

Contribution of innovative approaches to health systems' sustainability: Health Technology Assessment and Chronic Disease Management

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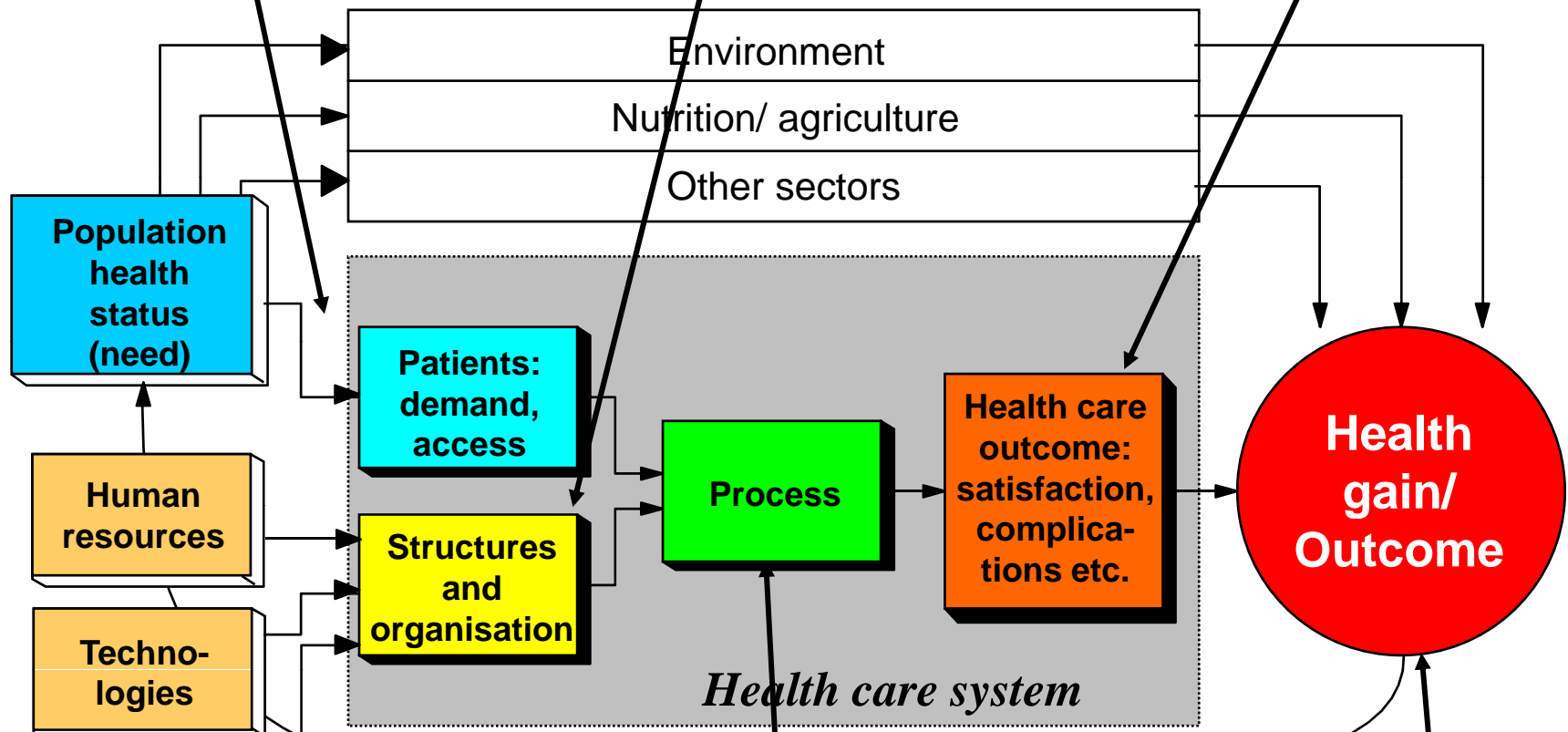
European Observatory on Health Systems and Policies



Needs-based access?

Personnel well qualified?
Institutions of high standards?
Technologies effective?

High-quality results?
Transparent?



