



ISPH

International Society
for Priorities in Health

PRIORITIES 2026

Abstract Book

Health Priorities in a World of Change

**15th Biannual Conference of the
International Society for Priorities in Health**

**7–9 October 2026
Bayreuth, Germany**



PRIORITIES 2026



Conference Programme

Health Priorities in a World of Change

Social Programme

Conference Dinner

Wednesday, 7 October 2026, from 19:00

"Beyond Bratwurst: A Taste of Franconia"

Location: Liebesbier, Andreas-Maisel-Weg 1, 95445 Bayreuth



Cultural Programme

Thursday, 8 October 2026, 17:30–19:00

Guided Walking Tour in Bayreuth

Choose one of the following tours:

- **"Following the Footsteps of Richard Wagner"**
- **"Following the Footsteps of Margravine Wilhelmine"**
- **"Jewish Life in Bayreuth"**

Location: Tourist Information Bayreuth, Opernstraße 22, 95444 Bayreuth

Optional meeting point (to walk there together): registration desk at 17:00

The city tour is followed by a small Get-together with drinks (non-alcoholic) and snacks



"Bayreuth between Wahn and Wine"

Thursday, 8 October 2026, from 19:00

Location: Iwalewahaush, Wölfelstraße 2, 95444 Bayreuth



All activities are included in the conference fee.

Keynote speakers

Wednesday, 7 October 2026

Institute of African Studies, Conference Hall

9.30 – 10.30

Aldo Faisal, University of Bayreuth



Aldo Faisal is Principal investigator of the borderless Brain and Behaviour Lab that works at the Interface of Machine Learning, Neuroscience & Biomedical Engineering. Aldo is professor and head of the Chair in Digital Health & Data Science applied to the Life Sciences at the

University of Bayreuth (Germany). He also holds a professorship in AI & Neuroscience at the Imperial College London. Aldo is also director of Behaviour Analytics Lab at the Data Science Institute (London), Associate Investigator at the MRC London Institute of Medical Sciences and its affiliated faculty at the Gatsby Computational Neuroscience Unit (University College London).

Agentic AI for Holistic Health

This keynote traces the intellectual arc from the birth of data-driven medicine to today's health foundation models. It begins with John Snow, who linked cholera cases to a single water pump and turned that observation into an intervention. It ends with Nightingale AI, the health foundation model we are developing.

The core logic has not changed: infer from data what to do. What has changed is its reach, from statistics and causal reasoning to large-scale, multimodal machine learning.

Modern systems move beyond static prediction towards continuous patient modelling. They combine health records, imaging, biosignals

and behaviour into one representation of a person's health over time. Foundation models, AI agents and reinforcement learning make this holistic view usable in care. They also meet institutions built for single-purpose products: we still regulate healthcare AI like a wheelchair, one device and one declared purpose at a time. For health economists this raises concrete questions about evidence generation, HTA and reimbursement when one model serves many clinical uses. The talk presents modern AI as a natural extension of data-driven reasoning and shows where fundamentally new methodological and conceptual challenges begin.

Gustav Tinghög, Linköping University

Friday, 9 October 2026

Faculty of Law and Economics, H24

9.30 – 10.30



Gustav Tinghög is a Professor of Economics at Linköping University, Sweden, where he earned his PhD in health economics in 2011. His doctoral research explored the economics and ethics of healthcare rationing. His current research examines how intuition, reflection and emotion shape human decision-making, both at the individual and societal level. As part of the JEDI Lab (Judgement, Emotion, Decision and Intuition), he uses experimental approaches to investigate cooperation, risk-taking, moral judgments and choices between immediate and future benefits. His work connects economics with psychology and ethics to understand how people make difficult decisions and how these insights can inform public policy. Alongside his research, he teaches behavioural economics, health economics and ethics, and microeconomic analysis.

Why People Hate Health Economics

Three Psychological Explanations and the Case for Health Economics

Priority-setting decisions based on health maximisation routinely conflict with the views of the general public. We argue that health economics has been largely oblivious to the role of emotions in decision making, and that this has limited its usefulness as an input to health policy. This paper presents a psychological account of why the outputs of health economic evaluations are unlikely to be compatible with public views. Three systematic phenomena — taboo trade-offs, compassion fade, and cost neglect — bias judgements about health-care priority setting, underpinned by a broader disconnect between how people reason about identifiable individuals and how they reason about aggregated groups. A health economics that ignores these mechanisms will continue to produce analyses that are technically correct and politically unusable. The constructive response is not to eliminate emotion from decision making, but to sequence analysis before it. Cost-effectiveness analysis, on this view, is not a decision rule but decision hygiene — a structured way of making visible the costs and foregone alternatives that the mind routinely fails to represent, so that emotional judgement operates on a more nearly complete picture of the decision. The wider implication is a reorientation of the field — what we call Health Economics — that treats affective engagement as constitutive of medical decision making rather than as an obstacle to it.

Conference programme

Wednesday, October 7

- 08.00 – 09.00 Registration; the registration desk is situated at the foyer of the Institute of African Studies
- 09.00 – 09.30 Welcome address; conference hall, Institute of African Studies
- 09.30 – 10.30 Keynote 1: “Agentic AI for Holistic Health”, Aldo Faisal (University of Bayreuth)
- 10.30 – 11.00 Coffee Break (walking to the Faculty of Law and Economics)
- 11.00 – 12.30 Organized Session 1: “Big, Bold Ideas for Priority Setting 2.0”, H24
- Organized Session 2: “When Crisis becomes the Setting for Health Priorities: Governance, Deliberation, and Resilience under Structural Constraints”, H25
- 12.30 – 13.30 Lunch at Mensa
- 13.30 – 14.00 (optional) Poster walk
- 14.00 – 15.30 Parallel Session 1: “Setting Fair Priorities”, H24
- Organized Session 3: “Expert Elicitation for Health Prioritisation: Methods, Applications, and Future Directions”, H25
- 15.30 – 16.00 Coffee Break

16.00 – 17.30 Organized Session 4: "From Country Experience to Global Guidance: FairChoices, Evidence-Informed Deliberative Processes and WHO PRIORITI", H24

Parallel Session 3: "Perspectives on Prioritisation", H25

17.30 – 19.00 Break

from 19.00 Conference Dinner "Beyond Bratwurst: A Taste of Franconia" at the *Liebesbier*, Andreas-Maisel-Weg 1, 95445 Bayreuth

Conference programme

Thursday, October 8

- 08.00 – 09.30 Registration; the registration desk is situated at the foyer of the Faculty of Law and Economics
- 09.30 – 10.30 Keynote 2: "Planetary Health in the Context of Priority Setting", Mary Eyram Ashinyo (Planetary Health West Africa Hub)
- 10.30 – 11.00 Coffee Break
- 11.00 – 12.30 Parallel Session 5: "Health System", S57

Organized Workshop: "Using Fair Choices for Value Informed Priority Setting", S58

Organized Session 5: "From Country application to a global public good: Costing Health Benefit Packages with the WHO UHC Compendium", H24
- 12.30 – 13.30 Lunch at Mensa
- 13.30 – 15.00 Organized Session 6: "Just pricing pharmaceuticals", H24

Organized Session 7: Difficult choices, rapid decisions: adapting priority setting to time and resource constraint, H25
- 15.00 – 15.30 Coffee Break
- 15.30 – 17.00 Parallel Session 2: "Assessing Outcomes", H24

Parallel Session 4: "Aligning Health Priorities", H25

- 17.00 – 17.30 Walking to the city center for the town sighting (Register at the reception)
- 17.30 – 19.00 Cultural program in the town: "Following the footsteps of Richard Wagner", "Following the footsteps of Margravine Wilhelmine", "Jewish Life in Bayreuth"
- from 19.00 Social event: "Bayreuth between Wahn and Wine"

Conference programme

Friday, October 9

- 08.00 – 09.30 Registration; the registration desk is situated at the foyer of the Faculty of Law and Economics
- 09.30 – 10.30 Keynote 3: "Why People Hate Health Economics", Gustav Tinghög (Linköping University)
- 10.30 – 11.00 Coffee Break
- 11.00 – 12.30 Organized Session 8: "What Implementation teaches priority setting-processes for essential packages of Health services", H24

Parallel Session 6: "Evidence-informed priority setting", S57
- 12.30 – 13.30 Lunch at Mensa
- 13.30 – 14.00 Poster Presentation
- 14.00 – 15.00 Closing Panel: "Priority Setting under Pressure - Germany and beyond"
- 15.00 – 15.30 Closing Address
- 15.30 – 16.30 ISPH: Member Meeting, H24

Parallel and organized session table

Wednesday, 7 October 2026

Time	H24	H25
11.00 – 12.30	Organized Session 1 Big Bold Ideas for Priority Setting Chair: Rob Baltussen, RadboundUMC • Edwine Barasa, KEMRI Wellcome Trust • Krishna Aryal, Bergen Center for Ethics and Priority Setting • Cassandra Nemzoff, RadboudUMC • Altea Sitruk, World Health Organization Come with your ideas! The aim of this session is to convene leading experts in the field of priority setting alongside the audience to discuss the successes and failures of past decades of priority setting efforts, and to discuss new, bold ideas for priority setting. This session is planned to be interactive with panelists and the audience. The discussion will be based on the following premise: You're not affiliated with any institution. You cannot promote the activities or tools developed by your current or former institution(s). You're an independent expert in the field of priority setting for health in LMICs.	Organized Session 2 When Crisis becomes the Setting for Health Priorities: Governance, Deliberation, and Resilience under Structural Constraints Chair: Reza Majdzadeh, University of Essex • Mojtaba Nouhi, Shahed University, Tehran • Maryam Rahbari Bonab, Ministry of Health and Medical Education, Iran • Musa Mohamed, United Nations Children's Fund (UNICEF) • Sajadi Haniye Sadat, Tehran University of Medical Sciences Health systems are increasingly asked to set priorities in a world where crisis is no longer rare or temporary. Armed conflict, forced migration, pandemics, climate disruption, fiscal shocks, sanctions, and geopolitical instability are reshaping how priorities are chosen, financed, implemented, and sustained. This session brings together conceptual, participatory, institutional, and country-level perspectives on priority setting in crisis-affected and structurally constrained health systems. Presenters bring first-hand research and policy experience from settings where priority setting is a difficult practice shaped by sanctions, interstate conflict, civil war, institutional fragility, and prolonged disruption. The session moves from context and decision-making to participation, deliberation, and the institutional conditions that keep priority setting credible and implementable.

Time	H24	H25
14.00 – 15.30	Parallel session 1 Setting Fair Priorities Mathias Barra, University of Oslo: <i>Calibration Implies Boundedness – Reassessing Calibration Arguments for Prioritarian Social Welfare Functions</i> Joseph Millum, St. Andrews University: <i>Should governments pay more for treatments of rare diseases?</i> Abhijith Jose, Marche Polytechnic University: <i>Should Age Count? Ethical, Economic and Policy Perspectives on Age-Based Health Rationing</i> Ann-Charlotte Nedlund, Linköping University: <i>The Bricolage of Priority Setting: A theoretical framework on how to understand the ambiguity of governance and practices of resource allocation and priorities in healthcare – an example from Swedish palliative care</i> Ritha Willilo, University of Bergen <i>Fair Processes, Uneven Practice: Institutionalising Procedural Fairness in Tanzania's Health Priority-Setting</i>	Organized Session 3 Expert Elicitation for Health Prioritisation: Methods, Applications, and Future Directions • Abigail Colson, University of Strathclyde • Nemzoff Cassandra, Radboud University Medical Center • Tina Nane, TU Delft • Andrew Mirelman, WHO Health prioritisation decisions frequently require action in the face of incomplete, uncertain, or context-dependent evidence. Decisions about which interventions to fund or which technologies to adopt often depend on evidence that is poorly measured, difficult to transfer across settings, or not yet available from empirical studies. Expert elicitation offers a structured approach for using expert judgement to fill evidence gaps, characterise uncertainty, and support transparent decision-making. This panel will examine how expert elicitation can contribute to health prioritisation, with particular attention to methodological choice, applied implementation, and institutional use.

Time	H24	H25
	Parallel session 3 Perspectives on Prioritisation Abubakar Alhassan, Bayero University Kano: <i>Global News Media and Global Health Priorities: BBC News and Universal Health Coverage</i> Wafa Aftab, University of Bergen <i>How Intersectoral Priority Setting Can Support Action on Social Determinants of Health: A Qualitative Case Study from Pakistan's Federal Health Ministry</i> 16.00 Eva Arvidsson, Linköping University: – <i>Priority Setting, Patient Safety and De-implementation: A Qualitative</i> 17.30 <i>Study of Health-Care Professionals' and Patients' Perspectives</i> Yasin Adil, Akerhus University <i>When Macro-Level Priority Policies Meet Bedside Reality: A Qualitative Study in a Universal Healthcare System</i> Ritha Willilo, University of Bergen <i>Setting Criteria for Prioritising Health Interventions in Tanzania: A Stakeholder-Participatory Approach</i>	Organized Session 4 From Country Experience to Global Guidance: FairChoices, Evidence-Informed Deliberative Processes and WHO PRIORITI Rob Baltussen, RadboudUMC Kjell Arne Johannsson, University of Bergen Sitruk Altea, WHO Countries setting health priorities must make technically sound choices under severe resource constraints and incomplete evidence, while ensuring that decisions are considered legitimate. This requires technical analysis to be combined with stakeholder participation and deliberation, and decisions to be connected to financing and implementation. The Bergen Centre for Ethics and Priority Setting in Health has developed FairChoices, while Radboudumc has developed evidence-informed deliberative processes (EDPs). Both approaches combine evidence, explicit criteria, stakeholder involvement and deliberation, but differ in their methods and practical organization. Building on these and other priority-setting approaches and extensive country experience, WHO has recently developed PRIORITI: an eight-step process for designing and revising universal health benefit packages. This session compares FairChoices in Zanzibar and EDPs in Rwanda and examines how these experiences relate to the emerging WHO guidance.

