



**SP-61-C9:
Making informed and
smart choices:
evidence-based
optimisation of
national strategies to
end TB**

**Maximising impact
with limited
resources:
optimisation
versus
prioritisation**

Kathy Fiekert

**50TH WORLD CONFERENCE ON
LUNG HEALTH**



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I have **no**, real or perceived, direct or indirect conflicts of interest that relate to this presentation.

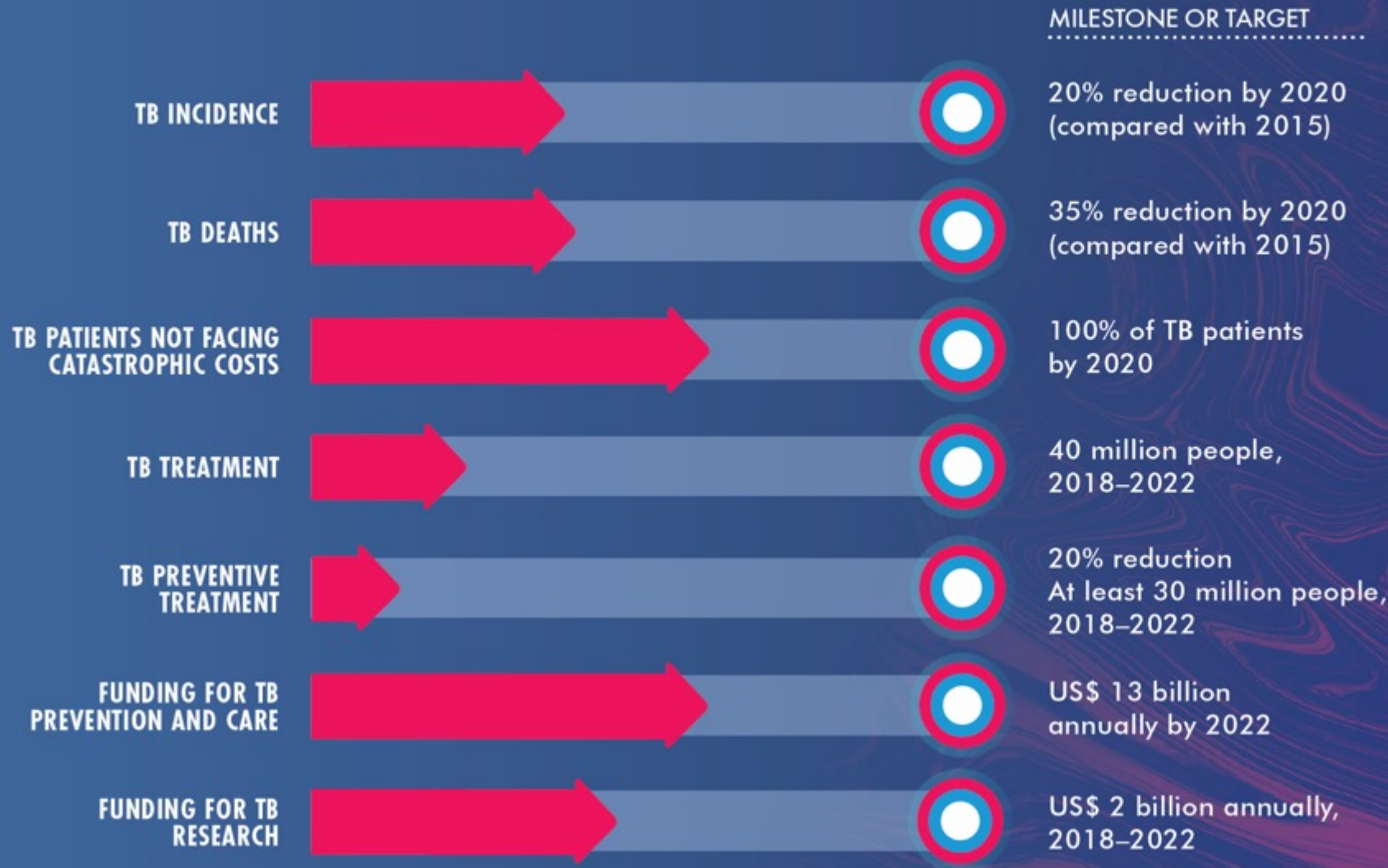
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PROGRESS TOWARDS END TB STRATEGY MILESTONES FOR 2020

