



2018 SKILLS BUILDING PROGRAM

# BIG DATA, ARTIFICIAL INTELLIGENCE AND DECISION SCIENCE IN HEALTH AND NUTRITION

## 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

*In partnership with*



# 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

Link for the Exercise Excel sheet and instructions:

<https://bit.ly/2xy6IVG>



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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

### Country engagement

Support countries to develop institutional capacities and transparent governance processes, enabling maximum health gains and transition from aid

#### Institutional Strengthening



#### Smart Purchasing




Empower countries to spend their own budgets smarter and implement more efficient and equitable HBPs and delivery platforms, making UHC and SDGs a reality

### Knowledge products

Generate, integrate and deploy policy-relevant data and knowledge to support better decisions at global and national levels

#### Data, Evidence, and Analytics



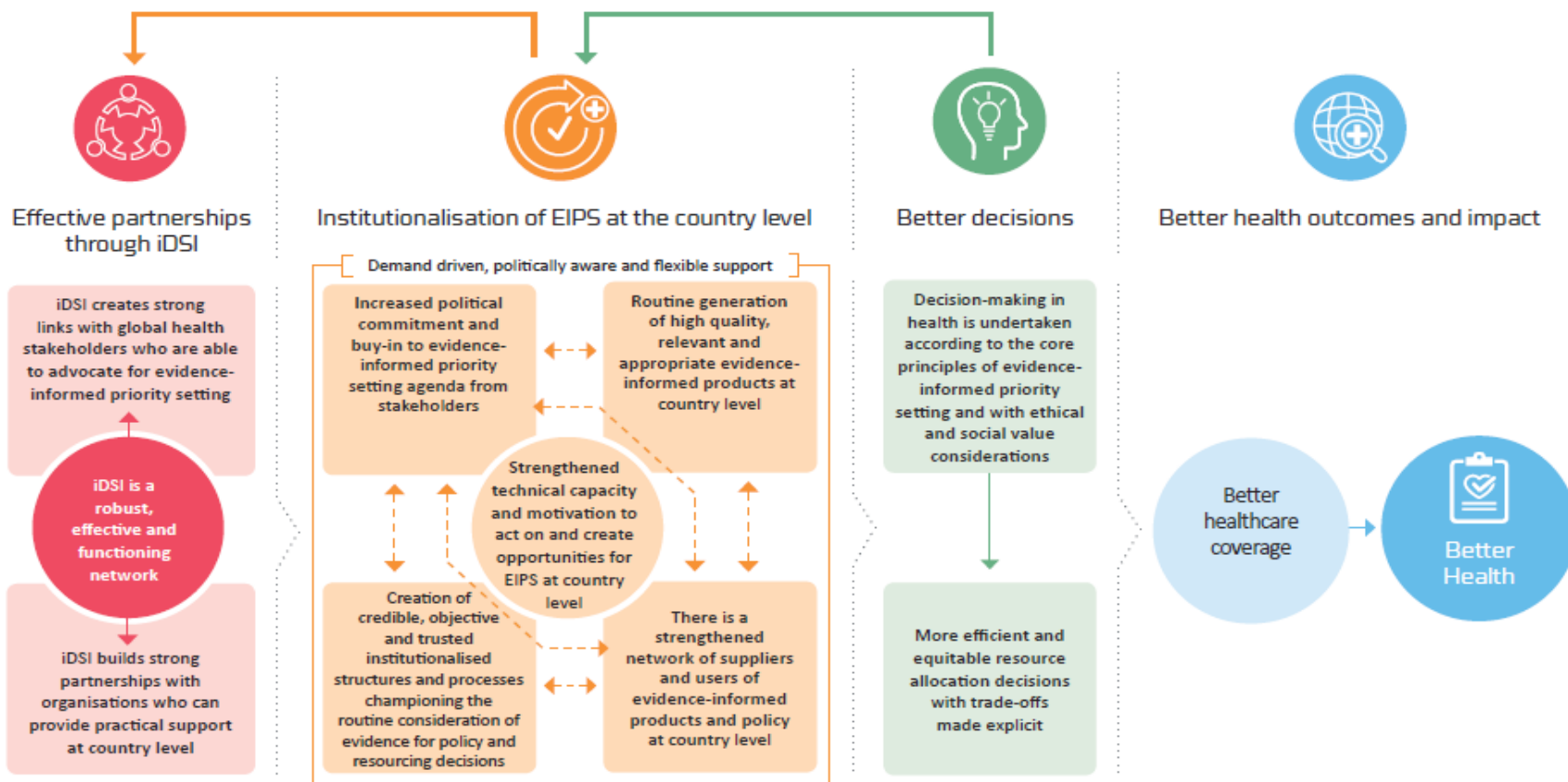
#### Methods, Processes, and Tools



Co-create global public goods to support countries and funders in standardizing, contextualizing and applying approaches to improve value-for-money in health



# iDSI Theory of Change





1. Introduction to iDSI and the work we do

## **2. The case for Priority Setting**

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# The need for priority setting



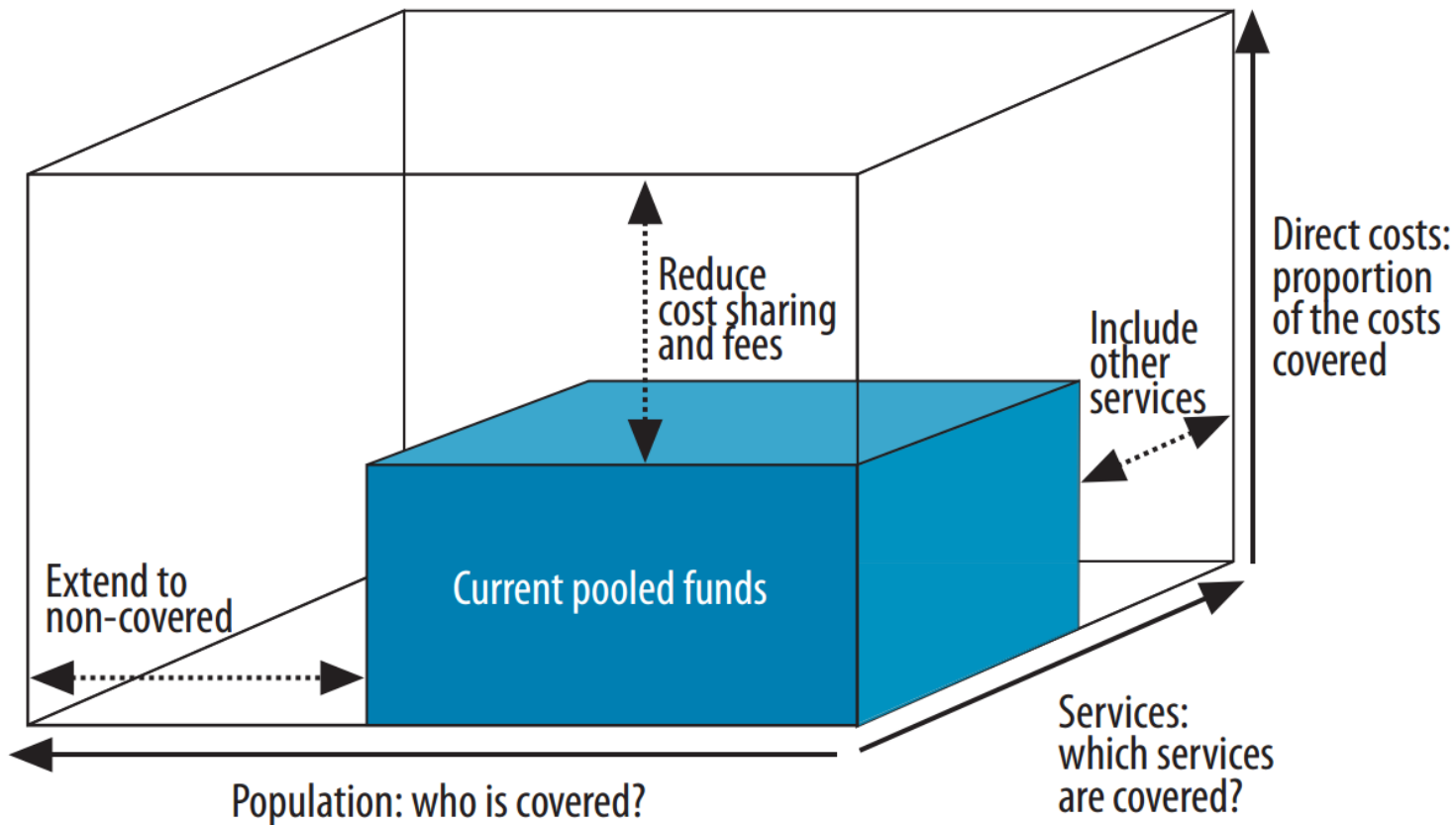
- **Resources are scarce and choices must be made**

