Technische Universität Berlin

„Vorfahrt für wen? Priorisierung im Gesundheitswesen“

Priorisierung in anderen Gesundheitssystemen

Reinhard Busse, Prof. Dr. med. MPH FFPH

FG Management im Gesundheitswesen,
Technische Universität Berlin (WHO Collaborating Centre for Health Systems Research and Management) &
European Observatory on Health Systems and Policies

European Observatory on Health Systems and Policies

1. Typ „Prinzipien & Methoden“

(zur Anwendung Makro- und Mikroebene)

- Hintergrund/ Ziel: regionale Unterschiede („post-code lottery), Wartelisten
  -> Unterversorgung vermeiden
- Beispiele:
  Norwegen Lønning I & II (1987/ 1997)
  Schweden Parlamentskommission (1993/ 1995)
  Dänemark Ethikrat (1997)
  Großbritannien National Institute for Health and Clinical Excellence (1999)

2. Typ „Konkrete Listen“

- Ziel Ausweitung der (Medicaid-) Leistungsempfänger: Oregon/ USA ab 1989
- Ziel Festlegung Leistungskatalog: Niederlande Dunning Komitee (1992/1995), Israel Krankenversicherungsgesetz (1995)
  einziges Land mit vom Parlament verabschiedetem Leistungskatalog
- Ziel Ungleichheiten beim Zugang zu definierten Leistungen mindern: Neuseeland ab 1993

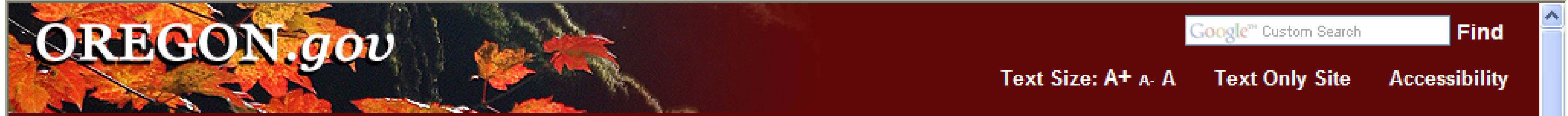
Oregon DHS: OHP priortized list overview - Windows Internet Explorer

http://www.oregon.gov/DHS/healthplan/priorlist/main.shtml

Datei Bearbeiten Ansicht Favoriten Extras ?

Oregon DHS: OHP priortized list overview

Seite Extras



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The Prioritized List

The Prioritized List of Health Services helps determine what health care services the Oregon Health Plan (OHP) covers. For detailed information about the creation of the Prioritized List, see the Health Services Commission's Brief History of Health Services Prioritization in Oregon or the biennial reports to the Oregon legislature on the HSC reports page. The OHP Overview also outlines how the List has changed over time, according to legislative mandates.

- Brief overview of the Prioritized List
- Where to find Prioritized List information
- Prioritized List information for OHP providers

Brief overview of the Prioritized List

From 1989-1993, the Oregon Legislature passed a series of laws known collectively as the Oregon Health Plan. One of those laws, **Senate Bill 27 (1989)**, extended Medicaid coverage to Oregonians with income below the federal poverty level. This bill also created the Oregon Health Services Commission (HSC) and charged the HSC to rank medical services in a way that represents the comparative benefits (*i.e,*. clinical effectiveness and cost-effectiveness) of each service to the entire population to be served. This ranking is known as the **Prioritized List of Health Services**.

- Following public hearings around the state, the HSC established the first Prioritized List with more than 700 lines that prioritized condition and treatment pairs for physical health, dental, chemical dependency and mental health services. Each line represents the rank order of those pairs. The List now contains 680 lines.
- The Legislature sets the funding level for the List, which determines the coverage policies for the OHP Plus and Standard benefit packages. For example, the current funding level is for lines 1 through 503 (out of the 680 lines).

Internet 100%

Start B. P. I. DE Desktop durchsuchen 18:05

Das hat nicht funktioniert …

COST/UTILITY FORMULA USED IN FIRST PRIORITIZATION ATTEMPT

$$B_n = \frac{C}{Y * \left[\sum_{i=1}^{5} (p_{i1} * QWB_{i1}) - \sum_{i=1}^{5} (p_{i2} * QWB_{i2}) \right]}$$

[With Treatment] [Without Treatment]

$$\text{with} \quad QWB_{ik} = 1 + \sum_{j=1}^{30} d_{ijk} w_j \qquad k=1,2$$

where:

- Bn = the net benefit value ratio for the nth condition/treatment pair to be ranked.
- c = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.
- Y = the years for which the treatment can be expected to benefit the patient with this condition.
- [term] = the difference in probability weighted QWBs with and without treatment.
- QWB = subjectively weighted sum of health limitations associated with a specific outcome.