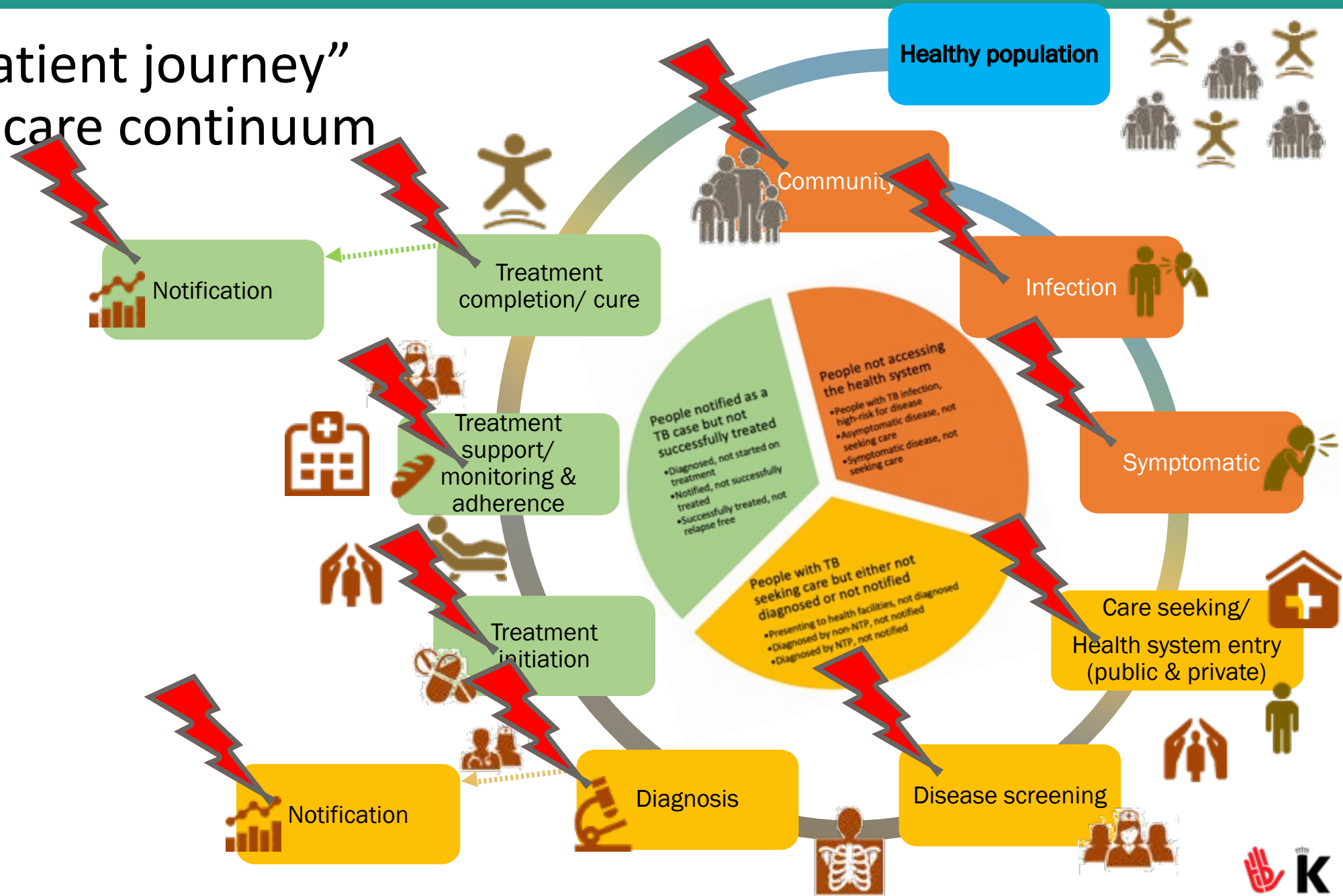
and the four global targets set in the political declaration at the UN high-level meeting on TB: latest status^A



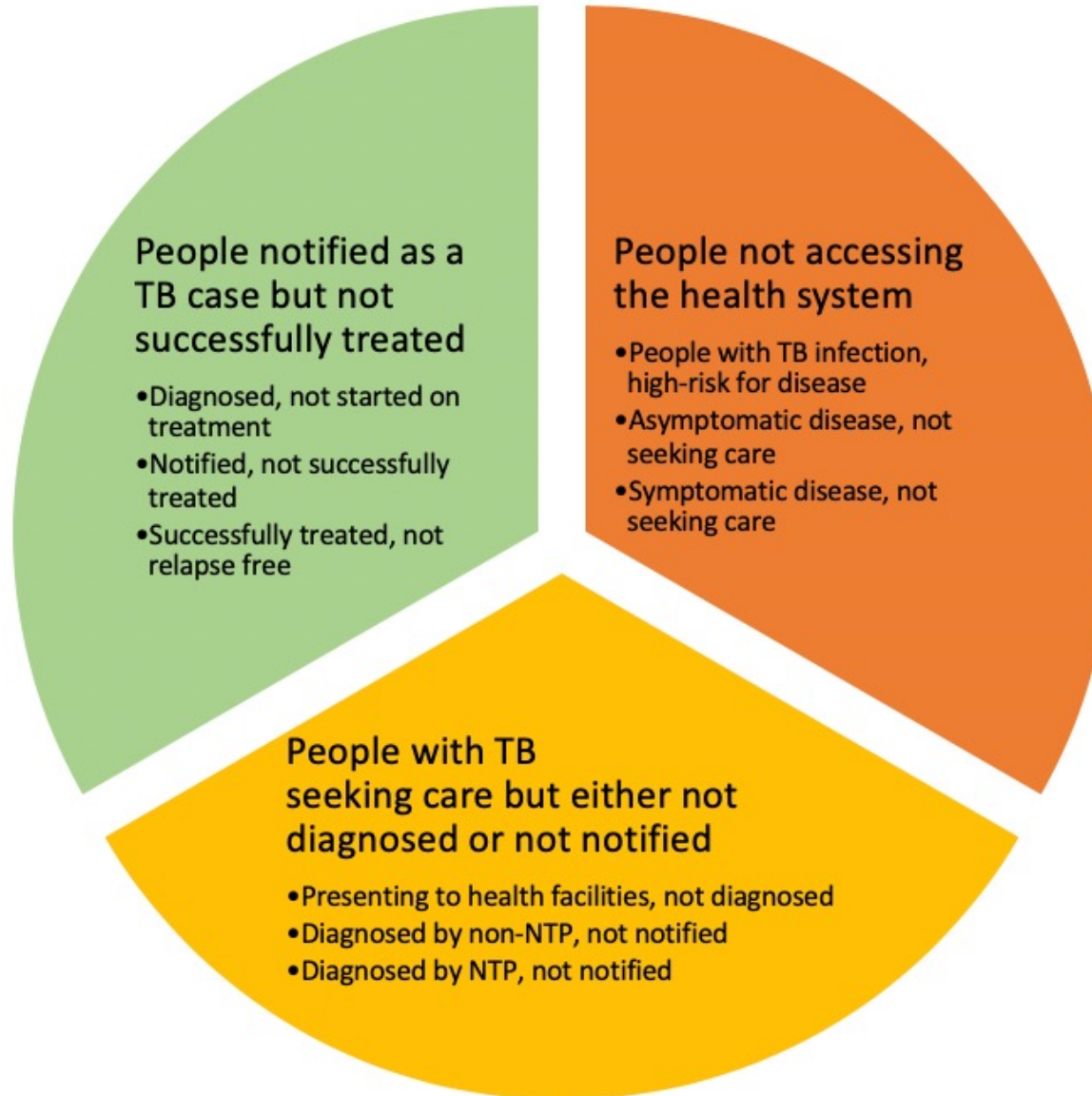
Source: WHO Global Tuberculosis Report 2019