“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



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**

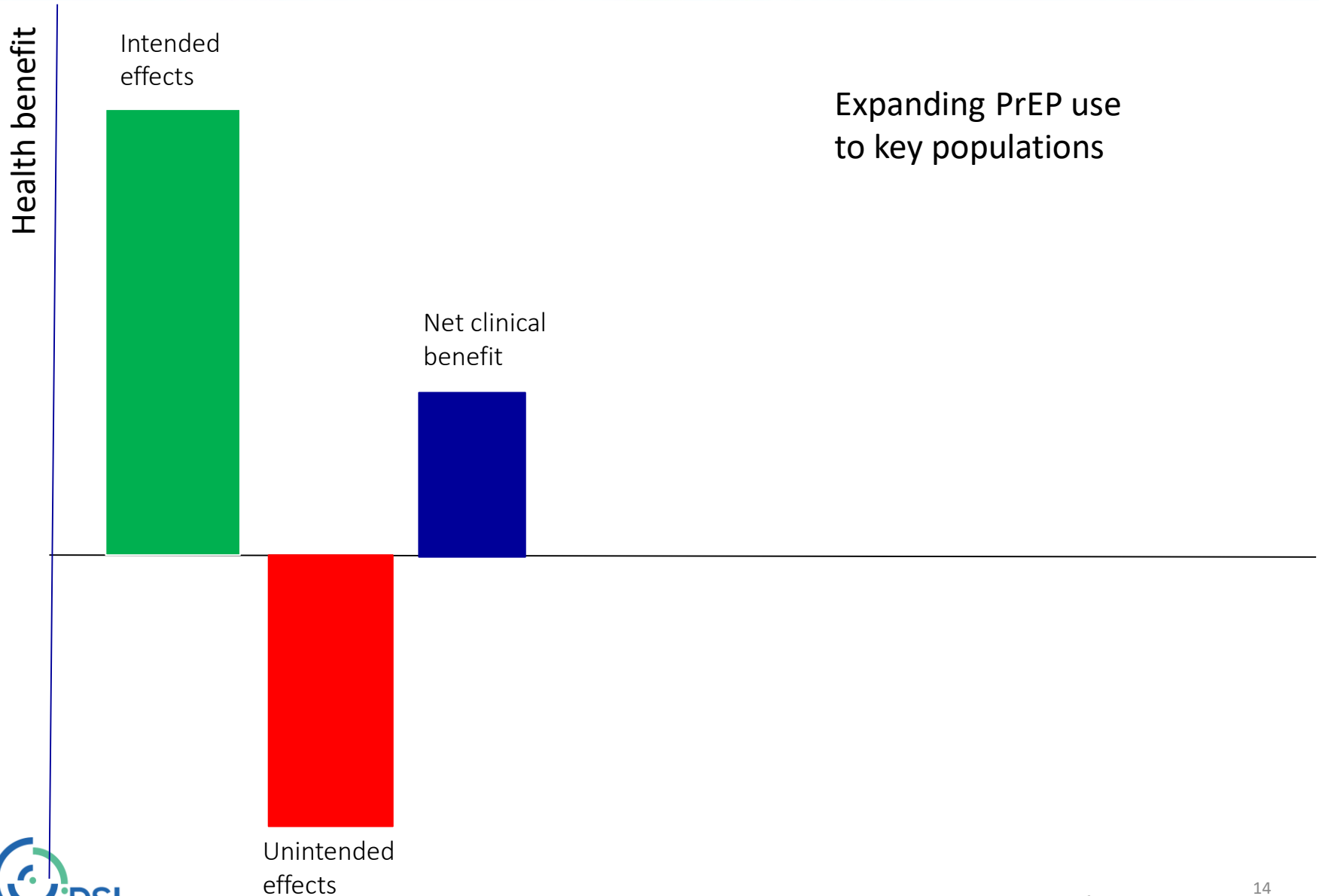
# Introducing opportunity costs...



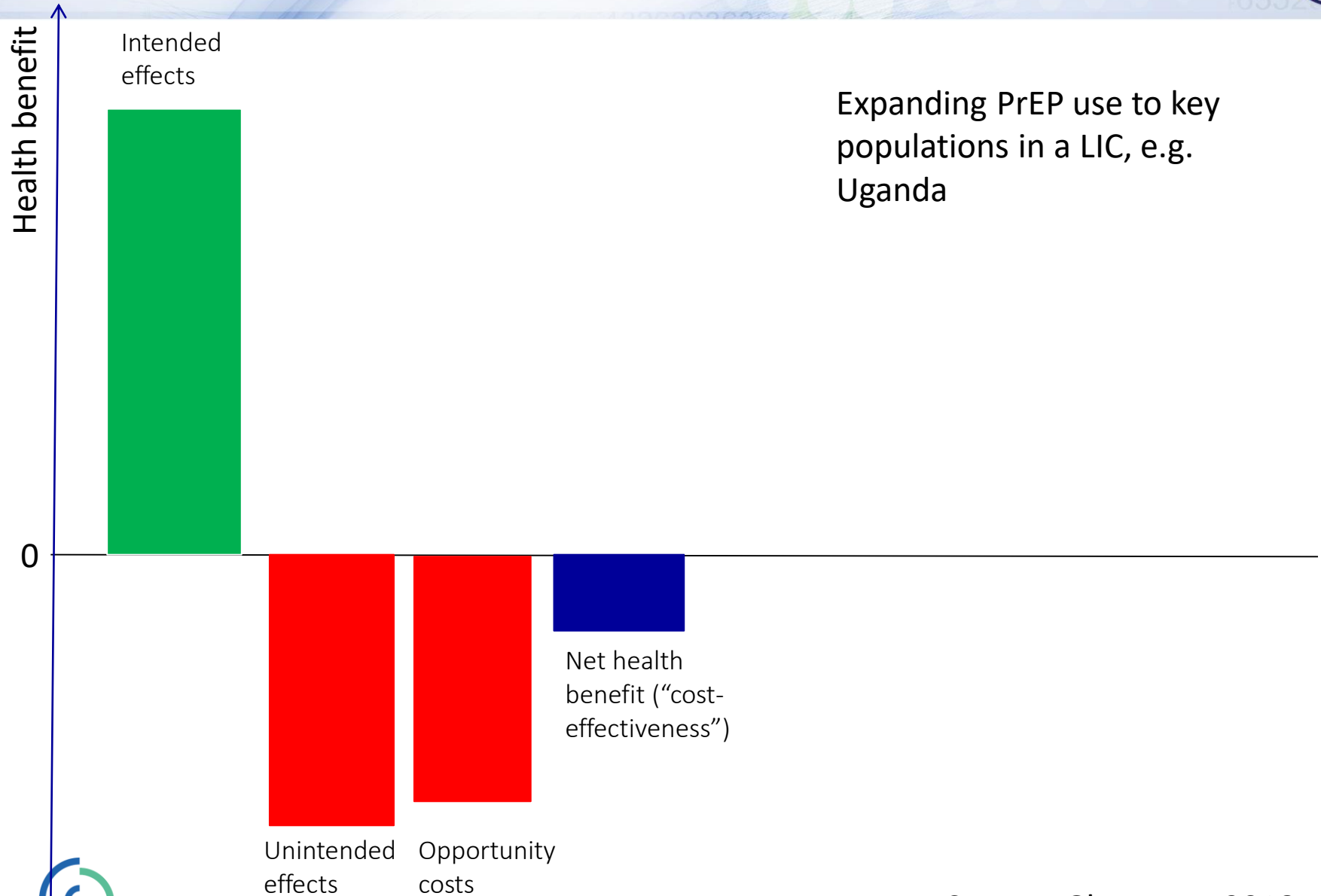
- Spending on an area means less spending in another
- This is particularly important in LMICs where budget constraints are high = high opportunity costs
- Opportunity costs = health gains that could have been gained (or lost) from spending on an alternative intervention



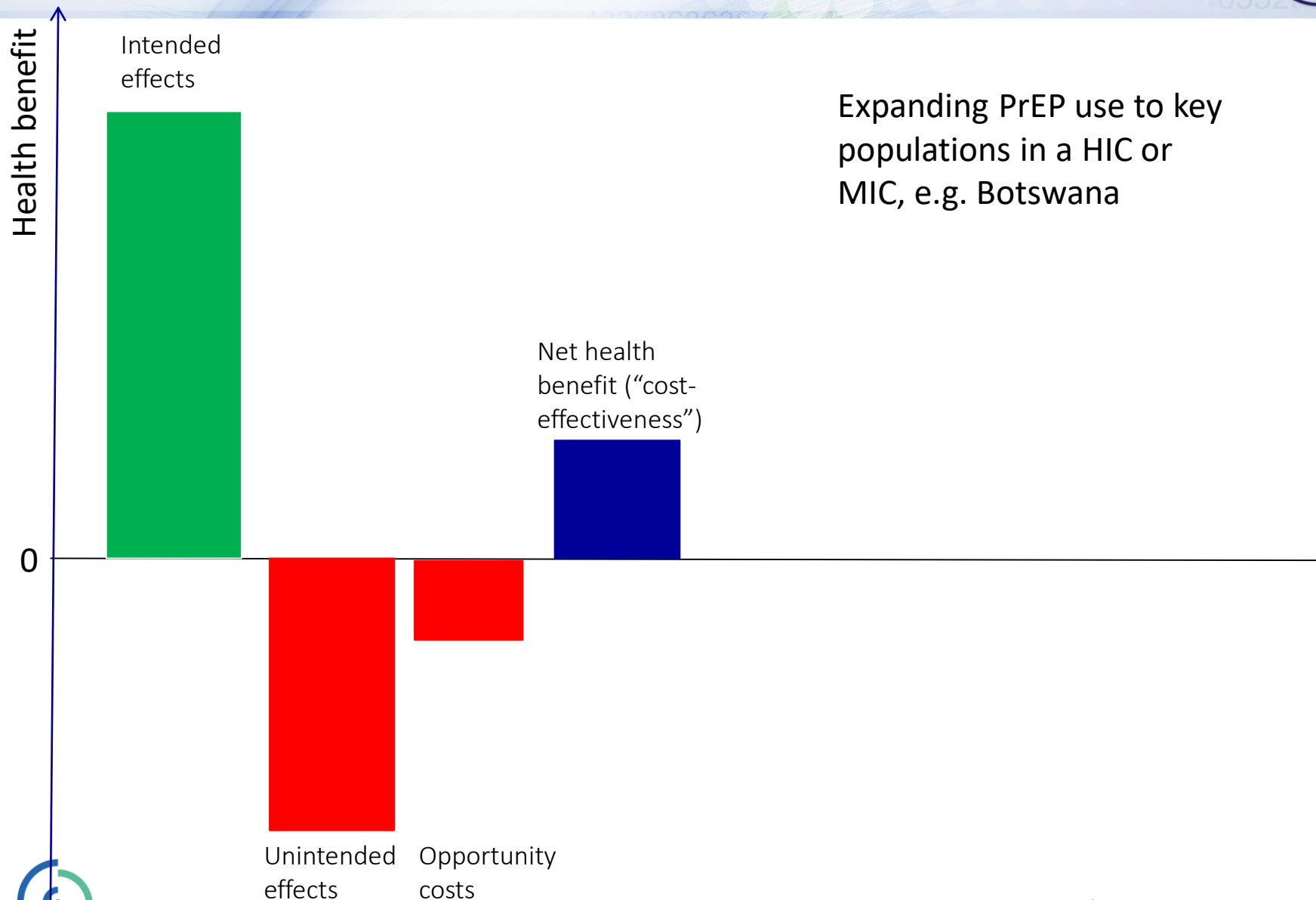
# Opportunity costs in local context



# Opportunity costs in local context



# Opportunity costs in local context





# What type of decisions are amenable to “Priority Setting”?

**Any resource allocation decision  
Any choice with competing alternatives**

- 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***.

# World Health Assembly HITA resolution 67:23



SIXTY-SEVENTH WORLD HEALTH ASSEMBLY

WHA67.23

Agenda item 15.7

24 May 2014



## **Health intervention and technology assessment in support of universal health coverage**

*“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?

