How CADTH Expert Committees Deliberate

February 4, 2021

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Disclosure

CADTH is funded primarily by contributions from Canadian federal, provincial, and territorial ministries of health.

CADTH also receives application fees from pharmaceutical companies for three programs:

- CADTH Common Drug Review
- CADTH pan-Canadian Oncology Drug Review
- CADTH Scientific Advice

Welcome from Nicole Mittmann.

Welcome from Martine Elias.

- The presentation will be recorded and will be posted on CADTH's YouTube channel later this week.

- Submit your questions at any time using the Q&A box in the Zoom control bar. Questions will be discussed at the end of the presentation.

- A feedback survey will open in a new tab once the webinar ends.

Questions for February 11th consultation with patient groups*:

1. What needs to occur during deliberations to ensure that patients' needs, expectations, and experiences be meaningfully heard and considered by the committee?
2. What aspects of the committee deliberation are important for you to see communicated in the recommendations document?
3. How would you suggest that CADTH communicates about evidence uncertainties?

**eligible groups include:* *patient groups, patient and family advisors, and members of civil society and community not-for-profit organizations*

Outline for Session

We have decisions to make.

Expert review committee processes vary by context.

CADTH expert review committees help inform these decisions.

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What is Health Technology Assessment (HTA)?

Why deliberative processes?

What is HTA?

Health Technology Assessment (HTA) is a multidisciplinary process that uses explicit methods to ***determine the value*** *of a health technology at different points in its lifecycle. The purpose is to* ***inform decision-making*** *in order to promote an equitable, efficient, and* ***high-quality health system***.[1]

References: 1. O'Rourke B, Oortwijn W, Schuller T. The new definition of health technology assessment: A milestone in international collaboration. Int J Technol Assess Health Care. 2020:1-4

What do we mean by value?

Value is*: "…an overall and balanced description of the* ***positive and negative*** *(costs)* ***aspects of a situation*** *(e.g. best value for money)"*[1]

Dimensions of value of a health technology*: "… clinical effectiveness, safety, costs and economic implications, ethical, social, cultural and legal issues, organisational and environmental aspects, as well as …* ***patient, relatives, caregivers****, and the population."* [1]

Note: *Overall value may* ***vary*** *depending on the* ***perspective*** *taken, the* ***stakeholders involved****, and the* ***decision context****.* [1]

References: 1. http://htaglossary.net

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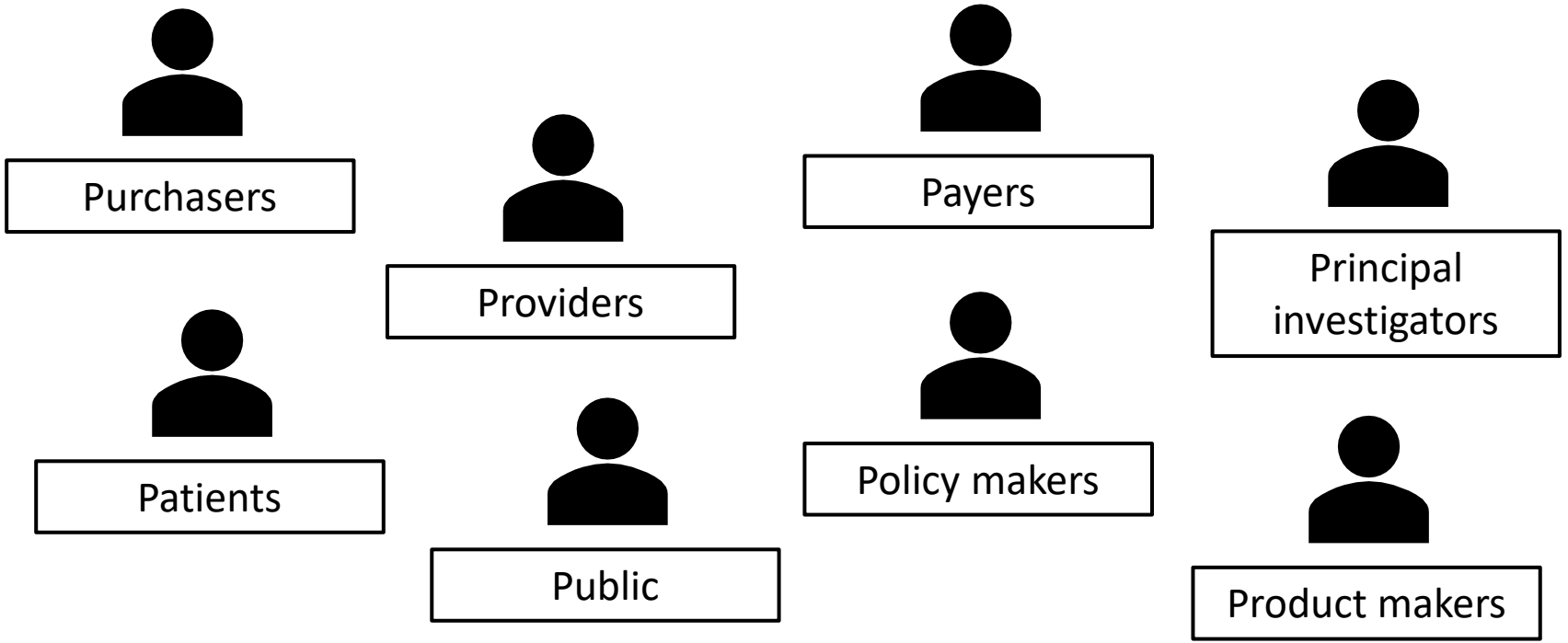
Value to whom?[1]



References: 1. Concannon TW, Meissner P, Grunbaum JA, et al. A new taxonomy for stakeholder engagement in patient-centered outcomes research. J Gen Intern Med. 2012;27(8):985-991

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Why deliberative processes?

FACTS …but even facts have **values**.

\+

HTA "*…evaluates facts that are produced because they are considered valuable*."[1]

VALUES

\+

PERSPECTIVES

"…increased stakeholder involvement (with different value perspectives)…"[1]

References: 1. Hofmann B, Bond K, Sandman L. 2018 Evaluating facts and facting evaluations: On the fact-value relationship in HTA; 2. Daniels N, Porteny T, Urritia J. 2015 Expanded HTA: Enhancing Fairness and Legitimacy.

Why deliberative processes?

FACTS …but even facts have **values**.

HTA "*…evaluates facts that are produced because they are considered valuable*."[1]

+

"Given the social disagreement that pervades many resource allocation decisions it is harder to agree on the fairness of such recommendation but there is considerable plausibility to accepting the outcomes of a fair process as fair."[2]

PERSPECTIVES

"…increased stakeholder involvement (with different value perspectives)…"[1]

References: 1. Hofmann B, Bond K, Sandman L. 2018 Evaluating facts and facting evaluations: On the fact-value relationship in HTA; 2. Daniels N, Porteny T, Urritia J. 2015 Expanded HTA: Enhancing Fairness and Legitimacy.

