Public health and HTA

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Introduction

- HTA is a much younger discipline than public health
- Public health provides some of the essential information and inputs to the HTA practice
- The problem of focus and weights
- Influences of different stakeholders and their respective powers

Background

- Public nature of health care systems in Europe
- Most of the services delivered are financed through public funds (either social insurance or taxation)
- Joint feature is scarcity of resources

Background 2.

- Control and cost containment mechanisms used:
  - Priority-setting
  - Intense prevention programmes
  - Explicit or implicit restrictions in access

Controversies between HTA and public health

- Focus – individuals vs. populations
- Priorities – balancing between benefits to the individual and the population
- Weights – high ‘yields’ for small populations or groups of patients or smaller ‘yields’ for larger populations

Controversies between public health and HTA 2.

- Easy consensus on prevention and screening programmes
- Difficult to explain restrictions and preferential treatments
- Singling out part of pathology or some particular diseases, favouring them in treatment and access

Equal access?

- New technologies at all levels challenge the stability and even the viability of the present health care systems
- Is equal and unlimited access to all ‘recognised’ treatments realistic?

Alliances between HTA and public health

- A lot of HTA’s scientific base is derived from analytical work produced in public health
- Interests of focusing on populations, beit smaller or larger, but still going beyond the individual’s level

Case for public health in HTA discussions

- Possible effectiveness and efficiency of early detection and early treatments
- Modification of outcomes irrespectively of the change in lifestyle
- Priority-setting or preferential selection of diseases and/or treatments

Problems

- Even with proven efficiency early detection and early treatment programmes still prove to be a strain on resources
- Lifestyle modifiers represent a special challenge – removing a symptom does not influence the causes of a disease
- Is it fair to finance such therapies from public funds in cases where patients are non-cooperating?

Is cost sharing an answer?

- Increasing availability and accessibility through cost sharing
- Health technology cannot be simply translated into a burden for the patients
- Priority-setting for constrained resources
- Biases of priority-setting

Issues with stakeholders

- Stakeholders are always weighted differently
- The need to steer the decision making process
- Finding compromises with different stakeholders

Conclusions

- HTA is part of the broader infrastructure in public health
- New technologies as a particular challenge to stability and viability of the systems
- Joint mission of HTA and Public health as there is common ground of interest and mutual co-operation.

Conclusions 2.

- Issues of fairness and equity will come forward
- Stressing the interests of a population problem cannot always overcome the individual's situation
- Lifestyle modifiers and the high-end expensive technologies as the challenge to public health strategies

