Cutting waste *en route* to Universal Healthcare Coverage

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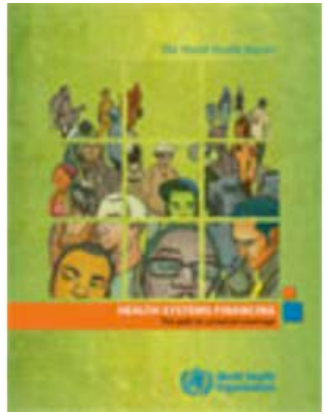
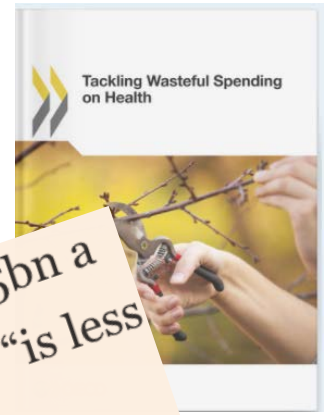


* http://www.who.int/

> “ US$ 26.2 billion will be required for the HIV response in 2020 ”

http://www.oecd.org/health/tackling-wasteful-spending-on-health-9789264266414-en.htm about one fifth of resources wasted (Jan 2017)



Status quo unfair and unsta

Between 20-40% annual … spent … wasted.*

FT Health: Combating Malaria

According to the Global Fund to fight tuberculosis, HIV and malaria, the $2.5bn a year received from governments and other donors that it spends on malaria “is less than half the amount required to maintain the gains against this disease”. Its

Every year 100 million people … poverty and 150 million peopl… catastrophe because of out-of… expenditure on health services. Over 1/3 of spending is OOP.

Globally, two thirds (38 million) of 56 million deaths each year are still not registered.

More than 18 million additional health workers will be needed by 2030 to meet the health workforce requirements of the Sustainable Development Goals and UHC targets, with gaps concentrated in low- and lower-middle-income countries.

http://www.who.int/mediacentre/factsheets/fs395/en/

Waste costs lives

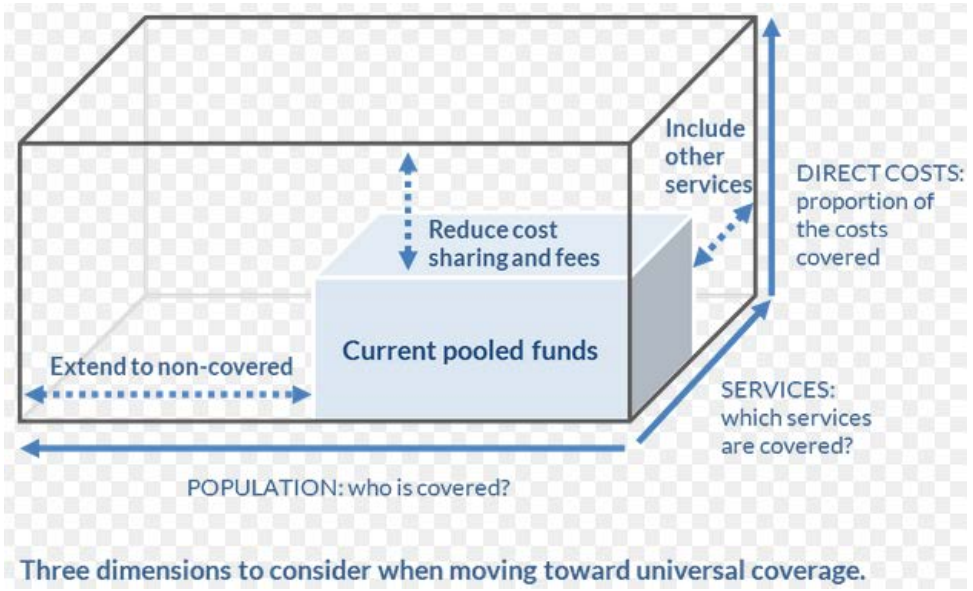
Making the trade offs of investment decisions explicit is a necessary condition for holding those making such decisions accountable. Generating better evidence of comparative clinical and cost effectiveness is a positive externality of such a system.

What's the problem? Coverage of wasteful technologies and services diverts valuable resources away from worth while investment

Colombia	• Avastin paid for for all indications (incl FDA unlicensed ones) • Regional variation in immunisation with parts of the country with <50% coverage
Kyrgyzstan	• >50% of insulin budget goes to analogues • Switching to human insulin can double the number of patients on treatment
HIV	• 40-50% of eligible patients NOT on treatment in Africa • 2nd and 3rd line ART for <5% of patients, consumes one fifth of the total ART budget
UK	• Cancer Drugs Fund has spent over £1bn on non-cost effective drugs • >14,400 QALYs lost across the NHS due to displacement of other needed, cost-effective care

iDSI
Better decisions. Better health.

The UHC cube: what about things that have to be left out?



Three dimensions to consider when moving toward universal coverage.

A “waste” typology

Managing entry of new expensive technologies through population/indication targeting and price negotiations

