

Gesundheit!

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on Health and Welfare

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Commentary

Valuing a unique commodity – Helen Disney and Meir Pugatch¹

Good health is an unusual commodity in that we only tend to value it when we no longer have it. From a policymakers' perspective, health policy decision making is also unique – it poses deep ethical questions about what kind of society we are and the difference between price and value when it comes to medical treatment.

The Stockholm Network has studied healthcare policy since its inception in 1997, with the aim of identifying policies that put consumers' best interests at heart. We have discovered, as many researchers have done before us, that no health system is perfect and that health policymakers are constantly juggling to try to find the right balance between social values, such as equity, and economic values, such as value for money.

The rise of health technology assessment or HTA is indicative of this struggle. It reflects in particular the tension between national health systems built on the use of public funding (especially in most European countries) and the rapid global growth of science and innovation in healthcare which is transforming our vision of the way future patients will be treated, as well as placing enormous pressure on healthcare budgets.

In a “perfect market” for healthcare, were such a concept possible, informed consumers would make rational choices from a range of medicines, doctors and hospitals. In practice, however, the creation of a welfare system which evolved to make sure health treatment would never be denied as a result of a patient's lack of money, means that the “informed consumer” in many cases becomes national governments who pay for treatment on our behalf.

Supporters of markets would not necessarily choose to have health decisions

taken out of their hands but, based on the kind of health systems we have in Europe, HTA has become an attempt to inject a less politicised, more “evidence based” process into the decision about which medicines and treatments should be funded by taxpayers' money.

HTA is certainly not perfect and, as Peter Pitts describes below, we are a long way from evolving a “patient centric” model of HTA. However, a comparative study of the different forms of assessment being used in different developed countries gives us the opportunity to exert pressure on HTA bodies to live up to some basic quality standards that patients can expect. These include transparency, fairness, involvement of all the relevant health stakeholders, and perhaps most importantly, a consideration of the external funding environment in which HTA operates. A “no” from the UK's NICE, for example, has different consequences for a patient than a “no” from another HTA body in a country where patients may have other options for obtaining and paying for a rejected treatment. No wonder that NICE comes under so much media scrutiny when it decides against a particular new medicine or treatment.

Yet, as Stuart Carroll and Paul O'Donohoe argue, health economics is having its moment in the sun and the expansion of HTA looks set to continue. In the absence of much greater pots of funding for healthcare or significant system reforms – even more unlikely in the current economic climate – we are likely to see a further expansion of HTA and a greater focus on companies being asked to prove their medicines are “worth it”.

This will provide scant comfort to patients waiting on HTA decisions about new medicines and treatments for their conditions. But pressing for greater efficiency, more transparency and a mechanism for extending patient choice in self-funding when HTA bodies say “no”, may be the least worst option in a highly

pragmatic world of finite healthcare resources. In the meantime, we can but dream of a world in which we are able to look beyond price and towards investing in the value of healthcare more broadly.

¹ Helen Disney and Meir Pugatch are, respectively, chief executive and director of research of the Stockholm Network.

Topic of the Month

Theory versus Practice: Discussing the Governance of Health Technology Assessment Systems – Paul Healy¹

Theory

The creation of welfare states throughout Europe and beyond has led in many cases to a system where national governments are the consumers of healthcare, purchasing health technologies on behalf of their citizens.

As a consequence of this arrangement, many national healthcare decision makers feel the need to rely on a cost-effective analysis of new and emerging health technologies, the results of which they use to decide whether to provide treatments to the patients that fund the whole system. This is known as Health Technology Assessment (HTA).

HTA is the focus of a Stockholm Network research series that aims to highlight the gap between the theory and practice of HTA, as well comparing the extent to which the HTA process is applied by separate national agencies.

The latest paper in this series - *Theory versus Practice: Discussing the Governance of Health Technology Assessment Systems* – concentrates on the conduct of HTA in four key countries – Australia, Canada, Germany and the United Kingdom – describing the key commonalities that exist

between each system, but also underlining their significant differences.