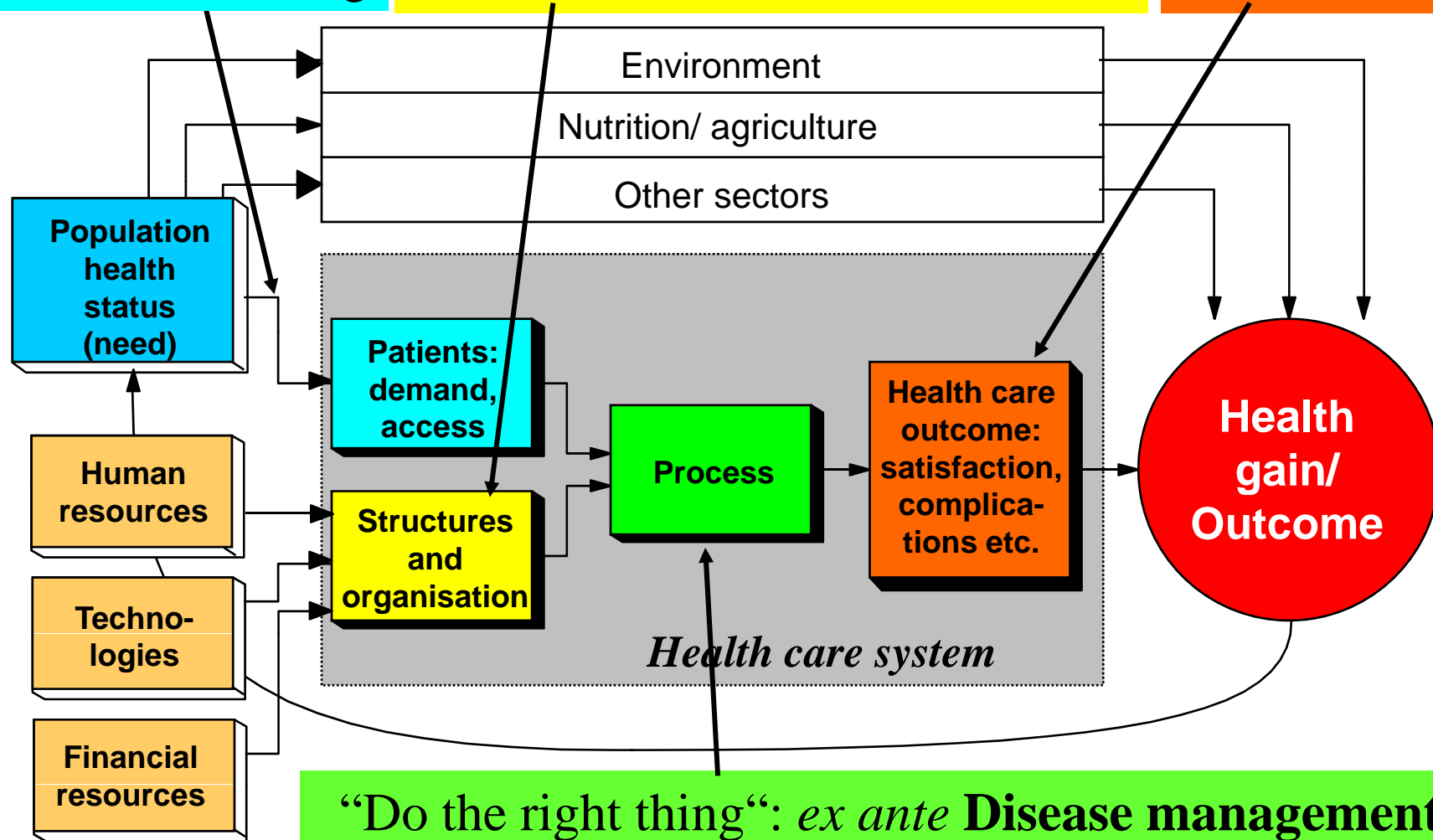
Patients receiving appropriate services?

How much?
Is it worth it?

Universal coverage,
appropriate
entitlements,
limited cost-sharing

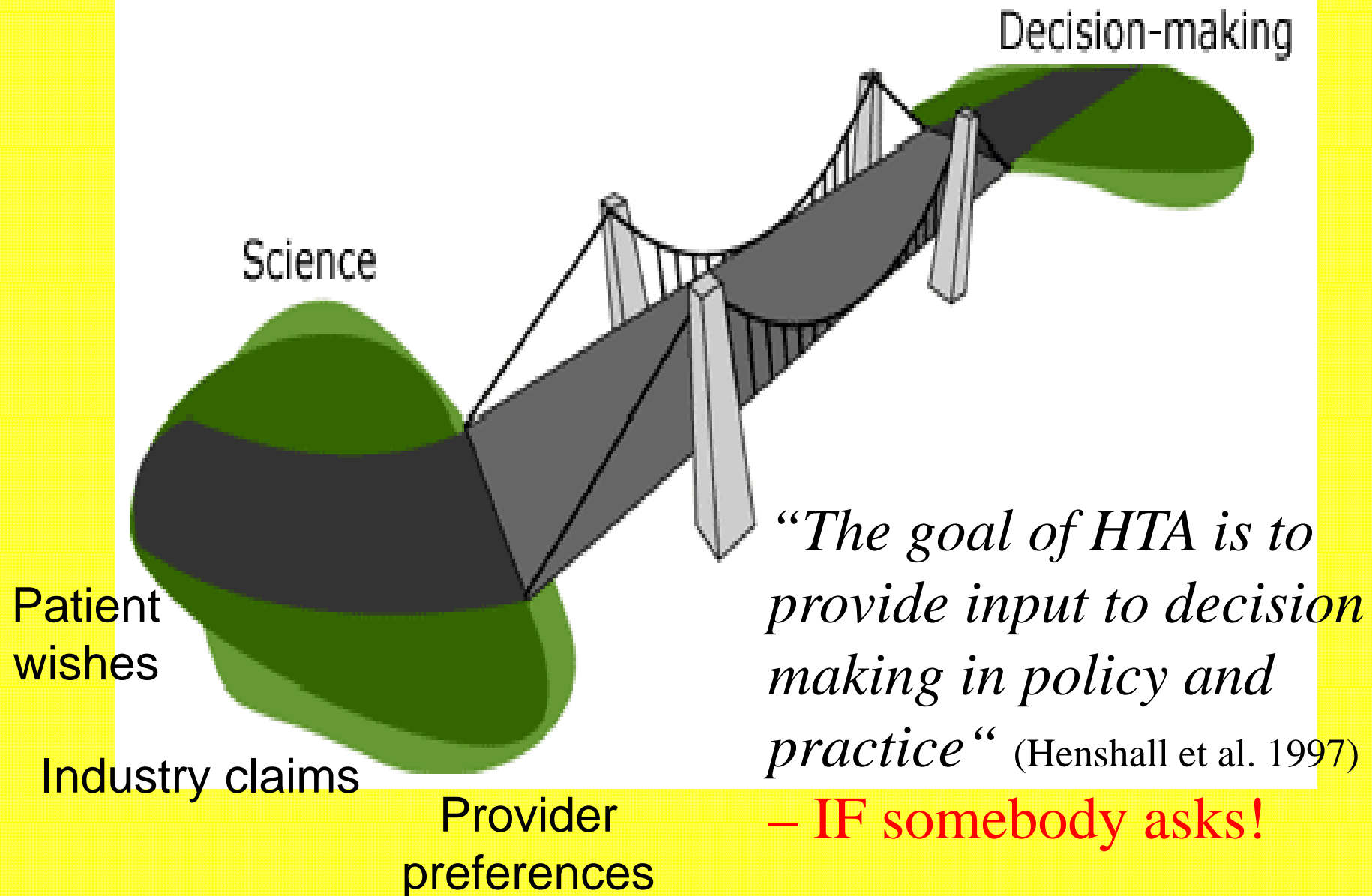
Professional (re-)certification
Provider (re-)accreditation
Health Technology Assessment
Concentration of services

