Approaches to Health Resources Prioritization: Overview of Methods and IDSI Experience

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International Decision Support Initiative (iDSI)
Consultant, Decision and Delivery Science Team, World Bank
Overview

1. Introduction to iDSI and the work we do
2. The case for Priority Setting
3. Concepts and methods used in Priority Setting
4. Exercise
5. Priority Setting and accountable decision making
6. Considerations when developing local processes

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The International Decision Support Initiative (iDSI)

Working in partnership with countries to build long-term institutional capacity for priority-setting and sustainable UHC.

- **Diverse global delivery network** with access to health, economics, development, policy translation, and capacity-building expertise
- **Strong government backing** from UK, Thailand, and China for North-South and South-South partnerships
- Major funders BMGF, DFID, Rockefeller and Wellcome
iDSI responds to policymaker demand, strengthening in-country networks to translate evidence into policy

Growing footprint in Africa to enhance preparedness for aid transition

Support in **South Africa** for priority setting under NHI/UHC reforms. iDSI is also supporting health benefits planning in **Ghana** and **Tanzania**.

In **Kenya**, iDSI’s work with GFATM and UNITAID to optimise novel HIV ART rollout has led government to request iDSI support in embedding HTA into NHIF and benefit package design.

Supporting governments in Asia with evidence-informed analysis and institutional strengthening

iDSI has supported **India**, **China**, **Indonesia**, **Vietnam** and **Philippines** in conducting health technology assessment (HTA) projects and processes, and building institutional capacity to use HTA in UHC health benefit package listing and procurement.
## Knowledge Transfer and Exchange (KTE) and Advocacy

Tailor and deliver evidence-informed messages to influence the right audiences to buy into iDSI’s model, enabling greater health gains and more value for money.

<table>
<thead>
<tr>
<th>Country engagement</th>
<th>Knowledge products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support countries to develop institutional capacities and transparent governance processes, enabling maximum health gains and transition from aid</td>
<td>Co-create global public goods to support countries and funders in standardizing, contextualizing and applying approaches to improve value-for-money in health</td>
</tr>
<tr>
<td>Empower countries to spend their own budgets smarter and implement more efficient and equitable HBPs and delivery platforms, making UHC and SDGs a reality</td>
<td>Generate, integrate and deploy policy-relevant data and knowledge to support better decisions at global and national levels</td>
</tr>
</tbody>
</table>

**Institutional Strengthening**

**Smart Purchasing**

**Data, Evidence, and Analytics**

**Methods, Processes, and Tools**

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**iDSI**

better decisions. better health.
iDSI Theory of Change

Effective partnerships through iDSI

- iDSI creates strong links with global health stakeholders who are able to advocate for evidence-informed priority setting.
- iDSI is a robust, effective and functioning network.
- iDSI builds strong partnerships with organisations who can provide practical support at country level.

Institutionalisation of EIPS at the country level

- Increased political commitment and buy-in to evidence-informed priority setting agenda from stakeholders.
- Routine generation of high quality, relevant and appropriate evidence-informed products at country level.
- Strengthened technical capacity and motivation to act on and create opportunities for EIPS at country level.
- Creation of credible, objective and trusted institutionalised structures and processes championing the routine consideration of evidence for policy and resourcing decisions.

Better decisions

- Decision-making in health is undertaken according to the core principles of evidence-informed priority setting and with ethical and social value considerations.
- More efficient and equitable resource allocation decisions with trade-offs made explicit.

Better health outcomes and impact

- Better healthcare coverage.
- Better Health.
1. Introduction to iDSI and the work we do

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3. Concepts and methods used in Priority Setting

4. Exercise

5. Priority Setting and accountable decision making

6. Considerations when developing local processes
The need for priority setting

- **Resources are scarce and choices must be made**

  “No country in the world can provide health services to meet all the possible needs of the population, so it is advisable to establish criteria for which services to provide”

  Bodabilla et al. (1994)

- Healthcare is not usually provided under ‘ordinary’ market conditions because of well recognised ‘failures’

- Many countries (especially as they pursue UHC) adopt risk pooling mechanisms so costs are shared and there is an emphasis on accessing care based on ‘need’ rather than ‘ability to pay’
  - Social insurance, e.g. France, Germany, Mexico, Indonesia
  - Taxation, e.g. UK NHS
The UHC Cube: country decisions

- Extend to non-covered
- Reduce cost sharing and fees
- Direct costs: proportion of the costs covered
- Include other services
- Services: which services are covered?
- Population: who is covered?
- Current pooled funds
Competing priorities can result in ad hoc or inertial processes of resource allocation => implicit rationing

Many ‘priorities’...