This comparative study allows for the understanding of different practices of HTA that could contribute towards promoting a “gold standard” for conducting HTA.

Practice

There is no single model for a HTA system, but rather a number of different arrangements that attempt to serve the same purpose. Indeed, the rationale for HTA and the overall process used to conduct it in the four countries covered shows a wide degree of consensus.

Yet, the countries begin to differ more prominently when looking at their individual systems of HTA, reflecting as they do the values and funding of the wider healthcare system within which the HTA agencies perform.

Therefore, as healthcare services continue to be provided in a variety of ways, so too will HTA.

In addition, whilst there may be a number of operational comments that can be made about the way in which HTA is conducted, some criticisms that are made against particular HTA decisions could be more appropriately aimed at the national health system of a particular country rather than the HTA body *per se*.

“Topping-up”

To give an example we may consider the recent “top-up” debate which has caused some controversy in the UK and has led to a significant amount of criticism aimed at NICE.

The “top up” debate opposed a practice that was happening in the NHS, which was denying patients who were paying for their own medicines privately (usually for cancer) from having access to publicly-funded care for the same illness. In this debate, NICE was seen as depriving patients of life-saving drugs as their decision to place a health technology on a negative list was directly prohibiting patients from having those treatments.

In this and indeed many similar examples, the problem stems mostly from the healthcare system itself and, in this case, the NHS's inability to accommodate a topping-up system.

Thus, it is very often the case that a healthcare technology assessment body is only as good as its governing healthcare system.

HTA's virtues

Although this may be true, there are certainly a number of lessons that can be learnt about the conduct of HTA and in particular there are certain “virtues” that a HTA body should work towards, regardless of the health system that it performs within.

One such “virtue” is flexibility and the ability to appreciate local needs and individual concerns. Whilst some can see a particular benefit from having an uncompromising system that focuses on a rigid idea of cost-effectiveness, it is valuable for a system to be able to shape its recommendations around the needs of the population.

The notion of a negative list, which many systems use, provides an indication of how inflexible some systems can be. It would be much more useful if HTA recommendations were used as a basis for trying to find ways of providing more expensive treatments.

Rather than a HTA agency declaring that “this treatment is not cost-effective”, it would be better if it said “this treatment would be cost effective if...” and outlined circumstances where a technology could be allocated.

Indeed, this allows for more flexible reimbursement arrangements which could detail that technologies could be allocated only to certain groups or only in certain circumstances.

Furthermore, national health systems need to be able to offer patients a variety of means of paying for healthcare treatments.

If a system is structured so that some patients can top-up their care, or if there is a helpful co-payments system, then the recommendations made by HTA agencies will not necessarily end in the denial of treatment for patients.

HTA systems should also focus on becoming as accessible as possible, allowing their decisions and decision-making processes to be open for all to see. Transparency does not just provide the reassurance that a decision has been reached fairly and sensibly, it also allows for a more comprehensive and effective recommendation.

By including health professionals, industry representations, lay people and patient groups, an agency can ensure that the assessments it makes are relevant and will guarantee a smoother rolling out of its recommendations.

Finally, it cannot be forgotten that HTA systems form part of the wider health system they conduct their assessments

within. In other words, one cannot look at the HTA system (or its decisions) as being isolated from the overall health system in a given country.

Accordingly, the policy actions and budgetary decisions that take place in the wider context of the national health system are likely to have a significant effect on the manner in which HTA decisions affect the

ability of patients to gain access to new healthcare technologies.

Decisions-makers and politicians cannot just hide under the "scientific veil" of HTA bodies. Rather both politicians and the public need to examine the HTA system with a more critical eye – to endorse its main points of strength but also to identify its limitations and weaknesses and to address them accordingly.

¹ Paul Healy is a policy analyst at the Stockholm Network.

