

Setting priorities using health benefits plans

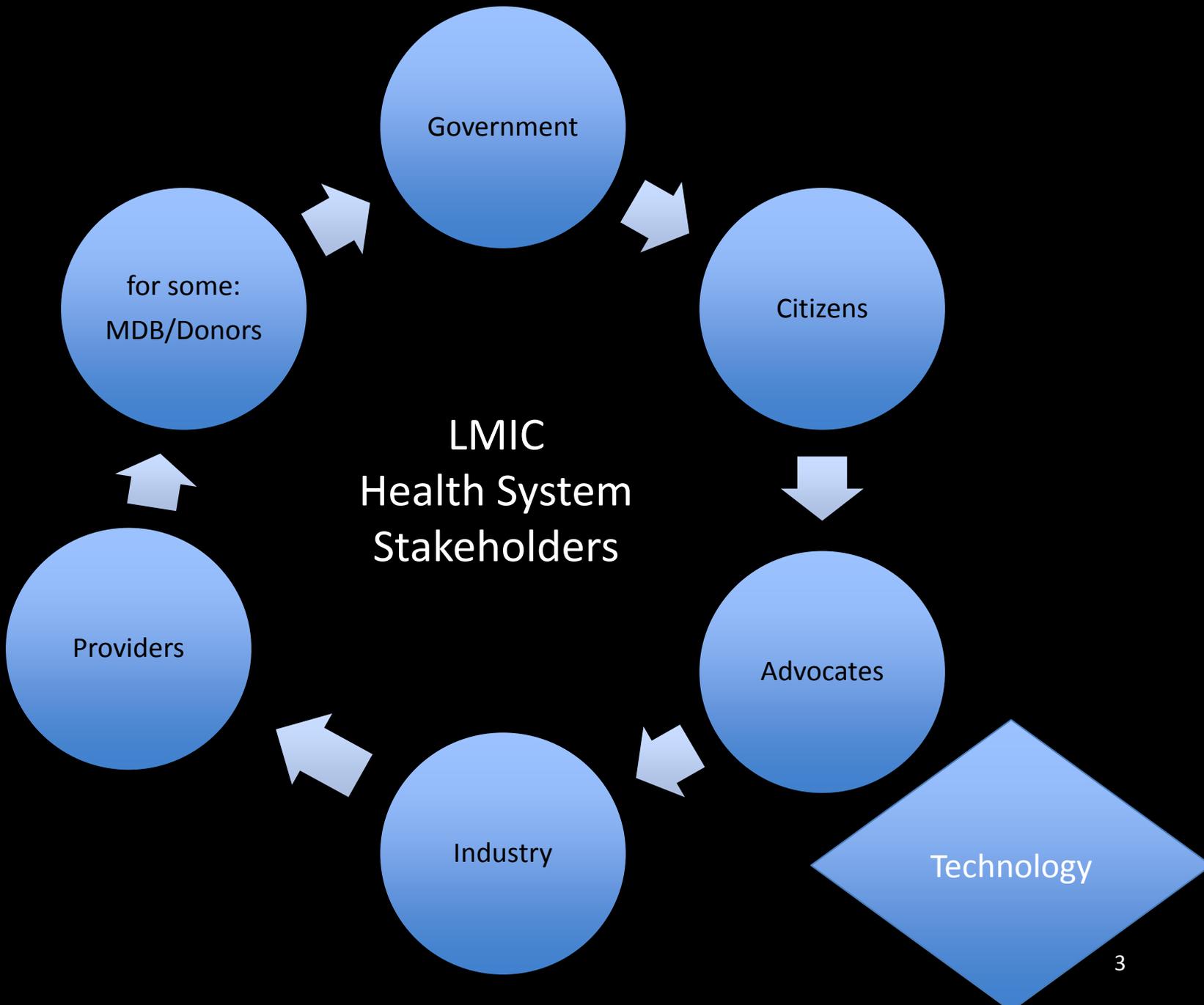
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Outline

