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HTA368

Health Inequalities in Women's Health HTA: Are NICE Decisions Equity-Informed?

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KEY FINDINGS **Women's health inequalities were recognised in most NICE appraisals reviewed, but rarely translated into evidence, evaluation or action.**

- **Inequalities were acknowledged in almost all NICE women's health technology appraisals, but consideration remained largely descriptive as part of expert testimonials or background information**
- **Real-world evidence (RWE) and patient-reported outcomes (PROs) described burden and unmet need, but were rarely used to quantify who is affected most and wider impacts**
- **No appraisal used formal equity modelling (e.g., DCEA) or inequality-focused subgroup analysis to quantify disparities, and inequalities did not explicitly change any recommendation**

Background

- Health inequalities are a growing priority within healthcare decision-making.
- Women's health conditions are often characterised by diagnostic delay, unmet need, substantial quality-of-life burden and variation in access to care.
- RWE and PROs could help identify, understand and address these disparities, yet their role in health technology assessment (HTA) remains unclear.

OBJECTIVES

1. **Assess how health inequalities are identified and described within NICE women's health technology appraisals (TAs).**
2. **Evaluate the role of RWE and PROs in supporting equity-informed decision making.**

Methods

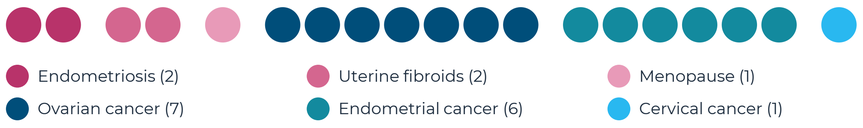
SCOPE
4 disease areas
Endometriosis, uterine fibroids, menopause and gynaecological cancers (ovarian, endometrial, cervical).

IDENTIFY
19 NICE TAs
Technology appraisals and committee papers, 2021–2026

EXTRACT
40+ data fields
Extracted for each TA via a structured framework across 3 key domains (below)

SYNTHESISE
5 vs 14 TAs
Coded counts and narrative themes compared: **non-cancer vs cancer**

Appraisals analysed by condition (n=19)



FRAMEWORK DOMAINS

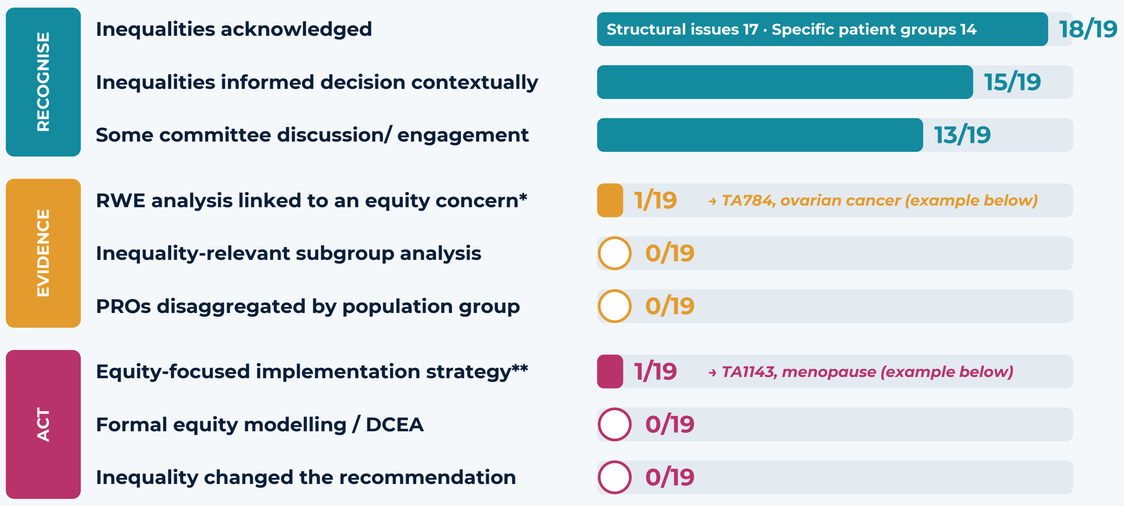
(i) **Identification and nature of inequalities**
(ii) **Use of RWE and PROs**
(iii) **Equity in economic evaluation, committee deliberation and implementation**

Results

Inequalities were recognised, often as structural issues (e.g., diagnostic delay, access); specific patient groups were named but rarely analysed, and no recommendation changed.