Can I afford this?

?

How does intervention A compare to intervention B?

Who are the beneficiaries of the intervention?

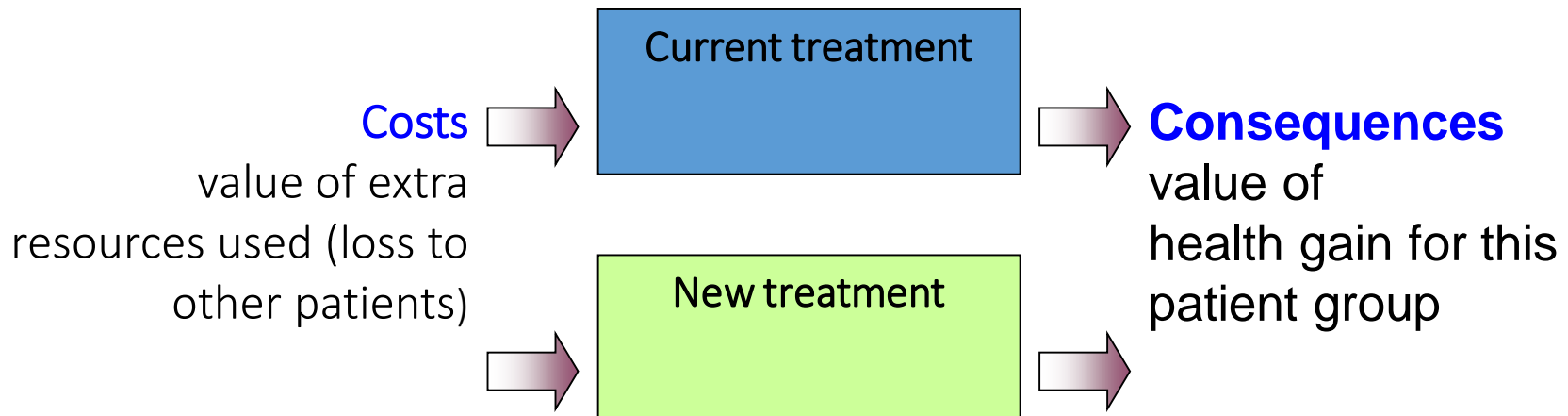
Where should I invest resources?





“... the comparative analysis of alternative courses of action in terms of both their costs and consequences.”

Drummond, Stoddart & Torrance, 1987



# Types of economic evaluation



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Type of analysis	Where it is used
Cost-of-illness analysis	A determination of the <b>economic impact of an illness</b> or condition (typically on a given population, region, or country) e.g., of smoking, arthritis, or diabetes, including associated treatment costs
<b>Cost-Effectiveness Analysis</b>	<b>A comparison of costs in monetary units with outcomes in quantitative non-monetary units.</b> 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)
Budget Impact Analysis	Can be conducted in addition to a CEA <b>to determine the impact of implementing or adopting a particular technology</b> or technology-related policy <b>on a designated budget</b> , e.g., for a drug formulary or health plan.
Cost-Consequence analysis	A form of cost-effectiveness analysis that presents <b>costs and outcomes in discrete categories</b> , without aggregating or weighting them
Cost-Benefit analysis	compares costs and benefits, both of which are <b>quantified in common monetary units</b>

# Assessing efficiency: the ICER

Weighing up the benefits, harms and costs

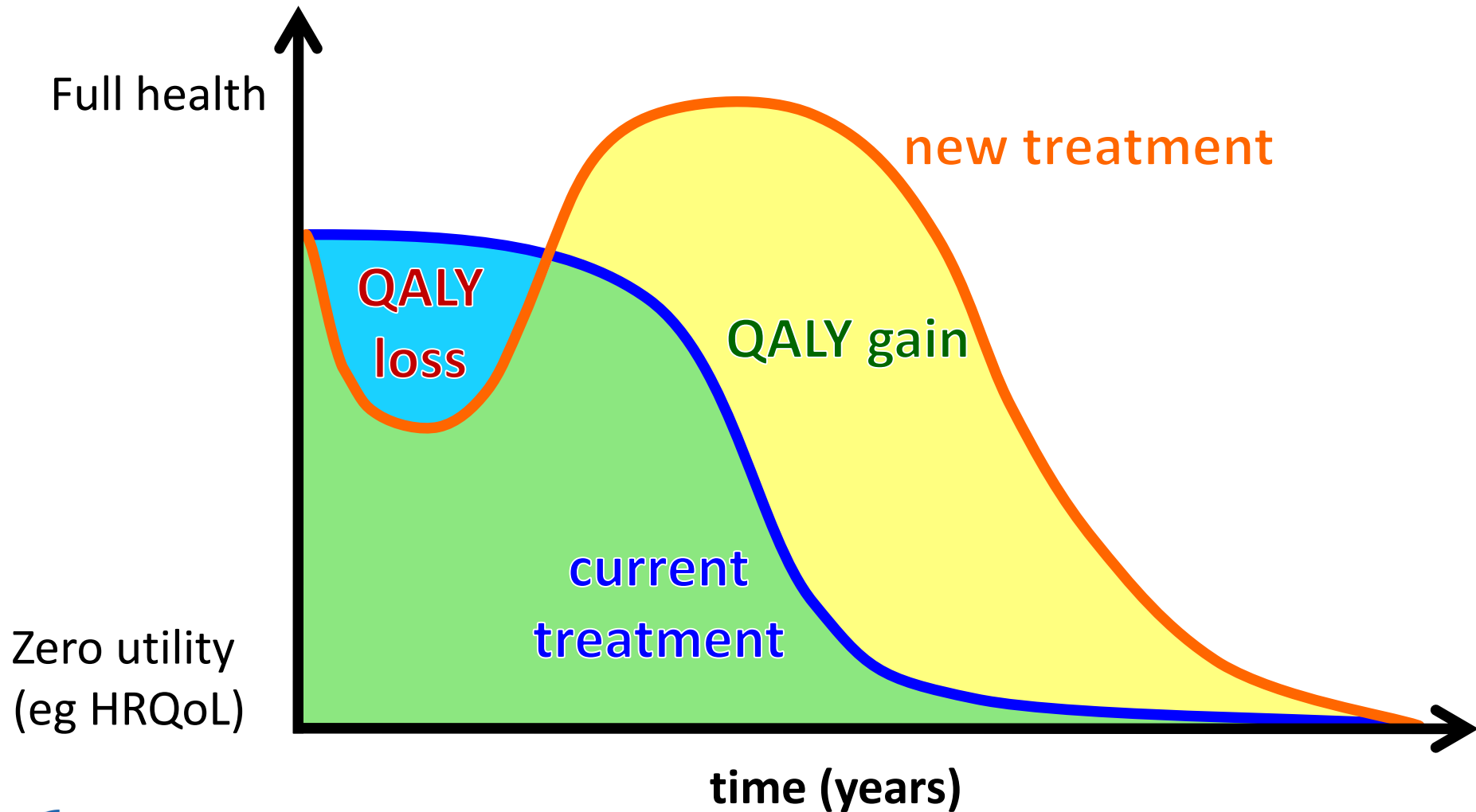


$$\frac{\text{cost}_{\text{new}} - \text{cost}_{\text{current}}}{\text{health gain}_{\text{new}} - \text{health gain}_{\text{current}}}$$