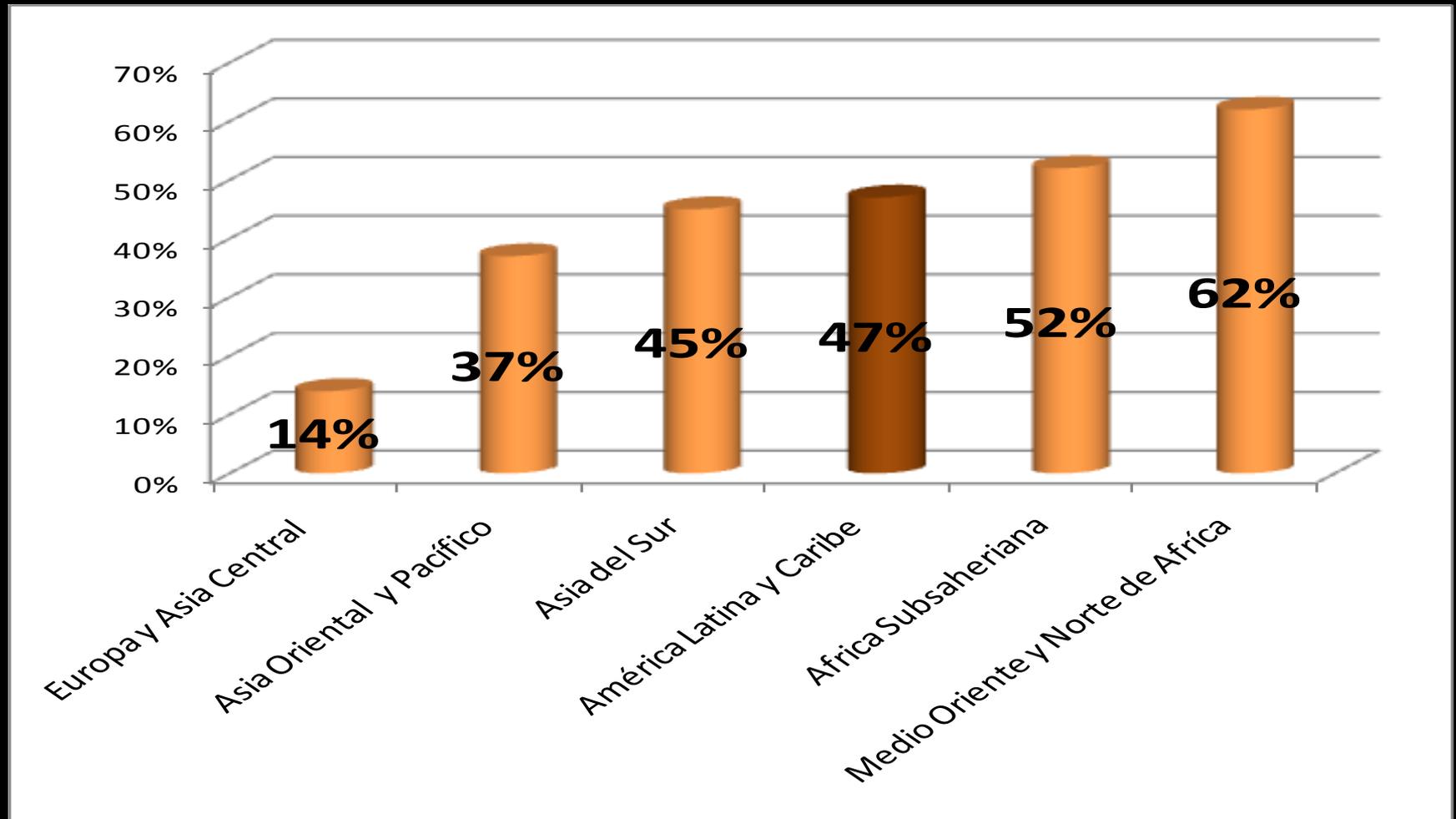
- 1 Why is it so hard for governments to set priorities?
- 2 One strategy to set priorities: health benefits plans
 - Terms and definitions
- 3 Current trends in HBP
- 4 Missing links



Governments: Easy to promise everything, but not to deliver

- “The state of Haiti has the **absolute obligation to guarantee** the right to life, **health** and protection without distinction...The State has the **obligation to ensure for all citizens the means to ensure the protection, maintenance and restoration of their health...**”

Citizens: As populations age, grow wealthier and more educated, their demand for health care increases



