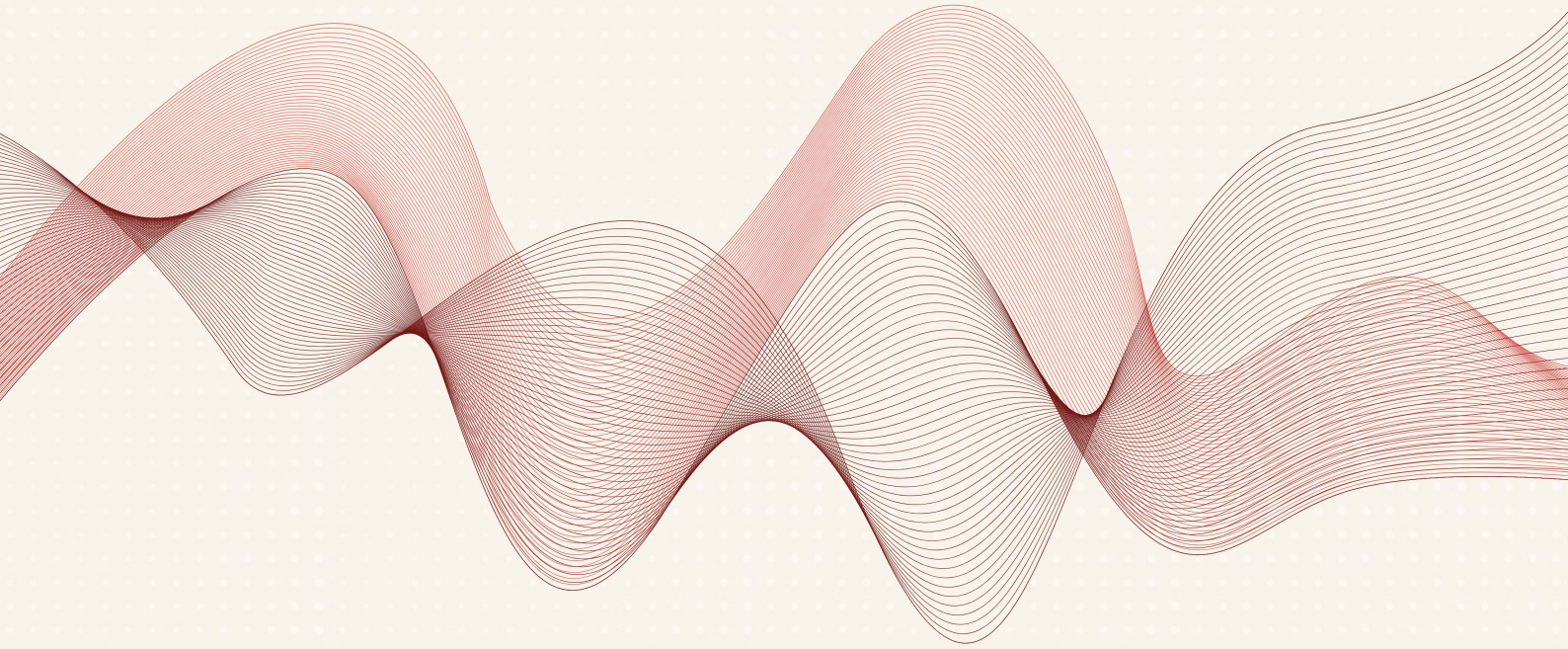

*Disease Control Priorities, Fourth Edition*
Volume 1, Disease Control Priorities in Practice

# Country Experiences with the Revision Process of the Zanzibar Essential Health Care Package

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## Preface

Since the early 1990s, researchers involved in the Disease Control Priorities (DCP) effort have been evaluating options to decrease disease burden in low- and middle-income countries. This working paper was developed to support the Fourth Edition of this effort. It is posted to solicit comments and feedback, and ultimately will be revised and published as part of the DCP4 series.

DCP4 will be published by the World Bank. The overall DCP4 effort is being led by Series Lead Editor Ole F. Norheim, Director of the Bergen Centre for Ethics and Priority Setting in Health, University of Bergen. Core funding is provided by the Norwegian Agency for Development Cooperation and the Norwegian Research Council.

