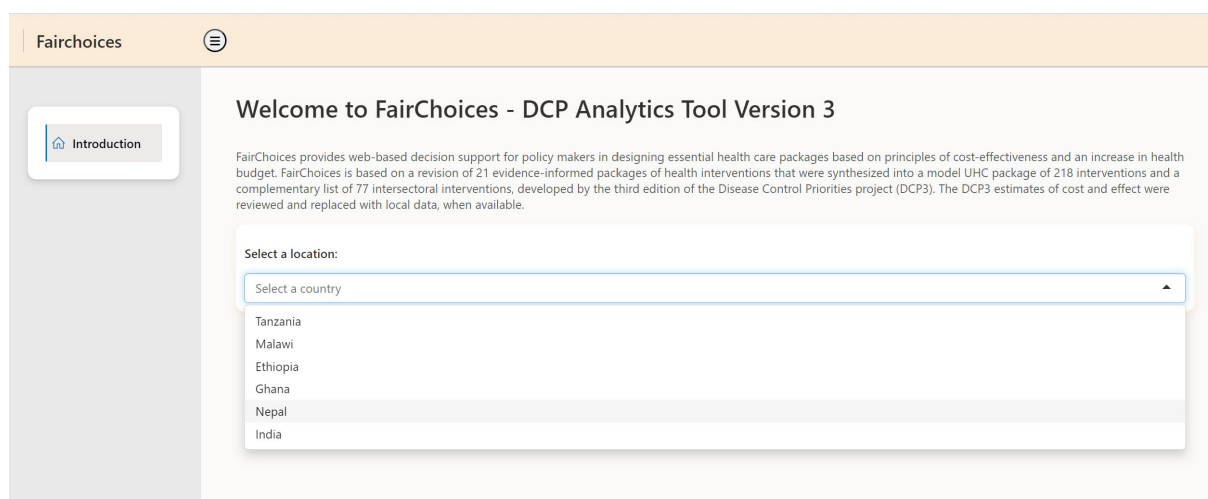


FairChoices user manual for policy makers

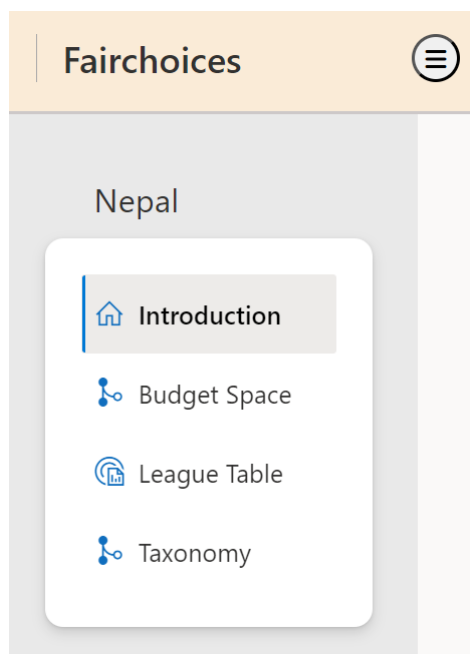
Landing page

The landing page is where you select your location of interest. In the example below we select Nepal.



Sidebar menu

Once a location has been selected, a sidebar menu will appear. The options are Budget Space, League Table, and Taxonomy.



Budget space

In the Budget Space module you can project how much extra money you will have to spend in your health budget over a period of, for example, 10 years. Based on the WHO's Global Health Expenditure database, we use information from the past to project a trend into the future in the areas of *government*, *external*, *private sector*, and *out-of-pocket* health expenditure.