Projected demography-related spending increases by region to 2030, World Bank 2007

Advocates: Everything is a priority according to someone

Review

Journal of INTERNAL MEDICINE

doi: 10.1111/j.1365-2796.2010.02269.x

Chronic kidney disease: a public health priority and harbinger of premature cardiovascular disease

Reducing tobacco use top priority says Lancet

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



Asthma management in general practice

A chronic disease health priority

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

Blood-pressure-related disease is a global health priority

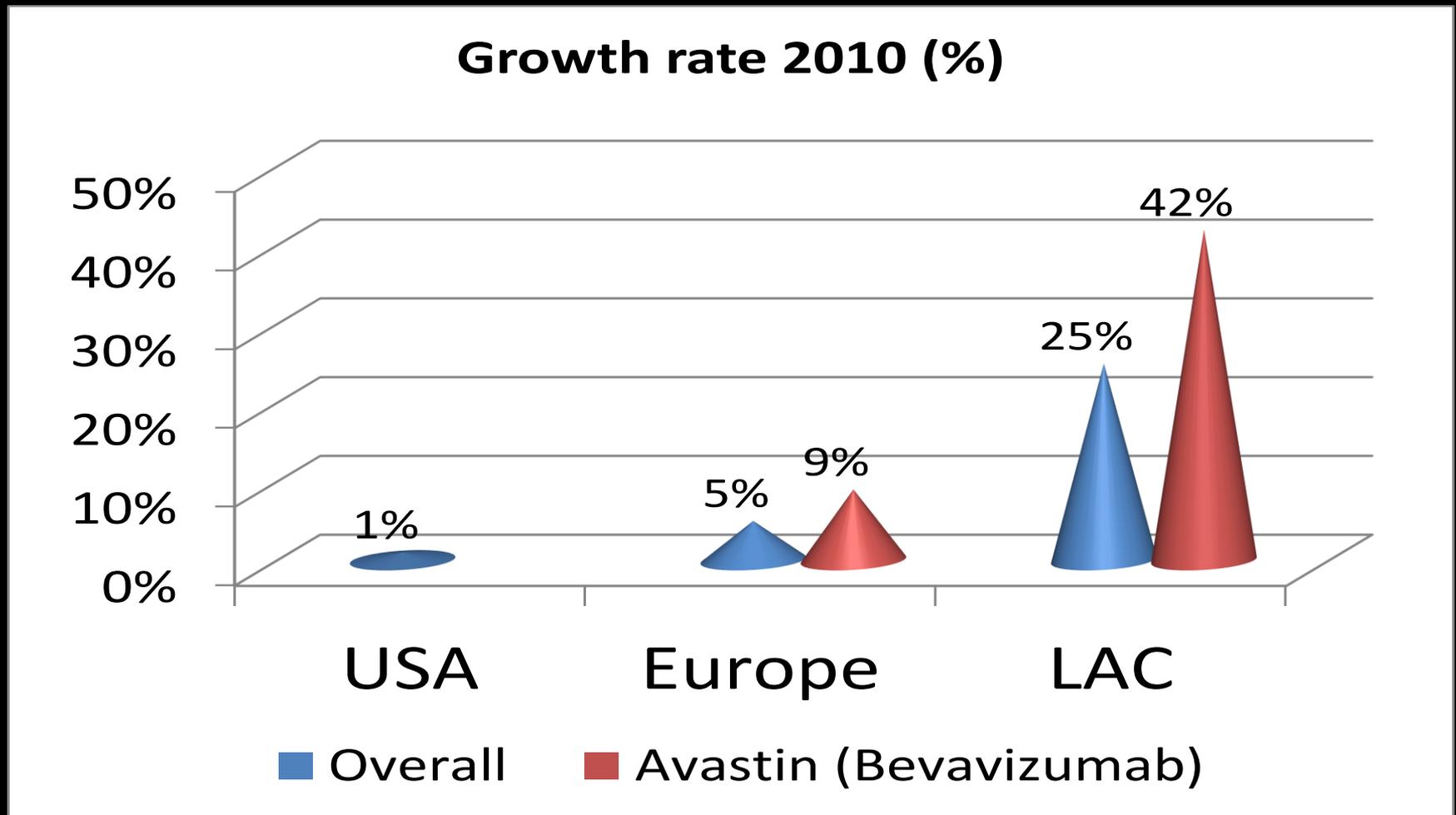
Palliative Care: A Public Health Priority in Developing Countries

Cáncer de mama en México: una prioridad apremiante¹

Breast cancer in Mexico: an urgent priority

Mental health problems will be the number one health priority for the world in the near future and workplaces must play their part in tackling it, a conference has heard.

