Prioritisation in the Swedish health care system

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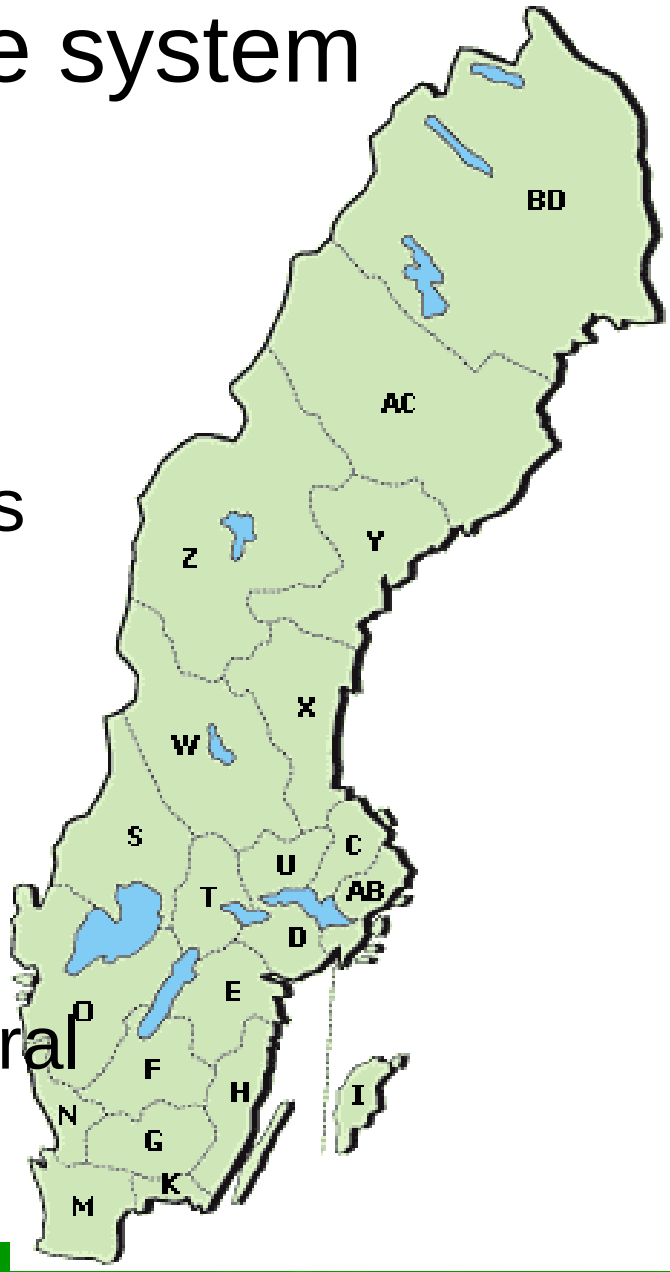
LiU expanding reality

Structure of the health care system

- 21 local government bodies (county councils/regions)
- 290 municipalities
  - Directly elected political bodies
  - Right to impose taxes
  - Right to decide on the appropriate health care package to the population
- Government agencies and central actors



Self local autonomy

- No hierarchical relation between municipalities, county councils, since all have their own self-governing local authorities.
- Elected representatives in municipalities, county councils take decisions about the services and they have independent powers of taxation.
- Decision-making based on regional and local conditions is known as local self-government.

Responsibilities for the county councils/regions related to health

- Health promotion and health prevention
- Primary care
- In- and outpatient hospital care
- Public dental care

Responsibilities for the municipalities related to health

- Caring for the elderly in the home or in special accommodation.
- Care for people with physical disabilities or psychological disorders as well as for school health care.
- Home health care

Governmental agencies

- The National Board of Health and Welfare (Socialstyrelsen, SoS)
- Swedish Council on Health Technology Assessment (SBU)
- The Medical Products Agency (Läkemedelsverket, MPA)
- The Dental and Pharmaceutical Benefits Agency (Tandvårds- och läkemedelsförmånsverket, TLV)

Another key actor

Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting, SKL)

- SKL is a member organisation for municipalities, county councils. SKL advocate their members interests and offer them support and service.
- A lot of negotiations and existing agreements between SKL and the central government.

About definition of the range of public health services

- No explicit defined basic package of services exist.
- Decisions are made by actors on national level but a majority on local level.
- Often complex processes of priority setting involving many actors and interest groups.