Health Technology Assessment and Quality of Care

What's in it for the transition countries

9th European Health Forum Gastein 2006

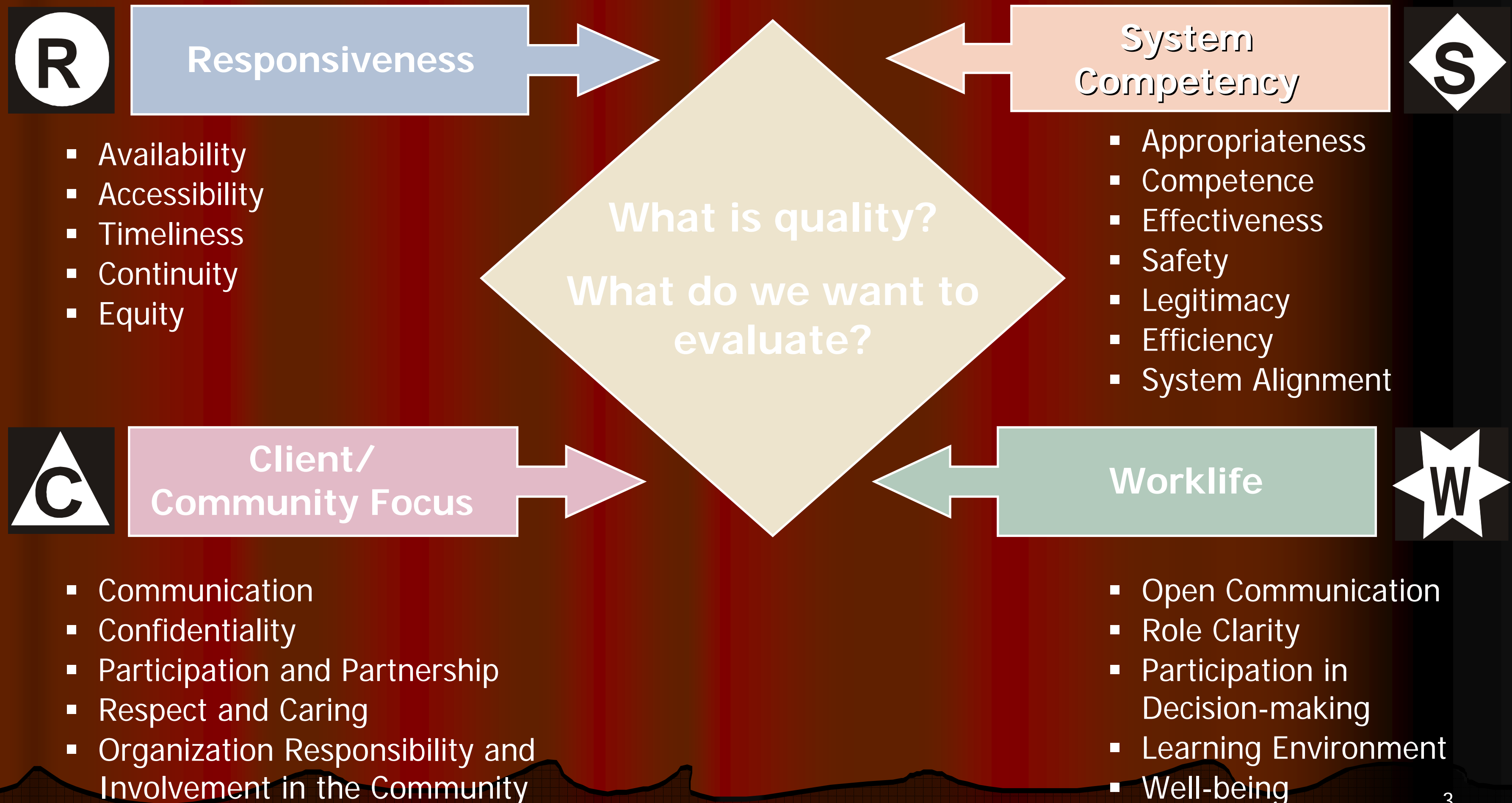
Jan Bultman, Lead Health Specialist,
World Bank, Washington, DC

The Answer

- A lot can be in it for the transition countries, but …
- They need your support

Quality Framework

Elma Heidemann, Antalya 2004



- Availability
- Accessibility
- Timeliness
- Continuity
- Equity

- Appropriateness
- Competence
- Effectiveness
- Safety
- Legitimacy
- Efficiency
- System Alignment

- Communication
- Confidentiality
- Participation and Partnership
- Respect and Caring
- Organization Responsibility and Involvement in the Community

- Open Communication
- Role Clarity
- Participation in Decision-making
- Learning Environment
- Well-being

HTA and quality
What binds them together?

- HTA provides for the structural aspects of the quality of health care:
  - Effective **benefits package and public health methodologies** prevents patients from exposure to harmful interventions or preventable external agents
  - Appropriateness of **distribution** of technology over country/region and level of care
  - Appropriateness of buildings, equipment, drugs, supplies for the specific technology delivered
  - Requirements for provision of recurrent costs maintenance, organization and training of staff

HTA and quality
What binds them together (II)?

- HTA provides also for the process aspects of the quality of health care:
  - Provides for basic input in clinical practice guidelines (CPGs), i.e. which technology, on what indication, by when and to which patient. Therefore HTA sets also:
  - Referral criteria and it fosters cooperation between levels of care
  - Participation of clinicians (opinion leaders) in HTA fosters uptake of CPGs and therewith quality care

HTA and quality
What binds them together (III)?

