PRINCE MAHIDOL AWARD CONFERENCE 2016 | PRIORITY SETTING FOR UNIVERSAL HEALTH COVERAGE

Conference synthesis:
Summary & Recommendations

Sunday 31 January 2016

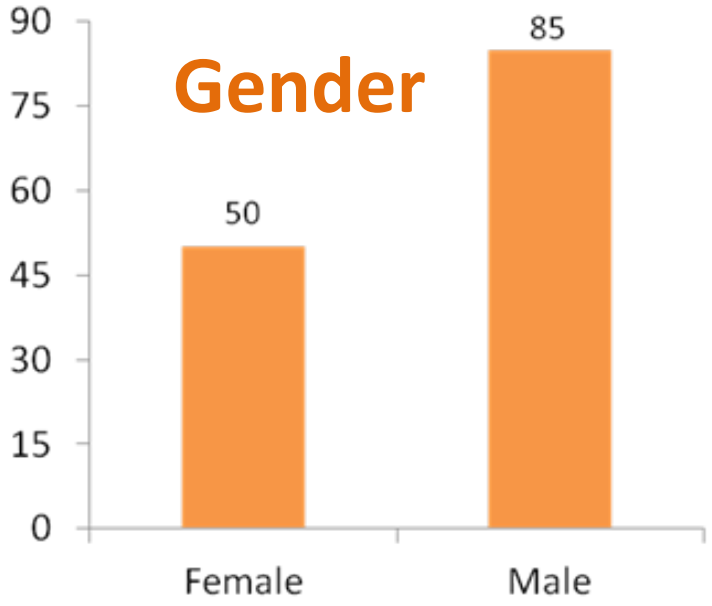
10.00-11.00

Conference programme structure

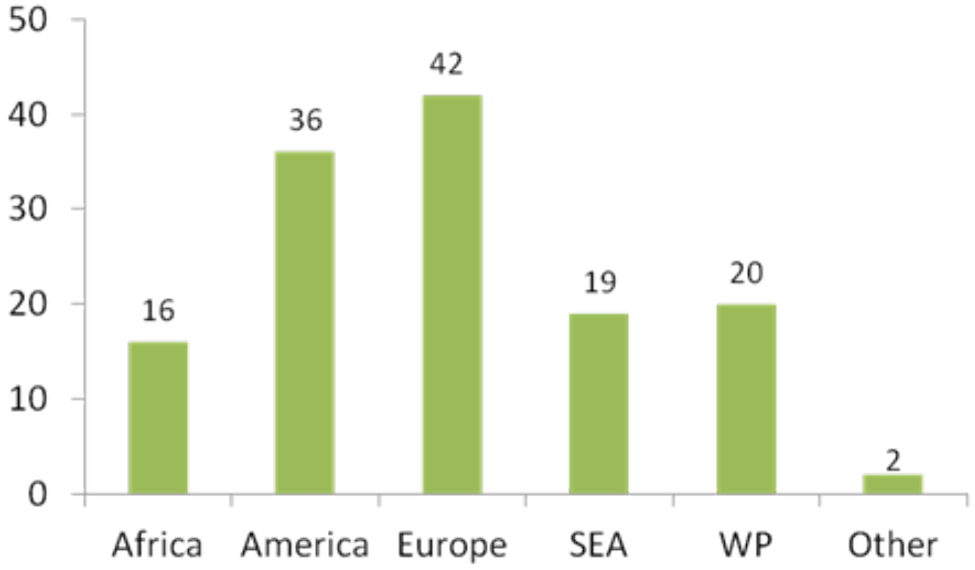
- Pre-conference: 26 – 28 January 2016
  - 52 side meetings
  - 6 field trips
- Main conference 29 - 31 January 2016
  - 4 Keynote addresses
  - 5 plenary sessions
  - 15 parallel sessions
  - 8 Launches: books, website, program
- Total registered participants,
  - 63 countries; 847 participants (F 39%, M 44%, NA 16%)