^A End of 2018 except for funding for TB prevention and care (2019) and funding for TB research (2017).

"TB patient journey" & the care continuum

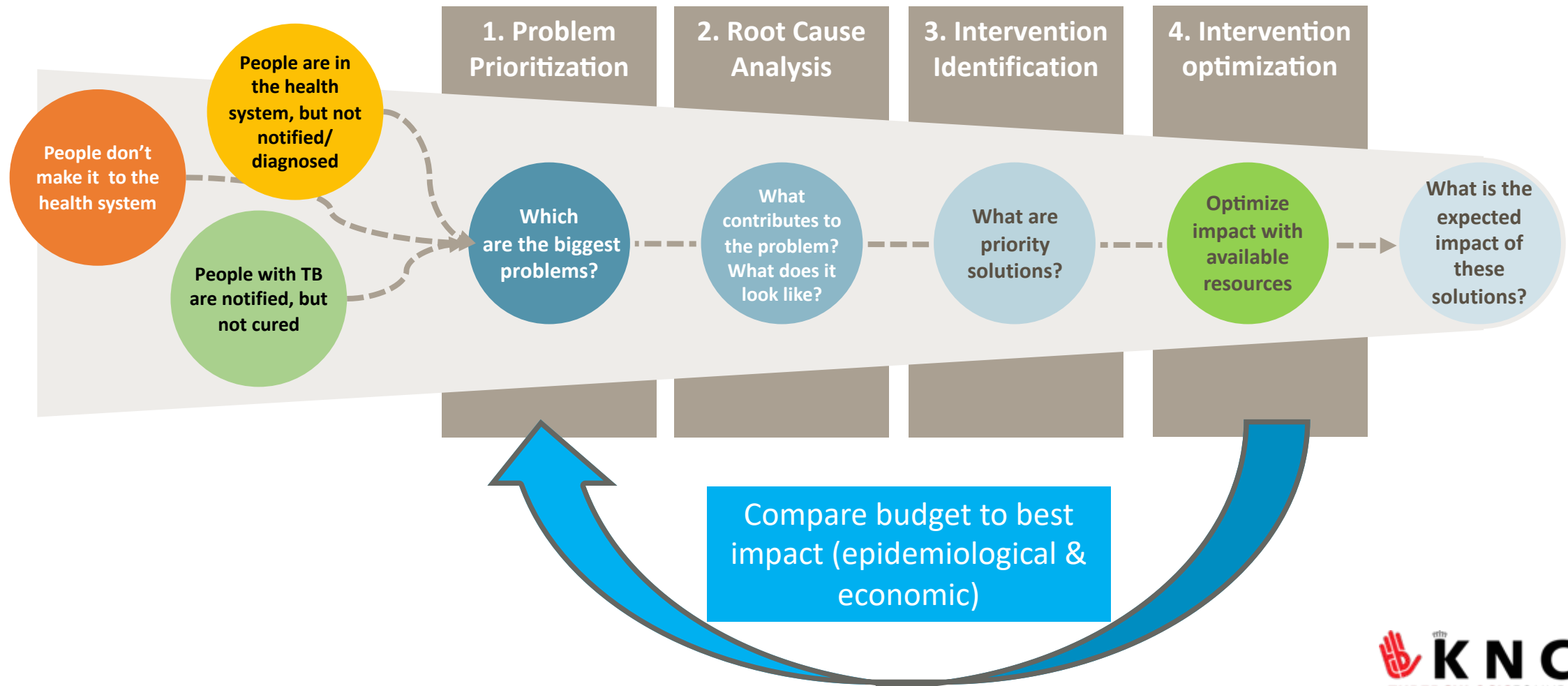


“TB patient journey” & the care continuum



Intervention optimization

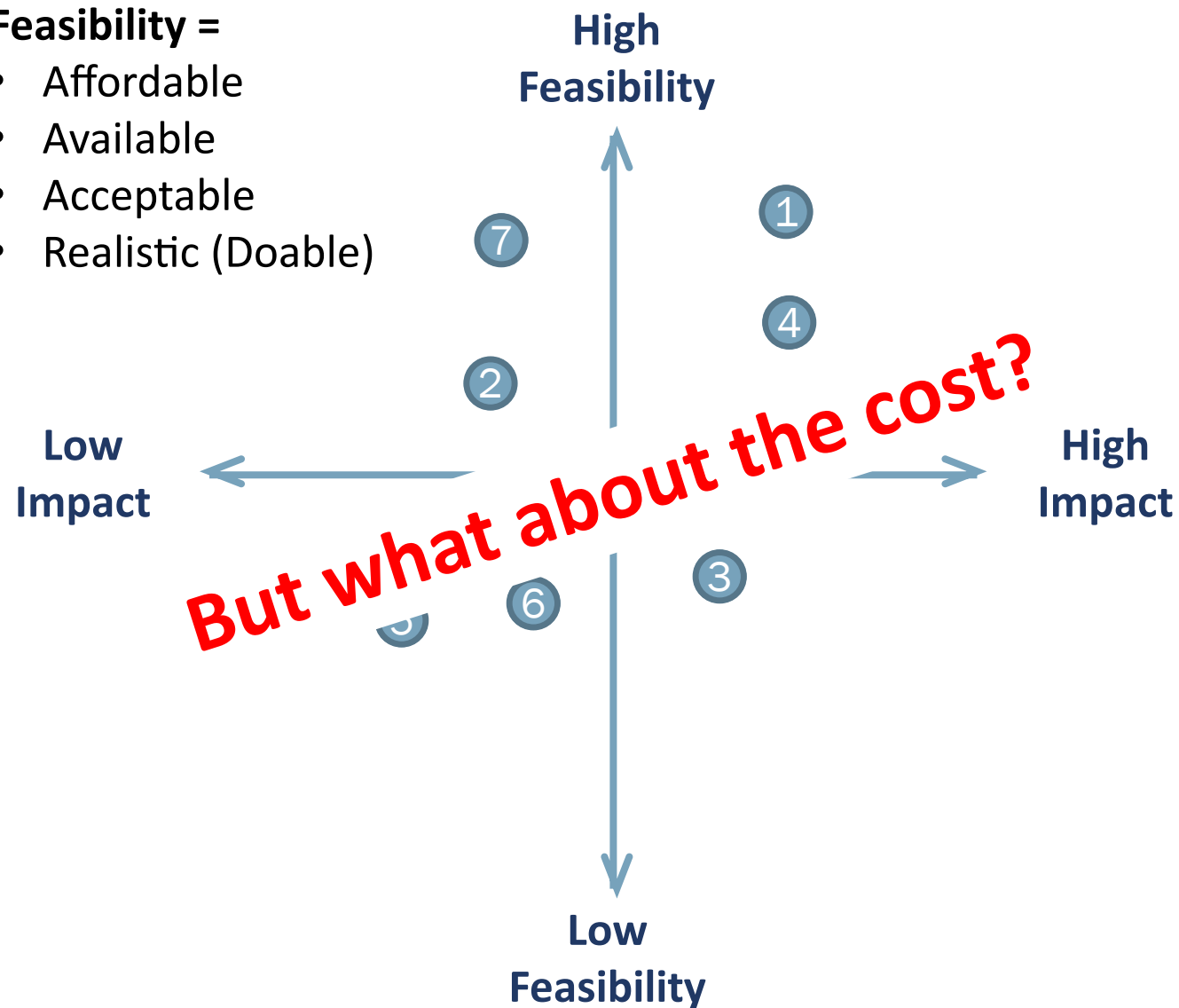
“What makes most sense?”



Modelling to support prioritisation/optimisation

Feasibility =

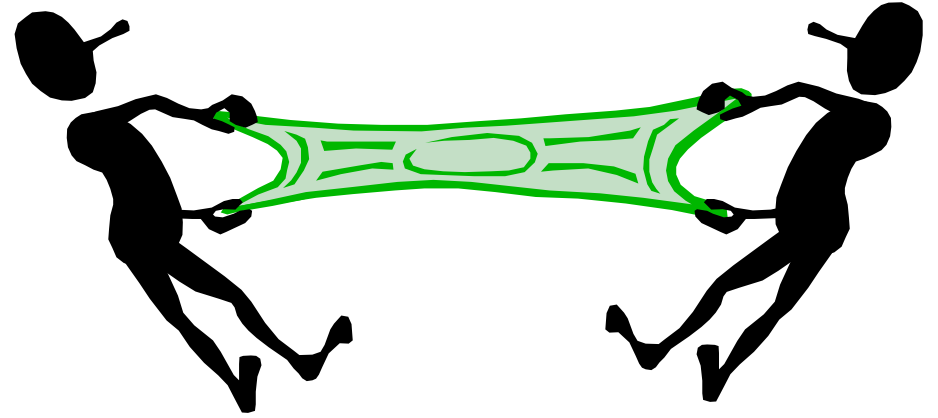
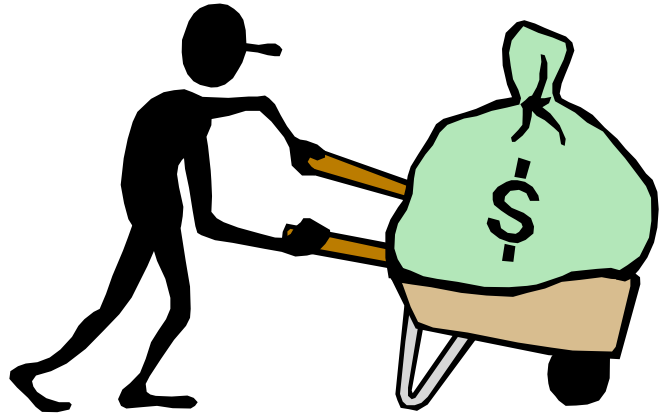
- Affordable
- Available
- Acceptable
- Realistic (Doable)



Impact modelling:

- Validation/ robustness/ limitations?
 - **Model ≠ “Crystal Ball”**
- But how to address complexity?
 - Intervention packages vs interventions
 - Strategies depending on available resources
 - Short-term vs long-term vision
 - Intervention interdependency (A before B)

How much?