“Do the thing
right“:
Registers;
benchmarking



“Do the right thing“: *ex ante* Disease management programmes/ guidelines/ reminders; *ex post* Review

Technology Assessment

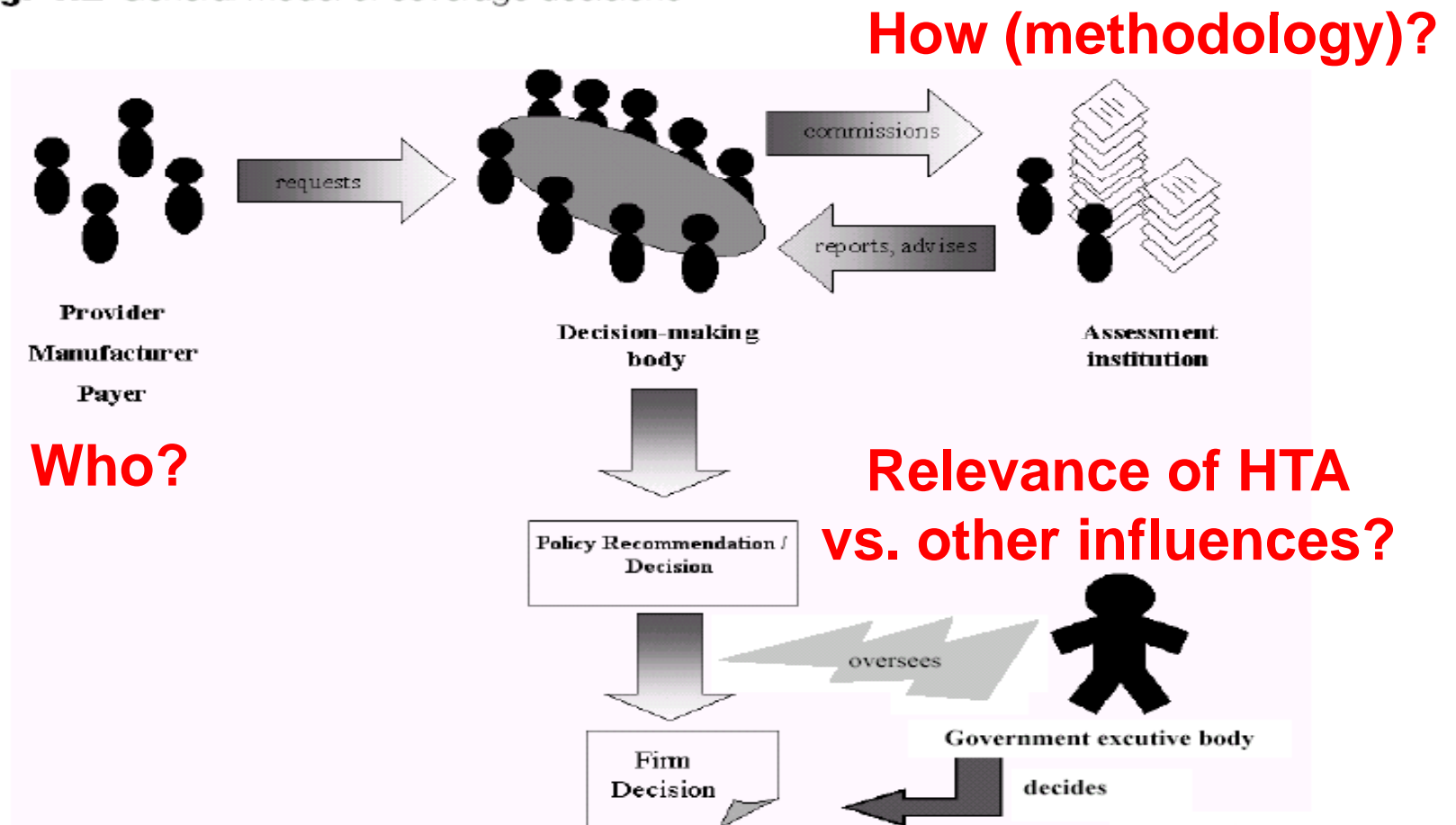


“The goal of HTA is to provide input to decision making in policy and practice” (Henshall et al. 1997)

– IF somebody asks!

HTA and Policy

Fig. 4.2 General model of coverage decisions



What? "Technologies" in hTa

- The **interventions** (drugs, procedures, complex multidisciplinary activities) which can be provided / reimbursed within the system when **delivering health services**
- The **interventions** applied to the system to **organize service** delivery, access, financing, payment of providers, etc.