Thursday, 8 October 2026

Time	S57	S58	H24
11.00 – 12.30	Parallel session 5 Health System Ravi Kanta Mishra, University of Bergen: <i>Doing More with Less: Health System Efficiency of Local Governments in Nepal</i>	Organized Workshop Using Fair Choices for Value Informed Priority Setting Krishna Aryal, University of Bergen Kjell Arne Johnsson, University of Bergen	Organized Session 5 From Country Application to a Global Public Good: Costing Health Benefit Packages with the WHO UHC Compendium Chair: Rob Baltussen, RadboudUMC
	Caleb Mulongo, Tunu Consulting Hub: <i>Trust as a Priority-Setting Outcome: Scheme Performance, Constitutional Failure, and Reform Correction in Kenya's Social Health Authority</i> Lelissa Assebe, MSH: <i>Prioritizing and Costing RMNCH Innovations for Scalable Impact: A Combined MCDA and Costing Approach from Ethiopia</i> Sanaa Said, SUZA: <i>Closing the NCD Gap: Prioritization of Rheumatoid Arthritis Care in Zanzibar's Essential Health Care Package</i>	FairChoices is an innovative analytics platform designed to help countries conduct rapid, policy-relevant cost-effectiveness analyses across long lists of health interventions, while incorporating equity and distributive outcomes into the decision process. Attendees will work directly with the tool, explore its analytic framework, and learn how equity, financial risk protection, and population subgroups can be explicitly evaluated alongside traditional cost-effectiveness metrics. This workshop is ideal for researchers, modelers, HTA practitioners, policymakers, and students interested in practical, data-driven approaches to equitable priority setting.	• Gerard Abou Jaoude, University College London • Gavin Surgey, RadboudUMC • Charlie Nederpelt, RadboudUMC • Wajeeha Raza, WHO • Mizan Kiros Mirutse, University of Bergen • Filip Meheus, WHO Countries developing health benefit packages must determine not only which services should be prioritized, but also whether these services are affordable and implementable. The WHO UHC Compendium provides standardized service definitions and structured information on the resources required for service delivery. This session will examine how UHC Compendium-based costing can support broader priority-setting processes, what was learned from its application in Kyrgyzstan, and what is required to develop the model into an adaptable global public good.

Time	H24	H25
13.30 – 15.00	Organized Session 6 Just pricing pharmaceuticals • Martin Henriksson, Linköping University • Anton Klockhoff, Linköping University • Lars Sandmann, Linköping University • Niklas Juth, Uppsala University Several European healthcare systems that apply value-based drug pricing have been criticized for not paying enough. It has been argued that low prices can delay market entry, that existing pricing frameworks fail to capture important elements of value, and that current pricing levels may undermine incentives for innovation and timely access to new treatments. This session focuses on three closely related questions. • First, which types of value should be considered relevant when setting pharmaceutical prices? • Second, to what extent should these values be reflected in prices? • Third, what constitutes an acceptable and sustainable distribution of value between patients, healthcare systems, and the pharmaceutical industry?	Organized Session 7 Difficult choices, rapid decisions: adapting priority setting to time and resource constraint <i>Altea Sitruk, WHO</i> <i>Cassandra Nemzoff, RadboundUMC</i> <i>Tom Sesay, MOH Sierra Leone</i> <i>Andrew Mirelman, WHO</i> <i>Anna Vassall, WHO</i> <i>Shufang Zhang, World Bank</i> <i>Rob Baltussen, RadboundUMC</i> Health systems are increasingly under pressure due to shrinking external funding, geopolitical instability, rising debt, and emerging health threats. As a result, there is an unprecedented need for rapid, evidence-informed, and country-led priority setting. Traditional health technology assessment (HTA) processes are not typically designed to produce timely recommendations under such conditions This session draws on complementary frameworks: the WHO PRIORITI framework for evidence-informed deliberative priority-setting; adaptive HTA methodology; and emerging applications of rapid processes and artificial intelligence to accelerate evidence-informed decision-making.

Time	H24	H25
15.30 – 17.00	Parallel session 4 Assessing Outcomes Maartje Tromm, Erasmus University Rotterdam: <i>What is normal health? Reflecting on the equity consequences of using an age- and sex adjusted population reference group in absolute and proportional shortfall estimations</i> Lelissa Assebe, MSH: <i>Scoping review of extended cost-effectiveness analysis in health policy assessment</i> Annapoorna Prakash, Radboud University Medical Center: <i>Patient-Related Evidence For the Assessment Of Digital Health Technologies to Inform Priority Setting</i> Hassan Thabit, State University of Zanzibar: <i>Association of Body Mass Index, Sedentary Lifestyle, and HbA1c with Cardiac Autonomic Neuropathy in Type 2 Diabetes in Zanzibar</i>	Parallel session 5 Aligning Health Priorities My Eklund Saksberg, Linköping University: <i>Policy integration under pressure: Priority-setting in potential times of crises and war in Municipal Health Care and Social Care in Sweden</i> Achyut Raj Pandey, University of Bergen: <i>Temporal Trends and Inequities in the Continuum of Care for Maternal and Newborn Health Services in Nepal, 2006-2022</i> Habtamu Wollebo, Clinton Health Access Initiative: <i>Prioritizing Provider Payment for Primary Health Care: Lessons from Ethiopia's Capitation Payment Reform under Community-Based Health Insurance</i> Srijana Khatiwada, University of Bergen: <i>Health Investment Package for Low-Income Countries: A Cost-Effectiveness Analysis Using FairChoices for Global Development Aid Donors</i>

Friday, 9 October 2026

Time	S57	H24
11.00 – 12.30	Parallel Session 6	Organized Session 8
	Evidence-Informed Priority Setting	What Implementation Teaches Priority-Setting Processes for Essential Packages of Health Services
	Krishna Aryal, University of Bergen <i>Evidence Informed Priority Setting: Design and application of priority setting criteria in Nepal's health benefit package revision</i>	Chair: Reza Majdzadeh, University of Essex
	Gavin Surgey, UCL <i>Reducing the Complexity of Health Benefits Package Revision: A Practical Application of the WHO UHC Compendium</i>	Rob Baltussen, Radboud University Medical Center Maryam Huda, Aga Khan University, Karachi Lyazzat Koshbayeva, Ministry of Health, Astana, Kazakhstan Ahmed Esawi, University of Toronto
	Wudalew Tesfaye, Clinton Health Access Initiative <i>Social Health Insurance in Ethiopia: A Synthesis of Evidence on Willingness to Enroll, Institutional Preparedness, Fiscal Space, and Service Readiness as a Platform for Policy Action</i>	The Essential Package of Health Services (EPHS) translates health priorities into explicit, defensible, financially accountable commitments. In many countries, EPHS design is informed by priority-setting processes that combine evidence, criteria, stakeholder engagement, institutional judgement, and social values.
	Deepshikha Sharma, Post Graduate Institute of Medical Education and Research <i>Lessons for Priority Setting through Publicly-funded Health Insurance Schemes: Evidence from a Systematic Review and Meta-analysis in India</i>	Good design does not secure success. An EPHS succeeds when implementation expands effective coverage, reduces inequalities, and strengthens financial protection.
	Shiva Adhikari, Nepal Health Economics Association <i>Creating Fiscal Space for health care services through Strategic Reprioritization: Evidence from Nepal</i>	This session treats EPHS priority setting not as a linear process for selecting services, but as a learning mechanism for defining, testing, and revising an EPHS.

PRIORITIES 2026

Abstracts

Health Priorities in a World of Change

Wednesday

7 October 2026

University of Bayreuth, Germany

Big Bold Ideas for Priority Setting 2.0

Chair: Rob Baltussen, RadboudUMC

- Edwine Barasa, KEMRI Wellcome Trust
- Krishna Aryal, Bergen Center for Ethics and Priority Setting
- Cassandra Nemzoff, RadboudUMC
- Altea Sitruk, World Health Organization

Come with your ideas! The aim of this session is to convene leading experts in the field of priority setting alongside the audience to discuss the successes and failures of past decades of priority setting efforts, and to discuss new, bold ideas for priority setting.

There has always been a need to legitimately and effectively set priorities in health to help fulfill health system goals and support countries in achieving universal health coverage. Creating effective and sustainable priority setting systems is a lengthy process – it takes years to develop and institutionalize methods and processes that are routinely used to prioritize resource allocation.

Historically, the development of methods and the support of institutionalization for evidence-informed priority setting have been heavily supported by external funding and technical assistance.

Global public goods for priority setting methods have proliferated such as WHO-CHOICE, Disease Control Priorities (DCP-1 to DCP-4), the WHO-UHC Compendium. Even still, the availability of economic evidence, which is central to priority setting, remains either weak or disproportionately focused on few diseases in low- and middle-income countries.

Moreover, few countries have built durable institutions, explicit and tangible review processes, and transparent decision-making processes needed to routinely apply these global public goods. In some cases,

institutionalization has also been supported by technical assistance projects such as the international Decision Support Initiative (iDSI).

However, in 2024 and 2025 alone, development assistance for health was estimated to drop 21%. In July 2025, USAID was dissolved. Funding for priority setting has declined alongside other development assistance, and yet priority setting is now all the more crucial.

This session is planned to be interactive with panelists and the audience.

The discussion will be based on the following premise: You're not affiliated with any institution. You cannot promote the activities or tools developed by your current or former institution(s). You're an independent expert in the field of priority setting for health in LMICs.

The session will be structured around three blocks of questions, with responses first from the panelists (<5 minutes each) followed by a mentimeter to the audience on the same questions.

Block 1:

- Why has institutionalization of priority setting stalled even in countries where technical capacity and tools exist?
- Why has the support for priority setting been discontinued?

Block 2:

- What's one big achievement of priority setting efforts in LMICs, in your opinion?
- What's one big priority setting failure in LMICs, in your opinion?

Block 3:

- What's your next big idea for priority setting?
- What needs to change institutionally to sustain priority setting in the future? (e.g. political/legal acceptance of the process, with decisions treated as binding and not advisory; the benefit package used as the

reference document for HSS and budget decisions, not a side technical output; a standing mandate/body that outlives election cycles and donor project timelines; explicit ownership from a donor funded unit to a domestic institution (e.g. MoH policy planning division).

The final block will be Q&A, and the audience will also be invited to pitch new ideas.

The session will be chaired by Rob Baltussen, Professor of Health Economics, RadboudUMC. Panelists will include:

- Edwine Barasa, Executive Director, KEMRI Wellcome Trust
- Krishna Aryal, Senior Researcher, Bergen Center for Ethics and Priority Setting
- Cassandra Nemzoff, Assistant Professor, RadboudUMC
- Altea Sitruk, Technical Officer, World Health Organization

When Crisis becomes the Setting for Health Priorities: Governance, Deliberation, and Resilience under Structural Constraints

*Reza Majdzadeh¹, Mojtaba Nouhi², Maryam Rahbari Bonab³, Musa
Mohamed⁴, Sajadi Haniye Sadat⁵*

¹ School of Health and Social Care, University of Essex, UK

² Department of Health Economics, School of Medicine, Shahed University, Tehran, Iran; High Council for Health Insurance, Ministry of Health and Medical Education, Iran

³ Department for the Follow-up of Bills and Legislative Proposals, Ministry of Health and Medical Education, Iran

⁴ United Nations Children's Fund (UNICEF), Sudan

⁵ University Research & Development Center (URDC), Knowledge Utilization Research Center (KURC), Tehran University of Medical Sciences, Iran

Problem definition

Health systems are increasingly asked to set priorities in a world where crisis is no longer rare or temporary. Armed conflict, forced migration, pandemics, climate disruption, fiscal shocks, sanctions, and geopolitical instability are reshaping how priorities are chosen, financed, implemented, and sustained.

Priority setting has long addressed scarcity, evidence, cost-effectiveness, fairness, and deliberation. These concerns remain central. Yet in crisis-affected settings, their assumptions become fragile: evidence may be incomplete, budgets unstable, supply chains disrupted, institutions weakened, and communities distrustful.

This organised session asks how health priorities can be set when crisis becomes the setting rather than the exception. It examines how criteria, participation, evidence-informed deliberation, implementation, and accountability must adapt. In fragile and conflict-affected settings, the

challenge is often not only identifying priorities, but implementing them amid insecurity, disrupted supply chains, workforce shortages, and financing constraints.

Theoretical foundation

The session treats priority setting not only as a technical exercise in ranking interventions, but as a social and institutional process through which difficult choices become legitimate and implementable.

Stable settings can often assume predictable financing, functioning institutions, available evidence, and manageable implementation. Crisis weakens these assumptions. Choices may require speed, but speed can narrow fairness. Evidence may be urgent, yet unavailable or contested. Participation may be difficult, although those most affected are often least heard.

Priority setting in crisis therefore requires more than better tools. It requires attention to context, resilience, fairness, institutional capacity, and the journey from decision to service delivery. Implementation feasibility and system resilience must be integral to priority-setting processes, not later delivery concerns. A health benefit package, priority list, or deliberative decision only matters if it can withstand financing gaps, procurement barriers, workforce strain, political disruption, and weak accountability.

Empirical research context

This session brings together conceptual, participatory, institutional, and country-level perspectives on priority setting in crisis-affected and structurally constrained health systems. Presenters bring first-hand research and policy experience from settings where priority setting is a difficult practice shaped by sanctions, interstate conflict, civil war, institutional fragility, and prolonged disruption.

The session moves from context and decision-making to participation, deliberation, and the institutional conditions that keep priority setting credible and implementable.

Results

First, it will clarify how crisis changes priority decisions. Scarcity is not only limited to money or competing interventions; it may also mean broken supply chains, volatile budgets, weakened institutions, political pressure, and unequal harm.

Second, it will examine how decision-making frameworks respond to uncertainty in evidence, resources, and implementation capacity, including how criteria, feasibility, resilience, and transparency should adapt.

Third, it will address participation in difficult conditions. Crisis can narrow deliberative space, but it also makes participation more important. Without meaningful engagement, priority setting may miss those who lose access first, have the least capacity to pay, or remain least visible to institutions.

