UNIVERSAL VALUE: THE WAY FORWARD

How do we reconcile universal value when it can mean different things to different stakeholders?

Alison Howell, Ph.D  
Director, Covance Market Access, London

Michael F. Drummond, MCom, DPhil  
Professor of Health Economics, Centre for Health Economics, University of York

Don Redding, BA  
Director of Policy, National Voices, London

Jane Erickson, BA, MHS  
Vice President, Covance Market Access, USA

Emanuela Castelnuovo, MSc  
Director, Covance Market Access, London

Ruth Zeidman, Ph.D  
Director, Covance Market Access, London

Wednesday, November 8, 2017

Outline

1. Universal value
2. The payer perspective
3. The patient perspective
4. Discussion
How to get involved?

1. Open browser
2. Go to slido.com
3. Join with event code #C245

Universal value
What are the **attributes of a valuable product?**

Unmet need

- Political pressure
- Innovation
- Affordability
- Value for money

**Product value**

- Clinical efficacy
- Safety
- Patient impact
- Convenience

Who judges a **product’s value?**

- Policy maker
- Prescriber
- Payer
- Patient
- Caregiver
- Pharmacist
Can a product offer **UNIVERSAL** value?

Who judges a product’s value?

Payer → Product value → Patient
How do healthcare payers view value?

Michael F. Drummond, MCom, DPhil
Professor of Health Economics, Centre for Health Economics, University of York

Outline

1. Who are the ‘payers’?
2. Focus on health improvements
3. International diversity
4. Issues arising
Who are the ‘payers’?

The term ‘payer’ is typically used to describe the officials representing the country’s healthcare system/insurance scheme, or the agencies advising them.

Payers generally focus on health improvements

- **Health improvement**
  - Clinical terms
  - Measure of health gain (e.g. QALY)

- **Net value**
  - Health improvements vs. cost incurred

- **Healthcare system with hard budget constraint**
  - Costs represent the value of treatments that are displaced when new treatments are introduced
Value assessment frameworks vary across Europe

<table>
<thead>
<tr>
<th>Strong preference</th>
<th>Mentioned as a possible approach</th>
<th>Not encouraged</th>
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</thead>
<tbody>
<tr>
<td>England</td>
<td>Belgium</td>
<td>France*</td>
</tr>
<tr>
<td>Wales</td>
<td>Portugal</td>
<td>Germany</td>
</tr>
<tr>
<td>Scotland</td>
<td>Slovakia</td>
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<tr>
<td>The Netherlands</td>
<td>Sweden</td>
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</tr>
<tr>
<td>Norway</td>
<td>Switzerland</td>
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*As the basis for making decisions

www.ispor.org Pharmacoeconomic Guidelines Around the World

France and Germany do not rely on QALY/cost-effectiveness analyses when assessing pharmaceuticals

**FRANCE**
- Expert committee
- Assessment of clinical ‘added value’ (ASMR)*
- ASMR guides price negotiations

**GERMANY**
Similar approach to France. In the absence of a price agreement in the first year, the manufacturer or the G-BA can request an economic evaluation conducted by the IQWiG.

*Manufacturers are asked to submit a cost-utility analysis ‘for information’ if they are requesting an ASMR of III or higher
Global scores for use in pharmaceutical price negotiations vary between France and Germany.

### Global scores

#### ASMR
- **I** – Major innovation ("majeure")
- **II** – Important improvement ("importante")
- **III** – Moderate improvement ("modérée")
- **IV** – Minor improvement ("mineure")
- **V** – No improvement ("inexistante")

#### G-BA/IQWiG level of added benefit
- **Major** ("erheblich")
- **Considerable** ("beträchtlich")
- **Minor** ("gering")
- **Non-quantifiable** ("nicht quantifizierbar")
- **No added benefit** ("kein Zusatznutzen")
- **Lesser benefit** ("geringerer Nutzen")

### Pros and cons of the cost per QALY approach

**Pros**
- Relatively transparent
- Encourages consistency in decision-making
- Can consider the opportunity costs under the budget constraint
- Can consider sub-groups and target therapy

**Cons**
- May not reflect all aspects of value
- Relatively inflexible
- Can discriminate against the elderly and disabled when different life-extending therapies are being considered
Can culture and values explain differences in attitudes towards QALYs?

### Pro-QALY jurisdictions
- Have a NHS, operating with a fixed budget
- Have an institutional tradition that requires more transparency
- Place a high value on horizontal equity (i.e. equal treatment of equals)

### Anti-QALY jurisdictions
- Have a social or private insurance system, where budgetary limits are less well-defined
- Less worried about transparency
- Place a high value on meeting an individual’s needs and wants

QALYs may not adequately reflect some elements of value

Possibilities include:
- Convenience and access
- Treating severe disease
- Treating rare disease
- Providing reassurance
- Bridging to other, effective therapies

### KEY QUESTIONS:

How much do decision-makers (and society at large) care about these issues?

What is the best way of incorporating them in the decision-making process (though analysis or deliberative decision-making)?
Summary

- Payers see themselves as those providing funds (e.g. taxpayers and insurance fund members).
- Payers mostly believe that the key elements of value from health care are health improvements.
- Whilst recognising that other elements of value may be important, payers question whether it is worthwhile giving up health improvements to secure them.

People, communities, value

Don Redding
Director of Policy, National Voices,
@MightyOredd
www.nationalvoices.org.uk
The Realising the Value programme

Led by: The Health Foundation  
Funded by: Nesta

In partnership with: National Voices, regional voices for better health, navca local focus national voice, PPL

www.nesta.org.uk/realising-value-programme-reports-tools-and-resources

Estimated annual net savings from implementing targeted peer support and self-managed education

Wider social savings:
Are based on offering peer support to individuals with HIV, and self-management education interventions to people with cancer.