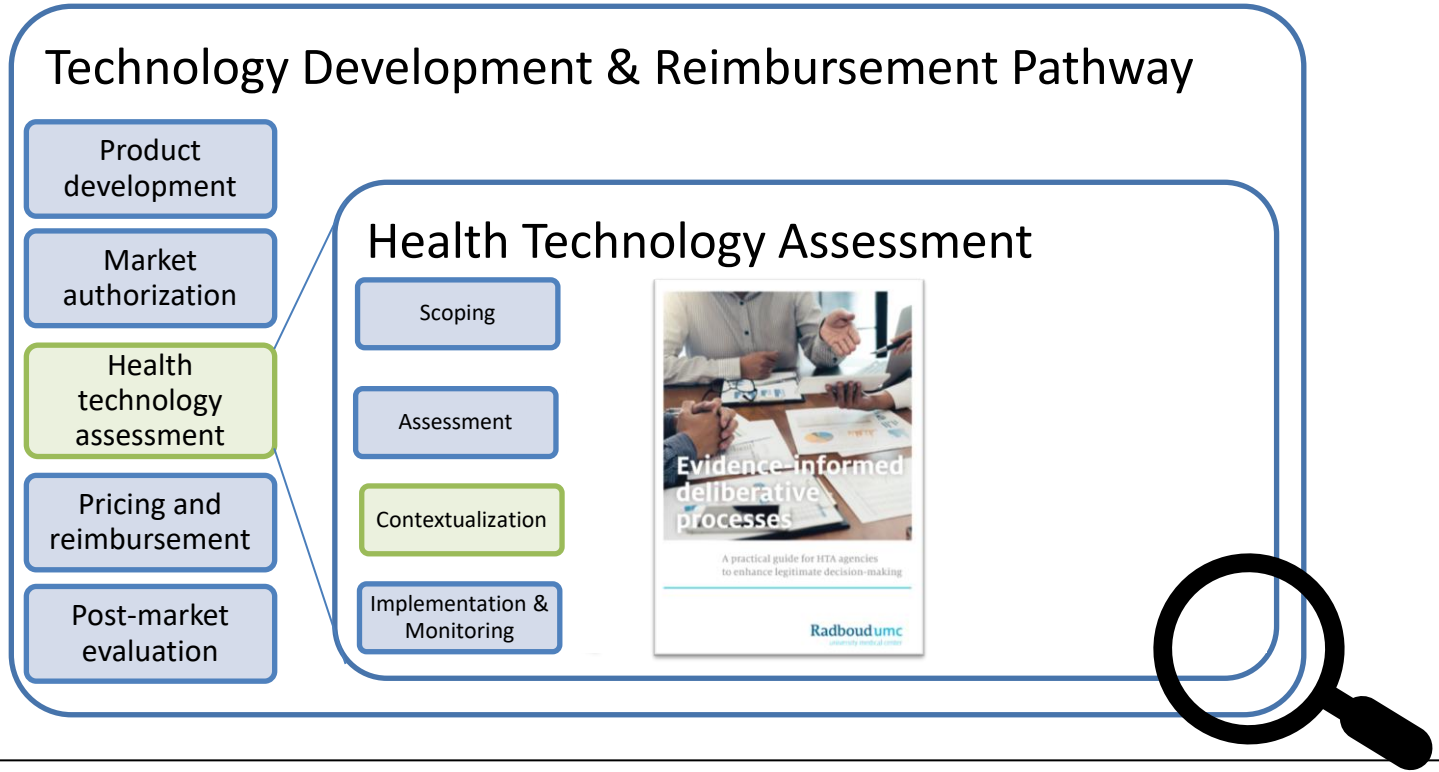
What are deliberative processes?

*"… a process allowing a group of actors to receive and **exchange information**, to critically examine an issue…"* [1]

*"…intended to improve the quality of decision making by **allowing for mutual decision making based on facts**."* [2]

References: 1. Cited in Gauvin 2009. Source: Fearon, J.D. (1998). Deliberation as Discussion. In J. Elster (Ed.), Deliberative Democracy (pp. 44- 68). Cambridge University Press; 2. Cited in Culyer 2020. Source: Culyer AJ, Lomas J. Deliberative processes and evidence-informed decision making in healthcare: do they work and how might we know? Evid Policy. 2006;2:357–371

Taking a step back for a minute…



References: 1. Oortwijn W, Baltussen R. Evidence-informed deliberative processes. A practical guide for HTA agencies to enhance legitimate decision-making. Nijmegen, Radboud Institute for Health Sciences. 2019; 2. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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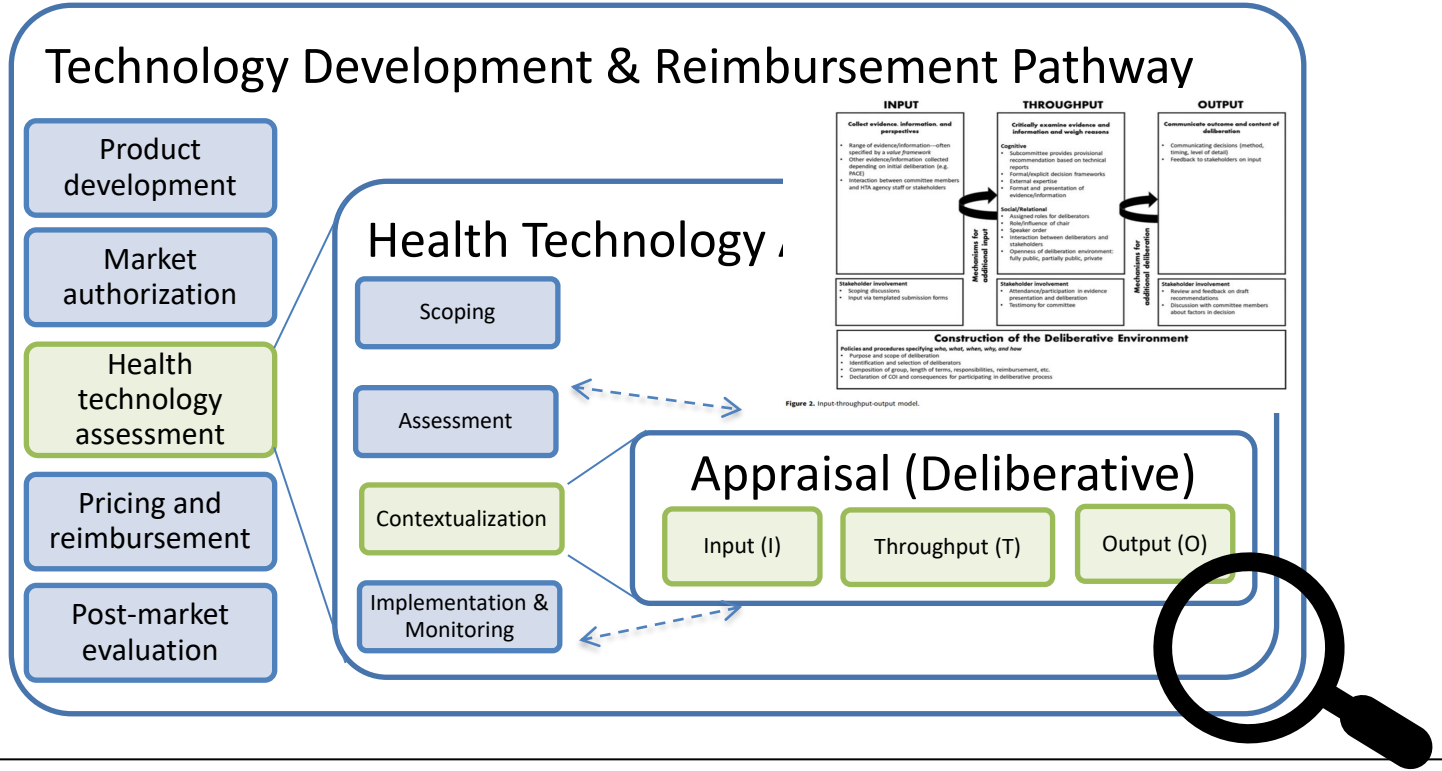
Taking a step back for a minute…