Industry: Growing economies and public spending mean LMIC are increasingly attractive



Providers: patient-centered, facing own incentives and unaware of larger system effects



http://www.newyorker.com/humor/issuecartoons/2012/01/23cartoons_20120116#slide=5

Donors: Sometimes have their own preferences

“If a (middle-income) country is perceived not to have the money to pay for vaccines, we need to go into the country to get them to prioritize that spending.”

- Bill Gates, June 13, 2011

Definition

- *A health benefits plan* is one way to set priorities:
 - the totality of services, activities, and goods covered by publicly funded statutory/mandatory insurance schemes (social health insurance, SHI) or by National Health Services (NHS)
 - can also be termed a list (+/-), a package, a basket, a catalogue, a fee schedule
 - Schreyogg et al 2005

Benefits plans set priorities explicitly ex ante, not ex post

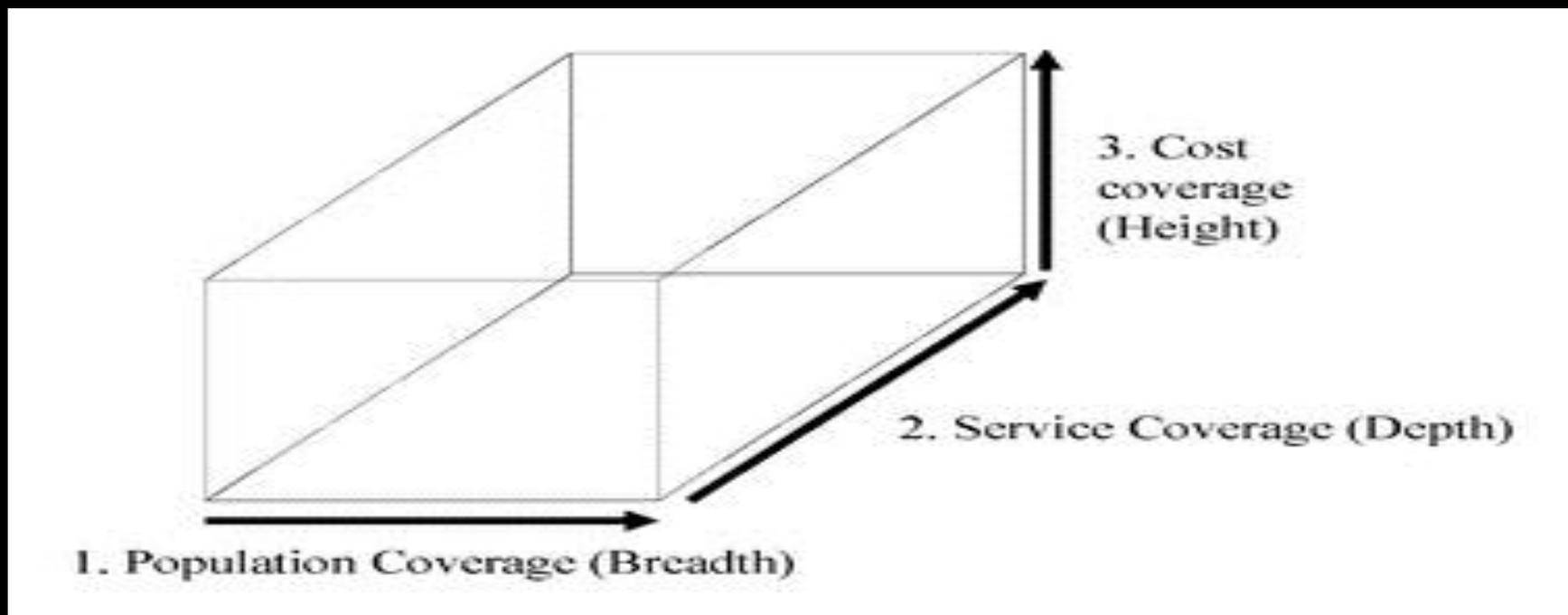
<i>Ex Ante</i> Rationing Mechanisms	<i>Ex Post</i> Rationing Mechanisms
Benefit package, essential package, covered services	Time
	Price
	Distance
	Chance

Why define health benefits?

