Volume 5:
Cardio-metabolic and Respiratory Diseases

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DCP³ | Disease Control Priorities

economic evaluation for health

Scope and Status

- Vol. 5 covers the major NCDs except cancer

- Large editorial team not all fully engaged

- Currently 22 chapters but consolidating

- Lead authors have been confirmed for all but 4 chapters, co-authors for many

- Roughly half of outlines received

- Have had 3 partial authors meetings

- Chapter drafts expected fall 2013

Volume Overview

1. Global and regional burdens of morbidity and mortality

2. Risk factors for cardio-metabolic disease

3. Vascular and respiratory conditions

4. Policies and platforms to deliver services, including integrated services and health promotion

5. Economics of addressing cardio-metabolic and respiratory diseases

Links to other DCP3 volumes

- Common risk factors, eg with cancer (tobacco), child development (nutrition), mental health (alcohol), air quality

- Co-morbidities, eg TB/diabetes, mental health, HIV/AIDS

- Treatment overlaps, such as acute management of stroke, surgery (CHD)

- Cross-cutting issues: drug supply chains, quality of care, integrated service delivery

What's New?

Part 4: Policies and Platforms

- Integrated delivery for co-morbid diseases

- Innovations in health management
  - community management (patient-driven?)
  - e-health
  - CHWs

Part 5: Economics

- ECEAs for primary and secondary population prevention

- Multisectoral BCA?

Preliminary Messages

- Guidance on technology choices less important than guidance on access and quality improvement

- Address drug choices, adherence, supply chain

- Need combined management of risk factors

- Both over- and underweight are important

- Choose pharma intervention for primary or secondary depending on indication

ECEA example: South Africa salt reduction

- South Africa's proposed policy is **complex:** involving **many food groups**, coverage assumptions, and a **mass media** campaign

- Target consumption is **5g/day** for all ethnic groups

- Our preliminary intervention is "**whatever policy is required**" to reach 5g/day in each quintile