An example

Practical Purpose

„improving survival after myocardial infarction“

Technologies

Aspirin

Stent

Early rehabilitation

Disease Management Programme

Payment for Performance

Health Technology Assessment: Efficacy vs. Effectiveness

Efficacy

- experimental conditions
- comparator: placebo
- outcomes: clinical, morbidity, mortality, adverse effects
- evidence packet

Licensing

Effectiveness

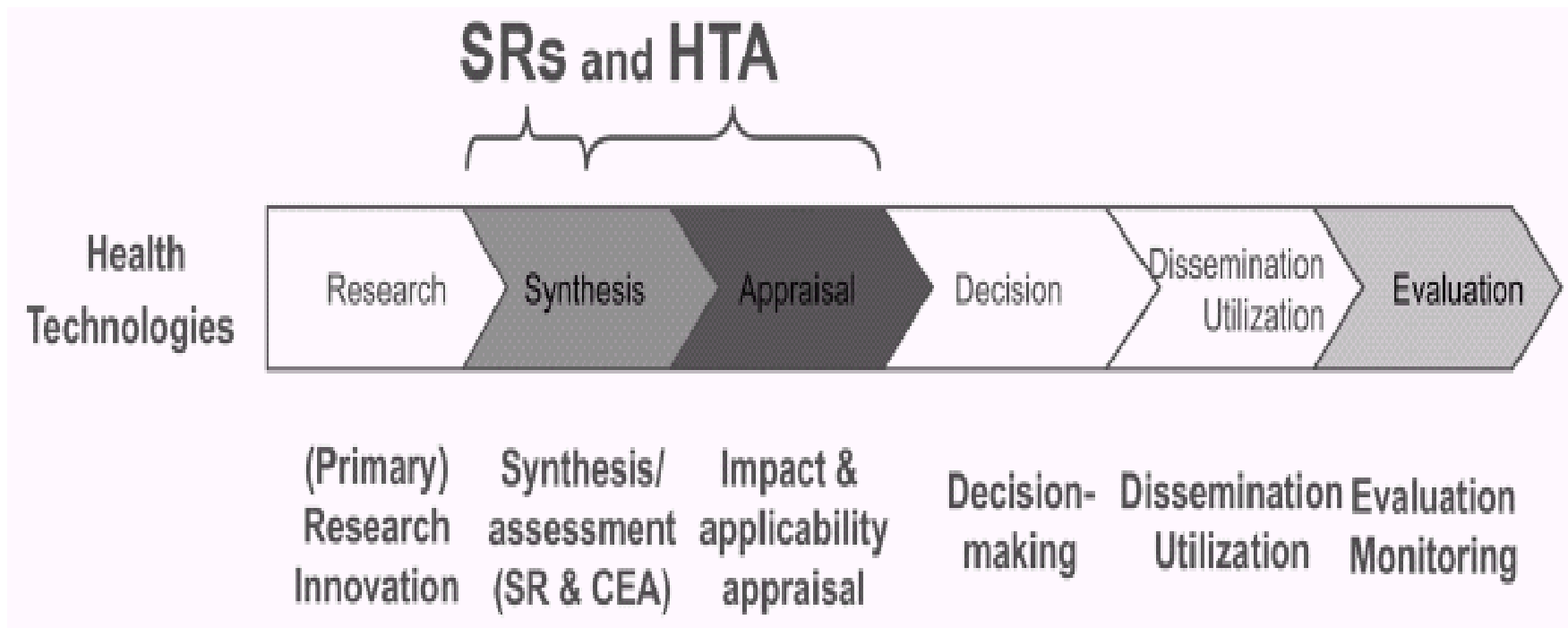
- real world conditions
- comparator: 'current (best) practice'
- outcomes: patient focused, downstream resources

Coverage

Evidence Gap

Role of HTA within "knowledge value chain"

