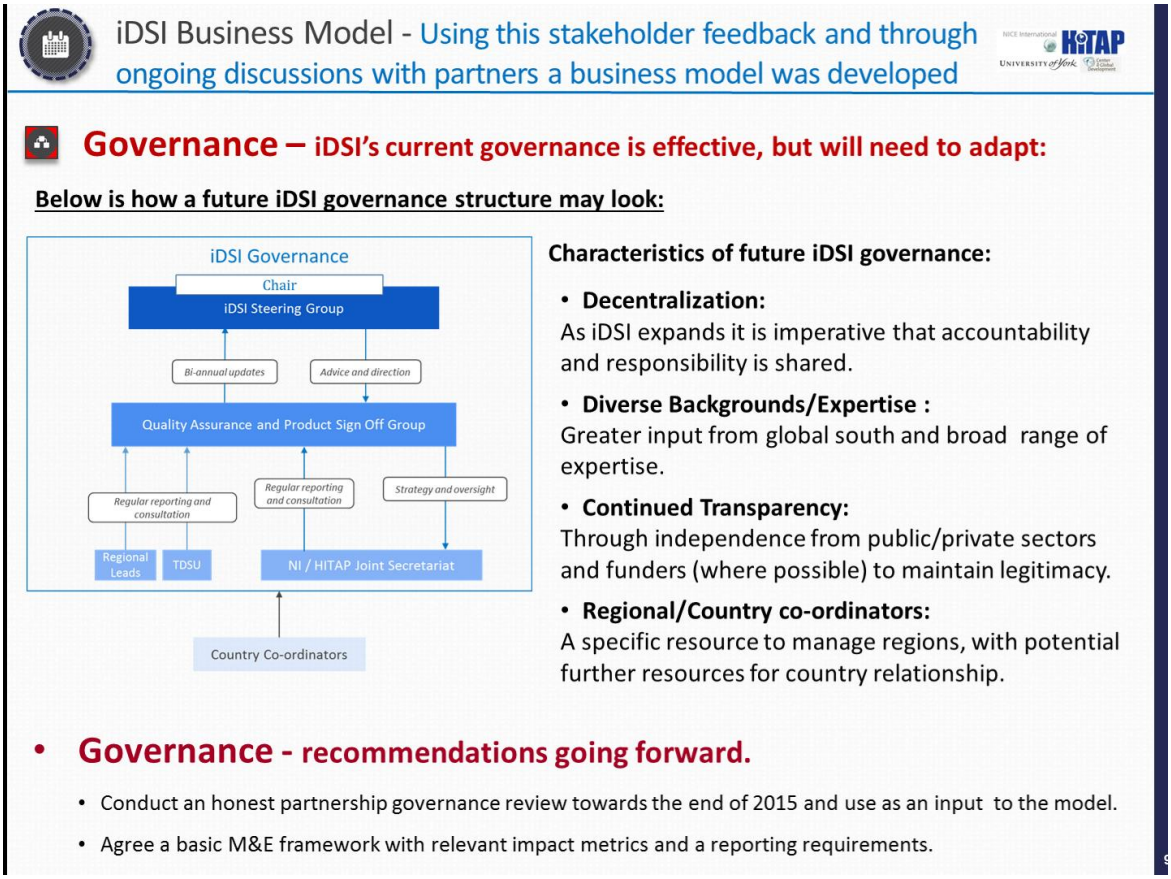
Action	Responsible parties	Status
Develop communications strategy for iDSI within existing budget, including a communication plan for each iDSI deliverable	CGD (lead), HITAP, NICE International	Strategy meeting held in Washington DC 27 – 29 October 2014, and draft communication plan circulated Website development in progress
Update iDSI website and marketing materials (slide deck and leaflet) to include agreed Vision, Mission and Guiding Principles, new support partners and new terminology (e.g. 'practical support' and 'knowledge products')	NICE International (Ryan Li) and ADP	Vision, Mission and Guiding Principles agreed Updating of marketing materials in progress
Develop Web platform for international communication and coordination among iDSI partners	NICE International	Website development in progress
Employ full-time, in-house communications specialist within iDSI secretariat, subject to resources	NICE International	In discussion with NICE HR
Finalise and publish iDSI taxonomy, including an accessible glossary on the iDSI website	Office of Health Economics and NICE International	Document under review by OHE Editorial Board

What should iDSI stand for?