Disinvesting away from obsolete or harmful technologies

Effective regulation and functional healthcare system

Effective generic competition and substitution

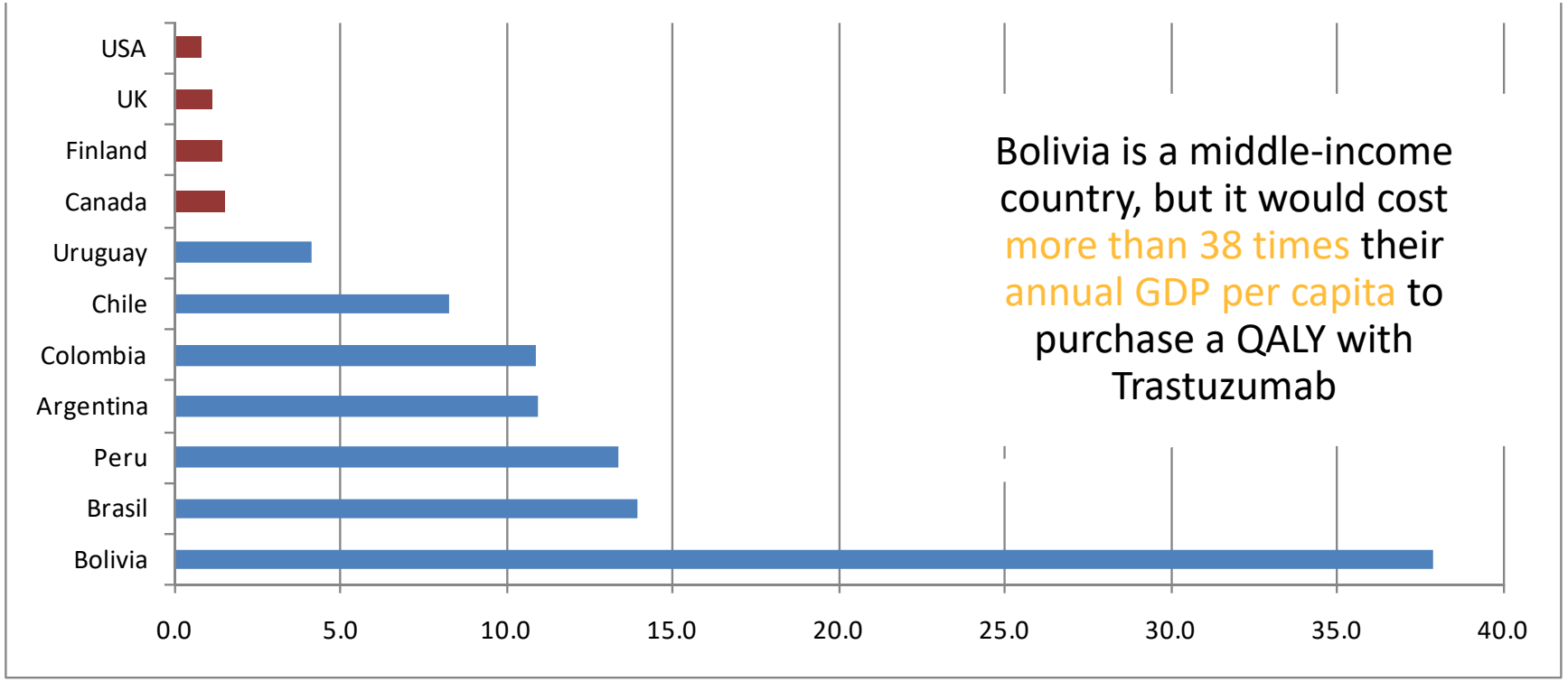
Cost-effective procurement

Cost effective global (and local) norms!

Managing entry of new expensive technologies through population/indication targeting and price negotiations

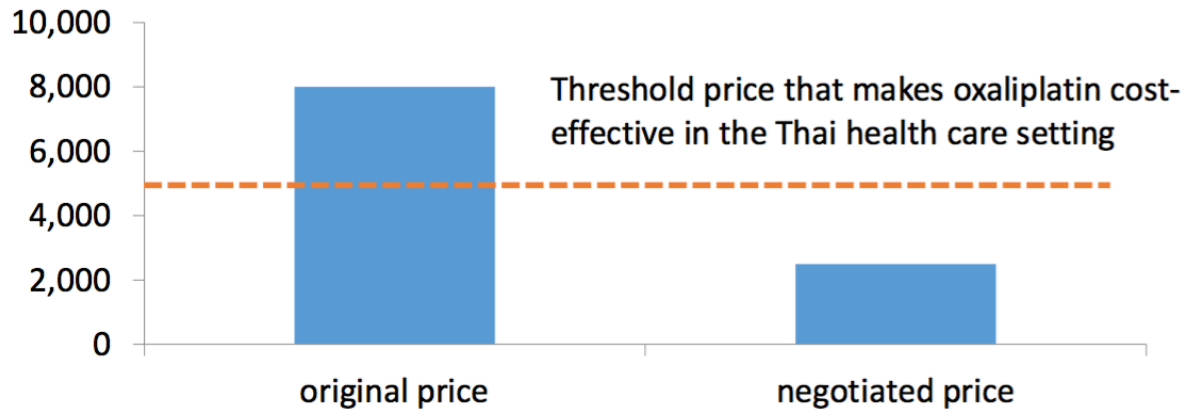
Data and evidence -- whereas efficacy is global, cost-effectiveness and affordability (and budgets!) are local

Cost-utility of Trastuzumab expressed as number of GDP per QALY



Managing entry of new expensive technologies through population/indication targeting and price negotiations

Threshold analysis for price of oxaliplatin



Use of HITA information in price negotiation

Medicine	Original price (THB)	Reduced price (THB)	Potential saving (THB per year)
Tenofovir	43	12	375 million
Pegylate interferon alpha-2a (180 mcg)	9,241	3,150	600 million
Oxaliplatin (injection 50 mg/25 ml)	8,000	2,500	152 million

From 2010- 2014	
Using Purchasing price in 2009 as basic price	
Item	**Saving (Bht)**
ARV Non CL	5328.59 million Bht (177.61 million USD)
ARV CL	10165.19 million Bht (353.84 million USD)
J2 and Clopidogrel	6830.37 million Bht (227.68million USD)
Flu vaccine	266.47 million Bht (8.88 million USD)

ELSEVIER

Journal of Evidence, Training and Quality in Health Care

Volume 108, Issue 7 , 2014, pages 397-404

What is the contribution of health-related evaluations to decision-making in healthcare? Experiences from 7 selected countries

main emphasis

The use of economic evaluation for the pharmaceutical industry in Thailand

Cost-benefit assessments as an instrument for establishing the list of medicines to be reimbursed in Thailand

Yot Teerawattananon [1] ,Nattha tritasavitol [1] , , Netnapis Suchonwanich [2] ,Pritaporn Kingkaew [1]