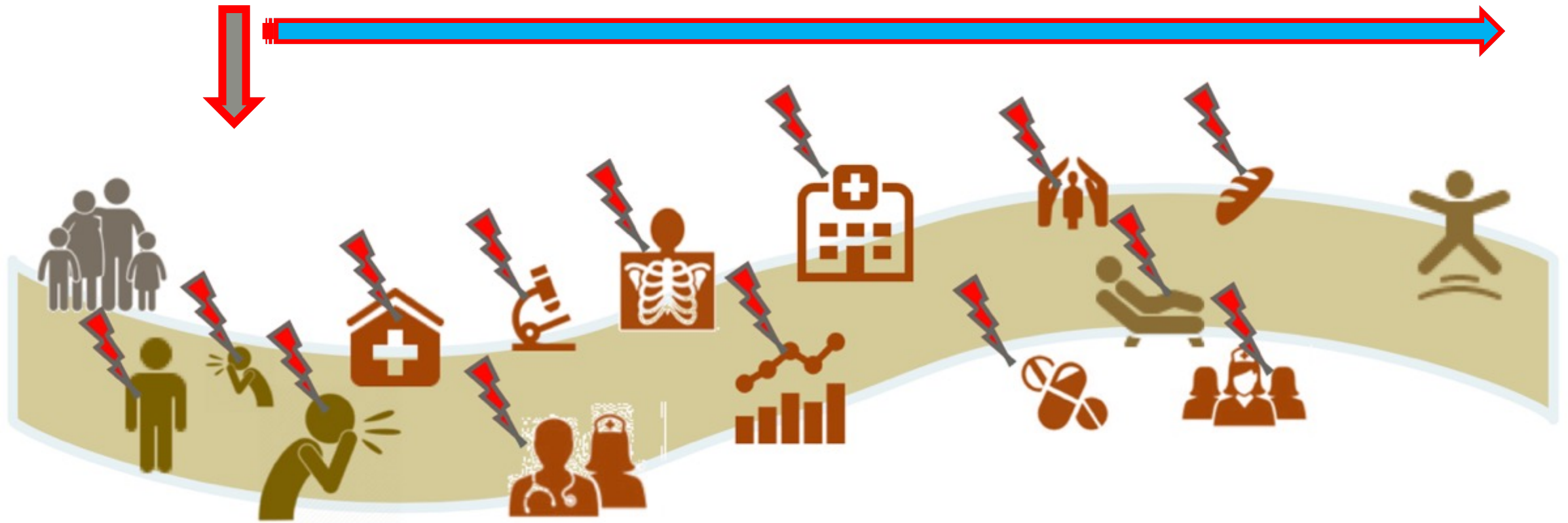
How much do we have?

How much does it cost?

What is it worth?

- long-term/ short-term
- Micro-economic/ macro-economic

Consider “true” and complete cost for both provider **and** patient



Don't ignore hidden and related costs and “knock-on effects”