More information on the project is available at: https://www.uib.no/en/bceps/156731/fourth-edition-disease-control-priorities-dcp-4.

# Country Experiences with the Revision Process of the Zanzibar Essential Health Care Package


## Abstract

Zanzibar undertook a revision of the Essential Health Care Package (EHCP) in 2019-2022 with the aim of providing a comprehensive, inclusive, evidence based and fair package of health services. The revision gained high political support and involved many key stakeholders through a participatory deliberative process. Several consensus building workshops were held from community to national level. The final EHCP in Zanzibar has a total of 302 interventions across 22 health program areas. It is a primary care focused package that will be scaled-up over ten years and the total package is expected to cost 198USD per DALY averted in total. With effective implementation it is expected to save around 120,000 lives and increase life expectancy from 65 to 71 years by 2032.



## Acknowledgments

Our deepest gratitude goes to the Ministry of Health Zanzibar, all stakeholders and funders who made this exercise possible.

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# 1.0 Introduction

Awareness and understanding of Universal Health Coverage (UHC) has increased both globally and in many countries like Tanzania and Zanzibar.[1,2] Key principles of UHC are to provide essential health services that people need without exposing them to financial risk. However, in Zanzibar and elsewhere resources are scarce and there are many competing priorities, especially in low- and middle-income countries (LMICs).[3,4] An explicit national essential health care package (EHCP), or a list of high-priority health services that the government promises to provide, is an important policy tool for setting health priorities in achieving UHC fairly and efficiently.[5] Thus, transparent and fair priority setting is key in the development process of EHCPs.[6] This can replace conventional implicit priority setting mechanisms like denial of services, dilution of quality of care, delay in providing services that patients have a right to, suboptimal standards of health facilities, and deterrence behavior of health workers due to overwhelming amount of tasks and responsibilities.[7] An EHCP explicitly defines essential services that should be prioritized within a limited budget using specified criteria, describes how these services should be financed, and who should receive these services. Concretely, such an explicit list of high-priority services can serve as overarching policy guidance over a longer period to assure feasible health financing systems, like public health insurance, and investments in the most important services within a country. Further, it can guide future plans and policies on health personnel and essential medicines.[8–10]

Even though many countries have gone through an EHCP revision, the implementation success will depend on the quality of the development process. Zanzibar has had two previous revisions of the EHCP, the latest one in 2018. Neither were comprehensive and both have failed to be implemented with a consequence of low coverage of essential health services in Zanzibar.[11] More comprehensive development processes was needed rather than rapid expert driven listing of essential health interventions. Selection of essential services and eligible populations into an EHCP requires a combination of robust methods and high-quality data as well as fair processes that includes adequate institutionalization and legal frameworks.[12] It also involves hard political choices, balancing the claims of various stakeholder groups engaged in the process.[13,14]

Currently, many countries are developing and revising EHCPs.[15,16] Comprehensive revisions of the national EHCPs has recently been conducted in Pakistan and Ethiopia and both countries are now in the implementation of these. Also, recent revisions of EHCPs have taken place in countries like Somalia and Sudan, settings with fragile health systems. Further, many international expert guidance reports have been published in the last five years and they all emphasize the importance of having a fair and democratic process when making the EHCP.[17–19] A recent review of EHCP revisions in six countries presented a framework for decision-making processes, including both practical organization and normative considerations in the revision of EHCPs.[12] Countries that took part in this review appeared to follow the elements of this framework, although there were organizational differences based on the specific context of each country.

Even though a democratic and transparent priority setting process is vital,[20] yet there is limited evidence from country experiences in conducting and applying democratic deliberative methods in priority setting of national EHCPs. While the literature shows widespread

application of sound technical and systematic processes in revising/developing EHCPs,[17,18,20–21] there is limited clarity on whether priority decisions were made through democratic processes and how stakeholders were actually involved in the revision. We still need more evidence from actual decision making on how substantial and complicated health economic analyses and equity impact assessments can be combined with input and participation of people that will be affected by these decisions. Aiming for fairness, legitimacy and impartiality in health priorities, such evidence is needed.[22,23] We need to go beyond inclusion of only individuals in strategic positions that are trained in expressing their preferences and opinions in the decision-making processes.[24–26] Zanzibar has demonstrated a good practice of engaging community while revising their EHCP, hence, this chapter aims to describe the overall the experience from Zanzibar.

