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Value for money of structural interventions: going beyond HIV-only cost-effectiveness analysis

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Background

• Structural interventions tackle the social drivers of HIV, but also have other health and development primary objectives

• In the context of shrinking HIV funding and pressure for sustainable financing, structural and development interventions with multiple outcomes are an opportunity

• UNAIDS Investment Framework: HIV funding can be “a catalyst to achieve synergies within the broader health and development programmes and to promote intelligent investment across several sectors” (Schwartländer et al., 2011)

• Despite their importance, structural interventions could be undervalued and potentially underfinanced

• HIV sector is reluctant to take on such structural interventions as they are expected to have low HIV-specific cost-effectiveness and accrue more benefits to other sectors

→ Result of methodological approach, since typical value for money assessments compare the HIV value only to the full programme cost, due to the indivisibility/lumpiness of such investments
Cash transfer scheme to keep girls in school – Zomba, Malawi

$10/month provided to in and out-of-school girls (13-22 yrs)

(Baird et al., 2010 & 2012)

35% reduction school drop-out rate

40% reduction early marriages

76% reduction in HSV-2 risk

58% reduction in depression risk

30% reduction in teen pregnancies

64% reduction in HIV risk

→ Cost per HIV infection averted = $5,000 – 12,500

> Cost per HIA for other interventions:
$1,315 for VCT; $857 for PMTCT;
$181 for male circumcision

(Galarraga et al., 2009)
Premise:
• HIV resources could be used to co-finance structural interventions with other benefiting (sub-) sectors
• Value for HIV-money of structural interventions could then be assessed, based on the HIV sector’s contribution

Objectives:
• To explore to what extent the HIV sector could consider co-financing structural interventions
• To analyse the consequences of various decision rules from the HIV perspective for the financing of structural interventions
## Economic evaluation methods & decision rules

<table>
<thead>
<tr>
<th>Method</th>
<th>Outcome unit</th>
<th>Implications for structural interventions</th>
<th>Decision rule/threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Minimisation Analysis (CMA)</td>
<td>n.a.</td>
<td>Assumes options have identical outcomes - highly unlikely with structural interventions with different objectives</td>
<td>Lowest cost option</td>
</tr>
<tr>
<td>Cost-Effectiveness Analysis (CEA)</td>
<td>Natural unit e.g. HIV infection averted</td>
<td>Considers variations in effectiveness between options But single outcome analysis impedes the incorporation of multiple outcomes (within HIV and beyond)</td>
<td>Lowest CER League tables (lowest CERs until budget spent)</td>
</tr>
<tr>
<td>Cost-Utility Analysis (CUA)</td>
<td>DALY QALY</td>
<td>Allows for HIV-wide and health sector wide comparisons But single health outcome makes it difficult to take non-health outcomes into account</td>
<td>Lower CERs League tables Below $25-150/DALY averted Below 1x or 3xGDP/cap per DALY averted</td>
</tr>
<tr>
<td>Cost-Benefit Analysis (CBA)</td>
<td>Monetised outcome ($)</td>
<td>Benefits from all sectors can be accounted for and monetised</td>
<td>Every option where B&gt;C (or BCR&gt;1)</td>
</tr>
<tr>
<td>Cost-Consequence Analysis (CCA)</td>
<td>Multiple natural units</td>
<td>Used to present multiple outcomes, where CBA is not feasible Does not combine measures of benefit into a single measure so cannot be used to rank</td>
<td>No rule</td>
</tr>
</tbody>
</table>

BUT the HIV sector thinks in terms of CEA outcomes

Preferred
Proposed HIV Willingness to Pay thresholds for co-financing

At most...
• Worth funding structural interventions up to the point at which they are considered HIV cost-effective (and affordable)
• Equal to WHO’s threshold of GDP per capita per HIV DALY averted

\[
\text{GDP/cap} \times \text{Total Costs}
\]

Cost/DALY

At least...
• Residual programme costs that would not be funded by other sectors, but would correspond CER < GDP/capita threshold

\[
\text{Total Costs} - \sum \text{WTP}_{\text{other sectors}}
\]

Its Fair Share...
• Another approach is to apportion the total programme benefits between (sub-) sectors based on CBA and then HIV paying its share
• Provided that BCR > 1 and HIV contribution < WHO threshold

\[
\frac{\text{Benefits}_{\text{HIV}}}{\text{Total Benefits}} \times \text{Total Costs}
\]
Methods (CEA threshold approach)

• CEA calculations:
  – Absolute impact from the trial was calculated based on published figures in the natural units of interest to each sector
  – Based on the DALY formula and/or DCP2 estimates of DALYs per health outcome, we estimated total DALYs averted
  – Maximum WTP for each health outcome = total DALYs averted x GDP per capita
  – Maximum WTP for education outcomes = total impact x highest CER in literature

• Sensitivity analyses:
  – Varied total programme costs based on actual trial costs and estimated costs at scale
  – Varied WTP for health outcomes to WHO CE threshold of 3x GDP per capita
  – Varied WTP for education outcomes to lowest CERs in the literature
Methods (CBA apportionment)