Asthma management in general practice
A chronic disease health priority

PRESS RELEASE
Sept. 19, 2011, 5:33 p.m. EDT
American Heart Association Urging Action at UN Summit on Non-Communicable Diseases
Organization Calls for More Focus on Cardiovascular Diseases - the World's No. 1 Killer

Palliative Care: A Public Health Priority in Developing Countries

Reproductive cancers: high burden of disease, low level of priority

...many interests

MSF asks India to make affordable hepatitis C medicines as Natco resists expensive US drug patent
• 12-04-2014
• By Sehat
• Bookmark

The new drug war
Hard pills to swallow

Drug firms have new medicines and patients are desperate for them. But the arguments over cost are growing

Jan 4th 2014 | NAIROBI AND NEW YORK |

Bad decisions cost lives

• In 2011, only 58% of children in Colombia were fully vaccinated, but Avastin was prescribed to treat breast cancer.
  • NICE in 2010 concluded that the ICER for avastin was potentially above £200,000 per QALY gained.
• In India, only 62%* of children (1-2 years old) are fully vaccinated, open heart surgery is subsidized in national public hospitals.

Source: CDG 2012

*Moral case* for priority setting

*rate in 2015-16
Introducing opportunity costs...

• Spending on an area means less spending in another

• This is particularly important in LMICs where budget constraints are high = high opportunity costs

• Opportunity costs = health gains that could have been gained (or lost) from spending on an alternative intervention
Opportunity costs in local context

- Intended effects
- Unintended effects

Net clinical benefit

Expanding PrEP use to key populations

Source: Glassman, 2018
Expanding PrEP use to key populations in a LIC, e.g. Uganda

Source: Glassman, 2018
Expanding PrEP use to key populations in a HIC or MIC, e.g. Botswana

Source: Glassman, 2018
What type of decisions are amenable to “Priority Setting”?

- Health Benefits Package
- Essential Medicines List
- Investment in infrastructure and capital
- Expanded Programs eg Immunization
- Design of policies (geographic roll out, scale up etc.)
Priority setting for a range of decision makers

- The Ministry of Health
- Any decentralised health authority (provinces, counties etc.)
- A disease programme
- A hospital or clinic
- A donor or development partner
An approach to setting priorities: Health Technology Assessment

HTA is the *multidisciplinary and systematic evaluation* of the properties and effects of a health technology, addressing the *direct and intended effects* of this technology, as well as its *indirect and unintended consequences*, and aimed mainly at *informing decision making*. 
“Urges member states to consider establishing national systems of health intervention and technology assessment, encouraging the systematic utilization of independent health intervention and technology assessment in support of universal health coverage to inform policy decisions”
HTA: a vehicle for the decision-making

• Way to systematically document what you want to know
• Multidisciplinary in nature – consequences =
  • Economic
  • Equity
  • Budget impact
  • Clinical effectiveness
  • Ethical
• Not a normative process, can include specific cultural considerations
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Type of questions

- Is this intervention worthwhile?
- How does intervention A compare to intervention B?
- Can I afford this?
- Who are the beneficiaries of the intervention?
- Where should I invest resources?
“... the comparative analysis of alternative courses of action in terms of both their costs and consequences.”