Figure 1. From recognising inequalities to acting on them

Number of appraisals (of 19) meeting each criterion: a baseline for measuring progress



***EXAMPLE · RWE (TA784, niraparib, ovarian cancer)**
Only one appraisal used RWE in relation to an access-related equity concern. Stakeholders argued the recommendation would leave ~80% of women (no BRCA mutation) without second-line maintenance access; SACT and UK real-world data informed a scenario addressing uncertainty in real-world survival benefit. Committee: "**illustrative but not robust**"; not a protected group, so no change.

****EXAMPLE · IMPLEMENTATION (TA1143, fezolinetant, menopause)**
Citing long waiting lists and location-dependent access to specialist menopause services, the company proposed primary care prescribing; strategy therefore reflected proposed access arrangements rather than formal equity programmes. Consultees warned that not recommending it could widen inequalities, as private care favours those who can pay.

Figure 2. Inequality themes differed by disease area

Appraisals mentioning each theme (n with mention / n appraisals; Counts reflect any documented mention irrespective of depth)

	NON-CANCER (n=5)			GYNAECOLOGICAL CANCER (n=14)			
	Endometriosis	Uterine fibroids	Menopause	Ovarian cancer	Endometrial cancer	Cervical cancer	All
Access barriers: pathway / service†	2/2	2/2	1/1	3/7	3/6	0/1	11
Explicit inequalities between population groups‡	1/2	0/2	1/1	3/7	1/6	0/1	6
Ethnicity	1/2	2/2	1/1	2/7	4/6	0/1	10
Biomarker / eligibility	0/2	0/2	0/1	6/7	3/6	0/1	9
Diagnostic delay	2/2	0/2	0/1	4/7	2/6	0/1	8
Geography§	0/2	2/2	1/1	3/7	0/6	0/1	6
Socioeconomic	1/2	0/2	1/1	1/7	3/6	0/1	6
Age	0/2	2/2	0/1	2/7	1/6	0/1	5

†Waiting lists, specialist services, testing capacity, CDF-only availability or line-of-therapy rules; excludes biomarker eligibility (own row). ‡Access differing by ethnicity, location, ability to pay, language or disability; overlaps related rows; never analysed. §Fibroids: regional differences in trial outcomes, not access.

Non-cancer: diagnostic delay, access barriers, service variation, ethnicity and socioeconomic factors (4/5 discussed ethnicity)

Cancer: biomarker-defined subgroups and eligibility-based access (9/14), with less focus on demographic inequalities

Role of RWE and PROs *Evidence explained "what", but rarely "who is affected most" or "how do we improve access?"*

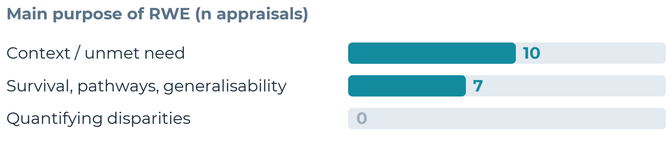
Real-world evidence

Described burden, pathways and unmet need

18/19 descriptive use only

1/19 informed a scenario on real-world survival, linked to BRCA status (TA784)

Main purpose of RWE (n appraisals)



Sources included SACT (5 TAs), NCRAS (4), HES and patient surveys; 5/19 relied solely on expert or patient testimony.

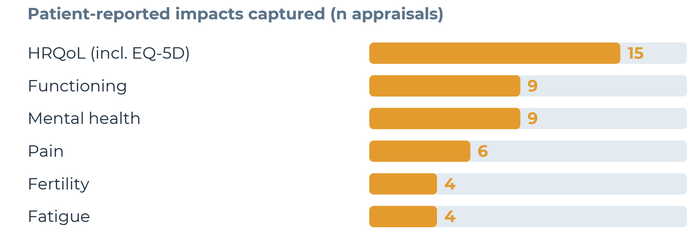
Patient-reported outcomes

Captured burden, but not its distribution

17/19 used PROs for utilities / QALYs

0/19 disaggregated PROs by population group (e.g. ethnicity, deprivation)

Patient-reported impacts captured (n appraisals)



EQ-5D insensitivity to cyclical symptoms was noted (TA996); only TA1143 adjusted utilities to reflect it.