Think Tanker's Corner

Patient-Centric Comparative Effectiveness – Peter Pitts¹

I recently attended a conference of French pharmaceutical executives, legislators, and regulatory officials that focused on the theme of "Economics and Ethics". While the consensus was that ethics are foremost, economics came in a very close second. This was particularly true when it came to a robust debate on "ethical standards based on resources", in other words, ethics in the reality-based world.

During the conference, one leading consultant suggested that pharmaceutical development programs should not proceed beyond mid-stage clinical trials until the company developing a given molecule meets with reimbursement agencies to gauge the likelihood of a positive coverage decision based on clinical endpoints. I found this not only frightening but wrongheaded. How could such a highly-paid consultant so completely miss the point?

Healthcare systems exist to serve their citizens, not to act primarily as actuarial bean counters. Is financial prudence

important? Certainly, but not at the expense of the right medicine for the right patient at the right time. That's a medical decision. That's ethics.

But when a healthcare system is a government-pay model, cost-based considerations often trump patient-centric ethics. Consider the remarks of Thomas Lonngren, executive director of the

European Medicines Agency (EMA), who warned that cost-benefit analysis could become a barrier to patients getting certain safe and effective medicines. Lonngren stated that "it could come to a situation where we are approving a product based on efficacy, safety and quality," he said, "...but the patient can't get it because the health technology institute says it is not cost-effective".

Today, health technology assessment (HTA) is a short-term, short-sighted, politically-driven policy that results in one-size-fits-all medicine.

While it may provide transitory savings in the short-term, current strategies result in a lower quality of care that result in higher healthcare costs over time. Restrictive formularies and healthcare systems that deny patients access to the right medicine at the right time but pay for more invasive

and expensive procedures later on, have their priorities upside down.

So why is the current HTA model enjoying such wide support? I believe it is because HTA drapes a veil of pseudo-science around the blunt instrument of one-size-fits-all price controls.

In the United Kingdom, Sir Michael Rawlins, chairman of UK's National Institute for Health and Clinical Excellence (NICE), told the British House of Commons that comparative effectiveness, a means of HTA, is not based on empirical research. "There is no empirical research anywhere in the world, it is really based on the collective judgment of the health economists we have approached across the country", he said. "It is elusive".

The problem is that HTA, as it is currently designed, places into conflict the short-term budgeting dilemmas of governments elected for relatively short periods of time with the ever-lengthening life spans of their electorates.

According to Professor Frank Lichtenberg of Columbia University, for HTA to yield valid patient-centric and cost-wise decisions, it is necessary to have reliable estimates of not only cost and quality-adjusted life years (QALY), but of other inputs as well, such as the value of a statistical life year (VSLY).

Professor Lichtenberg believes that incorrect estimates of some or all of these key inputs are often used and, due to these estimation biases, health technologies that are truly cost-effective may often be rejected as cost-ineffective. For the patient, these mistakes can be deadly.

Consider the QALY equation. It is an out-dated and blunt tool when you consider that, at \$50,000 per individual (at the high end), it is not even close to the most modest VSLY projection.

One study, by Kip Viscusi and Joseph Aldy, argues that the value of a statistical life for prime-aged workers has a median value of about \$7 million in the United States. A second study, by Kevin Murphy and Robert Topel, puts the VSLY at \$373,000.

Attention must be paid. If the devil is in the details (and it is), it's time for a deep dive beyond simplistic and self-serving HTA perspectives on "comparative effectiveness."

A new patient-centric model

So, where does HTA data come from? Christian Behles, director and professor of drug regulatory affairs at the University of Bonn and an advisor to the German government, points out that while Germany's Institute for Quality and Efficiency in Healthcare (IQWiG) casts a suspicious eye on industry-designed pharmaco-economic studies, they use industry-sponsored randomised controlled trials (RCTs) as the basis of their comparative effectiveness findings.