## Country Context

Zanzibar is semi-autonomous country which forms part of United Republic of Tanzania. It is made up of two islands (Unguja and Pemba) and surrounded by smaller satellite islets in the Indian Ocean. Despite being united, health remained among the non "union matters"; thus, all Zanzibar's health priorities are addressed independently. Zanzibar has a per capita health expenditure of 34 US$ per year in total,[27] and 30% of this comes from donor funds and 16% out of pocket.

The first EHCP in Zanzibar (ZEHCP), from 2007, was considered important as part of the strategy for improving the population health, economic growth and the reduction of poverty[28]. An evaluation of the success of the first ZEHCP, and later revisions, is difficult since many of the specific priorities and health intervention targets in these policies were too broad to be evaluated (e.g. "Conduct Blood glucose screening"). Little was said about the cost-effectiveness and actual resources needed for each intervention, finance mechanisms and which target coverage levels to aim for at various delivery platforms. Nevertheless, the fact that the Ministry of Health chose a national ZEHCP as one of the milestones for its overall health policy, 2006-07 Plan of Action, reveals the importance that the national health authorities attached to the first edition of the EHCP.

## Health Care System

The health care system in Zanzibar has for many years been categorized in four levels: (i) Primary level which include Primary Health Care Units, Primary Health Care Unit + and Primary Health Care Centers; (ii) District level; (iii) Regional level and (iv) Tertiary level. However, the categorization at primary level has been found to be complicated. The Ministry of Health thus proposed in the 2019-2022 revision of ZEHCP to have a simplified structure of health care delivery platforms and that priorities should be mapped to delivery platforms. The revised delivery platforms are presented in table 1. Currently, there is a total of 167 public health care facilities[29] of which the ZEHCP will be implemented.

**Table 1: Number of health facilities by district and delivery platform in Zanzibar in 2022, immediately after the revision of the Essential Health Care Package and 1 year later (January 2024).**

| | Primary level | | Secondary level | | Tertiary level | Total |
|---|---|---|---|---|---|---|
| | Dispensary | Health Center | District hospital | Regional hospital | Referral and specialty hospital | |
| **Unguja** | | | | | | |
| 2022 | 73 | 19 | 2 | 0 | 3 | 97 |
| 2024 | 73 | 19 | 6 | 1 | 3 | 102 |
| **Pemba** | | | | | | |
| 2022 | 52 | 15 | 2 | 1 | 0 | 70 |
| 2024 | 52 | 15 | 4 | 0 | 0 | 72 |
| **Total Zanzibar** (2024) | 125 | 34 | 4 | 1 | 3 | 167 |

# 2.0 Scope and Mandate

In 2019 the Zanzibar Minister of Health requested World Health Organization (WHO) and Bergen Center for Ethics and Priority Setting (BCEPS) to provide technical support in the revision of the EHCP. Omar Mwalim, first author of this chapter, former Head of the NCD unit in the Ministry of Health in Zanzibar and now a PhD student in BCEPS, led the core group at the Ministry of Health in the revision process. The mandate given to the core group was to provide an explicit list of essential health services that addresses the most important health needs of Zanzibar's population across their life course, with special emphasis on services at the primary, secondary and tertiary healthcare levels.

The final ZEHCP report was intended to provide relevant guidance for future health policies and actual priority setting at all levels of the health system in Zanzibar in the coming 10 years, with subsequent regular reviews and updates. The revised ZEHCP is part of the operationalization of Zanzibar Health Sector Strategic Plan IV and Zanzibar's commitment to pursue the Sustainable Development Goals.

Description of methods and results is influenced by our applied involvement of this process. The 2019 revision of ZEHCP followed a participatory deliberative process involving many relevant stakeholders from the community to the national levels. Through various organized consensus-building workshops, the core team led the revision with support from Technical Working Groups (TWGs). During the first six months, decision on which criteria to use for priority setting and which interventions to consider as candidates in the revised ZEHCP were made. The next 18 months focused on analytics and collection of evidence to use in the assessment of consequences of various priority decisions and information needed to set

priorities. A budget space analysis was conducted and decision on the feasible size of the health budget increase up to 2032 was made, and final approval of the ZEHCP was made at the highest political level in Zanzibar. The final comprehensive ZEHCP report was published in November 202230 included details about criteria for priority setting, interventions in the package, and financing scenarios. Further, implementation arrangement as well as monitoring framework was also proposed.