Profile: moderators/speakers/panelists

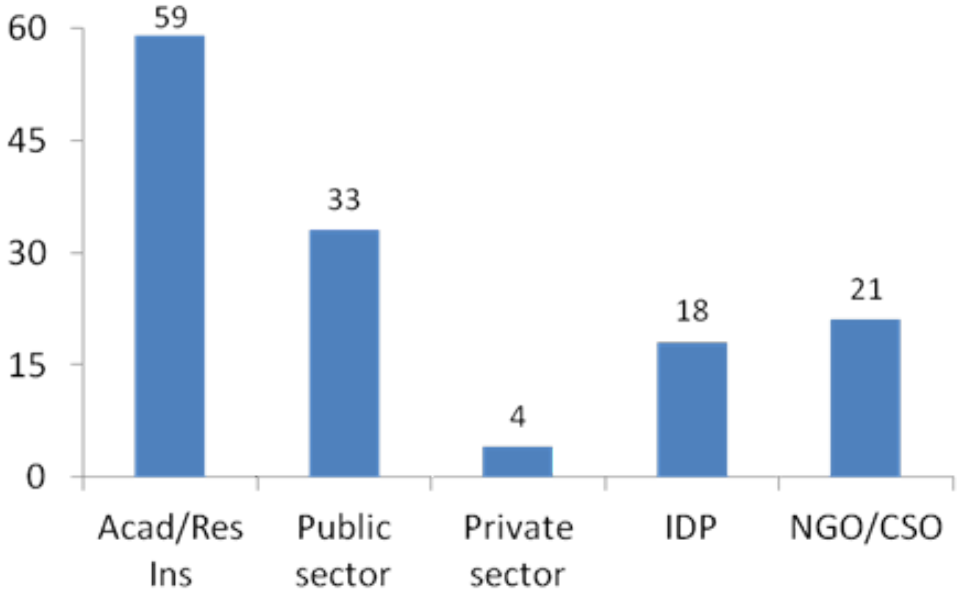
20 Plenary & parallel sessions	
Chairs/moderators	26
Speakers	59
Panelists	50
Total	**135**



WHO Regions



Organization



Rapporteuring

- Each session had three or four rapporteurs
- Pre-meeting for rapporteurs
- Templates for abstract and summary
- Abstracts are used for this session
- Both abstracts and summaries will be used for the conference proceedings
- All presentations are uploaded on the web site : www.pmaconference.mahidol.ac.th
- Gratefully acknowledge the contributions of all 71 rapporteurs

