# How Do Culture, Values and Institutional Context Shape the Methods and Use of Economic Evaluation?

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## Background to the Issue

- Methods and use of economic evaluation vary across countries
- High users (Canada, UK), low users (Japan (until recently), US)
- 'QALY lovers' (Australia, Sweden, UK), 'QALY skeptics' (Germany, US)
- In some case there are very transparent processes (UK), others less so (France)

## Issues for Discussion

- Can we explain why these differences across the various jurisdictions?
- What is the influence of culture, values and institutional context?
- Can a better understanding of these influences help in determining the best way forward for those jurisdictions contemplating a greater use of economic evaluation?

## Panelists

- *Paul Scuffham PhD*

  Professor, Griffith University, Australia

- *Yen-Huei (Tony) Tarn PhD*

  Taiwan Pharmacists Association, Taiwan

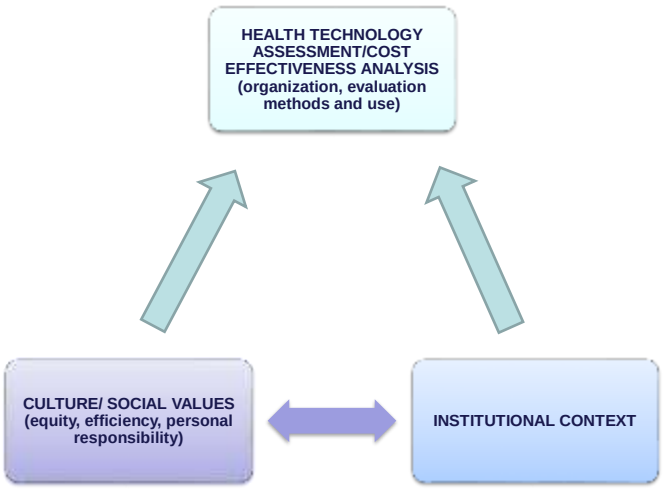
- *Takashi Fukuda PhD*

  National Institute of Public Health, Japan

# Explanations for the Observed Variations in Approach

- A recent study in the largest 5 EU countries shows how these differences can be explained by cultural differences(eg the weights given to equity, efficiency, need and personal responsibility) (Torbica et al, 2016)
- These factors influence the methods and use economic evaluation *directly*, or *indirectly* by how they shape the financing and organization of health care

## Conceptual Framework



# Research Scope

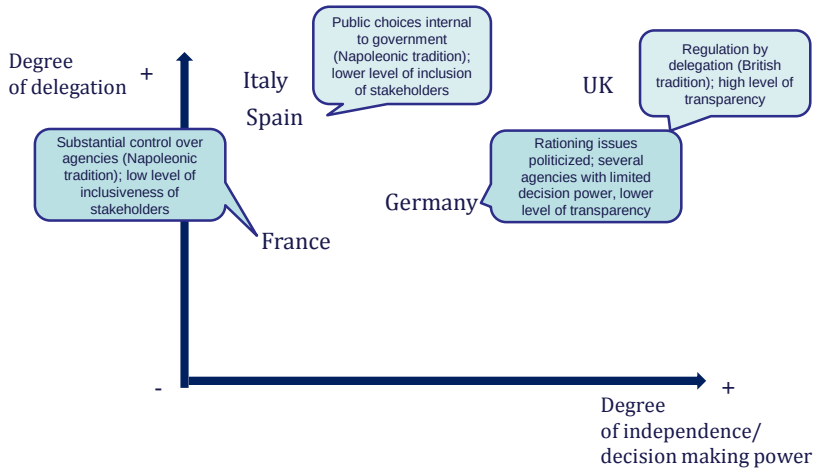
- Five largest European countries (France, Germany, Italy, Spain and the UK).
- The countries selected cover different types of healthcare systems with different culture, social values and administrative traditions underpinning them.

| | France | Germany | Italy | Spain | UK |
|---|---|---|---|---|---|
| **Social values** | | | | | |
| Equity | * | 0 | ** | ** | ** |
| Efficiency | 0 | * | 0 | 0 | ** |
| Personal Responsibility | 0 | * | - | - | - |
| **Institutional context** | | | | | |
| *- Type of healthcare system** | | | | | |
| Beveridge | | | X | X | X |
| Bismarck | X | X | | | |
| *- Collection of funds* | | | | | |
| Sickness funds | X | X | | | |
| Local level | | | X | X | |
| Central level | | | X | X | X |
| *- Level of allocation of funds* | | | | | |
| Centralized | X | X | | | |
| Decentralized | | | X | X | X |
| *- Administrative tradition* | | | | | |
| Anglo-American | | | | | X |
| Germanic | | X | | | |
| Napoleonic | X | | X | X | |