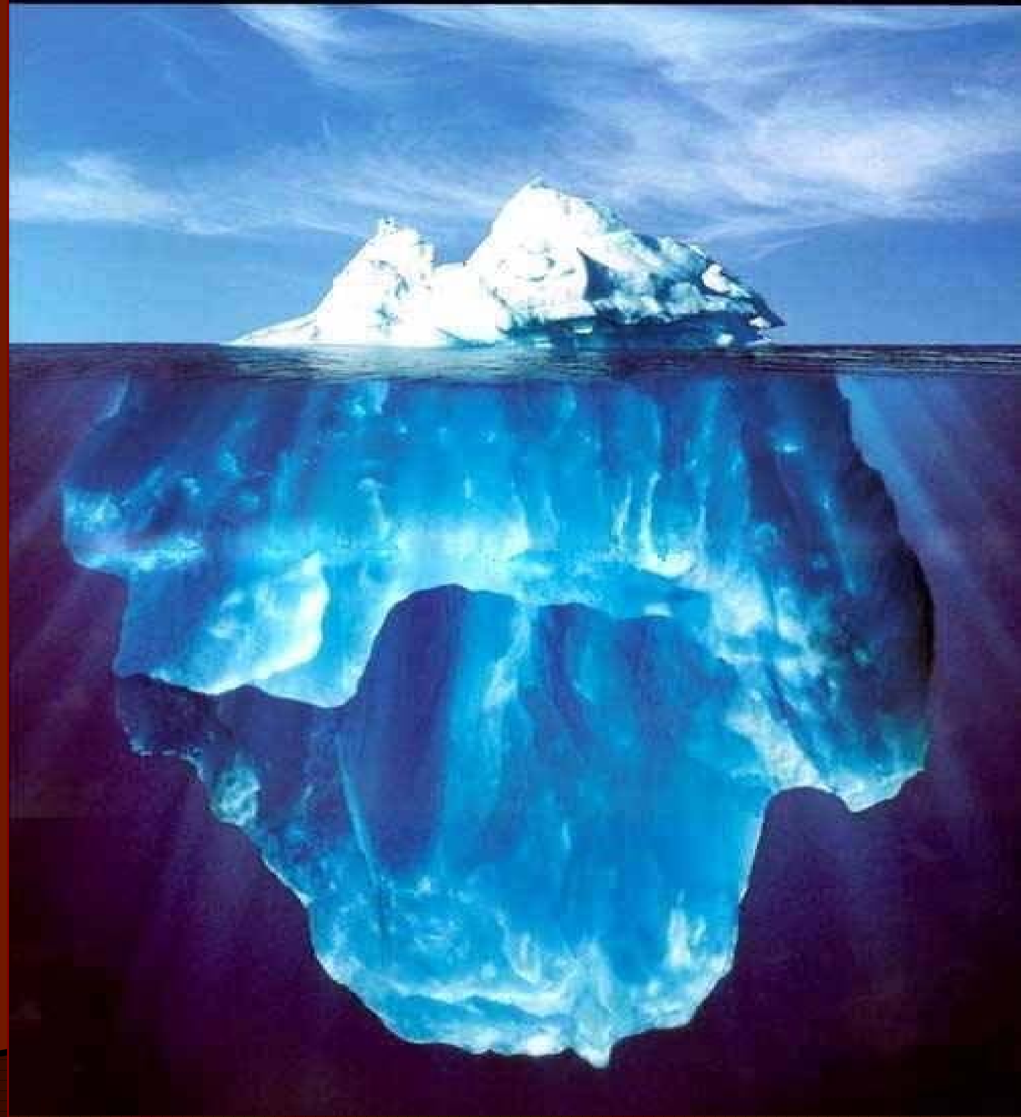
- HTA optimizes the use of resources in budget constrained environments

Key Issues in transition countries

- Medical equipment is often purchased **without:**
  - Any needs assessment,
  - Cost-effectiveness analysis,
  - Estimates of the future recurrent costs for the nation and the health care facility
  - No commitment on how to cover these recurrent costs
  - A services policy plan as to where, on what level of care to place what type of technology

AFFORDABILITY and SUSTAINABILITY
The "Iceberg Problem"

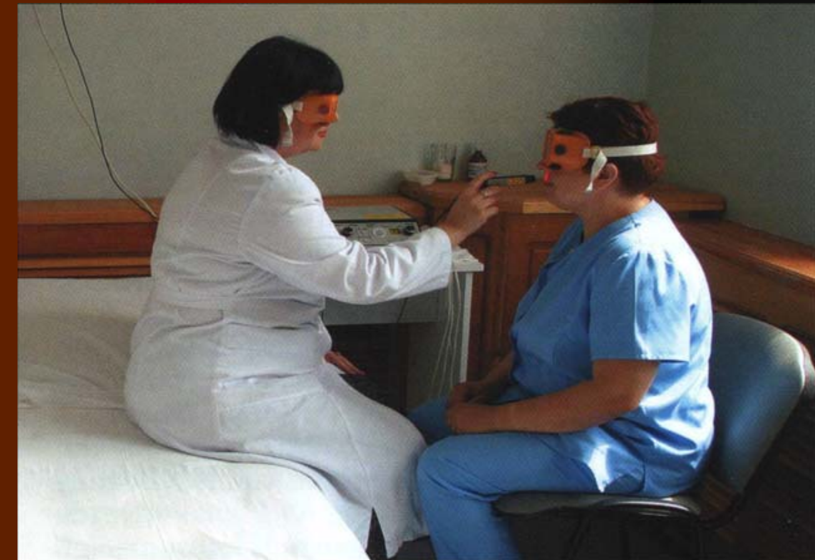
Recognized Costs
Hidden Costs



Source: Binseg Wang

Key Issues in transition countries

- Eminence based medicine: Use of **unproven methods of treatment** (dysbacteriosis; physiotherapy; low frequency lasers etc.) or on the wrong indication (infusion therapy),
- Medical Information Systems: inadequate, unreliable unconnected, non-standard, with little or no data security
- Few staff are trained to operate equipment safely or maintain it properly



Laser therapy in Russia

Medical science in transition countries

1. *Concept of randomization not much known!*
2. *Modern epidemiology?*
3. *Medical statistics not reliable!*
4. *Ineffective methods!*
5. *Concept of sampling not wide spread?*
6. *"We deadly need evidence of the effectiveness of interventions and on the diseases' incidence and prevalence, but we also are in the need of qualitative improvement of methodology of research"* (Vasiliy V. Vlassov, Director, Russian Branch of the Nordic Cochrane Centre: March '03)

HTA and quality assurance

- Provides the evidence to the inside and outside assessors about what works in health care :
  - Quality managers in health care facilities
  - Purchasers of health care services
  - Licensing bodies for health professionals
  - Accreditation bodies
  - Public health system managers

HTA and Quality Assurance

- Medicine is **probability science**, how successful it may be, it is using a **reductionist model**. I.e. please, no mechanical approach to the review of the appropriateness of provided services in individual cases.
- Meanwhile, **rebalancing responsibilities** of professionals and government/supervisory bodies is needed towards:
- **Clinical governance**: clear responsibility, transparency and accountability for providers
- **Using positive incentives** in a learning environment: are working best to change behavior of providers, although a stick behind the door is needed for the really unwilling characters

What has been done in transition countries
a mixed picture

- Some embarked on establishing some HTA capacity (like Latvia, Poland, Serbia, Kazakhstan, Slovenia and others)
- Many feel confronted with apparently wrong investments and benefits package decisions of the past
- Many have embarked on quality improvement and quality assurance activities in a areas like
  - Education of professionals (from re-training, the introduction of continuous professional development towards total revamping of the medical education system
  - Licensing and accreditation
  - CPG development, dissemination and implementation

What has been done in transition countries
a mixed picture (II)

- Not many have developed a comprehensive and integrated quality improvement strategy, based on an identification of the weak links in the health system and systematically working on their improvement.
- HTA was ignored too often but is now more and more seen as a necessary tool for:
  - more explicit decision making about the benefits package
  - investment decisions

What next?

- Consider a comprehensive quality strategy for public health and curative health services
- Dependent of a country's wealth and size, invest in HTA capacity
  - Capability on the policy level to ask the right questions at the right time, to the right national and international experts and other sources of HTA and EBM knowledge; via
  - Commissioning the transfer of international HTA in national terms; and
  - Contracting original HTA, up to comparative clinical and field trials; towards
  - Capacity to interpret the results; and
  - To implement the policy, using established rules/conditions of the game for planning, fee setting, CPG development and benefits package updating
- EU based HTA networks accessible for NON EU Members?

Conditions

- Time is ripe!
- Options available!
- Adequate patient protection in NON-EU Members is a must if involving them in clinical research:
  - informed consent
  - Ethical committees to review proposals
  - Adequate compensation for patients/relatives in case of adverse outcomes
  - Functioning and timely acting judicial system

Conclusion

- HTA and Quality of Care and Public Health are closely interlinked but the marriage has not yet come to full fruition
- International Bodies and Agencies, individual Governments, Associations and experts could support fostering further ties with transition countries on HTA and Quality to the benefit of all, as to keep our health systems viable and to allow for

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