Important lines of development

- Development of common principles for priority setting and knowledge support.
- National guidelines for health services.
- Reimbursement of drugs.
- A recent trend: more cooperation between state and county councils and between county councils.

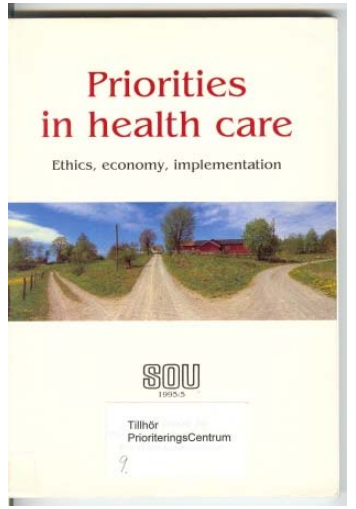
A priority setting committee focused on values and openness

Late 1980 - priority setting became an political issue .

1992-1995 - a commission for priority setting in health care.

1995 - an ethical framework and principles for priority setting are established.

1997- changes in the Health Care Act.



Ethical criteria for prioritisation

The principle of **human dignity**: all people are equal in dignity regardless of personal characteristics and functions in society.

The principle of **need and solidarity**: resources should be commited to the person or activity most in need of them.

The principle of **cost-effectiveness**: … a reasonable relation between cost and effect … should be aimed for

Also important in the governments proposal

"For the population to have a high confidence in the health care the basis for priority setting must be discussed openly.”

(Prop 1996/97:60)

The ethical principles were supposed to be used on all levels in health care

- National level: Ministry of Health and Social Affairs and Governmental agencies etc.
- Regional level
- Clinical level.
- Individual/patient level.

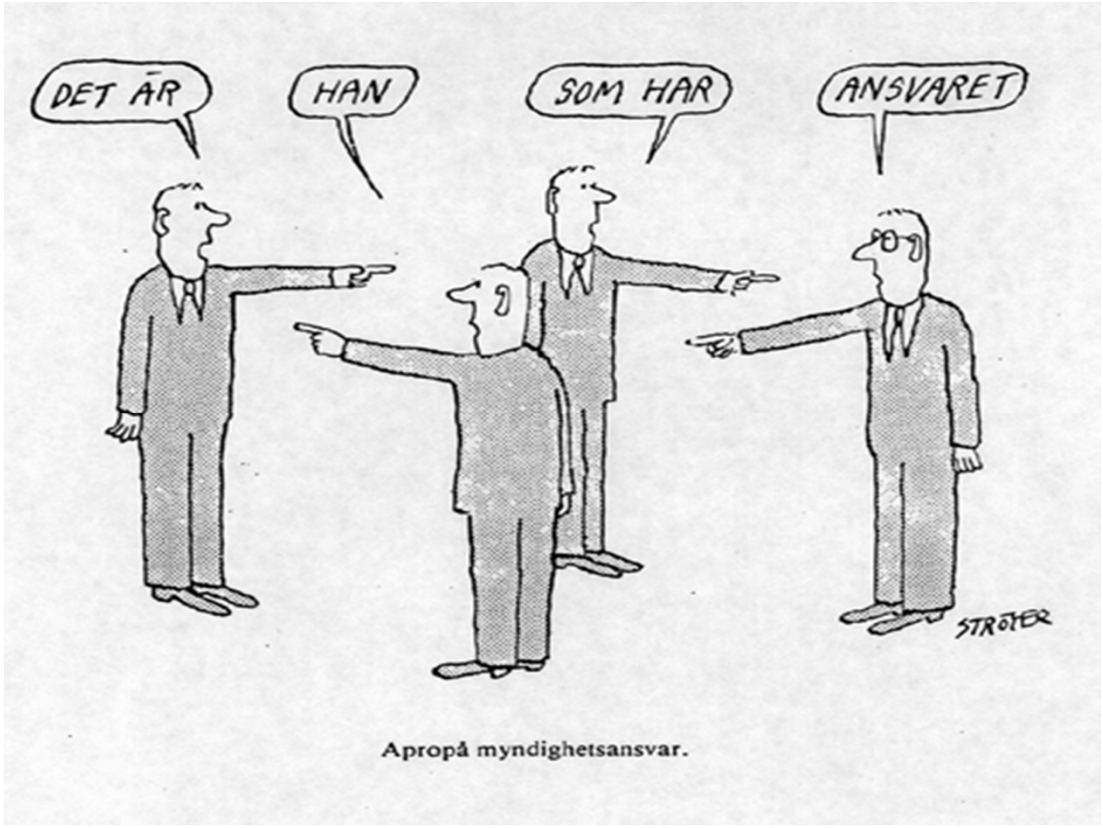
Who is responsible for implementation of the principles for priority setting?
Who decide which health services are provided by public funding makes decisions?