Drummond, Stoddart & Torrance, 1987

<table>
<thead>
<tr>
<th>Costs</th>
<th>Current treatment</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>value of extra resources used (loss to other patients)</td>
<td></td>
<td>value of health gain for this patient group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New treatment</th>
</tr>
</thead>
</table>

Economic evaluation
### Types of economic evaluation

<table>
<thead>
<tr>
<th>Type of analysis</th>
<th>Where it is used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-of-illness analysis</td>
<td>A determination of the <strong>economic impact of an illness</strong> or condition (typically on a given population, region, or country) e.g., of smoking, arthritis, or diabetes, including associated treatment costs</td>
</tr>
<tr>
<td>Cost-Effectiveness Analysis</td>
<td><strong>A comparison of costs in monetary units with outcomes in quantitative non-monetary units.</strong> When outcomes are in a measure of utility such as Quality Adjusted Life Years (QALYs) or averted Disability Adjusted Life Years (DALYs), it is often termed “cost-utility analysis” (CUA)</td>
</tr>
<tr>
<td>Budget Impact Analysis</td>
<td>Can be conducted in addition to a CEA to <strong>determine the impact of implementing or adopting a particular technology</strong> or technology-related policy on a designated budget, e.g., for a drug formulary or health plan.</td>
</tr>
<tr>
<td>Cost-Consequence analysis</td>
<td>A form of cost-effectiveness analysis that presents <strong>costs and outcomes in discrete categories</strong>, without aggregating or weighting them</td>
</tr>
<tr>
<td>Cost-Benefit analysis</td>
<td>compares costs and benefits, both of which are <strong>quantified in common monetary units</strong></td>
</tr>
</tbody>
</table>
Health gain can be expressed in any metric that suits the nature of the decision or the needs of the decision maker – e.g. hospitalisations avoided, life years gained, no. of people successfully initiated on treatment.

A generalised measure that takes into account length and quality of life eg Quality Adjusted Life Years (QALYs) or Disability Adjusted Life Years (DALYs averted) allows comparability across decisions and consideration of allocative efficiency.
Generalised measure of health outcome

- Full health
- Zero utility (e.g., HRQoL)

**QALY loss**
**QALY gain**
**current treatment**
**new treatment**

Time (years)

Acknowledgement: National Institute for Health and Care Excellence, UK
Cost-effectiveness analysis

Ex. Avastin: £200,000/QALY (NICE, 2010)

• What to do with an ICER?
  
  • Compare two or more interventions to identify which is preferred (same objectives)
  
  • Estimate the value for money of an intervention using a cost-effectiveness threshold
  
  • Compare interventions against a range of competing or previous decisions
How do we use the ICER to assess value for money?

- New treatment more expensive...
  - ... but some savings from reduced need for care in future

- New treatment more effective...
  - ... but harmful side effects for some people

Cost ($)

Effect (outcomes)
How do we use the ICER to assess value for money?

Treatment options in the shaded region are judged to provide good value for money (are ‘cost effective’)
New treatment dominated

<table>
<thead>
<tr>
<th>Cost Effect (DALYs averted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New treatment dominates</td>
</tr>
<tr>
<td>New treatment dominated</td>
</tr>
<tr>
<td>High extra cost; low health gain</td>
</tr>
<tr>
<td>Low extra cost; high health gain</td>
</tr>
</tbody>
</table>

Cost-per-DALY threshold

Effect (DALYs averted)

New treatment dominates
Introducing the bookshelf metaphor

Height of bars is “cost effectiveness”, width of bars is budget impact

Source: adapted from Culyer (2016)
Budget impact and cost effectiveness: determining interventions that are in... and out

Reproduced from Culyer, AJ (thanks to Chris McCabe and Richard Edlin for some animation of Culyer et al. (2007))

Interventions ranked highest to lowest

Health benefit per $1,000

Better than some current technologies

Worse than all current technologies

Other candidates (e.g., new technologies)

Health care expenditures

Budget

Source: adapted from Culyer (2016)
Budget impact and cost effectiveness: determining interventions that are in... and out

Source: adapted from Culyer (2016)
Budget impact and cost effectiveness: determining interventions that are in... and out

If an intervention is “cost effective but not affordable”, then the threshold used to determine “cost effectiveness” is too high.

