Protocol for Prioritization of Health Interventions for Revision of the Essential Health service Package in Ethiopia

Federal Democraic Republic of Ethiopia
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Foreword

The Ministry of Health continues to develop critical strategies that can lead to Universal Health Coverage (UHC). Realization of universal health coverage requires strategic investments, and the strategies should be implemented successively over time. In order to make stratic decision, in addition, our decision should be based on robust evidence on cost, effectiveness, budget impact, and acceptability of the health interventions.

I believe that we cannot progress towards UHC without clearly identifying the most pressing health problems and the essential and affordable interventions to address health problems. In the 2019 revised Essential Health Service Package (EHSP), we identified the most pressing health challenges and interventions that were deemed appropriate, affordable, and equitable to address the key health problems in the country. For the preparation of the EHSP, so many relevant interventions were identifies. Interventions were compared and prioritized based on a set of prioritization criteria, and wide conulation with public and health policybmakers ws conducted.

However, continuous update of the essential health service package is very important for progressive realization of universal health coverage. Subsequent inclusion or exclusion of intervention into the EHSP should be done based on thorough evaluation of the intervention using Health Technology Assessment (HTA) mechanism. Thefrore, the primary purpose of this protocol is to guide the prioritization of health interventions in the revision of Ethiopian essential health service package and health technology assessment.

November, 2019
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1. Purpose of the protocol

Despite a large reduction of mortality and morbidity and outstanding improvement of life expectancy of the population in the last couple of decades, Ethiopia is yet one of the countries with a huge burden of diseases from reproductive, maternal, neonatal, child health, and infectious diseases compare with most other sub-shararan africal countries [1]. Recent evidence also shows that the magnitude of non-communicable diseases and injuries are rising in Ethiopia [2]. Furthermore, both coverages of basic health services and health service utilization are low [3]. There is high catastrophic out-of-pocket health spending [4].

In order to address these needs, the government of Ethiopia has developed strategies that can lead to UHC. Some of the strategies include first, clearly defining the Essential Health Service Package (EHSP) of the country and identify priority health interventions. Second, exemption or cost-sharing of those high priority interventions. Third, the expansion of community-based health insurance (CBHI) and social health insurance (SHI) programs. Fourth, integration of the health services with other sectors, from national to the district level, to address social determinants of health using a 'Woreda Transformation Program'. Therefore, these strategies can improve both coverage of essential health services and provide financial risk protection for the whole population.

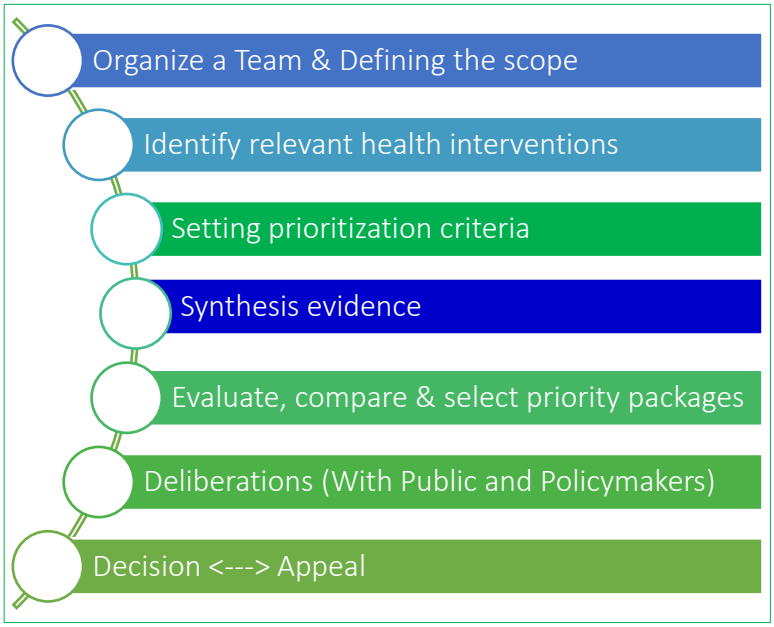
Citizens all over the country and donors are demanding greater accountability for how limited health resources are used to meet health system goals. Since demand for health care usually exceeds resources available, priority setting in health is an important and inevitable undertaking at all levels and for all contexts in the health system.

Priority setting is selecting interventions, among long-list of options, which can address the most important health needs of the population. However, selection of specific intervention to be included in the EHSP, CBHI or SHI; which intervention to provide free from user-fee-charge, cost-sharing or cost recovery; which intervention to scale-up or scale-down in the health sector plans is challenging without a clear guiding principle. Therefore, the primary purpose of this protocol is to guide the prioritization of health interventions in the revision of Ethiopian essential health service package. In addition, the protocol can be used for appraisal of the health technology assessment (HTA) in Ethiopia or an other prioritiy-setting excersise in the health sector.

