Erasmus MC
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HTA in health policy

options for CEECs

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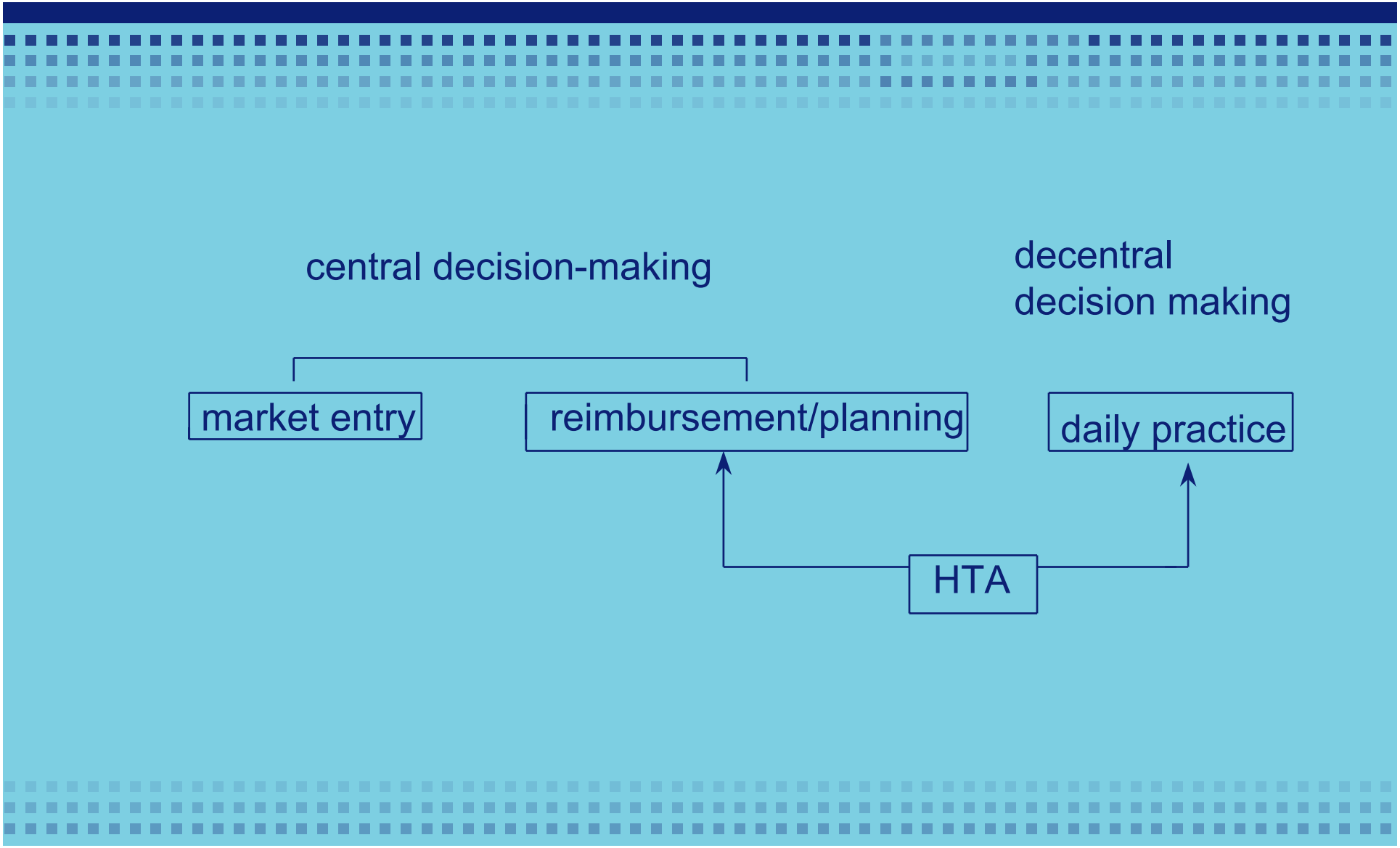
Outline of the presentation

- HTA and policy
- Transferability of HTA evidence
- Examples of transferring HTA-results for CEECs
- Conclusions