He also notes that these RCTs were not designed for head-to-head comparisons. In other words, IQWiG embraces industry-sponsored data that was not designed to be used comparatively, while rejecting industry-sponsored data that was specifically designed to show the value of a new innovative medicine. When is an industry study not an industry study? It seems that, for IQWiG, the answer is "when it's convenient".

What we need is new perspective and a new model – and they must both begin by explicitly acknowledging that the core philosophy must be a patient-centric proposition.

A HTA model for the 21st Century should reflect and measure individual response to treatment based on the combination of genetic, clinical, and demographic factors that indicate what keeps people healthy,

improves their health, and prevents disease.

Our rapidly ageing society demands a new healthcare paradigm capable of providing for its needs in the 21st century. Equality of care must be matched with quality of care.

Comparative effectiveness strives to show which medicines are most effective for any given disease state. Is there a “more effective” statin? A “more effective” treatment for depression?

But how do you compare two molecules (or three or more) that have different mechanisms of action or patients who respond differently to different medicine based on their personal genetic make-up?

Comparative effectiveness in its current form leads to a one-size-fits-all approach to healthcare, which means that it doesn't fit anyone all that well. The concept is good, but the tools are wrong. And the results are unacceptable.

This is why it is so important for physicians to maintain the ability to combine study findings with their own experience, expertise and knowledge of the patient in order to make optimal treatment decisions.

Government sponsored studies that conduct head-to-head comparisons of drugs in “real world” clinical settings are regarded as a valuable source of information for such coverage and reimbursement decisions — if not necessarily for making clinical decisions.

Two such studies, the Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE) study, and the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) study, were two such “practice-based” clinical trials, sponsored in part by the National Institutes of Health, to determine whether older (cheaper)

medicines were as effective in achieving certain clinical outcomes as newer (more expensive) ones.

The findings of both CATIE and ALLHAT were highly controversial, but one thing is crystal clear: even well-funded comparative effectiveness trials are swiftly superseded by trial designs based on better mechanistic understanding of disease pathways and pharmacogenomics. And, since most comparative effectiveness studies are underpowered, they don't capture the genetic variations that explain differences in response to medicines by different patients.

When you use the same 20th century tools for clinical trial design – you get the same 20th century data. Not acceptable.

Those in favour of comparative effectiveness favour large scale randomised trials to compare drugs. The problem is that randomised trials tend to ignore differences in clinical outcomes due to side effects or genetic variations. The result is that researchers will almost always find no difference in the effect of medicines, a result that is biased in favour of older, cheaper drugs.

But it's important to move beyond criticising comparative effectiveness in its current form, and instead focus on creating a policy roadmap for integrating technologies and science that is more patient-centric. We need a new model. We need to develop proposals that modernise the information used in the evaluation of new treatments.

Just as the key scientific insights guiding the U.S. Food and Drug Administration's (FDA) Critical Path program are genetic variations and biomedical informatics that predict and inform individual responses to treatment, we must establish a science-based process that incorporates the knowledge and tools of personalised medicine into HTA decision-making.

For example, the FDA, in cooperation with many interested parties, has developed a Critical Path opportunities list that provides 76 concrete examples of how new scientific discoveries in fields such as genomics and proteomics, imaging, and bioinformatics can be applied to predict the safety and efficacy of investigational medical products.

What we need is a Critical Path for Comparative Effectiveness to begin the process of developing a similar list of ways new discoveries and tools (such as electronic patient records) can be used to improve the predictive and prospective nature of HTA. It's a complicated proposition, but an essential goal. Cost must never be allowed to trump care, and short-term savings must not be allowed to trump long-term outcomes. Just as we need new and better tools for drug

development, so too do we need them for comparative effectiveness measurements.

Where you stand often depends on where you sit. If you're a payer (either public or private), saving money can often mean denying expensive care. If you're a patient, you might have another view.