Source: adapted from Culyer (2016)
## Cost Effectiveness Analysis

- Quantify the health trade off with other health system objectives
- Consider allocative efficiency, which underpins sustainable UHC
- Reveals technical inefficiency
- All patients, conditions, are equal
- Quantify the opportunity cost per $ spent
- Answers the question: should we do it

## Budget Impact Analysis

- Quantify the financial trade off with other health system and wider policy objectives
- Does not consider efficiency
- Does not consider effectiveness
- Discriminates on size of the population
- Facilitates program budgeting, strategic purchasing
- Pragmatic, easily understandable
- Answers the question: can we do it

Combining CEA with BIA allows us to quantify the opportunity cost in of the decision terms of total health.
Ghana: hypertensive medicines

- NHIS under considerable financial pressure: reduction in expenditure
  - 46% of claims costs = polypharmacy, inappropriate medicines
  - Antibiotics and antihypertensives – 60% of total drug expenditure

- Model the cost-effectiveness of four first line drugs to reduce blood pressure and prevent CVD
  - ACE inhibitors (ACE)
  - Beta blockers (BB)
  - Calcium channel blockers (CCB)
  - Thiazide-like diuretics (TZD)
  - Antagonist receptor blockers (ARP)
  - No intervention – comparator

- Outcomes: Disability Adjusted Life Years (DALYs)
Change from CCB to TZD (10% shift) could save 18.4% of the total hypertensive expenditure, although with a slight deterioration of health outcomes.
Fifty-seven studies were eligible for inclusion in the all-disease review. The most common subject disease was HIV/AIDS, followed by malaria. A diverse range of modelling methods, outcome metrics and sensitivity analyses were used, indicating little standardisation. Seventeen studies were included in the mosquito-borne disease review.

*With notable exceptions, most studies did not employ economic evaluation methods beyond calculating a cost-effectiveness ratio or net benefit. Many did not adhere to health care economic evaluations reporting guidelines, particularly with respect to full model reporting and uncertainty analysis.*
How are economic evaluations being reported?

- Describing intervention and comparator(s) being compared: 85%
- Informing reasons for choosing the comparator(s): 50%
- Reporting characteristics of target populations: 90%
- Describing the perspectives adopted: 90%
- Reporting time horizon used: 65%
- Discounting costs, where relevant: 92%
- Discounting outcomes, where relevant: 92%
- Informing unit of cost data: 100%
- Informing price date: 75%
- Explaining currency conversion method: 40%
- Describing the method of cost adjustment for time differences: 35%
- Describing all key model parameters, where relevant: 79%
- Reporting ICERs: 85%
- Discussing generalisability/transferability: 30%
- Discussing equity considerations: 30%
- Discussing affordability: 35%
- Informing role of funders: 60%
- Describing conflicts of interest: 60%

Source: Santatiwongchai et al 2015
*using the DALYs-averted outcome measure and BMGF-funded in vaccine, HIV/AIDS, TB, malaria program areas (n = 20)
Methods for economic evaluation: the iDSI Reference Case

The International Decision Support Initiative Reference Case for Economic Evaluation: An Aid to Thought

Thomas Wilkinson, MSc1, Mark J. Sculpher, PhD2, Karl Claxton, PhD3, Paul Revill, MSc2,
Andrew Briggs, DPhil4, John A. Cairns, MPhil5, Yot Teerawattananon, PhD6, Elias Asfaw, MSc7,
Ruth Lopert, MD, MMedSc8,9, Anthony J. Culyer, BA, Hon DEcon10, Damian G. Walker, PhD11

1PRICELESS SA, Wits Rural Public Health and Health Transitions Unit, School of Public Health, University of Witwatersrand, Johannesburg, South Africa; 2Centre for Health Economics, University of York, York, UK; 3Department of Economics and Centre for Health Economics, University of York, York, UK; 4Institute of Health and Wellbeing, University of Glasgow, UK; 5Department of Health Services Research & Policy, London School of Hygiene & Tropical Medicine, UK; 6Health Intervention and Technology Assessment Program (HTAP), Ministry of Public Health, Bangkok, Thailand; 7Economics department, University of KwaZulu-Natal, Durban, South Africa; 8Department of Health Policy and Management, George Washington University, Washington DC, USA; 9Management Sciences for Health, Arlington VA, USA; 10Department of Economics & Related Studies and Centre for Health Economics, University of York, UK; 11Global Development Program, Bill & Melinda Gates Foundation, Seattle, USA

journal homepage: www.elsevier.com/locate/jval
Methods for economic evaluation: the iDSI Reference Case

An aid to decision making

- Comparator
- Evidence
- Costs
- Time horizon and discount rate
- Transparency
- Impact on constraints
- Uncertainty
- Heterogeneity
- Perspective
How should the budget be allocated amongst these ‘n’ programs, modalities, and delivery options, considering their interactions with synergies and limitations?
A CEA on a single intervention provides important information about the intervention’s efficiency.

