Priority setting - Norwegian Systems and Experiences

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National Council for Priority Setting in Health and Care Services

Topics

- The history of priority setting
- The National Council (current status, composition and organization, external evaluation, future etc.)
- Legal basis, principles and processes
- Case examples («good and bad», challenging)
- Patient views/involvement
- Report on priority setting 2014
- Future plans and visions
- The National system for introducing new methods (drugs and technologies) into specialized health services
- Priority setting guidelines
Me

Disclosure

• Previously consultant in anaesthesia and clinical researcher
  • Depth of anaesthesia-monitors
  • Computer-assisted pumps

• Previously received honorarium from pharmaceutical and med-tech companies

• Since 2011 head of the secretariat for the Priority Council

• No financial interests

Norway
Norway

“The richest country in the world”

Health services system in Norway

- **Norway**
  - Population: 5 mill.

- **Ministry of Health and Care Services**
  - Norwegian Directorate of Health
  - Norwegian Knowledge Centre for the Health Services
  - Norwegian Medicines Agency
  - Norwegian Radiation Protection Authority
  - Additional agencies

- **Health Care Services**
  - Primary health care
  - Specialist health care
    - 4 Regional Health Authorities
Health services in Norway

- Publicly provided and financed
- Regular GP scheme
- The regular GPs serve as gatekeepers to specialist services
- Specialist health care services financed through a combination of lump sum grants and activity-based reimbursement (DRG)

Health care expenditure in Norway

<table>
<thead>
<tr>
<th>year</th>
<th>1939</th>
<th>1949</th>
<th>1962</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of GDP</td>
<td>0,8</td>
<td>2,8</td>
<td>5,7</td>
<td>9,4</td>
</tr>
</tbody>
</table>
Health care expenditure in Norway

Figure 1. Offentlige helseutgifter, prosent av BNP og totale offentlige utgifter. 1884-2004

% of all public finances

% of GDP

Source: Health at a Glance 2013, annual OECD-report

Health care expenditure

Source: Health at a Glance 2013, annual OECD-report
1985: The first commission

Inge Lønning, 1928-2013
• Professor in theology
• Rector at the University of Oslo
• President of the Parliament

Commission reports on Priority setting

1987: Guidelines for Priority Setting in Norwegian Health Care
- severity
- effect

1997: Priority Setting revisited
Framework for priority setting

- “The Lønning criteria”:
  - **Severity**
    - “the patient will experience a certain reduction in prognosis with regard to life expectancy or a considerable reduction in quality of life if the provision of a health intervention is deferred”
  - **Effectiveness**
    - “the patient may expect to benefit from the health intervention”
  - **Cost-effectiveness**
    - “the expected costs are in a reasonable proportion to the intervention’s effects”

The Priority Setting Regulation is founded on the Patient’s Rights Act.

Priority commission number 3

- June 2013 - Nov 2014. Mandate:
  - Principles, criteria and tools for priority setting
  - Processes for user involvement, transparency, general acceptance and implementing priority decisions (e.g. how to deprioritize)
  - How to use the criteria in practical decisions
    - Clinical decisions
    - Reimbursement of drugs
    - Introducing new technologies
  - Other criteria (rarity, potential for innovations, lack of alternatives)
  - Thresholds for willingness to pay for effects of health interventions; e.g. costs/QALY gained

Ole Frithjof Norheim, professor in medical ethics
Three new criteria suggested

- **Health gain criterion**
  - The priority increases in line with the expected health gain (and other relevant welfare gains).

- **Resource criterion**
  - The priority increases the fewer resources it demands.

- **Health loss criterion**
  - The priority increases in line with the expected life course health loss for those who receive the health benefit.

The health loss criterion was heavily debated

- The commission’s advice was to take into account the loss of health throughout the life span – including the past.
- Favors chronic diseases that hit young people
- (Previous) health loss from the actual condition/disease or also from concomitant conditions?
- Clinically relevant?
Age was controversial

- Not a criterion, but indirectly be weighted due to the criteria «health loss» and «health gain»

Is age relevant in priority setting?