“It is”

“he”

“who has”

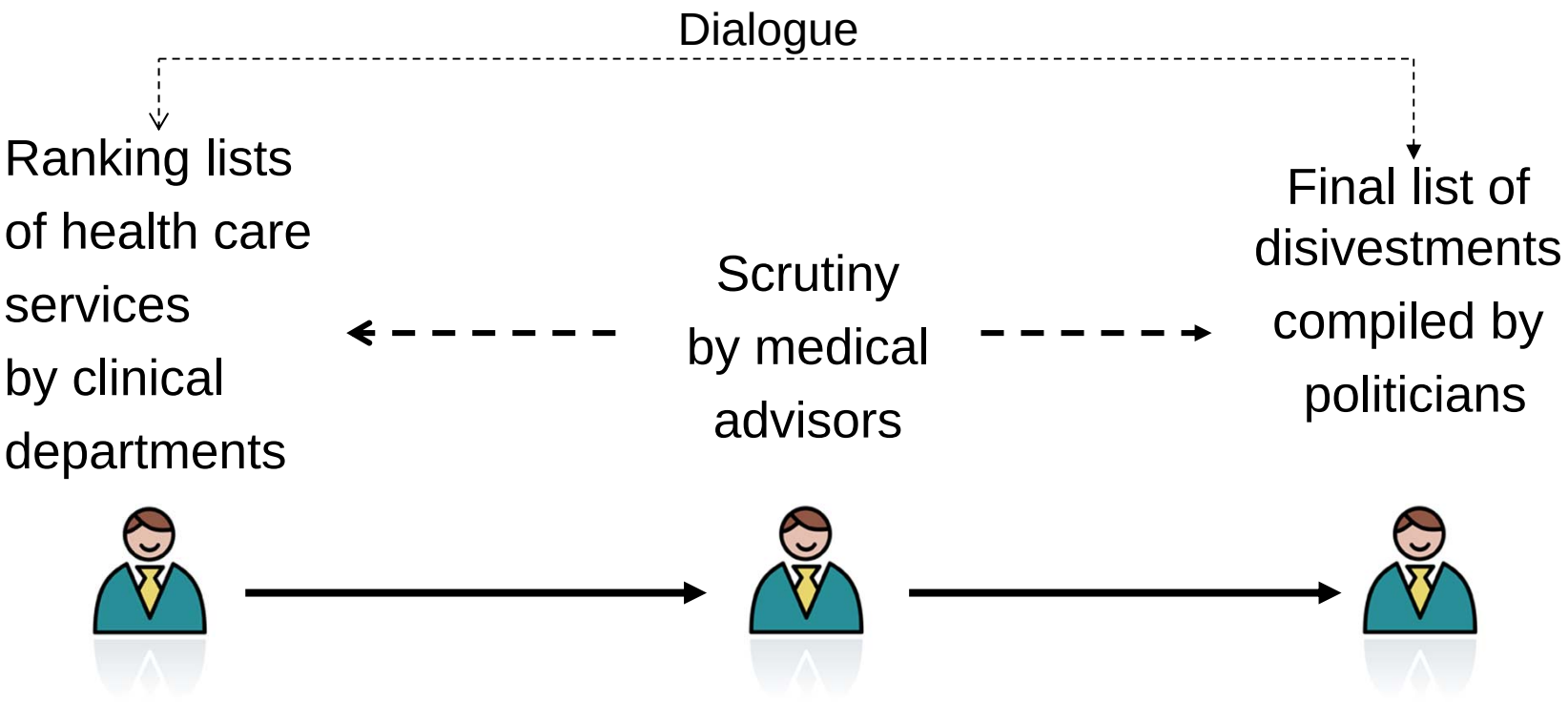
“the responsibility”



The short answer

- The county councils and the municipalities are responsible defining the range of public health services with support from the state.
- Conflict between local autonomy and equal access to health care irrespective of where you live.
- The central government put pressure on the county councils and the municipalities to become more equal in their supply of services.