- The **difference** between current and target **salt consumption levels** was used to **calculate reductions in blood pressure** (He and MacGregor 2004)
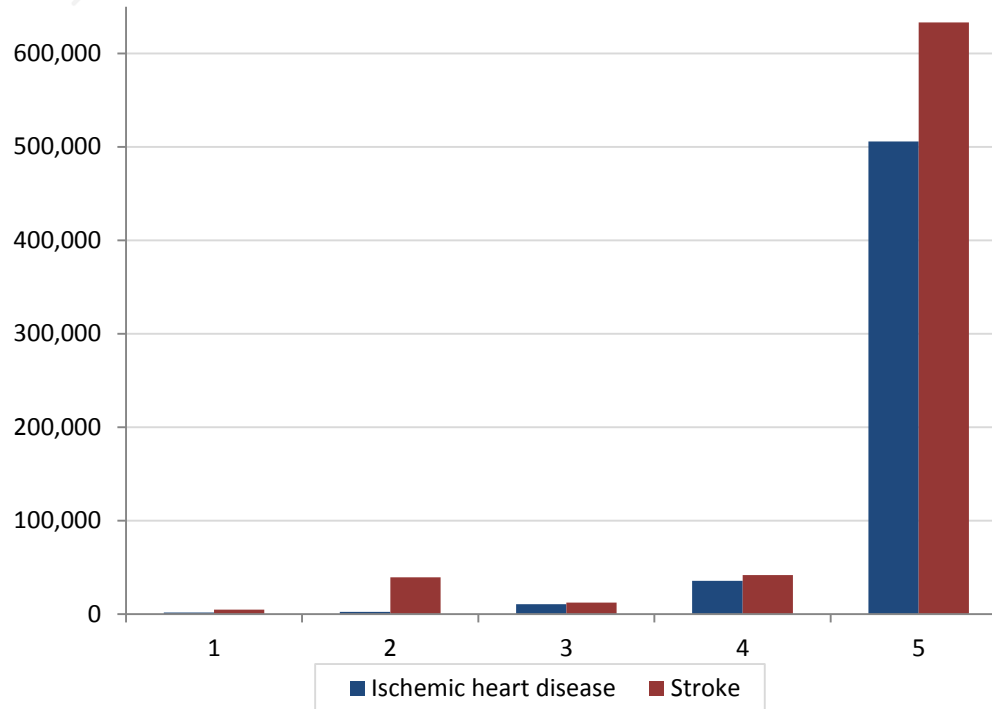
CVD deaths averted
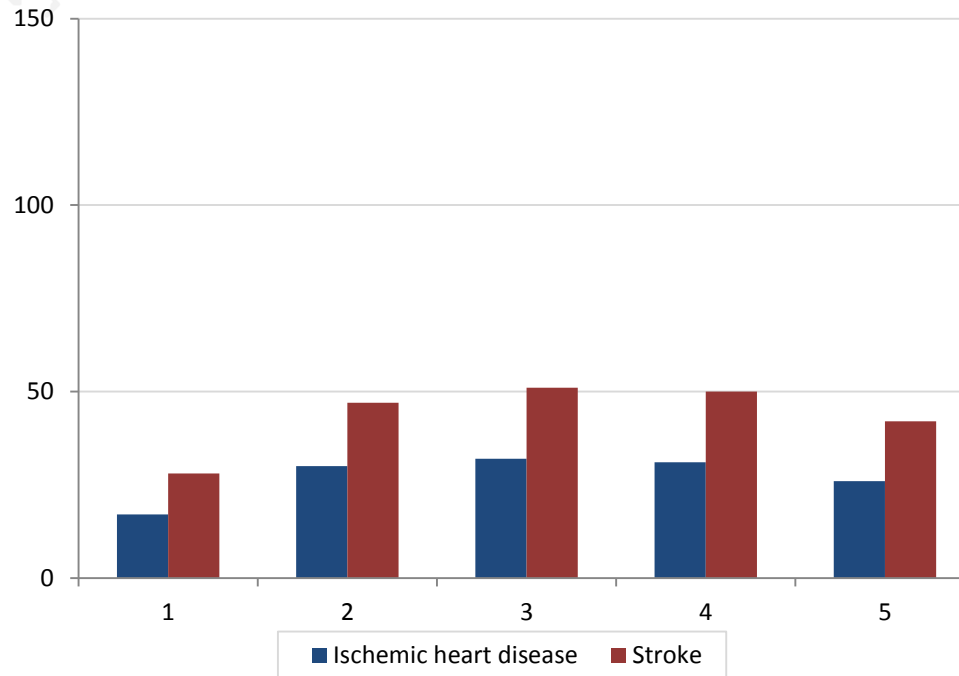
	Q1	Q2	Q3	Q4	Q5	total
Stroke	28	47	51	50	42	**218**
Ischemic heart disease	17	30	32	31	26	**136**

354 CVD deaths averted per 1 million adult population over 40 years

→ Projected **4425 total deaths averted nationally in 1 year**

Private expenditures averted (ZAR)

|	Q1	Q2	Q3	Q4	Q5	total
Stroke	4533	39339	12031	41587	633169	**730659**
Ischemic heart disease	1599	2160	10497	35617	505687	**555560**

ZAR 1.3 million (~USD 160,000) total; ZAR 1.1 million in Q5

Why so much financial protection for the wealthiest?

Tobacco Taxation

- Tobacco taxation can reduce smoking and increase government revenue.

- Effects may vary across income quintiles.

- Concerns that a tax will disproportionately harm the poor.

- Need to understand how a policy will impact different groups to make appropriate policy recommendations.