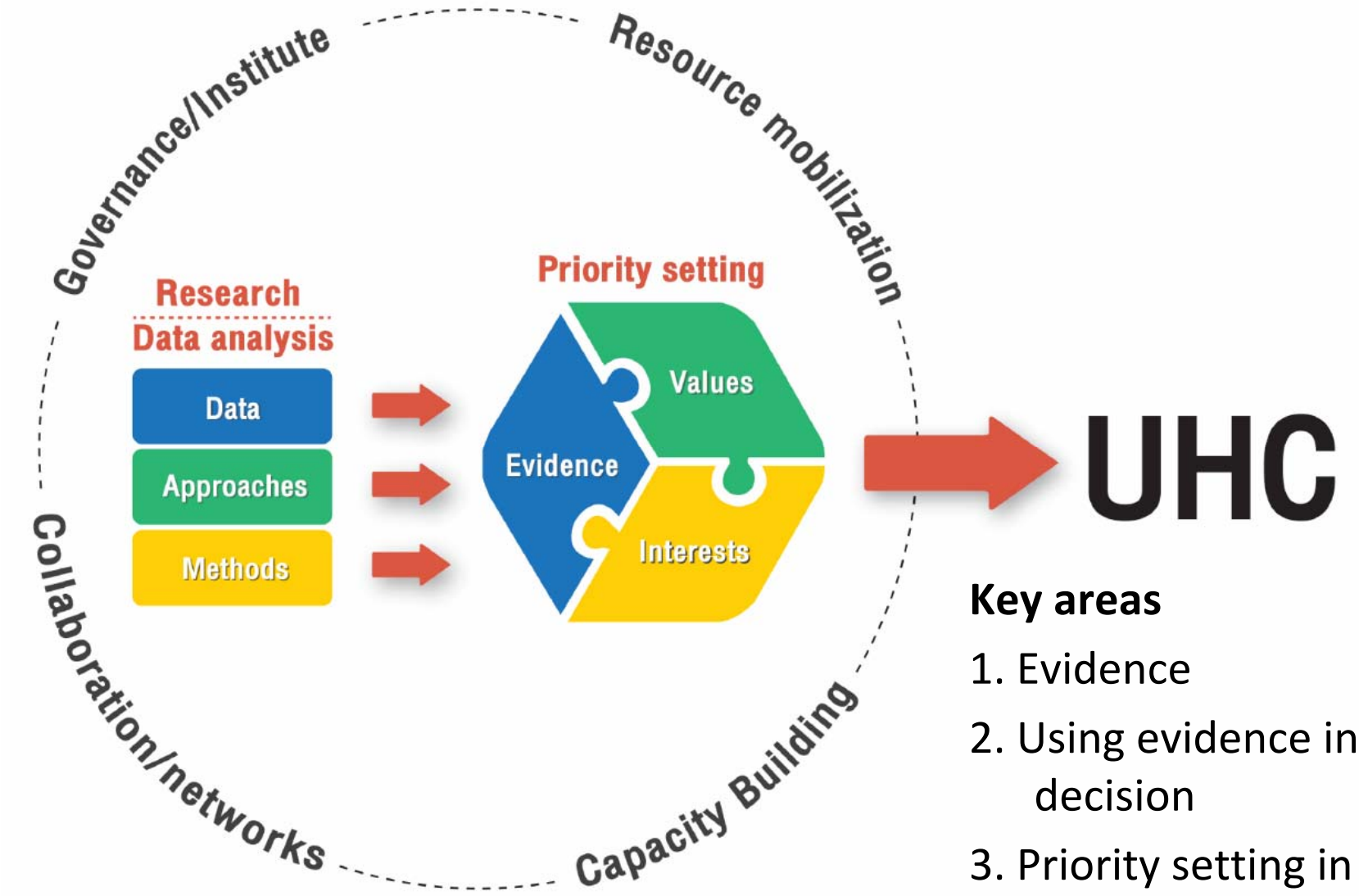
Global context

- Commitments to Universal Health Coverage (UHC)
  - UNGA Resolution A/70/L.1 “Transforming our world: the 2030 Agenda for Sustainable Development” Oct 2015
    - UHC in SDG3.8
- Commitments to Health Intervention and Technology Assessment (HITA)
  - WHO AMR/PAHO resolution, CSP28.R9 “Health Technology Assessment and Incorporation into Health Systems” Sep 2012
  - WHO SEA Regional Committee Resolution SEA/RC66/R4 “HITA in support of UHC” Sep 2013
  - World Health Assembly Resolution WHA67.23 “HITA in support of UHC”, May 2014
    - *Inter alia*, call for strengthening national capacity, regional and international networking

Matching resources and demand for health

- Health resource is finite, demand is infinite in light of demographic, epidemiological transitions, technology advancement and increased expectations
- Government must be accountable to people to make best use of limited public resources
- HITA essential to inform resource allocation
- Goal of PMAC2016
  - Learning and sharing to drive ***Priority Setting for UHC***