# 3.0 Priority Setting Process

The revision of the ZECHP was initiated with a meticulous planning phase, where a core team followed a 10-step revision process that has been presented in detail elsewhere.31 Initially a comprehensive roadmap was developed and it underwent rigorous scrutiny and approval through workshops and consensus-building meetings, involving experts from various organizations, including the WHO, as well as senior officials from the Ministry of Health and other stakeholders. Following input from diverse stakeholders, the Ministry of Health sanctioned the roadmap for operationalization.

Stakeholder engagement played a pivotal role in the process, involving participants from community to national levels, each representing distinct interests. The stakeholders actively contributed to defining criteria for intervention selection, acknowledging the crucial role of ZECHP in achieving UHC. Consultative meetings with civil society organizations, medical experts, and other key stakeholders resulted in the agreement on six criteria: budget impact, disease burden, cost-effectiveness, financial risk protection, equity, and political/public acceptability, forming the basis for intervention selection.

Subsequently, 11 extensive consultation meetings were conducted to review and accept 302 interventions spanning preventive, curative, rehabilitative, and intersectoral domains for inclusion in the EHCP. Controversial interventions, such as induced abortion, were excluded, considering feasibility, affordability, and positive gains during the selection process. Baseline and target coverages were assigned to each intervention.

Regarding financing, stakeholders recommended a budget increase for effective EHCP implementation, noting the inadequacy of the per capita expenditure, set at $34 according to the National Health Accounts. Doubling the health budget and a new health financing reform was introduced that identified a new Universal Health Insurance scheme and a pro-poor Zanzibar Health Equity Fund as enduring financial mechanisms to succeed with implementation of the ZEHCP.

Implementation considerations highlighted the crucial role of District Health Management Teams, especially in primary healthcare, where the majority of interventions were concentrated. To succeed with effective implementation, it was agreed to assure proper resource allocation to facilities and to establish an efficient referral system, and robust links between health facilities and communities. The final consideration in the process was monitoring and evaluation, entrusted to the Health Management Information System. Collaborative evaluation meetings held biennially were designed as crucial checkpoints to identify areas for improvement and ensure the successful implementation of ZECHP. This

collective effort aims to guide Zanzibar's health sector towards overarching goals, ultimately resulting in improved health outcomes for the population.

# 4.0 Analytics

In the revision process of the ZECHP, a comprehensive analysis was conducted utilizing two analytical tools, namely the WHO One Health Tool and the BCEPS tool FairChoices: DCP Analytics Tool. The integration of FairChoices and One Health Tool in the analytics of ZEHCP revision facilitated a comprehensive assessment of costs, benefits, cost-effectiveness, and equity impact for various health interventions. Details of the FairChoices methods in the Zanzibar revision is explained elsewhere.32 During the revision, a technical team prepared local parameters into both OHT and FairChoices, undertaking a thorough cost analysis that considered various scale-up scenarios for interventions within the Zanzibar health system over a 10-year period.

These tools employed distinct cost analysis approaches: OHT utilized an ingredient-based costing methodology, involving the summation of quantities and prices for all necessary components, while FairChoices employed a broader unit cost approach that was combined with population in need and baseline-target coverage assumptions for each intervention. The unit cost approach encompassed aggregate cost to deliver health interventions per patient, including factors such as human resources, drugs, equipment, and other relevant elements. Local sources, including the Central Medical Store, Health Management Information System, published reports, and surveys, provided local data, which were further supplemented with information from published cost-effectiveness papers.

To align the policies of ZEHCP and Health Sector Strategic Plan IV, an intermediate cost analysis was undertaken for HSSP-IV using OHT. Simultaneously, FairChoices was employed to estimate the health benefits and equity associated with the candidate interventions.