Modeling Economic and Health Costs of Tobacco
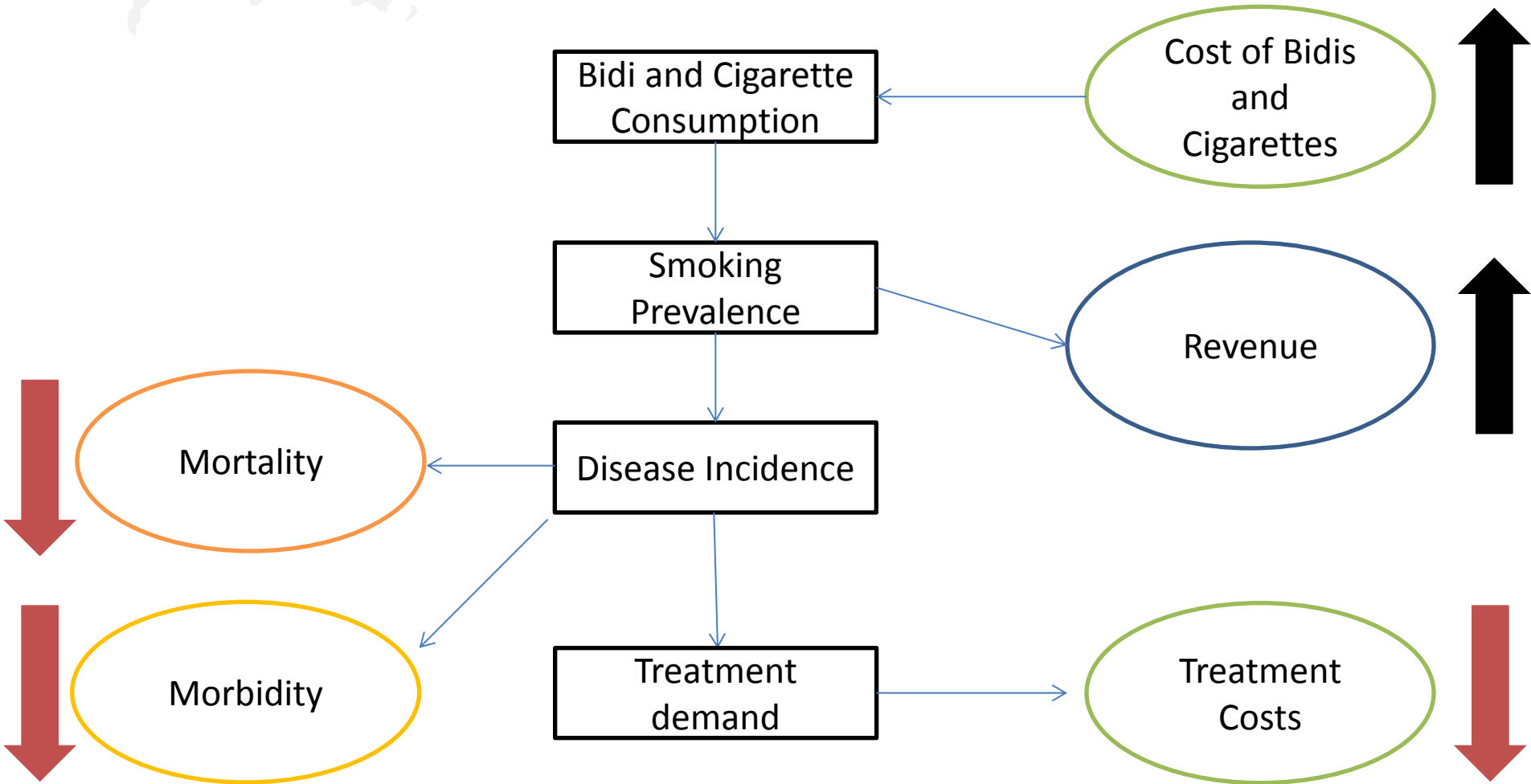
Conclusions

- Tobacco taxation reduces smoking-related mortality across all income groups with the bulk of those health gains being concentrated in the two lowest income quintiles.

- We also find that individuals reduce their expenditures on both tobacco- and medical treatment related to tobacco consumption.

- Tobacco taxation in India produces health gains for all income quintiles and reduces total tobacco-related expenditures in all but the richest quintile.