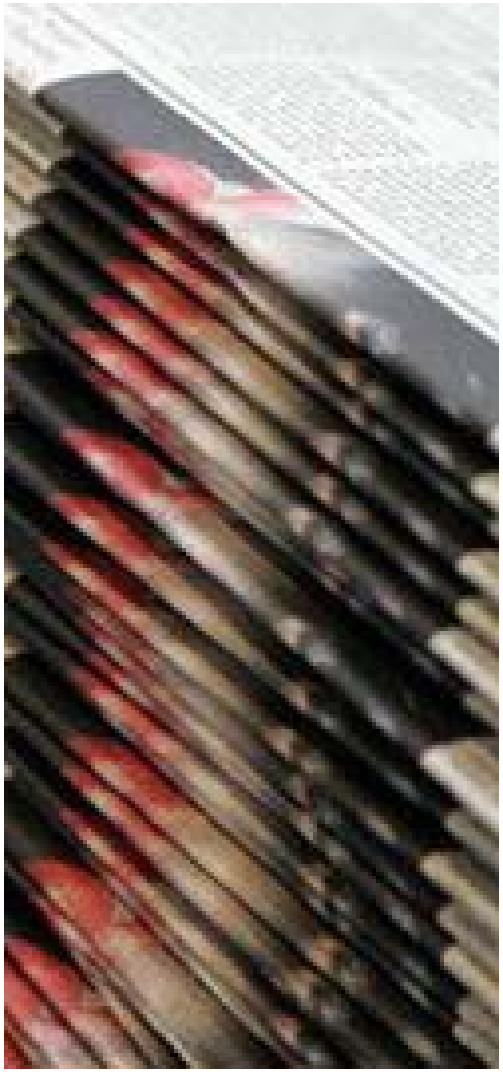
The first political initiative of open priority setting in Östergötland county council 2003



The politicians decided to exclude around 40 minor services

During 5 months (3 before an 2 after the decision), 198 articles related to the priority setting decision were published in four local newspapers.

National newspapers, television and radio were also active.



Local politicians in Östergötland were very much criticised by their “political friends” in other parts of Sweden.

Why did first initiative failed at this time?