The role of HTA in health care policy and practice



Market entry

- Considerable harmonisation in Europe
- EMEA and mutual recognition procedure
- no consideration of cost effectiveness

HTA and reimbursement / finance

- HTA supported introduction of public programs in most countries
- Evaluation of major health care programs before introduction
  - UK: NICE guidance becomes ‘compulsory’
  - Netherlands: special fund for HTA to support reimbursement policy
  - France/Sweden: agencies producing HTAs to inform decision making (ANAES and CEDIT in France, SBU in Sweden)

Reimbursement of pharmaceuticals

- 5 EU member states demand CEA info from manufacturer (NICE guidance in UK increasingly about medicines)
- few differences in requirements (exceptions: valuation health states, productivity costs and discount rate)
- different weighting of criteria:
  - CEA information and cost per QALY threshold
  - budget impact (dominant in France, Italy and Spain)
  - severity of illness (in relation to co-payment in Belgium and France)

Role of HTA in reimbursement

- Provide reference basis for policy makers
- Clinical data vital, but HTA data often used to identify subgroups which can be efficiently treated
- Often relevant for showing savings (smaller budget impact)

Use of HTA by insurers and providers (regional level)

- *power tends to shift from central to regional levels of decision-making and therefore insurers, providers and decentral government agencies should learn to use HTA*
- UK: appraisals and NICE guidance are used by NHS actors at regional and district level
- insurance based systems: insurers still behind in understanding and applying HTA; hospital management lacks expertise and incentives to use HTA information; future environment (market conform allocation) may provide more incentives for these actors to get involved.

HTA and medical practice

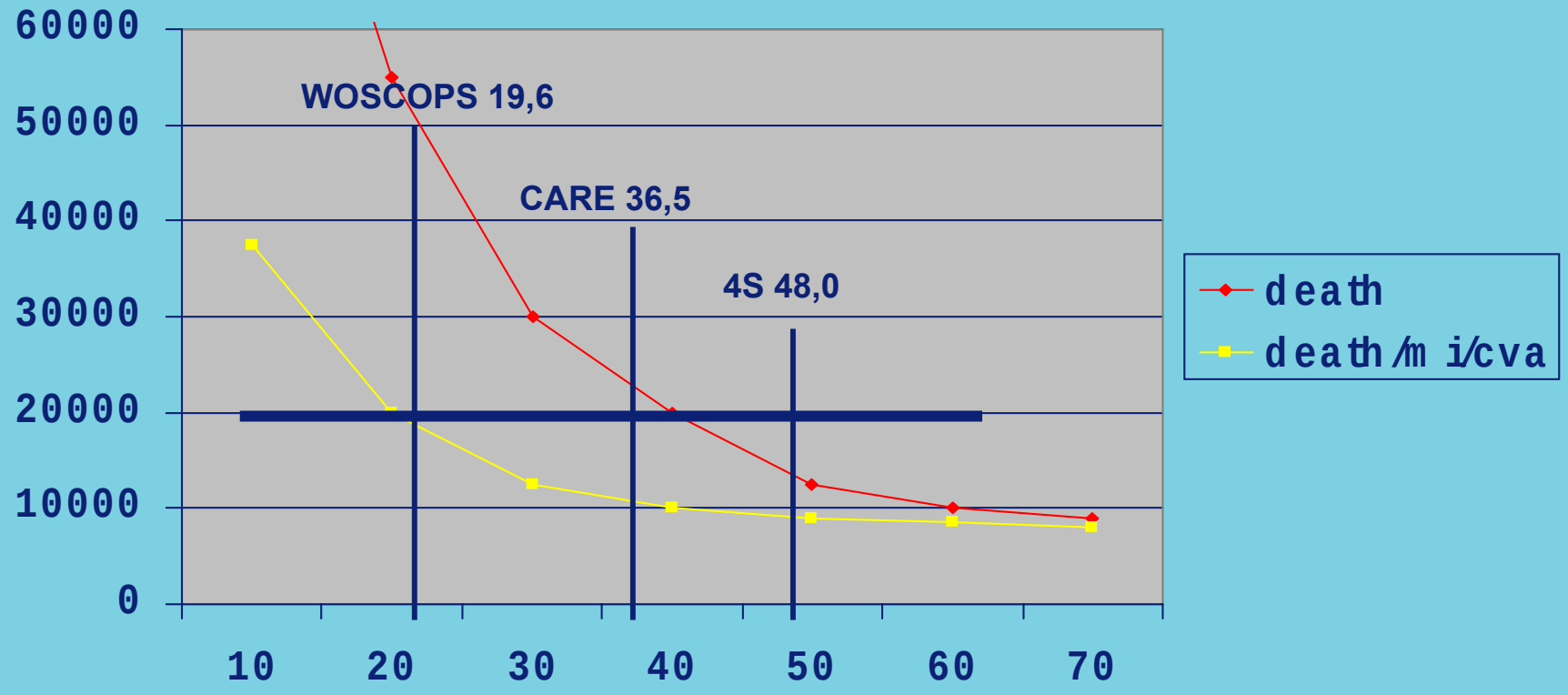
- Practice guidelines incorporating CEA information are scarce in most EU countries and available at a limited scale in UK and Netherlands.
- Limited evidence of the impact of practice guidelines on actual practice.