In an era of personalised medicine, one-size-fits-all treatments and reimbursement strategies are dangerously outdated. We may not all agree on the answers – or even on the path to the answers – but at least we can all agree that this is not, and must not be exclusively, a debate about saving money. It must be about patient care.

¹ Peter Pitts is president and co-founder of the Center for Medicine in the Public Interest (CMPI) and Partner/Director Global Healthcare, Porter Novelli. This article is taken from a presentation he gave in Stockholm, Sweden on 23rd February 2009.

Experts' Corner

Peering Down the Kaleidoscope: A Changing Healthcare Scene Where Evidence and Health Economics are Now the Future – Stuart Carroll and Paul O'Donohoe¹

Demonstrating product value now constitutes an essential requirement for pharmaceutical companies to jump the “fourth hurdle” and thereby gain market access and reimbursement. As healthcare budgets increasingly come under additional scrutiny, reimbursement authorities are placing extra emphasis on the importance of evidence-based decision-making. This is particularly the case when assessing the suitability of modelling techniques and the validity of associated data inputs.

However, this in itself raises two fundamental questions: Why does evidence matter? And what are the requirements for building a solid evidence base?

Why Does Evidence Matter?

It is axiomatic that good evidence makes for better decisions. In the context of healthcare and difficult decisions pertaining to health technology coverage, this is arguably more important. Decision-makers naturally seek to reduce the uncertainty of a given value judgement – and the risk associated therewith – in order to facilitate focused investment and “value for money”.

Nonetheless, it is seminal to understand the prevailing reasons and driving factors as to why evidence is deemed important. This in turn allows for a better understanding of the type of evidence that is required for companies to foster optimal outcomes.

Four key reasons can be identified: the political imperative; the disintegration of the “blockbuster model”; the shifting healthcare landscape; and, changes in pricing and reimbursement activity.

The Political Imperative

Publicly insured healthcare is political and thereby commands the attention of elected representatives. As health assumes the mantle as the “number one issue” with voting publics in many countries, healthcare payers are increasingly seeking better value for money from significant healthcare investments. This is not least the case when considering spending on drugs, i.e. only reimbursing those treatments where there is reasonable evidence of clinical benefit and cost-effectiveness.

In the UK, the recent Parliamentary inquiry into National Institute for Health and Clinical Excellence (NICE) accentuates the increased political interest in decisions pertaining to NHS drug availability. A key finding from the inquiry concerns the need for pharmaceutical companies to provide more complete and “independent” data that are relevant to clinical practice and amenable to economic evaluation. In general, decision-makers are becoming more cost-conscious and thus evidence really does matter. Politicians can no longer make or defer decisions safe in the knowledge that those judgements will not be questioned, and hence the need for supporting evidence.

The Disintegration of the “Blockbuster Model”

One of the major issues confronting the pharmaceutical industry is the challenge to, and shifting focus of, the traditional business model. It is widely considered that the conventional strategy of pursuing “blockbuster” medications (products achieving peak sales of £1 billion or more) appears to be in sharp decline as major companies experience increasingly sparse product pipelines.

As some have stated, the disintegration of the “blockbuster model” and the growth in generic products and “add on” therapies has essentially scuttled the economics of pharmaceutical development to a business of margins.

To some extent, this is being driven by a narrowing of product pipelines and the shifting of clinical advances towards a more incremental model of clinical advances. It could therefore be argued that the role and importance of evidence to guide investment decisions is growing, i.e. to show the marginal benefit outweighs the marginal cost.

Don’t Get Caught Beneath the Landslide!

It is widely acknowledged that the delivery of modern healthcare is rapidly evolving as policymakers seek an irrevocable shift from past paradigms in favour of a new type of service provision.

A central part of this landslide is the increasing move from reactive to preventative healthcare. Ageing populations and tightening budget constraints – not least driven by the current economic climate – have led many governments to promulgate the importance of the “better to prevent than have to cure” approach to healthcare strategy.