2. Priority-setting process

Ethiopia's Essential Health Services Package (EHSP) should constitute a set of priority health interventions to be provided at all levels of the Ethiopian health system in an equitable and sustainable manner. These interventions must promote population health in general, and take into account health promotion, prevention of diseases, curative care, and rehabilitation. Ethiopia cannot move toward universal health coverage (UHC) without clearly defining the most urgent health problems and the best interventions to address them.

The revision of Ethiopia's EHSP is based on a priority-setting process that uses available evidence and input from experts and stakeholders. This revision will determine the strategic direction of the country's health plan in the years ahead. Health needs vary across the Ethiopian population as do the health services required to address these needs. There is growing attention on how to align health services to public needs. This has cultivated an interest in establishing a participatory priority-setting process, involving representation from all constituents across society.



Decision-making processes like these need to account for economic reasoning (i.e. value for money), ethical standards, in addition to societal values. Overall, priority setting should be made in an open and transparent way.

Cognizant of the importance of open deliberation, several rounds of consultative workshops with technical experts, public representatives, professional associations, patient families, and unions, policymakers were held in Addis Ababa from June 2018 to July 2019. The major objectives of the workshops were to ensure wide participation, gather public input, and create full ownership of the public for the EHSP preparation process. During the workshops, the EHSP revision core-team presented the priority setting concepts, general information about priority setting criteria selection, theories and practice of priority setting in other countries.

Several stakeholders participated in the organized participatory small-group and plenary discussions, and collected feedback about the criteria for inclusion.

3. Priority-setting Criteria's

Based on the review of the health policy, relevant strategic documents of the health system, and several rounds of consultation with global and local experts, the EHSP revision core-team proposed four major criteria (namely burden of the disease, cost-effectiveness, priority to the worse off, and financial risk protection) and three additional criteria (budget impact, political feasibility, and public acceptability) for public deliberation. These are common priority-setting criteria and have been applied in many other contexts [5]. Participants were asked to comment and suggest modifications to the the proposed criteria and/or suggest new criteria. Based on these discussions the following seven criteria have been recommended for the EHSP revision:

1. **Size of the disease burden**
2. **Cost-effectiveness**
3. **Budget impact**
4. **Equity**
5. **Financial risk protection**
6. **Public acceptability**
7. **Political acceptability**

Both the participants at the workshops and the experts agreed that application of these criteria should vary according to the availability of current evidence and the character of the criteria. However, in general, the prioritization approaches applied data, dialogue, and decision.

The burden of disease criterion should be used to identify relevant health interventions in the Ethiopian context; the cost-effectiveness criterion should be used to quantitatively rank and compare health interventions; the equity and financial risk protection criteria should be used to further compare health interventions to give priority to health interventions which can afford greater benefits to the worse off and protect catastrophic out-of-pocket (OOP) health expenditures. Budget impact, public acceptability, and political acceptability will be taken into account into the decision-making using the qualitative deliberative process. Most importantly,

the services to be included in the EHSP should be delivered at the highest standard. Therefore, monitoring and evaluation of the implementation of the EHSP will be crucial.

1. Burden of Disease

Burden of disease (BoD) is the impact of a health problem or a risk factor as measured by mortality, morbidity, or a combination of the two. In a low-income country, like Ethiopia, it can be quantified in terms of constructed summary measures like disability-adjusted life years (DALY), which aggregate both mortality and morbidity outcomes. By construction, DALYs account for severity and prevalence of disease, as well as mortality.

Therefore, all diseases and conditions will be ranked and compared based on DALY lost. Using the recent BoD estimates for Ethiopia, all diseases, conditions, or risk factors will be listed; and corresponding health interventions will be solicited from the comprehensive list of interventions available. In addition, this criterion will be used to match the targeted health interventions with the actual country BoD.

2. Cost-effectiveness

Cost-effectiveness analysis (CEA) is designed to compare the relative costs and health outcomes of different courses of action or implementation of interventions (relative to other interventions or doing-nothing). In the EHSP revision, generalized cost-effectiveness analysis (GCEA)—comparing interventions with a 'doing-nothing' scenario—will be applied [6].

All interventions will be ranked in ascending order based on their average cost-effectiveness ratio (ACER), in order to extract the most cost-effective health services to be included into the EHSP until budget is exhausted.

The cost-effectiveness evidence will be extracted using two major approaches: Estimation of ACER from WHO-CHOICE GCEA OneHealthTool and Contextualization of CEA evidence from literatures. For WHO-CHOICE OneHealthTool, local input data will be populated to compute the cost-effectiveness ratios.

In addition, data from the literature will be used after critically appraising the studies based on the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) checklist [7]. Studies are appraised by reviewers, and will be considered to meet a minimum standard will be accepted for adaptation to Ethiopian data.

