

# **A conversation with the International Decision Support Initiative (iDSI), June 22, 2018**

## **Participants**

- Prof. Kalipso Chalkidou – Director of the Global Health and Development Group, Imperial College London (ICL); Director of Global Health Policy and Senior Fellow, Center for Global Development
- Amanda Glassman – COO and Senior Fellow, Center for Global Development (CGD)
- Dr. Ryan Li – Adviser for the Global Health and Development Group, ICL
- Reetan Patel – Head of Operations for the Global Health and Development Group, ICL
- James Snowden – Research Consultant, GiveWell

**Note:** These notes were compiled by GiveWell and give an overview of the major points made by Prof. Chalkidou, Ms. Glassman, Dr. Li, and Mr. Patel.

## **Summary**

GiveWell spoke with Prof. Chalkidou, Ms. Glassman, Dr. Li, and Mr. Patel of iDSI as part of its work investigating organizations trying to influence government policy. Conversation topics included iDSI's background, its current activities and impact, and potential plans for scale-up and/or establishing a standalone organization.

## **About the organization**

iDSI is a network of global health and policy experts that partners with healthcare funders including governments to more systematically assess evidence and direct resources towards the most cost-effective public health interventions, resulting in more value for money for their limited health budget. iDSI also aims to help governments put policies and budgetary and prioritization processes in place that allow them to directly pay for basic public health interventions so that the country's health programs are not reliant on outside philanthropic funding in the long-term.

iDSI's core partners are:

- The Center for Global Development (CGD)
- Imperial College London (ICL)
- The Thai Health Intervention and Technology Assessment Program (HITAP)
- China National Health Development Research Center (CNHDRC)
- Priority Cost Effective Lessons for System Strengthening (PRICELESS) South Africa

## **Background**

In 2012, a working group organized by CGD and co-chaired by Prof. Chalkidou and Ms. Glassman produced a report entitled "Priority-Setting in Health: Building Institutions for Smarter Public Spending". The working group examined the potential benefits of health technology assessment (HTA) for informing public spending decisions and improving value for money, and looked at progress-to-date in countries that had implemented those approaches. The working group made some recommendations about steps the global health community could take to move forward in this area, including a recommendation to set up an entity with a mission like iDSI's to work with governments to promote policy decisions based on the working group's findings. The working group initially decided to form a network based at the National Institute for Health and Clinical Excellence (NICE) to play that role (rather than create a standalone entity), in part because the UK government at that time was providing NICE's services to other countries.

Following a review by the UK government of arm's-length bodies, which resulted in a greater emphasis at NICE on doing work which could produce a profit margin for the organization, iDSI moved to ICL.

### **Scale-up and potentially forming a standalone organization**

iDSI has existed for about five years. It is currently in the process of deciding how best to scale up in order to influence more public spending while sustaining the impacts it has had so far.

iDSI is considering becoming a standalone organization (rather than a network of collaborators at several partner organizations). It hopes to have made a decision and formed a plan on this front by the end of the year. iDSI has a commitment of funding from the Bill & Melinda Gates Foundation, the exact amount of which it expects to learn within the next couple of weeks. The size of that grant might influence whether iDSI decides to become a standalone organization.

### **Staff**

iDSI has about 13 full-time equivalents (FTEs) at ICL who support specific country projects and research. About 30 additional FTEs (both directly employed and sub-granted) contribute to iDSI's work across a number of countries (e.g. Thailand, Indonesia, Vietnam, the Philippines, Myanmar, India, China, and South Africa). iDSI is in the process of forming new and deeper partnerships with institutions in Kenya, Ghana, Tanzania, and Zambia; its engagement in other countries is on a more case-by-case basis.

iDSI also sub-contracts some work to institutions other than the core partners (e.g. the University of Glasgow). iDSI and its partners also sometimes hire individuals directly, including consultants on the ground and clinical experts from the UK National Health Service.

### **Funding and budget setting**

iDSI has multiple funders consolidated under a single reporting arrangement, and it receives its funds in a single package. Core partners receive sub-grants through ICL from iDSI's funders for various types of work. iDSI's institutional partners have different strengths and work in different geographies.

iDSI's core partners collectively propose a budget for each upcoming "phase" of the project (each is essentially a separate grant lasting 2-3 years). Once high-level budget decisions are made, iDSI has an internal governance structure for monitoring and managing the strategic delivery of funds.

## **iDSI's activities and estimating its cost-effectiveness**

iDSI has three main goals:

1. Improve the efficiency of health spending by governments and private insurers.
2. Improve the efficiency of health spending by donors.
3. Identify ways to make product development more efficient, more targeted, and better address the needs of a given population.

iDSI considers it important to both a) take advantage of windows of opportunity to generate and/or package evidence and work with governments engaged in specific spending decisions on a single issue or product, and b) partner to build improved decision-making mechanisms within governments to affect spending going forward.

