LSE Department of Health Policy

IMPACT HTA

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IMPACT HTA Final Workshop

Improved methods and actionable tools for enhancing HTA

DISCLAIMER

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WP11 : From HTA results to guidance implementation: paving the way

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WP11: Decrementally cost-effective interventions (d-CEIs)

d-CEIs: cost-saving interventions that may marginally diminish individual health outcomes

WP11 addresses the following gaps:

- d-CEIs present an optimal cost-outcome combination (just as incrementally cost-effective interventions) but their potential remains undervalued: they have received much less attention from HTA bodies
- Lack of evidence about the willingness of decision-makers to accept a quality reduction for a cost-saving: => Are they ready to consider d-CEIs amongst the range of treatment strategies? To adopt d-CEIs ? If so, under which conditions?

How does WP11 contribute to improving the conduct of HTA?

- A systematic literature review to 1/identify evidence on d-CEIS (n=94); 2/document HTA bodies' practices on a subset d-CEIs; 3/ inform the empirical part of WP11
- A discrete-choice experiment to elicit decision-makers' preferences (n=156) from 18 countries: Results: 1/ health loss and reversibility are indeed the most important attributes; 2/ cost-savings play a greater than expected role decision-making; 3/Disease severity and uncertainty about cost-savings important sensitivity attributes; 4/ need to calibrate carefully DCE (e.g. exclude high severity) using qualitative approach; 5/usefulness of DCE to discuss individual and collective benefits
- A political economy report to document the distinctive characteristics and welfare properties of d-CEIs, analyze their ethical underpinnings and compare respective health care policies

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#1st analytical dimension: efficiency and equity considerations

From cost-containment to efficiency and equity enhancement

- d-CEIs differ from cost-containment *per se* and can contribute to:
  - overall sustainability (by eliminating obsolete or dominated interventions)
  - maximize population health (by reallocating savings on key incrementally CE interventions)
  - accommodate special needs (by prioritizing costlier alternatives on target populations)
- Including d-CEIs in the set of comparators will trigger explicit, thus transparent and participatory, discussions about underlying principles and judgements

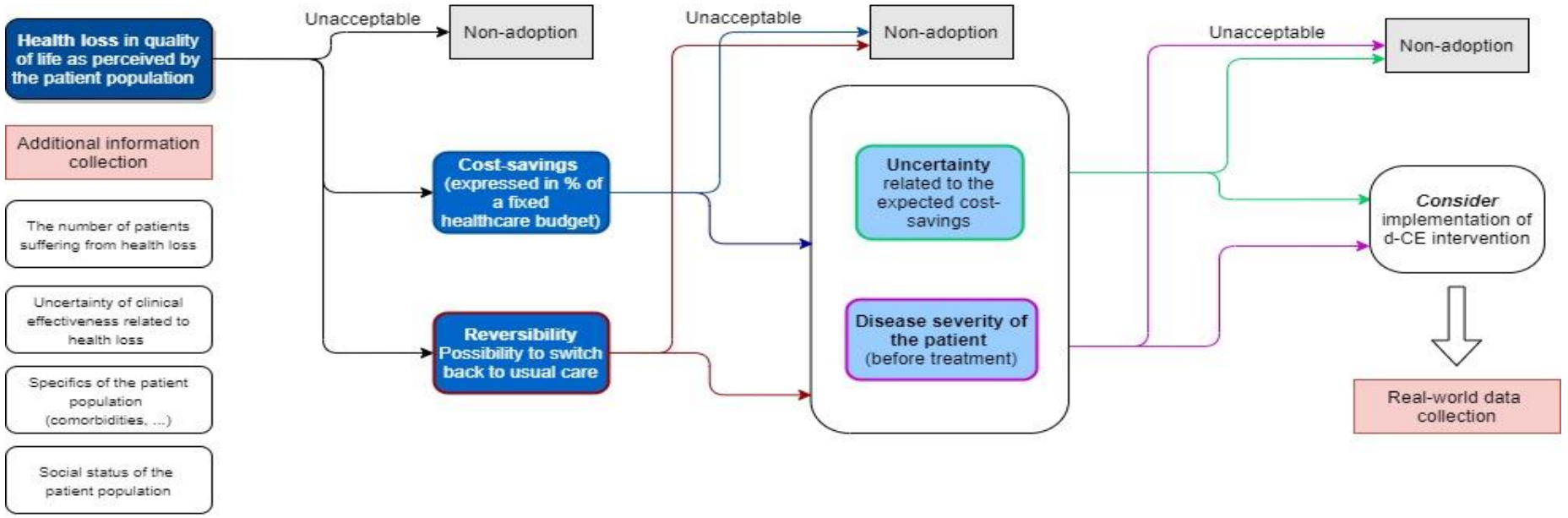
Four main policy recommendations to ensure appropriate adoption of d-CEIs