Starting year

2020

Target year

2033

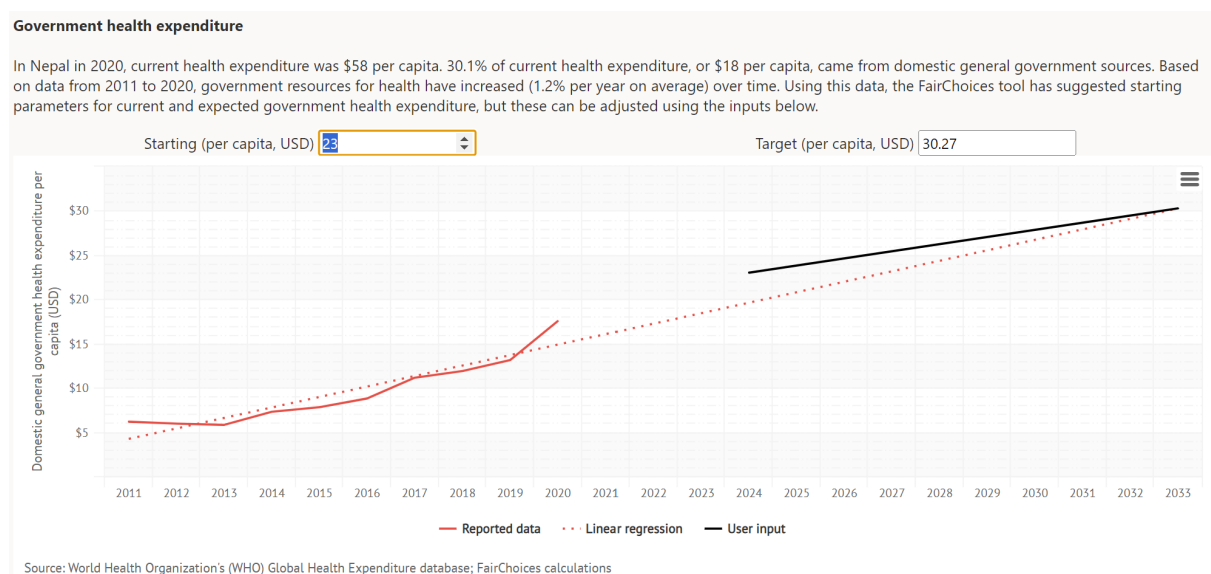
Budget space

Budget space for health (also called fiscal space for health) refers to how much money the government has available to spend on health. In general, most low- and lower-middle income countries seek to expand their budget space for health in order to achieve their health system objectives. However, this is not easy or straightforward, and it is an inherently political process, as there are many competing priorities for government resources.

This page of the FairChoices tool helps users understand and envision their country's budget space for health. The graphs below showcase data from the recent past (years 2010 and later) to provide important context for future budget planning. Users can define their budget space planning period using the inputs below. To promote accuracy, feasibility, and realism, it is advised that users parameterize this tab in collaboration with staff from both the ministries of health and finance, as well as health financing experts and relevant stakeholders.

Government health expenditure

You can change the projected government health expenditure by inputting your own data. In the example below, starting year has been changed to 2024 and per-capita health expenditure has been changed to \$23 in 2024. The target per-capita health expenditure has not changed from the automatic projections.

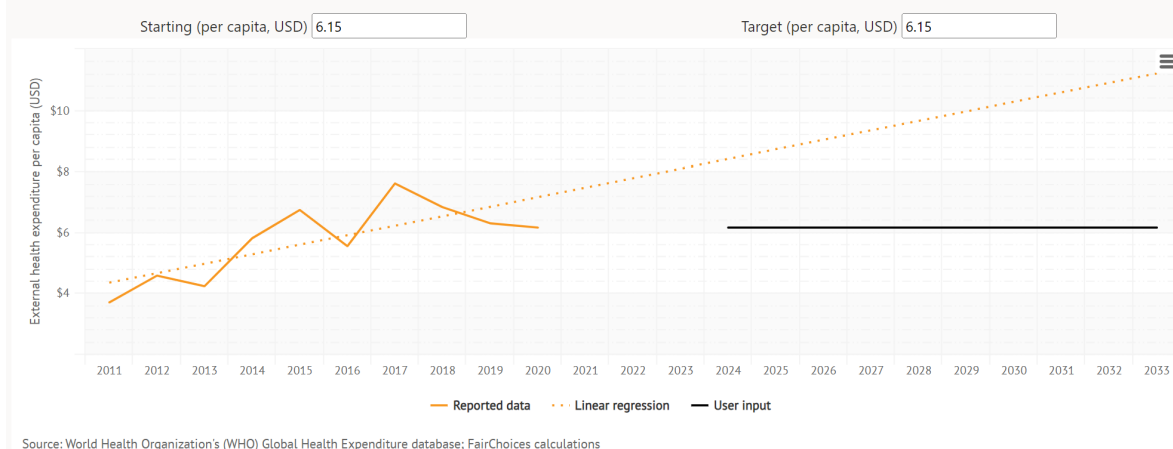


External health expenditure

The external health expenditure projections are also based on the past, but FairChoices assumes that this expenditure will not increase during the period. Hence, the black line in the plot is flat instead of following the orange dotted line. Of course, this is also possible to change.

