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Funder: Bill & Melinda Gates Foundation
• Valid cost estimates are critical to improved resource allocation and planning.
• Widespread uncertainty regarding costs per unit of service for prevention and treatment.
• Due to variation in intervention content and implementation, as well as costing methods.
• Geographic and programmatic gaps and inaccessibility.
Examples of cost challenges

• ART cost per person year $250 - $650 in similar LIC settings, due to different implementation practices and costing methods

• Costing quality checklists long and unprioritized for contribution to valid estimates
Large variation in efficiency (consistent method) ... scale plus ??

From: S. Bautista, Orphea Study
Disaggregation as tool to understand and address efficiency variation.

**Modeled ART Delivery Cost ($USD/person/year)**

<table>
<thead>
<tr>
<th>ART Delivery Cost Model</th>
<th>With VL</th>
<th>No VL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$529</td>
<td>$445</td>
</tr>
<tr>
<td>B</td>
<td>$480</td>
<td>$396</td>
</tr>
<tr>
<td>C</td>
<td>$405</td>
<td>$321</td>
</tr>
<tr>
<td>D</td>
<td>$334</td>
<td>$250</td>
</tr>
<tr>
<td>E</td>
<td>$320</td>
<td>$236</td>
</tr>
<tr>
<td>F</td>
<td>$351</td>
<td>$267</td>
</tr>
</tbody>
</table>

**Figure 1. Estimated ART Delivery Costs under Modeled Scenarios of Efficient ART Scale-Up.** Costs for ART delivery under six modeled scenarios are displayed inclusive of viral load testing. Model costs excluding viral load testing are also shown. **Model A:** steady-state patient load, MJAP program salary scale and standard core laboratory monitoring schedule. **Model B:** model A + lowest available ARV drug costs. **Model C:** model B + Uganda Ministry of Health 2013 salary scales. **Model D:** model C + increased healthcare worker efficiency due to full use of workday. **Model E:** model D + expansion of healthcare worker effort to full 8-hour workday. **Model F:** model E + higher MJAP program salary scales.
Efficient micro-costing: Challenge / Opportunity
Situational analysis

Goal

• Develop a business case to
  – improve the quality, quantity, usability and accessibility of data on the cost of delivering services for HIV and TB
  – support policy makers and researchers for decision-making
Situational analysis

Methods

• Interview key producers and users of cost information
• Review published costing studies, tools and guidelines
• Identify gaps and challenges with current cost data
• Identify solutions & needed efforts
• Despite growing efforts to produce and disseminate cost data, enormous challenges.

• Hundreds of costing studies since 1990s, yet:
  – methods and tools too disparate for comparison
  – gaps in interventions and service delivery models
  – even for good cost data, scattered across actors and institutions, impairing access
## Use case for GFATM

<table>
<thead>
<tr>
<th>#</th>
<th>User</th>
<th>Current use of cost data*</th>
<th>Desired use of cost data</th>
<th>3-year project output</th>
<th>Change in behavior/policies</th>
<th>Impact</th>
<th>+ 5 project notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>GFATM</td>
<td>Financial planning and budgets for proposals at the country level without full range of accurate and consistent unit costs.</td>
<td>Set and enforce benchmarks and ranges for standardized unit costs for budgeting specific HIV/AIDS and TB inputs and services</td>
<td>Gaps filled in essential unit cost data on website Standardized unit costs are used to support the review of concept note budgets.</td>
<td>Agreement and promotion by GFATM to use GHCC unit cost data in country concept notes through budgeting tools Use standards and unit costs developed by GHCC to refine budgets in 2 pilot countries. Use of website to refine budgets in additional countries</td>
<td>More realistic and efficient country concept notes; cost control</td>
<td>Web database, capacity development in budgeting, quality assurance, cost control, wide national and international participation</td>
</tr>
<tr>
<td>+ 5 year project output</td>
<td>Change in behavior/policies</td>
<td>Impact</td>
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</table>
| Website, database and capacity development using high quality unit cost data for wide use in national planning | Broader use by countries of standards and unit costs developed by GHCC                        | Greater accuracy and reliability of budget estimates  
Efficient use of GF resources                              |
Situational Analysis