- Improve effectiveness
- Control spending growth
- Reduce care variations or inequalities
- Cost out budgets and define what will be financed
- Create specific, enforceable, contractable entitlements
 - Create provider accountability (contracts, supervision, audits)
 - Empower users (“I’m supposed to get this.”)
 - Part of purchasing reforms from insurance to P4P

How to go about defining HBP?

- At least 3 dimensions – breadth, depth, height, but also VALUE
 - Limited scope – essential medicines lists
 - Broader scope – set of interventions



Limited scope HBP: essential medicines lists

- Even if NHS, will always buy medicines (and devices, but...)
- From 1977, “medicines that satisfy the priority health care needs of the population.”
- Model list published every 2 years by WHO “with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness.”
 - More evidence-based now, but run by clinical pharmacologists and limited transparency and standardization on incorporation processes
- Widely adopted, tracking of effectiveness began only recently
 - Omits most NCD (statins only recently incorporated), v. limited attention to local costs and affordability
 - Not necessarily linked to budgets

Broader scope HBP - some international antecedents

- Oregon Health Services Commission
 - *1989: develop a prioritized list of health services rank-ordered cost-effectiveness ratios*
 - *2012: develop a prioritized list rank-ordered into general categories of health services based on relative importance as gauged by public input and on Commissioner judgment. Within these general categories, individual condition/treatment pairs are prioritized according to impact on health, effectiveness and (as a tie-breaker) cost.*

Broader scope HBP: Plans that will purchase the largest improvement in health for a given budget

World Development Report 1993 (\$8 p.c.)

WHO Macroeconomics and Health Report 2001 (\$40 p.c.)

Focus on INTERVENTIONS, the sum of component medicines, devices and procedures, and associated inputs



Controversies

- Weak data, generalizing effectiveness and costs – and therefore production functions-
across settings
- Value judgments implicit in DALY/QALY, such
as age weighting
- Initially focused on health maximization, not
considering equity, financial protection,
preferences and other health system goals
- Still commonly used references!

Next came more studies, more syntheses, better models and tools

- Disease Control Priorities Project 1, 2, now 3
- Boom in published cost-effectiveness studies using LMIC data, leading to clearinghouses like EVIPNet and GPSHealth
- Build-your-own-HBP models like CHOICE, LiST, EVIDEM, MCDA with pilot applications in LMIC
- Modest, unconnected support to primary data collection via HMN, DHS, MICS, NHA but little on costs and spending
- Still limited attention to institutions and budgets in LMIC, mainly produced and used by academics, donors and advocates

LMIC governments began to adopt

- At least 63 LMIC currently use intervention-based HBP to structure a portion of their health expenditure
- More common in systems where purchasing and provision are separate, but increasingly common in integrated systems as well
 - Pay for performance