External health expenditure

In 2020, 10.5% of Nepal's current health expenditure (\$6 per capita) came from external sources. Based on data from 2011 to 2020, external resources for health have increased slightly (0.3% per year on average) over time. For planning purposes, many LMICs anticipate declines in external funding in the medium- to long-term, as external and donor funding typically declines as countries develop economically (i.e., as GDP increases). Based on this assumption and data from Nepal, the FairChoices tool has suggested starting parameters for current and expected external health expenditure, but these can be adjusted using the inputs below.

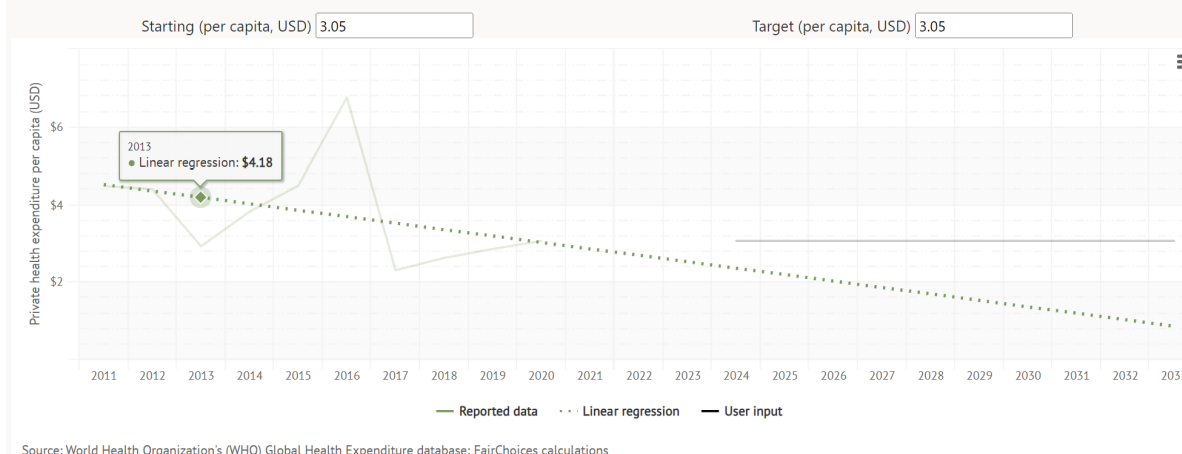


Private health expenditure

The private health expenditure projections are also based on the past, but FairChoices assumes that this expenditure will not decrease during the period. Hence, the black line in the plot is flat instead of following the green dotted line. Of course, this is also possible to change.

Private health expenditure

In 2020, 5.2% of Nepal's current health expenditure (\$3 per capita) came from private sources. Based on data from 2011 to 2020, private resources for health have decreased slightly (-0.2% per year on average) over time. For planning purposes, LMICs may anticipate increases in private funding in the medium- to long-term if the country is developing economically, households are becoming wealthier, and there is growing interest in private health insurance. Based on this assumption and data from Nepal, the FairChoices tool has suggested starting parameters for current and expected private health expenditure, but these can be adjusted using the inputs below.