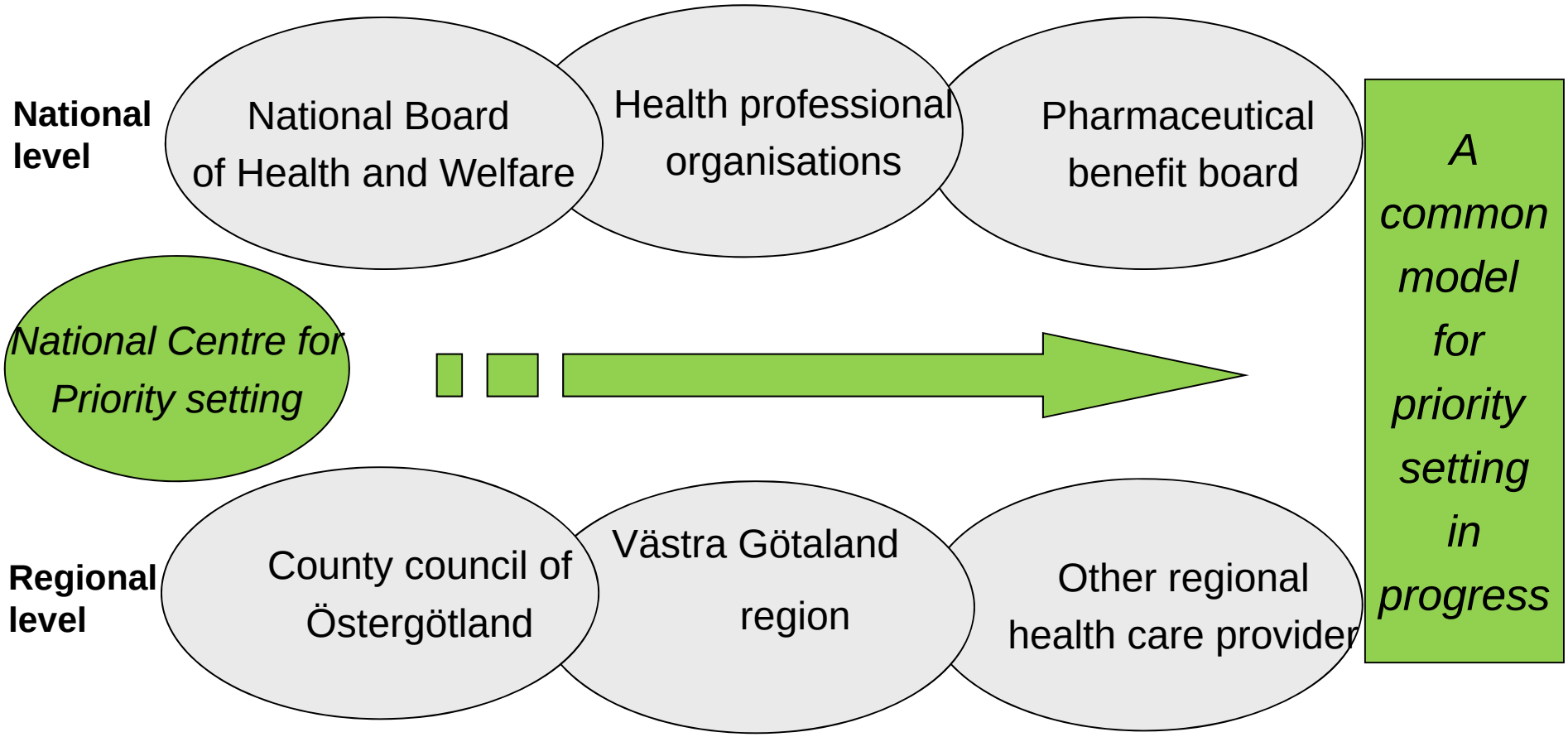
Some explanations:

- First out.
- Mix of priority setting and structural changes.
- Weak methodology/procedure for priority setting.
- Weak support from national level.

The National Board of Health and Welfare

- Produces national guidelines including priority setting in order to support decision making in the county councils.
- First case:Cardiac diseases 2002-2004
- Involves all kind of medical interventions/technologies (drugs, procedures etc.)

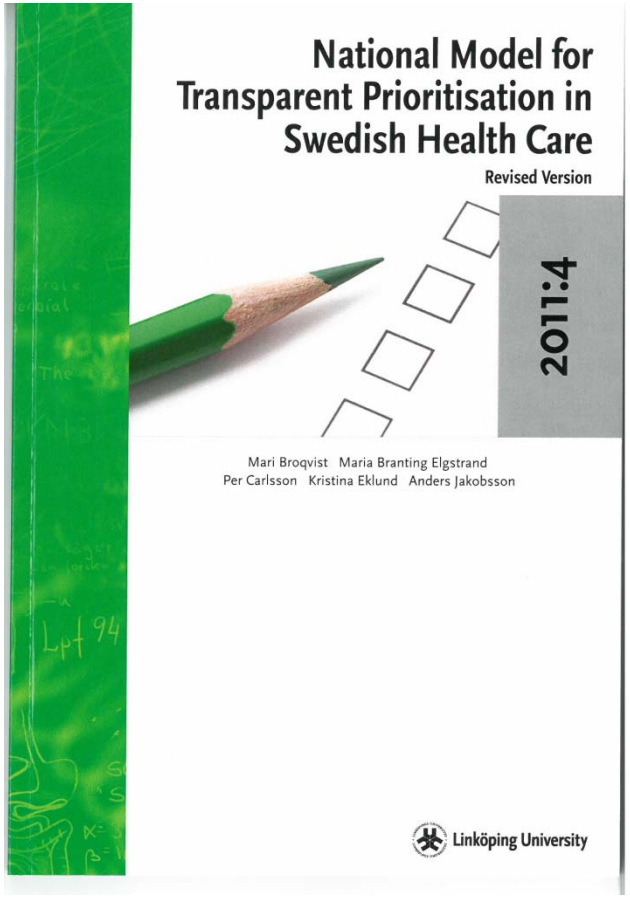
Development of explicit work model for priority setting (First edition 2006)



National Model for Transparent Prioritisation in Swedish Health Care – Revised Version

Rapport 2011:4

Mari Broqvist, Maria Branting Elgstrand, Per Carlsson, Kristina Eklund, Anders Jakobsson



Defining aim and subareas for prioritisation.