CEA can also be conducted on multiple mutually exclusive interventions for a condition or patent population (e.g., hypertension).

CEA results from existing studies can be grouped in league tables to give an indication of relative efficiency of different interventions in local context.
“To address the limits of cost-effectiveness analysis and consider broader factors in decision systems, packages of services and technologies should be considered together rather than in isolation and analyses incorporate overall health, financial and equity objectives and relevant constraints. Optimization tools have recently emerged to do this and can help to optimize a health benefits package tailored to specific objectives and time horizons within available budget envelopes, local and changing epidemiology, dynamic costs, and variable, non-linear benefits on different populations.”

Gorgens, Petravic, Wilson, and Wilson, 2017
Optimization approach: applying CEA to a broad package of interventions

An optimization approach can apply an analysis over multiple interventions, incorporating dynamic effects between interventions and incorporate underlying disease burden.

Schematic of an optimization algorithm in two dimensions of health services
Example Optimization approach: Incorporating dynamic interactions between interventions

- South Africa has extensive HIV program involving multiple interventions
- Ranking HIV interventions in the South African context by ICER provided an indication of relative efficiency in isolation
- Incorporating the interactive effects of the most cost-effective interventions at scale, increased the estimated ICERs of other interventions and changed rankings

League table ranking by ICERs by conventional and optimized routine in South Africa

Source: Chiu et al (2017)
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Mini case study exercise

- You are budget holder of a child immunization program
- Treasury has agreed to increase your budget to $4 million
- How to allocate the budget?

Four scenarios
- No budget constraints
- Burden of disease
- Cheapest vaccine
- Priority setting
What you need

Group work #2: The health impact of different resource allocation scenarios

This exercise is being used in a fictional setting, primarily aimed at applying concepts discussed in the previous sessions but a lot of it is from existing data and evidence (e.g. Disease priorities Central, Govt, IMME).

You will need:
- This instruction sheet
- A pen
- A computer to load the excel spreadsheet with the exercise (please ask a staff member if you do not have a computer or have difficulties opening the spreadsheet).

You are the budget holder of the child immunization programme at JN in JN. JN has made major strides in decreasing under-5 mortality (USM) in the last decade. Deaths from diphtheria, tetanus, whooping cough and meningitis have declined drastically from the introduction of the Pentavalent vaccine. However, USM in JN is still high compared to the regional average and much of the USM has been attributed to vaccine preventable diseases. Despite the expansion of the immunization programme, coverage for some key vaccines is still incomplete, resulting in lost lives.

This year the Ministry of Health of JN decided to increase funding to the vaccine programme to $4 million to further increase immunisation rates. You will have to allocate programme resources to the 5 vaccines that are currently in your programme portfolio (Table 1).

Table 1. Vaccines and the diseases targeted, with corresponding burden of disease

**Guidelines for the use of the excel spreadsheet**

**Scenario #4: Allocation based on burden of disease**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>% of budget</th>
<th>Budget in $</th>
<th>Number of children immunized</th>
<th>DALYs averted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentavalent</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Measles vaccine</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BCG vaccine</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rotavirus vaccine</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0%</td>
<td>4,000,000</td>
<td>N/A</td>
<td>0</td>
</tr>
</tbody>
</table>

Enter the answer

Do not touch anything else!

Outcomes automatically update
What data do you have

Table 1. Vaccines and the diseases targeted, with corresponding burden of disease

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Target</th>
<th>Share of total burden of disease attributed to the diseases targeted by vaccine¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentavalent (combined vaccine)</td>
<td>Diptheria, Tetanus, pertussis, HiB and HepB</td>
<td>40%</td>
</tr>
<tr>
<td>Measles vaccine</td>
<td>Measles</td>
<td>20%</td>
</tr>
<tr>
<td>BCG vaccine</td>
<td>Tuberculosis</td>
<td>15%</td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td>Pneumococcal disease</td>
<td>15%</td>
</tr>
<tr>
<td>Rotavirus vaccine</td>
<td>Rotavirus</td>
<td>10%</td>
</tr>
</tbody>
</table>