References: 1. Oortwijn W, Baltussen R. Evidence-informed deliberative processes. A practical guide for HTA agencies to enhance legitimate decision-making. Nijmegen, Radboud Institute for Health Sciences. 2019; 2. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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Input-Throughput-Output Model[1]

Common considerations:

- Who is at the table.
- Conflicts of interest.
- Open versus closed meetings.
- Recommendation document, public disclosure of meeting.

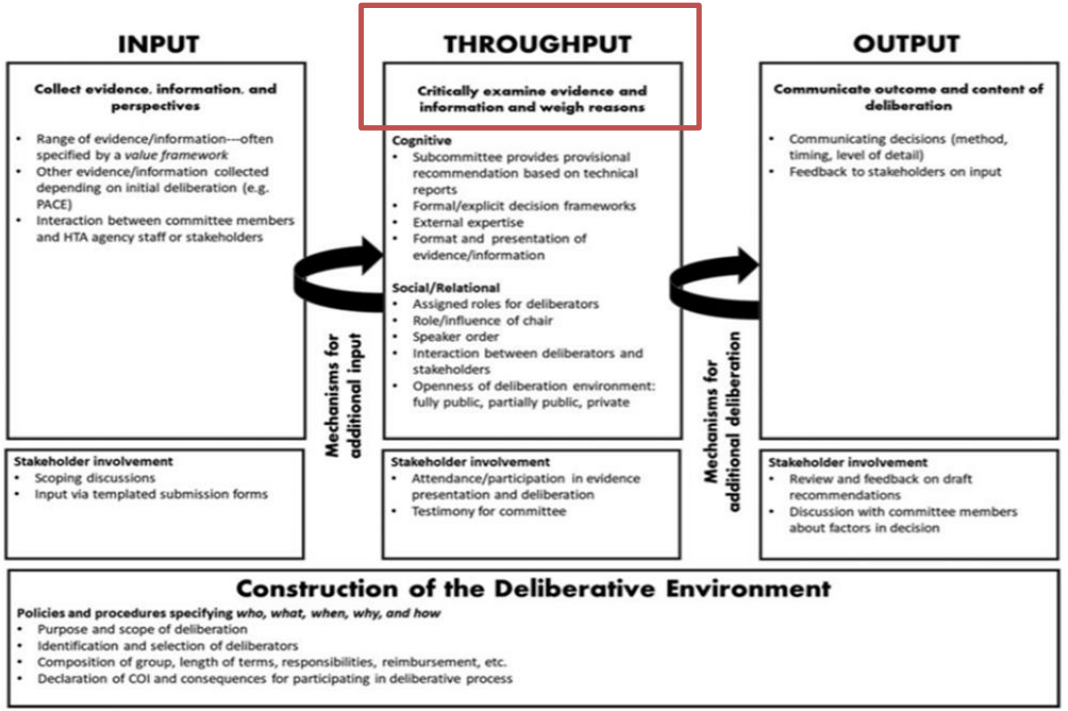

Figure 2. Input-throughput-output model.

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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Input-Throughput-Output Model[1]

Less common considerations: [2]

- Role/influence of the committee chair.
- Informal discussions at breaks.
- Balancing power dynamics.
- Opportunities to present dissenting opinions.
- Format of meeting (e.g., speaker order.)
- Virtual Sessions?

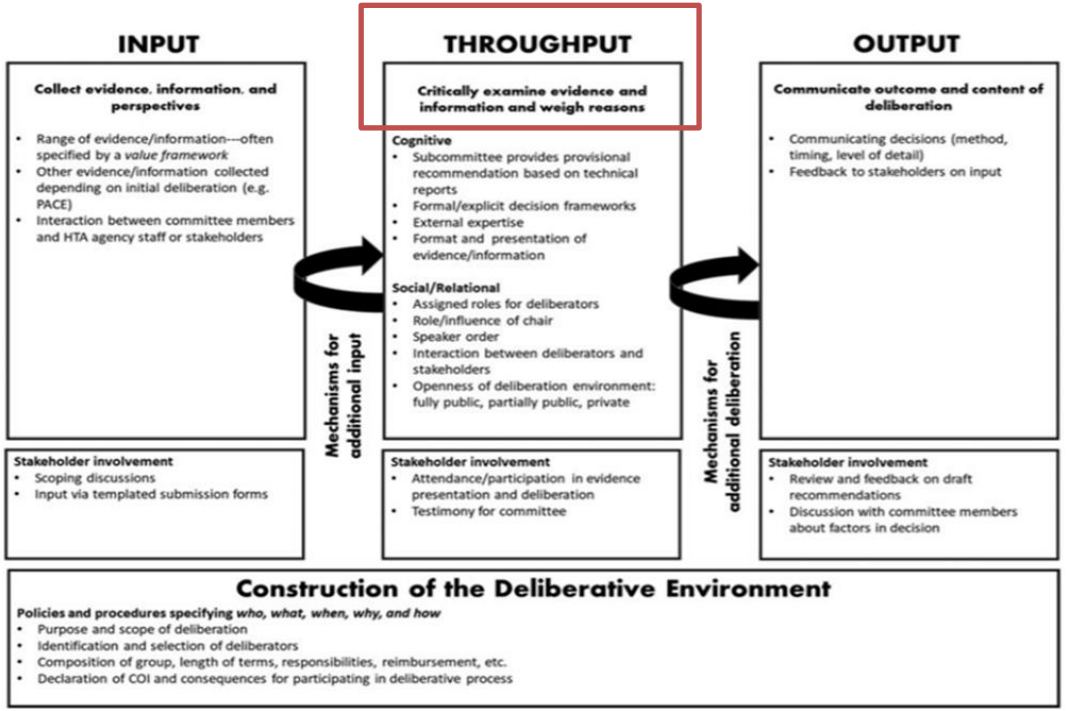

Figure 2. Input-throughput-output model.