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

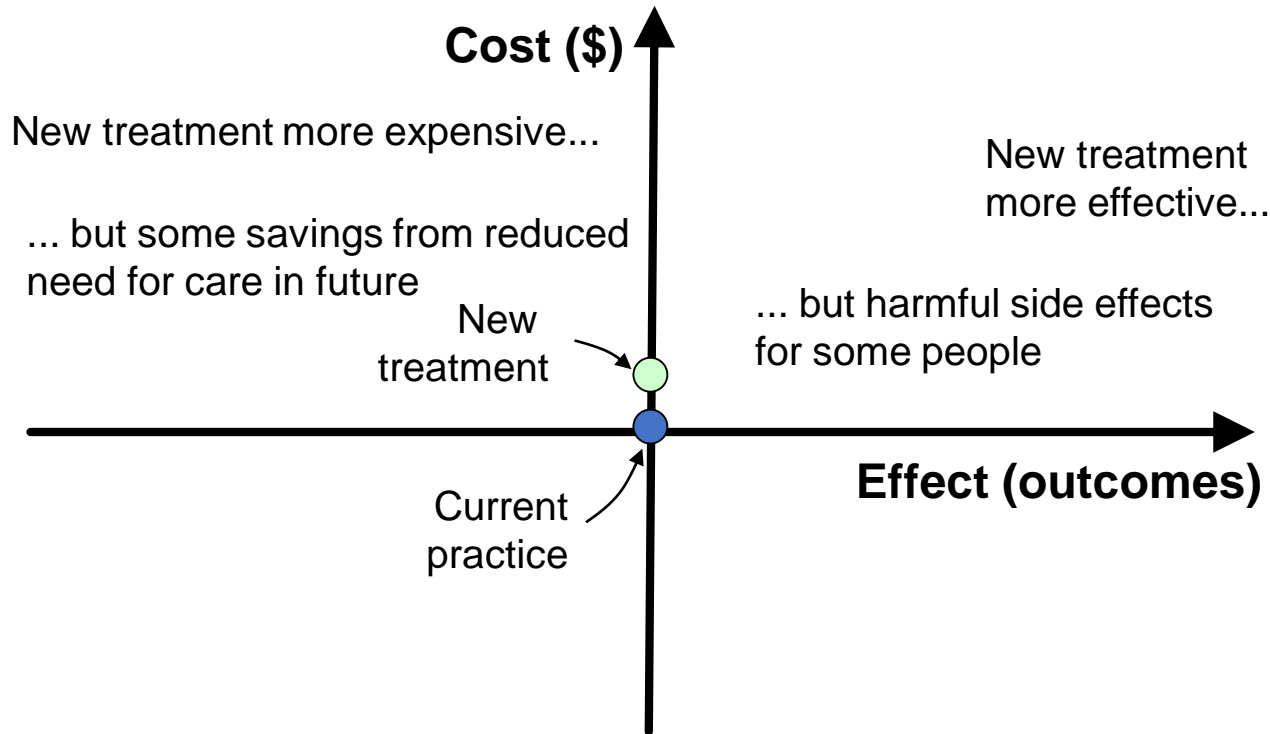




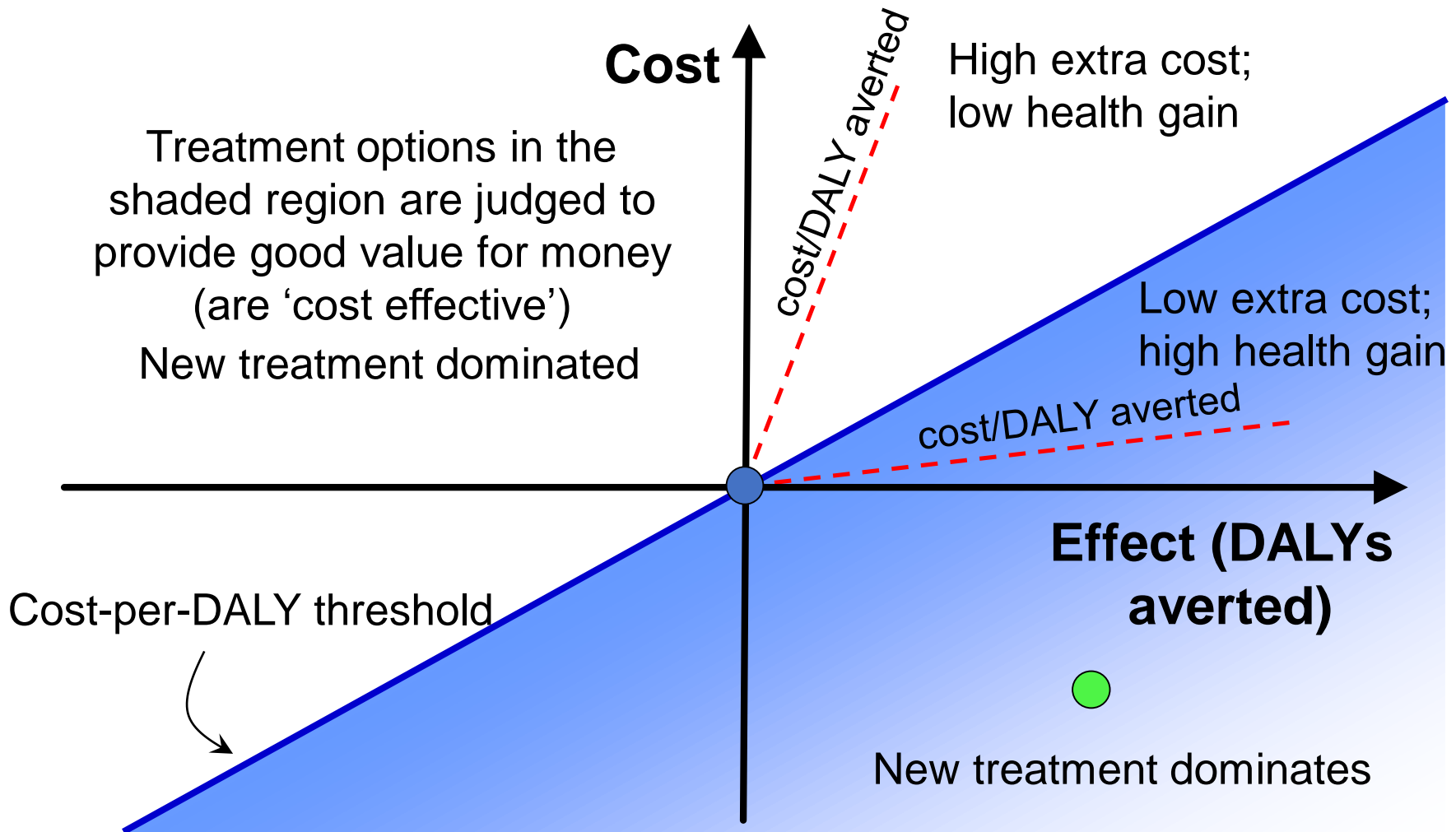
Ex. Avastin: £200,000/QALY (NICE, 2010)

- 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?



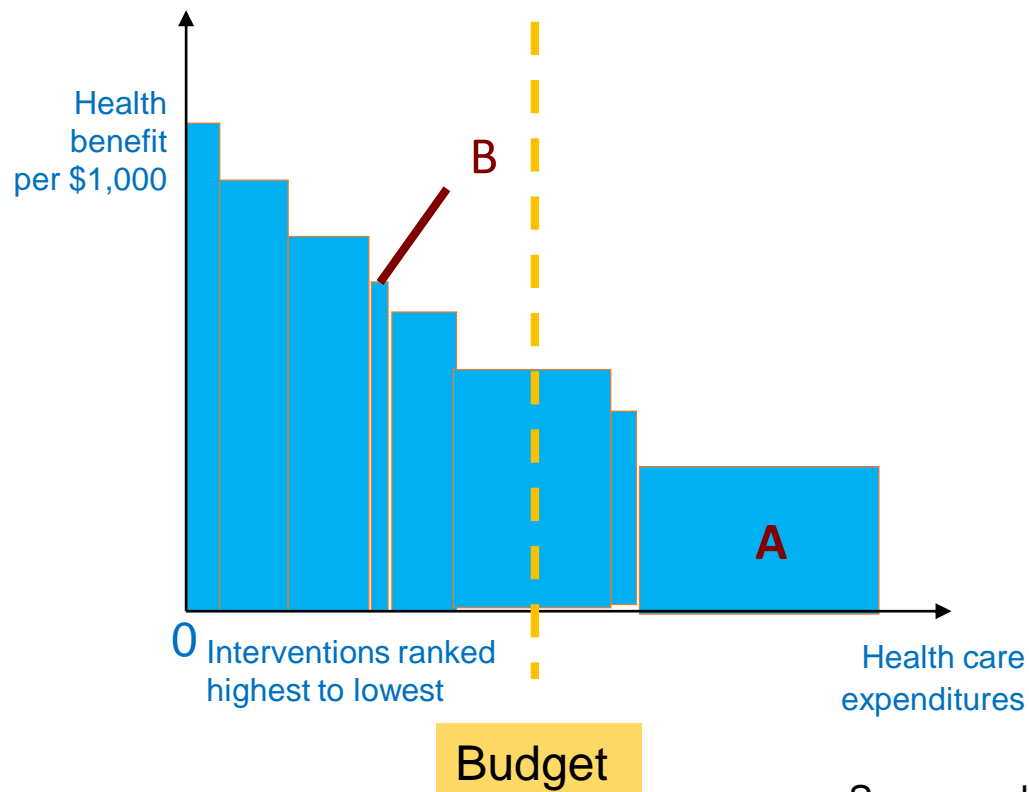
# How do we use the ICER to assess value for money?



# Introducing the bookshelf metaphor



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

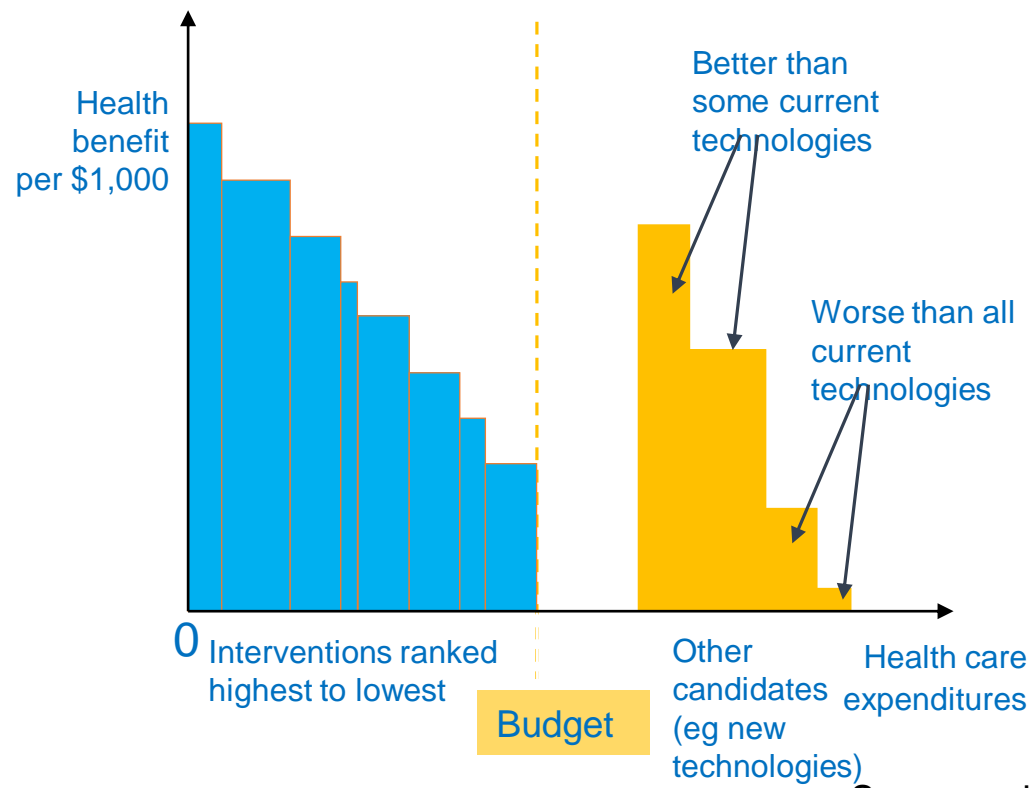


Source: adapted from Culyer (2016)