The prioritisation process should start from a general categorisation of health problems.

As a rule when these categories cover several organisational units, specialties, or professional groups, it provides a more multidimensional view of the priority-setting problem.

What should be the subject to prioritisation?

That which is ranked, i.e. one of the choices, we refer to as a *prioritisation object*.

Prioritisation objects should consist of different combinations of health conditions and interventions.

Underlying principles

All forms of vertical prioritisation should be based on the three ethical principles that the Riksdag decided should apply in prioritising health services.

A common conceptual framework

The principle of all people being equal in dignity and value

The principle of need and solidarity | **The principle of cost-effectiveness**

Severity of condition	**Expected benefit of health care intervention**	**Cost-effectiveness**
*** Present health state** - suffering - functional ability - quality of life	*** Expected effect on present health state** - suffering - functional ability - quality of life	*** Direct costs** - medical costs - non-medical costs
*** Risk for** - untimely death - permanent disease/injury - deteriorated quality of life	*** Effect on risk for** - untimely death - permanent disease/injury - deteriorated quality of life	*** Indirect costs** - loss of production - other time costs
*** Duration**	*** Side effects and risk for complications of the intervention**	*…in relation to the expected benefit of the intervention.*

EVIDENCE

A structured worksheet is used

Condition	Inter-vention	Condition's severity level	Patient benefits	Quality of knowledge base	Costs/ effects	Quality of knowledge base	Ranking	Comments/ consequen-ces

Figure 3. Worksheet for docu[illegible] steps in the Nat[illegible]al Model for Transparent Prioritisation in Swedish Hea[illegible]

Effects on current health condition
- suffering
- disability
- quality of life

Effects on risk
- premature death
- disability/continued suffering
- reduced health-related quality of life

Risks for side effects and serious complications from the intervention

Collection and appraising the facts.

The scientific basis vary a lot between specialities and sectors as well as resources to collect evidence.

However, it is important that those working with prioritisation describe their reasoning

Weighting of facts and ranking.

A 10-level ranking list should be used.

In the absence of an objective quantitative/mathematical method, a qualitative method should be used in the appraisal.

Socialstyrelsen also use two extra levels: Not do and R&D (FoU)

In SoS guidelines each prioritisation object is presented with a comment and rank.

D05.15	Tidig reumatoid artrit – symtomduration ≤ 12 månader *Screening för ogynnsamma bakgrundsfaktorer innefattande vart och ett av utbildning, alkohol och tobak, nutritionsstatus, språksvårigheter, etnisk bakgrund, co-morbiditet*	Avgörande för rekommendationen är att det saknas vetenskapligt underlag för att åtgärden har effekt.	**FoU**
D05.16	Tidig reumatoid artrit – symtomduration ≤ 12 månader *Livsstilsrådgivning vid behov utan strukturerad kartläggning*	Avgörande för rekommendationen är att det saknas vetenskapligt underlag för att åtgärden har effekt.	**FoU**
D06.01	Tidig reumatoid artrit – symtomduration ≤ 3 år Metotrexatnaiva patienter med medelhög till hög sjukdomsaktivitet *TNF-hämmare + metotrexat*	Avgörande för rekommendationen är tillståndets mycket stora svårighetsgrad och att åtgärden har en stor effekt. Kostnaden per effekt är måttlig.	**2**
			Rekom-

The National Board of Health and Welfare

- Cardiac diseases
- Asthma and COPD
- Stroke
- Cancer (prostate, colorectal, breast and lung cancer)
- Depression
- Diabetes

In total 16 guidelines are produced and continuously revised

To sum up about national guidelines

- Produced at national level by local experts
- Explicit criteria
- Selection of topics based on proposals from CC
- Prepared by experts and sometimes with support from SBU
- Politicians are consulted during process.
- Costs-effectiveness as well as budget impact (not in the priority setting)
- No explicit threshold
- So far recommendations but the new gorvernment want to make them legally binding
- Accepted and play a role in the CC.
- Very little engagement and major criticism from public

The Dental and Pharmaceutical Benefits Agency (TLV)

1. Value based reimbursement decisions regarding new out-patient pharmaceuticals.
2. Continuous review of reimbursed out-patient pharmaceuticals.
3. Pilot project regarding CEA of in-patient pharmaceutical (support to CC).
4. Pilot project regarding CEA of medical devices (support to CC).