Is iDSI trying impose particular values (such as “fairness”) on countries? Our general consensus was that we should stand by some fundamental principles: making explicit in terms of health and resources, the trade-offs of resource allocation decisions in order to help policymakers make accountable decisions. And our role should be to help policymakers navigate murky waters; for example, through the ethics of priority-setting workstream with the Berman School at Hopkins. An outline proposal can be found in Appendix 3. iDSI Ethics & Equity Taskforce: Application for Seed Funding.

Sustainability, funding and governance

In the short to medium term, iDSI should continue to seek grants to work with countries. We’ll use the opportunity to build a case for longer-term grant funding (5 – 7 years) from various sources, including the BMGF and the Rockefeller Foundation and sustained funding from the UK government



We will need to ensure funding continuity given the commitment made by our partners including our academic partners at the universities of York and Glasgow. Any gaps in funding could compromise progress – as it was agreed that impact cannot be achieved without a long term horizon given the political nature of our work.

Furthermore, a streamlined reporting mechanism, e.g. one progress report for all funders based around our theory of change, would be efficient for all and needs to be agreed between funders. iDSI already has a converged Steering Group for its BMGF, DFID and Rockefeller grants. No fundamental changes to its structure are expected in the foreseeable future, although it would be useful to map the skills within this group and try to fill the gaps (e.g. communications, business skills), and to consider adaptations (e.g. decentralisation, regional/country co-ordination) as the network expands. The final business model proposal for iDSI, developed by Accenture Development Partnership, can be found here.

Stronger institutions

Engagement with LICs and graduating countries through Global Fund and GAVI

A central question for iDSI in future is whom we will serve as our "clients". Whilst UHC will still be an important entry point for priority-setting, we needn't be constrained to UHC-committed countries in the longer term. With longer-term funding, we envision that practical support in countries would also be longer term (5 years or more) and more strategic in achieving our vision, including through partnerships and capacity-strengthening in regional hubs. The practical support project led by PRICELESS SA for Southern Africa is already seeing initial engagement with Zambia.

Low-income countries, and to a lesser extent lower-middle income countries, are major priorities for donors. Africa is strategically important both for donors and for the iDSI network, especially given limited traction compared to Asia. Global Fund and GAVI are important entry points for LICs, of which most are African countries, with the potential to generate a lot of impact.

"The problem is that most funding is for LICs, but most demand comes from MICs."

iDSI can work with Global Fund and GAVI to introduce cost-effectiveness analysis into their spending decisions, but this will be a lengthy stepwise process and necessarily (at least initially) within the context of vertical programmes. Given a fixed malaria budget, how much should a country invest in vaccines versus nets? And how could the Global Fund better allocate funding between HIV/AIDS, malaria and TB? And for GAVI 'graduating' countries, the focus should be to leave a legacy through building support infrastructure, and institutionalising accountable decision making. Without a nudge from those funding GAVI and the Global Fund, however, such work is unlikely to be seen as a priority.

Actions	Responsible parties	Status
Explore existing initiatives (e.g. SIVAC, ProVAC, PATH) to identify feasible test-case countries for GAVI	CGD and GAVI (Robert Newman)	

Participation and engagement of wider stakeholders

We recognised the importance of wider stakeholder participation in priority-setting, as stakeholders (particularly patients and the public) can bring an understanding of the decision problem not captured by quantitative analysis, and help increase the acceptance of the decision-making process and perhaps the final decision. NICE and HITAP provide useful

models for patient and public engagement at different levels; from participating in the decision-making to consultation and appeal.

> ***"Participation is not just about making better decisions, but also about generating political support for difficult decisions."***

We must not assume that participatory experiences for HICs are the same as those in LMICs; the lack of social solidarity means it is hard to mobilise the grassroots in participatory decision-making. In the absence of a strong process, advocacy groups as well as groups with financial links to industry sponsors make such engagement problematic; and Thailand provides an interesting contrasting model with its government-funded patient organisations, iDSI can work on building capacity among different stakeholder groups to engage constructively.

> ***"It is impossible to run priority-setting processes without public engagement."***

We should proactively engage advocacy groups that are active in the global health space, for instance HIV and advocacy groups, and Medecins Sans Frontieres, as well as regional human rights groups such as SECTION27 in South Africa, as we all share the same objective of improving health. And aside from Meteos' stakeholder consultation meeting planned for July / September 2015, we should also seek other platforms for engagement, for instance inviting industry representatives for annual presentation meetings, and regular slot at ISPOR.