The CEA will take the health services provider perspective. The reference year and currency will be 2019 USD. Cost per Healthy Life Years (HLY)/ or QALY gained, or DALY averted will be used. Both health outcome and cost should be be discounted by 3% per year.

3. Budget Impact

The cost of implementation and scale up of health services depends on the budget impact of the interventions. For some interventions, the cost-effectiveness ratio might be very low but the actual delivery of the service to the target population might have large budget implications on being able to implement other interventions (i.e. opportunity costs). In addition to cost-effectiveness, each intervention and a group of interventions will be assessed in terms of cost of their actual implementation and scale up. First, starting with higher-value, lower-cost health interventions is appropriate. Interventions with a very high budget impact may need strong additional justification to be included.

Therefore, among the cost-effective interventions, the EHSP revision core-team together with the Federal Ministry of Health (FMoH) Management Committee will examine the budget impact of each intervention and decide which interventions should be considered for further analysis and which interventions should be on the waiting list.

Mythological guidance provided by ISPOR task force on budget impact analysis will be applied to keep the standard methods of budget impact estimation [8]

Costs should be presented as a total cost for entire population affected (for 1 year, 5 year, and 10 year) at universal coverage targets (95%) and reasonable attainable coverage target in the next 10 years. In addition, cost per capita will be estimated.

4. Equity

Equity as a criterion arises from the policy commitment of the government and local social values to creating a fair, just, and pro-poor society and health system in Ethiopia. The equity criterion will be applied in a way that give high score for health interventions targeting diseases, conditions or risk factors which mainly affect the worse off. Health interventions which target diseases, conditions or risk factors which are mainly prevalent among the better off will have lowest score.

The worse off in the Ethiopian context are defined as being children less than five years of age, pregnant mothers, economically poor, and populations who live in a very remote areas. Therefore, health interventions targeting these groups will be given high priority.

Using the Delphi technique, a panel of experts will score interventions from 1 to 5; where 5 indicates interventions with high impact on the worse off while interventions which have minimal impact on the worse off will be scored 1.Therefore, in addition to the cost-effectiveness criterion, health interventions will be compared based on their equity score to give priority for interventions which can afford high benefits to the worse off.

5. Financial Risk Protection (FRP)

Shift from OOP payments toward prepayment mechanisms is very important to reach UHC, and therefore including FRP as a prioritization criterion will address this to some extent. In addition, both the public representatives and experts strongly recommended that FRP (afforded for patients and their families) should be strictly monitored during the actual implementation of the EHSP.

Using the Delphi technique, a panel of experts will score interventions from 1 to 5; where 5 indicates interventions which can provide higher FRP to the individuals seeking the interventions or their families while interventions which can only provide minimal or no FRP will be scored 1.

6. Public Acceptability

The voice of the public should be directly accounted in the revision process as well as critiques and deliberation on the final list of the health interventions to be included in the EHSP. The voice of the public will be accounted through a series of meetings and workshops, indirectlyu using public representatives, patient unions, professiona associations etc. Furthermore, there should be contonouse direct public engagement through the ues of mass-media.

7. Political Acceptability

Priority setting is a highly political process since it involves an agreement between the government and citizens to determine the type and mix of health services to be delivered. Therefore, the politically designated body in the country must approve and ratify the final

EHSP. In the revision of EHSP, the Ministry of Health is delegated to be the main body responsible for developing the EHSP, and therefore, the FMoH Management Committee will decide on both individual interventions and the overall package.

Table 1: Sources of data for the prioritization criteria.

Criteria	Data sources/Methods
Burden of disease	*HMIS data, Global Burden of Disease data (2016) (http://www.healthdata.org/gbd)*
Cost-effectiveness	*Cost-effectiveness ratio estimated from One Health Tool (OHT), Tufts CEA registry literature review.*
Budget impact	*Budget impact analysis*
Equity	*Primary data from experts panel*
Financial risk protection	*Experts panel, primary data.*
Public acceptability	*Public representative meeting reports and proceedings, mass media reports*
Political acceptability	*FMoH Management Committee minutes*

4. Decision and appeal

The technical evaluation committee undertaking the evaluation and present the full result for the Ministry of Health leadership for decision wether to include or exclude a certail interventions. The decision will be made at the MoH level and will be documented and publicly communicated.

An appeals process is a fundamental component to overall perceived fairness of the priority setting process. The appeals process also enhanced the involvement of stakeholders and increased overall participant satisfaction. It will have an effect on the way that priority setting is implemented in terms of both the substance and the process. Therefore, if there is any complaint on the final decision of included and excluded interventions, any organization, professional association, individual can submit a written appeal report to the Ministry of Health Office of the Minister enclosing all relevant evidence supporting the appeal. All individual and organization submitting the appeal should also declare that they have no conflict of interest.

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