Kategorien seit 2006 (mit höherer Positionierung von Prävention und Disease Management)

Category 1:	Acute fatal condition, treatment prevents death with full recovery
Category 2:	Maternity care
Category 3:	Acute fatal condition, treatment prevents death without full recovery
Category 4:	Preventive care for children
Category 5:	Chronic fatal condition, treatment improves life span and quality of life
Category 6:	Reproductive services (excluding maternity and infertility services)
Category 7:	Comfort care
Category 8:	Preventive dental care
Category 9:	Proven effective preventive care for adults
Category 10:	Acute non-fatal conditions, treatment causes return to previous health state
Category 11:	Chronic non-fatal condition, one-time treatment improves quality of life
Category 12:	Acute non-fatal condition, treatment does not result in a return to previous health state
Category 13:	Chronic non-fatal condition, repetitive treatment improves quality of life
Category 14:	Self-limiting conditions where treatment expedites recovery
Category 15:	Infertility services
Category 16:	Less effective preventive care for adults
Category 17:	Fatal or non-fatal condition, treatment causes minimal or no improvement in quality of life

Horizontal + vertikal!

PRIORITIZED LIST OF HEALTH SERVICES
October 1, 2009

Diagnosis: PREGNANCY (See Guideline Notes
Treatment: MATERNITY CARE
ICD-9: 640-673,674.0,674.2,674.4-674.9,675-679,V07.2,V22.0-V22.1,V23,V24,V28,V72.4,V89
CPT: 01958-01963,01967-01969,12021,57022,59000-59001,59012,59015,59020,59025,59030,59050-59051,59070-59076,59100,59160-59622,59830,59866,59871,76801-76828,84163,84704,86336,96150-96154,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
HCPCS: G0406,G0407,G0408,S0265,S0270,S0271,S0272,S0273,S0274,S2401,S2402,S2403,S2405,S2411,S8055,S9208,S9209,S9211,S9212,S9213,S9214
Line: 1

Schwangerschaft - Mutterschutzleistungen

Diagnosis: BIRTH OF INFANT (See Guideline Notes 64,65)
Treatment: NEWBORN CARE
ICD-9: 760.6,763,765.29,779.81-779.82,779.84,779.89,V30-V37
CPT: 92586,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99460-99464,99468-99480,99605-99607
HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
Line: 2

Geburt

Diagnosis: PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE (See Coding Specification Below) (See Guideline Notes 64,65) (See Prevention Table
Treatment: MEDICAL THERAPY
ICD-9: V01.0-V01.2,V01.4-V01.9,V02,V03.2,V03.5-V03.9,V04.0,V04.2-V04.3,V04.6,V04.81-V04.82,V04.89,V05.0-V05.1,V05.3-V05.4,V05.8,V06.1,V06.3-V06.6,V06.8,V07.0,V07.2,V20,V65.3,V65.41-V65.45,V70.6,V71.09,V72.0-V72.1,V73-V75,V77-V81,V82.0-V82.6,V82.8-V82.9
CPT: 90465-90472,90633-90634,90645-90663,90669,90680,90681,90696,90698-90710,90713-90714,90716,90718-90723,90732-90734,90740,90744,90747-90749,92002-92014,92586,96110,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
HCPCS: G0008,G0009,G0010,G0396,G0397,G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
Line: 3

Prävention bei Kindern bis 10 J.

Birth to 10 Years

Hinterlegt sind Leitlinien und empfohlene Maßnahmen …

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death
- Conditions originating in perinatal period
- Congenital anomalies
- Sudden infant death syndrome (SIDS)
- Unintentional injuries (non-motor vehicle)
- Motor vehicle injuries

Interventions for the General Population

SCREENING

Height and weight
Blood pressure
Vision screen (3-4 yr)
Hemoglobinopathy screen (birth)[1]
Phenylalanine level (birth)[2]
T_4 and/or TSH (birth)[3]
Effects of STDs
FAS, FAE, drug affected infants[4]
Hearing, developmental, behavioral and/or psychosocial screens[5]
Learning and attention disorders[6]
Signs of child abuse, neglect, family violence

COUNSELING

Injury Prevention

Child safety car seats (age <5 yr)
Lap-shoulder belts (age >5 yr)
Bicycle helmet; avoid bicycling near traffic
Smoke detector, flame retardant sleepwear
Hot water heater temperature <120-130°F
Window/stair guards, pool fence, walkers
Safe storage of drugs, toxic substances, firearms and matches
Syrup of ipecac, poison control phone number
CPR training for parents/caretakers
Infant sleeping position

Diet and Exercise

Breast-feeding, iron-enriched formula and foods (infants and toddlers)
Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables (age >2 yr)
Regular physical activity*

Substance User

Effects of passive smoking*
Anti-tobacco message*

Dental Health

Regular visits to dental care provider*
Floss, brush with fluoride toothpaste daily*
Advice about baby bottle tooth decay*

Mental Health/Chemical Dependency

Parent education regarding:
- Child development
- Attachment/bonding
- Behavior management
- Effects of excess TV watching
- Special needs of child and family due to:
  - Familial stress or disruption
  - Health problems
  - Temperamental incongruence with parent
  - Environmental stressors such as community violence or disaster, immigration, minority status, homelessness
- Referral for MHCD and other family support services as indicated