Fourth, it will consider how evidence-informed deliberative processes can be adapted in fragile and conflict-affected settings, not as a fixed template, but to protect deliberation, evidence use, and legitimacy when the health system is under strain.

Fifth, it will examine governance conditions that allow priority setting to endure: institutions, accountability, coordination, monitoring, and the capacity to correct harm before policy failure appears as delayed care, avoidable suffering, or loss of trust.

Together, the presentations will identify how priority-setting processes can remain legitimate, feasible, equity-sensitive, and resilient under crisis conditions.

Conclusions

Fair priority setting cannot be designed for an ideal health system and then applied to one under pressure. When crisis becomes the setting, priority-setting must be more adaptive, honest about uncertainty, attentive to those carrying the heaviest burden, and serious about implementation.

By bringing together perspectives on context, decision-making, participation, evidence-informed deliberation, and institutions, the session offers a practical contribution to Priority Setting. It speaks to researchers, practitioners, and policymakers concerned with choices that are evidence-informed and fair on paper, yet credible, resilient, and humane in practice.

Calibration Implies Boundedness – Reassessing Calibration Arguments for Prioritarian Social Welfare Functions

Mathias Barra¹

¹ Division of Health Services Research and Psychiatry, University of Oslo

Problem definition (research gap/objective)

Nebel and Stefánsson (2023) reinterpret Rabin's risk-aversion calibration theorem for prioritarian social welfare functions (SWFs), arguing that any social planner who prefers an equal split (x,x) over a fair gamble between $(x-\ell, x+g)$ is thereby committed to preferring a fixed, tiny but certain benefit to one person to an arbitrarily large benefit to another. This has been taken to be highly counterintuitive trade-offs. These arguments are typically discussed in the context of concave utility transformations. This work asks a more fundamental question: what follows from the calibration conditions themselves?

Theoretical foundation

The analysis is situated within the prioritarian social welfare framework developed by authors such as Adler and Atkinson, where social value is represented by a sum of transformed ("weighted") individual benefits. I study additive and multiplicative calibration conditions that formalize the judgments underlying recent calibration arguments.

Methodology

I investigate the implications of the additive and multiplicative calibration conditions under minimal formal assumptions. In contrast to previous discussions, the analysis requires only that the transformation function be monotone increasing and does not assume continuity, differentiability, concavity, or other regularity conditions. Elementary real-analytic arguments (bounding telescoping sums over arithmetic and geometric progressions) are sufficient to prove that each condition forces the

transformation function to be bounded above, demonstrate the equivalence between additive and multiplicative conditions, and characterise exactly when the Atkinson and Kolm–Pollak families satisfy them.

Results

I show that the calibration conditions themselves imply that the transformation function must be bounded above. Boundedness is therefore not an auxiliary assumption but a direct consequence of the calibration premises. This result holds for every increasing transformation function satisfying the calibration-condition and thereby strengthens existing calibration results developed for more restricted classes of functions. The analysis further identifies which members of the Atkinson- and Kolm-Pollak families satisfy a calibration-condition, and clarifies the role played by boundedness in generating the calibration results.

Conclusions

The findings suggest that recent calibration critiques have a more limited scope than is often assumed. Rather than applying to weakly prioritarian social welfare functions in general, they apply only to a restricted class of bounded transformation functions. However, the calibration condition is also stronger than previously recognised: one need not postulate concavity. More broadly, the results raise questions about the relationship between bounded prioritarian and sufficientarian approaches and about the role of calibration arguments in normative theories of healthcare priority setting.

Should governments pay more for treatments for rare diseases?

Joseph Millum¹

¹ Philosophy, University of St. Andrews

Problem definition

Worldwide, approximately 300 million people have a rare disease. Under the intellectual property regime governing most drugs and devices, research into rare diseases would often not be profitable. The market for new products for any particular rare disease is small but the research and development inputs required are similar to those required for developing new products for more common diseases. For-profit research organizations therefore need special incentives to develop rare disease treatments. One approach taken by some high-income country governments is to accept higher prices for products that provide the same level of benefit when the benefit accrues to rare disease patients. This presentation addresses the question of whether paying more for treatments for rare diseases can be ethically justified.

Theoretical foundation

This is a question of justice. Answering it requires answering the philosophical question of what justice requires in this context.

Methodology

A review of the literature on the ethics of rare disease research and treatment identified multiple arguments for and against paying more for rare disease treatments. Preliminary analysis indicated that the main question could be usefully divided into two. First, the question of whether rarity is relevant to justice-based claims to health care. Second, the question of whether being more expensive to treat is relevant. The

arguments from the literature were assessed using the standard methods of analytical ethics. Additional original arguments were then developed, building on those published arguments that withstood critical scrutiny. Results: First, in the literature on ethics and rare diseases there are no compelling arguments for treating the prevalence of a condition as independently important for allocation purposes. Rarity itself is not a good reason for giving one patient group higher priority than another. Second, paying for treatments that are not cost-effective is—*ex hypothesi*—inefficient. However, there might still be reasons of fairness to pay for non-cost-effective treatments for patients who are more expensive to treat. It is widely held that equality of outcomes matters for justice. However, this principle of fairness will support paying more for more expensive patients only under limited conditions. A principle of input equality would better support paying more for expensive patients, but such a principle is more difficult to defend.

Conclusions

There might be fairness-based reasons to pay more for patients whose treatment is more expensive, including some rare disease treatment. This verdict is tentative, since it depends on uncertain empirical facts and controversial conceptions of fairness

Should Age Count? Ethical, Economic and Policy Perspectives on Age-Based Health Rationing

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Problem definition (research gap / objective)

When Italian hospitals ran out of intensive care beds during COVID pandemic, SIAARTI guidance recommended clinicians to weigh biological age alongside comorbidity and functional status. The backlash was immediate, and it exposed something uncomfortable: health systems had no settled answer to a question they were suddenly forced to decide in real time. Does age belong in allocation decisions at all? Ethicists, health economists and policy scholars have largely argued past one another. This review brings the three literatures into one frame and asks whether age-based rationing can be justified, and with what safeguards.

Theoretical foundation

Four positions are used to defend a role for age: utilitarian and cost-effectiveness reasoning, fair innings, Daniels' prudential lifespan account, and prioritarianism. Against them sit egalitarian and human-rights commitments, the capabilities approach, and the plain fact that people of the same age differ enormously in health. Rationing is treated as something every health system does implicitly.

Methodology / empirical research context

A narrative review with thematic synthesis, since the evidence base - conceptual argument, economic evaluation, opinion surveys, policy documents- cannot sensibly be pooled statistically. PubMed was searched for peer-reviewed English-language work published since 2000 using "age-

based rationing” and related terms, returning 1,451 records. Screening removed 1,375; of the 76 full texts assessed, 44 were retained, with older foundational texts added where the argument required them. Sources were coded thematically within each domain, with arguments for and against examined side by side.

Results

The domains do not converge. Efficiency reasoning favours weighting by age; equity and dignity reasoning rejects it; actual policy mostly avoids naming age while relying on clinical criteria that track it closely. Cost-effectiveness metrics carry rarely stated normative assumptions, and the familiar claim that older populations drive spending growth holds up poorly. Surveys of the public and of clinicians point to a middle position: age is tolerated as a tiebreaker, rejected as a cut-off. Crisis triage and standing policy also look ethically different.

Conclusions

The defensible position is age-sensitive rather than age-determined allocation. Where scarcity is genuine, age can be one consideration among several, provided the rule is transparent, publicly deliberated in advance, and leaves clinical judgement intact. Two implications follow: geriatric expertise should be considered in pandemic planning, and crisis triage logic should not be based on any arbitrary cut-off criterion.

The Bricolage of Priority Setting: A theoretical framework on how to understand the ambiguity of governance and practices of resource allocation and priorities in healthcare – an example from Swedish palliative care

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The governance of resource allocation and what should be priorities is carried out both at the frontstage as well as the backstage of healthcare system. In the frontstage of healthcare, activities are presented according to a rational and often linear, instrumental logic, typically through steering mechanisms that emphasise knowledge codified in policy documents and expected to be implemented and evaluated. However, there is also a backstage of healthcare, where collegial interactions and reasoning within regional political committees, clinical units, and among professionals shape how steering signals, together with situated knowledge, become practice. Priority setting thus does not occur in a vacuum, nor does it follow pure rationality. Rather, frontstage and backstage activities are independent, and instead of being the outcome of formal decision-making by an abstract category of "policy-makers", the governance of resource allocation constitutes an ongoing and interactive practice involving multiple actors.

Against this backdrop, this paper develops a theoretical framework for understanding resource allocation and priority setting as processes enacted across the frontstage and backstage of healthcare. We conceptualise priority setting as an ongoing and situated process, shaped through practice rather than determined in advance. More specifically, priority setting is understood as constituted through two interrelated processes: a vertical process and a horizontal process.

Drawing on extensive empirical material from Swedish palliative care, including policy documents and interviews with policymakers and

healthcare professionals, the paper shows how these processes are intertwined in practice.

The findings indicate that priority-setting is constituted by three dimensions that are continuously pieced together in a creative bricolage and reworked by those engaged in health care, shaping how priorities take form in concrete situations.

By integrating vertical and horizontal dimensions of governance with multiple dimensions of policy work, this paper makes an original theoretical contribution that redefines priority setting as a situated, relational, and practice-based accomplishment of healthcare governance. The Bricolage of Priority-Setting framework further enables an understanding of how and why healthcare professionals come to agree on courses of action in specific situations, and how such situated agreements contribute to the emergence of new forms of governance, associated with strengthening both internal and external legitimacy.

Fair Processes, Uneven Practice: Institutionalising Procedural Fairness in Tanzania's Health Priority-Setting

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Problem definition

Procedural fairness is increasingly recognised as central to fair priority-setting in health systems. However, empirical evidence on how fair processes are implemented and sustained in real-world governance contexts remains limited, particularly in low- and middle-income countries. This study examines how procedural fairness is operationalised during the revision of Tanzania's national Essential Health Benefits Package (EHBP).

Theoretical foundation

This study draws on procedural justice theories, particularly the Accountability for Reasonableness (A4R), which emphasises fairness in priority-setting processes rather than outcomes. Building on this, the World Bank operationalises procedural fairness as institutionalised decision-making within health system governance. This approach

emphasises priority-setting processes that are not only well-designed but also embedded and sustained within institutional arrangements.

Methods

A qualitative case study design was employed. Data were collected through in-depth interviews with policymakers, practitioners, and technical experts involved in the EHBP revision process. Data were analysed using reflexive thematic analysis, combining inductive coding with theory-informed interpretation. The World Bank's procedural fairness guide, organised into three domains: voice, information, and oversight, was applied during interpretation to structure the findings in analysis.

Results

Within the voice domain, participation followed a structured and sequential process, progressing from public consultation to stakeholder-led deliberation. This shaped opportunities for engagement, while influence remained mediated by institutional roles and technical expertise. With the information domain, facilitator-led presentations supported reason-giving, with decisions justified by layered criteria that combined efficiency, equity, feasibility, and impact. Transparency was most evident in the accessibility and practical use of the EHBP, while the evidence base remained diverse yet constrained, requiring interpretation informed by both data and expert judgement. Oversight domain, these constraints extended into governance arrangements, where oversight mechanisms were weakly institutionalised. Limited coordination authority contributed to irregular revision cycles and constrained policy continuity.

Conclusions

These findings show that procedural fairness in priority-setting depends not only on the design of processes but on their institutional integration. An “institutionalisation gap” emerged between formally defined procedures and their consistent implementation in practice.

Expert Elicitation for Health Prioritisation: Methods, Applications, and Future Directions

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Problem definition

Health prioritisation decisions frequently require action in the face of incomplete, uncertain, or context-dependent evidence. Decisions about which interventions to fund or which technologies to adopt often depend on evidence that is poorly measured, difficult to transfer across settings, or not yet available from empirical studies. Expert elicitation offers a structured approach for using expert judgement to fill evidence gaps, characterise uncertainty, and support transparent decision-making. This panel will examine how expert elicitation can contribute to health prioritisation, with particular attention to methodological choice, applied implementation, and institutional use.

Theoretical foundation

Expert elicitation involves structured methods for defining uncertain quantities, selecting and engaging experts, reducing bias, quantifying uncertainty, and integrating judgements into decision processes. The session will consider the role of expert elicitation to support health prioritisation decisions, including how recent ISPOR guidance on structured expert elicitation can inform practice and how contextual considerations should guide methods choice. It will also present several examples of elicitations conducted in various global health contexts.

Panel perspectives

The panel will bring together four complementary perspectives on the use of expert elicitation in health prioritisation.

Abigail Colson will introduce the ISPOR guidance on expert elicitation and discuss how contextual considerations should guide methodological choices. She will consider how the degree of uncertainty, legitimisation burden, and available resources shape the design of an elicitation exercise. Her contribution will focus particularly on how these choices play out in global health and health prioritisation settings.

Cassandra Nemzoff will discuss the use of expert elicitation in adaptive health technology assessment and health benefits package design. Drawing on applied experience, she will describe examples where experts have been asked to provide inputs such as proxy EQ-5D values, effectiveness estimates, cost-effectiveness judgements, or other parameters needed to support priority-setting when direct evidence is unavailable or incomplete. Her contribution will highlight the practical challenges of using elicited inputs in decision models.

Tina Hane will present experience using Cooke's Classical Method in a large-scale expert elicitation undertaken as part of the World Health Organization's global burden of foodborne disease estimations. This case provides an example of a formal, performance-weighted elicitation approach applied at a large-scale to a complex global health problem. Her contribution will explore the design and conduct of the elicitation, the role of calibration and expert weighting, and lessons learned from implementing a structured method at scale in an international setting.

Andrew Mirelman will offer a WHO perspective on where, how, and why expert elicitation could be useful in future global health decision-making. He will reflect on the kinds of evidence gaps faced by international organisations, the potential role of elicitation in supporting priority setting, and the institutional conditions needed for elicited expert judgement to

be useful, trusted, and appropriately integrated with other forms of evidence.