### **Supporting government decision-making**

iDSI has helped governments analyze specific decisions for which there is a well-developed cost-effectiveness model that includes specific estimates of, e.g., lives saved or government spending saved.

For example, iDSI worked with the government of Vietnam to develop a process to review its health benefits package and update its essential medicines list by removing drugs that were unsafe or ineffective. If fully implemented, those changes would lead to up to 22% savings to Vietnam's social security reimbursement budget. Those savings alone would amount to about nine times iDSI's total budget of roughly \$25 million over the past 5 years, which suggests that doing similar work in other countries could potentially make iDSI very cost-effective.

iDSI supported the government of Kerala, India, in developing and introducing standard treatment guidelines for the identification and treatment of post-partum hemorrhage based on cost-effectiveness considerations, after which maternal emergencies saw a major decrease. While other factors may have been at play in this outcome, the reduction can be partially attributed to the intervention, given the size and timing of the reduction and the targeted nature of the intervention. In other cases, it is harder to attribute outcomes to specific interventions.

What is required for iDSI to get its recommendations adopted and implemented in a given country depends on how the country's health system is organized. iDSI thinks that having additional scale and ability to engage in-depth with countries will likely

make the difference in terms of more frequently getting its recommendations adopted. Country governments have generally been more receptive to iDSI's work than some funders – for instance, the Global Fund has committed to a performance agreement on value for money, but work remains to see it operationalized.<sup>1</sup>

### **Evaluating longer-term cost-effectiveness of HTAs**

Estimates of the benefits from specific decisions do not fully capture the benefits of a government having an ongoing resource allocation and purchasing strategy informed by an HTA entity. It might be possible to produce an estimate of foregone potential health gains associated with a government's current resource allocation patterns to get a rough sense of the possible gains from allocating future spending in a more cost-effective way. Research done at the University of York allows iDSI to analyze such opportunity costs based on country panel data.<sup>2</sup> For example, if iDSI expects a country's public health spending to increase by 10%, it could estimate the potential health gains associated with that spending increase if it were guided by HTA.

While such estimates would be fairly broad approximations, they could be useful for getting a more complete picture of iDSI's effectiveness, in conjunction with iDSI's track record of influencing specific government decisions.

#### *Measuring costs and outputs of HTAs*

iDSI has some basic data on the costs of investing in and setting up entities to do health spending analysis at a national or sub-national level in low- and middle-income countries, as a percentage of total national healthcare expenditure.

Measurable outputs may include savings in terms of QALYs/DALYs, duration and quality of life, reductions in government spending (including direct savings through investing in cost-effective interventions and eliminating poor value interventions, and indirectly through greater ability to negotiate prices with manufacturers), etc. It is likely helpful to analyze outputs in both a granular, bottom-up way (e.g. analyzing the savings in specific case studies) and in a top-down way (e.g. using estimates of total waste in health spending, estimates of healthcare system productivity, etc.).

Two studies by RAND in the UK have attempted to assess the returns on HTAs. These studies do not quantify all of the returns, since some important outcomes are not straightforwardly quantifiable (e.g. increasing capacity, providing training and education, and improving governance structures and government accountability.)

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<sup>1</sup> See <https://www.cgdev.org/publication/six-reasons-why-global-fund-should-adopt-health-technology-assessment> : [http://www.ijhpm.com/article\\_3330\\_9a977eb22d03aa30f4b4452141931166.pdf](http://www.ijhpm.com/article_3330_9a977eb22d03aa30f4b4452141931166.pdf)

<sup>2</sup> Ochalek J, Lomas J and Claxton K. Cost Per DALY Averted Thresholds for Low- and Middle-Income Countries: Evidence From Cross Country Data [version 1; not peer reviewed]. *F1000Research* 2017, 6:488 (document) (doi: [10.7490/f1000research.1113912.1](https://doi.org/10.7490/f1000research.1113912.1))

iDSI has commissioned work from the University of Glasgow<sup>3</sup> examining two or three country-level case studies analyzing how much money could be saved by adopting the most cost-effective options in those instances.

*All GiveWell conversations are available at <http://www.givewell.org/conversations/>*

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<sup>3</sup> Grieve E, Hesselgreaves H, Wu O *et al.* The Value of Health Technology Assessment: a mixed methods framework [version 1; not peer reviewed]. *F1000Research* 2017, 6:2171 (document) (doi: [10.7490/f1000research.1115169.1](https://doi.org/10.7490/f1000research.1115169.1))