Fig. 8.1 *Knowledge value chain in the health sector*

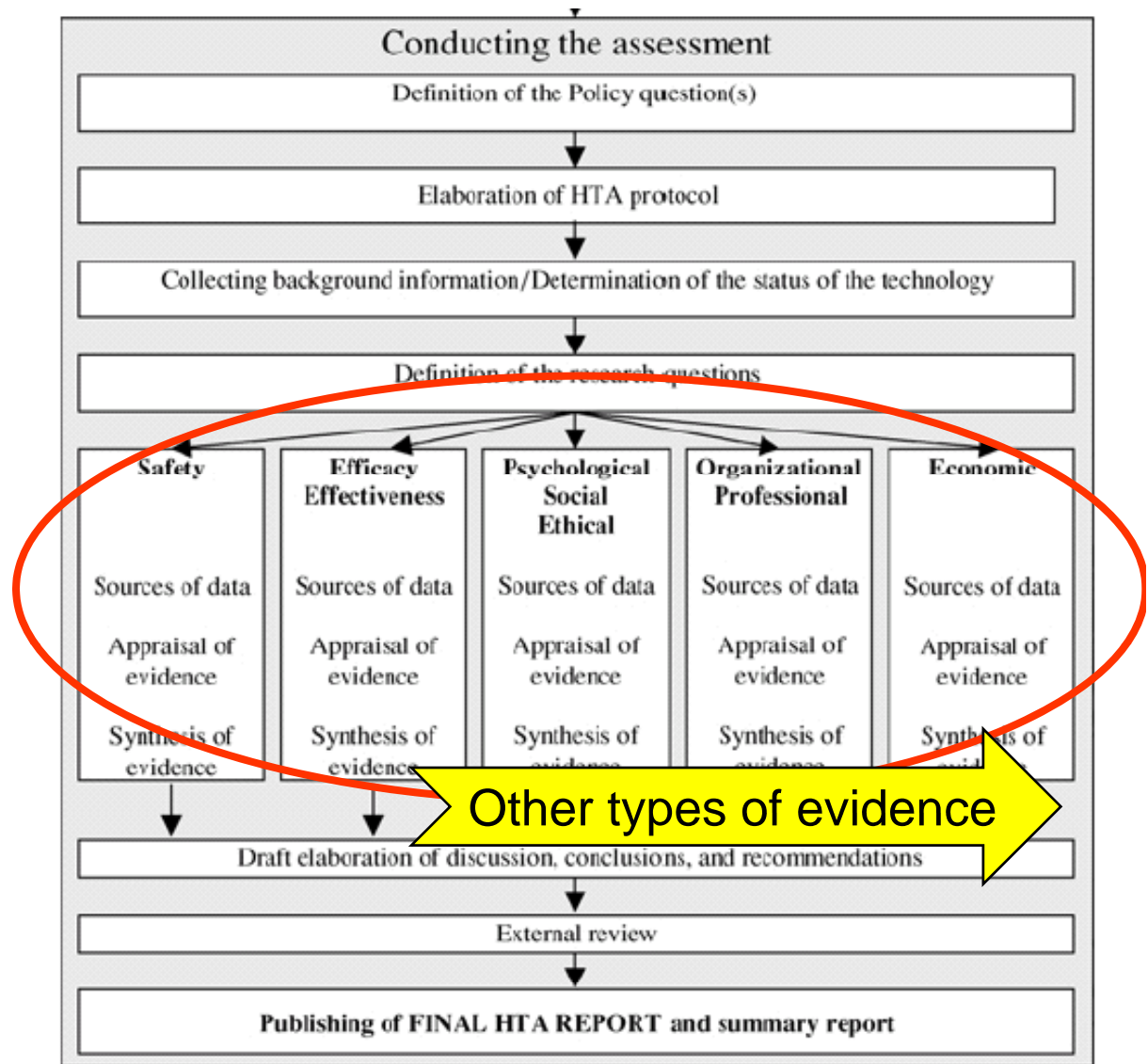


BEST PRACTICE IN UNDERTAKING AND REPORTING HEALTH TECHNOLOGY ASSESSMENTS

Working Group 4 Report

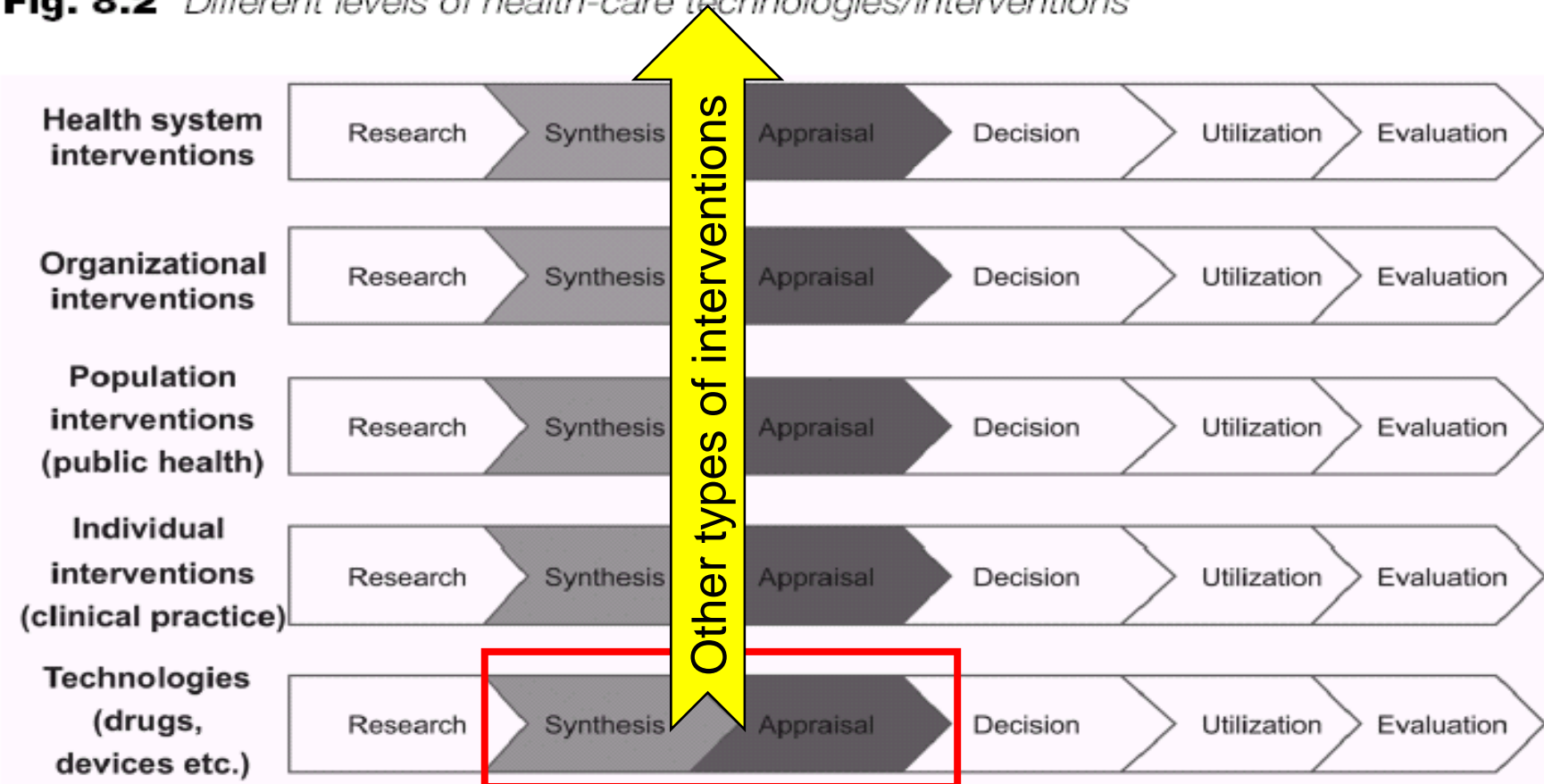
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Technologies and the "knowledge value chain"