Cost-effectiveness played a pivotal role in ranking interventions based on their potential to maximize population health. The Incremental Cost-Effectiveness Ratio (ICER) was utilized whenever feasible, representing the incremental cost and incremental effect of transitioning from the current baseline coverage of each intervention to a defined target coverage level. In this context, achieving coverage levels exceeding 90% was designated as the UHC endpoint.
To ensure the robustness and validity of the ICER values derived from FairChoices, the revision team conducted a thorough validation process. This involved referencing peer-reviewed publications and the grey literature spanning the years 2010 to 2019.

# 5.0 Results

## Structure of the ZEHCP

The Zanzibar Essential Health Care Package (ZECHP) encompasses a total of 302 interventions distributed across 22 health program areas. Each program area represents a distinct health domain, and the number of interventions allocated to each area highlights the comprehensive nature of the healthcare package. This comprehensive package strategically prioritizes a diverse array of health interventions, addressing a wide spectrum of health needs within the Zanzibar healthcare system.

**Table 2: Overall summary of cost, effect and health outcomes by program area over a 10-year period in Zanzibar, 2022**

| Program | Cost-effectiveness ($/HLY) | Cost (10 year, $) | Healthy life years (10 year) | Life years (10 year) | Lives Saved (10 year) |
|---|---|---|---|---|---|
| Surgery | 2,348 | 15,402,854 | 6,560 | 4,303 | 35 |
| Emergency care | 25,956 | 11,498,754 | 443 | 493 | 4 |
| Maternal and newborn health | 52 | 18,583,478 | 359,765 | 411,720 | 6,171 |
| Child and adolescent health | 182 | 44,605,652 | 245,699 | 283,327 | 1,707 |
| Reproductive health | NA | NA | NA | NA | NA |
| HIV and Sexually Transmitted Infections (STIs) | 86 | 6,413,687 | 74,443 | 89,743 | 1,202 |
| Malaria | 1,083 | 1,704,379 | 1,574 | 1,811 | 16 |
| Tuberculosis | 213 | 4,804,053 | 22,554 | 26,009 | 209 |
| Neglected tropical diseases | 904 | 321,263 | 355 | 119 | 1 |
| Infections in general | 720 | 11,596,866 | 16,104 | 17,912 | 173 |
| Cancer | 9 | 3,982,554 | 448,295 | 587,838 | 575 |
| CVD and diabetes | 4,748 | 58,976,782 | 12,422 | 14,899 | 347 |
| Musculoskeletal disorders | 21,612 | 651,210 | 30 | 18 | 1 |
| Respiratory disorders | 51,029 | 32,450,618 | 636 | 736 | 6 |
| Mental & SUDs | 5,864 | 21,833,853 | 3,723 | 3,461 | 35 |
| Neurological disorders | 117 | 629,111 | 5,386 | 2,493 | 20 |
| Rehabilitation | NA | | | | |
| Nutrition | 414 | 3,841,319 | 9,271 | 7,604 | 72 |
| Hearing and vision improvement | 5,080 | 1,375,382 | 271 | | |
| Interpersonal violence | NA | | | | |
| Epidemic infections (including COVID-19) | NA | | | | |
| Intersectoral interventions | NA | | | | |
| **Total** | **198** | **238,671,814** | **1,207,531** | **1,452,485** | **10,572** |

The number of interventions, expected costs and health benefits (Healthy Life Years) within the ZEHCP are spread out across various delivery platforms of the healthcare system in the analyses. Primary health care facilities play a predominant role, constituting 68% of the interventions in the ZEHCPS, 65% of the associated costs in the ZEHCP, and contributing to 82% of the overall effects in the ZEHCP in terms of Healthy Life Years. Secondary level health care facilities follow, representing 22% of interventions, 31% of costs, and contributing to 16% of Healthy Life Year impact. Referral hospitals, while comprising 10% of interventions, contribute 3% to the overall costs and yield 1% of the total Healthy Life Year impact.

## Funding the ZEHCP

The revised ZEHCP anticipates a $39 USD per capita increase in annual health expenditure by 2032, necessitating a doubling of total health spending to $73 USD per capita annually within the next decade. A comprehensive 10-year fiscal space analysis was conducted in collaboration with the Ministries of Health and Finance and later presented and discussed with policymakers, development partners, MOH program managers and other stakeholders. This expert driven analysis considered various factors such as economic growth expectations, population growth, governmental investment, donor funding, and the introduction of a social health insurance scheme.