TB Financing

CLOSING FINANCING GAPS



US\$ 10.1 BILLION
REQUIRED
ANNUALLY FOR **TB**
IMPLEMENTATION

FUNDING GAP
\$ 3.3 BILLION
IN 2019

FUNDING GAPS IN TB RESEARCH



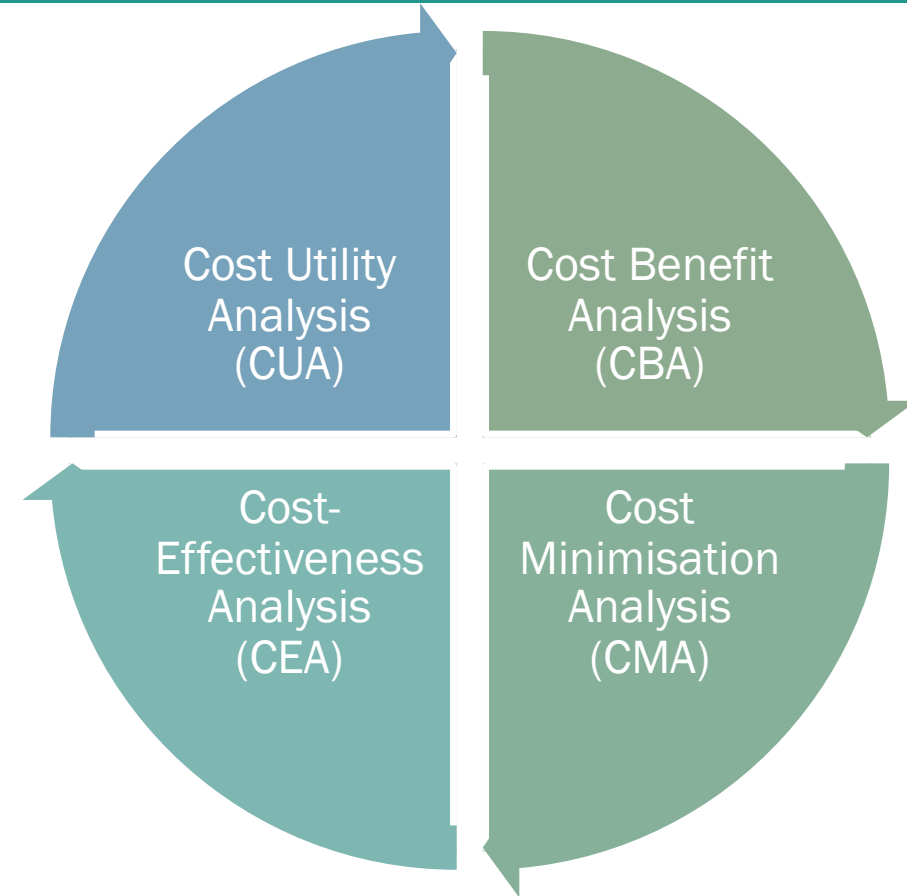
US\$ 2 BILLION
REQUIRED
ANNUALLY FOR
TB RESEARCH

FUNDING GAP
\$ 1.2 BILLION
IN 2017

Economic evaluation is paramount

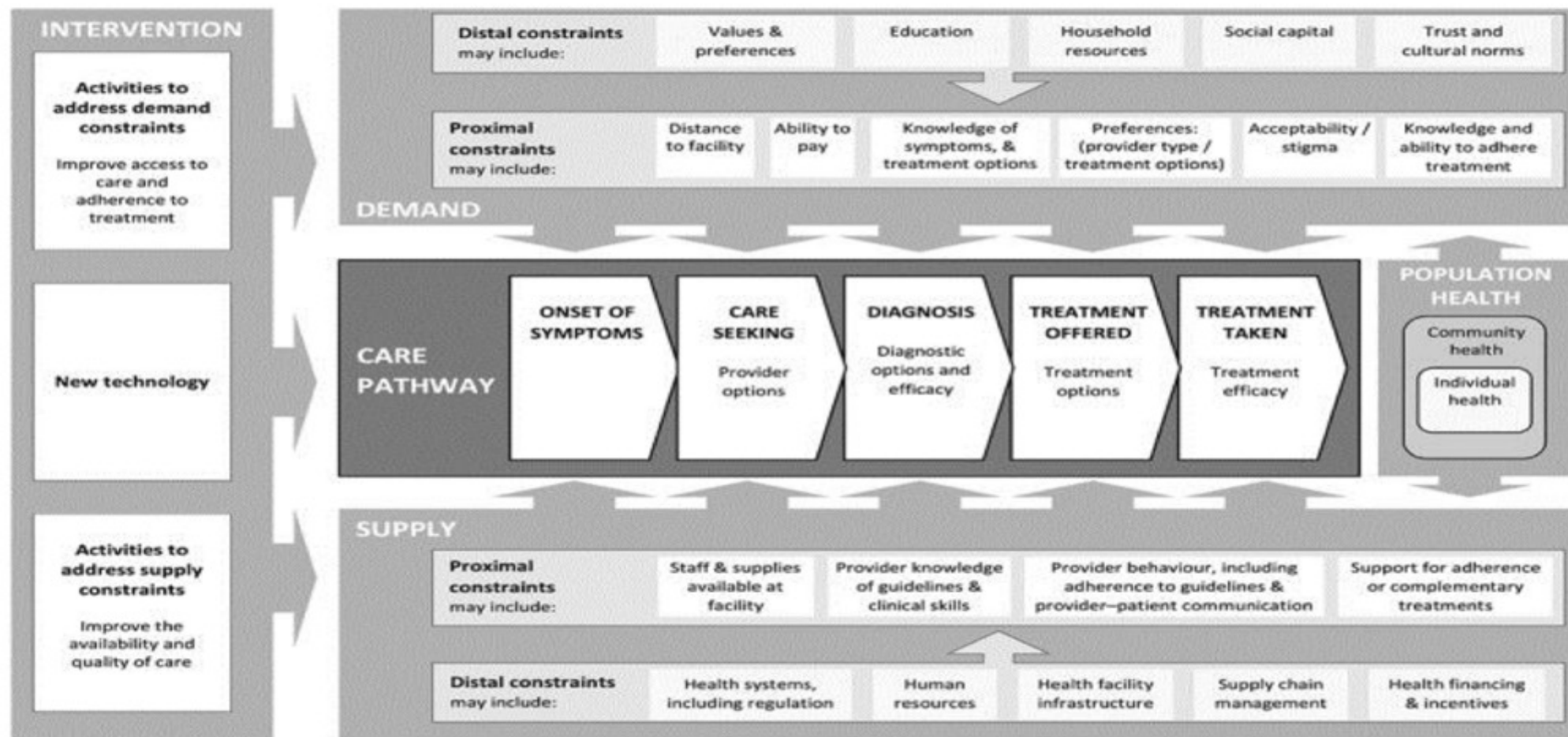
Is it worth the effort?

- *Short-term and long-term gains (including future cost savings)*
- *Wider economic impact*
 - healthy workforce = higher productivity & GDP)
- *ICERs (Incremental Cost Efficiency Rates)*
- *“Business case”....*
 - “invest now, save later”, “Best buy”, etc.



Costing ≠ economic evaluation!

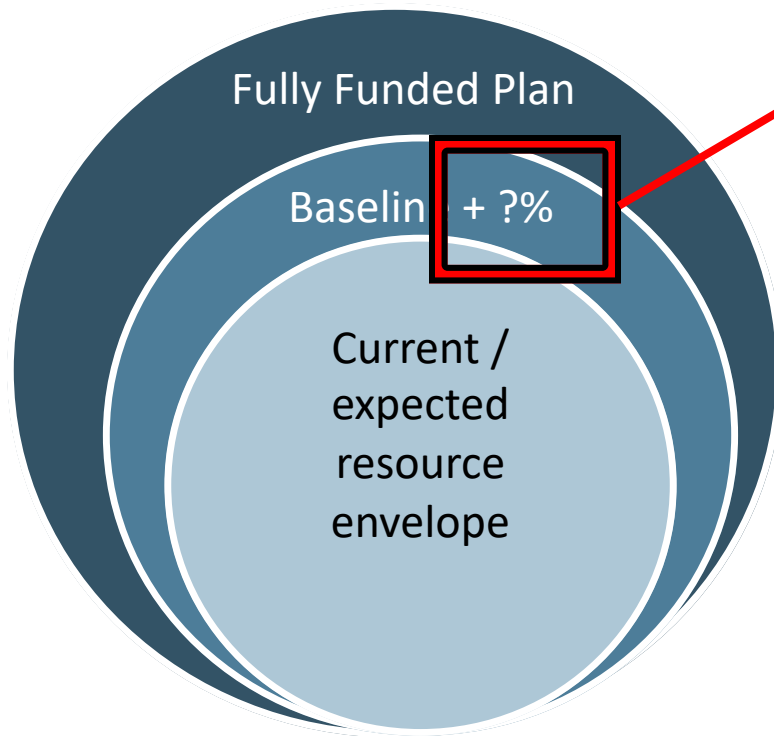
Understanding the intervention and cost



Vassall A, Mangham-Jefferies L, Gomez GB, Pitt C, Foster N. Incorporating Demand and Supply Constraints into Economic Evaluations in Low-Income and Middle-Income Countries. *Health Econ.* 2016 Feb;25 Suppl 1:95-115.