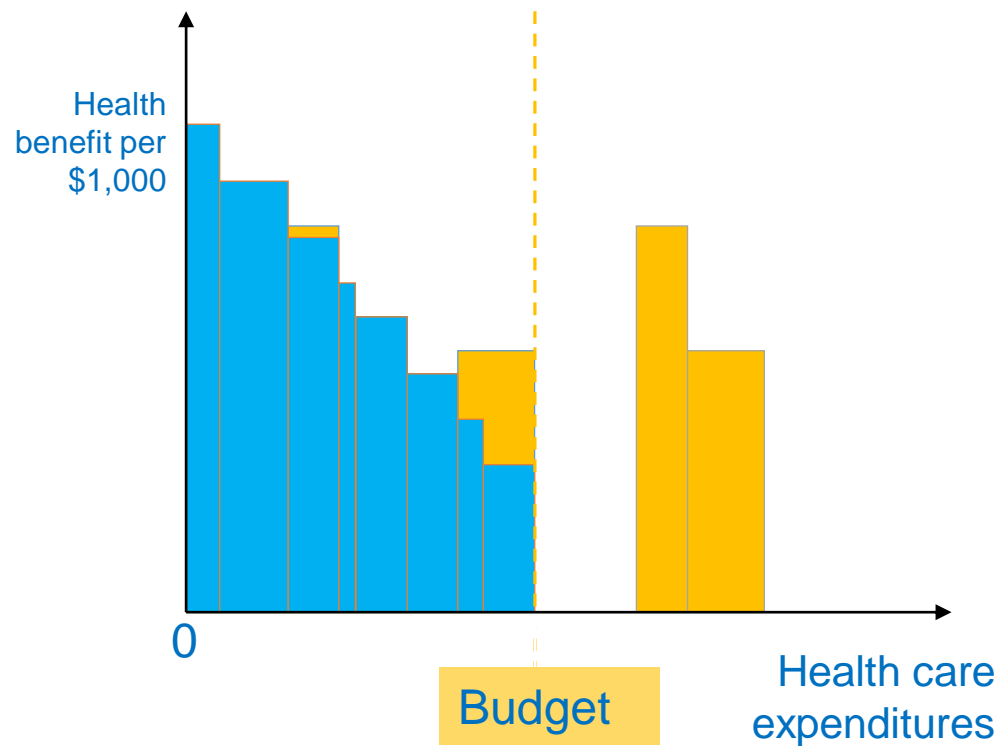
# Budget impact and cost effectiveness: determining interventions that are in... and out

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



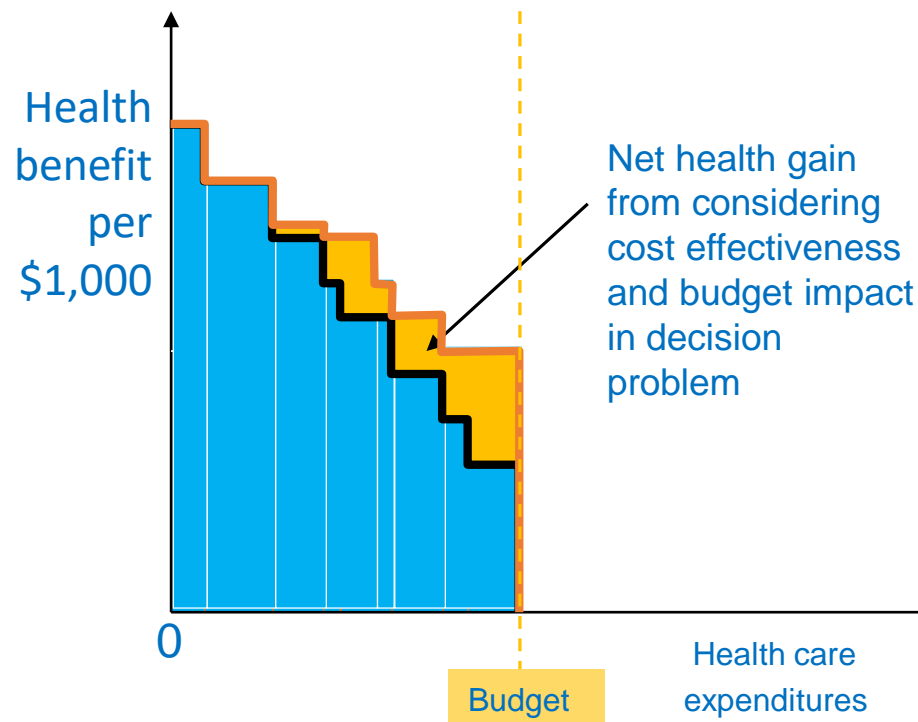
Source: adapted from Culyer (2016)

# 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



## 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



- 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)
  - Antotensin receptor blockers (ARP)
  - No intervention – comparator
- Outcomes: Disability Adjusted Life Years (DALYs)



## Results: ICER & budget impact

### Incremental cost-effectiveness analysis (per 100 people treated over lifetime horizon)

**Policy scenarios**

Change from CCB to TZD (10% shift) could save 18.4% of the total hypertensive expenditure, although with a slight deterioration of health outcomes

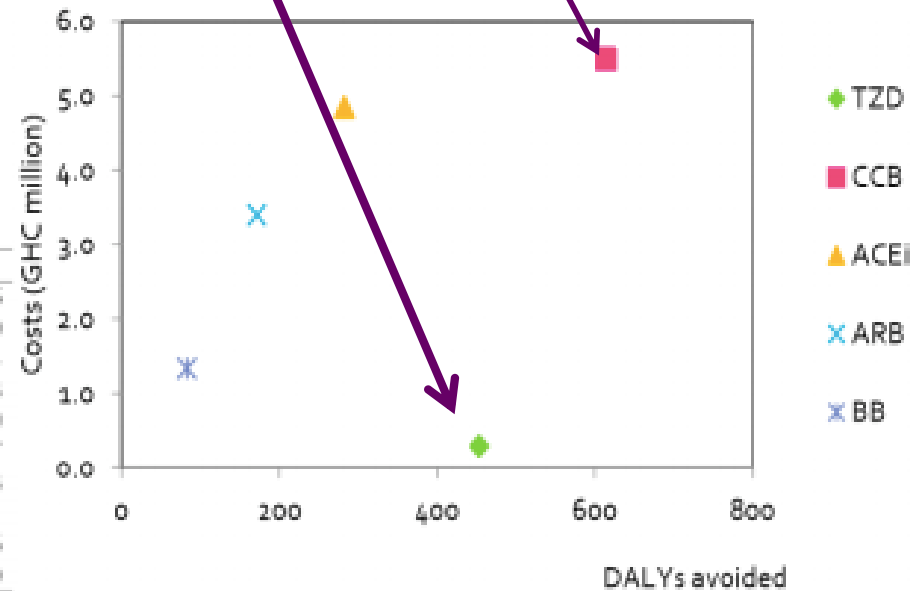


100 people treated over lifetime horizon

	Compared with no intervention		DALYs avoided	ICER (GH¢/DALY)	Dominance
	Additional cost (GH¢)	DALYs avoided			
TZD	290,933	453	512	512	
CCB	5,498,126	614	32,482	8953	
ACEi	4,847,175	282	Dominated		
ARB	3,398,147	171	Dominated		
BB	1,334,573	83	Dominated		

### Budget impact over 5 years

	Total costs (GH¢ discounted)				
	Year 1	Year 2	Year 3	Year 4	Year 5
NI	5,347,183	6,082,649	6,499,465	6,708,038	6,781,829
TZD	8,181,309	12,548,675	12,526,516	12,373,027	12,134,744
CCB	69,386,769	127,865,019	121,118,914	114,705,942	108,654,743
ACEi	64,168,270	117,113,688	110,582,387	104,394,251	98,589,550
ARB	47,124,757	84,772,356	80,167,115	75,758,854	71,599,337
BB	21,841,437	37,149,504	35,569,569	33,942,948	32,335,183
TZD vs NI	2,834,127	6,466,027	6,027,051	5,664,989	5,352,915
CCB vs TZD	61,205,459	115,316,343	108,592,399	102,332,914	96,519,999





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# How do we ensure we are using the right methods to conduct economic evaluation? the iDSI Reference Case

HEALTH ECONOMICS

*Health Econ.* 25(Suppl. 1): 124–139 (2016)

Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/hec.3303

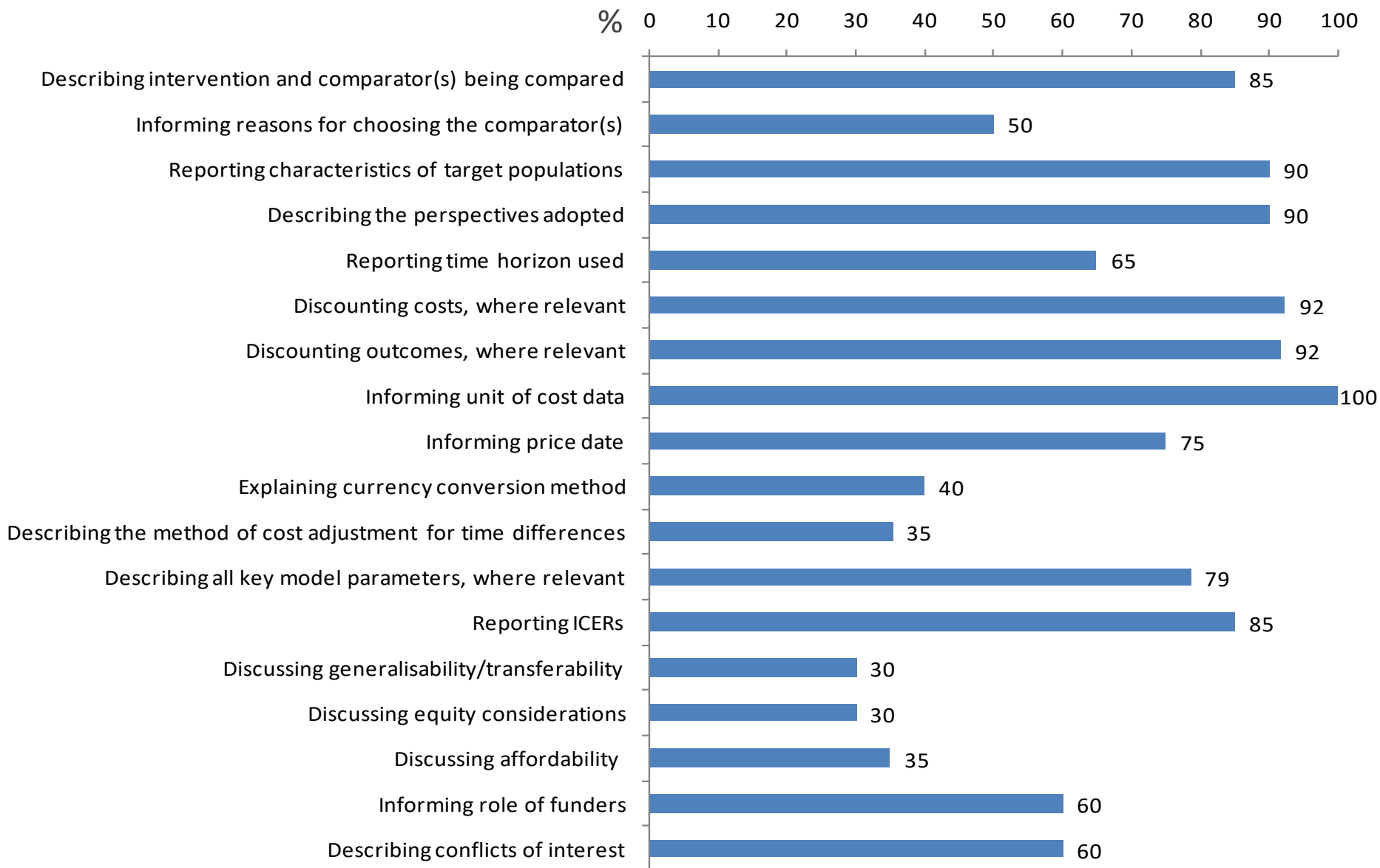
## DYNAMIC TRANSMISSION ECONOMIC EVALUATION OF INFECTIOUS DISEASE INTERVENTIONS IN LOW- AND MIDDLE-INCOME COUNTRIES: A SYSTEMATIC LITERATURE REVIEW

TOM L. DR.