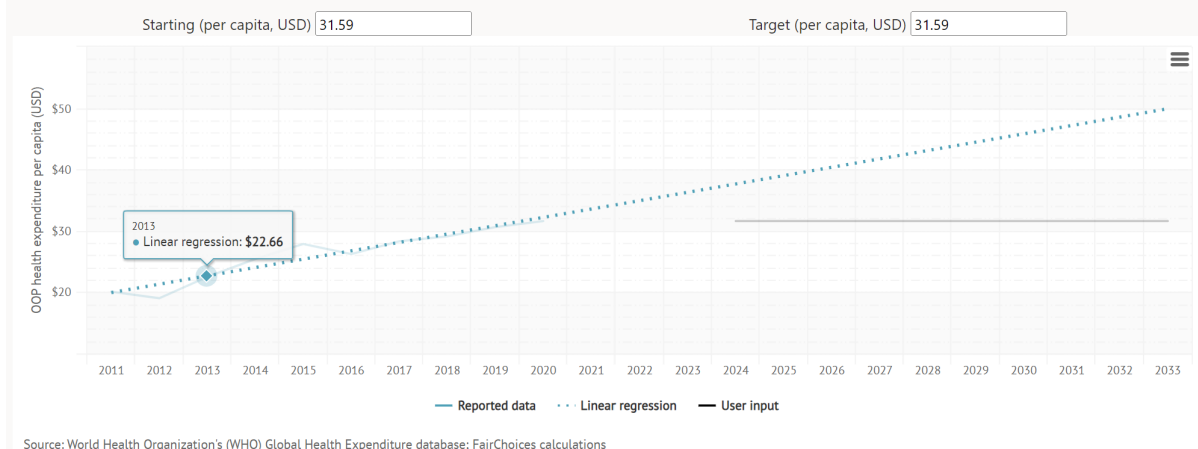


Out-of-pocket expenditure

The out-of-pocket health expenditure projections are also based on the past, but similarly to external health expenditure, FairChoices assumes that this expenditure will not increase during the period. Hence, the black line in the plot is flat instead of following the blue dotted line. Of course, this is also possible to change.

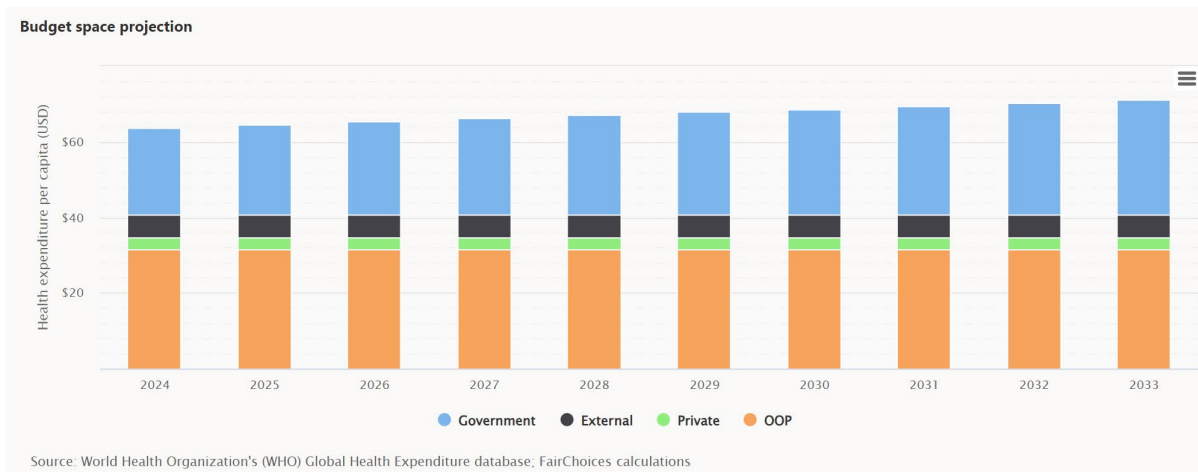
Out-of-pocket (OOP) health expenditure

In 2020, 54.2% of Nepal's current health expenditure (\$32 per capita) came from households directly through out-of-pocket (OOP) payments at the point of service. Based on data from 2011 to 2020, OOP resources for health have increased (1.4% per year on average) over time. For planning purposes, LMICs may anticipate decreases in OOP funding in the medium- to long-term as policymakers strive to implement policies that promote universal health coverage (UHC) and financial risk protection. Based on this assumption and data from Nepal, the FairChoices tool has suggested starting parameters for current and expected OOP health expenditure, but these can be adjusted using the inputs below.



Budget space projection

The budget space projection shows the projected development across the four areas (government, external, private, and OOP). The difference in height between the 2033 and 2024 columns is the total budget space. In the below figure this is about \$7.




League table


The League table module projects health gains and costs of scaling up interventions from baseline coverage to target coverage.

League table

Interventions can be sorted according to cost-effectiveness (ICER), disease severity (HAAD), and baseline coverage.