- Mainstreaming: when deciding about implementing a new intervention, decision-makers shall be encouraged to systematically consider d-CEIs as ethically licit and politically acceptable alternatives to usual care;
- Inclusiveness and transparency: decision-makers shall be encouraged to actively involve all stakeholders early on in the decision-making process for securing understanding and possible adherence in case of adoption;
- Exhaustivity: all forms of d-CEIs should be considered, such as complementary non-pharmaceutical interventions (such as physical activity) or stepped care approaches (first/second line of treatment).
- Social justice and ethics: considering d-CEIs in the HTA process should foster an explicit discussion of the underlying value-judgements, ethical and social justice principles embedded in the anticipated savings reallocation

#2nd analytical dimension: a toolkit to decision-makers

A **toolbox** provides guidance for the implementation of the policy-recommendations and comprises 3 tools:

- The **actual discrete choice experiment** to be used in many different settings, such as HTA committees or for teaching purposes, to illustrate the individual and collective stakes associated with adopting d-CEIs
- An **ethical/political check-list** that aims to inform the appropriateness and acceptability of **considering** d-CEIs as part of the treatment choice set.
- A **decision-tree** focusing on the three main attributes which have been found to be most influential in the discrete choice experiment, to guide decision-makers' choice of **adopting** d-CEIs.



Impacts and Future Agenda

Impacts

By providing an extensive and multidisciplinary analysis of d-CEIs, WP11 **offers margins of actions to scale up interventions and to maximize population health**, **while ensuring core values** identified for European healthcare systems

By questioning the validity of the justification often used by policy-makers for not considering d-CEIs (their 'unethical nature'), **WP11 opens doors to further democratic debate on resource allocation practices**

Future developments

Multi-disciplinary research in d-CEIs is only just beginning, compared to other fields of application:

- **More collaborative research action** is needed, jointly with HTA agencies, in order to further investigate the willingness of decision-makers in the European Union to consider the implementation of d-CEIs according to the specificities of their national healthcare and legal systems
- By **enhancing the current the discrete choice experiment results** in order to:
  - document population preferences, to be compared with those of decision-makers
  - expand research to mixed clinical approaches, such as stepped care or combined use of pharmaceutical and non-pharmaceutical interventions, to further document the true potential of d-CEIs

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From HTA results to guidance implementation: paving the way	**Lise Rochaix (EEP PSE)** **Comments by Pr. Jean-Michel Josselin (University of Rennes 1)**

To accept discussing dCEIs implies the extension of the scope of efficiency analysis

- From partial equilibrium reasoning on health condition X, with its current and potential patients (northeast quadrant)
- To general equilibrium reasoning on conditions X, Y, Z etc. with "rational Rawlsian patients" (Dowie 2004:457)

Those patients: represented by Health Authorities in charge of carrying out the social contract (after "under the veil of ignorance" discussions)

To accept implementing dCEIs requires the elicitation of Health Authorities' preferences

- To what extent are they willing to include the southwest quadrant into their choice set?
- To what conditions are they willing to select dCEIs?

The impact HTA report elicits preferences through discrete choice experiment

The Impact HTA report pertinently distinguishes:

- Willingness to **consider** dCEIs: shall we include them in the choice set?

  From

- Willingness to **adopt** dCEIs: how do we select them within the choice set?

Dowie (2004) Why cost-effectiveness should trump (clinical) effectiveness: the ethical economics of the South West quadrant. Health Econ 13.

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An appropriate choice of DCE attributes …

Central attributes:
- Extent of health loss
- Reversibility of the loss
- Extent of cost-saving

Sensitivity attributes:
- Extent of disease severity
- Uncertainty in cost-saving

… Leads to important findings (non exhaustive)

The choice perspective is a persisting dilemma
- Patient's health standpoint: health loss reversibility attribute prevails
- Population's health standpoint: cost-saving attribute prevails in relation to priority area setting

Double agency phenomenon

Significant health losses hardly are an acceptable prospect
- But what does "significant" mean? Marginal versus discrete health loss?
- Kinked thresholds might be unethical, but they are resilient!

Selling price of a QALY > its buying price?
(O'Brien et al. 2002:179)

Switching back to usual care matters
- But there seems to remain a kind of tradeoff with the cost-saving item
- Switching back is not neutral from a population (general equilibrium) viewpoint!

Social acceptability of such a policy backshift?
("Why did you do it in the first place?")

O'Brien, Gertsen, Willan, Faulkner (2002) Is there a kink in consumer's threshold value for cost-effectiveness in health care? Health Econ 11.