

Helping poorer countries make locally informed health decisions

Health spending in low income countries is too often driven by outside pressure rather than local evidence. **Kalipso Chalkidou**, **Ruth Levine**, and **Andrew Dillon** report on efforts to help them match spending to local needs

With more money available for health in poorer countries, as well as increasing demand for services and new products, policy makers are looking for ways to expand access, reduce out of pocket spending, and improve outcomes without bankrupting national budgets. Decisions are still largely driven by historical norms, the priorities of foreign donors, and lobbying pressures, and it is uncommon for countries to have functional mechanisms for making decisions based on their own needs. However, demand is growing from foreign governments and funding agencies to give countries technical and strategic support to develop the capability to make decisions based on local evidence and values. The National Institute for Health and Clinical Excellence (NICE) has been working in partnership with national governments to strengthen local decision making. We use this experience to suggest ways in which decision makers can be empowered locally.

More money

Recently, development aid for health has increased substantially, from \$5.6bn (£3.7bn; €4.5bn) in 1990 to \$21.8bn in 2007.¹ The increase has coincided with the emergence of partnerships focusing resources on specific diseases or products such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance for promoting access to vaccines.²

National spending in poorer countries is also growing. With the encouragement of the international community, countries such as Sierra Leone and Ghana are making services free for vulnerable populations³ or launching insurance schemes.⁴ The Chinese government has committed over \$120bn over the next three years to expand healthcare coverage to all 800 million Chinese farmers.⁵ India is making a similar, albeit more fragmented, attempt to improve access to services for rural populations through its Rural



Health Mission,⁶ and an urban scheme will be launched soon.

More products

Social enterprise initiatives from drug companies, whether part of a public relations strategy or a marketing plan for penetrating emerging markets, mean that more products are being made available in poorer countries. GlaxoSmithKline recently announced measures for sharing its compound libraries for neglected diseases,⁷ and Merck and Gilead are also considering sharing intellectual property rights for drugs for neglected diseases and HIV/AIDS so that affordable generics can be manufactured.⁸ Product development public-private partnerships—a type of non-profit drug company bringing together academia and drug industry to stimulate research in neglected diseases—are also beginning to produce new products, such as vaccines for pneumonia and diagnostic tests for tuber-



Are donor set priorities for HIV/AIDS skewing Rwanda's wish for greater focus on child and maternal health?

Box 1 | Top down targets and donor-set priorities in Rwanda

The Rwandan government says that the main problem in making better use of existing resources is the development partners.¹³ In 2006, Rwanda had “\$18m earmarked for malaria (the biggest cause of mortality and morbidity) and just \$1m for the integrated management of childhood illnesses, compared to \$47m for HIV/AIDS, grossly disproportionate in a country with a 3% infection rate.” The emphasis on HIV means that: “physicians employed by NGOs to deliver HIV/AIDS services [are] paid almost six times as much as physicians paid by the [Ministry]. Such differences

in salaries make it particularly challenging to keep well qualified health personnel in the public sector.”

The 2006 government analysis showed that an extra \$20 per person could reduce maternal and child mortality to meet international targets. The first \$9 were “estimated to deliver three quarters of the reduction in child mortality, and 63% of the reduction in maternal mortality.” Scaling up antiretroviral treatment for HIV/AIDS was judged to be the lowest priority, costing an additional \$8.30 per person but making “little additional contribution to maternal

mortality, while the 6% reduction in child mortality [was] achieved at high unit cost.”

But with foreign non-governmental organisations managing a larger share of total health expenditure than government, such systematic cost-benefit analyses do not influence national spending priorities. By 2008, the US President's Emergency Plan For AIDS Relief had invested about \$200m in HIV/AIDS programmes in Rwanda, including scaling up antiretroviral treatment, which remained one of its main measures of success.¹⁴



China is expanding health cover to all its farmers

and sustained change. This requires at least three things: local data, local technical expertise, and local institutions.