** Beveridge-type- tax based national health systems that focus on ensuring universal coverage and equity of access; Bismarck-type, insurance based systems where the primary aims are plurality, solidarity and abundance of choice.*

# Organization and Governance of HTA/CEA

- Preexisting institutional structures and administrative traditions in different health-care system **influence the choices for delegation** of regulatory and decision making powers to more or less independent agencies in charge of HTA/CEA



# Methods for Assessing the Value of Pharmaceuticals in France and Germany

- ***France***
  - primarily uses an assessment of 'added value' (ASMR), made by an expert committee
  - manufacturers are asked to submit a cost-utility analysis 'for information' if they are requesting an ASMR of III or higher

- ***Germany***
  - primarily uses an approach similar to France
  - in the absence of an agreement of price in the first year, the manufacturer or the G-BA can request an economic evaluation conducted by IQWiG

# Global Scores in France and Germany for Use in Price Negotiation for Drugs

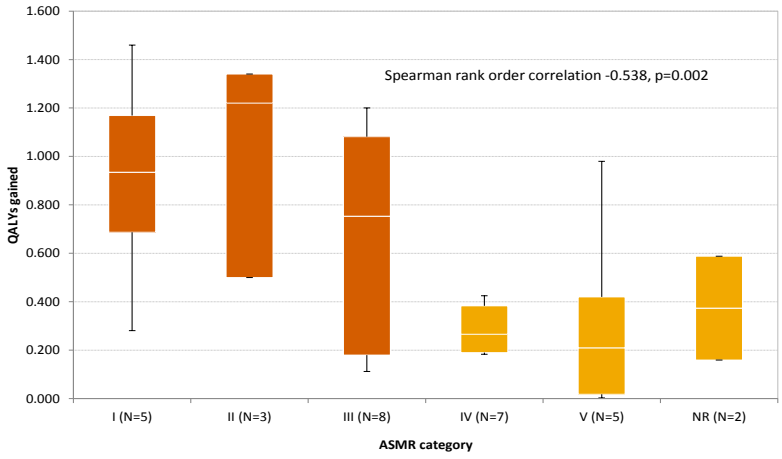
| | France | Germany |
|---|---|---|
| | **ASMR** | **G-BA/ IQWiG Level of Added Benefit** |
| **Innovative** | I – Major innovation ("majeure") | Major ("erheblich") |
| | II – Important improvement ("importante") | Considerable ("beträchtlich") |
| | III – Moderate improvement ("modérée") | |
| **Non-innovative** | IV – Minor improvement ("mineure") | Minor ("gering") |
| | V – No improvement ("inexistante") | Non-quantifiable ("nicht quantifizierbar") |
| | | No added benefit ("kein Zusatznutzen") |
| | | Lesser benefit ("geringerer Nutzen") |

# IQWiG's Methods for Economic Evaluation in Germany

- No use of QALYs as a generic outcome measure
- Argued that QALYs discriminate against the seriously ill or disabled
- The cost per unit of (clinical) outcome is compared with the existing 'efficiency frontier' for drugs in the therapeutic area concerned
- A measure similar to a QALY can be used *within a given therapeutic area*, if there are multiple outcomes that need to weighed one with another

## Comparisons of Value Assessments by NICE (UK) and HAS (France) on 49 Cancer Drugs

(Drummond et al, *Pharmacoeconomics*, 2014)



## Can Culture,Values and Institutional Context Explain Differences in Approach?

- *'QALY' jurisdictions are more likely to*:
  - have a NHS, operating with a fixed budget
  - have an institutional tradition that requires more transparency
  - place a high value on horizontal equity (ie all QALYs valued the same

- *'Non-QALY' jurisdictions are more likely to*:
  - have a social or private insurance system, where budgetary limits are less well-defined
  - be less worried about transparency
  - place a high value on meeting individuals' needs and wants

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# Questions for Panelists

- What is the approach to economic evaluation of drugs and other health technologies in your country?
- Can this approach be explained by culture, values and institutional context?
- Are there features of the approach in your country that cannot easily be explained?
- Are there any arguments for a change in approach, based on culture, values of institutional context?