League Table						
 Download		Select a column to sort:			Select Target Value:	
Search		Select a column			0	
		ICER HAAD baseline				
<input type="checkbox"/>	Group	Intervention		Baseline coverage	HAAD	Target coverage (%)
	All					
<input type="checkbox"/>	Communicable diseases	BCG vaccine	63.59	84	43.7	84 ✓
<input type="checkbox"/>	Communicable diseases	MMR vaccine	24.88	84	55.2	84 ✓
<input type="checkbox"/>	Communicable diseases	Pentavalent vaccine (DPT-HepB-Hib)	0.84	84	21	84 ✓
<input type="checkbox"/>	Communicable diseases	Pneumococcal vaccine	26.82	84	56.2	84 ✓
<input type="checkbox"/>	Communicable diseases	Rotavirus vaccine	49.37	84	59.4	84 ✓

Target coverage can be selected in two ways. The first is to input the number directly into the *Target coverage (%)* column. See below.

League Table						
 Download		Select a column to sort:			Select Target Value:	
Search		Select a column			0	
<input type="checkbox"/>	Group	Intervention	ICER (\$/HY gained)	Baseline coverage	HAAD	Target coverage (%)
	All					
<input type="checkbox"/>	Communicable diseases	BCG vaccine	63.59	84	43.7	95 ✓
<input type="checkbox"/>	Communicable diseases	MMR vaccine	24.88	84	55.2	84 ✓
<input type="checkbox"/>	Communicable diseases	Pentavalent vaccine (DPT-HepB-Hib)	0.84	84	21	84 ✓
<input type="checkbox"/>	Communicable diseases	Pneumococcal vaccine	26.82	84	56.2	84 ✓
<input type="checkbox"/>	Communicable diseases	Rotavirus vaccine	49.37	84	59.4	84 ✓

The second is to select a number of interventions and use Select Target Value. See below.

Download

Select a column to sort:

Select a column

Select Target Value:

95

Search

95

<input type="checkbox"/>	Group	Intervention	ICER (\$/HY gained)	Baseline coverage	HAAD	Target coverage (%)
	<div>All</div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>
<input type="checkbox"/>	Communicable diseases	BCG vaccine	63.59	84	43.7	<div>95</div> <div></div>
<input checked="" type="checkbox"/>	Communicable diseases	MMR vaccine	24.88	84	55.2	<div>84</div> <div></div>
<input checked="" type="checkbox"/>	Communicable diseases	Pentavalent vaccine (DPT-HepB-Hib)	0.84	84	21	<div>84</div> <div></div>
<input checked="" type="checkbox"/>	Communicable diseases	Pneumococcal vaccine	26.82	84	56.2	<div>84</div> <div></div>
<input checked="" type="checkbox"/>	Communicable diseases	Rotavirus vaccine	49.37	84	59.4	<div>84</div> <div></div>

Selecting a target coverage below baseline is not possible. Hence, selecting all and setting target coverage to 0 will “reset” the league table (i.e., all target coverages will be set to baseline coverage).

Results

Once a set of target coverages has been selected, results will appear in the Results section of the module.

Results	
Costs Extra per-capita costs (\$, End year): 0.2616714 Extra cost (\$, Whole period): 8,882,500 Extra cost (\$, End year): 1,552,375	Health Gain Healthy years gained over the full period (typically 10 years): 1,487,202 Lives saved over the full period: 17,686
ICER: \$ / HY gained 5.97	Opportunity Cost: HYs lost compared to most cost-effective use of money 929,000

Costs

The output is *Extra per-capita costs* in the final year of the scale-up period (2033, in our example), *Extra costs* in the whole period (assuming that all interventions are scaled up at the same rate every year from baseline to target coverage),

Health gain

The output is healthy years gained and lives saved over the full period. In our example, from 2024 to 2033. Healthy years gained are obtained using a lifetable approach. FairChoices calculates age- and sex-specific healthy life-expectancy for all individuals