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8; 2. Daniel Ollendorf and Carleigh Krubiner. The Dynamics of Health Technology Assessment: Is it Just About the Evidence? 2019.

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What happens at CADTH expert review committee meetings?

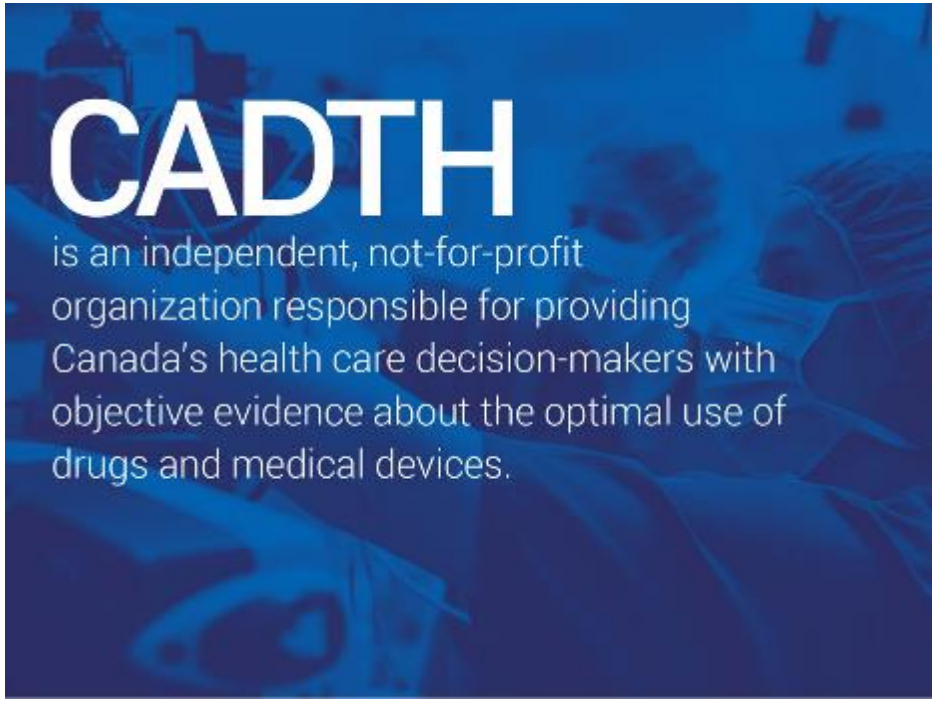
What role does CADTH play?

Support decision-makers with:

- ❑ Horizon Scans
- ❑ Reference Lists
- ❑ Reimbursement Reviews
  - ☑ **Includes recommendations from expert deliberative appraisal committees (pERC and CDEC)**
- ❑ Health Technology Reviews
  - ☑ **May include appropriate use recommendations from an expert deliberative appraisal committee (HTERP)**

Other Programs and Services:

- ❑ Scientific Advice



Three CADTH Expert Review Committees

CADTH Canadian Drug Expert Committee (CDEC)

CADTH pCODR Expert Review Committee (pERC)

CADTH Health Technology Expert Review Committee (HTERP)

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Three CADTH Expert Review Committees

Examples of committee similarities	CDEC	pERC	HTERP
Input			
Patient perspectives considered	Yes		
Throughput			
Deliberation of evidence	Yes		
Committee Structure	Experts + committee chair		
Ethicist	Yes		
Industry representative	No		
Health economist(s)	Yes		
Health care practitioners	Yes		
Output			
Meeting recordings	Recorded. Not disclosed to the public.		
Relationship to decision making	Non-binding recommendations to decision makers		

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Three CADTH Expert Review Committees

Examples of committee differences	CDEC	pERC	HTERP
Input			
Throughput			
Meetings per year	12		4 (+ as needed)
Avg. # recommendations/meeting	3-6 (approx. 1-2 hrs each)		0-1 (approx. 2-3 hrs each)
Committee Structure	14 + committee chair	16 + committee chair	6 + committee chair
Patient & public members	2 “public” members	3 “patient” members	1 “public” member
Additional expert members	Yes (plasma protein products*)	No	Yes (by technology)
Reaching a recommendation	Majority vote		Consensus (vote option)
Output			
Receptor of recommendation	Public Drug Plans & Canadian Blood Services	Public Drug Plans & Cancer Agencies	Topic must be of interest to at least one public decision maker.

*Canadian Plasma Protein Product Expert Committee (CPEC): subcommittee of CDEC

Three CADTH Expert Review Committees

CDEC	pERC	HTERP

8.3.3 Deliberative Framework and Process

- At the expert review committee meeting, committee members consider and discuss each committee brief on the meeting's agenda in order to make a recommendation.
- Consideration of each submission or resubmission begins with presentations by each of the assigned discussants.
  - The public member makes the first presentation, focusing on the perspectives and issues of patients and/or their caregivers related to the condition for which the drug under review is indicated, the impact and unmet needs of current therapy, the treatment outcomes of greatest importance, and the expectations for the drug under review, as identified in the input submitted by patient groups. This information provides context for deliberating the clinical and economic evidence.
  - The other two discussants present their overviews of the clinical and pharmacoeconomic evidence.
- Following the discussant presentations, all expert review committee members provide input, and the review team and invited external experts provide input (as required).
- The key elements supporting the expert review committee's recommendations include the following information available at the time of the review:
  - input from patients and caregivers
  - clinical and economic evidence
  - input from clinical experts
  - existing treatment options (e.g., what is or is not reimbursed and who is covered for reimbursement)
  - the submitted price of the drug under review and the publicly available prices of comparators
  - the sponsor's requested reimbursement conditions (if any) and the evidence supporting those conditions
  - implementation considerations at the jurisdictional level.
- The committee must make a recommendation or defer if additional clarification is needed. If the expert review committee needs additional information from CADTH, the sponsor, or from external experts, the matter will be deferred to a subsequent meeting of the expert review committee, pending the collection of such information. No new information will be allowed at this time. CADTH will determine whether the additional information provided constitutes new information or not.