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?







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# Methods for economic evaluation: the iDSI Reference Case



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Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

ScienceDirect

journal homepage: [www.elsevier.com/locate/jval](http://www.elsevier.com/locate/jval)



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

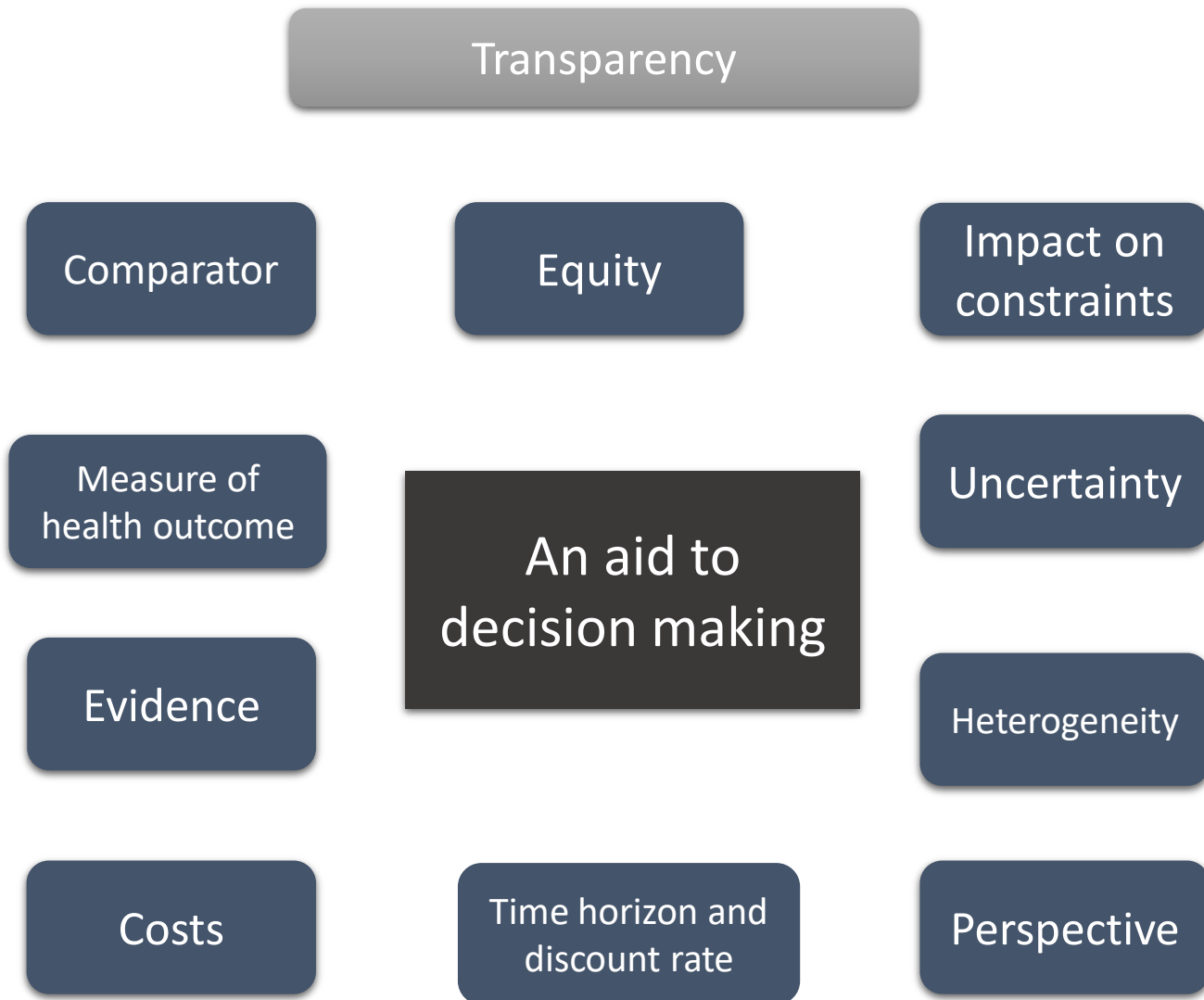


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# Methods for economic evaluation: the iDSI Reference Case



# Optimize resource allocation to best meet objectives

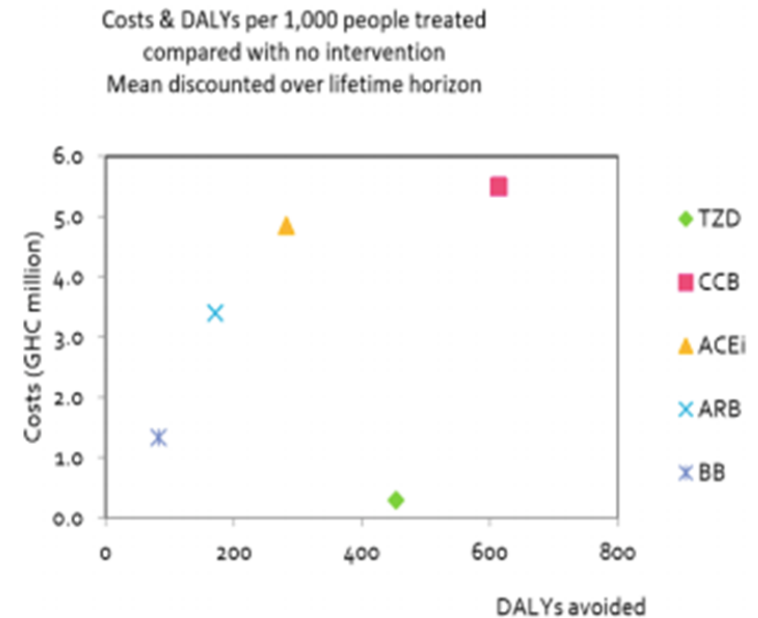


How should the budget be allocated amongst these 'n' programs, modalities, and delivery options, considering their interactions with synergies and limitations?

# Optimization approach: applying CEA to a broad package of interventions



- 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 patient population (eg 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



# Optimization approach: applying CEA to a broad package of interventions



*“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, Petracic, Wilson, and Wilson, 2017