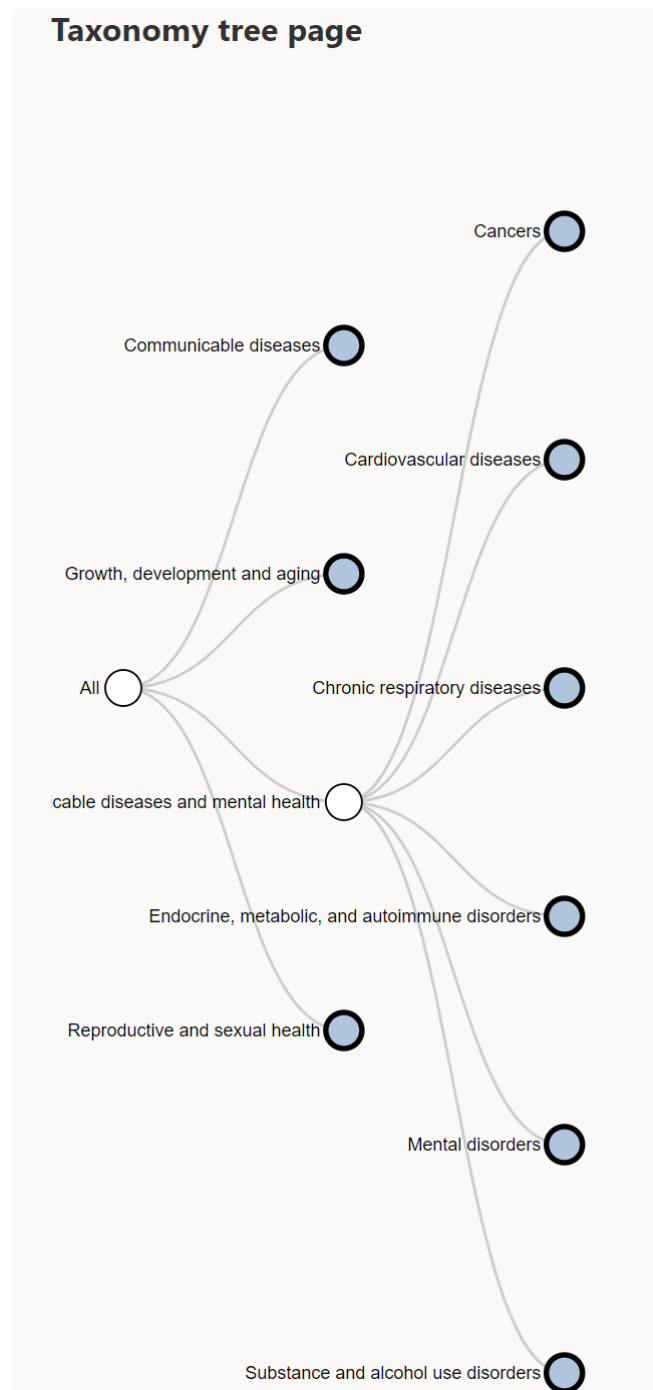
alive today and born during the scaleup-period assuming both that intervention coverage is kept at baseline and that it is scaled up to target coverage. The healthy years gained is the sum of the difference in these estimates across the whole population. Lives saved are calculated by comparing age- and sex-specific mortality rates with and without intervention scale-up.