Table 1. Criteria Definitions and Sources of the pERC Deliberative Framework

Criteria	Definition	Sub-Criteria	Source
Overall Clinical Benefit	A measure of the net health benefit of using the drug to diagnose or manage a cancer related condition (e.g., lung cancer) or cancer care related issue (e.g., skeletal related events in metastatic disease)	• Effectiveness • Safety • Burden of Illness • Need	Clinical Guidance Report provided by Clinical Guidance Panel, which incorporates the pCODR systematic review and registered clinician input
Alignment with Patient Values	An assessment made after considering information on patient values	• Patient values	Patient advocacy group input sought at beginning of the review
Cost Effectiveness	A measure of the net efficiency of the drug and companion technology compared to other drug and non-drug alternatives (no cut-off threshold)	• Economic evaluation • Costs, cost per QALY, cost per life year gained, cost per clinical event avoided • Uncertainty of net economic benefits	Economic Guidance Report, which incorporates the Economic Guidance Panel review of the pharmacoeconomic model.
Feasibility of Adoption into the Health System	An assessment of the ease with which the drug can be adopted into the overall health care and cancer care systems	• Economic Feasibility - Budget Impact Assessment • Organizational Feasibility	Provincial Advisory Group input Economic Guidance Report, which incorporates evaluation of budget impact assessment assumptions

Note: pERC Deliberative Framework adapted from Johnson, Sikich, Evans et al. Health technology assessment: A comprehensive framework for evidence-based recommendations in Ontario. International Journal of Technology Assessment in Health Care, 25, pp 141-150. 2009

HEALTH TECHNOLOGY EXPERT REVIEW PANEL DELIBERATIVE FRAMEWORK

Table A1: HTERP Deliberative Framework

Framework Domain	Examples of Information / Element(s)	Possible HTERP Discussion Question(s)
Background / Context	• Audience; issue and policy question(s)	• Who requested this assessment? • Why?
Need	• Background on health condition • Size of affected population	• What condition does this health technology address? • How many patients could potentially be affected?
	• Availability of alternatives	• Are there existing therapeutic / diagnostic technologies that address the same problem?
Benefits	• Efficacy • Clinical effectiveness • Impact on patient-centred outcomes • Impact on clinical management • Non-health benefits (e.g., patient autonomy, dignity)	• Has the clinical effectiveness of the candidate technology been established? • Compared to what? • What improvements does this technology purport to offer over others? • What types of evidence is this based on? • Are we aware of any better quality evidence likely to be produced in the near future? • Are there any non-health benefits?
Harms	• Safety	• What is known about safety in absolute terms, and in comparison to the existing technologies? • What types of evidence is this based on?
Patient Preferences	• Acceptability of health technology by the patient	• How will it potentially affect patients and what are their opinions about the technology? • How acceptable it is to patients?
Economic Impact	• Cost-effectiveness • Infrastructure support costs • Budget impact	• What will the technology cost (including initial purchase price and consumables, maintenance, and training of personnel)? • Is there evidence of value for money? • How is value defined? • What is the expected lifespan and total budget impact of the technology?
Implementation	• Integration of technology into existing workflow • Training / competency requirements • Repair and maintenance	• Have issues of implementation of the technology in a real world health system environment been identified and addressed?
Legal	• Legal impacts	• Are there potential legal or regulatory aspects to the introduction and use of this technology?
Ethics	• Consistent with Canadian ethical values	• Are there potential issues of equity (access to particular populations, for example) with respect to introducing this technology? • Are there any other ethical issues to consider?
Environmental Impact	• Environmental impact of health technology	• What potential impact on the environment does this technology have?
Other		• Are there particular questions with regard to professional fees that have been identified and addressed? • Does this candidate technology raise some particular questions that are not addressed by the above set of questions?

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CADTH CDEC

CADTH CDEC

Input (I)

"Collect evidence, information and perspectives" [1]

Patient input | **Clinician input** | **Payer input** | **Sponsor submission**

CADTH Evidence Reports
(clinical, economic, patient input) and **supporting material** (e.g., sponsor comments on CADTH reports, submission history, input from clinical panels (if applicable), original patient input submission)

Committee member reports for presentation during meeting

Throughput (T)

"Critically examine evidence and information and weigh reasons" [1]

CADTH (CDEC) MEETING

AGENDA

1. Welcoming Remarks/Approvals
   - 1.1. Approvals
   - 1.2. Conflict of Interest Declarations
2. Drug Review #1
   - 2.1. **Public member presentation (patient and clinician input)**
   - 2.2. Payer input (potential implementation issues)
   - 2.3. Ethicist presentation (if applicable)
   - 2.4. Primary and secondary presenter (clinical & economic evidence)
   - 2.5. Clinical expert input and CADTH review team input
   - 2.6. Deliberation
   - 2.7. Develop recommendations
   - 2.8. Vote
3. Drug Review #2, #3, etc.
4. Updates
5. Next meetings and adjournment

Output (O)

"Communicate outcome and content of deliberation" [1]

Draft Recommendation Issued

Stakeholder feedback

CADTH COMMON DRUG REVIEW
CADTH Canadian Drug Expert Committee Recommendation
(Final)

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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CADTH pERC

CADTH

CADTH pERC

Input (I)

"Collect evidence, information and perspectives" [1]

Patient input | **Clinician input** | **Payer input** | **Sponsor submission**

CADTH Evidence Reports
(clinical, economic, patient input) and **supporting material** (e.g., sponsor comments on CADTH reports, submission history, input from clinical panels (if applicable), original patient input submission)

Committee member reports for presentation during meeting

Throughput (T)

"Critically examine evidence and information and weigh reasons" [1]

CADTH (pERC) MEETING

AGENDA

1. Welcoming Remarks/Approvals
   - 1.1. Approvals
   - 1.2. Conflict of Interest Declarations
2. Drug Review #1
   - 2.1. **Patient member presentation (patient and clinician input)**
   - 2.2. Payer input (potential implementation issues)
   - 2.3. Ethicist presentation (if applicable)
   - 2.4. Primary and secondary presenter (clinical & economic evidence)
   - 2.5. Clinical expert input and CADTH review team input
   - 2.6. Deliberation
   - 2.7. Develop recommendations
   - 2.8. Vote
3. Drug Review #2, #3, etc.
4. Updates
5. Next meetings and adjournment

Output (O)

"Communicate outcome and content of deliberation" [1]

Draft Recommendation Issued

Stakeholder feedback

pCODR PAN-CANADIAN ONCOLOGY DRUG REVIEW

pCODR EXPERT REVIEW COMMITTEE (pERC)
FINAL RECOMMENDATION

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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CADTH HTERP

CADTH HTERP

Input (I)

"Collect evidence, information and perspectives" [1]

Topic Identification and Scoping

↓

CADTH Evidence Reports (e.g., **patient engagement**, clinical, economic, ethical, legal, social implications, patient preferences.)

↓

CADTH evidence summaries for presentation during meeting

Throughput (T)

"Critically examine evidence and information and weigh reasons" [1]

CADTH (HTERP) MEETING

AGENDA

1. Welcome and Introductions
2. Technology Review #1:
   - 2.1. Summary of findings and stakeholder feedback presented (CADTH review team). Components may vary depending on technology:
     - 2.1.1. Summary of decision problem
     - 2.1.2. **Patient engagement**
     - 2.1.3. Clinical review
     - 2.1.4. Economic evaluation
     - 2.1.5.**Perspectives and experiences review**
     - 2.1.6. Ethics review
     - 2.1.7. Stakeholder consultation
     - 2.1.8. Conclusions and implications
   - 2.2. Deliberation
   - 2.3. Develop draft recommendations
3. Other Technology Review #2, etc.
4. Closing remarks

Closing and next steps

Output (O)

"Communicate outcome and content of deliberation" [1]

Draft Recommendations Issued

↓ Stakeholder feedback

CADTH OPTIMAL USE REPORT

Optimal Use of Minimally Invasive Glaucoma Surgery: Recommendations

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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Features of deliberative processes around the world

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Why does language matter?
Why does context matter?