Cross-cutting discussion themes

Together, the panellists will address when expert elicitation is most valuable, how different elicitation methods can be matched to different decision needs, and what standards are needed to ensure that elicited judgements are rigorous, transparent, and policy-relevant. The discussion will consider the opportunities and challenges for using elicitation to inform prioritisation decisions, as well related ethical and practical questions.

Intended contribution

The panel will clarify the potential role of expert elicitation in health prioritisation, while also identifying the methodological, practical, and institutional conditions needed for its responsible use. Participants will leave with a clearer understanding of the potential contribution of expert elicitation to health prioritisation, the methodological choices involved, and the opportunities for strengthening its use in settings where decisions must be made despite unavoidable uncertainty.

Global News Media and Global Health Priorities: BBC News and Universal Health Coverage

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The global news media are among the leading actors in setting, or at least shaping, the global public policy agenda including global health priorities. BBC has consistently been ranked among the top five leading global news media. Thus, to understand global news media's agenda setting role in global health policy, this study will examine BBC's coverage of one of the major global health priorities, universal health coverage, which is not only a target of SDGs but also one of the major global challenges prioritized by WHO, the progress of which is tracked jointly by the WHO and World Bank.

A Rapid Qualitative Analysis of BBC News website is to be conducted in order to gauge how one of the leading global news media's narrative and framing of universal health coverage may shape public perception and therefore likely influence public policy regarding one of the most important strategies for attaining health for all.

How Intersectoral Priority Setting Can Support Action on Social Determinants of Health: A Qualitative Case Study from Pakistan's Federal Health Ministry

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Background and objectives

Intersectoral interventions for health i.e., interventions that involve one or more non-health sectors but have a substantial effect on health, can improve population health and reduce health inequities by addressing determinants of health. Due to additional non-health effects and relevance to a broader set of stakeholders these interventions do not fit into priority setting processes for health interventions. Priority setting frameworks are often concerned with questions of intervention outcomes isolated from political and institutional realities into which intersectoral decision-making is necessarily embedded. The aim of the study was to explore whether priority setting could be a potentially useful approach for the health ministry to systematically address determinants of health within local political and institutional realities.

Methodology and theoretical foundations

We conducted a qualitative case study, using key informant interviews, of an intersectoral priority setting exercise undertaken by Pakistan's Federal

Ministry of Health between 2019–2022. We drew on theories of policy agenda setting and priority setting concurrently because examining their interactions could help identify intersectoral opportunities, which neither framework alone would. Priority setting's predominantly technical perspective was insufficient to study the broader political and institutional context that determines the intersectoral decision space, policy options, and collaboration opportunities for the health ministry.

Results

Our findings reveal that the process of intersectoral priority setting is deeply influenced by its political and institutional context. According to respondents, existing institutional structures and norms in Pakistan are not optimally suited to support intersectoral actions for health, although there is growing recognition of their importance. Regardless of sector, all respondents view engaging in intersectoral actions as part of the health ministry's responsibility for population health. Priority setting, thereby, is viewed as a way of clarifying the health ministry's intersectoral agenda. However, intersectoral priority setting methods are seen as underdeveloped in terms of available evidence, standardized economic and policy evaluation, and deliberative mechanisms. Respondents suggest that to implement the prioritized intersectoral agenda, the health ministry must effectively navigate the political space outside the health sector, such as by highlighting shared benefits, grounding the intersectoral agenda in local needs, and leveraging the political dynamics of other sectors. Moreover, this political engagement must be complemented by competence in evidence generation and communication to influence cross-sectoral policy dialogues.

Conclusion

Using a priority setting approach, health ministries can systematically advance intersectoral health agendas by building political coalitions around shared priorities supported by rigorous evidence and analysis.

Priority Setting, Patient Safety and De-implementation: A Qualitative Study of Health-Care Professionals' and Patients' Perspectives

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Problem definition

De-implementation of low-value care has received increasing attention as a strategy for improving quality, sustainability and resource use in health care. Research has primarily focused on identifying low-value care and developing de-implementation strategies, while less attention has been paid to how health-care professionals and patients reason about such decisions in clinical practice. In particular, knowledge is limited regarding how priority-setting ethics, evidence, patient safety and displacement are invoked and weighed in deliberations about de-implementation. The aim of this study was to explore how health-care professionals and patients reason about the identification and de-implementation of low-value care, as well as about priority setting and displacement.

Theoretical foundation

The study draws on research on priority setting in health care and the de-implementation of low-value care. The analysis focuses particularly on the interplay between priority-setting ethics, scientific evidence, patient safety and resource allocation in a publicly funded health-care system.

Methodology / empirical research context

A qualitative focus group study was conducted at a Swedish university hospital after ethical approval. Focus groups were held with physicians, nursing staff, physiotherapists, line managers and patients. The interviews were analysed using qualitative content analysis, with an inductive approach followed by theory-informed interpretation.

Results

Preliminary analyses indicate that priority-setting considerations permeate deliberations about de-implementation, although they are rarely expressed explicitly. Participants described recurring tensions between patient benefit, patient safety, resource use and professional responsibility. Evidence was viewed as important not only as a source of knowledge but also as a source of legitimacy, and stronger evidence was often required to discontinue established routines than to continue them. Patient safety was used both as an argument for maintaining and for discontinuing interventions. Two partly competing safety logics were identified: one in which increased monitoring and additional interventions were expected to improve safety, and another in which more selective use of interventions was expected to improve both patient safety and resource use.

Conclusions

The findings suggest that de-implementation of low-value care is not primarily perceived as a technical question of evidence but as a process in which evidence, patient safety, priority-setting ethics and professional responsibility are continuously balanced against one another. The study contributes to understanding how priority-setting considerations are addressed in clinical practice and how more transparent and ethically reflective approaches to de-implementation may be developed.

When Macro-Level Priority Policies Meet Bedside Reality: A Qualitative Study in a Universal Healthcare System

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Background

Increasing expectations and opportunities in healthcare present challenges related to the allocation of health services. Limited resources require sound priority setting at all levels. Norway's tax-financed universal healthcare system has a well-developed framework for healthcare priority setting that has gradually been extended from macro-level policy decisions to micro-level clinical settings. However, translating population-level criteria into bedside practice requires alignment with clinical norms, incentives and pressures. There is limited knowledge about what clinicians themselves emphasize when making priority-setting decisions in everyday clinical practice.

Objective

To explore the aims that guide clinicians' priority-setting decisions in clinical practice within a universal healthcare system.

Method: 77 clinicians from various professions and specialties participated in 14 focus group interviews. An iterative interview guide was used and refined throughout data collection. Transcribed audio recordings were analyzed using reflexive thematic analysis.

Results

The analysis resulted in three themes. The theme "The Patient's Advocate" captures patient-centered outcomes as a central aim of clinical priority-setting decisions. These aims partly align with established priority-setting

criteria such as benefit and severity, but patient satisfaction also emerged as an explicit objective. "Preserve the Clinician" contrasts this with aims related to maintaining clinicians' own capacity, avoiding complaints and regulatory scrutiny, and reducing personal uncertainty. The third theme, "The System Must Go On", captures priority setting decisions aimed at maintaining workflow and throughput, adhering to guidelines and system requirements, and placing patients at the lowest effective level of care. The three themes illustrate how clinical priority-setting decisions may be shaped by competing considerations related to patients, clinicians, and the healthcare system.

Conclusion

Clinical priority setting decisions involve balancing distinct but overlapping aims related to patients, clinicians, and the healthcare system. Awareness of these aims is important for the development and implementation of effective, legitimate and fair priority setting frameworks, guidelines, and criteria – bridging the gap between macro-level policies and bedside realities.

Setting Criteria for Prioritising Health Interventions in Tanzania: A Stakeholder-Participatory Approach

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Problem definition

Priority-setting in health systems involves trade-offs among competing interventions under resource constraints and requires explicit criteria to support systematic, transparent decision-making. Although many criteria have been proposed and global frameworks provide guidance, these do not fully capture country-specific values and population needs. This study aimed to identify and rank contextually relevant priority-setting criteria for national use in Tanzania through a participatory stakeholder process.

Theoretical foundation

The study draws on Evidence-Informed Deliberative Processes, a framework designed to ensure meaningful stakeholder participation by promoting deliberation that fosters fair processes and legitimacy in health priority-setting. It integrates Multi-Criteria Decision Analysis (MCDA) and Accountability for Reasonableness (A4R) to guide decision-making. MCDA supports the structured identification and ranking of criteria across multiple dimensions. A4R emphasises fairness, transparency, and

legitimacy in decision-making. Together, they promote stakeholder participation, reflect local values, and strengthen accountability in resource allocation.

Methods

A five-step participatory process was applied, including stakeholder identification, criteria listing, organisation, ranking, and validation. A total of 36 participants listed and ranked criteria according to perceived importance using a scale from 1 (least important) to 9 (most important). Data were analysed using descriptive statistics. Criteria were assessed based on recognition (frequency of identification), valuation (scoring patterns), and variation (distribution of responses across stakeholders). Final rankings were based on weighted mean scores. Validation involved in-depth interviews with 21 stakeholders engaged in revising the national Essential Health Benefit Package to assess contextual relevance.

Results

Participants identified ten criteria. Burden of disease received the highest weighted mean score (7.0), reflecting both its higher frequency of identification and its relative importance. Five criteria were ranked moderately (scores 4–6): cost to patients, affordability, health benefits, equity, and political acceptability. Lower-ranked criteria (scores 1–3) included cost-effectiveness, cost to the provider, public acceptability, and feasibility. Twelve equity dimensions emerged, with severity of disease most frequently mentioned. Validation findings revealed conceptual overlap among several criteria, suggesting differences in interpretation in practice.

Conclusions

Identifying locally relevant criteria can support more context-sensitive and transparent priority-setting. The participatory approach demonstrated in this study may be adapted in other resource-constrained settings to strengthen decision-making toward universal health coverage.

From Country Experience to Global Guidance: FairChoices, Evidence-Informed Deliberative Processes and WHO PRIORITI

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Problem definition

Countries setting health priorities must make technically sound choices under severe resource constraints and incomplete evidence, while ensuring that decisions are considered legitimate. This requires technical analysis to be combined with stakeholder participation and deliberation, and decisions to be connected to financing and implementation.

The Bergen Centre for Ethics and Priority Setting in Health has developed FairChoices, while Radboudumc has developed evidence-informed deliberative processes (EDPs). Both approaches combine evidence, explicit criteria, stakeholder involvement and deliberation, but differ in their methods and practical organization.

Building on these and other priority-setting approaches and extensive country experience, WHO has recently developed PRIORITI: an eight-step process for designing and revising universal health benefit packages. This session compares FairChoices in Zanzibar and EDPs in Rwanda and examines how these experiences relate to the emerging WHO guidance.

Session format and contents

Kjell Arne Johansson and Rob Baltussen will introduce FairChoices and EDPs and establish a common framework for comparing their application.

Omar Mwalim will present the use of FairChoices in health benefit package development in Zanzibar. A second presentation will describe the use of EDPs for cancer priority setting in Rwanda. Both cases will address the policy decision, evidence and criteria used, stakeholder involvement, deliberation, resulting recommendations, and progress towards implementation and institutionalization.

Altea Sitruk will present WHO PRIORITI. She will explain how the framework links priority setting to governance, financing, implementation, performance monitoring and revision, and how it can be adapted to different contexts.

The session will conclude with a moderated discussion on lessons from Zanzibar and Rwanda, their relationship to PRIORITI, and how global guidance can support legitimate, implementable and sustainable country-led priority setting.

PRIORITIES 2026

Abstracts

Health Priorities in a World of Change

Thursday

8 October 2026

University of Bayreuth, Germany

Doing More with Less: Health System Efficiency of Local Governments in Nepal

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Background

In Nepal, federalization has transferred responsibility for Basic Health Service (BHS) delivery to local governments, resulting in variations in capacity and performance. Despite increased health sector investments, evidence on the efficiency of resource utilization at the local level remains limited. This study assesses the efficiency of local governments in delivering BHS to inform evidence-based resource allocation and strengthen health system performance.

Methods

A quantitative analytical study was conducted using secondary data from 753 local governments in Nepal during 2020–2022. Based on production theory and efficiency principles, data envelopment analysis (DEA) was used to assess the efficiency of BHS delivery using input-oriented CCR and BCC models, while scale efficiency was examined to assess operational optimality.

Results

The efficiency of local governments in delivering BHS in Nepal improved moderately over the study period. Mean CCR efficiency increased from

0.64 in 2020 to 0.68 in 2021 before slightly declining to 0.66 in 2022, whereas BCC efficiency remained relatively higher (0.76–0.79), suggesting comparatively stronger managerial performance. Scale efficiency consistently remained high (0.84–0.88), indicating that most local governments operated near the optimal scale and that inefficiencies were primarily associated with managerial and operational factors.

Conclusion

Substantial variation was observed in the efficiency of BHS delivery across local governments in Nepal, with inefficiencies primarily driven by managerial and operational limitations. DEA provides a useful evidence-based approach for monitoring health system performance.

Trust as a Priority-Setting Outcome: Scheme Performance, Constitutional Failure, and Reform Correction in Kenya's Social Health Authority

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Background

Public trust is the operating condition on which contributory health schemes depend - and its erosion is measurable in loss ratios, membership dropout, provider arrears, and litigation. Kenya's 2023 Social Health Insurance Act (SHIA) established the Social Health Authority (SHA) to achieve UHC in an economy where 80–85% of employment is informal and the tax-to-GDP ratio is 13%. Eighteen months later, the scheme carries a 158% loss ratio and the High Court has declared the rollout unconstitutional- making Kenya a critical case for how priority-setting decisions at the design stage determine both scheme viability and public trust. This paper identifies the priority-setting failures that produced this outcome and evaluates fiscally viable, rights-based corrections.

Methods

Narrative policy analysis is applied through three lenses: equity, fiscal sustainability, and context-responsiveness. Sources include international social protection standards, Kenya's legislation, the 2026 Economic Survey, Auditor-General reports, independent assessments, Government revenue reports, Ministry of Health reports, peer reviewed and gray literature.