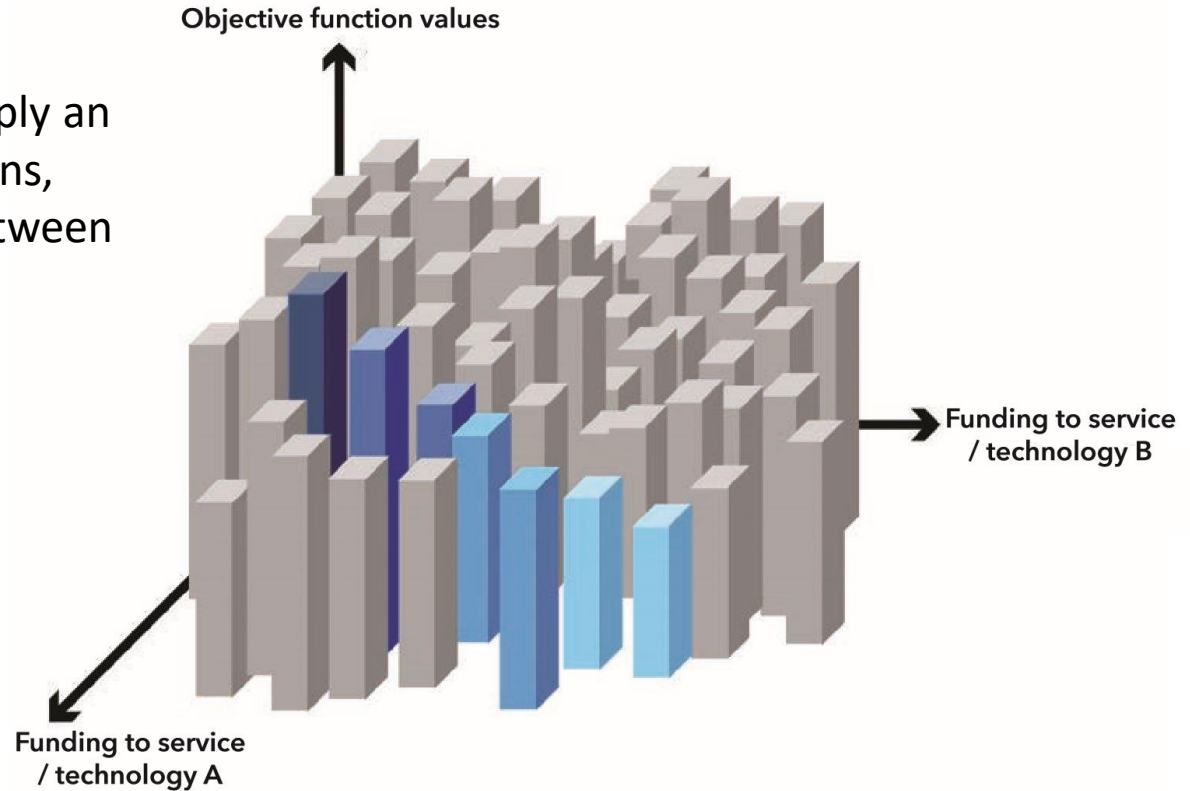






# Optimization approach: applying CEA to a broad package of interventions

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

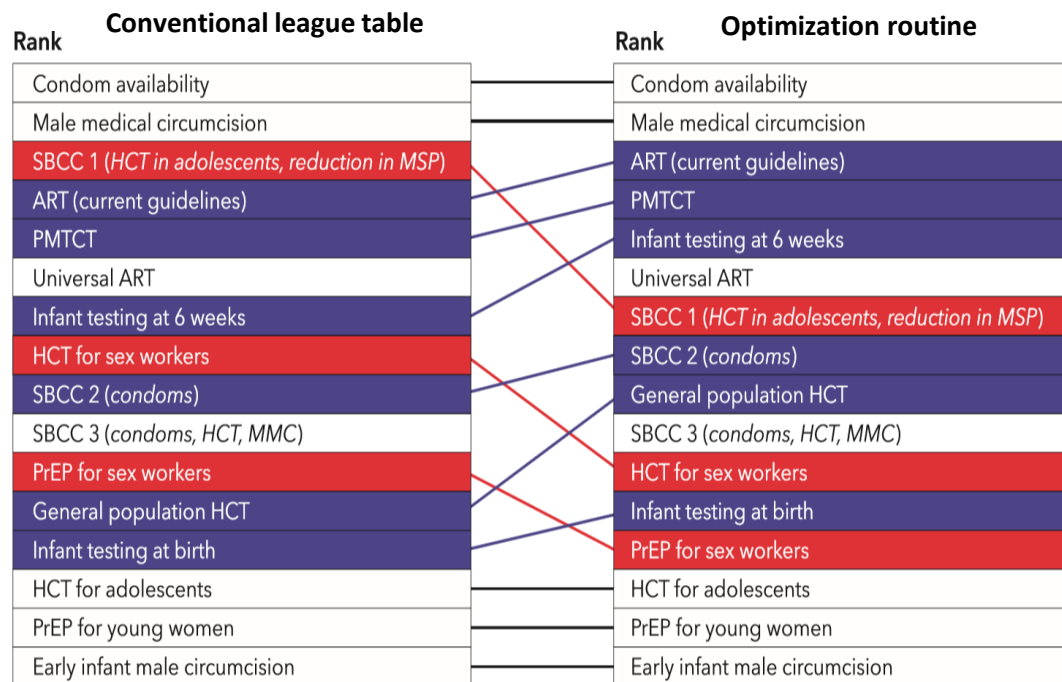


Schematic of an optimization algorithm in two dimensions of health services



# 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)



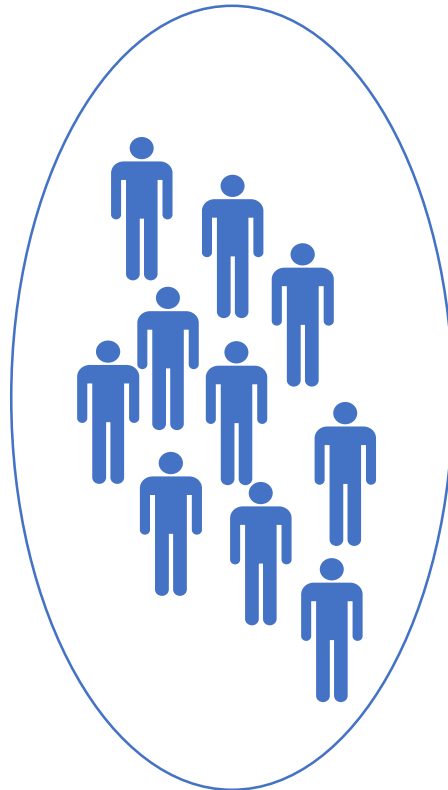
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# Mini case study exercise

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



## Four scenarios

- No budget constraints
- Burden of disease
- Cheapest vaccine
- Priority setting

# What you need



Link for the Excel sheet and instructions:

<https://bit.ly/2xy6IVG>

## 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 Control, Gavi, IHME).*

### 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**).

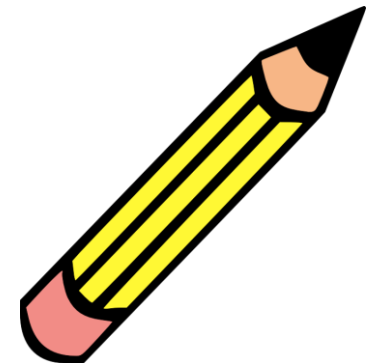
You are the budget holder of the child immunization programme at **JLNtopia**. **JLNtopia** has made major strides in decreasing under-5-mortality (USM) in the last decade. Deaths from diphtheria, tetanus, whooping cough and meningitis have declined drastically from the introduction of the **Pentavalent** vaccine. However, USM in **JLNtopia** 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 **JLNtopia** 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



Excel sheet  
exercise





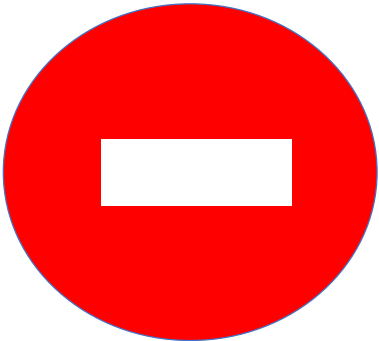
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# Guidelines for the use of the excel spreadsheet

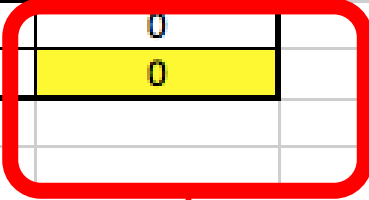
Enter the answer

Scenario #4: Allocation based on burden of disease

Vaccine	% of budget	Budget in \$	Number of children immunized	DALYs averted
Pentavalent		0	0	0
Measles vaccine		0	0	0
BCG vaccine		0	0	0
Pneumococcal conjugate vaccine		0	0	0
Rotavirus vaccine		0	0	0
<b>Total</b>	<b>0%</b>	<b>4,000,000</b>	<b>N/A</b>	<b>0</b>



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

Vaccine	Target	Share of total burden of disease attributed to the diseases targeted by vaccine <sup>1</sup>
<u>Pentavalent (combined vaccine)</u>	<u>Diphtheria</u> , Tetanus, pertussis, <u>HiB</u> and <u>HepB</u>	40%
Measles vaccine	Measles	20%
BCG vaccine	Tuberculosis	15%
Pneumococcal conjugate vaccine	Pneumococcal disease	15%
Rotavirus vaccine	Rotavirus	10%

**Budget: \$4 million**

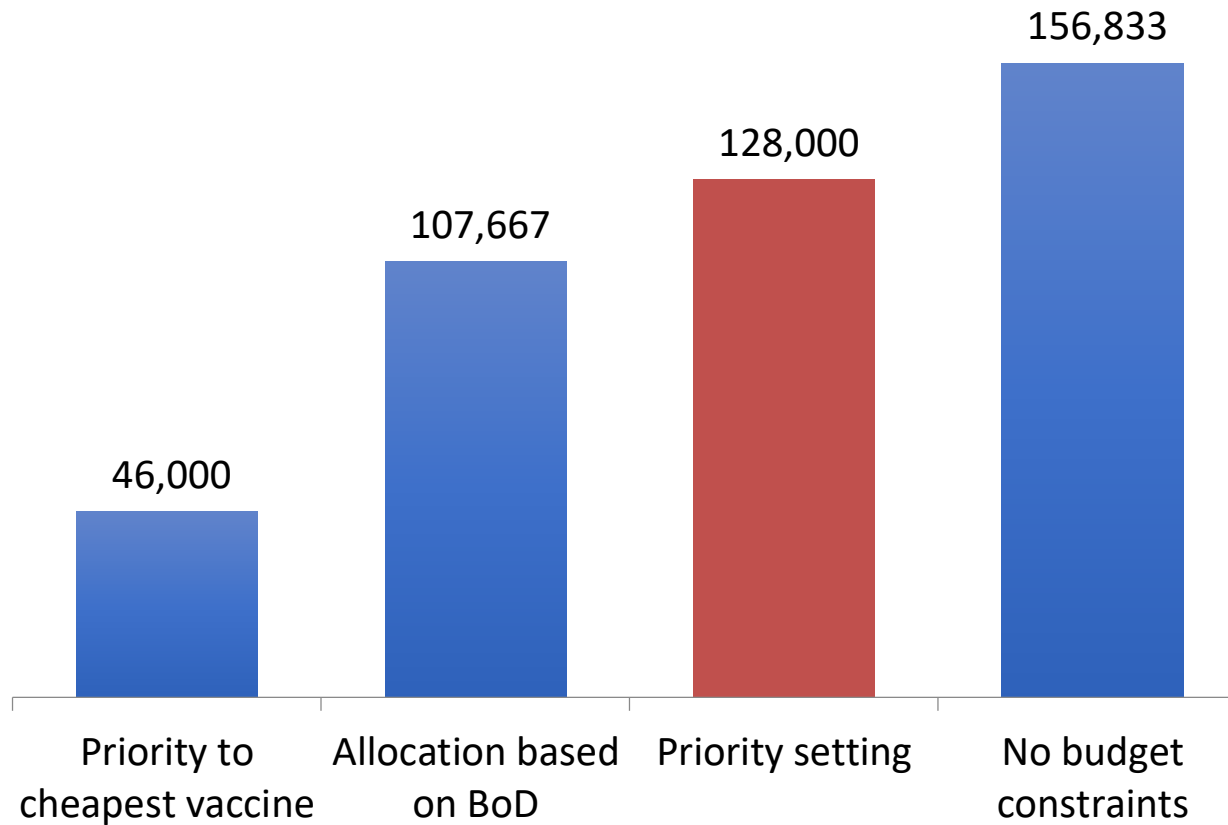
**Patients: 200,000**

Link for the Excel sheet and instructions:  
<https://bit.ly/2xy6IVG>

Table 2. Cost and cost-effectiveness ratios

Vaccine	\$ <u>per immunization</u>	\$/ <u>DALYs averted</u>	<u>DALYs averted per immunization</u>
<u>Pentavalent (combined vaccine)</u>	10	20	0.50
Measles vaccine	6	60	0.10
BCG vaccine	4	120	0.03
Pneumococcal conjugate vaccine	8	100	0.08
Rotavirus vaccine	8.5	120	0.07