Why does language matter?

What's the best name? Patient expert, patient member, patient representative, public member, expert member?

Experiences

Have lived experience with the disease?

A caregiver caring for someone with the disease?

Patient Member on Committee

Roles and responsibilities

Responsible for bringing forward patient perspectives?

Are they supposed to represent ALL patients with the disease?

How is this different from a public member?

Duration of committee membership

Are they a standing committee member or does this depend on the review? Do they vote?

Why does context matter?

Are there time constraints?

Which technology or condition is being considered?

What is the relationship between the HTA body and the decision-maker?

What are jurisdiction-specific social values that need to be considered during deliberations?

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Deliberative processes around the world: US ICER

Timeline: 8 months to final report issued.

Technologies: Pharmaceutical and non-pharmaceutical

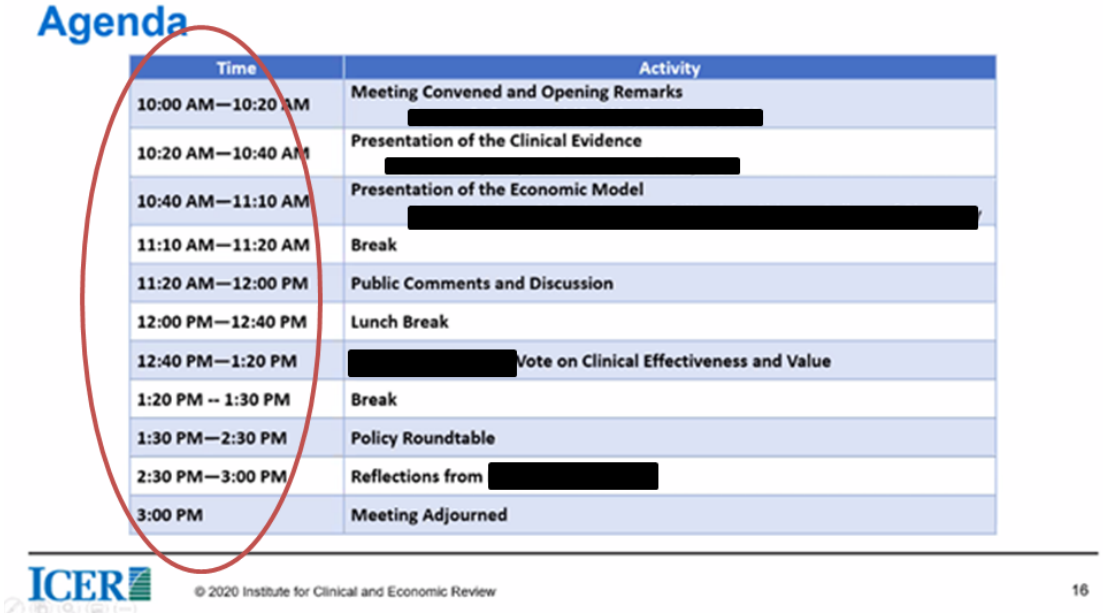
Decision-makers: No direct “payer”; independent consultancy and is funded by non-governmental, non-profit organisations.

Committees: Advisory; three independent evidence appraisal councils.

References: Institute for clinical and economic review (ICER); https://icer.org/

Deliberative processes around the world: US ICER

US: ICER



Agenda

Time	Activity
10:00 AM—10:20 AM	Meeting Convened and Opening Remarks [redacted]
10:20 AM—10:40 AM	Presentation of the Clinical Evidence [redacted]
10:40 AM—11:10 AM	Presentation of the Economic Model [redacted]
11:10 AM—11:20 AM	Break
11:20 AM—12:00 PM	Public Comments and Discussion
12:00 PM—12:40 PM	Lunch Break
12:40 PM—1:20 PM	[redacted] Vote on Clinical Effectiveness and Value
1:20 PM -- 1:30 PM	Break
1:30 PM—2:30 PM	Policy Roundtable
2:30 PM—3:00 PM	Reflections from [redacted]
3:00 PM	Meeting Adjourned

ICER

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References: https://icer.org/

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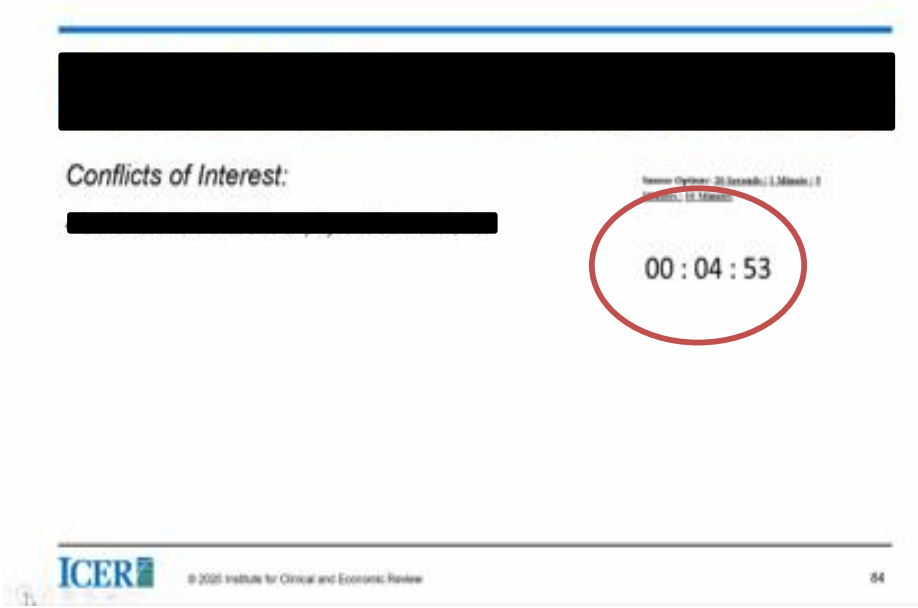
Deliberative processes around the world: US ICER

US:
ICER



References: https://icer.org/

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Deliberative processes around the world: US ICER

Identify and vote on other benefits or disadvantages and contextual considerations.

2. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to [redacted]

A. 1

B. 2

C. 3

Likert Scale of Potential Other Benefits and Contextual Considerations		
1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Uncertainty or overly favorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too optimistic.		Uncertainty or overly unfavorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too pessimistic.
Very similar mechanism of action to that of other active treatments.		New mechanism of action compared to that of other active treatments.
Delivery mechanism or relative complexity of regimen likely to lead to much lower real-world adherence and worse outcomes relative to an active comparator than estimated from clinical trials.		Delivery mechanism or relative simplicity of regimen likely to result in much higher real-world adherence and better outcomes relative to an active comparator than estimated from clinical trials.
This intervention could reduce or preclude the potential effectiveness of future treatments.		This intervention offers the potential to increase access to future treatment that may be approved over the course of a patient's lifetime.
The intervention offers no special advantages to patients by virtue of presenting an option with a notably different balance or timing of risks and benefits.		The intervention offers special advantages to patients by virtue of presenting an option with a notably different balance or timing of risks and benefits.
This intervention will not differentially benefit a historically disadvantaged or underserved community.		This intervention will differentially benefit a historically disadvantaged or underserved community.
Small health loss without this treatment as measured by absolute QALY shortfall.		Substantial health loss without this treatment as measured by absolute QALY shortfall.
Small health loss without this treatment as measured by proportional QALY shortfall.		Substantial health loss without this treatment as measured by proportional QALY shortfall.
Will not significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.		Will significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.
Will not have a significant impact on improving return to work and/or overall productivity vs. the comparator.		Will have a significant impact on improving return to work and/or overall productivity vs. the comparator.
Other		Other

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References: https://icer.org/

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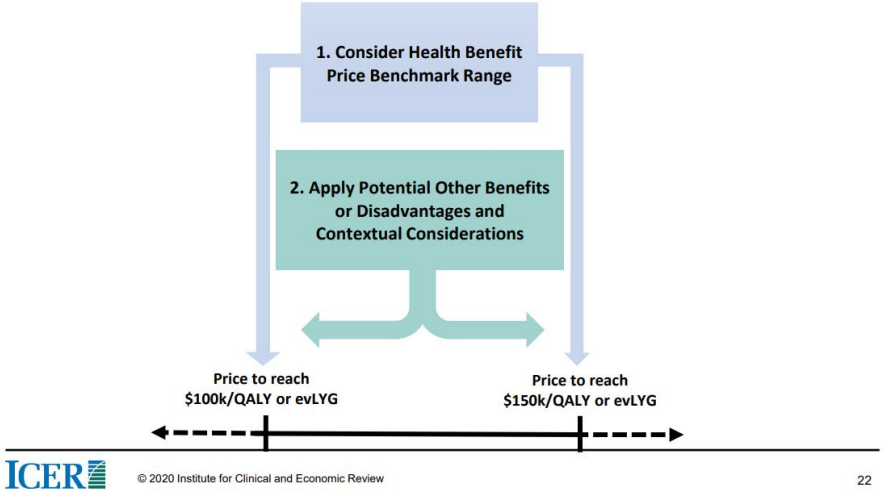
Deliberative processes around the world: US ICER

Identify and vote on other benefits or disadvantages and contextual considerations.



References: https://icer.org/

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Deliberative processes around the world: UK NICE

Timeline: 8 months to final appraisal document issued

Technologies: Pharmaceutical and non-pharmaceutical

Decision-maker: National Health Service (NHS) in England and Wales

Committees: binding recommendations; multiple advisory committees (highly specialized technologies, diagnostics, public health, etc.).

References: https://www.nice.org.uk/get-involved/meetings-in-public#advisory-committee

Deliberative processes around the world: UK NICE

A few features:

- Technical briefing.
- Highlight of key issues: clinical and cost for questions for the committee members.
- Patient, commissioning, and clinician expert, and industry representative present for questions: e.g., context, patient-support program, evidence clarification.

References: https://www.nice.org.uk/get-involved/meetings-in-public#advisory-committee

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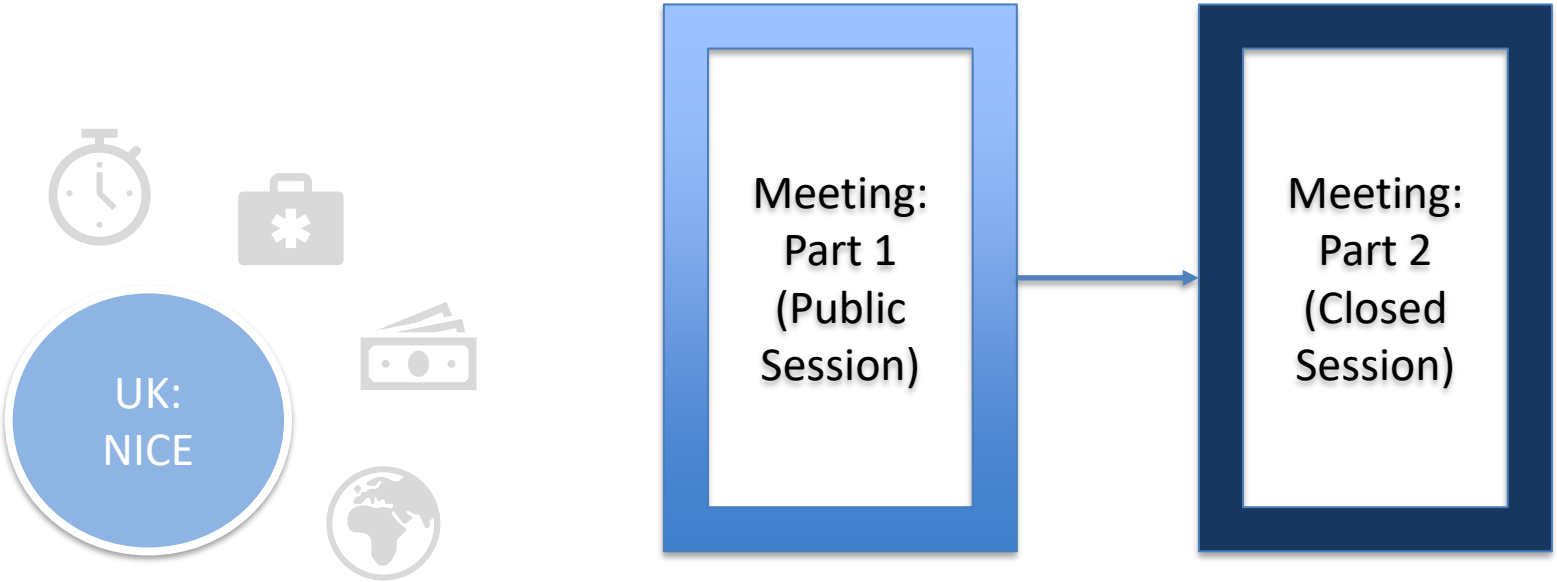
Deliberative processes around the world: UK NICE



References: https://www.nice.org.uk/get-involved/meetings-in-public#advisory-committee

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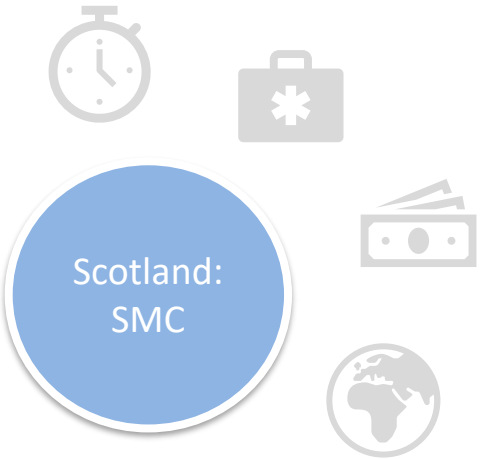
Deliberative processes around the world: Scotland SMC



Technologies: Pharmaceuticals

Decision-maker: NHS Scotland

Committees: Advisory; two committees exist:

i. **New Drugs Committee (NDC):** preliminary advice issued prior to consideration by the SMC.

ii. **SMC Committee:** includes preliminary advice from the NDC and may include additional evidence from, for example, the Patient and Clinician Engagement (PACE) process.