Saved 768.01 million USD in 5 yrs

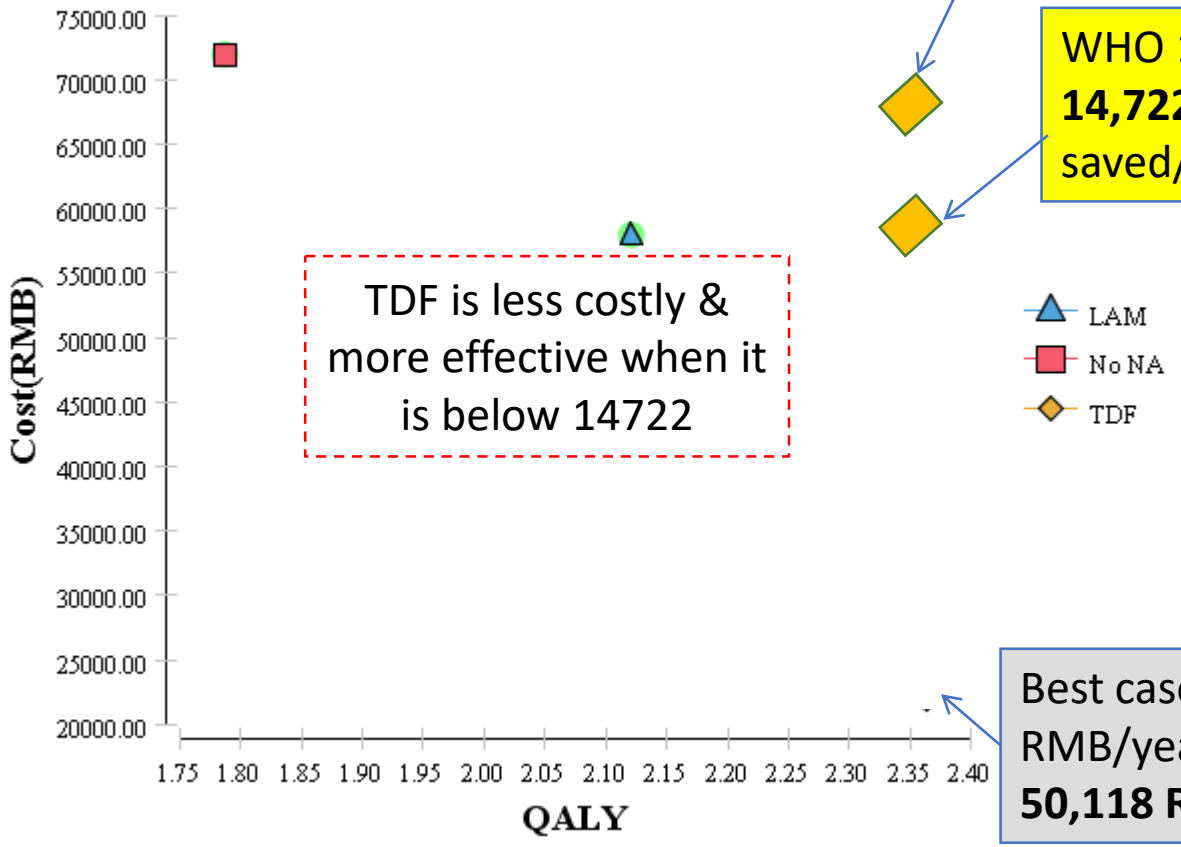
Managing entry of new expensive technologies through population/indication targeting and price negotiations

CNHDRC: How much should TDF cost?

China:
- 93 million people carry HBsAg
- 20 million are active CHB patients ,>50 % of them are HBeAg+
- 7 million are in need of treatment urgently

Base case list price (TDF **16,680** RMB/year), cost saved/person : **6,275 RMB**

WHO 1 GDP pc threshold (TDF **14,722** RMB/year), cost saved/person : **13,976 RMB**



TDF is less costly & more effective when it is below 14722

Best case @ ARV price (TDF **1,800** RMB/year), cost saved/person : **50,118 RMB**

CEA plane(in 5 year)

Disinvesting away from obsolete or harmful technologies

Revision of a 17,000 item Benefits Package

Step 1: Guidelines & Literature Review

Process: Review of selected guidelines and systematic reviws of systematic reviews and meta-analysis of studies

Outcome: List of medical indications with and without clinical and economic evidence to support the use

Step 2: Matching indications

Process: Analysis of hospital data for matching patients with and without known medical indications identified from the review (Step 1)

Outcome: The percentage of patients with medical indications where prescriptions of medicines/medical devices deemed inappropriate based on the review.

Step 3: Clinical Expert Review

Process: Clinical expert review of anonymised patient records with medical indications i.e. principal diagnosis, co-morbidity and complications where prescription of medicnes/medical devices deemed inappropriate by the review.

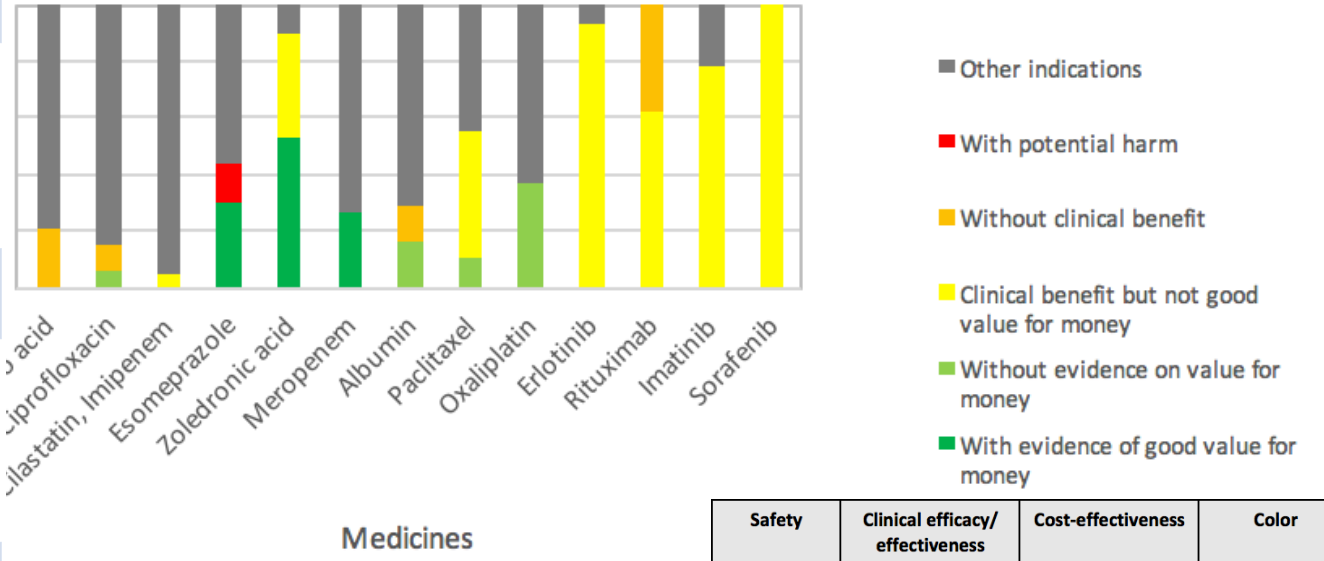
Outcome: Percentage of patients with medical indications where prescription of medicines/medical device deemed inappropriate by the review but deemed appropriate by clinicains

Step 4: Developing list of indications

Process: Analysis of medical indications not identified by the review but recommended by clinical experts