Today around 100 employees at TLV

TLV
TANDVÅRDS- OCH LÄKEMEDELSFÖRMÅNSVERKET

TLV's main tasks (1)

Decisions regarding which new out-patient pharmaceutical are eligible for reimbursement status and included in the high-cost threshold.

The decision-making process

1. Initiative from the company
2. An application is sent in to the TLV.
3. The investigation is carried out.
4. The preliminary decision is prepared for the board and communicated to the company.
5. Deliberation.
6. Final decision by the board.
7. Appeal mechanism.

Decision-making criteria

- Human dignity principle

 - respect for equality

- Need and solidarity principle

- those in greatest need take precedence

- Cost-effectiveness principle

- from a societal perspective (so far)

- Threshold defined by the board

- Budget impact not part of the decsion

Balancing of cost-effectiveness and severity of disease

Effectiveness

Estimated value	**Uncertainty**
Good/Fair/ Bad	Large/Moderate/ Small

Cost

Estimated value	**Uncertainty**
Specified figure	Large/Moderate/ Small

Cost per effect

Estimated value	**Uncertainty**
Low/Moderate/High/ Very high	Large/ Moderate/ Small

Severity of disease

Estimated value	**Uncertainty**
Low, Moderate, High, Very high	Large/ Moderate/ Small

Combined judgement

Decision

- The decisions are made by an expert board.
- Consists of a chairman and 6 members.
- Appointed by the Government for two years.
- Meeting once a month.
- Decisions and motives are presented publicly.

Restrictions and special conditions

- In exceptional cases a drug can be included for a restricted area of use or a limited patient group.
- The board can also attach certain conditions to their decisions.

To sum up

- Expert committee on national level.
- Condition and drug treatment.
- Costs are considered from a societal perspective.
- Legally binding but the CC could treat and pay for drugs not included in the “basket”.
- Well accepted system.
- Many ethical issues to be solved, e.g. prices for orphan drugs.

Weaknesses of the system

- Division of responsibility state-county councils
- TLV has the competence (medical, legal and economic) and capacity to make transparent priority setting decisions but the CCs have the formal power and responsibility to make decisions.
- Target for development : Increased formalized collaboration.

Extended reviews

- About 2 000 pharmaceuticals were to be reviewed.
- Divided into 49 therapeutic groups.
- Biggest groups (by sales volume) reviewed first.
- Very ambitious approach, systematic literature review and if necessary construction of economic models.
- Very time consuming.

A new area for TLV- still a pilot project

Assessment of cost-effectiveness of medical devices with a recommendation:

- Implantable defibrillator
- Airshower for severe asthma
- Insulin pumps
- Monitor for home blood pressure measurement.

The second wave of explicit priority setting at county council level (2008-2011)

County councils of:

- Västerbotten
- Jämtland
- Kronoberg
- Västmanland
- Gävleborg

The general stages of the priority setting exercise (e.g. Västerbotten)

- All clinical departments separately identified options for disinvestments, corresponding to 10 % of the net budget, including an estimate of potential cost reduction (the vertical prioritisation).
- A critical review of data, followed by group decisions on options for resource release, corresponding to 4-6 % of the net budget (the horisontal prioritisation).

The general stages of the priority setting exercise

- A second review of data and a final decision, applying also political criteria, scaling down to 2–3 % of the net budget (final decision).
- The decision included allocation of around 12 million Euro to new services, and exclusion of about 300 activities/medical services.
- The decision was presented publicly.

The common features of the second wave

- Learning from past experiences.
- Positive framing (priority setting as reallocation with the aim to modernise health care).
- Proactive communication strategy.
- Shared responsibility for the result between political and clinical directors.
- Transparency on the process and the result.

Results from the second round

- Minimal opposition (staff and public).
- Experiences so far are encouraging.
- One county council has repeated the process.