Findings

Five interconnected priority-setting failures have compounded into a scheme performance crisis that is simultaneously destroying public trust. First, Section 26 of the SHIA conditioned access on contribution status- a constitutional right made contingent on payment, declared

unconstitutional by Kenya's High Court. Second, the SHA Means Testing Instrument overcharges approximately 80% of the poorest households and undercharges over 60% of the wealthiest, with a 39% exclusion error rate in the bottom 40%- a flaw the scheme was warned about before launch. Third, the 158% loss ratio reflects classic adverse selection: the unobservable informal majority cannot be compelled to contribute, producing a risk pool too sick and too small to be solvent. Fourth, the KSh 104.8 billion digital platform was procured without competitive bidding; 2.5% of contributions and 5% of claims flow to the private consortium owner under London arbitration. Fifth, only six in ten public facilities are adequately equipped to deliver the benefits promised- making every denied claim a trust-destroying encounter between citizen and state.

Conclusion

Restoring scheme performance requires fiscal repair and structural correction simultaneously- fiscal repair alone does not rebuild trust. Ring-fencing 25–30% of existing sin-tax excise and earmarking 1.0 percentage point of the existing 16% VAT would mobilise KSh 63–67 billion annually, closing the SHIF deficit and the indigent subsidy gap without new taxes. Structural corrections- repeal of Section 26, retirement of the Means Testing Instrument, separation of SHA's regulator and purchaser roles, contract renegotiation, and quarterly public reporting of loss ratios- each produce a visible, trust-restoring institutional signal. Many Sub-Saharan African countries face comparable design choices. Trust is the priority-setting outcome that makes or breaks scheme viability- and it is measurable.

Prioritizing and Costing RMNCH Innovations for Scalable Impact: A Combined MCDA and Costing Approach from Ethiopia

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Objectives

There is growing interest in LMICs in scaling promising health innovations to accelerate national health goals and achieve the 2030 SDGs. Many existing and promising innovations fail to scale up for various reasons, including a lack of evidence on their cost-effectiveness and budgetary impact. Amidst these evidence gaps and limited fiscal space, the objectives of this research are to develop and test an approach for prioritizing and costing reproductive, maternal, newborn, and child health (RMNCH) innovations in Ethiopia and to develop a scale-up plan for their implementation, informed by cost evidence and aligned with available resources from partners and government.

Methods

In 2025, a comprehensive RMNCH innovation mapping was conducted with the MOH and partners in which more than 100 innovations were identified. A multi-criteria- decision analysis prioritization framework was developed to enable the MOH to assess, prioritize, and select RMNCH innovations using clearly defined criteria. During the MCDA process, participants selected additional criteria and weights covering impact, feasibility, scalability, cost-effectiveness, sustainability, and alignment with national priorities. Upon shortlisting innovations, detailed costing analyses and resource mapping are underway to determine the financial, logistical, and operational requirements as well as potential resources available for scaling these prioritized innovations.

Results

Overall, more than 100 innovations were mapped during the maternal and child health innovation landscape assessment. Following the application of multi criteria decision analysis, four high-potential innovations were selected: (1) Neonatal Intensive Care Unit (NICU) Mentorship Program, (2) Preconception Care (PCC), (3) Integrated Kangaroo Mother Care (iKMC)/Mini-NICU, and (4) Geo Mapping of Immunization Zero-Dose & RED/REC Microplanning in Ethiopia. These innovations were prioritized based on their potential impact, feasibility, and scalability to strengthen maternal, newborn, and child health services.

Conclusions

Combining MCDA-based prioritization with detailed costing can provide a practical and transparent approach to selection innovations in resource-constrained settings. This approach supports governments in aligning innovation scale-up with affordability, system capacity, and equity objectives while strengthening the link between priority setting and planning.

CLOSING THE NCD GAP: PRIORITIZATION OF RHEUMATOID ARTHRITIS CARE IN ZANZIBAR'S ESSENTIAL HEALTH CARE PACKAGE

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¹ State University of Zanzibar

Background

Universal Health Coverage (UHC) is an important strategy to ensure populations receive the fundamental right to health, particularly in resource-constrained settings with competing health interests. With the rising prevalence of non-communicable diseases (NCDs) amidst infectious disease challenges, chronic disabling conditions such as rheumatoid arthritis (RA) are often overlooked. They often receive little attention in Essential Health Care Packages (EHCP) despite causing severe disability, reduced health-related quality of life (HRQoL) and economic hardship. In many low- and middle-income countries (LMIC) where rheumatological conditions were believed to be rare, their inclusion in EHCP are often hindered by the lack of locally generated evidence. This study describes how evidence generated in Zanzibar informed priority-setting deliberations and contributed to the inclusion of essential RA services within the revised Zanzibar EHCP (ZEHCP).

Methods

Evidence was derived from a prospective cohort of 135 patients with RA enrolled in Zanzibar's first rheumatology clinic and followed up for four years. Clinical characteristics, disease severity, treatment outcomes, and health-related quality of life (HRQoL) were assessed using validated instruments. A cost-effectiveness analysis (CEA) compared six treatment options from a health-care provider perspective. Incremental cost-effectiveness ratios were estimated and evaluated against a willingness-to-pay (WTP) threshold of US\$282 per quality-adjusted life year (QALY)

gained. Findings were integrated into the ZEHCP revision process through a structured priority-setting framework.

Results

Patients with RA presented at a relatively young age and commonly experienced delays exceeding one year before diagnosis and treatment initiation. At presentation, most had moderate-to-high disease activity and evidence of early joint damage, indicating a substantial burden of preventable disability. Following treatment, disease activity improved significantly; however, HRQoL remained substantially lower than among healthy controls, even in patients achieving disease control. Diagnostic delay was independently associated with poorer HRQoL outcomes.

Economic evaluation demonstrated that methotrexate monotherapy was the only RA intervention meeting the WTP threshold. Drug cost was found to be the single most influential factor in determining treatment option. The availability of locally generated evidence on disease severity, treatment effectiveness, HRQoL and CEA enabled transparent deliberations among policymakers, clinicians, and stakeholders.

Conclusions

The Zanzibar experience demonstrates how locally generated evidence can bridge the gap between research and policy. By combining locally generated data within a transparent decision-making framework, policymakers were able to determine suitable interventions for RA and incorporate them into the ZEHCP. The approach provides a practical and transferable model for other LMICs seeking to strengthen UHC through evidence-informed prioritization of neglected NCDs.

Thursday, 8 October, 11.00-12.30
Organized Workshop

Using FairChoices for Value Informed Priority Setting

Krishna Aryal¹, Kjell Arne Johansson¹

¹ Bergen Centre for Ethics and Priority Setting in Health, University of Bergen

FairChoices is an innovative analytics platform designed to help countries conduct rapid, policy-relevant cost-effectiveness analyses across long lists of health interventions, while incorporating equity and distributive outcomes into the decision process. As global health systems face increasing pressure to allocate limited resources transparently and fairly, tools like FairChoices are becoming essential for evidence-informed priority setting. In this interactive workshop, we will guide participants through real-world examples of how FairChoices is being used to support national priority-setting processes.

Attendees will work directly with the tool, explore its analytic framework, and learn how equity, financial risk protection, and population subgroups can be explicitly evaluated alongside traditional cost-effectiveness metrics. Krishna will be joined by members of the global FairChoices Analytics Team, offering participants a unique opportunity to engage with the tool's core developers and contribute to discussions about future applications in global and national decision making.

This workshop is ideal for researchers, modelers, HTA practitioners, policymakers, and students interested in practical, data-driven approaches to equitable priority setting.

From Country Application to a Global Public Good: Costing Health Benefit Packages with the WHO UHC Compendium

Rob Baltussen¹, Gerard Abou Jaoude², Gavin Surgey¹, Charlie Nederpelt¹, Wajeeha Raza³, Mizan Kiros Mirutse⁴, Filip Meheus³

¹ Radboudumc

² University College London

³ WHO

⁴ University of Bergen

Problem definition

Countries developing health benefit packages must determine not only which services should be prioritized, but also whether these services are affordable and implementable. This requires consistent service definitions and credible estimates of resource requirements, costs and budget impact. Producing such estimates is complex and time-consuming, requiring extensive data, technical expertise and numerous methodological choices. In many low- and middle-income countries, this work is further constrained by fragmented information systems and limited analytical capacity.

The WHO UHC Compendium provides standardized service definitions and structured information on the resources required for service delivery. Building on this architecture, Radboudumc and University College London developed a health system-wide costing model and applied it in Kyrgyzstan. The model is now being further developed into a common WHO costing resource.

This session will examine how UHC Compendium-based costing can support broader priority-setting processes, what was learned from its application in Kyrgyzstan, and what is required to develop the model into an adaptable global public good.

Session format and contents

The session will be chaired by Filip Meheus (WHO) and Rob Baltussen (Radboudumc). In a joint introduction, they will position the UHC Compendium and costing within the broader process of health priority setting in low- and middle-income countries. They will discuss how cost estimates can inform package design, assessment of fiscal feasibility, resource allocation and implementation planning.

Gerard Abou Jaoude (University College London) and Gavin Surgey (Radboudumc) will present the development and application of the costing model in Kyrgyzstan. The model generated initial estimates for 424 service bundles and refined estimates for 181 services prioritized by national stakeholders. The presentation will show how global data were contextualized, how different levels of costing precision supported successive policy decisions, and how the results informed package prioritization and assessment of affordability. It will also discuss limitations related to data availability, utilization estimates and assumptions about scaling up service coverage.

Charlie Nederpelt (Radboudumc) and Wajeeha Raza (WHO), will jointly present the further development of the Kyrgyzstan model into a common WHO costing model. They will describe how standardized global data on resource requirements and costs can be combined with country-specific information. They will also explain how the model could support rapid package costing, more detailed budget-impact analysis, implementation planning and the identification of gaps between required and available resources. The presentation will address requirements for accessibility, transparency, validation and long-term maintenance.

Mizan Kiros Mirutse (University of Bergen, BCEPS) will critically reflect on the presentations and the UHCC costing tool. He will also consider the role and limits of costing within priority setting, including how cost estimates should be interpreted alongside health impact, equity, financial protection and other social values.

The session will conclude with a moderated panel and audience discussion. It will address the appropriate balance between global standardization and country adaptation, the level of precision required for different policy decisions, and how costing can be integrated into legitimate and sustainable national priority-setting processes.

Just Pricing of Pharmaceuticals

Anton Klockhoff¹, Lars Sandman¹, Martin Henriksson², Niklas Juth³

¹ Linköping University, Department of Health Medicine and Caring Sciences, Division of Society and Health, National Centre for Priorities in Health

² Linköping University, Department of Health Medicine and Caring Sciences, Division of Society and Health, Centre for Medical Technology Assessment

³ Uppsala University, Department of Public Health and Caring Sciences, Centre for Research Ethics & Bioethics

Problem Definition and Objectives

Several European healthcare systems that apply value-based drug pricing have been criticized for not paying enough. It has been argued that low prices can delay market entry, that existing pricing frameworks fail to capture important elements of value, and that current pricing levels may undermine incentives for innovation and timely access to new treatments. At the same time, a growing body of empirical work suggests that some European countries may already be paying more for pharmaceuticals than the benefits justify, as all healthcare spending carries an opportunity cost in terms of forgone health.

This session focuses on three closely related questions.

- First, which types of value should be considered relevant when setting pharmaceutical prices?
- Second, to what extent should these values be reflected in prices?
- Third, what constitutes an acceptable and sustainable distribution of value between patients, healthcare systems, and the pharmaceutical industry?

The objective of this session is not to resolve these debates definitively, but to examine the evidence and justifications behind competing claims

from the perspectives of economics, philosophy, and law. We hope for a constructive discussion that clarifies key concepts, disentangles questions of value and questions of fact, and recognizes where evidence is strong, weak, or absent.

Participants will leave with a clearer understanding of the key issues currently debated within pharmaceutical pricing, how these issues can shape prices, and how the resulting prices impact surplus for patients, healthcare systems, and producers. By combining conceptual and normative analysis with empirical evidence, the session will help participants critically examine common claims about value-based pricing.

The session is presented by members of the multidisciplinary research project Just Pricing of Pharmaceuticals.

Theoretical Foundation

This session examines challenges to value-based pricing from philosophy, economics, and law. Philosophy asks which values should count and why. Economics shows how value affects prices and how it is shared. Law sets the legal limits for pricing systems.

Session Contributions

Introduction and Setting the Scene

Speaker: Martin Henriksson

Presentation 1

Speaker(s): Lars Sandman

Title: Cost-effectiveness, pharmaceutical pricing and the value flower -- doing some gardening

Description: In this presentation, we will briefly present two ideas on the relationship between value and pricing, a one-to-one relationship and an instrumental relationship, along with their pros and cons. We will also briefly present an analysis of selected petals from the so called 'value flower' to illustrate how ideas about added value aspects for pricing should be analyzed from the perspective of (1) what kind of value it is, (2) its likely

impact on pricing, and (3) how incorporating the value would affect the opportunity cost of drugs.

Presentation 2

Speaker(s): Anton Klockhoff

Title: Back to basics -- Applying fundamental microeconomics to real-world pricing evidence from Sweden

Description: Using empirical evidence from real-world reimbursement decisions in Sweden, we explain and apply fundamental principles of microeconomics to discuss whether current value-based frameworks result in reasonable distributions of surplus between producers and public payers.

Presentation 3

Speaker(s): Niklas Juth

Title: Four systems of drug pricing: legal and justice-based considerations

Description: There are different actual and conceivable systems for drug pricing, such as 1) the value-based one used in some European countries, 2) systems where governmental agencies determine the price to pay pharmaceutical companies based on an estimation of the companies' costs for research and development (R&D), 3) systems where R&D is done at public institutions like state-run universities, or 4) completely libertarian models, where pharmaceutical companies meet consumers of drugs directly on the market. Here, we compare these four ideal types of systems from the point of international human rights convention and justice-based egalitarian principles.