References: https://www.scottishmedicines.org.uk/how-we-decide/

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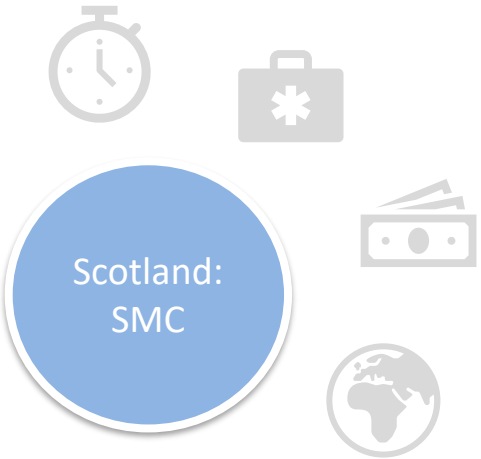
Deliberative processes around the world: Scotland SMC



Healthcare Improvement Scotland | SMC Advice on new medicines

Patient and Clinician Engagement (PACE) Meetings Overview

Introduction

For medicines used to treat end of life and/or rare conditions, the Scottish Medicines Consortium (SMC) offers the submitting company the opportunity to request a Patient and Clinician Engagement (PACE) meeting which gives patient groups and clinicians a stronger voice in SMC decision making.

References: https://www.scottishmedicines.org.uk/how-we-decide/pace/

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Deliberative processes around the world: The Netherlands ZIN

Technologies: Pharmaceutical and non-pharmaceutical

Decision-maker: Ministry of Health

Committees: Advisory; two committees exist:

i. **Scientific advisory committee** considers the scientific evidence base underlying the HTA report.

ii. **Appraisal committee** considers the balance between the cost-effectiveness, severity of disease as well as other considerations (intended to include societal considerations).

References: https://english.zorginstituutnederland.nl/binaries/zinl-eng/documents/reports/2015/06/16/cost-effectiveness-in-practice/Cost-effectiveness+in+practice.pdf

Deliberative processes around the world: The Netherlands ZIN

Committee deliberates on the balance between severity of disease, cost-effectiveness, and other considerations.

Severity of Disease	Cost-effectiveness threshold (€ per QALY)
0.1 to 0.4	€20,000/QALY
0.41 to 0.7	€50,000/QALY
0.71 to 1.0	€80,000/QALY

References: https://english.zorginstituutnederland.nl/binaries/zinl-eng/documents/reports/2015/06/16/cost-effectiveness-in-practice/Cost-effectiveness+in+practice.pdf

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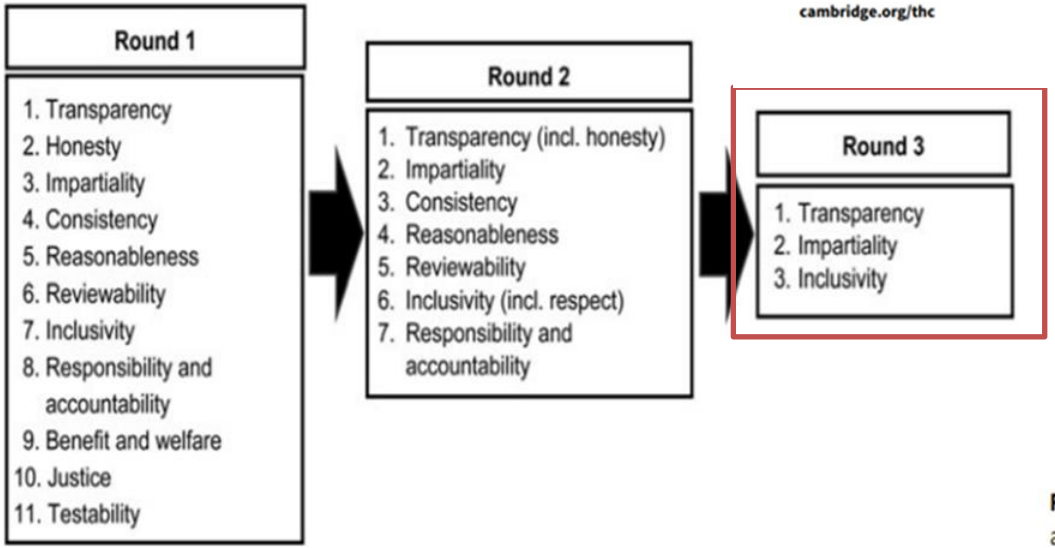
Where do we go from here?

Principles for deliberative processes in HTA



International Journal of Technology Assessment in Health Care

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Principles for deliberative processes in health technology assessment

Kenneth Bond[1], Rebecca Stiffell[2] and Daniel A. Ollendorf[3]

[1]Institute of Health Economics, Edmonton, Canada; [2]HTAi Secretariat, Edmonton, Canada and [3]Value Measurement and Global Health Initiatives, Center for the Evaluation of Value and Risk in Health, Tufts University, Boston, USA

Figure 1. Identification of "core principles" for deliberative processes.

References: 1. Bond K, Stiffell R, Ollendorf DA. Principles for deliberative processes in health technology assessment. Int J Technol Assess Health Care. 2020:1-8.

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Consensus definition for deliberative processes in HTA

*"The task force's goal is to develop a **consensus definition for a deliberative process** from an HTA perspective and internationally recognized **good practice recommendations** on the use of deliberative processes in HTA."*

References: https://www.ispor.org/member-groups/task-forces/joint-htai---ispor-deliberative-processes-for-hta

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Questions for February 11th consultation with patient groups*:

1. What needs to occur during deliberations to ensure that patients' needs, expectations, and experiences be meaningfully heard and considered by the committee?
2. What aspects of the committee deliberation are important for you to see communicated in the recommendations document?
3. How would you suggest that CADTH communicates about evidence uncertainties?

eligible groups include: *patient groups, patient and family advisors, and members of civil society and community not-for-profit organizations*

Questions and Discussion

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Thank You

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