Aim: To create a national plan that is prioritized to reflect optimal allocative efficiency given at least 3 funding scenarios: 1) current / expected resource envelope, 2) +X% increase; and 3) fully funded

Acceptable additional resource input vs worthwhile enhancement/ improvement of impact

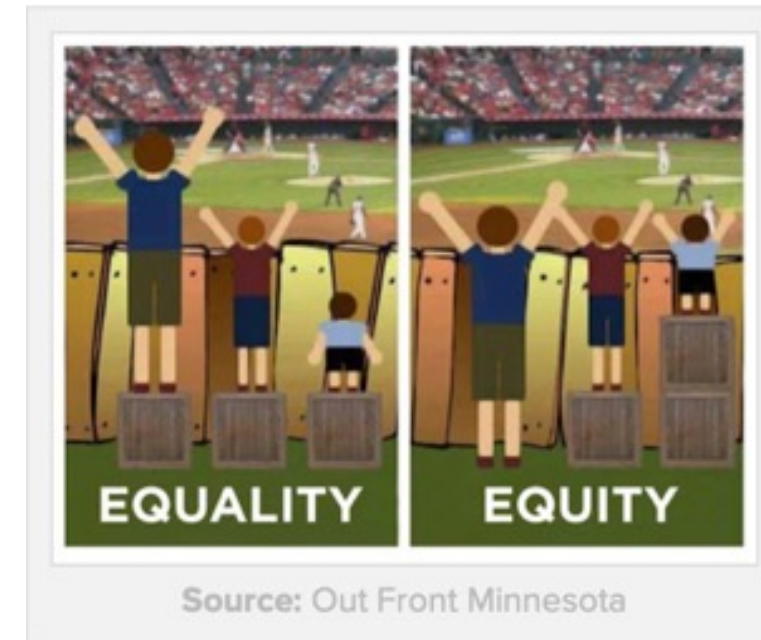


Which will enable:

- Prioritized allocation of domestic budget
- Framework for allocation of sub-national budgets
- Prioritized investment case
- NSP-based funding application to Global Fund
- Expression of priorities for other donor funding and research activities

And yet ... there is still a tendency ...

- To prioritise rather than **optimise** – i.e. chose one intervention or risk group over another
- For donors & policy makers to “pick & choose” certain aspects to focus on and invest in rather than seeing the programme as a whole
 - *(e.g. gender bias, investment has to equal lives saved, etc.)*
- To oversimplify a complex situation
 - *Assuming heterogeneity*
(programming based on national aggregated average)
 - *Misunderstanding UHC as*
“everyone needs and is getting the same”



A note on modelling:



ARTICLE

<https://doi.org/10.1038/s41467-019-10447-y>

OPEN



Introducing risk inequality metrics in tuberculosis policy development

M. Gabriela M. Gomes ^{1,2}, Juliane F. Oliveira ², Adelmo Bertolde³, Diepreye Ayabina¹, Tuan Anh Nguyen⁴, Ethel L. Maciel⁵, Raquel Duarte⁶, Binh Hoa Nguyen⁴, Priya B. Shete⁷ & Christian Lienhardt^{8,9}

“Global stakeholders including the World Health Organization rely on predictive models for developing strategies and setting targets for tuberculosis care and control programs. **Failure to account for variation in individual risk leads to substantial biases that impair data interpretation and policy decisions.**”

=> Call for Risk Inequality Coefficient (RIC) compliant transmission & impact models

Purpose



Closing the gaps along the care continuum to find and cure **ALL** people with TB



Differentiating subnational responses to address TB in local contexts



Optimizing the implementation of TB services within UHC



Preventing infection, active disease, morbidity and mortality due to TB



Enabling patient-centered approaches which promote quality of care

Tools & Resources

People-Centered Framework for TB programming: Development of Optimized National Strategic Plans

The fight against tuberculosis (TB) is at a defining moment in its history. Global political will is at a high since countries at the 2018 United Nations High Level Meeting (UNHLM) have affirmed their political will towards the ambitious third SDG and the global End TB strategy. The Lancet Commission on Tuberculosis has emphasized the need to "explore how countries can improve outcomes and optimize use of available resources by realigning them to ensure that all tuberculosis care is people-centered and by prioritizing interventions that increase efficiencies in the delivery of tuberculosis services." Global TB surveillance data however suggests that targets for TB control set by the End TB strategy and the SDGs are steadily moving out of reach, as national program gains are progressing much slower than necessary. The gap between estimated numbers of TB patients and those ultimately found and provided with adequate care is slowly decreasing, but it is not sufficient to get on top of the epidemic, end transmission and eliminate unnecessary suffering.