Observation: through HTA based practice guidelines the efficiency of medical practice may be significantly enhanced, but the low availability of such guidelines and the inefficiency of dissemination policies restrict their actual impact.

Relevance of HTA based policies for CEECs

- EU systems range from state financed to insurance based and decision making ranges from centralised to decentralised.
- HTA has different positions in these systems and this may be similar in CEECs
- CEECs differ from EU countries in willingness to pay for health care and in capacity to provide country specific HTAs (supply side) and to interpret and implement HTA-info (demand side)
- therefore priorities for HTA research may differ in CEECs

Shifting WTP downwards decreases target group for cholesterol lowering



Choosing topics for HTA

- Selection of topics often not explicit and generally researcher driven
- Formal process of agenda-setting for UK's R&D programme:
  - 5 criteria: reducing uncertainty, time to impact, value for money, urgency, other related priorities
  - 3 panels (pharmaceuticals, therapeutic procedures,diagnostics), 3 step procedure to narrow down selection
- NICE prioritisation process in 4 stages: scanning, first selection (health benefit, impact other health related policies, budget impact, added value of guidance), Dept of Health final selection, NICE determines scope (technologies/comparators, subgroups, outcomes)
- CEECs may learn from experience in the UK

Categories of HTA info

- Primary research: collection of new data in RCTs or from clinical or routine databases (British and Dutch R&D fund)
- Secondary research: systematic review with economic modelling (SBU)
- Tertiary research: guidelines and other forms of disease wide syntheses of evidence (NICE)
- Similar generalisation issues in all 3 categories

Transferability of HTA evidence

- Both effectiveness and costs may be country specific
  - treatment and patient group may differ across countries and so the impact of treatment on health
  - resource use and unit prices differ
- Countries require modelling to extrapolate from evidence produced in other settings
- Use a checklist of 8 points for translation to a specific setting

Checklist differences across settings

1 choice of comparator

2 patient characteristics (inclusion/exclusion, randomisation)

3 demography and epidemiology (incidence/prevalence, disease phase, risks/life expectancy, public programs as breast cancer screening)

4 availability and use of resources (culture, infrastructure,compliance)

5 financial incentives (fee for service versus capitation/budget)

6 price levels (labour costs, equipment)

7 relative prices (drugs/consultation/patient day)

8 methodology of costing (method of depreciation, handling overhead)

Price difference USA-Netherlands (€)