• Modelling adopted for RethinkHIV analysis:
  – Coverage: 100% of girls currently in secondary school living on less than $1.25 a day (constrained by existing coverage)
  – Unit costs: estimated from Zomba trial published data and simplified (conservative) assumption of no scale effect
  – HIV impact modelled using estimates of impact on HIV incidence among direct beneficiaries (64% reduction)
  – DALYs estimated using standard formulae
  – Incremental cost per DALY averted includes cost savings and life expectancies adjusted for ART (modelled on current levels of ART coverage)
  – Other benefits modelled = higher earnings, reduced child mortality (King et al., 2007)
# Results: CEA thresholds

<table>
<thead>
<tr>
<th>(Sub-) Sector</th>
<th>Outcome</th>
<th>Total Zomba Impact</th>
<th>Total DALYs Averted</th>
<th>Threshold per unit of outcome (US$)</th>
<th>Funding (US$)</th>
<th>Share of programme costs</th>
<th>Share of programme costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>At Scale ($110,250)</td>
<td>At Scale ($110,250)</td>
</tr>
<tr>
<td>HIV</td>
<td>HIV infections averted</td>
<td>5.5</td>
<td>83</td>
<td>Min: 303</td>
<td>25,050</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Max: 327</td>
<td>27,055</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Education</td>
<td>Drop-outs averted</td>
<td>24</td>
<td></td>
<td>535</td>
<td>128,730</td>
<td>117%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Drop-outs re-enrolled</td>
<td>193</td>
<td></td>
<td>79</td>
<td>15,208</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>School attendance (additional years)</td>
<td>144</td>
<td>n.a.</td>
<td>303</td>
<td>58,537</td>
<td>53%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>English test scores (0.1 SD gains)</td>
<td>708</td>
<td></td>
<td>5.4</td>
<td>3,807</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Sexual &amp; Reproductive Health</td>
<td>HSV-2 infections averted</td>
<td>15.6</td>
<td>78</td>
<td>327</td>
<td>25,483</td>
<td>23%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Teen pregnancies averted</td>
<td>9.8</td>
<td>38</td>
<td>327</td>
<td>12,399</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Cases of depression averted</td>
<td>45.8</td>
<td>19.6</td>
<td>327</td>
<td>6,410</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Funded</td>
<td>Not funded</td>
</tr>
<tr>
<td>All sectors</td>
<td>Silo budgeting (highest sector WTP)</td>
<td></td>
<td></td>
<td></td>
<td>206,283</td>
<td>Funded</td>
<td>Not funded</td>
</tr>
<tr>
<td></td>
<td>Co-financing (total WTP)</td>
<td></td>
<td></td>
<td></td>
<td>277,631</td>
<td>Funded</td>
<td>Funded</td>
</tr>
</tbody>
</table>
Results: CBA apportionment

<table>
<thead>
<tr>
<th>National scale 5-year programme</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV benefits (US$)</td>
<td>75 million</td>
</tr>
<tr>
<td>Share of total benefits</td>
<td>44%</td>
</tr>
<tr>
<td>HIV costs (US$)</td>
<td>16.8 million</td>
</tr>
<tr>
<td>HIV DALYs averted</td>
<td>14,550</td>
</tr>
</tbody>
</table>

- 996 US$
- 327 GDP per capita
- 981 3 x GDP per capita

In Malawi, national scale programme has benefit-cost ratio of 2.9.

If the HIV sector were to fund only its share of benefits, the cost per HIV DALY averted would go from $2,464 to $996, but would still be above WHO’s cost-effectiveness thresholds → not HIV cost-effective.
Affordability in Malawi

<table>
<thead>
<tr>
<th>(Sub-) Sector</th>
<th>National scale (million US$)</th>
<th>National sector budget (million US$) 2011/12</th>
<th>Donor disbursements (million US$) 2010/11</th>
<th>Average size of donor projects (million US$) 2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>0.7</td>
<td>78</td>
<td>298.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Health</td>
<td>1.3</td>
<td>222</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>6.0</td>
<td>312</td>
<td>167.7</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8.0</strong> (national programme)</td>
<td><strong>1,980 (national budget)</strong></td>
<td><strong>1,022 (overall)</strong></td>
<td><strong>2.3 (overall)</strong></td>
</tr>
</tbody>
</table>

Based on national sector budget and donor disbursements in 2010/11, the relative contributions for a national-scale scheme appear quite affordable, even assuming trial costs.
Conclusion

• With silo approach, certain structural interventions with potential could be underfinanced or go unfunded

• Co-financing provides an opportunity to realise development synergies, but will require multi-sectoral coordination/negotiation mechanisms

• Cost-effectiveness is but one criterion in resource allocation, which is a political process – other considerations include equity, acceptability, affordability, foregone programmes, etc.

• Nonetheless, only considering HIV outcomes in the economic evaluation of structural interventions would provide incomplete evidence for policy-makers and could lead to undesirable decisions from an HIV and societal perspective
Thank you

This work is being pursued as part of the STRIVE (Tackling the structural drivers of HIV) Research Programme Consortium, funded by DfID.

http://strive.lshtm.ac.uk/
Presentation also available at http://same.lshtm.ac.uk/