

# Priority setting in health care

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## Scope

- Priority setting for topics' selection
- Priority setting for implementation
  
- Criteria derived from the theory of rational allocation vs other theories
- Impact on HTA & horizon scanning

## Background

- Can priorities be defined at the national level within the EU?

## EU ruling

However, in 1998 the Court established additional principles through its rulings in the cases of Mr Kohll and Mr Decker. In its rulings, the Court made clear that as health services are provided for remuneration, they must be regarded as services within the meaning of EU Treaty **and thus relevant provisions on free movement of services apply.**

The Court also ruled that measures **making reimbursement of costs incurred in another Member State subject to prior authorisation are barriers to freedom to provide services, although such barriers may be justified by overriding reasons of general interest.** These include a risk of seriously undermining the financial balance of social security systems; the need to ensure provision of a balanced medical and hospital service accessible to all; or the maintenance of a treatment facility or medical service on national territory which is essential for public health.

Council Conclusions on Common values and principles in EU Health Systems  
2733rd EMPLOYMENT, SOCIAL POLICY, HEALTH and CONSUMER AFFAIRS Council meeting  
Luxembourg, 1-2 June 2006

« All systems have to deal with the challenge of prioritising health care in a way that balances the needs of individual patients with the financial resources available to treat the whole population”

## Priority setting

- Topic selection for HTA reports, guidelines, review criteria (analytical priorities)
- Reimbursement & implementation decision= health care priorities

## Priority setting for topics' selection: analytical priorities

- Used in the negotiation process between HTA / CPG agencies and the stakeholders
- The choice of criteria to prioritize topic selection reveal values and shape the health policy

# Example of selection criteria, 1

- Prevalence of the disease
- Severity

The combination of both severity and prevalence results in the burden of disease (BoD) established for each disease by WHO.

- Political risk or crisis (potential)

Assessment of what are the worst outcomes for the population with or without the technology

- Cost of the technology, economic evaluation of the diagnostic or therapeutic strategy

## Example of selection criteria, 2

- Importance for patients: how do patients representatives feel about the technology
- Structuring effect for the health care system: does the technology stimulate cooperation between health professionals and sectors
- Improvement of access to care for patients (ease of use, better compliance ...)

## Example of selection criteria, 3

- Magnitude of the expected effect on professional practice
- Measurable effect on professional practice
- Added value of the involvement of a national (public) institution: another possibility is to subcontract to professional societies, but the risk is conflicts of interest

## Real life criteria for topic selection

- Ex post justification of a political decision
- « scapegoat » effect for unpopular / difficult decisions
- procrastination
- Response to pressure groups

## Priority setting for implementation

- Explicit (stated) criteria are usually rational and normative:
- Maximization of the health benefit for the population
- Based on cost-effectiveness analysis

# Clinical criteria (1)

Projects	INDIVIDUAL		POPULATION			
	Nb life years gained/ cas (a)	Cost/case (b)	Target population size (c)	Total life years gained (d=a x c)	Total costs (e=b x c)	cost/life year(f=e/d)
1	40	6 500 €	40	1 600	260 000 €	163 €
2	33	7 249 €	16	528	115 984 €	220 €
3	29	975 €	34	986	33 150 €	34 €
4	25	1 589 €	6	150	9 534 €	64 €
5	16	7 388 €	64	1 024	472 832 €	462 €
6	14	1 550 €	70	980	108 500 €	111 €
7	12	2 995 €	95	1 140	284 525 €	250 €
8	10	1 200 €	50	500	60 000 €	120 €
9	8	1 890 €	65	520	122 850 €	236 €
10	3	2 700 €	50	150	135 000 €	900 €

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## Clinical criteria(2)

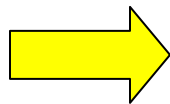
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# Efficiency

Projects	cost/life year gained (f=e/d)	INDIVIDUAL		POPULATION		
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# Synthesis

	CRITERIA		
	Effectiveness 1	Effectiveness 2	Efficiency
Total expenditure	1 000 000 €	1 050 507 €	994 543 €
Total projects financed	6	4	8
Total patients treated	230	233	376
Total life year gained	5 268	4 750	6 404



**1 136 à 1 654 additional life years gained**

## Real life criteria for implementation

- Frequent disregard for the evidence on Cost-effectiveness
- Implentation of inefficient or inadequate technologies
- Continued use of inefficient technologies

# Useful theories in political economy

M Goddard et al. Health economics, policy and law, 2006

- Rationality
- Majority voting models
- Interest groups
- Bureaucratic decision making
- Rent seeking models

## ... and political science

Health, Population, Nutrition discussion paper  
World Bank 2004

- Unability to make long term commitments
- Coalition forming and bargaining
- Destructive competition
- Uncertainty about the consequences of change, sunk costs
- Unwillingness to make explicit trade offs between beneficiaries

# What do stakeholders try to maximise?

- Professionals
- Patients
- Politicians
- Investors

## Majority voting models

- Politicians tailors health policies to satisfy a majority of voters
  - TECHNOLOGIES THAT BENEFIT A LARGE POPULATION
  - TECHNOLOGIES THAT ADDRESS A BROADLY PERCEIVED RISK

## Interest groups

- Lobbies, pressure groups (professionals, industry, patients)
- What turns a group of individuals into a pressure group:
  - Low cost of co-ordination
  - Low cost of reaching the decision makers

## Bureaucratic decision making

- Economic theory of bureaucracy:
  - Overprice
  - Over quality
  - Under quantity
- Bureaucracies
  - Seek to increase their budget
  - Agencies seek to capture their commissioners

## Rent seeking models

- Professionals find « niches » and develop technologies in excess of what the population requires
- This occurs when the price paid is greater than the actual cost (e.g. colonoscopy, ambulance)
- It may delay the dissemination of a more efficient substitute

## Gouvernement failure

- Why priority setting fails to improve health and contain costs

## Unability to make long term commitments

- Implementation in stages
- Early stages favourable to all
- Later stages benefit some groups more than others
- Creating opposition from the far-sighted losers
- e.g. cervical cancer screening

## Coalition forming and bargaining

- Imperfect information
- Dynamic
- e.g. cooperation between professionals:
  - Nurses & physicians
  - Ophthalmologists vs opticians

## Destructive competition

- Raising the costs for competitors
- e.g. using regulation to raise entry costs

## Uncertainly about the consequences of change,

- sunk costs (large initial investments):  
increase the efficiency requirement for  
new programmes and reduce it for  
established technologies
- differing a decision (watchful waiting) is an  
attractive option

## Unwillingness to make explicit trade offs between attributes

- E.g. 5 interventions with 4 attributes:
  - child mortality
  - Adult mortality
  - Workdays lost
  - Costs
- Requires transparent value judgements

## Impact on HTA and horizon scanning, 1

- Coordinate EU agendas on analytical priorities
- Horizon scanning is not only about health technologies but also about external factors that influence priority setting (elections, new lobbies, bureaucracy & reimbursement changes)

## Impact on HTA and horizon scanning, 2

- Multidisciplinary approach: political economy, political science
- Try to use this framework prospectively

## Conclusion

- Prioritization is a negotiation process, the list of criteria is a negotiation tool
- The actual priorities reveal the values and the policy of the government which are often suboptimal in efficiency terms
- External (i.e. other EU countries) influence is likely to add further complexity