

Cost-effectiveness of typhoid vaccine strategies: evidence gaps and recommended methods

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TyVAC Typhoid Vaccine Acceleration Consortium

- What are the types of questions that can be addressed through economic evaluations?
 - Is it cost-effective to implement typhoid vaccination in conjunction with existing public health interventions?
 - Is it more cost-effective to introduce routine vaccination with TCV alone or in combination with a one-time catch-up campaign?
 - Is targeted or universal typhoid vaccination more cost-effective?



- Clearly define question and target audience (e.g. MoH vs Gavi)
- Type of evaluation
 - **cost-utility analysis** (\$ per DALY averted) vs **cost-benefit analysis** (compare monetary investment vs costs averted)
- Target population
 - e.g. specific age group or geographic area
- Define comparators:
 - type of vaccine (e.g. TCV vs Vi-PS)
 - delivery strategy (routine EPI vs catch-up campaign) and coverage
 - “current practice” should be baseline comparator
- Perspective of analysis:
 - healthcare provider vs societal (ideally)
- Analytical horizon:
 - should be long enough to capture all impacts from the vaccine (*at least 10 years for TCV*)

Vaccine costs

- Include wastage rate and uptake of vaccination

Administration associated costs

- Depends on the vaccine delivery strategy selected

Costs of strategies to increase uptake of typhoid vaccination

- The uptake of typhoid vaccination affects both costs and outcome of the program

Costs for patients and family

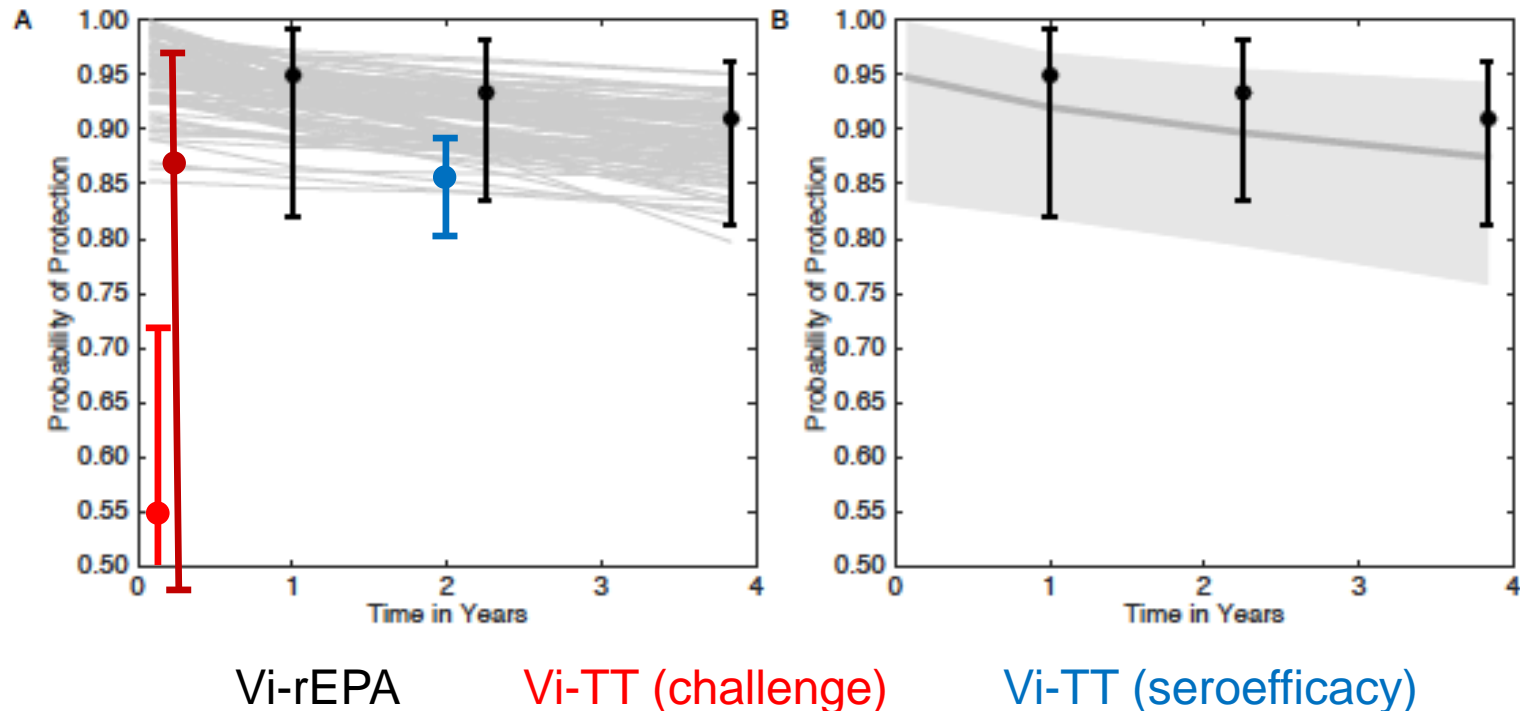
- Inclusion of indirect costs in societal perspective or patients out of pocket expense when patient perspective is selected, but report separately