With regard to our relationship with industry, Meteos are (with DFID support) convening health ministries and national insurers from four countries and CEOs/senior leadership from three multinationals through a 16-month dialogue process known as Groundwork. The Groundwork dialogue will explore the political and technical pitfalls that may obstruct priority-setting, and to set a tone and approach to these issues that results in collaborative problem-solving between governments and the pharmaceutical industry. Although separate from iDSI, Groundwork aims to ensure its findings are an input to the iDSI stakeholder engagement meeting.

Actions	Responsible parties	Status
Develop draft proposals for 2015 stakeholder consultation meeting	Meteos	Included on agenda for Dec 2015 Steering Group meeting
Ensure patient/public engagement in practical support projects (Indonesia, South Africa and others)	NICE International, HITAP, PRICELESS SA	
Ensure there will be chapter on patient/public engagement, and consider representation within Working Group membership	CGD	
Apply for Wellcome Trust funding for workshops (http://www.wellcome.ac.uk/Funding/Biomedical-science/WTX063744.htm) and research on the	Berman Institute of Bioethics (lead), CGD, NICE	Developed outline for seed funding (see page 18),

ethics of priority-setting, including patient participation and empowerment perspectives	International, CMTP	including two planning meetings in 2015
Consider workshop to convene advocates and activists	University of York (Paul Revill)	

Strengthening capacity for priority-setting in LMICs

Focusing on southern Africa, we identified a general need to strengthen technical capacity for priority-setting both among the supply side, and among the demand side (so that policymakers and advisers can articulate appropriate demand for the technical products).

> ***"This is a chicken and egg issue: stimulating supply and demand needs to be simultaneous."***

Parallel to broader institutional strengthening for higher-education institutions across Africa, iDSI can strengthen producer capacity using a number of models:

- investing in local academic programmes, such as that already available at Wits University
- borrowing capacity from other sectors (e.g. finance ministries) and build up health-sector expertise, such as through short courses (which could be closely linked to iDSI deliverables)
- distance learning, MOOCs and 'train-the-trainer' initiatives, including through linkage with HIC institutions.

Stimulating demand among policymakers and their advisers will on one level be around messaging, for example tailoring teaching materials towards different audiences. On another level, reaching the right audience will be critical: in many countries, finance ministries ultimately hold the health budget, and we could reach them through health economics think-tanks in Africa, network events for African finance ministry officials (e.g. OECD sister networks, WHO), and potentially through the World Bank Flagship course.

Although brain-drain to HICs and to the pharma industry is a potential challenge, it is no bad thing if pharma can make high quality HTA submissions and contribute constructively within the process. In the long run, strong academic and government institutions, where they provide a nurturing environment for employees to make an impact, will attract the right people.

Better decisions

The opportunity cost of not making evidence-informed decisions

Opportunity cost was highlighted repeatedly as a crucial concept for iDSI to communicate to wider stakeholders. The concepts of cost-effectiveness thresholds and opportunity cost are intimately linked. Whilst establishing thresholds may be more important for global organisations such as Global Fund and GAVI, the quick wins for iDSI in terms of country work would be not to try and calculate thresholds for a number of countries – but to communicate:

1. The general argument that not using evidence in decision-making has real consequences for real individuals: real number of cases of cancer, real lives lost, etc.
2. Uncalibrated thresholds set by global organisations can be dangerous;
3. Willingness-to-pay is not a good decision rule when it comes to insurance schemes and tax funded initiatives, though the issue of out of pocket spending complicates matters.

"Choosing less good things has a human cost."

We can start with a ballpark figure (e.g. average for given GDP/capita), and illustrate expected consequences of getting it wrong. This has already been done by our partners in the field of HIV (see York CHE Research Papers 98 and 99; Revill et al, 2014a, 2014b), and in the UK for the National Health Service (CHE RP 81; Klaxton et al, 2014). We can build capacity by putting good quality research in the hands of LMICs. We shall also make available tools (such as an opportunity cost calculator; see Appendix C, Addendum 4 in CHE RP 81) to help policymakers understand the consequences of their decisions and the trade-offs in terms of health impact, out-of-pocket payments and to the wider economy, and to argue the case for active priority-setting.