WB country grouping	Number	Positive or negative list of health benefits
Eastern Europe and Central Asia (ECA)	18	<p>Health Insurance schemes: Azerbaijan (SAMHI Decree as of 2008) [24]; Bulgaria (NHIF 1998 [25]; Croatia (HZZO) [26]; Estonia (2001 EHIF) [27]; Georgia (SMIC 1996) [28]; Hungary (OEP1992) [29]; Kyrgyz Republic (MHIF 1996) [30]; Lithuania (NHIF) [31]; Macedonia (HIFM) [32]; Moldova (MHI 2002) [33]; Poland (2003 NFZ) [34]; Romania (NHIF 2002) [35]; Russia (1993 MHIF) [36]; Slovenia (HIIS 1992) [37];</p> <p>Tax Funded Systems: Armenia (SHA 1998) [38]; Kazakhstan (MOH 2005) [39]; Slovak Republic (MOH) [40]; Tajikistan (MOH 2007) [41]</p>
Latin America and Caribbean (LAC)	14	<p>Health Insurance schemes: Argentina (PMO 1997) [42]; Chile (AUGE) [43]; Colombia (POS, 1993)[44]; Dominican Republic (SENASA 2002) [45]; Nicaragua (LPMQSS, 1996) [46]; Peru (PEAS 2009) [47]; Uruguay (PIAS 2007) [48]</p> <p>Tax Funded Systems: Argentina (Plan Nacer 2005) [49]; Bolivia (SUMI 2003) [50]; Brazil (lists conditional on DECIT evaluation)[51]; Honduras (IHSS 1995) [52]; Mexico (CAUSES, 2001) [53]; Nicaragua (MINSa) [54]</p>
Asia	8	<p>Health Insurance Schemes: Lao PDR (HEF 2008) [55]; Philippines (PhilHealth, 2006) [56]; Vietnam (HCFP, 2003) [57]</p> <p>Tax Funded Systems: Cambodia (HEF 2000) [58]; China (NRCMS, 2003) [59] ; India (NRHM 2005) [60]; Malaysia (MOH) [61]; Thailand (2001 UCS) [62]</p>
Middle East and North Africa (MENA)	16	<p>Health Insurance schemes: Egypt (HIO 1964) [63] Israel (NIH 1995) [64]; Lebanon (CNSS) [65]; Malta (NHS 1956) [66]; Syria (NHIS 2010) [67]; Tunisia (CNAM 2007) [68]; United Arab Emirates (Daman 2006) [69]; West Bank and Gaza (GHI) [70]; Yemen (in planning as of 2009) [71]</p> <p>Tax-funded systems: Bahrain (MOH 1979) [72]; Djibouti (MOH) [73]; Jordan (MOH1965) [74]; Morocco (AMO 2005) [75]; Oman (MOH) [76]; Qatar (SCH) [77]; Saudi Arabia (NHS) [78]</p>
Sub-Saharan Africa (SSA)	9	<p>Health Insurance schemes: Ghana (NHIS 2004) [79]; Kenya (NHIF 1998) [80]; Namibia (NMBF In Progress) [81]; Nigeria (NHIS 1999) [82]; Senegal (CBHI) [83]; South Africa (NHI Est 2012) [84]; Tanzania (NHIF 1999) [85]; Uganda (NHI Proposed) [86]</p> <p>Tax-funded systems: Zambia (MOH 1993) [87]</p>

Challenges in HBP adoption

Challenge	Effects
Technical	<ul style="list-style-type: none">• Poor or no local data on costs and epidemiology• HBP based on “ground zero” assumption, not considering existing health system and its effectiveness• No explicit criteria or method for defining inclusions or exclusions, insufficient documentation
Fiscal	<ul style="list-style-type: none">• HBP not linked to available resources and/or not allocated according to the cost of the plan.• No budget impact analysis of inclusion decisions
Institutional	<ul style="list-style-type: none">• Conducted as short-term, one-off exercises, no mechanism to update analyses based on new data• No consultative, transparent process to consider evidence, design HBP, and make adjustments, or allow for non-quantitative criteria to play a role in coverage decisions
Political	<ul style="list-style-type: none">• Plans legislated prior to costing due to political urgency• No disclosure of conflicts of interest• No explicit process to manage competing groups

HBP operate within a larger system of incentives

- Defining HBP is only a first step in assuring that interventions are effectively delivered and used (= a “real” priority)
 - Governance and ownership
 - Financing and payment
 - Supervision
 - Performance monitoring and measurement
 - Other

Trends

- UHC push
 - What does it mean?
 - “Emerging paradigm” - separation of payment and provision functions even within public sectors
 - Increasing litigation and pressures
 - Beyond the “basic” package
- MDB/donor trends
 - Results-based funding
 - Specific technologies

Missing links

- HBP not usually connected to HTA (next)
- Need to build and support institutional structures in LMIC permanently tasked with design, costing, implementation and tracking of HBP
 - Affordability and budget impact
 - Ethical and non-quantitative issues
 - Accountability and transparency



Working Group on Priority- Setting Institutions for Health

Preliminary Recommendations

PMAC Consultation

January 24, 2012

Thesis

- There are opportunities to
 - create, expand, and strengthen HTA systems in LMIC that inject objective and ethical assessment of risks, benefits, costs and value into decision-making on publicly-funded health services and technologies
 - bring HTA to the design, adjustment and evaluation of HBP and the purchasing decisions of donors (“unify the clans”!)
 - build permanent institutional capacity to use HTA to inform coverage/payment/reimbursement
 - consolidate currently dispersed and piecemeal efforts on medicines, devices and interventions; specific diseases and conditions

What do we mean by “HTA system”?