Conceptual framework for the conference

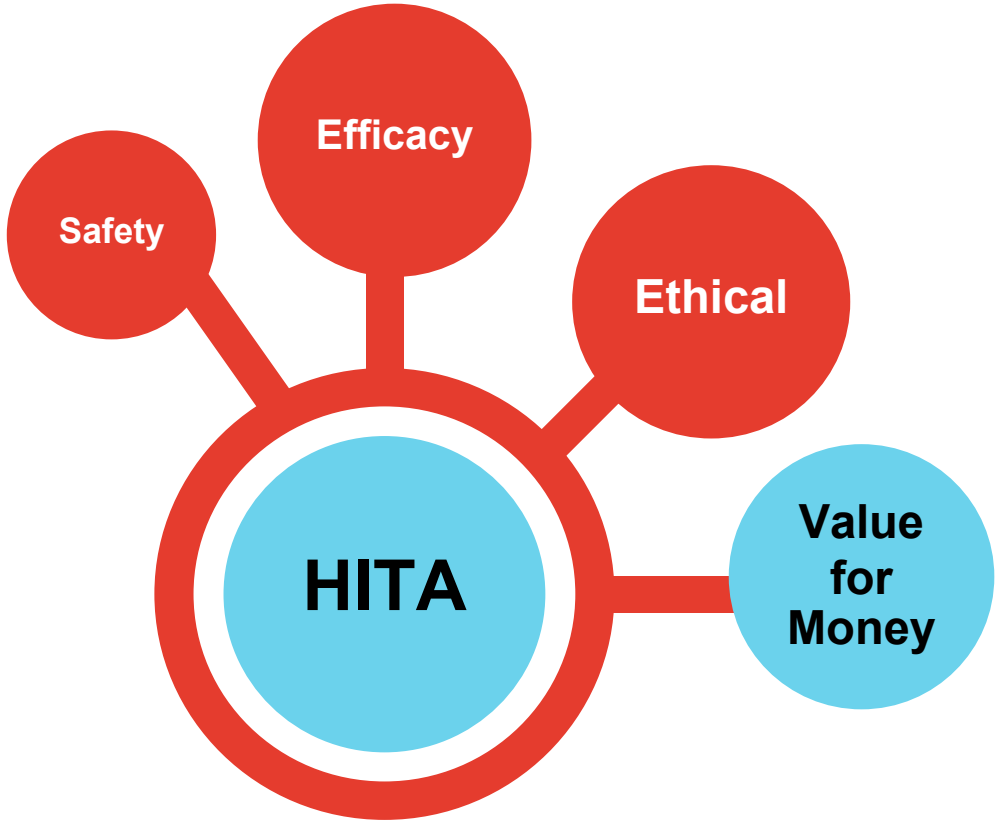


Key areas

1. Evidence
2. Using evidence in making UHC decision
3. Priority setting in action

1. Evidence for priority setting

Basic information on priority setting and its technical terms, with in-depth dialogues on current challenges



Markov
Meta-analysis
HTA
QALY
DALY
Economic Evaluation
EQ-5D
CEA
Utility
ICER
CBA
Threshold
CUA
Discount rate
Decision Tree

Evidence - overview

- Priority setting takes place at many different levels
  - Global, national, sectoral, local, individual
- Ministries of Finance consider a range of factors when choosing how much to allocate to health – impact on productivity/growth, cost-effectiveness, evidence that resources are used efficiently; comparisons across sectors are hampered by the absence of appropriate metrics
- Countries increasingly seeking to use evidence of cost-effectiveness in establishing benefit packages
- Lack of country level data on costs and effectiveness leads to reliance on global sources (eg. CHOICE, DCP)
- Range of initiatives to strengthen collection of national cost data –tools need to bridge theory and practical guidance

Evidence: Extending perspectives

- Methods need to take account of health system constraints, and to connect priority setting with the health system architecture
  - Human resources / capital; Costs of implementing changes (transition costs); System interdependencies (eg. economies of scope); Governance and decision making processes
- Such adaptation would aid process of generalisability of evidence across settings, and improve the effectiveness of priority setting
- Scope for wider application of methods which explicitly incorporate multiple criteria in decision making; but given uncertainties, their value may lie in the deliberative process they encourage

Evidence (cont)

- Important that evidence covers range of preventive and promotive interventions as well as curative ones
- Economic evaluation of system strengthening interventions is rare (e.g. pay-for-performance; strategic purchasing)
- Evidence on some social determinants and non-health interventions, although challenging, should not be ignored
- Considerable debate about appropriate thresholds for decision making; these must reflect opportunity costs and affordability (budget constraints/impact) in a particular setting; and not confuse the issue of thresholds with ensuring incentives for innovation.
- Thresholds have important implications for both health system sustainability and accountability.

Evidence (cont)

- Financial risk protection is also an objective of UHC: interventions may prevent households from falling into poverty, which can be captured through extended CEA or other methods
- Generating evidence is a dynamic process: need to keep the system up to date, be prepared to revise priorities as new evidence becomes available (examples from Thailand, New Zealand and South Korea)
- Horizon scanning / early assessments of new technologies are also part of the HITA continuum; important to remember "frugal innovation" as well as those innovations that improve outcomes but at considerable additional cost
- Particular challenges of de-listing / addressing the "trailing edge" of technologies

2. Using priority-setting evidence in making UHC decision

Economy

Interests

Policies

Equity

Social value

Evidence

Decision making

Understanding priority-setting

- Analysis of evidence is an essential starting point, but values and interests also come into play to protect human rights
  - Different interests can skew or better shape priority-setting
  - Different values can be in conflict

    => How to reconcile evidence, values and interests?

