



Universal Health Coverage & Health Technology Assessment

Dr. Jitendar Sharma

**Head, Division of Healthcare Technology & Director, WHO
Centre for Health Technology Policy
National Health Systems Resource Center, India**



Changing times! Changing trends!

- Every south east Asian nation moving towards Universal Health Care
 - Each program is unique
 - Coverage of each scheme is varied
 - Goal to social protection goal is unique
 - Pathway to reach the unreached is varied

Health is not a subject of national importance only

- Technology acceptance have wide impact on import/export; cross border trade; traffic; outbreaks; medical tourism, medical insurance mechanisms all get affected

A global perspective

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY- WHA67.23

Agenda item 15.7 : 24 May 2014

“Health intervention and technology assessment in support of universal health coverage”

Noting that *The world health report 2012* indicates that as much as 40% of spending on health is being wasted and that there is, therefore, an **urgent need for systematic, effective solutions** to reduce such inefficiencies and to enhance the **rational use of health technology**; Urges member states to

to consider also **collaborating** with other Member States' health organizations, academic institutions, professional associations and other key stakeholders in the country or region in order **to collect and share information** and lessons learnt so as to **formulate and implement national strategic plans concerning capacity-building** for and introduction of health intervention and technology assessment, and **summarizing best practices in transparent, evidence-informed** health policy and decision-making;

Goals for an HTA

- Eliminating services that are lesser effective or lesser cost-effective compared to alternatives
- Estimating reimbursement thresholds
- Defining Insurance Packages
- Selecting priority technologies/services on scientific merit
- Assessing best choices in public health provisioning

Why conduct an HTA

- Evidence around technologies rapidly change with inclusion of newer and larger studies/trials
- Innovations have no formal or objective mechanism for uptake
- Cheaper technologies may not always mean cost-effective technologies
- Designs of Clinical trails and research studies may not capture social/ethical dimensions around technologies

Limitations in using HTA

- Use in reimbursement is limited if reimbursement systems are not strong
- Use in standard treatment guidelines is not wholesome if too many medical associations bring out STGs; also if STGs are changed too quickly
- Using HTA would be a challenge if cost-effectiveness results are negative but clinical efficacy is well established
- Once HTA results are accepted, review may take few years, which means knowledge from newer evidence gets delayed
- Once HTA results are in practice, it is difficult to change practices on mere 'theory'

HTA in Technology Life Cycle

- **Innovations**- identifications- uptake and improving **access**
- **Management** of technologies- to improve reliability, efficacy and **access**
- **Inclusion** of technologies to improve **access**

Life Saving Implants

- Life saving implants remain a massive component of out of pocket spending in development systems where cost of care is not fully insured
- Catastrophic and episodic high expenditure leading to social and economic impoverishment and impact future quality of care & follow up
- Among the leading ones being cardiac stents, orthopedic implants, cochlear implants and Pacemakers

Industry's enigma

- Implants may be already lesser priced than the cost as in other countries !
- Other modalities such as clinical/ pharmaceutical interventions may still exist

Health Systems enigma

- Cost may be lesser, but C1/GDP (PC1) may be much higher than C2/GDP (PC2)
- Standard of care may still point towards surgical intervention forcing payer to look at cost control

How industry practice impact the decisions

- No printed label of MRP on the life saving implants
- Even if MRP is printed, the sticker is removed after crossing of trade borders/port offices
- Information asymmetry leading to unknown costs
- Landing costs only 10-20% of the costs to patients

Choices that payer governments have

- Request for voluntary cost reduction
- Notification for mandatory disclosure of MRP
- Inclusion in the national list of life saving commodities/drugs/devices/health products
- Price Control on a very selective range of life saving products

Process of HTA on LSIs

- Comparison of health effects of various categories within a product vertical (DES, BMS)
- Health effects are selective and are meta-analyzed
- For eg. In case of DES/BMS- TVR, MACE, Mortality
- Selection of patient age groups were done to arrive at appropriate estimates
- CEA was performed using the WHO-CHOICE database
- CE Thresholds were selected to be 3 X GDP (PC)

	DALYs averted (000s)	DALYs averted/person	Base Cost (Bare Metal Stent)	Service Cost/Hospital handling charges (12.36%)	TOTAL COST (BMS)	Base Cost (Drug Eluting Stent) (BMSX 1.476)	Service Cost/Hospital handling charges (12.36%)	TOTAL COST (DES)
Population in 30-70+ age group (534689000)								
Cost Effectiveness (1 DALY for INR 270000)								
If Stents are required for 100% of (A+B+C) Cases	55666.60	0.104	28109.76	3474.37	31584.13	41490.01	5128.17	46618.18
If Stents are required for 80% of (A+B+C) Cases	44533.28	0.083	22487.81	2779.49	25267.31	33192.01	4102.53	37294.54
If Stents are required for 60% of (A+B+C) Cases	33399.96	0.062	16865.86	2084.62	18950.48	24894.01	3076.90	27970.91
If Stents are required for 50% of (A+B+C) Cases	27833.30	0.052	14054.88	1737.18	15792.07	20745.01	2564.08	23309.09
If Stents are required for 40% of (A+B+C) Cases	22266.64	0.042	11243.91	1389.75	12633.65	16596.01	2051.27	18647.27



Thanking you for patient listening