Typhoid fever treatment costs

- Inclusion of medical costs related to typhoid treatment, possibly accounting for AMR

- ***Which costs components to be included depends primarily on the perspective of the analysis***

- Should be based upon the best available evidence of vaccine effectiveness
 - including duration of protection
 - rate of vaccine uptake

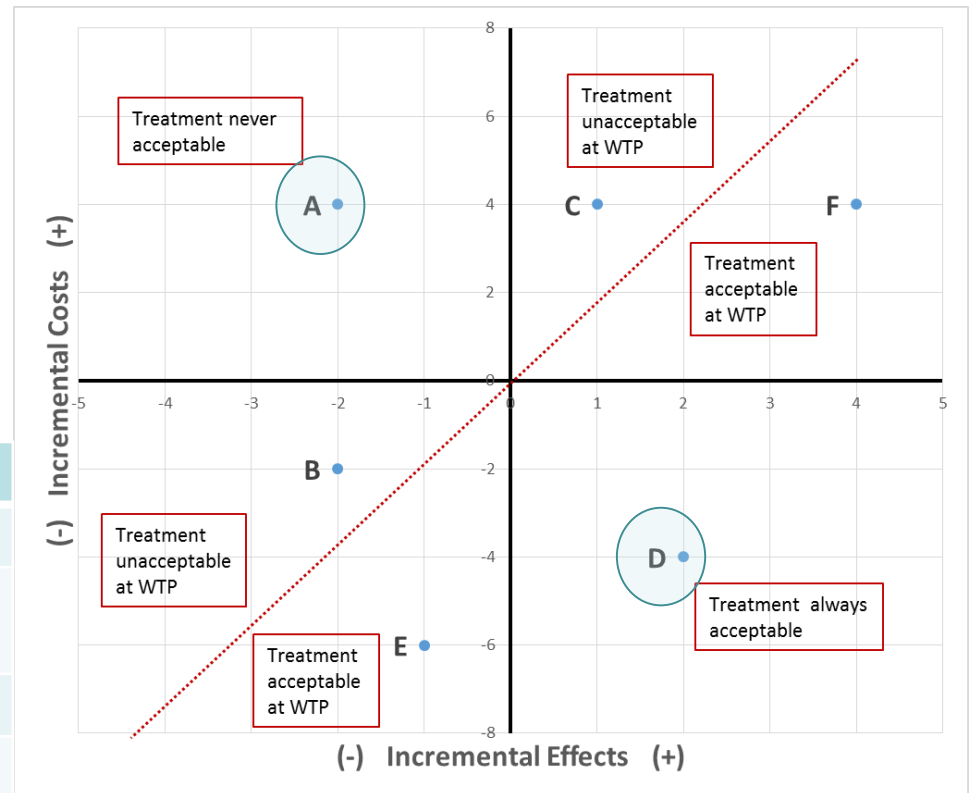


- Incorporation of herd effects
 - **Dynamic transmission models** needed to estimate the overall impact across different levels of coverage
 - **Chronic carriers** are expected to affect the level of indirect protection: the more carriers, the lower the level of indirect protection expected
 - Indirect effects could lead to an **increase in age of infection** by decreasing transmission and the rate at which immunity from natural infection is acquired among unvaccinated
 - Incorporating indirect effects in **static models** should be done in sensitivity analysis **only**