Savings to the health system
Are based on providing peer support to people with mental health issues and coronary heart disease, and self-management education to people with cardiovascular disease and asthma.

<table>
<thead>
<tr>
<th></th>
<th>Savings per person</th>
<th>Savings for one CCG</th>
<th>National savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential wider social savings</td>
<td>~£20,800</td>
<td>~£22m</td>
<td>~£4.5bn</td>
</tr>
<tr>
<td>Estimated savings to the health system</td>
<td>~£2,100</td>
<td>~£5.2m</td>
<td>~£950m</td>
</tr>
</tbody>
</table>
Porter critique of **value**

<table>
<thead>
<tr>
<th>Shift from:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Value</td>
</tr>
<tr>
<td>System driven by supply and provider activity</td>
<td>Patient-centred</td>
</tr>
<tr>
<td>Outcomes of specific products/treatments/care episodes</td>
<td>Summary outcomes of all interventions through ‘cycle of care’</td>
</tr>
</tbody>
</table>

Social value

Decisions on the use of public funds
should not only consider value for money, but also economic, environmental and social value

The duty of all commissioners
is to think about how they can also secure wider social, economic and environmental benefits under the Public Services (Social Value) Act 2012

Only 13% of CCGs are making active, committed use of the Social Value Act*

*See: ‘Heathy Commissioning’, National Voices, 2017

Public value

Public value
What adds value to the public sphere + what the public value most

Public service managers
Constant engagement with citizens to negotiate and shape public preference for what is valuable and they should produce


PRINCIPLES

Outcomes

Long-term perspective

Co-creation with citizens
"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

**Public value**

- **Person**
- **Place**
- **Population**
- **Co-ordination**

**Wider societal value**

- **People involved in own care:** £150 return on £100 invested
  - **People-powered health:** £4.4 billion per year

- **Informal carers:** >6 million people
  - 1.5 million full time: £132 billion per year

- **Volunteers:** A quarter of all adults
  - £24 billion per year

- **Voluntary sector:** 160,000 organisations
  - £12.1 billion gross value added
What do people value?

- **Quality of life and death** more than specific treatments
- **Values** such as choice, control, and dignity more than medical/clinical concerns
- **Life goals** such as wellbeing and independence, not just healthcare-related goals

Value: **broadening the focus**

<table>
<thead>
<tr>
<th>Not only:</th>
<th>But also:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific clinical outcomes</td>
<td>Wider health and wellbeing impacts</td>
</tr>
<tr>
<td>What the system values (e.g. costs</td>
<td>What people and their communities value (i.e. the outcomes most important to them)</td>
</tr>
<tr>
<td>and value for money indication)</td>
<td>Wellbeing (e.g. quality of life), people feeling supported and in control, socially connected and independent</td>
</tr>
<tr>
<td>Patient experience (i.e. what direct contact with services feels like)</td>
<td>Outcomes over time of all the services, and the support a person or community may draw upon</td>
</tr>
<tr>
<td>Immediate outcomes of a single service (e.g. success of treatment)</td>
<td>Equity in health and wellbeing, with greatest value achieved by targeting people and groups with greater need, lower health literacy, and least success</td>
</tr>
<tr>
<td>Individual outcomes for the person</td>
<td></td>
</tr>
</tbody>
</table>
We value

Outcomes that are most important to people and their communities

People’s contributions (their strengths, time effort, and skills)

Sustainable outcomes over time, achieved through working together, as services and in partnership with people

The creation of health and wellbeing

People feeling supported, in control, socially connected and independent

Equity, and the gains to be made by targeting and tailoring our approaches to people with greater need for our partnership

“I know that people with a wide range of characteristics and backgrounds will be included in, and benefit from, research and innovation

I know that patients and citizens are involved in deciding priorities for research, including decisions about funding

I know that what matters most to patients and citizens is taken into account in setting priorities for research and developing innovations

“The historical model where innovators simply throw new products at healthcare systems and allow them to layer these into existing pathways is no longer viable…. Patients should be involved in horizon scanning and prioritisation, and this involvement should continue along the whole innovation pathway.”
AAR offers patients:

- **Earlier access** to important, life-changing innovations that improve outcomes.
- **A greater say** in determining what innovations are important to them.
- **Participation at the earliest stage** of the evaluation of new products so they can help influence the products that will go on to reach patients.
- **Easily digestible information on the impact innovation has** on patients and on the NHS.

**Patients, clinicians and charities** should be the **key drivers** in the development, prioritisation, evaluation and adoption of innovation:

- Improved commercial capability to deliver better value.
- **Committed to driving innovation**:
  - Woven into NHS planning
  - Increased capacity
  - Clinical leadership
  - Adoption incentives
- **AAR prioritises strategically important innovations** which benefit patients and the NHS.
- **Open and transparent pathway** for all health technologies.

The **Academic Health Science Network (AHSN)** coordinates, promotes and supports local innovation.

New **Accelerated Access Partnership** brings together key parts of the health system to **provide a single source of national-level guidance** to all innovators and oversee the innovation pathway.
Get in touch

Email: info@nationalvoices.org.uk
Phone: 020 3176 0738
Website: www.nationalvoices.org.uk
Twitter: @NVtweeting

Discussion
Value means **different things to different people**

- Payer
- Patient

*Efficacy and value for money and/or affordability*

*Impact on your life*

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**How do we reconcile universal value** when it can mean different things to different stakeholders?