Interventions for the High-Risk Population

POPULATION	High risk for mental health disorders POTENTIAL INTERVENTIONS (See detailed high-risk definitions)
Preterm or low birth	Hemoglobin/hematocrit (HR1)
Infants of mothers at risk for HIV	HIV testing
Low income; immigrants	Hemoglobin/hematocrit (HR1); PPD (HR3)
TB contacts	PPD (HR3)
Native American/Alaska Native	Hemoglobin/hematocrit (HR1); PPD (HR3); hepatitis A vaccine (HR4); pneumococcal
Residents of long-term care facilities	vaccine (HR5) PPD (HR3); hepatitis A vaccine (HR4); influenza
Certain chronic medical conditions	vaccine (HR6) Blood lead level (HR7)
Increased individual or community lead exposure	Daily fluoride supplement (HR8)
Inadequate water fluoridation	Avoid excess/midday sun, use protective
Family h/o skin cancer; nevi; fair skin, eyes, hair	clothing* (HR9) Screen for child abuse, neurological, mental
History of multiple injuries	health conditions Increased well-child visits (HR10)

High-Risk Groups

HR1 = Infants age 6-12 mo who are: living in poverty, black, Native American or Alaska Native, immigrants from developing countries, preterm and low-birthweight infants, infants whose principal dietary intake is unfortified cow's milk.

HR2 = Infants born to high-risk mothers whose HIV status is unknown. Women at high risk include: past or present injection drug use; persons who exchange sex for money or drugs, and their sex partners; injection drug-using, bisexual, or HIV-positive sex partners currently or in past; persons seeking treatment for STDs; blood transfusion during 1978-1985.

HR3 = Persons infected with HIV, close contacts of persons with known or suspected TB, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), residents of long-term care

90% des vorherigen Budgets

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Diagnosis: BREAST CYSTS AND OTHER DISORDERS OF THE BREAST (See Guideline Notes 64,65)
Treatment: MEDICAL AND SURGICAL TREATMENT
    ICD-9: 610,611.2,611.5,611.89
      CPT: 19000-19001,19030-19103,19110-19112,19125-19126,19295,98966-98969,99024,99051,99060,
           99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
    HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
     Line: 501

Diagnosis: CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, AND NONINFLAMMATORY DISORDERS OF THE
           VAGINA (See Guideline Notes 64,65)
Treatment: MEDICAL AND SURGICAL TREATMENT
    ICD-9: 616.0,623.6,623.8-623.9,624.5
      CPT: 56405,56501,56515,57135,57200,57210,57511,57513,57520,57530,98966-98969,99024,99051,
           99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
    HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
     Line: 502

Diagnosis: CYSTS OF BARTHOLIN'S GLAND AND VULVA (See Guideline Notes 64,65)
Treatment: INCISION AND DRAINAGE, MEDICAL THERAPY
    ICD-9: 616.2,616.5-616.9
      CPT: 10060-10061,11004,56440,56501,56515,56740,57135,98966-98969,99024,99051,99060,99070,
           99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
    HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
     Line: 503

_____________________________________ Funding Level as of 1/1/08

Diagnosis: LICHEN PLANUS (See Guideline Notes 64,65)
Treatment: MEDICAL THERAPY
    ICD-9: 697
      CPT: 11900-11901,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,
           99379-99444,99468-99480,99605-99607
    HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
     Line: 504
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10% des vorherigen Budgets

Diagnosis: VULVAL VARICES (See Guideline Notes 64,65)
Treatment: VASCULAR SURGERY
ICD-9: 456.6
CPT: 98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
Line: 606