Fig. 8.2 *Different levels of health-care technologies/interventions*



Broad HTA Institutions



The roles and responsibilities of NICE since 1 April 2005

NICE produces guidance in three areas:

Public health – the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

Health technologies – the use of new and existing medicines, treatments and procedures within the NHS

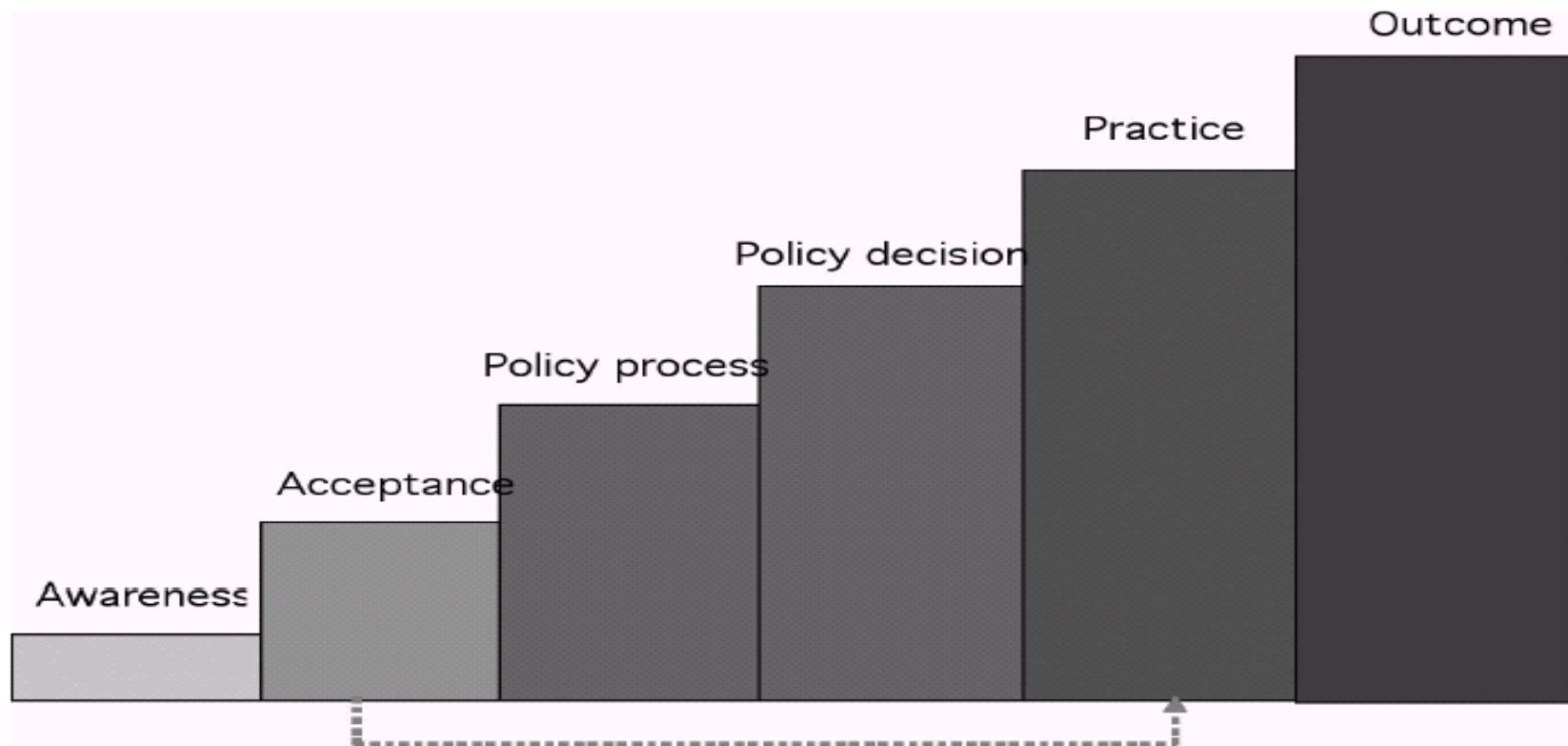
Clinical practice – the appropriate treatment and care of people with specific diseases and conditions within the NHS.



- l'analyse des pratiques cliniques et le développement de recommandations de bonne pratique (Good Clinical Practice)
- l'évaluation des technologies médicales (Health Technology Assessment)
- le financement et l'organisation des soins de santé (Health Services Research)
- l'équité et l'étude du comportement des patients (Equity and Patient Behaviour)

Impact?

Fig. 6.1 *Hierarchical steps of the impact of HTA reports*



- Policy processes and HTA
- Health systems, health policy and HTA
- HTA producers
- Impact of HTA
- Needs and demands of policy-makers
- Future challenges for HTA in Europe



www.euro.who.int/observatory

Disease management programmes: key elements

- comprehensive care: multidisciplinary care for entire disease cycle
- integrated care, care continuum, coordination of the different components
- population orientation (defined by a specific condition)
- active client-patient management tools (health education, empowerment, self-care)
- evidence-based guidelines, protocols, care pathways
- information technology, system solutions
- continuous quality improvement

DMPs are popular – at least in Germany, where they were tied to financial incentives until 2008

DMP	Number of patients enrolled in DMP 2008
Diabetes mellitus type 2	2,708,154
Diabetes mellitus type 1	93,357
Coronary heart disease	1,221,374
Asthma	313,914
COPD	264,299
Breast cancer	100,499
Total	4,701,597 (7% of all insured)

DMPs: How effective?

- *Crucial and weak point!*
- Most publications report on relatively small-scale interventions without control group or inadequate control (e.g. no randomization, no risk adjustment)
- (As for pharmaceuticals etc. :) the weaker the study design, the larger the published effects
- Logic of Evidence-based Medicine applies: best available evidence counts

How effective are Disease Management Programmes?