Interventions may have various purposes:

- Cure
- Increase life expectancy
- Prevent or relief suffering (palliative care)
The health loss criterion discarded

- June 2015: New working group appointed
  Professor in health economics Jon Magnusssen
- Report launched Nov 4th

Magnussen’s recommendation

- “Severity” criterion should be understood as “future absolute prognosis loss”
  - Not past
  - Not relative
Relative versus absolute prognosis loss

Relative prognosis loss
- Chronic disease that starts early in life is equally severe as chronic disease that starts late in life.
- Loosing 2 out of 4 remaining living years is just as severe as loosing 20 out of 40 remaining living years.

Absolute prognosis loss
- It is more severe to get a chronic disease early than late in life.
- Loosing 20 out of 40 remaining living years is more severe than loosing 2 out of 4 remaining living years.

What’s next?
- A white paper on priority setting will be launched in 2016.
- The Parliament has to decide.
- The framework will probably be updated and possibly be extended to new areas, like
  - Primary health care?
  - Drug reimbursement after individual application?
National Council for Priority setting in Health and Care Services

- Established in 2007 by the Ministry; reappointed in 2011 and 2015
- Until now: “Quality and Priority setting”
- 19 members
  - Executives from the central health administration
  - Directors from the regional health authorities
  - Executives from municipalities and their organization
  - Leaders from patient associations
  - Representatives from universities and colleges
- Chaired by the Director-General of the Norwegian Directorate of Health

Transparent and open processes

- The meetings are open for the press and the public.
- All documents are published on the Council’s website 3 weeks before the meeting.
- The meeting protocols are published.
- Everyone can propose topics for discussion in the Council.
Transparent and open processes

Examples of cases discussed in the Council

- Screening programmes
- Vaccination
- Coordination between the levels of services
  - Palliative care in nursing homes
  - Rehabilitation services
- Bariatric surgery
- Extremely expensive drugs (ivakaftror for cystic fibrosis)
- Guidelines for multimorbidity
- Single technologies (heart pumps, long-term ventilators, robotic surgery)

The Council gives recommendations, no decisions.
Next meeting in the Council

Secret drug prizing – consequences for the Council’s work?

Are comparable cases given the same priorities?
Ataluren/Translarna® for Duchenne’s muscular dystrophy

Access to specialized psychiatric services for children in «child’s protective services»

Initial treatment and long-term follow-up of extremely preterm infants
  - Variation in practice in weeks 22 and 23
  - Long-term prognosis
  - Do we as society provide enough resources for the follow-up of those that survive with disabilities and extra need?
The National System for the Introduction of New Health Technologies (methods) within the Specialist Health Service

- Planned since 2007, launched in 2013
- Based on a broad cooperation between:
  - Ministry of Health and Care Services: Owner of the system
  - The 4 health regions responsible for specialist health care
  - Norwegian Medicines Agency
  - Norwegian Directorate of Health
  - Norwegian Knowledge Centre for the Health Services
  - Norwegian Radiation Protection Authority
  - Stakeholder Group (Patient organisations, professional organisations, industry, Universities etc.)

The main component of the system
### System for evaluation?

<table>
<thead>
<tr>
<th>Mini-HTA</th>
<th>Single Technology Assessments (STA)</th>
<th>Health Technology Assessments</th>
</tr>
</thead>
</table>
| • Limited assessment at hospital level. Published in national database to share knowledge.  
• Used for medical devices, procedures, organisation  
• Performed by clinicians and supporting units | • Assessment at national level focused on a single health technology  
• Medicines: Norwegian Medicines Agency  
• Other technologies: Norwegian Knowledge Centre | • Broad assessments at national level  
• Norwegian Knowledge Centre for the Health Services |

### What about decision?

- Horizon scanning
- Health Technology Assessment
- Priority setting-Decisions
- Implementation
The National System for the Introduction of New Health Technologies (methods) within the Specialist Health Service

- Decisions at local hospitals subsequent to mini-HTAs
- Decisions on a national level are made by the «decision-forum»
  - The Directors from the four regional health authorities
  - One patient-representative without the right to vote
- Website: www.nyemetoder.no

The National System for ....