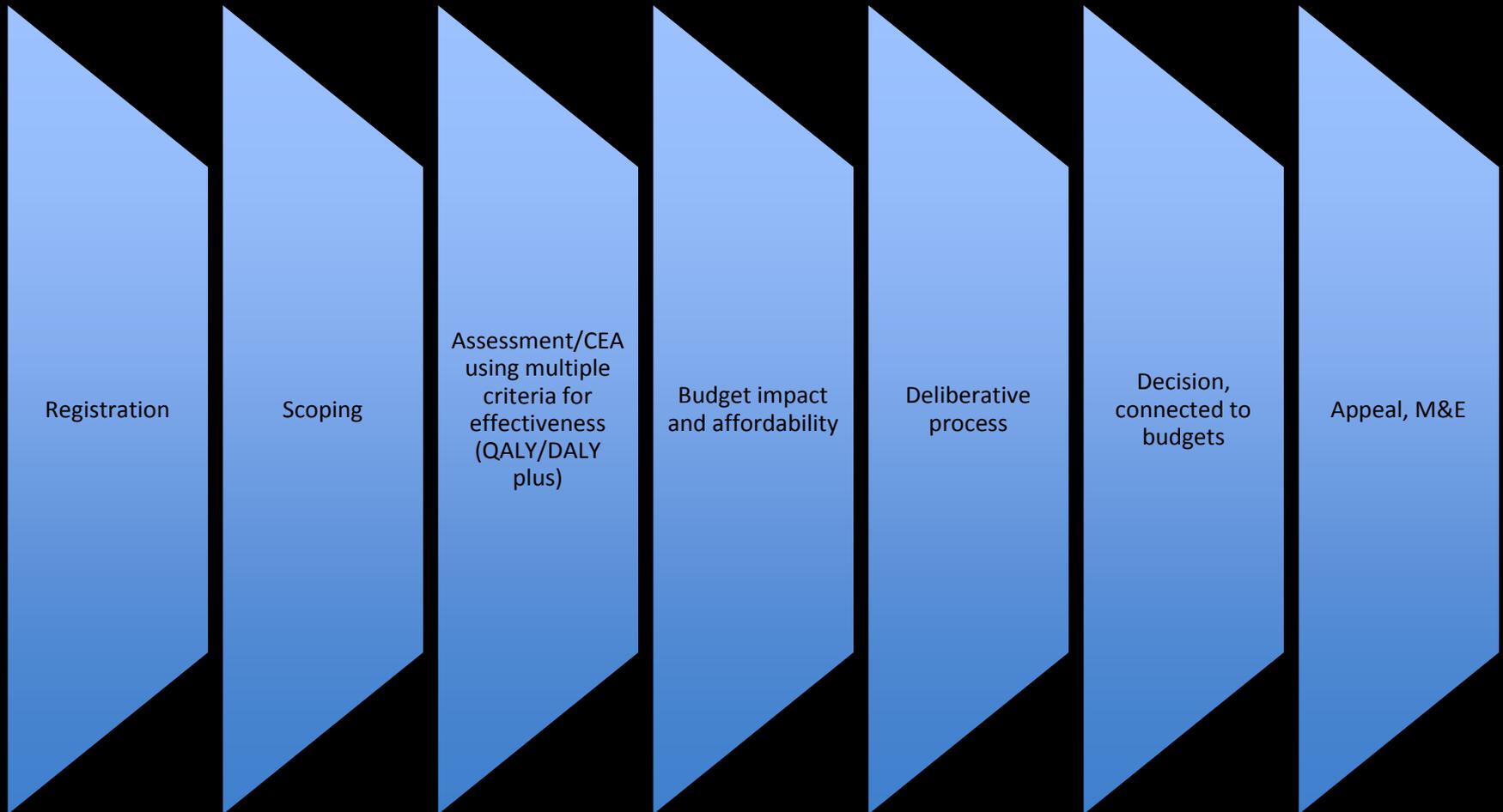
- HTA does not refer exclusively to the technical and analytic function of assessing an individual technology or intervention...
... but instead to the entire decision-making process and context of setting priorities for public expenditure on health...
...including the legislative, regulatory, policy, payment and reimbursement framework within which evidence is developed and used.