The analysis projects an increase in the government's healthcare expenditure as a percentage of GDP from the current 1.7% to 2.5% by 2032. Further, it proposed the increase in government spending from 53% to 60%; reduce donor contributions from 29% to 15% and decrease in out-of-pocket expenditure from 16% to 10%.

To fulfill commitments outlined in the updated 2022 ZEHCP, significant financial reforms were undertaken by the Government of Zanzibar, including the introduction of Universal Health Insurance (UHI) and Zanzibar Health Equity Funds (ZAHEF). UHI, initially targeting formal sector individuals and later will be extended to the informal sector, with the aim to improve healthcare accessibility and affordability. Meanwhile, ZAHEF focuses on supporting vulnerable groups, particularly those below the poverty line. These reforms aim to ensure sustainable funding for ZEHCP implementation, highlighting the government's commitment to securing accessible and quality healthcare in Zanzibar.

However, when comparing the ambitious target of increasing per capita spending to $73 USD with the reality on the ground, scenarios of increasing one dollar and two dollars per capita per year were considered and documented.

## Implementation Monitoring and Evaluation

The ZEHCP implementation plan is guided by strategic priorities aligned with the Ministry of Health's strategies. The focus is on enhancing the healthcare financing system, providing comprehensive health services, ensuring equitable distribution of the health workforce, improving the availability of drugs and equipment, strengthening health information systems and patient management, fostering community and stakeholder involvement, and reinforcing governance, leadership, and accountability within the health system.

In the realm of healthcare financing, the plan aims to progressively increase government health expenditure, provide health insurance to the entire population, introduce earmarked taxes on specific products, and establish trust funds for enhanced domestic-resource mobilization. The provision of health services involves developing a clear referral system, updating treatment guidelines, and strengthening disease-specific registries. Additionally, efforts are directed towards recruiting qualified health workers, enhancing training programs for equitable deployment, and improving the availability of drugs, supplies, and diagnostic equipment.

The focus on health information systems and patient management includes strengthening national monitoring teams, digital medical record systems, increasing service access through partnerships, and aligning outcome metrics with ZEHCP objectives.

The planning unit through the Health Management and Information System and the Monitoring & Evaluation Division at the Ministry of Health, in collaboration with Health Sector Reform Secretariat, will be responsible for the continuous evaluation of the ZEHCP. In addition, the heads of the departments and sections, and healthcare providers, shall ensure the smooth implementation of the healthcare package. The grassroots level will also be engaged in the evaluation. This bottom-up approach in implementing ZEHCP will be highly emphasized.

# 6.0 Lessons Learnt

The benefit package should be designed to reflect the priorities of respective countries. With that in mind, it is highly recommended countries to manage the entire process themselves and ensure full participation of stakeholders at different levels. Additionally, the process requires the availability of sufficient and reliable evidence to be able to project cost and effect for the defined period. In this process, Zanzibar has been able to learn a number of lessons that other countries might need to consider while doing similar work. Below are specific points that we considered to be important lessons learnt from the revision of the ZEHCP.

## Ownership of the Process

For a benefit package development process to be carried out efficiently, the country must be at the forefront in leading the exercise. This is a crucial aspect for consideration because it is the local counterparts who know who to involve and where to obtain the necessary information needed. Further, being in the front line makes the country build trust with what it has produced and can advocate for resources needed.

## Local Capacity Building

It has been a common practice for many countries to employ foreign experts to undertake some assignments that could essentially be done by local staff. This has not been the case in Zanzibar while revising the benefit package. A core team was recruited and given basic health economic and priority setting training which was organized by the Addis Center for Ethics and Priority Setting (ACEPS) and BCEPS. These trainings which were done in Ethiopia and Zanzibar enabled them to manage the entire exercise themselves. The knowledge gained has helped a lot to clarify different issues that have been emerging during deliberative meetings.

