WHO-CHOICE FREQUENTLY ASKED QUESTIONS

Q: Describe the WHO initiative, WHO-CHOICE, in a nutshell.
A: WHO-CHOICE is a program in the World Health Organization that helps countries decide priorities based on considerations of impact and cost-effectiveness.

Q: WHO-CHOICE results are presented for regions. How do these apply to my country?
A: WHO-CHOICE analyses are compiled into regional databases which can then be modified for specific country settings by policymakers, using a country contextualization tool which makes it possible to adapt regional results to the country level.

Q: What is involved in a country contextualisation of a CHOICE analysis?
A: WHO-CHOICE tools, including disease models and costing tools, are pre-set with regional average data. For a contextualisation, data including epidemiology, intervention impacts, and prices can be replaced by a country analyst in order to use data that is more appropriate to the local setting. WHO-CHOICE staff can provide support and assist with analyses. Please contact the CHOICE team to discuss your needs.

Q: How is the WHO-CHOICE methodology for determining cost-effectiveness different from others?
A: WHO-CHOICE incorporates any activities that may be considered policy-relevant: either because they’re highly cost-effective or the opposite. All options are compared to a common comparator, a null scenario in which the impacts of currently implemented interventions are removed. This enables us to compare interventions across diseases.

Q: Does CHOICE continue to use the null comparator and why?
A: Yes, the null is used as the comparator for all interventions. This gives us a common comparator for all scenarios, so that interventions from different diseases can be compiled into an analysis across the spectrum of diseases. Rather than looking only at incremental costs and benefits, the use of the null also enables us to look at allocative efficiency – i.e. what allocation of resources will give the greatest health impact.

Q: How do you determine the “Costs” and “Effects”?
A: The impact on the population of interest when it is given a certain technology gives the estimate of effectiveness, which is applied to a population level model to project the likely impact in health adjusted life expectancy over the next 100 years. For cost, the costs of administration, training, and programme elements are added to the cost of operations as determined from best practice guidelines.

Q: My disease/risk factor of interest is not included in the CHOICE results. Can it be added?
A: WHO-CHOICE uses a generic set of tools which can be applied to any health condition. The CHOICE team would be happy to discuss the addition of additional diseases to our knowledge base. Please contact the team to discuss.
Q: What are some examples of one of the more significant results of WHO CHOICE so far?

A: In 2005, we published an analysis that implicitly determined the price at which an HPV vaccine could be sold and compete with current screening and prevention programs in terms of cost effectiveness. It subsequently turned out that the price negotiated by the procurement agencies with the vaccine manufacturers for the HPV vaccine – a much lower price than the prevailing market price – was surprisingly close to the one suggested by WHO-led research. This can be interpreted as the positive impact WHO-CHOICE has had on these discussions, though it is acknowledged that other factors could equally have pointed in the same direction.

Another case in point is that we found comprehensive cancer care that involves a full spectrum of prevention, detection, and treatment to be cost-effective. In fact, packaging these interventions together in one program is nearly as cost-effective as just the most cost-effective part of the group. This is highly valuable information for considering programs because ethical, medical, and social considerations often prevent splitting up the spectrum of care, so it’s good to have an economic argument that confirms this practice and WHO-CHOICE has been able to provide that argument.

Q: What are the various changes over the past ten years?

A: A lot has changed with technological and operational progress. For example, HIV treatment has changed a lot – it previously was all about school-based education, condom distribution, and reaching out to high-risk groups. But now we have cheap and affordable treatment programs, and this is one example where treatment becomes prevention because if you get the viral load of HIV-positive people down low enough, through effective treatment, they cease to be as infective.

Malaria is another place where the game has changed a lot. We’ve seen a massive increase in the use of bed nets with both high coverage (the number of households with bednets) and high usage (the number of people actually sleeping under bednets). Ten years ago, this coverage was basically zero in most areas. Furthermore, there’s a malaria vaccine coming out that’s currently in phase three clinical trials.

However, we’re shifting away from an era of “magic bullets”, i.e. the model of disease elimination by single-dose vaccines conferring lifelong immunity. The HPV vaccine and the malaria vaccine won’t provide lifelong immunity. Much of the ‘low-hanging fruit’ and quick fixes are gone, so the easy victories in global public health might be over. We seem to be heading now to the next frontier of progress, one that involves more complex methods and doesn’t have any magic bullets. But the huge progress that is possible to make at this next stage, in cancers and cardiovascular disease and a whole host of non-communicable diseases, not to mention the unfinished battle against HIV/AIDS, TB and Malaria, this still could be an exciting message if it were conveyed effectively.

Q: Why does the malaria treatment need to be promoted so heavily? Is there a funding gap in that area?

A: With the global financial crisis, there has been more competition for resources and international donor funds for malaria have stabilized and slightly tailed off. Furthermore, trends and fashions in global health have moved on; and, malaria is not seen as much of a priority, making way for other global health challenges.

Sometimes donors like funding magic bullets because they are game changers – it’s a nice thing to say you’ve done. But we need to change the paradigm from this kind of thinking to a more science-based, rationality-based, understandable, effectively communicated paradigm.