Actions	Responsible parties	Status
Ensure practical support projects in Indonesia and South Africa include discussion of thresholds, e.g. estimating 'ballpark' figure using country panel data, identifying potential disinvestment	University of York, Imperial College London with HITAP, PRICELESS SA, NICE International	
Develop 'opportunity cost calculator' for iDSI website	University of York (Karl Claxton)	Background analytic work in progress

Consider assessing methods, quality of evidence, and global policy recommendations from key global players (e.g. WHO, BMGF, GAVI, Global Fund), to demonstrate potential impact of iDSI	University of York (Paul Revill)	Initial approach made by BMGF to review and critique economic evaluation studies on HIV prevention; to be followed up by BMGF

Ammunition: Ex-ante and ex-post impact assessment

Having ammunition to demonstrate our impact, and to make the case for iDSI and for priority-setting, will be essential as iDSI increasingly engages with the wider world, including at our planned stakeholder consultation meeting in summer 2015. We would need to establish what policy decision changed following the input of iDSI; what would have been chosen in the absence of an explicit priority-setting process; and what would have been the consequences of choosing the counterfactual. There are necessary assumptions, but we should not shy away from demonstrating our potential impact.

> ***"[Funder] would have the data to look at the proportion of patients with NCD coverage as a result of iDSI input. We would use that internally – you certainly should."***

Beyond numbers, demonstrations and stories will captivate. What are the qualitative health and other consequences from decisions, e.g. the effects of fistulae for women who have undergone unnecessary hysterectomies?

HITAP already has examples from their MCH voucher scheme in Myanmar, where they modelled the likely outcomes *ex ante*, and subsequently measured outcomes *ex post*. For iDSI, gathering 6 or 7 country cases in an accessibly written book, in the style of *Millions Saved* by CGD (http://www.cgdev.org/initiative/millions-saved) would be very powerful ammunition for iDSI.

Actions	Responsible parties	Status
Demonstrate impact through existing/previous practical support engagement with Vietnam, Philippines and India	University of Glasgow (lead), with support from HITAP, NICE International, University of York	In discussion

Where do we go from here?

The meeting was a great success for iDSI, and we left Bellagio buzzing with new ideas, renewed enthusiasm, and stronger partnerships – towards a world where decision-makers are making better decisions for better health.

Can we achieve the following visions in 10 years? Let us work on it together.

> ***"There will be 15 HTA institutions across LMICs with their own infrastructure and processes, and we'll be redundant."***
>
> ***"There will be widespread acceptance of a scientific approach to priority-setting across the planet. Any debates about its validity and legitimacy will have been disposed of."***
>
> ***"iDSI will be seen by multilaterals as the go-to people for priority-setting."***

Appendix 1. Final list of participants at the iDSI Bellagio meeting

Name	Organisation
Dr Ximena Aguilera	Universidad del Desarrollo, Chile
Dr Michael Borowitz	Global Fund to fight AIDS, Tuberculosis, and Malaria, Switzerland
Becky Buell	Meteos, UK
Micael Canavan	Accenture Development Partnerships, UK
Prof Karl Claxton	University of York, UK
Dr Kalipso Chalkidou	NICE International, UK
Prof Tony Culyer (Event chair)	NICE International, UK / University of York, UK / University of Toronto, Canada
Derek Cutler	NICE International, UK
Amanda Glassman	Center for Global Development, USA
Prof Kara Hanson	London School of Hygiene and Tropical Medicine, UK
Prof Karen Hofman	University of the Witwatersrand, South Africa
Iain Jones	Department for International Development, UK
Carleigh Krubiner	Johns Hopkins Berman Institute of Bioethics, USA
Dr Ryan Li	NICE International, UK
Dr Kate Mandeville	World Bank, USA
Dr Robert Newman	GAVI Alliance, Switzerland
Natalie Phaholyothin	Rockefeller Foundation, Thailand
Prof Mark Sculpher	University of York, UK
Prof Kenji Shibuya	University of Tokyo, Japan
Prof Peter Smith	Imperial College London, UK
Natasha Sunderji	Accenture Development Partnerships, USA
Dr Yot Teerawattananon	Health Intervention and Technology Assessment Programme, Thailand
Nattha Tritasavit	Health Intervention and Technology Assessment Programme, Thailand
Dr Sean Tunis	Center for Medical Technology Policy, USA
Dr Damian Walker	Bill & Melinda Gates Foundation, USA