Cost-effectiveness and opportunity cost

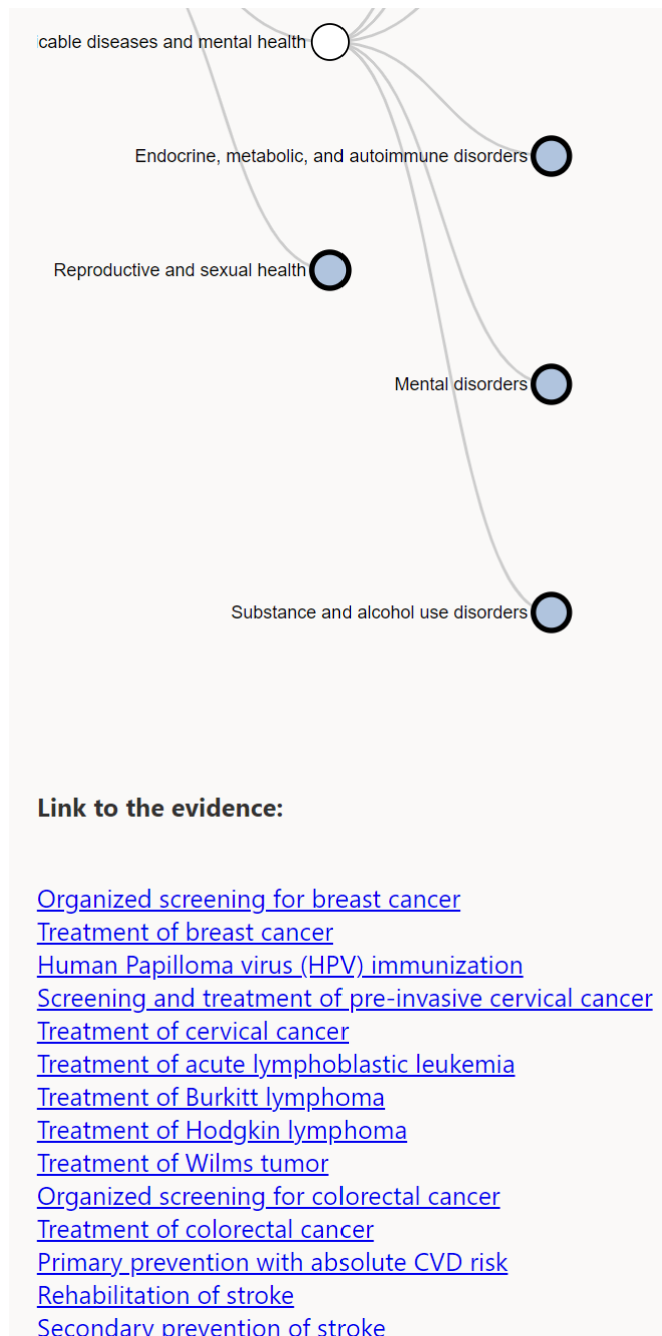
The cost-effectiveness is presented as the ICER (i.e., total cost divided by healthy years gained). The opportunity cost is the healthy years that could have been gained if the whole budget had been spent on the most cost-effective interventions (i.e., the interventions with the lowest ICERs).

Taxonomy

The Taxonomy module shows the FairChoices intervention taxonomy, which is based on the WHO's UHC Compendium.



Selecting a node will not only give you an overview of the interventions belonging to that cluster but will also provide a list of files with the evidence on costs and effects that are the basis of the FairChoices analytics.



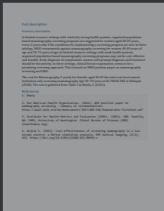
Clicking one of the links will provide an evidence brief.



1



2



3

Last Update: 2024-05-31

Organized screening for breast cancer

Authors: Merkesvik AI, Pickersgill S, Kaur G, Ahmed S, Watkins D, Coates MM, Økland JM, Haaland ØA, Johansson KA

Date of revision: 2024-04-16

Main Delivery platform: District Hospital

Type of Intervention: Diagnostic

Description of intervention (short)

Organized screening for breast cancer with mammography 2-yearly for females in the age group 40-69

Description of Condition and Intervention

Organized screening for breast cancer, particularly through mammography, is a fundamental intervention aimed at early detection of breast cancer at an early, treatable stage. Mammography screening programs target asymptomatic women in the specified age range, typically between 40 and 69 years old, as this population benefits the most from routine screening due to their increased risk of breast cancer. Regular mammography screening every two years allows for the detection of breast abnormalities, including tumors and calcifications, before they become clinically evident. Mammography is the primary imaging modality used for breast cancer screening due to its high sensitivity in detecting early-stage tumors and its ability to identify changes in breast tissue that may indicate the presence of cancer. The recommended age range for mammography screening is based on evidence showing that women in this age group derive the most benefit from screening in terms of mortality reduction. While breast cancer incidence increases with age, the balance between benefits and harms of screening shifts in older women, making biennial screening intervals optimal for balancing detection of clinically significant cancers while minimizing overdiagnosis and false-positive results. Organized screening programs ensure that eligible women are invited to undergo mammography at regular intervals, often through centralized scheduling systems and reminders. These programs also provide standardized protocols for screening, including quality assurance measures to maintain imaging quality, interpretation standards for radiologists, and follow-up procedures for abnormal findings. Patient education and informed decision-making are integral components of organized breast cancer screening programs. Women are provided with information about the benefits and limitations of screening, as well as the potential risks, such as false-positive results and overdiagnosis. This empowers women to make informed choices about participating in screening based on their individual preferences and risk factors.