Some healthcare payers are increasingly looking to reimburse preventative interventions that offer opportunities for significant cost savings or offsets. For example, it has been estimated that the cost of heart disease to the UK economy is £29 billion per year.² As the UK Health Secretary, Alan Johnson MP, recently stated, reducing this cost through preventative treatment is desired.

Evidencing preventative capabilities and associated cost offsets is therefore important as the reimbursement focus shifts to new ground. This is not least the case when demonstrating the wider social benefits of treatment for those countries

where the societal perspective is adopted, e.g. showing the preventative cost saving by reducing caregiver burden.

The Reimbursement Revolution

As healthcare budgets face heightened scrutiny and governments increasingly promote principles of cost-effectiveness and value for money as part of formal economic evaluation, it is clear that the “terms and conditions” of pricing and reimbursement decisions are set to sharpen.

Risk-sharing schemes, and a greater use of value-based pricing, are likely to increase in use and application. This is not least the case given that it is estimated that most drugs – more than 90% – only work in 30% to 50% of people. Obviously, payers only want to reimburse the 30-50% of treatments that work. In the UK, this has already been witnessed in the form of Lucentis (Novartis) and Velcade (Janssen-Cilag) where the NHS only reimburses the drugs dependent upon patient response to treatment and the need for ongoing therapy.

An expansion of such schemes is expected. Pharmaceutical companies will therefore need to better evidence product value to justify optimal upfront reimbursement or favourably shape the terms of possible risk-sharing to their advantage. Without the evidence to support approval, payers are unlikely to pay or take the bulk of the risk.

What are the Requirements for Building a Solid Evidence Base?

The exact requirements for building a solid evidence base will necessarily be dependent on the product, disease area and wider reimbursement objectives.

However, there are four key areas of great significance: use of health economics; application of cutting edge approaches; reimbursement strategising; and, understanding the HTA environment.

Use of Health Economics

Demonstrating cost-effectiveness, or at least a reasonable budget impact, is central to many reimbursement submissions, and therefore increasingly requires the use of health economic evidence. Moreover, it has been argued that the *ex ante* use of health economics offers strategic advantages for optimising the allocation of scarce R&D resource thereby fostering a steady stream of “winners” through the product pipeline.

Although health economics has traditionally been used to support pricing and reimbursement activities at market launch, early application of basic concepts at the start of the product pipeline can help focus planning around revenue-maximising potential, whilst tapering the pursuit of unprofitable “pet products”.

“Out of the Box” Strategising

As the requirements for jumping the “fourth hurdle” become more exacting, the need for creative and forward-thinking planning is set to become more important. As far as possible, this effectively concerns reconciling decision-making made today with the evidence needs of tomorrow. Focusing clinical trial design around the requirements of future reimbursement submissions (i.e. selection of appropriate clinical markers and collection of relevant data) is one such example.

Cutting Edge Approaches

It is widely accepted that to properly translate a product’s risk/benefit to an interpretable value economic modelling is needed. The complex nature of the typical decision-making problem allied to demonstrating product value dictates the need for a more realistic approach to modelling. This essentially means the application of innovative and flexible techniques, such as discrete event simulation (DES), to supplement existing methodologies. Similarly, as companies

grapple with the need to better handle incomplete or “missing” data, evidence-based techniques such as meta-analysis and Bayesian applications will grow in significance.

Understanding the HTA Environment

Keeping abreast of the dynamic changes defining the healthcare landscape is essential to a clear understanding of the shifting requirements associated with pricing and reimbursement decisions. Monitoring policy changes, as driven by ongoing political developments, is therefore important for evidence needs and associated activity.

Gazing into the Crystal Ball: Which Path Will You Take?