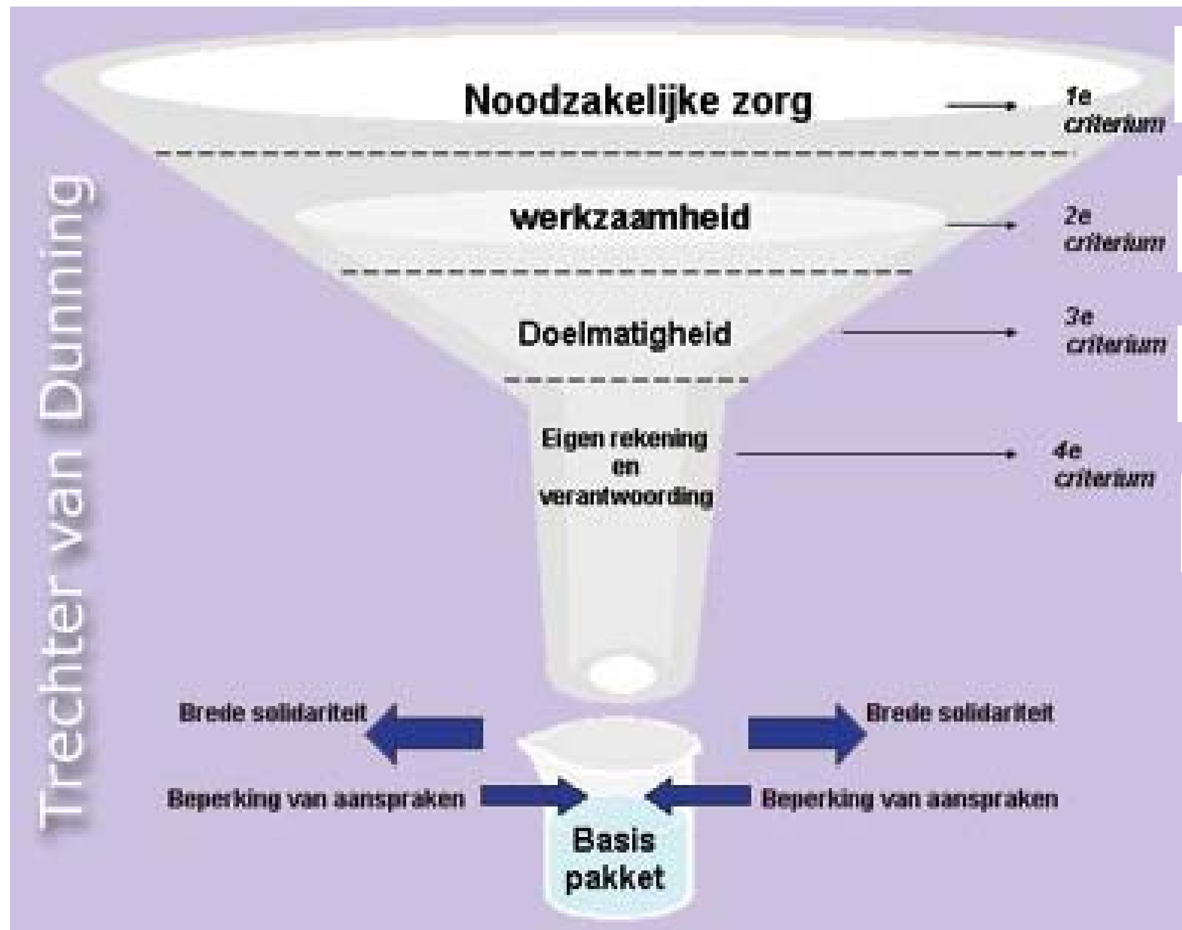
Diagnosis: DISEASE OF NAILS, HAIR AND HAIR FOLLICLES (See Guideline Notes 64,65)
Treatment: MEDICAL THERAPY
ICD-9: 703.8-703.9,704.0,704.1-704.9,706.3,706.9,757.4-757.5,V50.0
CPT: 11000-11001,11720-11765,11900-11901,17380,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
Line: 607

~~Diagnosis: OBESITY (See Guideline Notes 61,64,65)~~
~~Treatment: NUTRITIONAL/PHYSICAL ACTIVITY COUNSELING AND BEHAVIORAL INTERVENTIONS; BARIATRIC SURGERY FOR OBESITY WITHOUT COMORBID TYPE II DIABETES & BMI ≥ 35~~
~~ICD-9: 278.0~~
~~CPT: 43644-43645,43770-43774,43845-43848,98966-98969,99051,99078,99201-99360,99366,99374-99375,99381-99412,99441-99444,99605-99607~~
~~HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274~~
~~Line: 608~~

[Line 608 and its associated guideline were deleted effective October 1, 2009. See lines 8 and 33 and their associated guidelines for situations in which obesity-related services are covered.]

Diagnosis: ACUTE TONSILLITIS OTHER THAN BETA-STREPTOCOCCAL (See Guideline Notes 64,65)
Treatment: MEDICAL THERAPY
ICD-9: 463
CPT: 98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607
HCPCS: G0406,G0407,G0408,S0270,S0271,S0272,S0273,S0274
Line: 609

Niederlande: “Dunning-Filter”

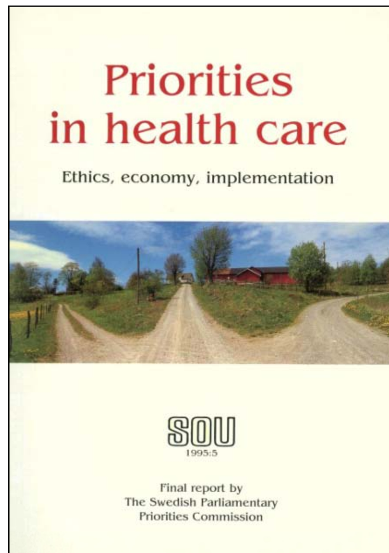


Notwendigkeit

Wirksamkeit

Kosten-Effektivität

Eigenverantwortung



Schweden: Kriterien für Priorisierung (1995)

„in ranking order"

„The Commission proposes three principles on which priorities should be based:

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-efficiency****: … a reasonable relation between cost and effect … should be aimed for.*"

Leitfaden zur Priorisierung bei klinischen Aktivitäten (SOU 1995:5; S. 103)