Session Format

The 90-minute session will include a 10-minute introduction, four 12-minute presentations, 30 minutes for discussion, and a 2-minute wrap-up.

Difficult choices, rapid decisions: adapting priority setting to time and resource constraints

*Altea Sitruk*¹, *Cassandra Nemzoff*², *Tom Sesay*³, *Andrew Mirelman*¹, *Anna Vassall*¹, *Shufang Zhang*⁴, *Rob Baltussen*²

¹ Department of Performance, Financing and Delivery, World Health Organization

² Radboud University

³ Directorate of Policy, Planning and Information, MOH Sierra Leone

⁴ World Bank/GFF

Objectives

Health systems are increasingly under pressure due to shrinking external funding, geopolitical instability, rising debt, and emerging health threats. As a result, there is an unprecedented need for rapid, evidence-informed, and country-led priority setting. Traditional health technology assessment (HTA) processes are not typically designed to produce timely recommendations under such conditions. Low- and middle-income countries (LMICs) in particular face difficult trade-offs: which services to protect, which to defer, and how to design or revise health benefit packages when time is limited, while data and institutional capacity are scarce. This session addresses an important gap between established priority setting approaches and the increasingly rapid decision-making demands of countries navigating crises.

Contents

This session draws on complementary frameworks: the WHO PRIORITI framework for evidence-informed deliberative priority-setting; adaptive HTA methodology; and emerging applications of rapid processes and artificial intelligence to accelerate evidence-informed decision-making. These are part of a "Priority Setting 2.0" agenda which upholds commitments to fairness, transparency, and accountability while building

the agility required in rapid decision-making contexts. The session also addresses questions of resource allocation under severe budget constraints and the implications of declining external aid for health in Africa and beyond.

Specifically, this session brings together the following four presentations:

1) The use of the WHO PRIORITI framework to respond to abrupt funding cuts in HIV, viral hepatitis, and STI programmes (Altea Sitruk, WHO)

This presentation will discuss the development of an early version of the WHO PRIORITI framework for evidence-informed deliberative priority-setting and its application to global recommendations for sustaining HIV, viral hepatitis and STI services following abrupt funding cuts. It will illustrate how the framework can be used to respond to the need for making difficult, time-sensitive trade-offs at both global and country levels.

2) Adaptive HTA: A methodological response to priority-setting under crisis (Cassandra Nemzoff, Radboud University)

Conventional HTA timelines and evidence generation are often not aligned with the speed required during crises or funding shocks. This presentation outlines the adaptive HTA approach, highlighting methods for rapid evidence review and iterative decision cycles, and discusses examples of how this approach has been embedded within national priority-setting processes while preserving rigor.

3) Rapid priority-setting in the design of a unified health benefit package in Sierra Leone (TBC: Tom Sesay/Michael Amara, MOH, Sierra Leone)

Sierra Leone's Ministry of Health will present its experience designing a unified health benefit package under significant time and resource constraints. The presentation will describe the topic selection, decision criteria, assessment and appraisal processes, highlighting the data sources used and the institutional and political challenges encountered. It

illustrates a practical example of rapid, country-led priority-setting in a low-resource context.

4) The use of artificial intelligence for rapid priority-setting in Rwanda (Andrew Mirelman, WHO)

A case example will be shown for AI applications to evidence synthesis in Rwanda. Specifically, it will highlight how AI has been used to facilitate the synthesis of cost-effectiveness evidence when prioritizing oral health services for national insurance schemes. The case study will highlight the learnings for implementation of such digital technologies across the evidence synthesis ecosystem.

The presentations will be followed by a moderated discussion on the shared lessons from the Sierra Leone and Rwanda experiences, pinpoint areas where further methodological development and international collaboration and support are needed, and highlight how countries can draw from the global guidance and approaches to implement rapid priority setting.

What is normal health? Reflecting on the equity consequences of using an age- and sex adjusted population reference group in absolute and proportional shortfall estimations

*Maartje Tromm*¹

¹ Erasmus Universiteit Rotterdam

Objectives

Severity weighting of incremental health benefits within Health Technology Assessment (HTA) serves to achieve an equitable allocation of limited healthcare resources. Two common operationalisations of severity are absolute and proportional shortfall (AS and PS), defined as the absolute and relative loss of Quality Adjusted Life Years (QALYs) with the disease and standard treatment as compared to the Quality Adjusted Life Expectance (QALE) in normal health, here referred to as the reference QALE. Though its exact definition differs across countries, the choice of reference QALE has received little attention in the literature. Our objective was to examine possible approaches to calculating the reference QALE, the reasons behind them, and implications for equity and policy making.

Methods

We first examined current methods of calculating the reference QALY in HTA guidelines of the Netherlands, Norway, and the United Kingdom, and searched the literature that contributed to the conceptualisation of AS and PS for their justification. We then investigated the normative underpinnings of AS and PS within the health economics literature and considered their relationship with current practice. Finally, we assessed the sensitivity of AS and PS outputs to changes in the reference QALE by analysing their functional forms.

Results

We found that in the Netherlands and the United Kingdom the reference QALE is calculated by adjusting the population average QALE for age and sex, while in Norway it is only adjusted for age. The academic and grey literature supporting the implementation of AS and PS suggest that the intended purpose of the reference QALE is to accurately represent the counterfactual QALE without the targeted disease, rather than a normative target. The Fair Innings and Prospective Health approaches have been cited as normative underpinnings of AS and PS, although only loosely reflected in their operationalisation. Within these approaches, the reference QALE most closely resembles the threshold of Fair Innings – a normative health target. Our findings suggest that leaving control variables that are highly predictive of QALE out of the calculation, such as socioeconomic status, leads to implicit prioritisation of worse-off groups. Varying definitions of the reference QALE may result in significantly different AS and PS outcomes.

Conclusions

Current calculation methods of the reference QALE seem to establish a middle ground between a counterfactual QALE without the targeted disease and a normative target QALE. Our analysis highlights the importance for policy makers to reflect on the normative objectives underlying the use of the reference QALE and shows how different definitions of the reference QALE may serve those objectives.

Scoping review of extended cost-effectiveness analysis in health policy assessment.

Lelisa Assebe¹, Nonvignon Justice, Walker Damian

¹ Health Economics and Financing, MSH

Background

This scoping review explores equity informed economic evaluation of health interventions, focusing on communicable and non-communicable diseases (NCDs), and immunization programs. The purpose of this scoping review is to explore the use of extended cost-effectiveness analysis (ECEA) in prioritization of health intervention and allocation of resource.

Methods

A scoping review was conducted to map the landscape of ECEA studies following the PRISMA-ScR guideline. A search was conducted using databases (PubMed, Medline, Web of Science, and Google Scholar) for ECEA studies published up to December 15, 2024, using keywords. An excel tool was developed to extract data on disease areas, geographic distribution, policy instruments, key findings and funding sources from the studies. The data were analyzed using descriptive statistics and narrative synthesis to identify trends and insights on use of ECEA's in health policy assessment.

Results

The review revealed that ECEA studies have grown over the past decades, with a focus on NCDs (23 studies) followed by immunization programs (10 studies), and communicable diseases (8 studies). The most studied NCDs include cardiovascular diseases, cancer, and chronic obstructive pulmonary diseases (COPD). Vaccines for children including

malaria vaccine and Human Papilloma Virus (HPV) vaccination were the main studied areas from immunization groups. The immunization programs primarily focused on childhood vaccinations including malaria vaccine and the Human Papillomavirus (HPV) vaccination. Geographically, most of the ECEA studies were conducted in low- and middle-income countries (LMICs), with one-fifth of studies were conducted in India and Ethiopia, and 5% in South Africa. The ECEA studies focused on evaluation of various policy instruments, including public finance, taxation, cash transfers, and subsidies etc. Health policies like scale-up of maternal health and communicable disease interventions, expansion of immunizations, alongside tobacco taxes were found to provide substantial health and Financial Risk Protection (FRP) benefits, especially for the poorest. Disease control priorities (DCP) grants were the primary source of funding for most of the studies.

Conclusions

The review underscores the substantial health and FRP benefits of health interventions, especially in LMICs. Policies addressing NCDs, immunization programs and communicable diseases improve health outcomes and reduce financial risks for vulnerable populations. However, the underrepresentation of certain regions and emerging health threats points to the need for broader, more inclusive ECEA studies. Expanding the geographic scope and addressing new health challenges will ensure more equitable and effective global health policies.

Patient-Related Evidence For the Assessment Of Digital Health Technologies to Inform Priority Setting

Annapoorna Prakash¹, Tummers Marcia¹, Pop Bianca², Oortwijn Wija¹

¹ IQ Health Science Department,, Radboud University Medical Center

² European Patients Forum

Problem definition

The rapid expansion of digital health technologies (DHTs) within health systems has increased the need for robust approaches to evaluate their value. DHTs exhibit characteristics such as iterative development, frequent updates, and adaptive artificial intelligence capabilities, which challenge the applicability of current health technology assessment (HTA) frameworks for assessing their value. While DHT-specific HTA frameworks have been developed to address these challenges, they offer limited support for capturing patient-related evidence. This is consequential because patient-related evidence is fundamental to understanding the benefits, harms, and broader implications of DHTs for patients and their communities. Failure to adequately incorporate such evidence may lead to inaccurate valuation of DHTs and inequitable priority-setting, particularly among populations facing digital exclusion and in rural and remote areas. To address this gap, this study identifies the dimensions and outcome measures to propose a framework that can be used to capture patient-related evidence in the assessment of DHTs.

Theoretical foundation

The study was conducted within the European Digital Health Technology Assessment Framework (EDIHTA) project, which aims to inform explicit priority setting, and uses the Warwick Patient Experience Framework (WaPEF) as a foundation for capturing patient-related evidence.

Methodology / empirical research context

A scoping review across Ovid Medline, Embase, Cochrane, Web of Science, and CINAHL was conducted on 13 December 2024. The references were screened using Rayyan. Data on DHT type, dimensions, outcome measures, validated instruments, and maturity lifecycle stages were extracted in Excel. Thematic analysis of outcome measures was conducted to clarify their meaning. Dimensions and outcome measures were then mapped to the WaPEF.

Results

The search identified 6,732 records, yielding 156 outcome measures across 12 dimensions, assessed with 48 validated tools. Thematic analysis identified substantial overlap of outcome measures among dimensions. Mapping dimensions and outcome measures to the WaPEF produced nine key dimensions: patient as active participant; responsiveness of services; lived experience; continuity of care; communication; information; support; caregiver burden; and satisfaction. Evidence on whether these should be assessed differently across DHT maturity stages was limited.

Conclusions

This study presents a framework of dimensions and outcome measures for assessing patient-related evidence of DHTs. This framework can support HTA bodies, researchers, and developers in generating consistent, meaningful patient-based evidence which can subsequently be used in priority-setting decisions. Since the framework is instrument-based rather than context-bound, it may be valuable in Low- and Middle-Income Countries (LMICs), where DHTs are scaling rapidly but HTA capacity for patient-related evidence remains limited.

Association of Body Mass Index, Sedentary Lifestyle, and HbA1c with Cardiac Autonomic Neuropathy in Type 2 Diabetes in Zanzibar

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Background

Cardiac autonomic neuropathy (CAN) is a serious but often underdiagnosed complication among type 2 diabetes mellitus (T2DM) patients that increases the risk of morbidity and mortality. Evidence on the burden of CAN and its associated factors in Zanzibar is very limited. Therefore, this study aimed to determine the prevalence and predictors of CAN in patients with T2DM attending clinics in Zanzibar.

Methods

This was a hospital-based cross-sectional study among patients with T2DM attending Mnazi Mmoja Hospital, Zanzibar. All participants were selected by systematic random sampling. CAN was measured using the CAN 504 analyzer with Ewing's cardiovascular reflex tests. Sociodemographic,

clinical, anthropometric, and biochemical data were collected using standardized procedures. A modified Poisson regression model with robust variance was used to identify factors associated with CAN.

Results

A total of 364 patients were analyzed, with a mean (SD) age of 56 (10.9) years, and the majority were female (n=243, 66.8%). The prevalence of CAN was found in 291 (79.9%) patients. Of those with CAN, 220 (60.4%) had early CAN, 65 (17.9%) had definite CAN, and only 6 (1.6%) had severe CAN. Patients with overweight body mass index (BMI) had higher risk of CAN (aPR 1.16, 95% CI 1.01–1.33, $p = 0.031$). Also, sedentary lifestyle (aPR 1.41, 95% CI 1.14–1.75, $p = 0.002$) and elevated HbA1c levels (aPR 1.23, 95% CI 1.07–1.41, $p = 0.003$) had higher risk.

Conclusion

This study revealed a high prevalence of CAN among adults with T2DM attending a tertiary diabetes clinic in Zanzibar. Overweight BMI, sedentary behavior and higher HbA1c was associated with higher CAN prevalence. These findings support earlier screening and targeted risk factor modification in high-risk patients.

Policy integration under pressure: Priority-setting in potential times of crises and war in Municipal Health Care and Social Care in Sweden

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Problem definition

Priority-setting under scarce resources in healthcare and social services is a persistent challenge, even under stable conditions. In crises and wartime situations, these challenges intensify as resource constraints increase, coordination becomes more demanding, and responsibilities are redistributed across organisational and administrative boundaries. Under such conditions, actors responsible for Municipal Health Care and Social Care must balance competing needs while maintaining functionality, equity, and access to care for vulnerable populations. Despite growing attention to crisis preparedness and societal resilience, research remains limited regarding how policy integration for priority-setting is organised and exercised within municipal health and social care systems. The aim of this study is to analyse how policy integration for priority-setting is shaped, organised, and exercised among actors responsible for municipal healthcare and social services in crisis situations, in both peacetime and wartime contexts.

Theoretical foundation

The study draws on March's (1999) framework for policy integration to analyse how priority-setting is coordinated across organisational boundaries through policy consistency, policy interdependence, and structural connectedness under conditions of uncertainty and resource scarcity

Methodology

The study is based on scenario-based focus group interviews with actors holding strategic and operational responsibilities within Municipal Health Care and Social Care in Sweden. An abductive analytical approach was applied, involving an iterative interplay between empirical material and theoretical concepts.