Key Challenges & Recommendations

• Poor accessibility: policy makers don’t know where to obtain cost data
  – One-stop web consortium to serve identified user needs
• Important methods variation, lack of reference case
  – Analytics-informed guidance, standards, tools
• Data gaps (countries, interventions, delivery models, enablers, technical efficiency)
  – Methods to fill gaps – data collection, extrapolation
• Non-standard reporting
  – Benchmark standards established
GHCC: Overall Aim

Enhance the impact of the TB and HIV response, within available resources, via informing resource allocation and funding by:

*systematically improving the quality, timing, local relevance, interpretation, and use of cost information on HIV/AIDS and tuberculosis.*
Primary activities

• Establish a global health cost consortium.
• Data analytics
  – “inside the box” to adjust for methods & changes
  – Establish cost ranges (by location, program features)
  – foster efficient & quality costing via core issues
• Establish methods and standards
  – cost data collection, compilation, reporting
• Develop advocacy & communication tools for cost data in policy and planning
Organization and governance

- UW leads consortium, responsible for activities to establish GHCC consortium
- Five partners:
  - Avenir Health (Dep Dir) leads advocacy & communications
  - UCSF leads data and analytics
  - LSHTM leads standards
  - INSP leads obtaining data as part of data and analytics
  - UCT supports standards work
- All partners support each aim, work collaboratively
- Time frame: 2016-2018
Theory of change

• Goal: understand how GHCC output can best
  – address needs of key users
  – Integrate smoothly with current practices
• Iterative interview process
• Led by Dalberg Associates, with GHCC participation
Stakeholders and Technical Advisors

- Producers (conducting cost studies in LMICs)
- Users (PEPFAR, GFATM, WHO, MOH, Nice International IDSI)
- Experts and practitioners (Academic institutions, other funded initiatives)
- Economic Reference Group of HIV/AIDS (ERG)
- TB and HIV modeling consortia
• **Systematically assemble and extract existing unit cost estimates.**
  - a) Typology of interventions and delivery modalities;  
    b) All available unit cost estimates - peer-review, grey literature, program proposals, public databases, our cost studies; 
    c) Extract (omissions, ambiguity, errors).
• **Develop and apply quality rating system for costing data.**
  - d) Assemble full list of quality indicators; e) Weight based on importance for unbiased and precise cost estimates, from structural scrutiny, sensitivity analyses, cost experts; statistically validate.
• **Synthesize cost data to estimate benchmark unit costs for each intervention, by delivery modality and setting.**
  - f) Process to fill data gaps and estimate unit costs across settings;  
    g) Optimal methods to translate tradable and non-tradable costs to other settings; 
    h) Describe the ranges in unit cost due to known influences (e.g., client demand and input prices) and unexplained variation.
One stop shop web resource

- Reports on costing evidence
- Repository of unit cost data
- Repository of data collection tools/guides
- Tools to utilize unit cost data
- Interactive data visualization tools
- Training resources – online videos; links to key courses etc.
- Links to primary data
Tools overview

• **Unit costs**
  – web-based, repository of cost data (empirical and syntheses), dynamic capabilities

• **Costing guidance**
  – Narrative reference case
  – Supporting tools/modules

• **Quality of cost data/reporting checklist** – checklist, guidance on application, scores

• **Analytical**
Unit cost repository

• Enhance existing repository (Avenir Health)
• Organized by country, income, setting, target population, intervention type and modality, other cost drivers
• Specify economic and financial costs
• Unit costs reflect analysis and corrections.
  – Unit costs, prices and quantities, cost functions
Piloting

- Work with use case organizations to pilot websites, costing tools
- Evaluate how well the improved unit costs meet use case needs (funders, countries)
- Solicit input on how to disseminate and encourage uptake
- Refine to maximum useability
Comments & Questions

• Now

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