Priorisierungs-gruppe	Versorgungsbereich
I A	Versorgung von lebensbedrohlichen Erkrankungen und Erkrankungen, die unbehandelt zu permanenter Behinderung oder vorzeitigem Tod führen
I B	Versorgung von schwer chronischen Erkrankungen. Palliative Versorgung. Versorgung von Menschen mit eingeschränkter Autonomie
II	Individualisierte Prävention in Kontakten mit medizinischen Diensten. Habilitation/Rehabilitation
III	Versorgung von weniger schweren akuten und chronischen Erkrankungen
IV	Grenzfälle
V	Versorgung aus anderen Gründen als Erkrankungen oder Verletzungen

Principle of Human Dignity			EVIDENCE
Need for intervention in health care			
Severity of disease	Patient benefit (effect of intervention)	Cost-effectiveness	
Current medical condition • *symptoms* • *functional capacity* • *quality of life* **Risk of:** • *premature death* • *permanent disease /injury* • *worsened quality of life* **Reduced autonomy**	**Effect on current medical condition** • *symptoms* • *functional capacity* • *quality of life* **Effect on risk of:** • *premature death* • *permanent disease /injury* • *worsened quality of life* **Risk of side effects and serious complications from interventions**	**Direct costs** • *medical interventions* • *non-medical interventions* **Indirect costs** • *loss of production* • *intangible costs* **...in relation to patient benefit**	
Prevention → Diagnostics → Treatment → Rehabilitation			

Figure 1. Basic principles for vertical ranking of an area of practice; for example, orthopedics, ear diseases, heart diseases, or stroke.

Beispiele (Indikationen Stroke Care 2005) – nur vertikale Priorisierung

Priorisierung über Rangplätze
1 – 3 „must do“
4 – 6 „should do“
7 – 10 „can do“

Position	Krankheitszustand/Maßnahme (Indikation)	Priorität
1	Smoking in person without previously known cardiovascular disease who seeks medical care regardless of reason – Short advisory session including nicotine substitute	1
4	Stroke – Care at stroke unit	1
34	Suspected sinus thrombosis – MRI examination	3
58	Impaired communication capacity in stroke – Communication training	5
94	Severe disorder of memory in stroke – Memory training	10

Beispiele unterschiedlicher Priorisierungen aus der Leitlinie Schlaganfall (Primärprävention durch Statine)

Klinischer Zustand *Intervention*	Blutfettstörung, ≥ 5 % Risiko für einen kardiovaskulären Tod innerhalb von 10 Jahren (Primärprävention) *Ratschläge für Lebensstiländerungen sowie Simvastatin-Generikum*	Blutfettstörung, ≥ 5 % Risiko für einen kardiovaskulären Tod innerhalb von 10 Jahren und nicht erreichtes Zielniveau (Primärprävention) *Ratschläge für Lebensstiländerungen sowie Atorvastatin, Pravastatin, Rosuvastatin und Fluvastatin*	Blutfettstörung, < 5 % Risiko für einen kardiovaskulären Tod innerhalb von 10 Jahren (Primärprävention) *Ratschläge für Lebensstiländerungen sowie Simvastatin-Generikum*	Blutfettstörung (Primärprävention) *Reduzierung der Blutfette mit Atorvastatin, Pravastatin, Rosuvastatin und Fluvastatin als Mittel der Wahl*
Schwere der Erkrankung und Bedarf für Intervention	Hohes Risiko eines kardiovaskulären Todes innerhalb von 10 Jahren (≥ 5 %)	Hohes Risiko eines kardiovaskulären Todes innerhalb von 10 Jahren (≥ 5 %)	Moderates Risiko eines kardiovaskulären Todes innerhalb von 10 Jahren (< 5 %)	Geringes Risiko eines kardiovaskulären Todes innerhalb von 10 Jahren (< 5 %)
Wirkung der Intervention	Geringfügige bis moderate Risikobeeinflussung eines kardiovaskulären Todes (1–10 %)	Geringe bis moderate Risikobeeinflussung eines kardiovaskulären Todes (1–10 %)	Geringfügige Risikobeeinflussung eines kardiovaskulären Todes (0–2 %)	Geringe bis moderate Risikobeeinflussung eines kardiovaskulären Todes (1–10 %)
Evidenz für die Wirkung	Evidenzstärke 1	Evidenzstärke 1	Evidenzstärke 1	einige wissenschaftliche Evidenz
Kosten pro gewonnenem Lebensjahr/ QALY	gering	gering bis moderat	gering bis moderat	moderat bis hoch
Gesundheits-ökonomische Evidenz	geschätzt	geschätzt	geschätzt	geschätzt
Rang	5	7	8	10

Akteure bei Priorisierung

	Regierungs-mitarbeiter	**Gesundheits-professionelle**	**Laien**
Norwegen	JA	JA	JA (Patienten)
Schweden	NEIN (aber Parlamentarier)	JA	NEIN (aber Parlamentarier)
Dänemark	NEIN	JA	JA
Oregon	**JA -> NEIN**	**JA (Mehrheit)**	**JA (plus initial öffentliche Anhörungen)**
Niederlande	NEIN	JA	NEIN
Israel	JA	JA	JA
Neuseeland	NEIN	JA	NEIN (allerdings öffentliche Anhörungen)