- The aim is
  - to assure that new effective and safe technologies and drugs are rapidly implemented in the services
  - to assure good priority setting
- Conflicting aims?
- Evaluation?
Controversial decisions: cancer drugs

«Hot» topic 1: cancer drugs

- **Cancer drugs**
- In common:
  - No cure
  - No palliative effect
  - Prolongs life expectancy
  - Side effects
  - High costs
  - Initially for few patients, now for many patients
New cancer drugs - examples

- Ipilimumab (melanoma)
- Pertuzimab (breast cancer)
- Nivolumab (lung cancer and melanoma)

- Cost-effectiveness is a criteria for priority setting.
- Budget impact is presently not a valid criteria.

«Hot» topic 2: secret pricing

- Secret prices for drug reimbursement recently accepted to get discounts
- Raises general questions about public control, avoidance of corruption etc.
- Raises questions about equality in priority decisions
- A key question: Will secret pricing result in lower pricing?
«Hot» topic 3: cost-effectiveness-thresholds

- Ongoing discussion
- Some «holes in the fence»
  - Individual reimbursement decisions
  - Different access/entry schemes
  - Participation in trials
- Statements in HTA can implement a certain threshold without democratic legitimacy

Thresholds for willingness to pay?

- What is a “reasonable” relationship?
- Lack of formal limits can lead to unintended de-prioritizations.
- Informal limits are established – democratic problem
- Established limits (formal or informal) can increase total costs
- The relationship between the three priority criteria is not clear.
- How to measure effect – QALY?
- What about other countries – look to UK?
The new reports recommend graded thresholds according to severity

![Health loss grade vs. Willingness to pay-threshold, nkr]

<table>
<thead>
<tr>
<th>Health loss grade</th>
<th>Willingness to pay-threshold, nkr</th>
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<tbody>
<tr>
<td>0</td>
<td>&lt; 250</td>
</tr>
<tr>
<td>1</td>
<td>250–500</td>
</tr>
<tr>
<td>2</td>
<td>500–750</td>
</tr>
<tr>
<td>3</td>
<td>&gt; 750–1000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gruppe</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolutt prognosetap</td>
<td>0–3.9</td>
<td>4.0–7.9</td>
<td>8.0–11.9</td>
<td>12.0–15.9</td>
<td>16.0–19.9</td>
<td>20.0–24.9</td>
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<tr>
<td>Vekt</td>
<td>1</td>
<td>1.4</td>
<td>1.80</td>
<td>2.2</td>
<td>2.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Upper limit for willingness to pay for one good lifeyear</td>
<td>275</td>
<td>385</td>
<td>495</td>
<td>605</td>
<td>715</td>
<td>825</td>
</tr>
</tbody>
</table>

Appr. 100,000 Euros

User/patient involvement

- Representatives for users in “every” council, board etc.
- Who do they represent?
- Professionalized patients?
- Compete for the total resources in health services?
- Responsible for the decisions, including voting?
Priority-setting guidelines

- Prioritize among patients referred to specialized health care
  - access or not access
  - suggested maximal waiting times before examination or treatment is started

Priority setting – a communication challenge

How a «no-decision» can be explained and sustained?

- patient’s organizations and groups/organizations of professionals
- new effect-data
- new prices
- political considerations
- patients exposed in media
- traditional media
- social media
- industry
- other decisions in other countries

The never-ending argument: The richest country in the world.
To conclude

The alternative to setting priorities openly and according to preset values, is not to refrain from priority setting.

The alternative is that the priorities are set due to unpredictable criteria in not-transparent processes.