Outcome: Policy recommendation: To fine tune medical indications to include in Basic Health Service Package (BHSP)

Figure 2: Results of Expert Review of Patient Records



Safety	Clinical efficacy/ effectiveness	Cost-effectiveness	Color
✓	✓	✓	
✓	✓	unknown	
✓	✓	×	
✓	Unknown, ×		
×			

✓ = there is a supportive evidence

× = there is no supportive evidence

unknown = no data

Cost-effective procurement

Money and institution gap: transition in doubt and real risk of regression

Duplicate and fragmented health supply chains in Senegal

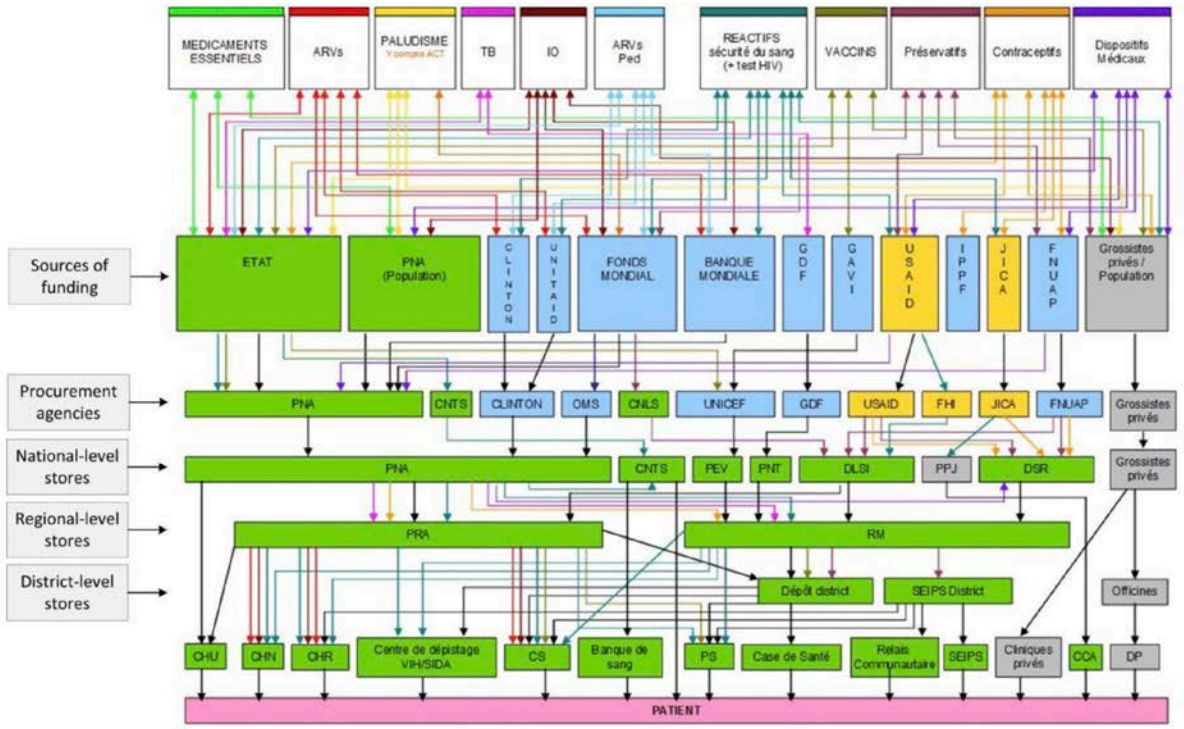
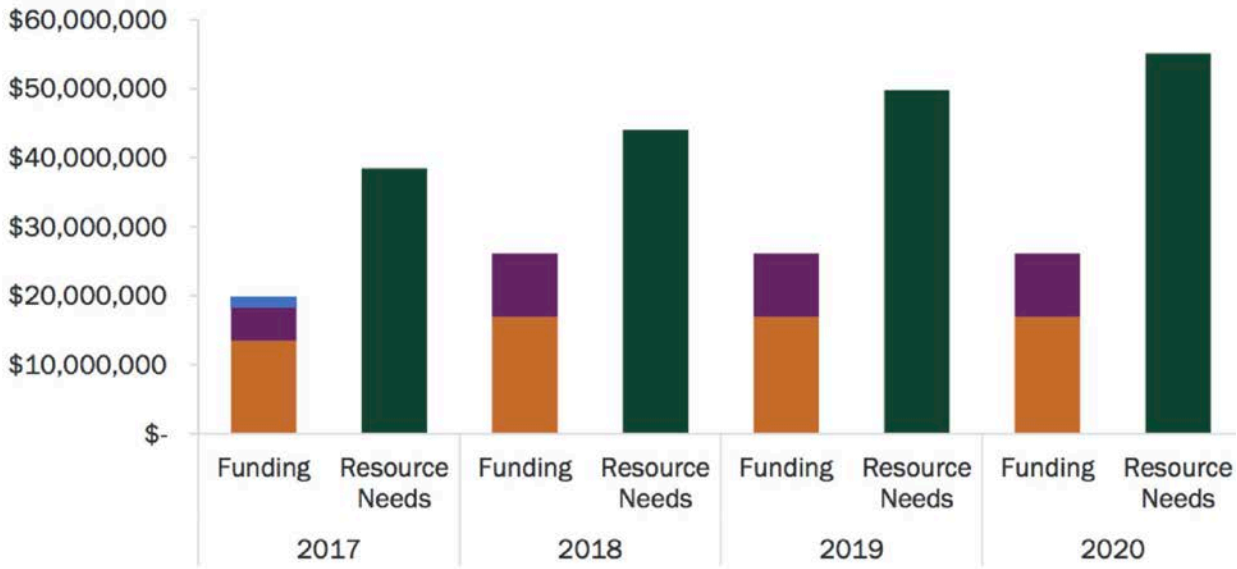