Data

WHO's Global Burden of Disease initiative and the Disease Control Priorities Project provide information on burden of disease and the relative cost effectiveness of interventions to tackle this burden, respectively.^{19,20} However, a lack of local unit costs, baseline risk, and quality of life data make it hard to use these global and regional data to make relevant local and national decisions.

Capacity

Countries need clinicians and policy makers sensitised to evidence informed policy making as well as technical experts such as epidemiologists, health economists, trialists, information specialists, and systematic reviewers to generate evidence, elicit social values, and help make and implement decisions. Groups like the Global Forum and the Council for Health Research for Development are promoting the need for dedicating more resources to local capacity building. At the same time, the Public Health Foundation of India was set up with the explicit objective to train experts locally who can then support policy makers to make better public health decisions.

Institutions

Institutions can target the development of local and locally appropriate technical expertise and data as well as of processes for decision making, from which they draw their legitimacy. The importance of institutions in supporting decision makers is acknowledged by national governments and global funders such as the World Bank, which are increasingly seeking the support of NICE to help developing countries improve their decision making.

NICE, which was set up to promote quality and inform resource allocation decisions in the NHS, established an international division in 2008. NICE International helps fellow policy makers from overseas with adapting guidelines to their own systems; assessing the value for money of health products; training clinicians, technical staff, and policy makers; and setting up transparent, consultative, and independent resource allocation processes that can survive lobbying and other pressures.

NICE International is small and relies heavily on the enthusiasm of NICE's staff and, most importantly, that of individual clinicians and academics, the same people on whom NICE depends to develop guidance for the NHS. It is by choice responsive to requests by policy makers from other countries, and does not seek to export the NICE or NHS model (box 3, see bmj.com).

culosis. In addition to establishing themselves in the global generics business, drug manufacturers in poorer countries are now entering the innovative drugs market.⁹

Who makes the decisions?

Among the newer trends in global health is an affirmation that development assistance should be aimed at supporting nationally determined priorities.¹⁰ The World Bank and UK and US government aid agencies emphasise the importance of national institutions¹¹; however, according to the World Health Organization "many countries report difficulties in attracting sustained, flexible funding that can be used to support the health system: staff, infrastructure, training, management."¹² As a result, decisions end up being informed more by political pressures and standard setting agencies, particularly WHO, rather than by local values and comparative evidence of clinical and cost effectiveness of what works locally.

In aid dependent countries, the preferences of donors are another influential, and often distorting, factor. According to the Rwandan government, donor priorities have resulted in a disproportional focus on antiretroviral drugs, despite decreasing marginal returns and significant unmet need for healthcare services elsewhere (box 1).

If countries are to decide on the use of externally provided resources, they need the institutional arrangements and analytical tools to make legitimate and evidence based decisions. This is even more important in the face of the active drug marketing in emerging economies.

A few poorer countries have built structures that enable local evidence and needs to inform local health decisions. For example, in 2007, Thailand set up the Health Intervention and Technology Assessment Programme (HITAP), a research insti-

tute to appraise health technologies and inform health policy using best available evidence as well as local values and local data.¹⁵ HITAP places particular importance on process and, in particular, on stakeholder involvement, consistent with the Thai tradition of consensus building. HITAP pioneered an innovative low cost model for building human capacity to synthesise and appraise evidence, through mentorship and hands-on training within the organisation. It also set up a freely accessible database of comparative studies in Thai. Since its establishment, HITAP has informed the development of the Thai essential drugs list, national vaccination programmes (box 2) and AIDS treatment strategies, and the country's policy on alcohol. It also evaluated the economic effect of the controversial Thai compulsory licensing policy for expensive patented drugs.