Results

The findings indicate that policy integration for priority-setting is characterised by uneven development of policy consistency, policy interdependence, and structural connectedness (March, 1999), making it an ongoing process rather than a stable organisational condition. Actors largely share understandings of responsibility, needs, and priority groups within municipal health and social care. However, integration is constrained by interdependencies across municipal, regional, and national levels, creating uncertainty regarding responsibilities, resource allocation, and priorities in crisis and wartime situations. Actors call for clearer strategic guidance for priority-setting while emphasising the need for local flexibility, pragmatic solutions, and professional judgement when established coordination and support structures are disrupted or insufficient

Conclusions

The study suggests that achieving coordinated, sustainable, and legally robust priority-setting during crises depends on both effective policy integration and organisational conditions that support local adaptation and informed professional judgement. The findings highlight the challenges of aligning the dimensions of policy integration (March, 1999) to support priority-setting across organisational boundaries in crisis and wartime contexts.

Temporal Trends and Inequities in the Continuum of Care for Maternal and Newborn Health Services in Nepal, 2006-2022

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² Nepal Health Economics Association, Nepal

Problem definition

Maternal and newborn health depends on a continuous care pathway from pregnancy through childbirth and the postnatal period. Although Nepal has expanded coverage at aggregate level, national averages often mask the inequities in completion of the full care pathway across socio-economic strata. We assessed temporal trends and inequalities in continuum-of-care (COC) for maternal and newborn health services in Nepal from 2006 to 2022.

Methodology

We analyzed Nepal Demographic and Health Survey data from 2006, 2011, 2016, and 2022. The analysis included the most recent live birth in five years preceding each survey; with sample size of 4,079, 3,938, 3,926, and 2,880 in 2006, 2011, 2016 and 2022 respectively. COC was defined as receipt of four or more antenatal care (ANC) visits, institutional delivery, and post-natal care within two days of delivery. Multidimensional poverty was assessed across three dimensions—health, education, and living standards—using a total of 10 indicators. We accounted for clustering and stratification through weighted analysis. Inequity was quantified using absolute concentration indices (ACI) and relative concentration indices (RCIs). We examined intersections of poverty with education and ethnicity. A Fairlie nonlinear logit decomposition assessed the contribution of population characteristics to the 2006-2022 coverage change.

Results

At national level, COC coverage increased from 10.9% in 2006 to 61.5% in 2022. While multidimensional poverty based ACI increased nominally from 3.2 to 3.3 between 2006 to 2022, RCI declined from 0.3 to 0.1 in the same period. There are persistent equity gaps across provinces: 2022 COC coverage was 43.7% in Madhesh and 52.5% in Karnali, compared with 76.0% in Sudurpashchim, 72.0% in Lumbini, and 71.9% in Gandaki. Intersectional differences were pronounced. In 2022, coverage was 37.4% among poor, relatively disadvantaged ethnic group women with primary education or less, versus 78.6% among non-poor, relatively advantaged ethnic group women with secondary education or above; with markedly lower odds of COC coverage (OR 0.16, 95% CI 0.12-0.22) among former group. There was equity gap of 41 percentage points (PP) between most advantaged and most disadvantaged group in intersectionality analysis. In decomposition analysis, 50.6 PP increase between 2006 and 2022 was 10.0% explained by compositional changes with education having largest contribution (4.8 points) and provinces contributing negatively (-2.1 points).

Conclusions

Inequities persist and are more pronounced when multiple forms of disadvantages intersect suggesting that targeted interventions, particularly aiming to improve coverage among women facing multiple forms of disadvantages can be helpful.

Prioritizing Provider Payment for Primary Health Care: Lessons from Ethiopia's Capitation Payment Reform under Community-Based Health Insurance

*Habtamu Wollebo*¹, Alemnesh Anjelo¹, Taema Bezabih², Felegush Lakewu³, Shewa Bedane³

¹ Clinton Health Access Initiative

² Deputy Director General, Ethiopian Health Insurance Services

³ Ethiopian Health Insurance Services

Problem definition

How a health system pays primary-care providers is itself a priority-setting decision, determining which services are rewarded and how pooled funds move between primary and hospital care. Ethiopia introduced capitation to address four structural weaknesses of fee-for-service (FFS) reimbursement under Community-Based Health Insurance (CBHI): scheme insolvency due to provider moral hazard; administrative overload and months-long payment delays; medicine stock-outs that eroded community trust; and absent enrollment incentives. Most evidence overlooks implementation-stage practices. This study evaluates Ethiopia's capitation implementation and its effects on different components of health service delivery.

Theoretical foundation

Drawing on strategic-purchasing theory and provider-payment agency models (Ellis & McGuire; Robinson), payment design determines whether the dominant risk is over-provision (FFS) or under-provision (capitation). Strategic purchasing reframes prospective payment as an allocation lever that prioritizes the primary level as the steward of pooled resources.

Methodology

A mixed-methods final evaluation compared capitation and control (FFS) facilities across all implementing regions, combining a patient chart audit (684 charts), prescription review, medicine-availability inventory, patient exit interviews, a provider payment-preference survey (186 respondents), reimbursement data, and focus group discussions with facility and scheme staff, analyzed descriptively and thematically after ethical clearance.

Results

Member-to-facility mapping evolved from top-down administrative assignment toward community engagement; participatory mapping reached 90% satisfaction, while administrative mapping produced resistance and bypass. Rate-setting matured through three generations but was set on available revenue only without actuarial costing, leaving facilities underpaid, the weakest implementation link. Capitation enabled proactive procurement, raising medicine availability (87% vs 80%) and shortening waiting times (under one hour, 88% vs 78%). Standard-treatment-guideline adherence was higher (93.3% vs. 89.5%), and underprovision was lower with no rise in inappropriate referrals. Patient satisfaction (90% vs. 81%) and 78% of providers favored capitation.

Conclusions

Ethiopia's expansion from four to over 400 districts in five years shows that capitation enhances facility cost control, product availability, financial sustainability, and service quality and strengthens gatekeeping without suppressing appropriate referrals—turning facilities into accountable budget holders. Strengthening implementation requires four specific actions: annual inflation-linked rate revision with actuarial costing; a pharmaceutical supply agreement guaranteeing reliable delivery; quality-based rather than volume-based facility categorization; and mandatory participatory digital mapping.

Health Investment Package for Low-Income Countries: A Cost-Effectiveness Analysis Using FairChoices for Global Development Aid Donors

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Problem Definition

Development Assistance for Health (DAH) declined an estimated 29% in 2025 - the largest contraction on record, with the share directed to low-income countries (LICs) falling from over 50% in 2000 to approximately 25% today. LICs in sub-Saharan Africa face average total health expenditure of just \$38 per capita, of which only \$7 is government spending. Unlike lower-middle-income countries (LMICs), LICs have fewer domestic resources to build resilient, self-funded health systems. Amid this scarcity, donors and policymakers need transparent, evidence-based tools to determine which interventions to fund first.

Methodology

Using the FairChoices R-package framework, 121 health interventions across 19 sub-Saharan African LICs (combined population ~415 million) were ranked by Marginal Cost-Effectiveness Ratio (MCER) - marginal health effects divided by marginal costs, from baseline to target coverage. Costs and effects measure the difference between 0% coverage and a predefined, expert-determined feasible UHC target, reflecting provider service delivery costs only; capital and indirect patient costs are excluded and would need to be added for a full cost estimate. Equity is embedded by anchoring every package in a non-negotiable bundle (Family Planning, Pregnancy and Childbirth, Vaccines, and Acute Childhood Illness) costing

\$10.62 per capita, which disproportionately benefits women, newborns, and children. Remaining interventions were added via a greedy algorithm in strict MCER order, producing packages at approximately \$15, \$20, and \$25 per capita, with expert clinical review excluding interventions undeliverable at primary care level.

Results

The \$15 package adds 17 interventions beyond the anchor, with trachoma treatment (\$0.45/healthy year) the most cost-effective. The \$25 package expands to 31 interventions, including TB-HIV-Malaria, mental health, and basic surgery. Thirty-nine interventions fell outside all packages due to high cost or poor cost-effectiveness.

Conclusions

These results can inform discussions among global development aid donors on which services to prioritize in future development assistance programs in LICs, offering a replicable model for cost-effective and equitable resource allocation.

PRIORITIES 2026

Abstracts

Health Priorities in a World of Change

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Evidence Informed Priority Setting: Design and application of priority setting criteria in Nepal's health benefit package revision

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Research gap and objective

Health systems globally face rising non-communicable disease burdens, fiscal constraints, and increasing pressure to deliver equitable and sustainable services. Challenges traditionally associated with low-income countries, such as limited resources, governance complexity, and implementation gaps, are now increasingly universal. Nepal's recent revision of its Basic Healthcare Services Package (BHSP) offers an opportunity to examine what works, and why, in evidence-informed health reform under constrained conditions. We aim to describe and reflect on a nationally led, evidence-informed priority-setting process used to revise Nepal's BHSP, to demonstrate design and application of priority setting criteria to inform revision of national health benefit package.

Methods

Nepal's Ministry of Health and Population implemented a multiphase priority-setting approach combining quantitative modelling and structured deliberation. Approximately 300 candidate interventions were identified through policy review, international recommendations, and stakeholder consultation. Six explicit prioritization criteria - health impact, disease severity, equity, policy relevance, social impact, and feasibility - were developed and validated across government levels.

Cost-effectiveness and severity were analyzed using the FairChoices: DCP Analytics Tool, while interventions falling within a defined “decision buffer zone” were assessed through documented, values-based deliberation involving policymakers, clinicians, and technical experts. Final validation and endorsement are ongoing within government decision-making processes with final results expected to be published before the conference dates.

Results

Preliminary analysis identified around 100 priority interventions for public financing. The revised package shows improved alignment with disease burden, equity concerns, service delivery capacity, and fiscal realities. Beyond technical outputs, the process strengthened transparency, cross-sectoral learning, and trust within a federal governance structure, key components of system resilience.

Conclusions

Nepal’s experience demonstrates how explicit criteria, integrated evidence, and inclusive deliberation can support effective health reform. The approach offers transferable lessons for countries, high- and low-income alike, seeking to strengthen universal health coverage through learning-oriented, resilient priority setting in complex health systems.

Reducing the Complexity of Health Benefits Package Revision: A Practical Application of the WHO UHC Compendium

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Problem definition

The WHO UHC Compendium, with over 500 interventions and 3,700 associated activities, is a tool designed to make benefits package design easier, but it can itself become the obstacle. For LMICs with tiny budgets and limited capacity in time, skills, and funding, comprehensiveness is not a feature; it is a challenge. Without a practical approach to work through this breadth, countries risk either abandoning the review or producing packages that miss the highest-value services. Theoretical foundation This work draws on the evidence-informed deliberative process (EDP) framework, which integrates technical analysis with structured governance to guide health benefits package decisions. Combined with the UHCC's standardised service definitions and resource requirements, this offers an adaptable approach to explicit priority setting in settings with limited health technology assessment capacity.

Methodology / empirical research context

We present a practical methodology for applying the UHCC in resource-constrained settings, illustrated through two LMIC applications. A staged prioritisation approach reduces review intensity: services meeting established cost-effectiveness thresholds or foundational criteria are automatically included, cutting the number requiring full deliberative appraisal. Remaining services undergo structured multi-criteria deliberation through technical working groups, incorporating evidence on cost-effectiveness, disease severity, equity, and feasibility. Service-level costing covers all services, and financing scenarios are modelled to identify realistic coverage options within available fiscal space.

Results

The staged approach cut the deliberative review from 500+ services to a manageable subset without losing rigour. In one country, 182 services were prioritised from 424 reviewed. In the other, a core package of 27 services covering pregnancy, HIV, TB, child health, and basic diabetes care (inclusive of medicines) came to USD ~30 per capita. Both gave decision-makers concrete, costed options rather than an unmanageable list.

Conclusions The WHO UHCC can be applied in LMICs without reviewing every intervention from scratch. Staged inclusion, structured deliberation, and scenario modelling reduce the burden while keeping the package anchored to the highest health gains within available resources. Countries with limited HTA capacity can use this approach to institutionalise priority setting. It has been applied; it works.

Social Health Insurance in Ethiopia: A Synthesis of Evidence on Willingness to Enroll, Institutional Preparedness, Fiscal Space, and Service Readiness as a Platform for Policy Action

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Ethiopia enacted Proclamation No. 690/2010 establishing a Social Health Insurance (SHI) scheme for formal sector employees, yet the program has remained non-operational for over fourteen years. With the government renewing its resolve to launch SHI and the National Health Compact (2025) projecting a doubling of the government health financing share by 2030, a consolidated review of current evidence is urgently needed. This narrative review synthesizes published evidence on four dimensions critical to SHI implementation: willingness to join and pay (WTJ/WTP), institutional preparedness, fiscal space, and health service availability and readiness.

Searches were conducted across PubMed/MEDLINE, Google Scholar, Scopus, and Hinari, supplemented by grey literature from the World Bank, WHO, ILO, UNICEF, and the Ethiopian Ministry of Health, covering 2010 to 2025. Pooled WTP for SHI among the formal sector workforce was 42.25% in a 2023 meta-analysis (19 studies), with average WTP at 1.6% of gross monthly income, well below the proposed 3% premium. Willingness to join ranged from 47% to 74% across settings, moderated by income, knowledge, quality perceptions, and provider network scope. Institutional readiness is constrained by gaps in EHS claims management, ICT infrastructure, and strategic purchasing capacity. Fiscal space is restricted by a tax-to-GDP ratio of only 6.8% and persistent high inflation, although the National Health Compact signals new financing ambition. Service readiness in public facilities is critically low, with basic amenities available in only 39% of facilities and diagnostics in 40%.

The four domains are deeply interconnected, and a launch that addresses WTP concerns without resolving service quality deficits will reproduce the

same impasse that has persisted since 2010. Coordinated, evidence-informed reform across all four domains is a prerequisite for a viable and equitable SHI program in Ethiopia.

