Health Benefits Packages: What’s In, What’s Out
Practical and Ethical Considerations for Priority Setting

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Setting Priorities Fairly - Sustainable policies for effective resource allocation in Africa
Accra, Ghana
The Challenge: What’s In, What’s Out

Many competing claims for resources to cover vast health needs

With limited resources, not everything can be covered

• Which specific health services and goods?
• For which populations (e.g., vulnerable or high-risk?)
• With what kinds of cost-sharing arrangements?

Priority-setting is unavoidable

“If you guarantee everything, you guarantee nothing.”

“All roads lead to universal health coverage ... For me, the key question of universal health coverage is an ethical one...”

-Tedros Adhanom Ghebreyesus
WHO Director General
July 17, 2017
Why institutionalised, explicit priority-setting?

The harms of implicit rationing:

- Wasted resources, unrealized health gains – opportunity costs
- Reinforced health inequities
- Lack of transparency - public distrust and dissatisfaction
- Unsustainable expenditures on health that can erode the HBP

These are all ethnically relevant and important!
This limit is imposed by the constrained health care budget.

New Technology

Cost: USD 5,000/QALY

New health technology with a cost-effectiveness ratio of USD 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.

Opportunity costs: An Illustration

Cost-saving (e.g. polio-Sabin vaccine)

Cost-effective (e.g. USD 1,000 per QALY)

Very cost-effective (e.g. USD 5,000 per QALY)

Relatively good cost-effectiveness (e.g. USD 5,000 per QALY)

Cost-effective (e.g. USD 7,500 per QALY)

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

Are the benefits gained 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)

Opportunity costs not just for health gains but equity gains!

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
Cost-Effectiveness: HIV Example (VLM vs CD4)

2013 WHO Treatment Guidelines recommend use of viral load monitoring (VLM) instead of CD4 counts

- Rationale was that VLM could improve adherence, could avoid unnecessary switches to 2nd line ART, may reduce transmission
- BUT VLM is significantly more expensive (US$ 45 vs. US$ 9)

What are the opportunity costs of adopting the VLM guideline???

- The same resources needed to cover VLM for existing patients could instead expand population coverage of testing & treatment – resulting in 3X the health benefits and more equitable access to tx!

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Table 3: Alternative ways of spending ART programme resources

<table>
<thead>
<tr>
<th></th>
<th>Illustrative per patient total costs</th>
<th>Illustrative per patient total health attainment (QALYs)</th>
<th>Incremental cost-effectiveness ratio (ICER)</th>
<th>ART coverage</th>
<th>Health attainment (QALYs)</th>
<th>Illustrative total costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>$2,000</td>
<td>5</td>
<td></td>
<td>49%</td>
<td>0.59m</td>
<td>$235m</td>
</tr>
<tr>
<td>ART with clinical/CD4 monitoring</td>
<td>$22,000</td>
<td>25</td>
<td>$1000 per QALY</td>
<td>0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ART with VL monitoring</td>
<td>$28,000</td>
<td>27</td>
<td>$3000 per QALY</td>
<td>51%</td>
<td>3.30m</td>
<td>$3,425m</td>
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<tr>
<td>Total</td>
<td></td>
<td>3.89m</td>
<td></td>
<td></td>
<td>$3,660m</td>
<td></td>
</tr>
</tbody>
</table>

(b) Invest in ART scale-up

<table>
<thead>
<tr>
<th></th>
<th>Illustrative per patient total costs</th>
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<th>Incremental cost-effectiveness ratio (ICER)</th>
<th>ART coverage</th>
<th>Health attainment (QALYs)</th>
<th>Illustrative total costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>$2,000</td>
<td>5</td>
<td></td>
<td>34%</td>
<td>0.41m</td>
<td>$162m</td>
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<td>ART with clinical/CD4 monitoring</td>
<td>$22,000</td>
<td>25</td>
<td>$1000 per QALY</td>
<td>66%</td>
<td>3.98m</td>
<td>$3,498m</td>
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<tr>
<td>ART with VL monitoring</td>
<td>$28,000</td>
<td>27</td>
<td>$3000 per QALY</td>
<td>0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4.38</td>
<td></td>
<td></td>
<td>$3,660m</td>
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</tr>
</tbody>
</table>

Note: Approx. ART eligible (CD4<350) adult population of Cameroon, 2013, is 240,000.

Beyond Cost-Effectiveness:  
Additional Ethics Considerations

Efficiency (as measured by CEA) is a key ethics consideration ...

But there are other ethics considerations to account for:

• Equity
  • Various dimensions: age, gender, ethnicity, geography, etc.
  • Equity in access, outcomes, financial protection
• Respect, Dignity, & Stigma
• Compassion
• Impacts on social relationships
• Financial impacts/impoverishment due to ill health

“Not everything that counts can be counted...”
The Black Box of Ethics in HTA

**In theory:** HTA includes not just economic evaluation (cost-effectiveness) – but also ethics and social values

**In practice:** HTA is mostly about *economic evaluation* of new drugs and rarely reflects on ethical implications, local values and context in a systematic way.
South African Values and Ethics for UHC
The SAVE-UHC Project

**Developing the Framework**

**Convene Stakeholder Working Group**
- Policymakers
- NGOs/CSOs
- Physicians
- Public Health Practitioners
- Academics
- Private Sector

**Document Review**
- Existing Ethics Frameworks – “menu” of considerations
- Legislative Docs
- Constitutional Court Cases

**Hypothetical Case Application**
- HPV Vaccine
- Rubella Vaccine

**Refinement of Pilot Ethics Framework**

**Pilot Testing**
CEA + Broader Ethics Analysis
Some Key Takeaways

• **Cost-effectiveness analysis** can help you figure out where to start to get the biggest impact for your health spend

• **Explicit ethics analysis** to address other important aspects like equity impacts & non-health impacts on wellbeing also critical

• Designated processes and institutions for explicit & systematic approaches to priority setting can lead to better decisions, more health gains, more trust in the system, and more fair, ethical, and sustainable HBPs

• The HBP can’t do *everything* – must be combined with other policy reforms and investments in the supply side to realize health gains

• Define a set of services that are affordable, implementable, and sustainable (okay to **start small with something doable** rather than have a vast list of undeliverable services)
More info and resources:

Available at: