Title:

# Criteria and Values Used in Setting Health Care Priorities in Developed and Developing Countries

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# Introduction

- Process of making trade-off decisions among competing programs
- Reality and challenge in all health systems
- Explicit Vs. Implicit Priority Setting

# Developing Countries

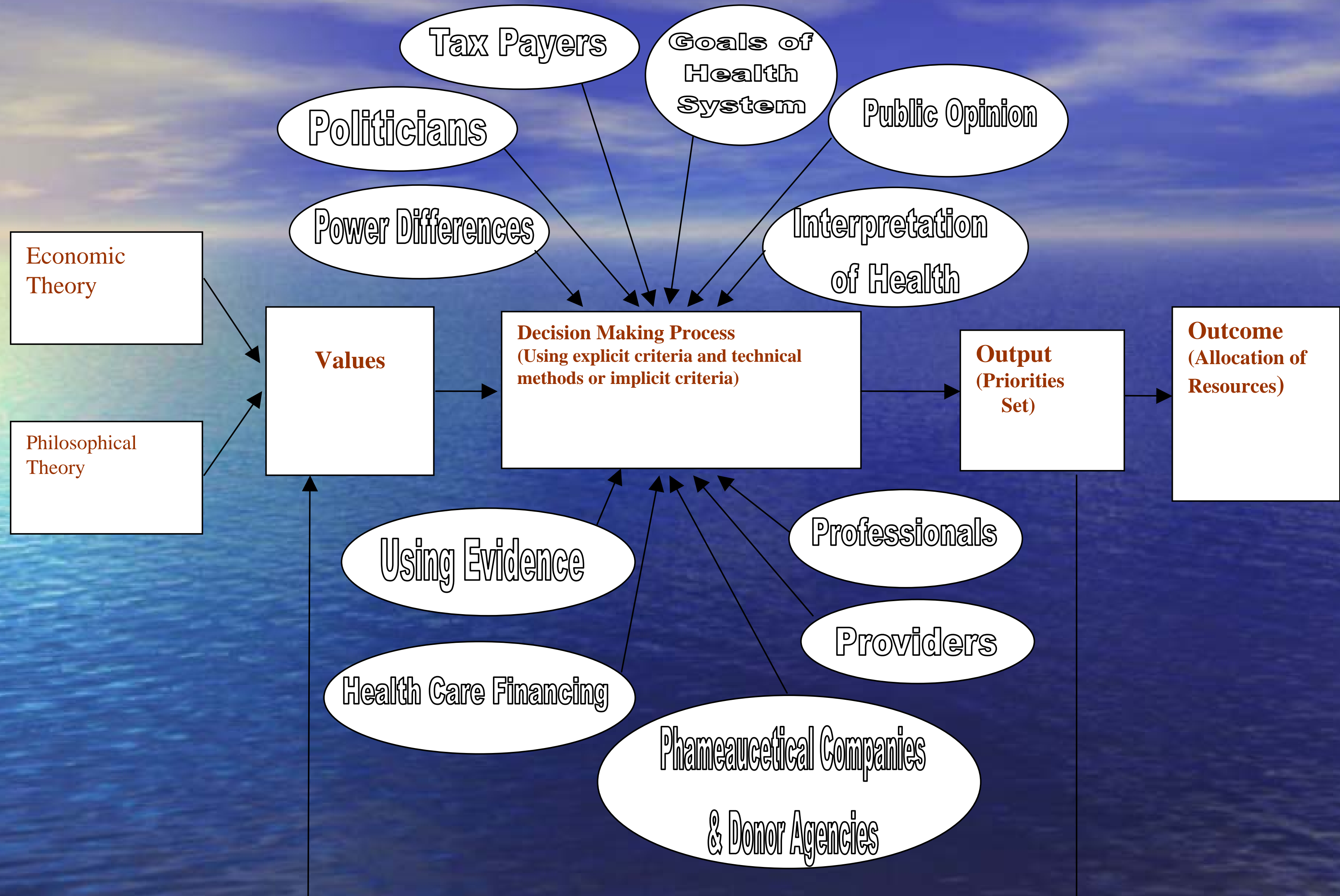
An ad hoc process, difficult and uncertain

- Lack of analytical methods for identifying priority options
- Lack of dependable evidence
- Lack of coherent processes for decision making
- Weak institutional infrastructure (Kapiriri, et al., 2003)

# Developed Countries

Challenging due to:

- Aging population
- Advancements in expensive medical technologies
- Increased demands fuelled by increasing access to information ( Kapiriri, et al.,2007)


Tax Payers
Goals of Health System
Politicians
Public Opinion
Power Differences
Interpretation of Health
Economic Theory
Values
Decision Making Process
(Using explicit criteria and technical methods or implicit criteria)
Output
(Priorities Set)
Outcome
(Allocation of Resources)
Philosophical Theory
Professionals
Using Evidence
Providers
Health Care Financing
Phameaucetical Companies
& Donor Agencies
Reflect

# USA

**Oregon State:**

Main criterion: **Cost-effectiveness**

1. Value to society
2. Value for an individual at risk of needing the service
3. Essential to basic health care (Ham& Robert, 2003)

# The Netherlands

1. ***Necessary care***:

According to Dunning Committee

- **community's viewpoint** at macro level
- professional's viewpoint at meso level
- individual's point of view at micro level

2. ***Effectiveness***

3. ***Efficiency***

4. ***Individual responsibility*** **(Hoedemearks &Dekkers,2003)**

# Sweden

1. Principle of human dignity

2. Principle of solidarity and equity

3. Principle of efficiency (Waldau,2007)

# New Zealand

- Benefit
- Value for money
- Fairness
- Consistency with the community's values
(Ham& Robert, 2003)

# United Kingdom

NICE incorporates **Cost-effectiveness** (efficiency) and **Clinical criteria**

Other implicit criteria are:

- Equity
- Responsiveness

New Zealand & UK place less emphasis on human dignity and individual rights than Sweden (Ham& Robert, 2003)

# Norway

The Loonning Commission defined 5 levels of severity of a health condition:

1. Life-saving and essential
2. Treatments in less severe situations where withholding them would be harmful
3. Treatments for chronic disorders with a proven benefit
4. Treatments with unclear benefits that can be marginally effective
5. No-priority level was used to exclude services of no proven value or no need (**Calltorp,1999** )

# Austria

- Equity (embodied at law)
- Cost-effectiveness (macro-level)
- Clinical effectiveness
  **(Stepan&Sommersguter-Reichmann,1999)**

# Finland

In 1993 a consensus meeting held in Finland concluding no choices at patient level.

- Dignity
- Autonomy
- Equality
- Equity
- Prognosis (Rissanen & Hakkinen, 1999)

# Developing Countries

- Burden of Disease (BOD) and Cost-effectiveness (Kapiriri&Norheim,2004)
- In 1993 the World Development Report (WDR) specified a basic package based on cost-effectiveness .
- In 2002 Commission on Macroeconomics and Health (CMH) added the Poverty Reduction criterion (Baltussen, et al.,2007).

# Uganda

According to national policy :

- Cost-effectiveness
- Severity of disease (Steen, et al.,2001)

In a survey stakeholders ranked criteria for priority setting:

- Severity of disease
- Benefit of the intervention
- Cost of the intervention
- Cost-effectiveness of the intervention
- Quality of the data on effectiveness
- Patient age
- Place of residence
- Lifestyle
- Equity of access (Kapiriri&Norheim,2004)

# Ghana

- Cost-effectiveness
- Poverty reduction (equity)
- Age of target group
- Severity of disease
- Health effects (amount of gain for a number of patients) ( Baltussen, et al., 2006)

# Nepal

- Age of target group
- Health effects (amount of gain for a number of patients)
- Cost-effectiveness
- Poverty reduction (equity)
- Severity of disease (Baltussen, et al., 2007)

# Mexico

1) At federal level public health interventions :

- Burden of disease
- Equity
- Cost-effectiveness

2) At state level with low & medium level complexity

- Cost-effectiveness
- Need to increase and regulate access to primary and hospital care for newly affiliated families

3) Centrally managed package high-complexity interventions

- Need to diversify financial risk among states with capacity constraints and social pressure (Gonzalez-Pier,et al.2006)

# Conclusion

- Transparent and explicit process in developed
- Explicit criteria embodied in law in developed so legitimate
- Rational and accountable process in developed
- Cost effectiveness and equity two common criteria
- Social status
- Gender
- Physical capabilities

} determinants of health

Influencing burden of disease and access to health services