Figure 18: GFATM and PEPFAR Supply Plan versus Resource Needs

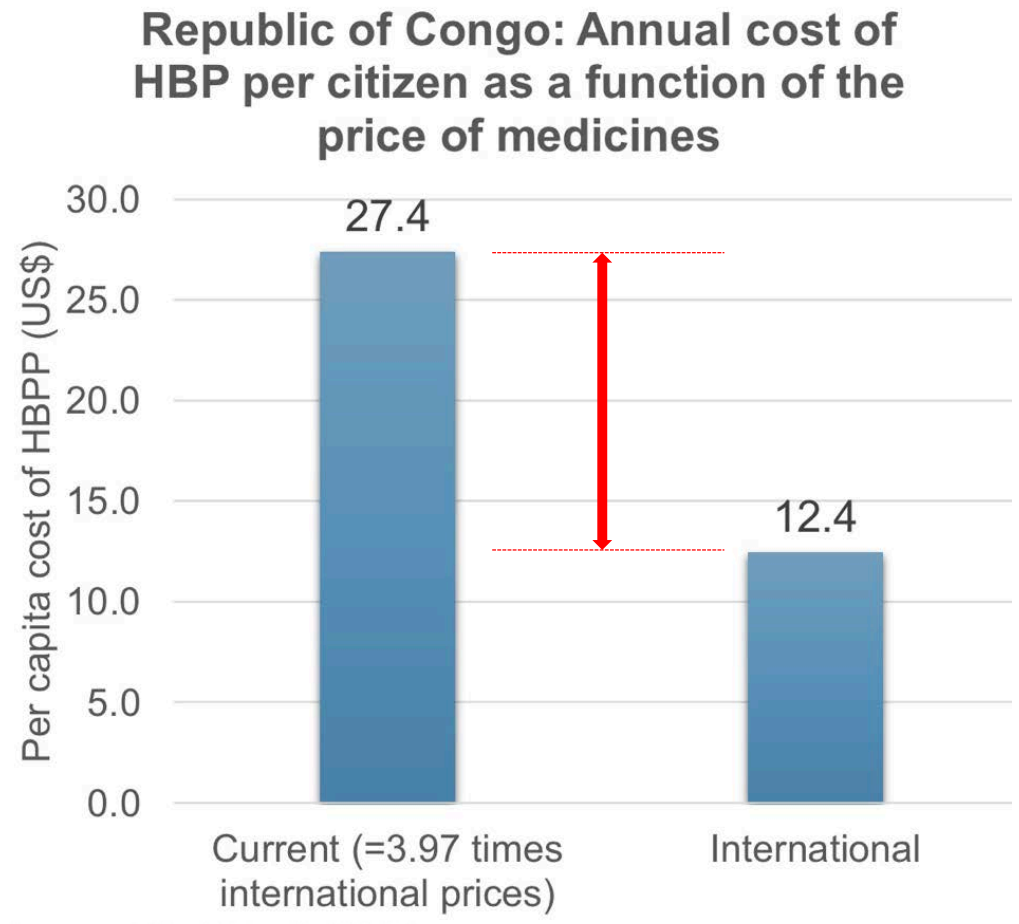


Senegal: 65% spending OOP – 35% NGOs/donors (head of pharmacy, Senegal Central Medical Store)

Ghana: by 2020, Ghana will need twice the GFATM+PEPFAR $ commitment to meet the WHO 90-90-90 target, for commodities alone (HP+ 2017). The country is already disinvesting away from older vaccines (anecdotal).

Effective generic competition and substitution

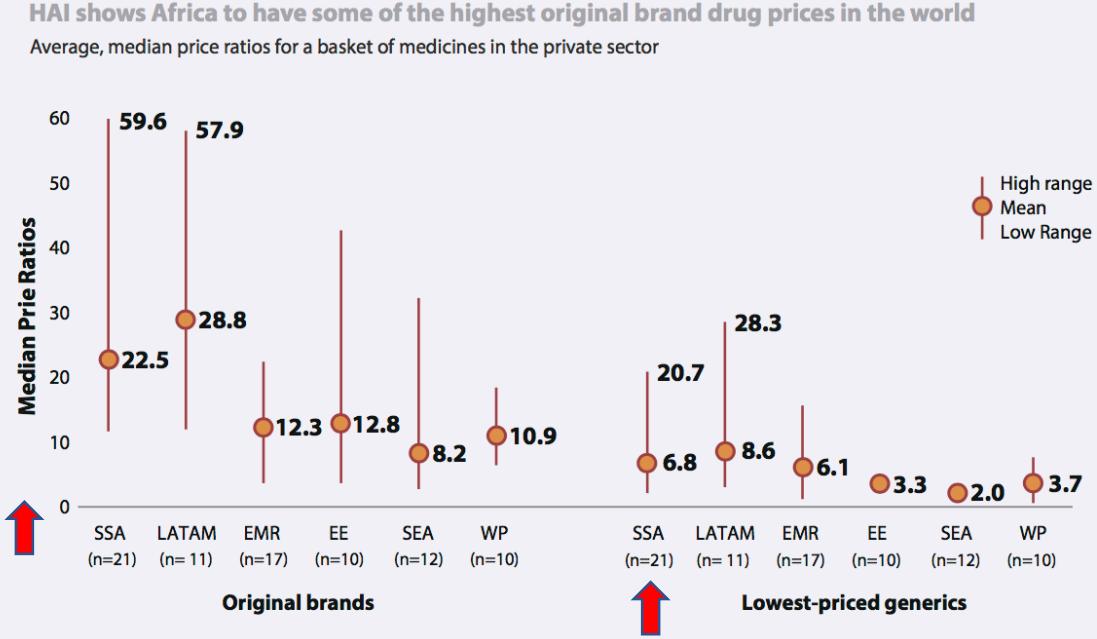
Some of the world's poorest countries have some of the world's highest drug prices



Source: World Bank (2017)

Ricardo Bitran, CGD Nov 2017

FIGURE 1: AFRICA HAS SOME OF THE HIGHEST ORIGINAL BRAND PRICES RELATIVE TO OTHER LOW INCOME REGIONS



Source: Cameron A, Ewen M, Auton M, Abegunde D. The world medicines situation 2011. Medicine prices, availability and affordability. Analysis updated in March 2014 by IMS Thought Leadership with data from http://www.haiweb.org/medicineprices/

REFERENCES:

[11] Cameron A, Ewen M, Auton M, Abegunde D. The world medicines situation 2011. Medicine prices, availability and affordability. [http://www.who.int/medicines/areas/policy/world_medicines_situation/WMS_ch6_wPricing_v6. pdf]. 2011;.

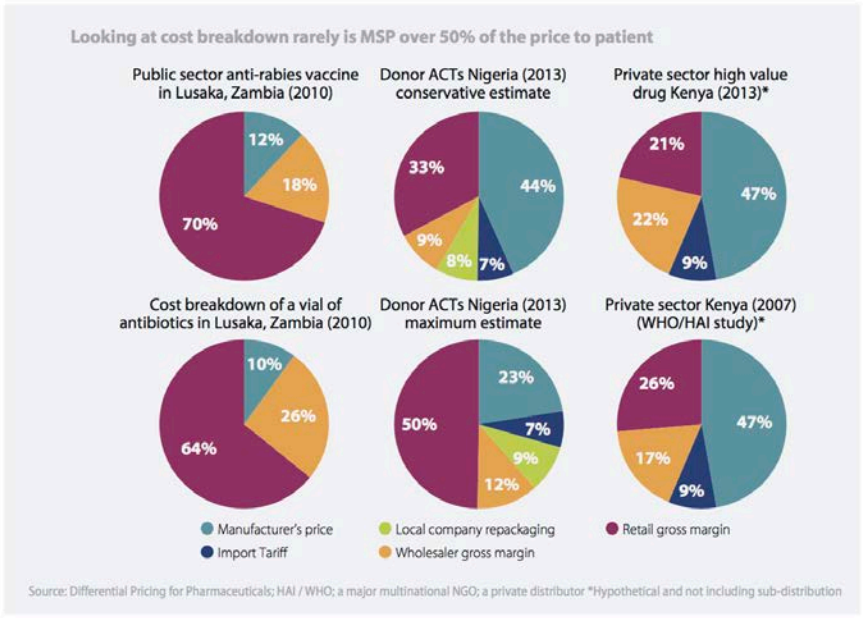
Table 16. PHC Unit resource costs (USD) for 100% and 50% coverage MSH EHBP Northern Syria, 2017

Break-down of Total Costs	*100% Coverage*	*50% Coverage*
Salaries (Technical Staff)	92,934	58,536
Technical Salaries as % of total	*14.9%*	*16.8%*
Salaries (Admin and Support Staff)	37,086	33,264
Admin Salaries as % of Total	*5.9%*	*9.5%*
Drugs, supplies and lab tests	474,432	237,216
Drugs, medical supplies, and tests as % of total	*76.0%*	*68.0%*
Other Operating Costs	19,800	19,800
Other Operating costs as % of total	*3.2%*	*5.7%*
Regional and Central Level support costs	0	0
Regional/central support costs as % of total	0.0%	0.0%

IMS Health

Effective generic competition and substitution

What drives prices up in Africa?



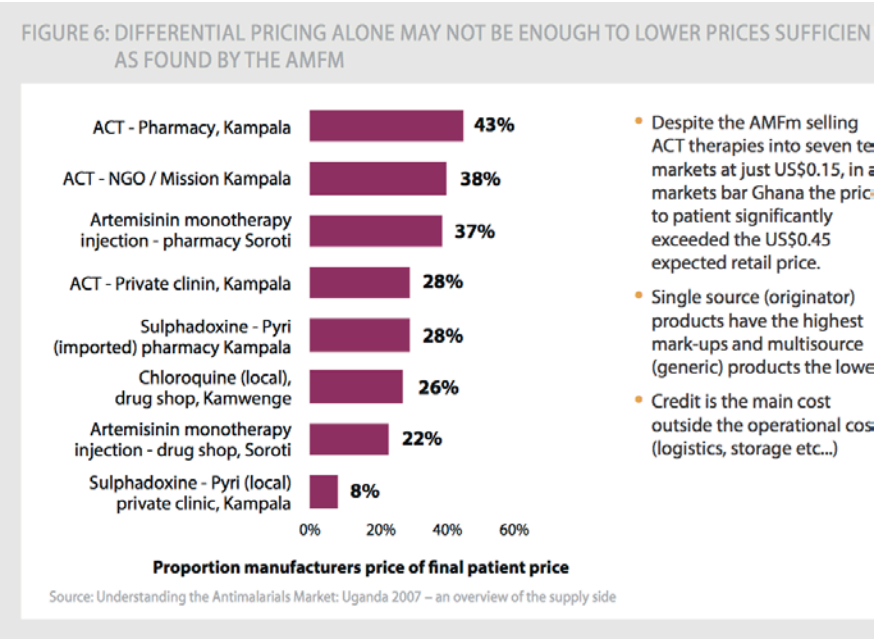


FIGURE 2: EFFICIENT DISTRIBUTION REQUIRES CONSOLIDATION AND COMPETITION

thepharmaletter

* Up to date news for the Pharmaceutical and Biotechnology industries

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Australia's PBAC makes world-first biosimilar drug substitution decision

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Patent wins for Pfizer in India, where NPPA looks to be disbanded

1 OF 5

Effective regulation and functional healthcare system

Cost of capital

Domestic industrial policies

corruption

Not just about IP - voluntary licensing of HepC drug results in limited access in SSA

Bad regulation

Transport costs

Forex fluctuations

Regressive taxes (eg VAT on essential medicines)

Snapshot

Gilead has agreements with 11 Indian companies to manufacture generic hepatitis C medicines for **101 developing countries**

There are **103 million** people living with hepatitis C in these developing countries

Gilead also offers its branded hepatitis C medicines at a **significantly reduced flat price** in these countries

Indian exports of branded generic Sofosbuvir to destination countries in number of packs - up until November 2016

Asia (Central and South)		Sub-Saharan Africa	
Myanmar	92626	Burundi	1299
Vietnam	42538	Cameroon	998
Mongolia	10412	Kenya	315
Nepal	7395	South Africa	180
Turkmenistan	2425	Ghana	46
Kyrgystan	2378		
Uzbekistan	1452		

rce: Indian export database 2014 – November 2016 – Zauba

AFRX CONSULTING

Price controls alone won’t do it

- Results show that, after direct price controls were enacted, price inflation decreased almost − 43%, but real pharmaceutical expenditure almost doubled due mainly to an increase in units sold. Such disproportionate increase in units sold maybe attributable to better access to drugs due to lower prices, and/or to an increase in marketing efforts by the pharmaceutical industry to maintain profits.

Effective regulation and functional healthcare system

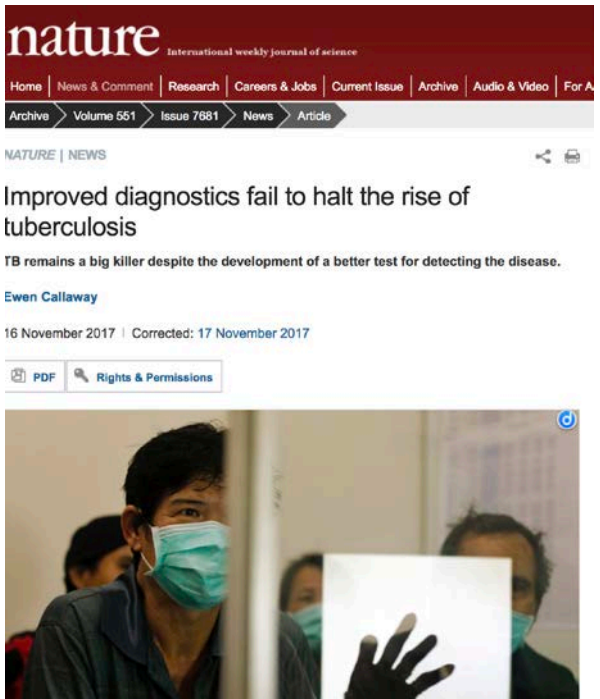
Cost effective global (and local) norms!