Priorisierungs-Prinzipien

Norwegen 87	Severity of disease, potential effect of intervention, cost-effectiveness
Niederlande 92	Necessity, effectiveness, cost-effectiveness, individual responsibility
Schweden 93	Human dignity, need & solidarity, cost-efficiency
Neuseeland 93	Effectiveness, efficiency, equity, acceptability
Dänemark 97	Values: Equal human worth, solidarity, security & safety, freedom & self-determination Goals: Social & geographical equity, quality, cost-effectiveness, democracy & consumer influence

Warum ist der „Priorisierungs-schwung“ international erlahmt?

Priorisierung ist mit Health Technology Assessment verschmolzen

- in Israel z.B. Ergänzung des nat. Leistungskatalogs durch HTA
- HTA nutzt neben dem Technologie-bezug auch den Indikationenbezug
- Medikamente zunehmend teuerste Technologien -> besondere Eignung für gesundheitsök. Evaluation

Schweden

SBU 1987

Priorisierungs-zentrum 2001

Pharmaceutical Benefits Board 2002

Prioritätensetzung **Leitlinien**

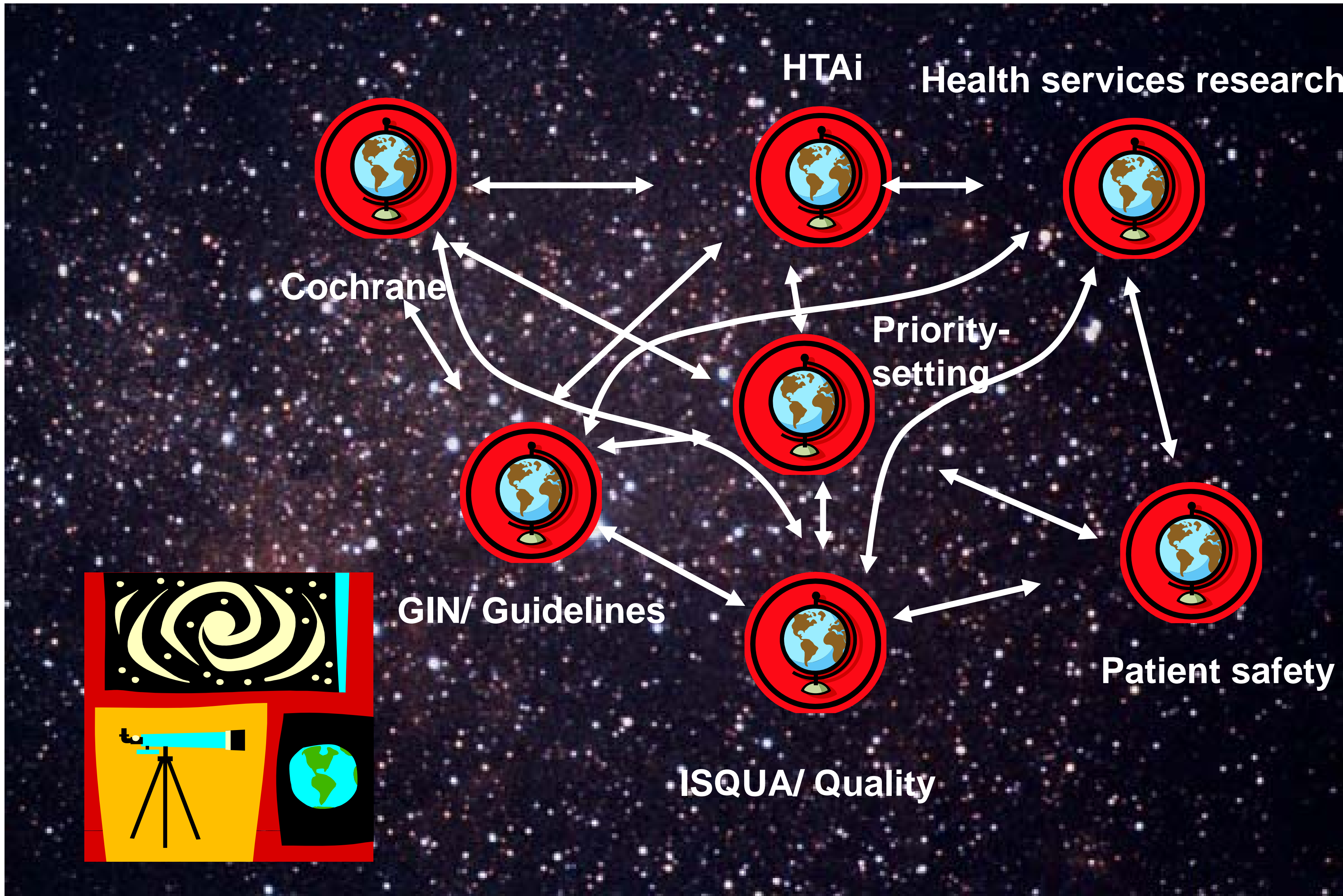
Patienten/ Bürger:
Soziodemographie
-> Equity