The Mexican National Institute of Public Health (INSP) focuses on measuring and evaluating the effect of health interventions. The institute is, for example, evaluating the government's health insurance programme *Seguro Popular*, a bold and costly initiative to improve access to health services for the poorest families.¹⁷ The resulting reports have triggered some criticisms of the scheme that would otherwise have not been possible.¹⁸

Institutions such as HITAP and INSP are the exceptions rather than the rule. For the most part, health services and technologies purchased with public funds are selected through idiosyncratic processes that often have little to do with systematic analysis of their potential health benefit or value for money.

Local capabilities

The challenge facing governments, global institutions, and funders is how to convert knowledge, experience, funding, and enthusiasm into real

Box 2 | Prevention and screening for cervical cancer in Thailand

In 2007, the Thai Food and Drug Administration licensed two commercial human papillomavirus vaccines for the prevention of cervical cancer. Under pressure from multinational drug industry, international agencies, and patient and professional groups, the Thai government commissioned the Health Interventions Technology Assessment Programme to: “generate reliable and relevant information to guide health policy choices regarding the prevention and control of cervical cancer in Thailand and other similar settings, especially in developing countries with limited financial and infrastructure resources.”¹⁶

The report:

- Looked at clinical and cost effectiveness of screening and prevention interventions
 - Used Thai cost and epidemiological data on prevalence and risk and on current uptake of alternative screening interventions
 - Compared the new vaccine to existing alternatives (cervical smear screening programme and visual inspection with acetic acid) and also their combinations
 - Made recommendations on human resources and other aspects linked with implementation
 - Was transparent, consultative, and scientific.
- The analysis found that the vaccine would be cost effective

only at 25% of the price quoted by the manufacturers. At the list price, the cost per quality adjusted life year (QALY) of the vaccine compared with a well implemented national screening programme (which was cost saving) was three times Thailand’s gross domestic product per capita (about £14 800/QALY). The equivalent in the UK would be about £81 500 per QALY, over four times NICE’s threshold.

As a result, the Thai government decided not to include the vaccine in its universal coverage programme. The report concludes: “A decision to adopt a new vaccine into a national program must be guided by country evidence, not market promotion and information from pharmaceutical industry alone.”



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No government funded vaccine for Thai teenagers

For example, at the request of the Turkish minister of health, NICE International has been working with the Directorate of Health Education and Turkish academics, patients, and clinicians to develop a short clinical guideline on caesarean section. The project is in collaboration with the National Collaborating Centre for Mental Health and funded by the World Bank. The intention is that the Turkish ministry will use evidence based standards to inform pay for performance and provider accreditation in the future. Over 10 months, NICE International helped Turkish policy makers convene a multistakeholder guideline development group, identify and critically appraise the evidence, and undertake an economic evaluation and also trained key stakeholders. As well as the guidance, the NICE and Turkish teams will produce a methods and process manual detailing how to repeat and improve the process in future.

Building a new model

Support for national institutions through hands-on pilots and partnerships with organisations such as NICE could help country owned healthcare policies to become a reality. However, NICE International has no core funding and needs to recoup its costs on a yearly basis, making its short-term survival uncertain. Unlike most organisations in the global development business, NICE International does not have professional development consultants and is not a university doing research in global health. Furthermore, its largely UK expertise cannot effortlessly be translated into poorer settings. Rich governments and global funders ought to be willing financially and technically to support (and evaluate) this fairly unconventional and untested form of knowledge transfer.

If NICE has a role in supporting fellow policy makers, the appropriate models for delivering such

support also have to be developed. These should combine public sector values and credibility with (public or private) funding and the skills to operate effectively in the global development business. A public-private partnership may be one vehicle; NHS Global, set up to “exploit the commercial potential of the NHS on the world stage and help the NHS fulfil its humanitarian role in world health care,”²¹ is another.

An international support service for decision makers, drawing on the experience of organisations like NICE and HITAP, can complement product focused initiatives and empower local policy makers to make informed decisions about health products. Without informed local decisions, new products (however effective and affordable) can have no effect on global health.

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