When norm setting ignores costs!

RECOMMENDATION E.7: Antenatal care models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care. *(Recommended)*

Remarks

- The GDG stresses that the four-visit focused ANC (FANC) model does not offer women adequate contact with health-care practitioners and is no longer recommended. With the FANC model, the first ANC visit occurs before 12 weeks of pregnancy, the second around 26 weeks, the third around 32 weeks, and the fourth between 36 and 38 weeks of gestation. Thereafter, women are advised to return to ANC at 41 weeks of gestation or sooner if they experience danger signs. Each ANC visit involves specific goals aimed at improving triage and timely referral of high-risk women and includes educational components *(12)*. However, up-to-date evidence shows that the FANC model, which was developed in the 1990s, is probably associated with more perinatal deaths than models that comprise at least eight ANC visits. Furthermore, evidence suggests that more ANC visits, irrespective of the resource setting, is probably associated with greater maternal satisfaction than less ANC visits.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NATURE | NEWS

Improved diagnostics fail to halt the rise of tuberculosis

TB remains a big killer despite the development of a better test for detecting the disease.

Ewen Callaway

16 November 2017 | Corrected: 17 November 2017

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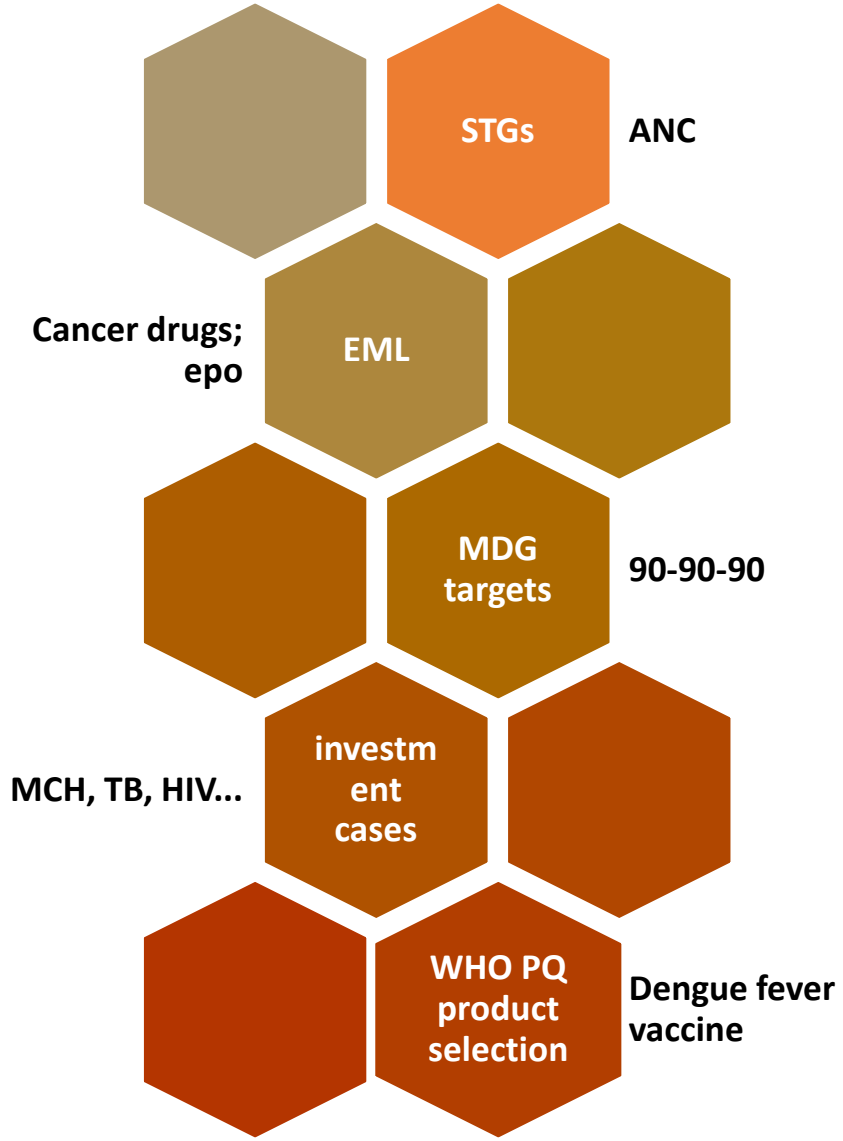
Cepheid cartridge price shoots up as company seeks to negotiate warranties country by country (StopTB)

"…we found less than 3% probability that Xpert introduction improved the cost-effectiveness of tuberculosis diagnostics."



Get the incentives right

HealthAffairs

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Changing Physician Incentives For Cancer Care To Reward Better Patient Outcomes Instead Of Use Of More Costly Drugs

Expand

Lee N. Newcomer[1]

"The use of pathways has been shown to lower the drug costs of cancer therapy. Neubauer and coauthors reported a 37 percent reduction in the drug costs for lung cancer patients using pathways developed by US Oncology, a national oncology management organization….**If pathways are not supported by a reimbursement schedule that pays a higher margin for generic and low-cost, effective brand-name drugs, then the physician could be biased to select high-cost drugs in his or her pathway.** Pathways do create an incentive for pharmaceutical firms to demonstrate that their drugs have major advantages in outcomes or costs, compared to those of competitors, so the drugs will be included in a pathway."