- Incremental Cost-Effectiveness Ratio (ICER) should be calculated and presented with a range of willingness-to-pay thresholds

$$\frac{\Delta Costs}{DALYs\ averted}$$

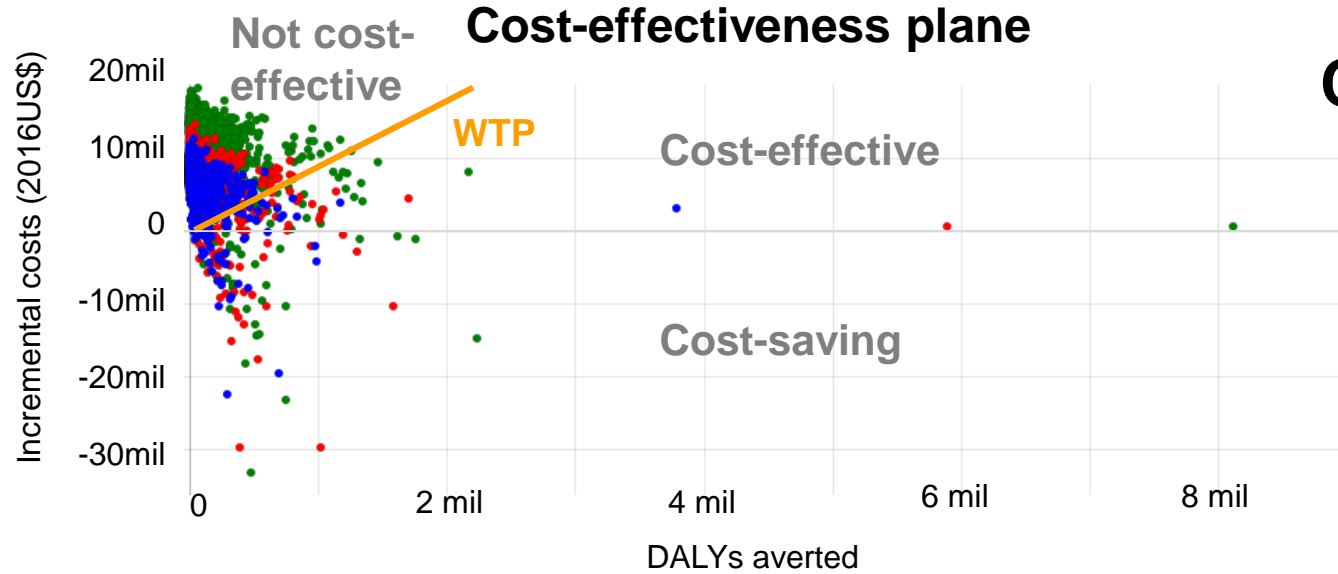
Program	D	A
Incremental Cost	-4	4
Incremental Benefit	2	-2
Preference	Dominant	Dominated
ICER	-2	-2



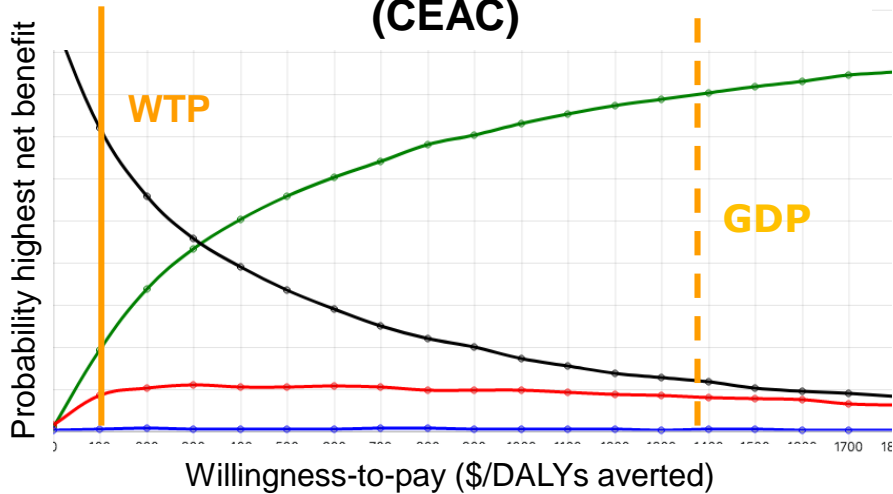
Sensitivity analyses

- Some parameters are uncertain or unknown especially for newly-developed TCVs
- Uncertainty can be explored using **probabilistic sensitivity analysis**, with results presented using cost-effectiveness acceptability curve (CEAC)
- Uncertain parameters:
 - costs of illness
 - vaccine price and delivery costs
 - vaccine effectiveness
 - hospitalization rate
 - case fatality rate
 - incidence of typhoid
- **Value of information analysis** (estimating EVPPI) is also recommended