- Principle for priority setting: (1) should be impartial, (2) treating equal as equal, (3) should aim at fair distribution and health maximization and (4) should satisfy with condition of fair process

- Priority-setting has a dynamic nature
  - Values and interests change
  - Evidence changes: new interventions, new methods

- Monitoring and evaluation is an important part of the priority-setting process
  - Did the outcome of the priority-setting process play out as anticipated?

Participation in priority-setting processes

- Strive to create TRUST in the process
- Process must be transparent
- Process must be inclusive; engage with all stakeholders
- Process must be impartial

- Will need to ACTIVELY ENABLE participation and facilitate dialogue across groups
- Not all stakeholders are equal in power: gender issues, marginalized groups, language, information gaps
- How do we level the playing field in which the priority-setting game is played?
- Need mechanisms to strengthen individual capacity; strengthen institutional capacity; overcome gender barriers to participation, facilitate inclusion of marginalized groups

- Engage EARLY and OFTEN

- Need to ensure that participation is not only inclusive, but MEANINGFUL in that it allows the views of participants to be reflected in the ultimate decisions

Donors also influence priority-setting

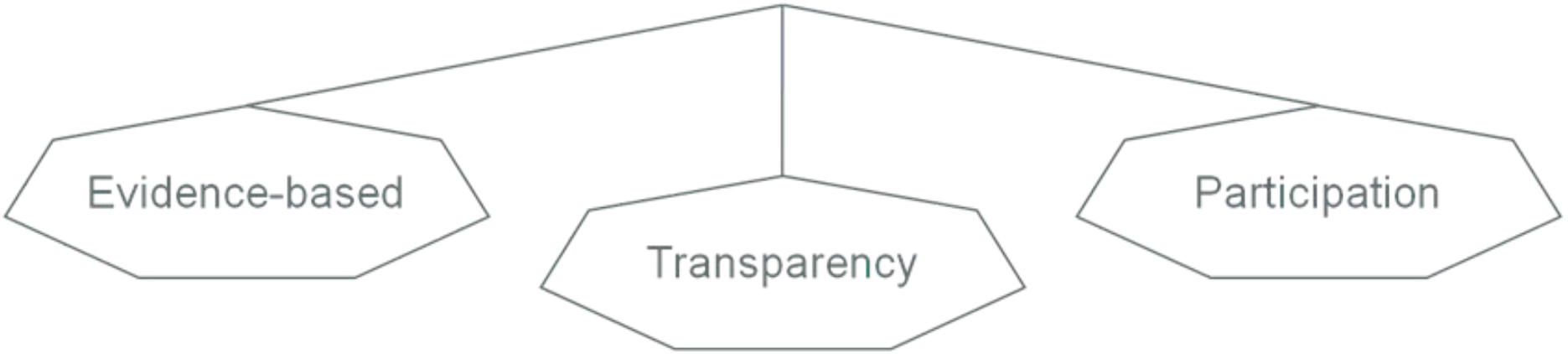
- Donors also have priorities, which reflect evidence, values and interests, which may be in conflict with other stakeholders in the priority-setting process
- They also bring important resources to support
  - Generation of evidence
  - Development of HITA capacity
- Donors should play a supporting, not a dominant role
- Can a systematic, participatory and transparent process of priority-setting at the country level help to persuade donors to prioritize differently?

3. Priority setting in action: learning and sharing experiences

Real world experiences

UCBP The Universal Health Coverage Benefit Package of Thailand
โครงการศึกษาเพื่อพัฒนาชุดสิทธิประโยชน์ ภายใต้ระบบหลักประกันสุขภาพถ้วนหน้า