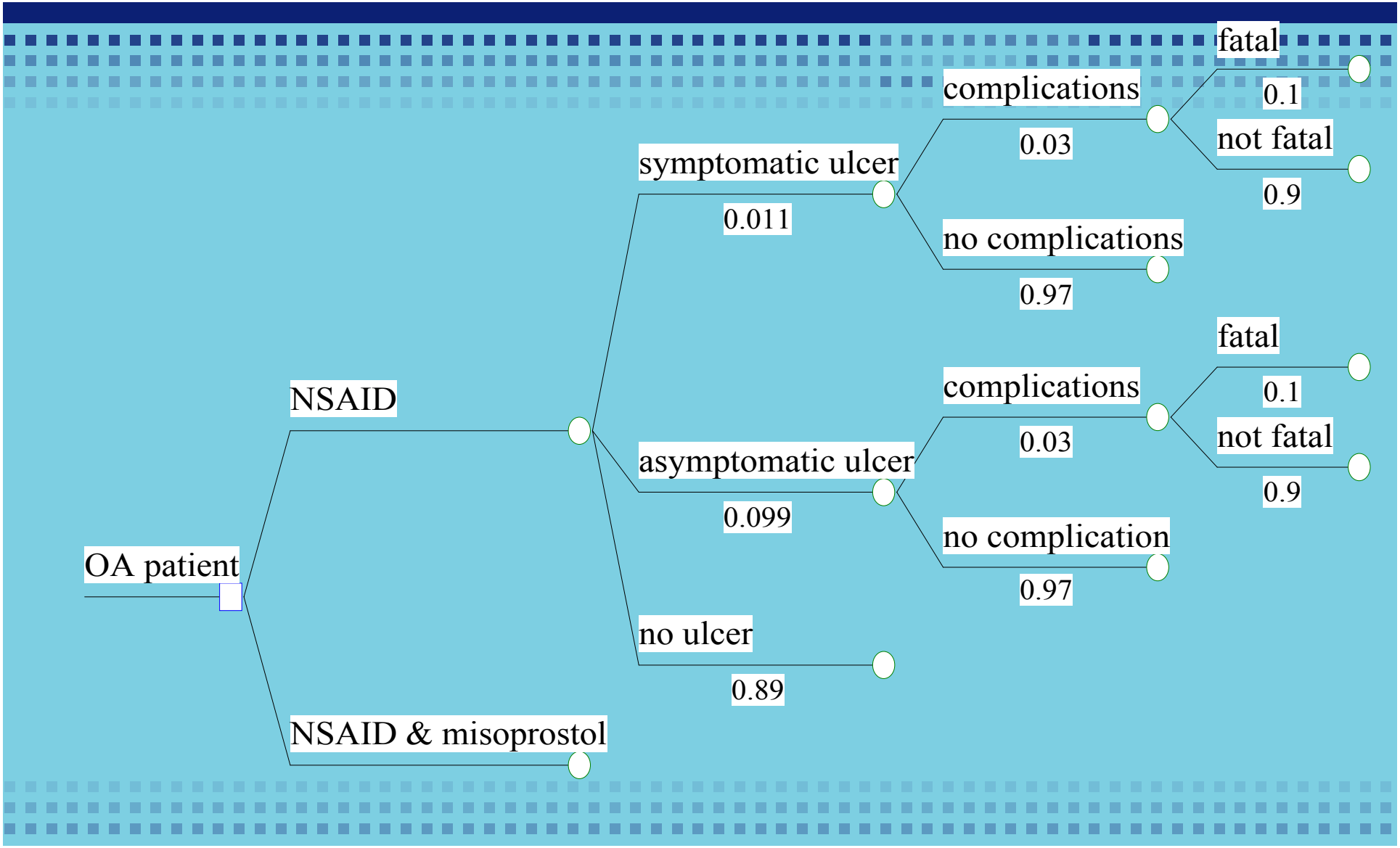
	Neth	USA
Patient day	215	1286
Specialist visit	41	42
Emergency dept visit	79	217