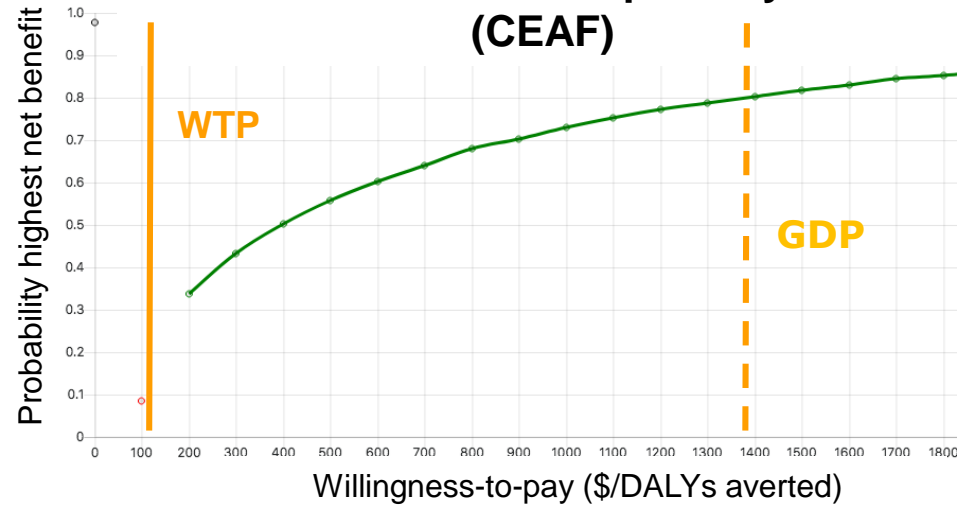
Cambodia



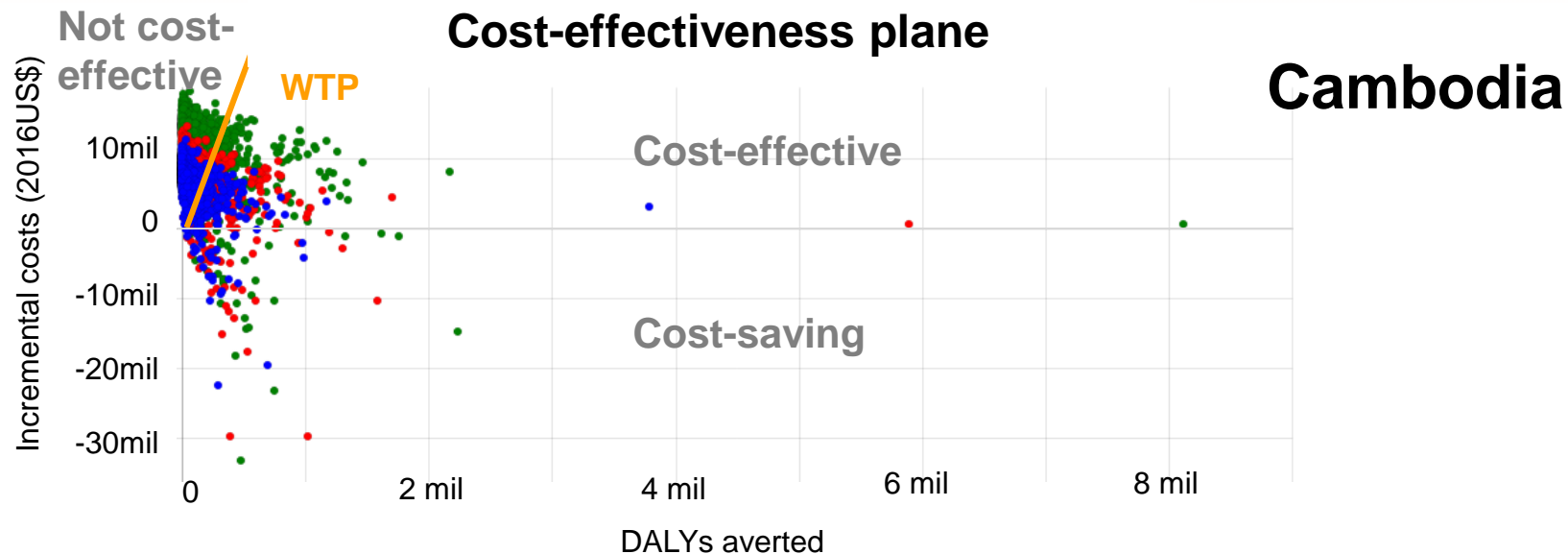
Cost-effectiveness acceptability curve (CEAC)