NLEM National List of Essential Medicines



Country level experiences

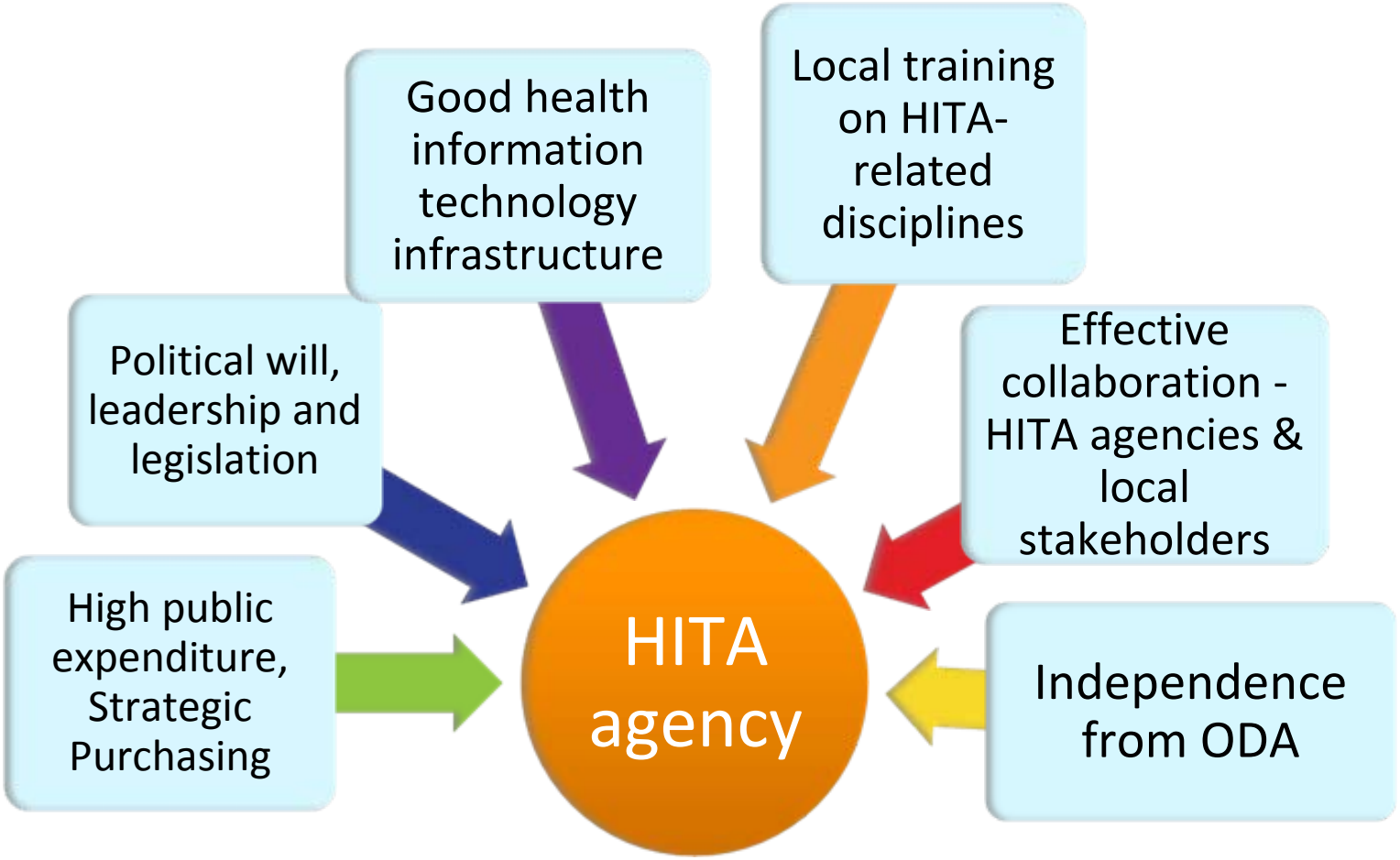
- Generate evidence
  - Local training and team building
  - Tapping expertise from universities, research institutes, reverse brain drain (ROK)
  - National guideline developed, endorsed and applied
  - HITA units, agencies established with or without legal entity
  - Supply (evidence) induced demand (users)
- Use of evidence for coverage decision
  - Enabling factor is demand for evidence by purchaser organizations
  - Large population coverage by purchaser organization is critical
  - Potential platforms for coverage decision
    - National Essential Drug List committee: one of the main users of evidence
    - Benefit package committee: e.g. Philippines, Malawi, China, Thailand
  - Use of HITA to inform coverage decision is mandatory in a few countries.
- Institutionalizing and sustaining capacities is critical
  - Different trajectories: context specific
    - HITA agencies established without legislative endorsement (e.g. HITAP-Thailand)
    - HITA agencies established, then legislative endorsement (NECA Republic of Korea)
    - Legislative endorsement upfront, then HITA agency starts (UK NICE)

