Disinvestment: Using HTA to create new value for cancer patients

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The problem:

There are unacceptable inequalities in access to care and survival across EU countries.

Cancer is a socio-economic problem, not just a public health emergency.

Healthcare systems are not providing the best care they can with the money they have.
Inequalities (survival) in cancer care: European reality
The example of colorectal cancer

Patients’ paradox
Can we truly access innovative drugs?

An exploratory analysis of the factors leading to delays in cancer drug reimbursement in the European Union: The trastuzumab case
Felipe Ades\textsuperscript{a}, Chistelle Senterre\textsuperscript{b}, Dimitrios Zardavas\textsuperscript{c}, Evandro de Azambuja\textsuperscript{a}, Razvan Popescu\textsuperscript{c}, Florence Parent\textsuperscript{d}, Martine Piccart\textsuperscript{a,*}

Fig. 1. Time periods for trastuzumab approval/reimbursement in the adjuvant and metastatic settings across European Union (EU) countries.
Inequalities in cancer care: an economic problem

Example: avg. cancer expenditures per citizen in the EU

...but more money does not (automatically) save lives

Figure 1: Relationship between cancer case fatality risk by country and healthcare costs.

From
Health policy: Putting a price on cancer
Richard Sullivan & Ajay Aggarwal
How are we spending money on cancer?

- **Best cancer care = Multidisciplinary care**
  - Radiotherapy and surgery save cancer patients;
  - Medicines are more and more effective, but they are not the sole instrument to fight cancer

- **Cost of cancer care = 126 billion EUR/year in Europe (2013)**

![Pie chart showing the distribution of costs]

- 60%: Direct cost
- 40%: Indirect costs
- 23%: Cost of medicines
- 77%: Cost of all other treatments (surgery, radio, staff etc…)

PAYED ONLY BY PATIENTS (loss of income, out of pocket payments, years of life lost…)

Lancet, 2013
To sum up…

• Fact: **where you live determines if you live/die of cancer**, even if we have perfectly good cancer guidelines

• When new drugs are effective, **they are not available to all European patients at the same time**

• Not all EU countries spend the same on cancer, but this doesn’t matter **IF cancer care is not well organised, multidisciplinary AND accessible**

• **Patients pay for cancer care twice**: once as patients (loss of productivity/income/years of life) and once as taxpayers
A possible solution: DISINVESTMENT

What is disinvestment?

- “The process of withdrawing health resources from any existing health practices, procedures, technologies or pharmaceuticals that are deemed to deliver little or no health gain for their cost, and thus are not efficient health resources allocation”

OR

A method to measure which treatments are obsolete/not cost-effective and should be replaced or not used anymore.

Final objectives: save money and avoid arm to patients
Examples

• Over-diagnosis (very expensive diagnostic tools for detection of small tumours that are not harmful)

• Aggressive surgeries or chemo/radiotherapy treatments

• Too many imaging tests

• Aggressive medical and surgical approaches in patients at the end of life

Disinvestment ≠ stop financing!!!
Disinvestment = understand how treatments are used
Disinvestment is nothing new

- **UK (NICE)**
  - Guide for containment of healthcare cost
  - Partnership with Cochrane for review of guidelines

- **Spain**
  - National law for removal of ineffective technologies

- **Australia**
  - Formal review of all healthcare procedures
  - ASTUTE study

- **USA/Canada**
  - Choosing Wisely Campaign

- **Italy**
  - Working group to find low-value interventions
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But no harmonised approach in cancer
The CanCon Policy Paper on Disinvestment

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Recommendations 1/2

1. **Disinvestment is not a cost cutting exercise**, but must aim at **creating better value for patients**

2. All resources disinvested must be **reused** to increase existing valuable treatments or for new effective treatments

3. The decisions on disinvestments must be **multidisciplinary** (include patients and healthcare professionals perspectives, not just economists!)

4. Disinvestment must aim at **reduce patients’ risk to be exposed to obsolete and low-value** (possibly dangerous!) treatments

5. **HTA remains the main instrument** to evaluate treatments
Recommendations 2/2

6. Disinvestment is not simple: **adequate resources and skills must be provided** to those evaluating health techs.

7. Governments must identify **priority areas for disinvestment**. Disinvest **first** in health tech that are not beneficial to patients.

8. Disinvestment is not only a top-down approach. **Governments must communicate decisions properly** (media campaigns, incentives to doctors, auditing of hospitals etc…)

9. **EU collaboration** on disinvestment is useful to find common problems and common solutions. Also, **countries should use the same HTA methodology** (for disinvestment AND pricing/reimbursement).

10. Government should **promote research in disinvestment**

11. **PATIENTS MUST BE INTEGRAL PART OF THE DISINVESTMENT PROCESS, FROM A TO Z**
Time to work on Health Technology Assessment

• It’s the instrument to make disinvestment happen
• Check the presentation from ECPC AGM 2016 for definitions and more info on HTA!!!

• The European Commission will present a new law to harmonise HTA in the EU (end of 2017). Why?
  • Every country does HTA in its own way, but the data they use is the same = waste of time and resources/duplication
  • A harmonised HTA can cut times for access and close the gap to access new treatments/technologies

Unique opportunity to involve patients in HTA at EU and national level
Health Technology Assessment
What ECPC suggests

• Centralised – 1 for whole of EU
• Relative EFFECTIVENESS assessment
• Done by new Agency, funded by EC/MS
• HTA valid, binding and directly implemented in all EU MS
  • Considers patients-reported outcomes
• Patients’ involvement in HTA must become the norm: need to identify precise methodologies

HTA shall be an instrument to evaluate ALL medical tech, including medical devices, pathways (in line with CanCon)
What is the Value of Innovation in Oncology?

- **ECPC vision for the future of cancer care**
- It answers to the questions:
  - *Why cannot cancer patients access the innovation they need?*
  - How can patients help decision-makers identify innovation that is meaningful to patients?
  - What can the Commission and Member States do in practice?
- It aims to:
  - Provide recommendations for decision makers
  - Guide our Members’ advocacy work at national level
- **Based on evidence – in line with CanCon recommendations**
How was the paper produced?

• November 2014, EP Event “Europe of Disparities”: access to innovation is a key drives of inequalities in cancer care;

• September 2015, “Challenging the Europe of Disparities in Cancer” (new ECPC policy strategy): access to innovation must decrease level of inequalities, not enhance it

• June 2016, ECPC AGM: debate on access to innovation, with more than 120 associations present.

• June – December 2016: ECPC drafts the paper (support from Interel)

• January 2017, Value of Innovation in Oncology launched at ECCO2017
Main systemic barriers to access to innovation in oncology

- Drug development
- Access to innovative medicines
- Pricing
- Registries
- HTA
- Disinvestment
- Radiotherapy
- Diagnostics
- Surgery
- Pathways
- eHealth/mHealth

Promoting wider innovation
Main systemic barriers to access to innovation in oncology

Drug development
Access to innovative medicines
Pricing

Registries
HTA
Disinvestment

Radiotherapy
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Surgery
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Promoting wider innovation
Conclusions

- MS should promote disinvestment policies to **cut resources to low-value treatments** and **reinvest in high-value ones**
  - Lower patients’ exposure to low-value treatments

- **HTA as instrument to assess value** of existing health technologies

- **Patients must be involved in all steps of the process to ensure value is not lost**

*Follow up ECPC work on the next EU legislation on HTA*
Thank for your attention

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European Cancer Patient Coalition

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