General lesson: A priority-setting process involving a whole county council is valuable but complicated and perceived too time consuming

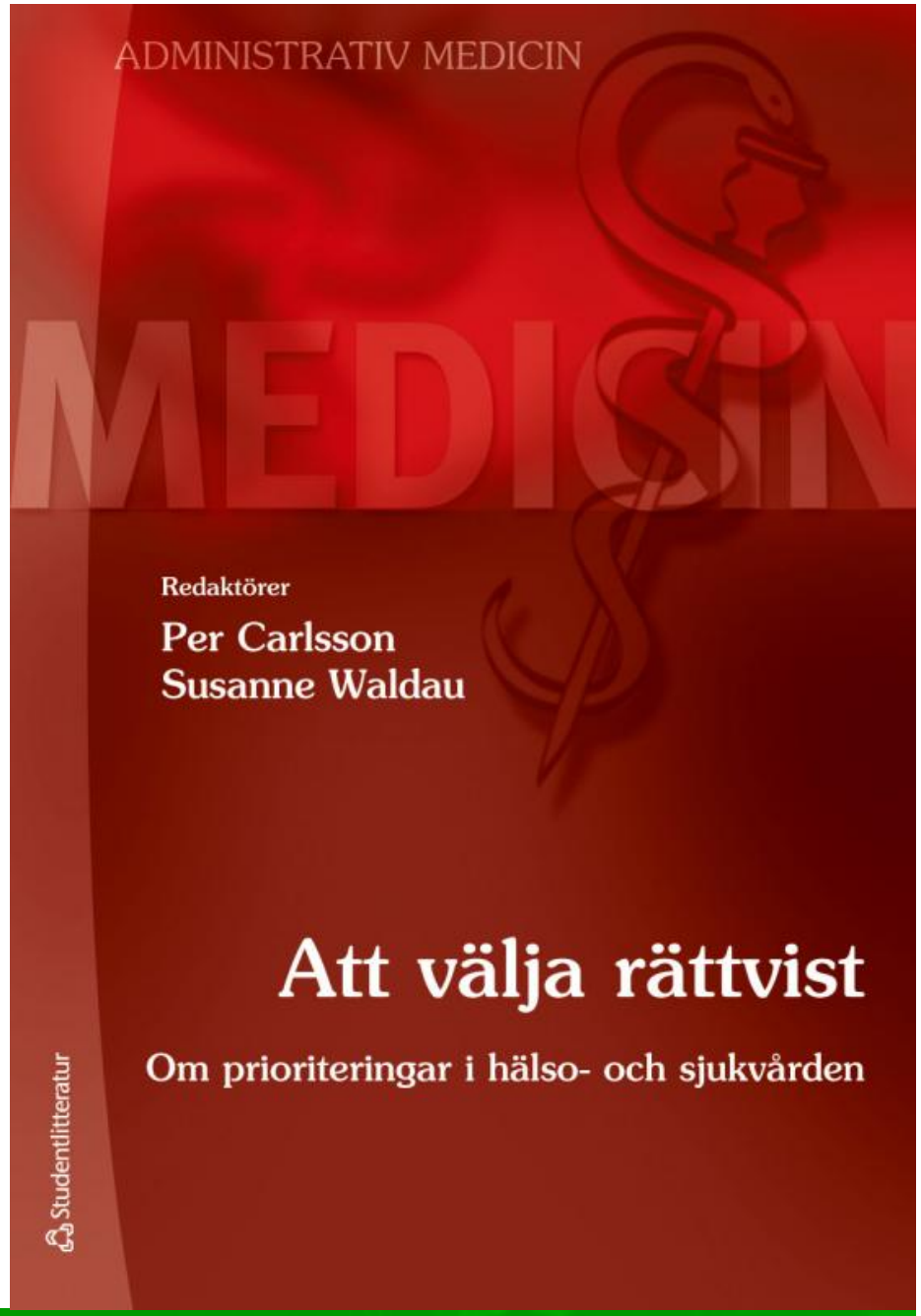
In summary

- Open priority setting is in Sweden well accepted among leading professional groups.
- Still few decisions are systematic and open.
- Politicians are uncertain about their role.
- Supportive procedures for priority setting at national level are becoming at place.
- Principles for priority setting are still unfamiliar among staff.
- Integration between national and region/local level is still an issue to be solved.

Still there is a lot of work to do!

Thank you for your attention!

För finländare som hyggligt kan läsa svenska rekommenderas:
Att välja rättvist
(www.studentlittertur.se)



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www.liu.se/prioriteringscentrum