Regional networks

- Networks are important for strengthening capacity and supporting economic evaluation through regional collaborations.
- Regional HTA networks exist in Europe, America, Africa, Eastern Mediterranean, Asia Pacific and Latin America
  - Build on existing capacities
  - Promote knowledge sharing
  - Expanding research networks
- How do we ensure a financial base for such networks that protects their impartiality and independence?

Characteristics of HITA capacity development:

experiences of 7 high and middle income settings



Source: ppt file in PS2.5 Huntington D.

Challenges at country level

- **Countries with limited capacities**
  - Limited capacities: human and financial resources to generate evidence and use for coverage decisions
  - Existing global evidence may not fit well or applicable to LIC context
- **Countries having some capacities**
  - Seven case studies in Asia Pacific: Silo-based decision making, poor decision-making criteria, strict controls on research, undue influence of “expert opinion”
  - Inadequate process of priority setting: transparency, engagement by stakeholders
  - Know-do gaps: assessment—appraisal--coverage decisions
- Priority-implementation gaps: health systems capacities to deliver the prioritized benefit packages

Lessons learnt from country experiences

- Essential capacities
  - Generate evidence
  - Ensure due process of engaging stakeholders
  - Establish and implement appraisal criteria: cost-effectiveness, budget impact, equity, financial risk protection, social values, transparency
  - Develop and implement national HITA guideline including threshold, National Clinical Practice Guidelines
- No single pathway
  - Highly dependent on local context

Conclusion

- Priority setting is an essential enabling process for UHC
- Priority setting processes make the decisions about rationing explicit, and based on evidence, values and interests
- The process of assessment and appraisal is as important as the evidence
- To deliver these priorities we need strong health systems; but priority setting can contribute to this strengthening
- Achieving UHC will require the health system to deliver on priorities: requires capacity, system design and supporting interventions

Actions for driving priority setting for UHC

- Maximize use of global public goods: WHO-CHOICE, DCP, Cochrane library, NCD guidelines
- Build, strengthen, sustain institutional capacities in assessment, appraisal and decisionmaking
- Assure a fair process of priority setting: transparent, accountable, participative
- Promote networking, learning and sharing, contributing to global public goods
- Apply Bangkok Statement in line with national context

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26	Marrten	Jansen
27	Masaaki	Uechi
28	Minjoo	Kang
29	Nattadhanai	Rajatanavin
30	Orana	Chandrasiri
31	Pandu	Harimurti
32	Pattarawalai	Talungchit
33	Phumtham	Limwattananon
34	Pien	Ploenbannakit
35	Pitipa	Chongwatpol
36	Pochamana	Phisalprapa
37	Prapaporn	Noparatayaporn
38	Prasinee	Mahattanatawee
39	Pritaporn	Kingkaew
40	Rapeepong	Suphanchaimat
41	Robert	Liu
42	Ryan	Li
43	Sandra	Khoury
44	Sangay	Wangmo
45	Sarocha	Chootipongchatvat
46	Saudamini	Dabak
47	Saya	Uchiyama
48	Sitaporn	Youngkong
49	Songhee	Cho
50	Songyot	Pilasant
51	Suchunya	Aungkulanon
52	Suladda	Pongutta
53	Sutayut	Osornprasop
54	Suteenoot	Tangsathitkulchai
55	Suvimol	Niyomnaitham
56	Tanita	Thaweethamcharoen
57	Thierry	Defechreux
58	Thitiporn	Sukaew
59	Thunyarat	Anothaisintawee
60	Titiporn	Tuangratananon
61	Tommy	Wilkinson
62	Udomsak	Saengow
63	Ully Adhie	Mulyani
64	Vasinee	Singsa
65	Vuong Lan	Mai
66	Wanrudee	Isaranuwatchai
67	Waraporn	Suwanwela
68	Xiaohui	Hou
69	Yothin	Thanormwat
70	Yumiko	Miyashita
71	Yuna	Sakuma

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Thank you for your attention