Krankheit & Schweregrad
("condition")

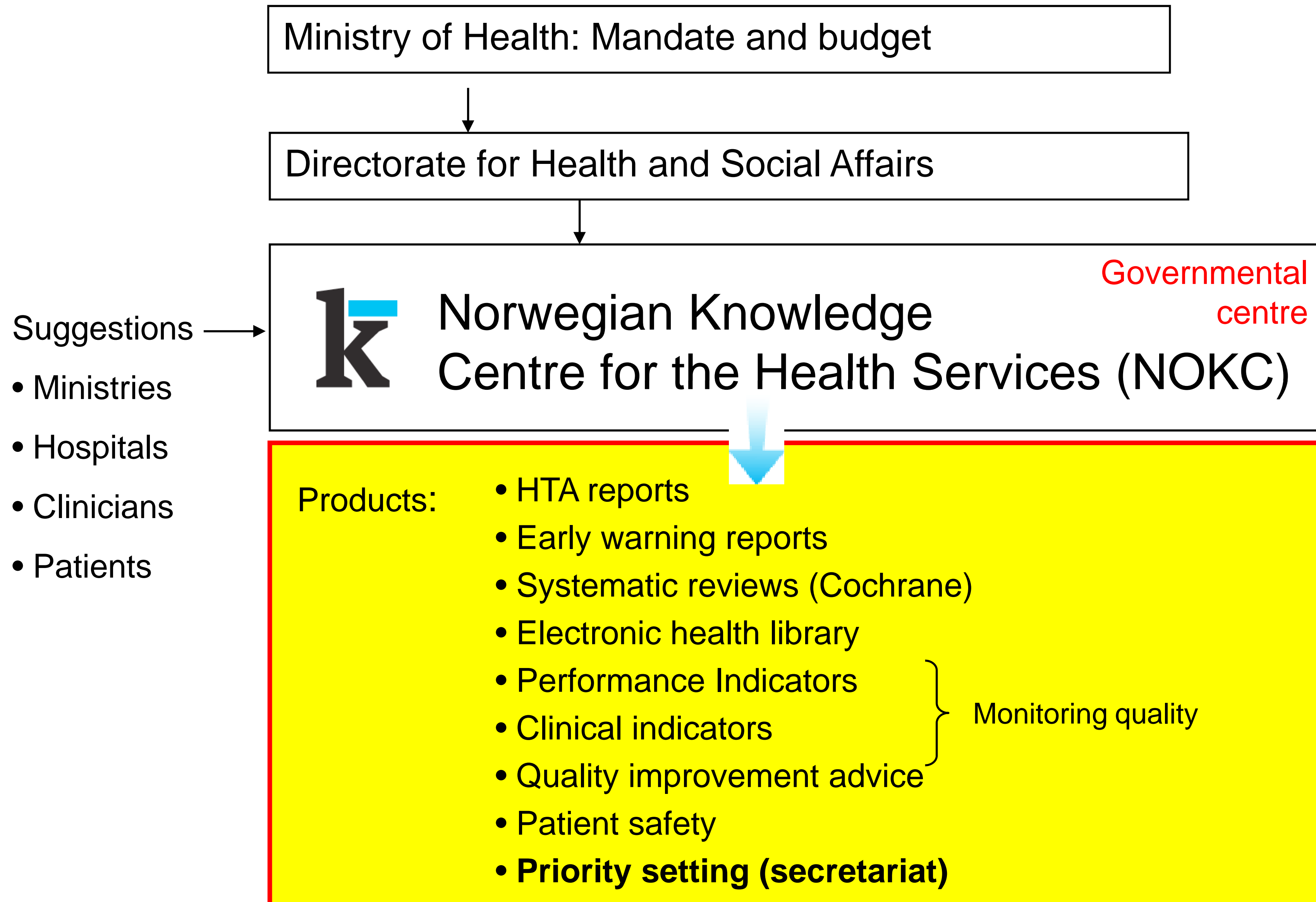
Technologie/ Intervention:
Wirksamkeit, Kosten-Wirksamkeit

Leistungserbringer:
Angemessenheit/ Indikationsstellung
("do the right thing") &
technische Qualität
("do the thing right")

Health Technology Assessment **Qualitätsmanagement**


HTAi
Health services research
Cochrane
Priority-
setting
GIN/ Guidelines
Patient safety
ISQUA/ Quality

Also alles zusammen?
Das Beispiel Norwegen seit 1.1.2004



Prioritätensetzung in Norwegen heute (1)

Background

Norway has introduced the following criteria for priority setting in health care:

- Seriousness of the disease
- Effect of treatment
- Cost-effectiveness of treatment

Norway has introduced the following fundamental values of the health service:

- Efficacy
- Safety
- User involvement
- Coordination and communication
- Cost-effectiveness
- Availability for all

Objective

The Council's mission is to advice on decisions in health care concerning priority setting and quality improvement.