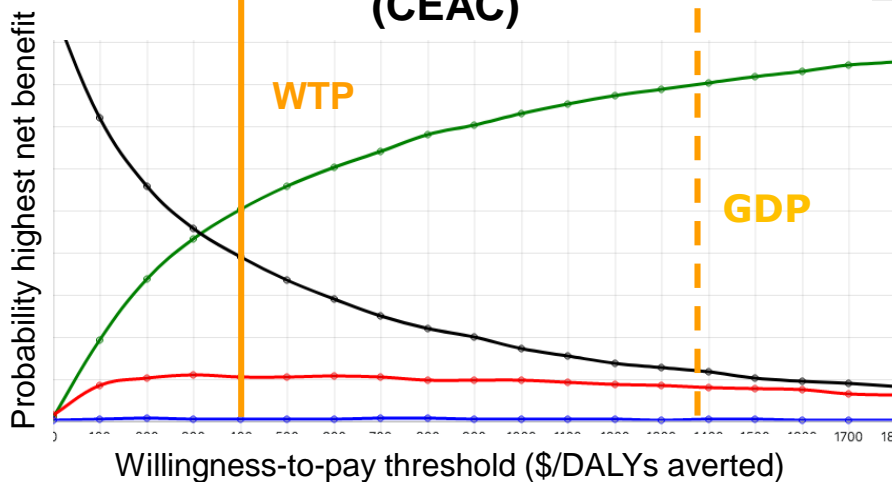
Cost-effectiveness acceptability frontier (CEAF)



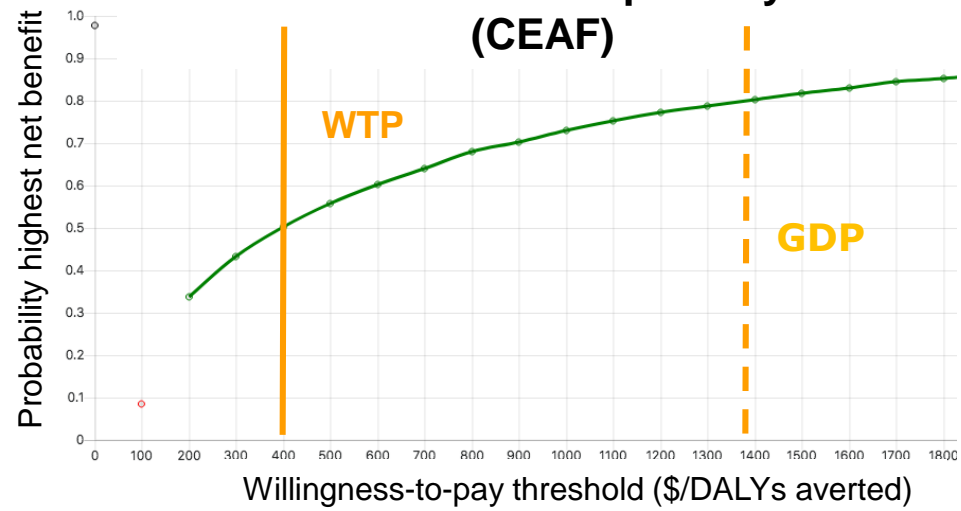
■ routine
 ■ routine + campaign up to 5 years
 ■ routine + campaign up to 15 years