Prices in 1998 EUROs

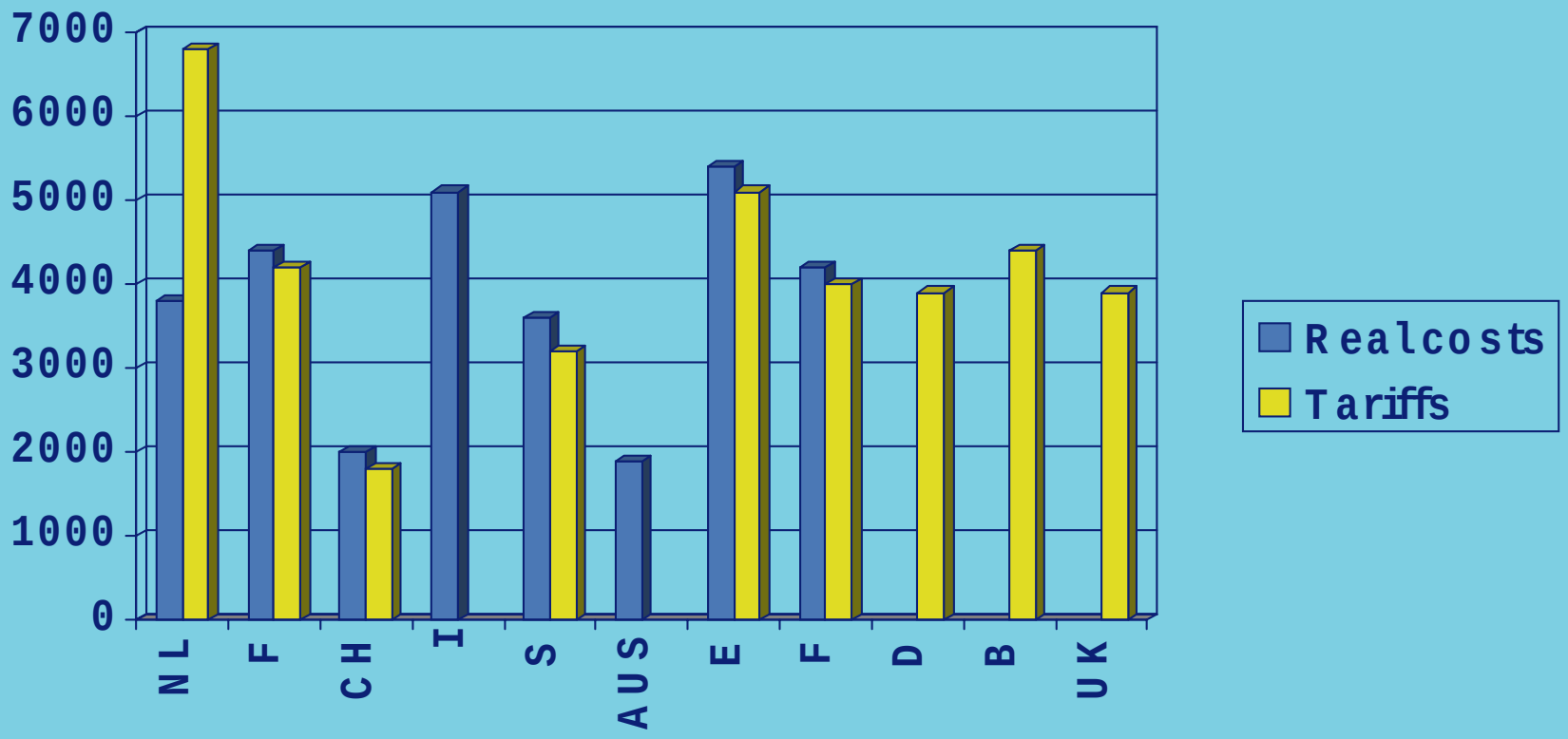
Methodology for extrapolation

- Regression technique to handle data from international trials (Willke et al., 1998)
- Specify Markov-model and estimate country specific transition probabilities (if necessary) and country specific cost profiles per Markov-state

Decision tree for OA patients



Treatment costs of NSAID-related gastrointestinal toxicity in 1999 $US



Chevat et al., PharmacoEcon 2001; 19 S1: 17-32

Conclusions

- Developing opportunities for using HTA in policy in CEECs
- Use of evidence from elsewhere using modelling to make it applicable to the country's circumstances
- Apply the checklist for proper transfer of findings
- Case study of Laszlo to illustrate that straightforward translation misleads

Translation to the Hungarian situation: Ace-inhibitor for high risk patients

- Translation of effectiveness data from the HOPE 2000 study
  - because of lower life expectancy in Hungary fewer life years gained
  - other prevalence of risk factors in Hungarian population (smoking)
  - differences in compliance of doctors and patients
- Relative prices
  - lower cost of manpower, but similar drug costs
- Budget impact
  - differences in disease prevalence, resource use and unit costs