The key to success is to understand the road ahead. From the perspective of ongoing changes in the world of pharma, this aphorism rings strikingly true. Political scrutiny, evolving product pipelines, a transforming healthcare landscape, and new approaches to reimbursement are accounting for the increased need to

cogently demonstrate product value. This in turn has catapulted health economics to the vanguard of importance for product development and associated pricing and reimbursement activities.

Understanding this imperative is central to maximising the return on product investment and consolidating opportunities moving forward.

The future has a funny way of arriving unannounced and is forever subject to sudden transformation. When peering down the healthcare kaleidoscope, a scene of conflicting colours and ongoing change can be seen. It is therefore best to look into the “crystal ball” and plan for what is coming. The future is evidence. The future is health economics. Make the most of it.

¹ Stuart Carroll is a senior health economist and policy advisor. Paul O'Donohoe is a research assistant and analyst. Both work for a global economics consultancy firm. This article is written in an independent capacity. All views expressed are those of the authors only.

² R Luengo-Fernández, J Leal, A Gray, S Petersen and M Rayner (2006) “Cost of cardiovascular diseases in the United Kingdom”, *Heart*, 92:1384-1389.

Stockholm Network Publications and Events

Stockholm Network Health Technology Assessment Series

Launched in March 2007, the Stockholm Network's Health Technology Assessment (HTA) series focuses both on the political motivations and economic rationale of HTA. Among other things, it aims to highlight the gap between the theory and practice of HTA, as well as the extent to which the HTA process is exercised by different national bodies. Details of the

papers that have been published within this series are outlined below:

An Introduction to Health Technology Assessment (2007)

Dr Meir Pugatch and Francesca Fici present an account of HTA and offer an analysis into its established growth.

To view this publication, please visit:
<http://tinyurl.com/SNHTA1>

A Healthy Market? Health Technology Assessment in Context (2007)

Dr Meir Pugatch and Helen Davison assess the cross-country differences in the importance and capacity of HTA, whilst attempting to relate these to the characteristics of the respective health systems.

To view this publication, please visit:
<http://tinyurl.com/SNHTA2>

Health Technology Assessment in the UK and Germany (2007)

Kristian Niemietz and Dr Meir Pugatch sought to compare the main actors of HTA in two indicative countries, a leader in HTA (United Kingdom) and a follower (Germany). This paper goes to great lengths to highlight how decisions within the HTA framework can be politically abused, both as a method of simple cost-cutting reasoning and in avoiding more challenging and profound healthcare reforms.

To view this publication, please visit:
<http://tinyurl.com/SNHTA3>

What Price for a Year of Life? The Threshold Discussion in Health Technology Assessment (2008)

This paper takes a more detailed look at a fundamental HTA issue by analysing the threshold discussion and the concept of placing a price upon a year of life in healthcare decision making. This study emphasises the need for greater transparency in the establishment of any HTA threshold in order for all interested parties to better understand decisions, so that they can either support or challenge them.

To view this publication, please visit:
<http://tinyurl.com/SNHTA4>

Health Technology Assessment event, Stockholm, Sweden

Nations across Europe and around the world all agree that healthcare technology assessment (HTA) is an important mechanism in the process of deciding which medicines should be paid for through public funding. But there is no consensus as to the appropriate tools for 21st century, patient-centric HTA.

In acknowledgement of the need for a debate on this issue, the Stockholm Network, the Center for Medicine in the Public Interest and Timbro joined together to host an event in Stockholm, Sweden. The event took place on 23rd February 2009.

Speakers at the event, included:

- Maria Rankka, president of Timbro;
- Tobias Nilsson, part of the political leadership at the Swedish Department of Health and Social Affairs;
- Peter Pitts, president and co-founder of the Center for Medicine in the Public Interest (CMPI);
- Richard Bergström, director-general of The Swedish Association of the Pharmaceutical Industry (LIF);
- Dr Meir Pugatch, director of research of the Stockholm Network.

To view the presentations made by the speakers, or for more information on this event, please visit:
<http://tinyurl.com/HTAEvent>