Budget: $4 million

Patients: 200,000


Table 2. Cost and cost-effectiveness ratios

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>$ per immunization</th>
<th>$/DALYs averted</th>
<th>DALYs averted per immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentavalent (combined vaccine)</td>
<td>10</td>
<td>20</td>
<td>0.50</td>
</tr>
<tr>
<td>Measles vaccine</td>
<td>6</td>
<td>60</td>
<td>0.10</td>
</tr>
<tr>
<td>BCG vaccine</td>
<td>4</td>
<td>120</td>
<td>0.03</td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td>8</td>
<td>100</td>
<td>0.08</td>
</tr>
<tr>
<td>Rotavirus vaccine</td>
<td>8.5</td>
<td>120</td>
<td>0.07</td>
</tr>
</tbody>
</table>
Results – total DALYs averted

- Priority to cheapest vaccine: 46,000
- Allocation based on BoD: 107,667
- Priority setting: 128,000
- No budget constraints: 156,833
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Challenging the status-quo

• Decision mechanisms already in place:
  • Historical budget allocations
  • Line item budgets: salaries, equipment purchase
  • Use of international guidelines (directly adapted to local context)
  • Expert opinions
  • GOBSAT*

• ‘Reasonable’ given constraints, but...
  • Rapid changing disease burden, health needs, medical technologies
  • Not transparent: vulnerable to influence from particular interests or industry
  • Narrow focus

GOBSAT = Good Old Boys Sat Around A Table
Decision making that is accountable for “reasonableness”

- **Scientific Rigour**: Strong, consistent, scientific methods; incorporation of critically appraised evidence and information.
- **Inclusiveness**: Wide and genuine consultation with stakeholders; willingness to change decision in light of new evidence.
- **Social values**: Incorporates values of society – eg whether to prioritise end of life.
- **Transparency**: Decision criteria, rationale, and evidence supporting decisions made public and accessible.
- **Independence**: “Arm’s length” from government, payers, industry and professional groups; conflicts of interest managed.
- **Review**: Regular updates of decisions and methods, formal opportunity to challenge decisions.
- **Support for implementation**: Implementation products eg schedules of benefits, quality standards; active communication with stakeholders.
- **Timeliness**: Decisions produced in reasonable timeframe; with minimal delay in publication.
- **Appeal**: Decisions produced in reasonable timeframe; with minimal delay in publication.

*Social Value Judgments, NICE 2008, adapted from Daniels N, Sabin J*
Can we afford to institutionalize priority setting?

<table>
<thead>
<tr>
<th>Country</th>
<th>Entity</th>
<th>Funding sources</th>
<th>Budget (as % of total health budget)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>IGWIG</td>
<td>Fees for each ambulatory visit and hospitalizations</td>
<td>US$19 million (0.01 percent of SHI expenditure)</td>
</tr>
<tr>
<td>Australia</td>
<td>PBAC</td>
<td>Mainly application fees to be paid when requesting an evaluation, complemented</td>
<td>US$15 million (0.01% of total health budget)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>by DoHA program funding</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>CV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>NICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>ANVISA</td>
<td>Public resources of the general budget</td>
<td>No stable budget allocation (less than 1% of SUS budget)</td>
</tr>
<tr>
<td></td>
<td>CITEC and DECIT</td>
<td>Public resources of the general budget</td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>n.a.</td>
<td>Public resources of the general budget</td>
<td>Not defined</td>
</tr>
<tr>
<td>Uruguay</td>
<td>FNR</td>
<td>Public resources of the general budget</td>
<td>Not defined as immersed in general budget of FNR, which also finances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>high-cost technologies</td>
</tr>
<tr>
<td>Colombia</td>
<td>CRES</td>
<td>Public resources of the general budget</td>
<td>Not defined as immersed in general budget of CRES, which carries out many</td>
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<td></td>
<td></td>
<td></td>
<td>other tasks besides evaluating and deciding on coverage of the benefits</td>
</tr>
<tr>
<td>Poland</td>
<td>AHTAPol</td>
<td>70% of support from the general budget. The rest comes from other sources,</td>
<td>The 2011 AHTAPol's budget is about PLN 10,500,000 (0.018% of the completely</td>
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<td></td>
<td></td>
<td>including statutory fees paid by pharmaceutical companies, which submit</td>
<td>separate NHF budget</td>
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<td>reimbursement applications, fees for training, grants, and interest</td>
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<tr>
<td>Thailand</td>
<td>HITAP</td>
<td>HITAP receives its main funding support from four public institutions: the Thai</td>
<td>About 30 million baht (about US$1 million) have been allocated to HITAP</td>
</tr>
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<td>Health Promotion Foundation; the Health Systems Research Institute; the Health</td>
<td>annually for all its health technology assessment activities, including</td>
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<td>Insurance System Research Office; and the Bureau of Policy and Strategy, Ministry</td>
<td>capacity building and health technology assessment dissemination</td>
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<td>of Public Health</td>
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</tbody>
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The question is not whether to set priorities - but how to improve priority-setting processes.
• Web: idsihealth.org
• Twitter: @idsihealth
1. Introduction to iDSI and the work we do
2. The case for Priority Setting
3. Concepts and methods used in Priority Setting
4. Exercise
5. Priority Setting and accountable decision making