"This Council will make us more confident that we are making wise choices"

Norwegian Minister of Health, 2007

The main areas for discussion in The Council:

1) Unacceptable differences in health care services; socially, geographically
2) Introduction of new (and costly) treatment options
3) Division of work and functions
4) National guidelines
5) Coordination between primary and specialist health care services

Prioritätensetzung in Norwegen heute (2)

Results

After one year, ca 25 items have been discussed, and most of them resulted in concrete actions from the responsible authorities :

Introduction of new and costly technologies.

The Council has drawn up guidance depending on knowledge and mutual understanding about both the benefits and costs of measures in the health service on

- New cancer drugs
- New biological treatments, i.e. Tysabri at MS Lucentis vs Avastin at AMD
- Costly equipment; i.e Cochlea implantation, PET-scan
- Routine screening procedures, i.e : Mammography 40-49 years, Newborns
- Vaccines, i.e. HPV

National guidelines

The Council has initiated work on guidelines on:

- Primary prevention for cardio-vascular diseases
- Diagnosis and Treatment of Sleep apnoe

Priority setting

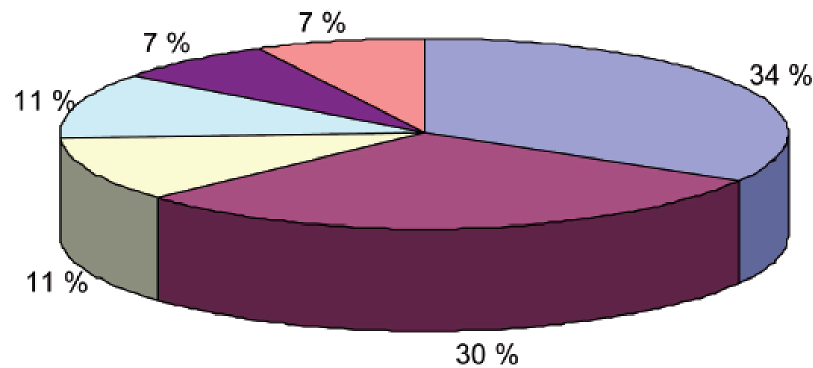
The Council has initiated guidance for priorities:

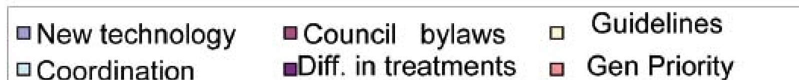
- Cochlea implantation for adults
- Long term mechanical ventilation at home

General systems

- Public initiation and financing of clinical trials
- National system for assessing and reimbursement of new technology
- Balance between health care professionals in primary and secondary health care

Prioritätensetzung in Norwegen heute (3)





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I HELSETJENESTEN

Fig. 1 Topics sorted by main areas: Introduction of new technologies most often discussed

Conclusions

The Council has based its debates on best evidence (HTAs), but also asked for assessments which illustrate the dilemmas and elements of uncertainty.

Andere breit aufgestellte HTA-Institutionen

The roles and responsibilities of NICE since 1 April 2005

NICE produces guidance in three areas:

Public health – the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

Health technologies – the use of new and existing medicines, treatments and procedures within the NHS

Clinical practice – the appropriate treatment and care of people with specific diseases and conditions within the NHS.

- l'analyse des pratiques cliniques et le développement de recommandations de bonne pratique (Good Clinical Practice)
- l'évaluation des technologies médicales (Health Technology Assessment)
- le financement et l'organisation des soins de santé (Health Services Research)
- l'équité et l'étude du comportement des patients (Equity and Patient Behaviour)

… und Schottland, Irland …

Wenn Priorisierung Teil von (einem breiteren) HTA ist, dann ist Prioritätensetzung für HTA wichtig

Systemat. Review von Noorani et al. 2007

- analysierte 12 Ansätze bei 11 Agenturen in 10 Ländern: Dänemark, Niederlande, England, Schottland, Schweden, Spanien, Ungarn, Kanada, USA, Israel
- bei Mehrheit erfolgt Priorisierung durch ein beratendes Gremium bestehend aus Vertretern der Kostenträger, Leistungserbringer und Wissenschaftlern
- (nur) vier Ansätze nutzen explizites Bewertungssystem

Kriterien für Prioritätensetzung

Kriterium	bei Agenturen angewandt
Alternativen	1 (9%)
Budget Impact	6 (55%)
Klinischer Impact	**11 (100%)**
Kontroverse	2 (18%)
Krankheitslast	7 (64%)
Ökonom. Aspekte	**10 (91%)**
Ethische, rechtl., psychosoziale Folgen	2 (18%)
Evidenzgrundlage	5 (45%)
Erwartetes Interesse	5 (45%)
Zeitgerechtigkeit	4 (36%)
Anwendungsvariation	3 (27%)

Quelle: Noorani et al. 2007

Technische Universität Berlin

Präsentation, Literatur zum Thema etc. auf:
www.mig.tu-berlin.de

Email: mig@tu-berlin.de