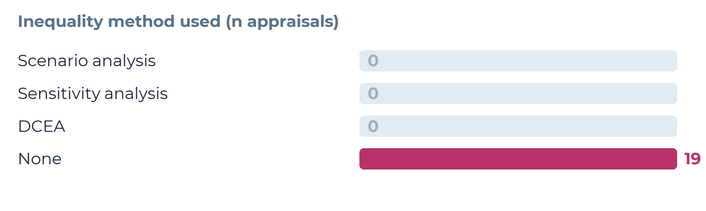
Equity analyses

Rarely supported inequality-specific analysis

0/19 DCEA or equity-weighted outcomes

14/19 subgroups were clinical only (e.g. BRCA, HRD, MMR), reflecting access constraints rather than wider inequalities

Inequality method used (n appraisals)



Subgroups by ethnicity or region (TA832) tested treatment-effect consistency, not differential access or outcomes.

INEQUALITIES RAISED IN THE APPRAISALS

"…black women are more likely to have multiple fibroids that are large, so are more likely to need hospitalisation or surgical intervention"
— ETHNICITY · TA996 · uterine fibroids · committee discussion

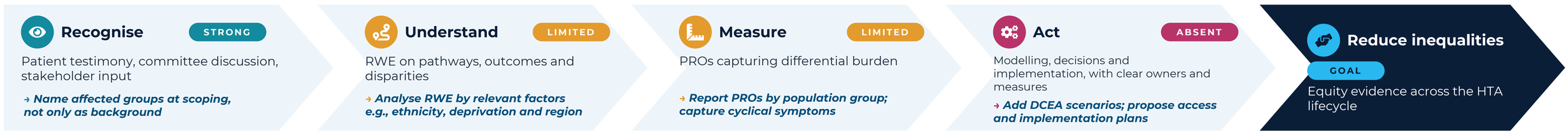
"…women from the middle and most deprived socio-economic groups were more likely to die from endometrial cancer, with a two-fold and a 53% increased risk…"
— DEPRIVATION · TA1064 · endometrial cancer · company submission

"…the current system favours those who can afford to pay for private care… not recommending this treatment may increase health inequalities"
— FINANCIAL · TA1143 · menopause · consultation response

Yet inequalities were generally judged to be outside the TA remit
Ethnicity-linked incidence and later diagnosis were deemed unaddressable within a TA (TA1092, TA1117); BRCA-negative status was "not a protected group" (TA784).

Figure 3. From evidence to action: where women's health TAs sit on the path to reducing inequalities

→ *Evidence planning opportunity*



LIMITATIONS

- Focused on published NICE TAs within selected women's health conditions.
- Some identified inequalities related to biomarker-defined treatment eligibility and may reflect differential access to treatment rather than traditional demographic or socio-economic inequalities.
- Classification involved reviewer judgement despite a structured framework.
- Most appraisals pre-date the May 2025 NICE health inequalities update[1]; findings provide a baseline.

CONCLUSIONS & IMPLICATIONS

- **Acknowledged, not integrated.** Inequalities were recognised in most appraisals reviewed, but considered largely as context.
- **Evidence under-used.** RWE and PROs characterised burden and unmet need, but were seldom disaggregated to quantify disparities.
- **An opportunity for change.** NICE's May 2025 health inequalities update[1] asks for evidence on how prevalence, uptake and treatment benefit differ across social groups: an opportunity to embed RWE, PROs and equity evidence across the HTA lifecycle.
- **From recognition to action.** Clearer ownership and measures of success could help turn recognised inequalities into action, from appraisal to implementation; evidence planning can address each stage (Figure 3).

REFERENCES & NOTES

NICE technology appraisals reviewed: TA779, TA784, TA832, TA904, TA908, TA939, TA946, TA962, TA963, TA996, TA1007, TA1055, TA1057, TA1064, TA1067, TA1092, TA1117, TA1129, TA1143. Available at nice.org.uk/guidance. Heatmap includes partial or implicit mentions coded at extraction.

[1]NICE. NICE health technology evaluations: the manual (PMG36). Updated May 2025 to include health inequalities; see also Support document: health inequalities. nice.org.uk/process/pmg36.

Abbreviations: DCEA, distributional cost-effectiveness analysis; HRQoL, health-related quality of life; PRO, patient-reported outcome; RWE, real-world evidence; TA, technology appraisal.

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