Challenges are country-specific, but getting to defensible “yes” and “no” decisions is a shared concern

- Each government or funding agency starts from its particular priority-setting challenge
 - Design a HBP during a reform
 - Address a major disease burden more effectively
 - Decide on a specific high-cost treatment
 - Decide on a new technology
 - Respond to a press scandal or a vocal constituent

And decisions in one country or by one international funding agency affect all countries, and the prices faced in the market.

Core processes of a HTA system



Budget impact and affordability

- The budget impact of a preliminary recommendation emerging from CEA should be assessed, and assessed against the counterfactual.
- Essential for LMIC that have highly constrained fiscal resources in the health sector, yet is almost never conducted as part of the introduction of new technologies.
 - A recent example is the adoption of the HPV vaccine by Rwanda

Deliberative process 1

- Why a deliberative process (Culyer 2010):
 - evidence from more than one expert discipline is involved;
 - stakeholders have conflicting interests;
 - there are technical disputes to resolve and the evidence may be scientifically controversial;
 - evidence gathered in one context is to be applied in another;
 - there are issues of outcome, benefits, and costs that go beyond the conventional boundaries of medicine;
 - there is substantial uncertainty about key values and risks that needs to be assessed and weighed;
 - there are other social and personal values not taken into account in the scientific evidence;
 - there are issues of equity and fairness;
 - there are issues of implementability and operational feasibility involving knowledge beyond that of the decision makers; and
 - wide public and professional 'ownership' is desired.

Deliberative process 2

- Setting up a rule-based, transparent, deliberative process around a technical recommendation for coverage allows for debate on the ethical and equity implications of decisions while providing a space for different interest groups to air concerns or bring new evidence to the table for consideration
 - ARV
 - Orphan diseases
 - Childhood cancers

Pervasive challenges, everywhere

- Scope large and unmanageable, demands are urgent
- Technical capacity shortfalls
- Roles and responsibilities in fragmented settings
- Weak governance and corruption
- Data problems
- Weak links to decision-making

Preliminary recommendations 1

- Global HTA Facility with regional hubs:
 - Develop standards and accredit country HTA systems
 - Conduct or facilitate HTA system for global health funders, create HTA conditions for receipt of funds
 - Generate economies of scale in adaptation of evidence dossiers, sharing and benchmarking coverage decisions
 - Coaching on process and institutional issues, other “know-how”, practitioner-to-practitioner
 - Standard data instruments

Preliminary recommendations 2

- Increased support to LMIC governments to
 - set up HTA systems and run pilots from a country's relevant priority-setting starting point
 - provide direct support to collect and analyze data needed to adapt international evidence to local decisions (costs, utilization, epidemiology)

Preliminary recommendations 3

- International agencies start
 - supporting global HTA facility and accreditation processes as conditions for funding
 - viewing HTA and priority-setting integrally
 - respecting country decisions
- International agencies stop
 - one-off consultancies to “define the package”
 - introducing new technologies with no regard to opportunity costs and affordability
 - generalizing cost data to specific country settings
 - using “don’t ask, don’t tell” and implicit rationing to decide who gets what (e.g. ARV)
 - treating medicines/devices/interventions/diseases as separate HTA categories

Questions for discussion

- How can the international community (WHO/PAHO, Global Fund, World Bank and others) best support HTA systems in LMIC? What should they start and stop doing?
- What issues can be addressed globally? What regionally? What nationally? Where are there opportunities for shared effort?
- What are main obstacles going forward? Do you agree with the obstacles identified? Are there missing issues?

- More comments and suggestions? E-mail:
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- For more information on the working group and its members, and for the draft report when available, see:
 - http://www.cgdev.org/section/topics/global_health/working_groups/priority_setting_institutions