6. Considerations when developing local processes
1. Seize your chance

• Priority setting on its own is a hard sell

• Find ‘windows of opportunities’
  • Announcement of UHC plans
  • Revisions of Essential Medicines List
  • Budget constraints/pressures

• Starting small and scale-up, ‘proof of concept’ project

India's 'Modicare' to cost about $1.7 billion a year: sources

Aditya Kalra
2. Be prepared: document the political economy

• Priority setting can be a disruptive force
• Who wins and loses from Priority Setting

• Hauck and Smith (2016) - broad lines:
  • Firms - maximise their profits
  • Consumers – maximise their own utility
  • Policy makers – political support or personal gain

• Stakeholder analysis and mapping
  • Identifying stakeholders, their relative power, interests and past ‘behaviour’

• Supportive groups (e.g. employers):
  • Voluntary testing and anti-retroviral therapy is provided by Anglo American (mining company) in Southern Africa

• Some groups have no representation!
3. Political commitment to PS

- Policy makers need to be sensitised
  - Not always welfare maximisers!
- Higher leadership at key Ministries (Health, Finance) must support the need for Priority Setting
4. Communication is key

- At minimum, information on decisions and methods featuring in MoH
- Lay versions, reports, consultations tailored to different audiences

OPINION

A baby is condemned to death by socialized medicine

Power of individual stories

Source: Washington Examiner, June 30, 2017
Example: HITAP’s communication strategy

• For each project:
  • Produces comprehensive research report
  • Policy brief for policymakers
  • Infographics on their website
  • Articles in peer reviewed journals

• From the onset:
  • Project announcement: newsletter updates 4 times per year
  • Press releases on topic selection
  • Individuals can enquire about projects

Source: Culyer et al., 2016
5. Building an inclusive process

- Not all stakeholders need to be part of the decision making

- Different forms of participation:
  - Information gathering, Consultation, Decision-making
  - Interests need to be defined

- Inclusion is resource-intensive and presents its own risks

- Colombia’s HBP was abandoned (1993), three attempts to build up HITAP
6. Building capacity to support Priority Setting

• Locally relevant expertise/skills: e.g. epidemiology, health economics, meta-analysis, policy analysis, mathematical optimization etc.

• Type of capacity
  • Knowledge generation
  • Users of evidence
  • Knowledge brokers

• Networks and local expertise rather than individuals working in silos
Not just technical capacity

Activities

- Political commitment
- HTA roadmap
  - Workshop
  - Budget
- HTA guidelines
- Involvement in related international organisations
- Good coordination within Ministry of Health
- Establishment of HTA committee
  - Full-time staff
  - Facilities
  - Action plan
- Technical training **
- Hands-on experience **

Source: Li et al., 2017
7. Ensuring long-term commitment

- Anchoring PS principles in institutions and even law/regulations. HTA examples:
  - Taiwan, South Korea and Indonesia have appointed by law HTA bodies

- Beware of legislative traps!

- Financial commitment
  - eg South Africa - funding to develop HTA processes in support of NHI included in the health budget