Health Affairs

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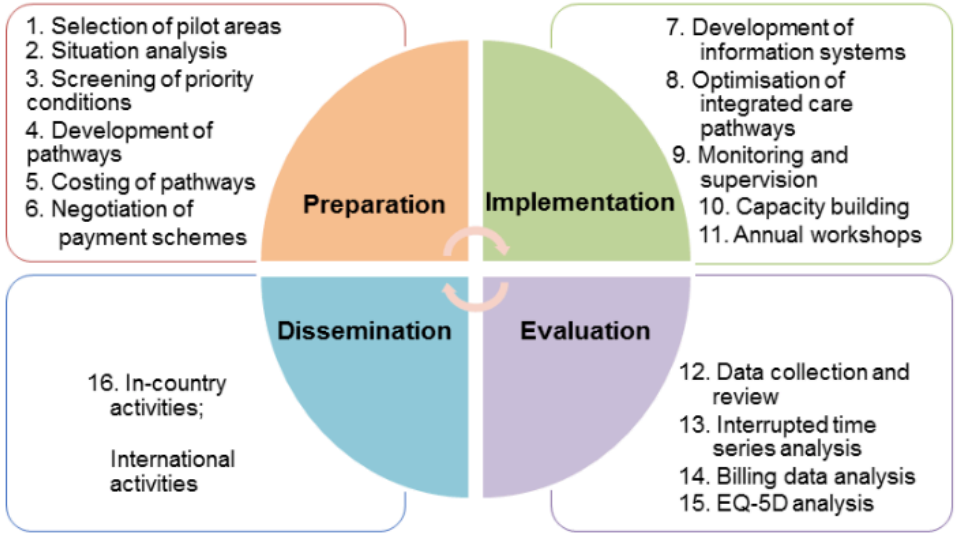
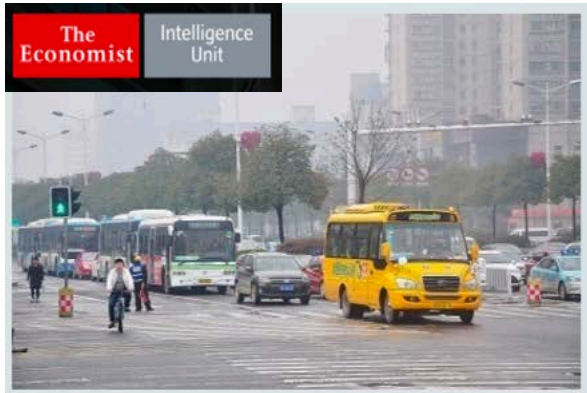
A Pilot Project Using Evidence-Based Clinical Pathways And Payment Reform In China's Rural Hospitals Shows Early Success

Expand

Tsung-Mei Cheng[1]



The Economist Intelligence Unit



China's healthcare challenges: The People's Hospital of Yiyang County in Henan Province

Since 2009, China's government has invested heavily in its healthcare system and has introduced a series of major reforms, including expanding health insurance coverage to most of the population. Experiments are underway across the vast country at all levels of system organisation, delivering better care for patients as well as reducing costs. Many of these projects are laying the foundation of value-based care.

CHINA NATIONAL HEALTH DEVELOPMENT RESEARCH CENTER

Strengthening evidence-based policy making in support of universal healthcare

Introducing evidence-based clinical pathways for stroke and COPD in rural China

CHINA NATIONAL HEALTH DEVELOPMENT RESEARCH CENTER

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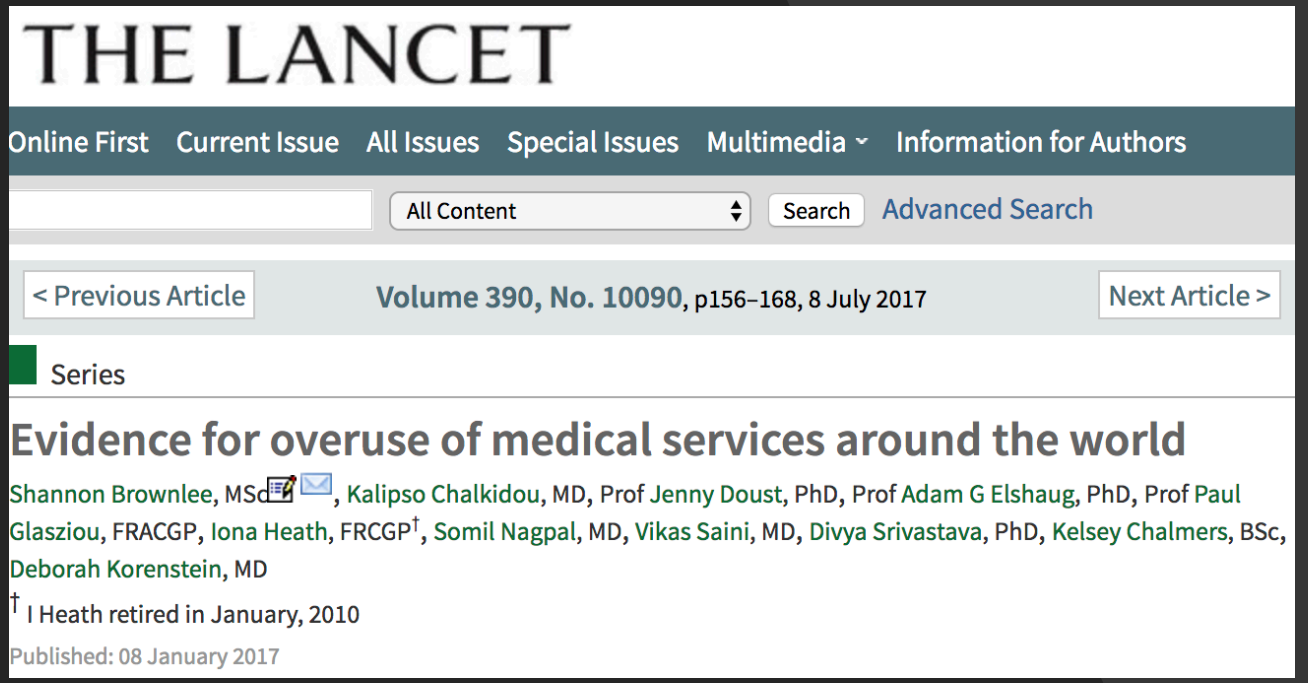
The stakes are high

- “As nations move toward universal health coverage (UHC), the stakes on quality of care rise. The poorest people in the world can least afford poor quality health care. They do not have the resources to repair the damage when care goes wrong, their development requires a healthy workforce, and money wasted on ineffective or harmful care is money denied to other essential services. Poor quality care damages wealthy nations, too. Few high-income countries have the political will to increase tax rates, and therefore government investments reflect zero sum choices—what public health care gets, public schools and public housing lose.”



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Better decisions. Better health.

"Action expresses priorities."

— Mahatma Ghandi

Thank you!

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