Lessons for Priority Setting through Publicly-funded Health Insurance Schemes: Evidence from a Systematic Review and Meta-analysis in India

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Problem definition

Many countries are expanding publicly-funded health insurance (PFHI) to accelerate progress towards universal health coverage (UHC), yet evidence on whether these large public investments improve healthcare access, financial risk protection (FRP), and population health remains fragmented. India has implemented one of the world's largest PFHI programmes—Pradhan Mantri Jan Aarogya Yojana (PM-JAY), alongside several state insurance schemes, providing an important opportunity to examine whether insurance expansion achieves its intended objectives. We systematically synthesised evidence on the impact of PFHI in India.

Theoretical foundation

Priority-setting in health systems requires that limited public resources are directed towards interventions and policies that generate meaningful improvements in health, equity, and financial protection. PFHIs therefore represents not only a financing mechanism but also a major allocation decision whose performance should be evaluated using robust empirical evidence. Systematic synthesis of implementation experience can strengthen evidence-informed decisions on the design, expansion, and refinement of such programmes across diverse healthcare settings.

Methodology

We systematically searched PubMed, Embase, Web of Science and Scopus, supplemented by grey literature. Empirical studies evaluating central or

state PFHIs were included irrespective of study design. Outcomes included healthcare utilisation, out-of-pocket expenditure (OOP), catastrophic health expenditure (CHE), impoverishment, health outcomes, and quality of care. Random-effects meta-analyses were performed for outcomes suitable for pooling, remaining evidence was synthesised narratively.

Results

A total of 121 studies were included. Insurance coverage was associated with an increase in hospitalisation-rate among insured by 8% (RR 1.08; 95% CI: 1.01–1.17). Studies conducted before and after introduction of PM-JAY, reported overall hospitalization-rates of 6% (5%–7%) and 9% (8%–11%), respectively. Most studies (66%) reported reductions in OOP expenditure among insured. PM-JAY beneficiaries had a mean OOP expenditure of US\$324 (95% CI: US\$188-US\$450). Evidence on CHE was mixed, although 26 of 30 studies reported lower CHE among insured, the reduction was statistically significant in only 61% studies. Evidence on health outcomes and quality of care was limited but indicated scheme-specific reductions in mortality, improvements in morbidity and care processes, and no evidence of increased length of stay.

Conclusions

PFHIs in India have expanded access to inpatient care and are associated with reductions in OOP spending. Translating these gains to effective FRP will require further strengthening of scheme design, implementation and monitoring. Future research should prioritise adequately powered quasi-experimental designs with credible counterfactuals, alongside triangulated use of claims and household-survey data to better establish causal impact of insurance coverage.

Creating Fiscal Space for health care services through Strategic Reprioritization: Evidence from Nepal

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Problem Definition

Expanding fiscal space for health is a central objective of Nepal's National Health Financing Strategy (NHFS) 2023–2033. The NHFS envisions allocating 10% of the total government budget to health. Yet recent budget trends suggest a movement in the opposite direction. After reaching a historic high of 7.46% during the COVID-19 response in FY 2021/22, the health sector's share of the national budget declined to 5.75% in FY 2022/23, 4.92% in FY 2023/24, and 4.88% in FY 2024/25. Health competes with other sectors for limited public resources. Given that total health expenditure in Nepal already approaches 5% of GDP and SDG costing estimates suggest that approximately 4% of national resources should be allocated to health and well-being, opportunities to substantially expand fiscal space through additional public funding appear limited. This highlights the need to explore efficiency gains as an alternative source of fiscal space.

Objective and method

The objective of this study is therefore to assess the potential for improving health system efficiency through reducing avoidable hospitalisations for Ambulatory Care Sensitive Conditions (ACSCs) and to estimate the extent to which such improvements could create fiscal space for strengthening basic health care services. The paper evaluates health service delivery performance using hospitalisation rates for selected ACSCs as indicators of primary health care effectiveness and health system efficiency.

Results

The findings indicate that hospitalisation rates for several ACSCs have increased or fluctuated over time, suggesting space for improvements in primary health care delivery. Significant variations remain across conditions and population groups, indicating continued opportunities to reduce avoidable admissions. ACSCs account for 17–22% of total hospitalisations, demonstrating the substantial scope for efficiency improvements through strengthened primary care. These inefficiencies represent an opportunity to generate fiscal space within the existing health budget. Redirecting resources from avoidable inpatient care toward essential primary health care services would improve both technical and allocative efficiency while enhancing health outcomes.

Conclusions

When additional funding is constrained, the most realistic source of fiscal space is not more money, but better use of the money already available. Reprioritising investments toward basic health care is not only a health system improvement strategy but also a practical fiscal strategy for sustaining progress toward Universal Health Coverage and the goals of the National Health Financing Strategy.

What Implementation Teaches Priority-Setting Processes for Essential Packages of Health Services

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Problem definition

The Essential Package of Health Services (EPHS) translates health priorities into explicit, defensible, financially accountable commitments. In many countries, EPHS design is informed by priority-setting processes that combine evidence, criteria, stakeholder engagement, institutional judgement, and social values.

Good design does not secure success. An EPHS succeeds when implementation expands effective coverage, reduces inequalities, and strengthens financial protection. If services cannot be delivered in low-capacity settings, if administrative or digital routes block disadvantaged groups, or if patients still face heavy out-of-pocket payments, the issue is not only delivery failure. It signals that priority-setting assumptions need revision.

It asks what implementation experience should bring back into priority-setting processes for EPHS. How should administrative capacity, subnational readiness, digital exclusion, local agency, accountability,

equity, and financial protection reshape criteria, sequencing, and revision of an EPHS?

Theoretical foundation

This session treats EPHS priority setting not as a linear process for selecting services, but as a learning mechanism for defining, testing, and revising an EPHS. Implementation makes feasibility, fairness, and financial protection visible.

Feasibility must be practical. Can selected services be delivered at national, provincial, district, and facility levels? Are workforce, supply chains, data systems, financing, and accountability strong enough? Can the same promise reach underserved areas, or only prepared places? If a service is undeliverable, that evidence should influence future criteria, sequencing, and resilience planning.

Equity must move from principle to design. It should shape rollout, access routes, monitoring, and correction. If prepared areas benefit first, digitally excluded groups fall behind, or patients carry hidden burdens, future EPHS processes should reconsider how equity, feasibility, financial protection, and readiness are weighed.

Empirical research context

This session brings together implementation experiences from Pakistan, Kazakhstan, Sudan, and England. The cases differ in income, institutional capacity, governance, and fragility.

Pakistan shows how a national EPHS meets provincial and district variation in readiness, management capacity, service availability, resources, and delivery conditions.

Kazakhstan shows how governance, data systems, and implementation capacity shape the translation of package decisions into usable services.

Sudan provides a case of EPHS implementation under prolonged conflict, where insecurity, displacement, disruption, scarcity, and fragile delivery capacity widen the design–implementation gap. It asks how EPHS priority setting should account for feasibility, resilience, and staged implementation in unstable environments.

England adds an analogous high-income case rather than a conventional EPHS case. The NHS 10 Year Health Plan—through neighbourhood care, digital access, population-based delivery models, new contracts, and Integrated Care Boards—shows how neutral-looking reforms may widen inequalities if equity is not built into sequencing, access design, and performance management.

Results

It offers three contributions to Priority Setting 2.0.

First, EPHS success should be judged by whether implementation improves effective coverage, reduces inequities, and strengthens financial protection.

Second, implementation exposes hidden assumptions. A service may be justified by evidence, disease burden, or social value, yet remain difficult to deliver where workforce, supply chains, data systems, or local accountability are weak. Such findings should affect criteria, sequencing, monitoring, and revision.

Third, equity must become implementation-sensitive within EPHS priority setting: where rollout begins, who may be left behind, which non-digital routes must remain, what support patients and implementers need, and when a decision should be corrected.

Together, these contributions reframe the implementation gap as evidence about priority-setting quality. The expected output is an account of implementation-sensitive criteria, equity safeguards, sequencing, accountability, and revision pathways for EPHS priority setting.

Conclusions

An EPHS is not complete when services are selected. It becomes meaningful when implementation turns those services into real, equitable, financially protective access.

Implementation learning must travel back into EPHS priority setting. It shows which decisions were realistic, which groups were left behind, which capacities were overestimated, and which accountability mechanisms should have been designed earlier.

By bringing together experiences from Pakistan, Kazakhstan, Sudan, and England, the session argues for a model of EPHS priority setting that learns from implementation to improve coverage, reduce inequities, and strengthen financial protection.

Who Benefits from Health Sector Subsidies in Ethiopia, and How Much?

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Ethiopia has committed strongly to universal health coverage (UHC), prioritizing access for rural and vulnerable populations. This study examines who benefits from public health spending, drawing on three household surveys, the CBHI national expenditure and utilization survey (2020), the household consumption and welfare monitoring survey (2015/16), and the Ethiopia Socioeconomic Panel Survey (2021/22), with the Ministry of Health's service cost database. The study uses a meta-analysis based on benefit incidence analysis (BIA) to estimate concentration indices across socioeconomic strata, facility types, and regions.

The annual subsidy averages USD 15.65 per capita, split across hospitals (USD 5.0), health centers (USD 9.0), and health posts (USD 1.7). Subsidy distribution favors wealthier households: the richest quintile captures 27% of total subsidies versus 14% for the poorest, with hospital services most skewed toward the better-off (30% richest vs. 12% poorest). Regionally, per capita subsidies range six-fold, from USD 39 in Addis Ababa to under USD 7 in Tigray and South Ethiopia Region. Subsidy use is also least equitable within Oromia and Amhara, Ethiopia's two largest regions.

These results suggest Ethiopia's UHC trajectory is sound, but public subsidies still disproportionately benefit wealthier and urban populations. Addressing rural and regional disparities will require coordinated multisectoral policy action, and equity-focused priority-setting of the health interventions.

A Framework and toolbox for person-centred integrated long-term care

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Problem Definition

There is a need to improve long-term care (LTC) across the EU by advancing person-centeredness and integration (PC-I-LTC). PC-I-LTC address the diverse needs and preferences of older adults, as well as those of their formal and informal caregivers, while also considering social inequalities. However, there is a need for a comprehensive framework that adopts a bottom-up perspective and translates them into social added value using the Social Return on Investment (SROI) methodology.

Methodology

First, literature reviews were conducted to map existing evidence on LTC concepts related to ecosystems, person-centeredness, information and communication technologies (ICT), and SROI. In addition, a mixed-methods approach was applied, including semi-structured interviews with care recipients and their formal and informal caregivers, as well as quantitative analyses. Furthermore, co-design and community engagement methodologies, in-depth interviews, and online consensus workshops were carried out to ensure stakeholder involvement.

Results

A framework was developed that incorporates the perspectives of relevant stakeholders. Through an integrated toolbox, the framework supports the identification of existing gaps and care needs and translates them into concrete actions while also assessing their potential social added value.

Conclusions

Future research should evaluate the extent to which the framework and its integrated toolbox can facilitate the transformation of existing LTC structures, enabling them to better align with the principles and normative requirements of PC-I-LTC.

Beyond Identifying Priorities: Challenges of Health Research Priority-Setting in Iran

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Problem Definition

Despite repeated efforts to set health research priorities in Iran, research investments and outputs remain insufficiently aligned with national health needs. Limited understanding of the barriers affecting priority-setting has reduced the effectiveness of these initiatives. This study aimed to identify challenges in the health research priority-setting process in Iran.

Theoretical Foundation

The study was informed by institutionalization theory, which emphasizes embedding decision-making processes within routine organizational structures. Key dimensions included governance, policy formalization, resource allocation, stakeholder engagement, organizational capacity, and monitoring and evaluation.

Methodology

A qualitative study was conducted in two phases. First, Iranian and international evidence on challenges of health research priority-setting in Iran was reviewed. Second, a stakeholder dialogue was held with researchers, policymakers, research managers, and funders to discuss and validate the findings. Data were analyzed using thematic content analysis.

Results

Challenges were grouped into four domains: managerial, structural, process-related, and motivational. Major barriers included weak

stewardship, frequent managerial turnover, limited stakeholder participation, insufficient transparency, inadequate use of explicit prioritization criteria, weak evidence and information systems, poor monitoring and evaluation, misaligned academic incentives, and limited translation of priorities into funded research.

Conclusions

Strengthening governance, institutionalizing transparent and participatory mechanisms, aligning incentives with national health needs, and improving accountability systems are essential to enhance the effectiveness and sustainability of health research priority-setting in Iran.

Cost-effectiveness of Population-based Screen and Treat for Anemia Reduction (STAR) Strategy in India: A Model-based Analysis alongside a Randomized Controlled Trial

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Problem definition

Anaemia remains a major public health challenge across many low- and middle-income countries (LMICs). Despite substantial investments in supplementation programmes, uncertainty remains regarding the most efficient implementation strategies for improving population health. We evaluated the cost-effectiveness of the Screen-and-Treat for Anaemia Reduction (STAR) strategy compared with India's routine Anaemia-Mukt Bharat programme.

Theoretical foundation

Priority setting requires identifying interventions that maximise health gains from limited resources. Economic evaluation provides a framework for comparing alternative programme designs and informing scale-up decisions.

Methodology

A model-based cost-utility analysis was conducted alongside a cluster-randomized trial. Decision-tree models simulated cohorts of 100,000 adolescent girls and women of reproductive age. Costs were estimated from an abridged societal perspective and outcomes measured as quality-adjusted life years (QALYs).

Results

STAR generated an additional 621 and 589 QALYs per 100,000 adolescent girls and women of reproductive age, respectively. Incremental cost-effectiveness ratios were US\$1,094 and US\$1,192 per QALY gained, with an 87% probability of being cost-effective at India's willingness-to-pay threshold.

Conclusions

STAR represents a cost-effective implementation strategy for anaemia control. Beyond India, the findings demonstrate how economic evaluation can support evidence-informed prioritization of preventive health programmes and efficient resource allocation in LMICs.



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