## Stakeholder Engagement

Benefit package designing is a participatory process that needs broad inclusion of different stakeholder groups.[33] During the revision process, Zanzibar held a total of 11 sessions that involved stakeholders from the community level, development partners, health professionals and various government leaders. The consultative meetings served as awareness creation platforms where several concerns were addressed. The biggest challenge from the stakeholders was to understand the concepts of priority setting. Following detailed sessions, the stakeholders gave their opinions about the criteria to be used for selecting interventions, the list of interventions to make the package as well as propose the budget increase in the health budget from the central government. The highest-level decision-making meetings of the country which is the Multisectoral Technical Committee (MTC) which includes all the Principal Secretaries of the government and that of the Minister's Cabinet chaired by the President are the ones that approved the final package.

## Advocacy of the Package

During the evaluation of the previous package, it was observed that majority of the stakeholders were not aware of the benefit package. Earlier, this had been more a top-down expert driven process. This was due to limited involvement during the development but also its lack of implementation contributed as well. If it is properly advocated, the package can be used as a resource mobilization tool of which, if resources are secured, will make its implementation successful. When making revision, Zanzibar used the opportunity to advocate for the package and explain the importance of setting priorities.

## Aligning the Package with Existing Financing Mechanism(s)

For efficient implementation of the package, several sources of funding must be identified of which funds can be allocated to the prioritized interventions. Zanzibar has been implementing a free health care policy for decades, but recently decided to introduce public health insurance. The challenge that has emerged is the lack of harmony between the insurance benefit package and that of the EHCP. Since neither of the two was officially endorsed, the teams of experts are trying to align the two. The lesson that Zanzibar has learnt is to ensure there is proper intra-communication when it comes to the development of such policy documents so as to avoid inconveniences.

## Prospects for Future Review

Amongst the key lessons learnt from revising the ZHECP include progress towards achieving SDG targets, efforts to address NCDs, and the development of national strategies to combat emerging health conditions. Additionally, there is significant optimism regarding the potential availability of funds to support package implementation due to major financial reforms underway. These insights suggest that the implementation of the package may evolve over time, indicating the possibility of reviewing this case study as we progress with its implementation.

### Legislation

Meanwhile, the existence of the ZEHCP is not bound by law. Hence, its implementation may not be as effective as expected and this could hamper resource allocation. Following conversation with the Attorney General of Zanzibar, it was advised to make its existence legally. Thus, having an Act in place will clearly identify a list of services that all Zanzibaris will have right to access, necessitate resource allocation for ZECHP implementation but will also prevent introduction of health interventions that may have huge budget impact. However, for a law to be made, the process of gathering opinions at all levels must be done and then a bill will be prepared and sent to parliament for discussion and approval.

## 7.0 Limitations

The ZEHCP review team had major difficulties in collecting all the quantitative and qualitative data necessary to review the current service package; hence, in some cases, reliable data were not readily available in the required format. For instance, the data about service outputs (in terms of numbers of clients served) at the level of health institutions, human resources and logistics were not adequate and thus had to be substantiated by data from the HMIS (DHIS2), and at that time, the data were not sufficient. Hence, evidence from TDHS 2010 and 2015/16 and OHT and data from the Global Burden of Disease (GBD) study Institute for Health Metrics and Evaluation (IHME/University of Washington) were used.

## 8.0 Conclusion

A national EHCP serves as an explicit mechanism for operationalizing entitlements to health. Ranking of services by priority should be according to WHO recommendations be evidence based and well aligned with other social goals.34 Competing priorities within the health sector and across other sectors needs to be handled carefully with fair process and rigorous and pragmatic methods. Successful implementation of UHC at the national level depends on compromises on the parts of various stakeholders, including policy makers, providers, payers, insurance companies, product manufacturers, and patients. Local engagement is important when defining an essential health care package at a country level. In Zanzibar, as elsewhere, multiple interests are involved, institutions are short of capacity, resources are extremely scarce, and the political setting is complex. The EHCP has outlined key interventions Zanzibar will avail to its population and work towards ensuring high coverage with public finance, so as to assure population health and wellbeing.

## Availability of Data and Material

Data, documents and any other materials used in this article will be fully available.

## Disclosures of Potential Conflicts of Interest

No authors of this article declare any competing interests.

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