Disease	Clinical Processes	Health-related Changes in Behaviors	Disease Control	Clinical Outcomes	Healthcare Utilization	Financial Outcomes	Patient Experience Satisfaction, Quality of Life, Etc
	Adherence to Evidence-based Guidelines		Changes in Intermediate Measures		Changes in Utilization of Services		
CHF	Improved	Inconclusive evidence	Improved	Inconclusive evidence	Reduced hospital admission rates	Inconclusive evidence	Improved
CAD	Improved	Evidence for no effect	Improved	Evidence for no effect	Inconclusive evidence	Inconclusive evidence	Insufficient evidence
Diabetes	Improved	Evidence for no effect	Improved	Insufficient evidence	Inconclusive evidence	Inconclusive evidence	Insufficient evidence
Asthma	Inconclusive evidence	Inconclusive evidence	Inconclusive evidence	Evidence for no effect	Inconclusive evidence	Evidence for no effect	Insufficient evidence
COPD	Insufficient evidence	Insufficient evidence	Inconclusive evidence	Insufficient evidence	Insufficient evidence	Insufficient evidence	Insufficient evidence
Depression	Improved	N/A	Improved	Inconclusive evidence	Increased utilization	Increased cost	Improved

Codes: N/A: not applicable, as no relevant health-related behaviors for depression exist.

Disease-end point combinations in which disease management seems to achieve the intended result are shaded.

Source: RAND analysis using identified articles.

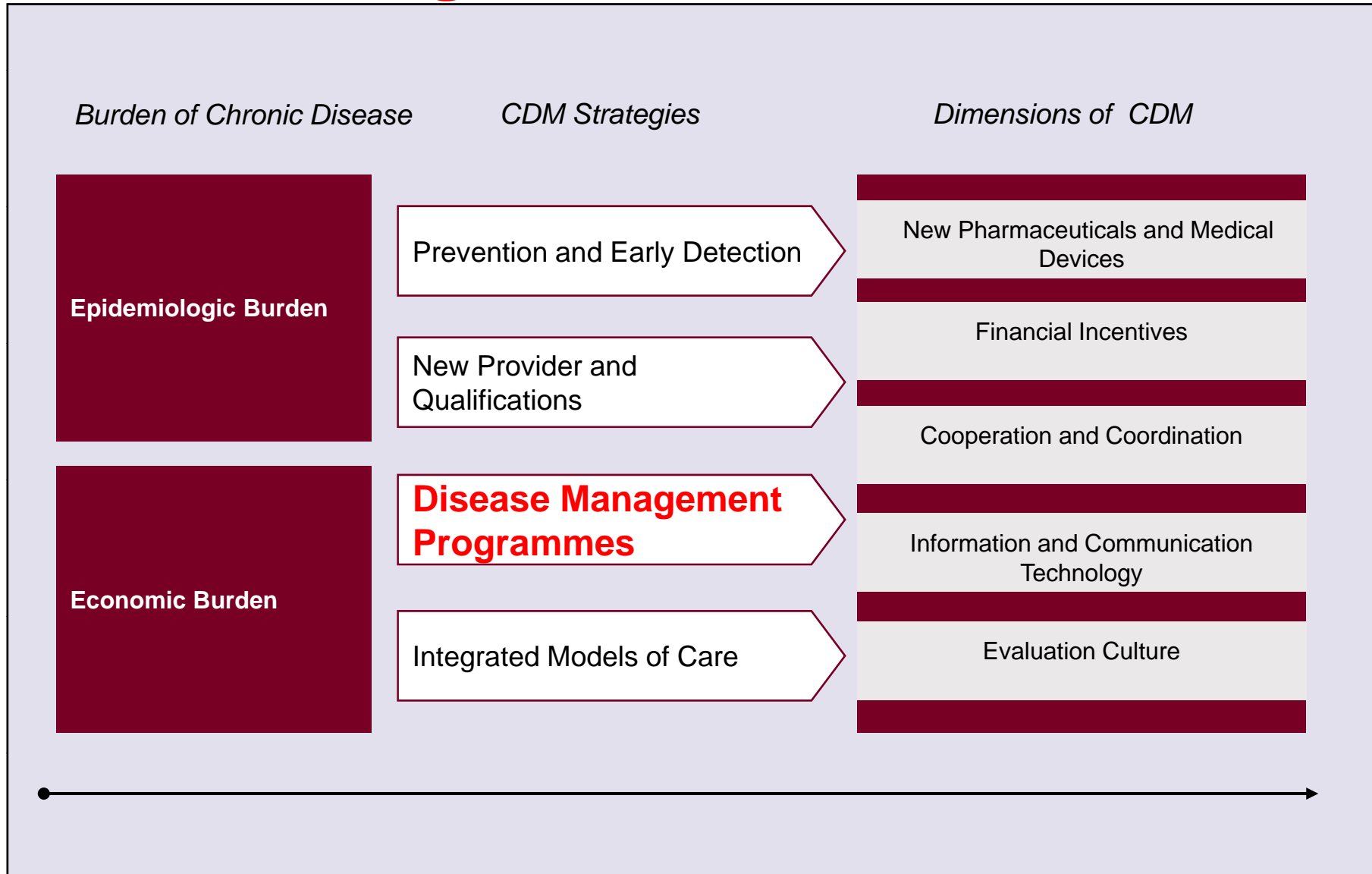
CHF indicates congestive heart failure; CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease.

Mattke et al. *Am J Manag Care*. 2007; 13: 670-676

DMPs: how costly and how cost-effective?