# Results – total DALYs averted





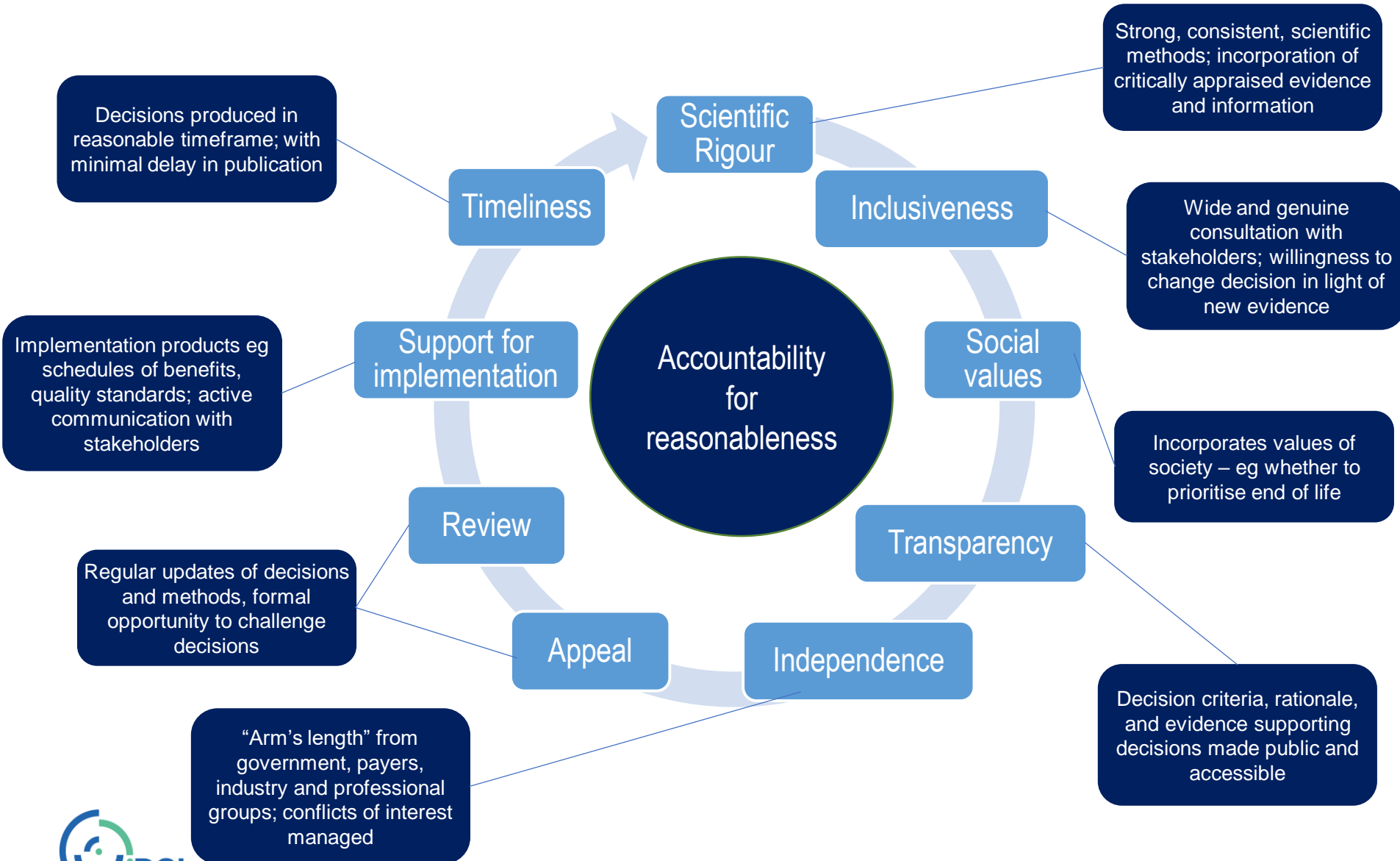
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# Challenging the status-quo



- 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

# Decision making that is accountable for “reasonableness”





# Can we afford to institutionalize priority setting?



Country	Entity	Funding sources	Budget (as % of total health budget)
Germany	IGWIG	Fees for each ambulatory visit and hospitalizations	US\$19 million (0.01 percent of SHI expenditure)
Australia	PBAC	Mainly application fees to be paid when requesting an evaluation, complemented by DoHA program funding	US\$15 million (0.01% of total health budget)
	MS		
	PL		
Netherlands	CV		
United Kingdom	NICE		6% of
Brazil	ANVISA	Public resources of the general budget	
	CITEC and DECIT	Public resources of the general budget	No stable budget allocation (less than 1% of SUS budget)
Chile	n.a.	Public resources of the general budget	Not defined
Uruguay	FNR	Public resources of the general budget	Not defined as immersed in general budget of FNR, which also finances high-cost technologies
Colombia	CRES	Public resources of the general budget	Not defined as immersed in general budget of CRES, which carries out many other tasks besides evaluating and deciding on coverage of the benefits package
Poland <sup>b</sup>	AHTAPol	70% of support from the general budget. The rest comes from other sources, including statutory fees paid by pharmaceutical companies, which submit reimbursement applications, fees for training, grants, and interest	The 2011 AHTAPol's budget is about PLN 10,500,000 (0.018% of the completely separate NHF budget)
Thailand <sup>b</sup>	HITAP	HITAP receives its main funding support from four public institutions: the Thai Health Promotion Foundation; the Health Systems Research Institute; the Health Insurance System Research Office; and the Bureau of Policy and Strategy, Ministry of Public Health	About 30 million baht (about US\$1 million) have been allocated to HITAP annually for all its health technology assessment activities, including capacity building and health technology assessment dissemination

The question is not whether to set priorities - but how to improve priority-setting processes



Better decisions. Better health.

- Web: [idsihealth.org](http://idsihealth.org)
- Twitter: [@idsihealth](https://twitter.com/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 ar project

BUSINESS NEWS FEBRUARY 2, 2018 / 2:23 AM / 11 DAYS AGO

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

Aditya Kalra

4 MIN READ



## 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



Dying cancer patients have grounds despite a Government



Announcing the fund last summer, Andrew Lansley, the Health Secretary, promised to end 'the scandal' of cancer patients being refused drugs. Photo: PA

#### Cancer research

## Cancer Drugs Fund condemned as expensive and ineffective

Treatments approved by David Cameron's scheme were not worth money, extended life very little and often had adverse side-effects, study finds

News

## £1.27 billion Cancer Drugs Fund a political 'quick-fix' that harmed some patients, review finds



- 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



# Example: HITAP's communication strategy



- For each project:
  - Produces comprehensive
  - Policy brief for policy
  - Infographics on the
  - Articles in peer reviewed
- From the onset:
  - Project announcement
  - Press releases on the
  - Individuals can engage

## Dr. Mana's Bittersweet decision:

High cost, high return?

### Recap episode

Dr. Mana – the health minister – would like to improve health for all. He approved all new health technologies to be included in the benefits package with expectation that it will improve patient quality of life. However, sharp increases in public health expenditure put the country budget at risk, and still, many patients could not access these services.



Source: Culyer et al., 2016



## 5. Building an inclusive process



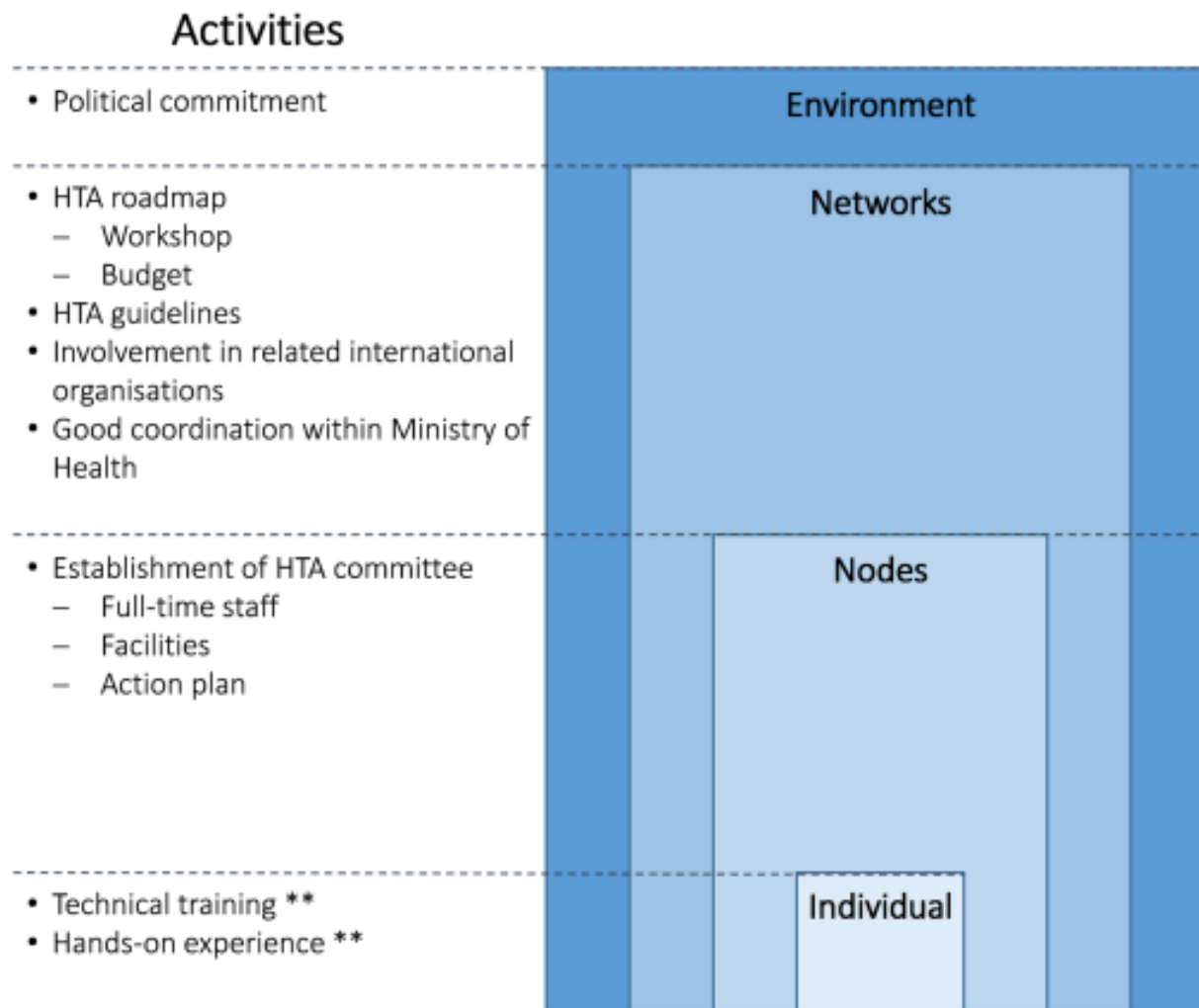
- Not all stakeholders need to be part of the decision making
- Different forms of participation:
  - Information gathering, Consultation, Decision-making
  - Interests need to be defined
- Inclusion is resource-intensive and presents its own risks
- Colombia's HBP was abandoned (1993), three attempts 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



# 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