DELIVERY OF PEOPLE-CENTERED TB SERVICES

Optimization can be reached through realigning and prioritizing intervention packages that increase efficiencies in the delivery of people-centered TB services, closer to where they should be delivered to meet patient preferences. Substantial investments in data systems, surveys, and tools have led to the availability of national and sub-national data that are comprehensive, current and usable. An unprecedented opportunity to use data on epidemiology, health system capacities and patient care seeking behavior is now in our hands to drive programmatic impact towards TB elimination. However, without rigorous synthesis and analysis, various sources of data can be overwhelming and not lead to

<https://www.kncvtbc.org/en/people-centered-framework-for-tb-programming/>

World Health Organization

People-centred framework for tuberculosis programme planning and prioritization
User guide

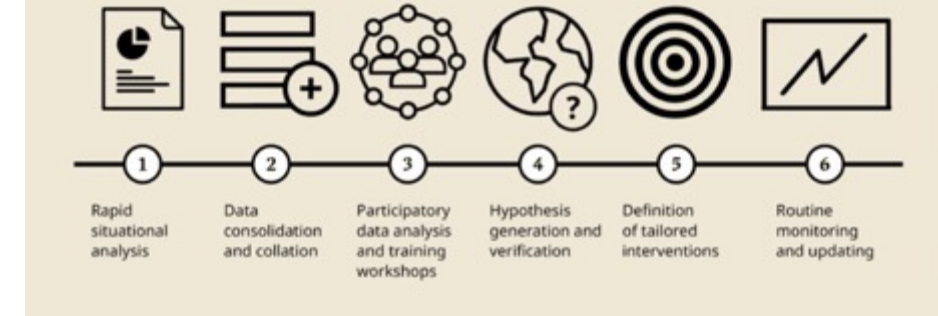
Patient Pathway Analysis Wizard
Turn raw data into PPA visuals in collaboration with your team.

The Patient Pathway Analysis (PPA) methodology combines data on care seeking and health service availability to better understand access to care. The PPA Wizard enables users to efficiently complete a PPA by automating the data analysis and visualization. Please consult the resources page below prior to starting a PPA in the wizard. Once you and your team understand the PPA methodology, use cases, general implementation process, and data sources necessary, you will be ready to create a PPA in the wizard!

Log In Register Resources

<https://ppa.linksbridge.com/home>

The KIT MATCH Approach for Enhancing TB Care Coverage



<https://www.kit.nl/project/the-kit-match-approach-for-enhancing-tb-care-coverage/>



<https://www.avenirhealth.org/software-onehealth.php>



Optimisation is about more than just the ingredients ...



New data acquired over the past 2-5 years will drive a **targeted and prioritised approach**.



NSP reflects a **patient-centred approach** to planning and **evidence-based prioritisation** of resource allocation to close the gaps along the patient pathway to quality care.



The NSP is operationalised through a **partnership framework** aligned to each **stakeholder's comparative advantage**.

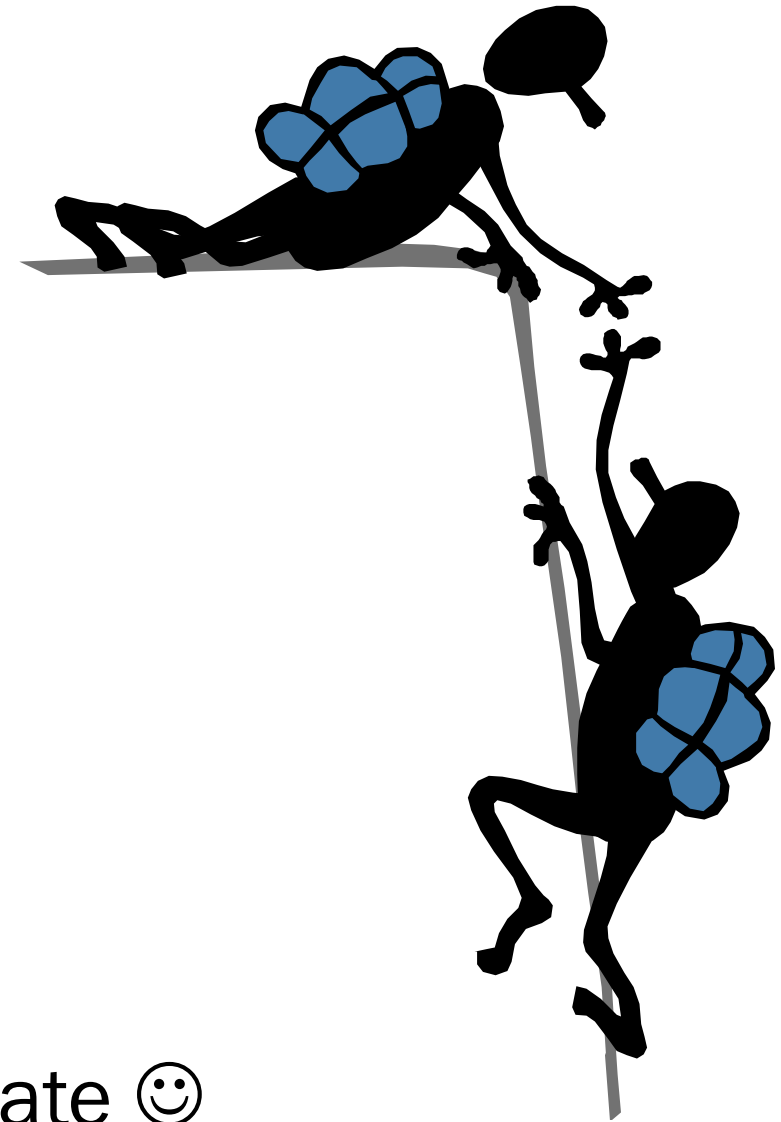


Activities **address systemic and root causes** of the gaps **along the patient pathway**, suggesting the **complementary roles** of sub-national and central governments, departments across the Ministry of Health, partners and other sectors.

The best strategic plan
... is only as good as its implementation

- Who is doing
- What
- When
- To what extend
- and for How much

--- and don't forget to monitor and evaluate 😊



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Linksbridge

TB MAC

LSHTM

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KIT

The Global Fund

KNCV Tuberculosis Foundation

Contact details:

Kathy Fiekert – kathy.fiekert@kncvtbc.org

<https://www.kncvtbc.org/en/people-centered-framework-for-tb-programming/>

<https://pcf4tb.org>