- Even less published evidence; if costs are reported in evaluations, the methodology is usually flawed!
- On macro-economic implications, we have to rely on models and projections!
- **Managing CD costs additional money (-> not effective for cost-containment in short run), but may be cost-effective (data missing!).**

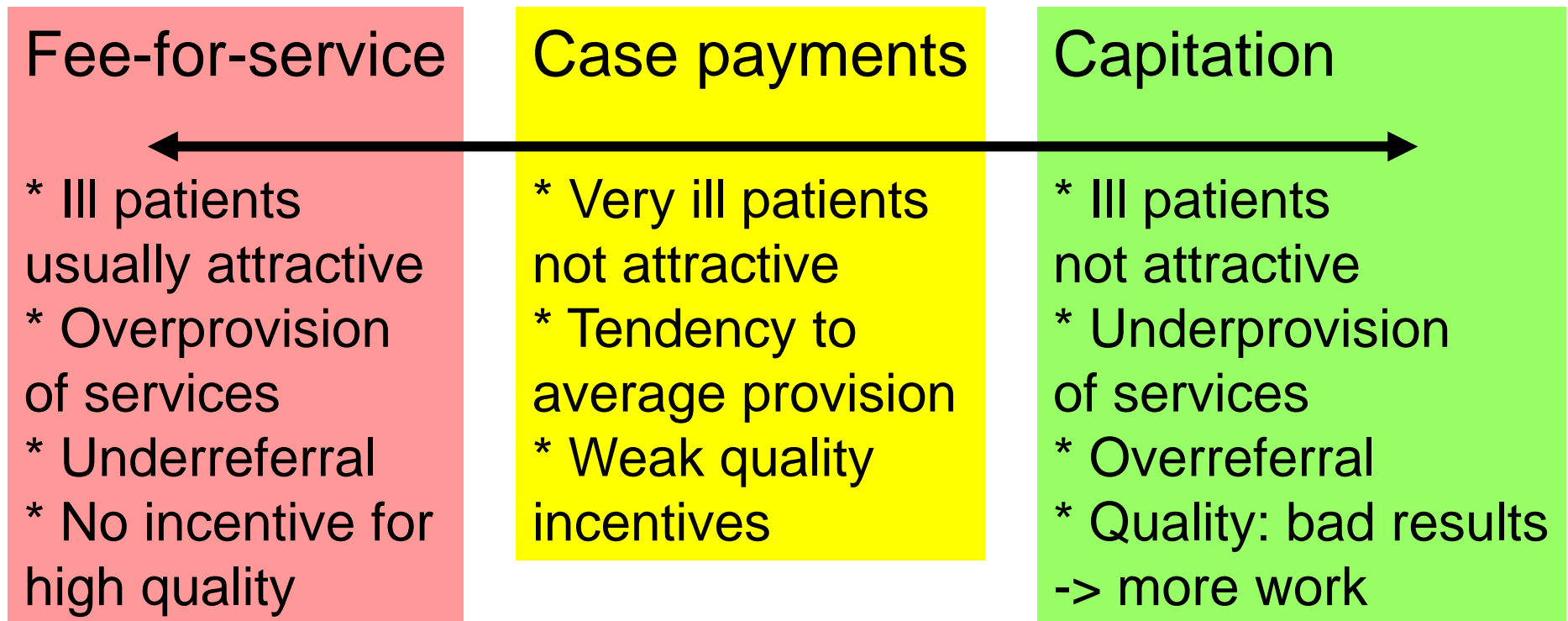
DMPs are only one component of dealing with chronic disease



Shaping the future of managing chronic diseases in Europe

- New pharmaceuticals and medical devices may help to improve CD -> but critical assessment regarding patient benefit, based on accepted methodology, crucial
- Right mix of financial incentives very important (for insured/ patients, payers, providers ...)
- Strengthen coordination (in access, orientation, provision of information, continuity/coordination/communication among professionals)
- Elaborated information and communication technologies crucial, but agreement on international technical standards necessary
- Establish evaluation culture without exceptions

Weaknesses of traditional ways of paying providers for chronic care



* No incentives for appropriate continuity of care across providers

Examples of new payment measures

- ‘year of care’ payment for the complete service package required by individuals with chronic conditions (DK)
- per patient bonus for physicians for acting as gatekeepers for chronic patients and for setting care protocols (F)
- bonus for DMP recruitment and documentation (D)
- 1% of overall health budget available for integrated care (D)
- boni for reaching structural, process and outcome targets (UK)
- ‘pay-for-performance’ boni (US -> Europe)

Chronic patients' cost-sharing – traditional approaches

- no co-payments for services related to their disease, e.g. 'ALD' (30 mainly chronic diseases) in France
- lower annual limits on co-payments
- certain drugs require lower cost-sharing if the indication is deemed serious

Chronic patients' cost-sharing – newer approaches

- 'ALD' exemption only if care protocol is established for each patient by their GP and signed by patient (France since 2004)
 - cost-sharing may be reduced or waived if patients enrol in DMPs
 - patients with chronic conditions/complex needs managed via a care plan/ inscribed in DMP receive rebates (Australia) or additional services (Germany)
- ↓
- 'ALD' exemption only if protocol is presented to every treating physician at each visit (France)
 - lower cost-sharing limit applies only if patient is compliant (Germany since 2007)

STRUCTURAL
QUALITY

PROCESS
QUALITY

Evaluation culture

- Many aspects of managing chronic disease are not properly *evaluated* -> effectiveness and cost-effectiveness of various prevention and treatment interventions not well established.
- Policy-makers are therefore not best equipped to make informed “HTA” decisions.

-> Policy-makers must ensure that evaluation based on rigorous methodology is an integral part of all strategies.

Existing data should be made available for research and review across different technologies, settings and providers.

This presentation and more material can be found on the following websites:

<http://mig.tu-berlin.de>

www.euro.who.int/observatory