*With special thanks to **Andy Burness**, President of Burness Communications for his invaluable input into wording the iDSI Mission & Vision.*

Appendix 2. Mailing lists for iDSI partners

iDSI Steering Group
Damian Walker
Julia Watson
Iain Jones
Natalie Phaholyothin
Tony Culyer
Kalipso Chalkidou
Amanda Glassman
Mark Sculpher
Peter Smith
Yot Teerawattananon
Karen Hofman
Robert Newman
Andreas Seiter
Marie-Paule Kieny
Jeanette Vega
Martha Gyansa-Lutterodt
Ursula Giedion
Karen Hofman
Ferdinandio Regalia
Tran Thi Mai Oanh
Derek Cutler

iDSI Core Partners
Tony Culyer
Kalipso Chalkidou
Derek Cutler
Francis Ruiz
Thomas Wilkinson
Ryan Li
Reetan Patel
Amanda Glassman
Mark Sculpher
Karl Claxton
Paul Revill
Jessica Ochalek
Peter Smith
Yot Teerawattananon
Nattha Tritasavit
Eleanor Grieve

iDSI Partners
Adrian Towse
Alec Morton
Amanda Glassman
Andreas Seiter
Andy Briggs
Angela Chang
Anna Vassall
Becky Buell
Carleigh Krubiner
Damian Walker

Derek Cutler
Eleanor Grieve
Francis Ruiz
Iain Jones
Inthira Yamabhai
Jessica Ochalek
Julia Watson
Kalipso Chalkidou
Kara Hanson
Karen Hofman
Karl Claxton
Karla Hernandez-Villafuerte
Kate Mandeville
Kenji Shibuya
Mark Sculpher
Micael Canavan
Michael Borowitz
Mwihaki Kimura
Nancy Devlin
Natalie Phaholyothin
Natasha Sunderji
Nattha Tritasavit
Paul Revill
Peter Smith
Ranjeeta Thomas
Reetan Patel
Robert Newman
Ruth Faden
Ruth Helstrip
Ryan Li
Sean Tunis
Sophia Tickell
Sripen Tantivess
Thomas Wilkinson
Tony Culyer
Trevor Sheldon
Vivek Muthu
Ximena Aguilera
Yot Teerawattanon
Yuna Sakuma
Zoe Scabbiolo

Appendix 3. iDSI Ethics & Equity Taskforce: Application for Seed Funding

Background & Intro

iDSI is committed to guiding decision makers to effective and efficient resource allocation strategies for improving people's health, through providing a comprehensive suite of knowledge products and practical support for priority-setting in health. As the initiative develops, it will be critical to ensure due attention to iDSI's central commitment to equity and other ethical considerations. Such considerations animate resource allocation decisions and processes, and the formation of priority-setting institutions; ethical guidance can serve as a central component of the comprehensive iDSI toolkit.

A dedicated iDSI Ethics & Equity Task Force will:

- provide practical guidance to help countries navigate the ethical challenges of priority-setting, in their specific contexts
- safeguard against egregious moral harms resulting from inappropriately directed resource allocation, and
- support the development of morally defensible heath policies and practices.

Aims

Recognizing that priority-setting for health presents a morally complex problem space, the Ethics & Equity Taskforce seeks to provide guidance and assistance responsive to the needs of policy makers on the ground. We will focus on three particularly relevant areas:

1. **Specifying Equity Objectives**

   Enable policy makers to articulate and specify their context-specific commitments to equity, operationalize a plan coherent with those commitments, and track progress on the fulfilment of their equity objectives

2. **Public Engagement for Priority-Setting**

   Provide guidance on best-practices strategies and common pitfalls to avoid when engaging relevant stakeholders in participatory decision-making processes for health

3. **Saying No: The Ethics of Denying and Delisting**

   Develop an ethics checklist for when policy-makers can and should say "no" to covering certain health services, the moral rationale for doing so, and best practices for communicating policies in respectful and transparent ways

Activities

We will use this seed funding to support activities exploring the three problem spaces, and which will enable us to specify the methods to be pursued in achieving the goals of the Ethics & Equity Taskforce in iDSI's next phase of work and funding. The activities will include a planning meeting in Summer 2015 to convene core iDSI members and relevant content experts to refine the vision, aims, and activities for a fully supported Equity and Ethics Task Force.