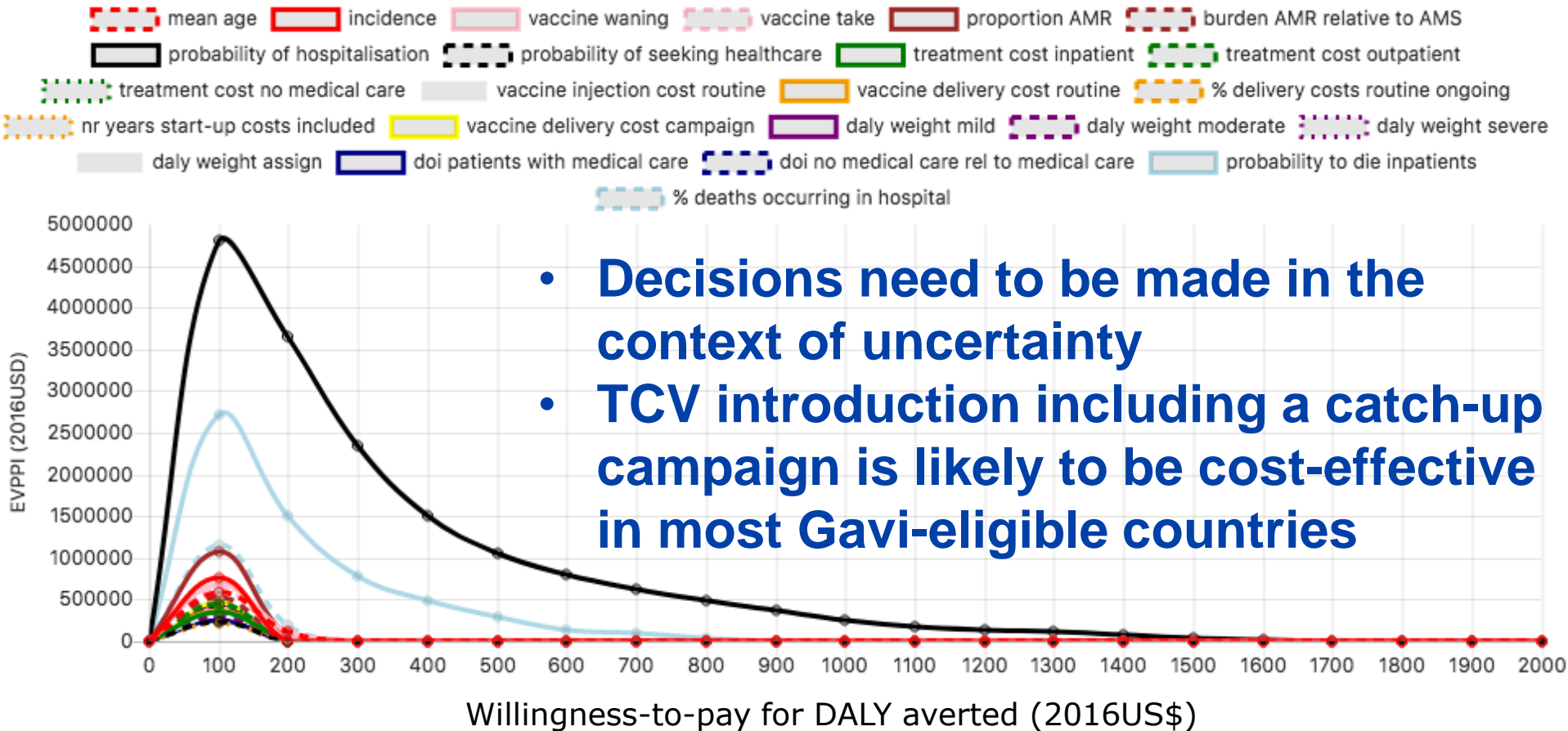
Cost-effectiveness acceptability curve (CEAC)



Cost-effectiveness acceptability frontier (CEAF)



■ routine
 ■ routine + campaign up to 5 years
 ■ routine + campaign up to 15 years



- Decisions need to be made in the context of uncertainty
- TCV introduction including a catch-up campaign is likely to be cost-effective in most Gavi-eligible countries

- **Probability of hospitalization, case fatality rate, and typhoid incidence rate** were the primary sources of uncertainty in most settings

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<https://ceatyphoid.uantwerpen.be/home/>

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