Vignette Presentations

VP01 A Disinvestment Toolkit: The Prioritization Of Technologies Of No Or Low Added Value

AUTHORS:

Julie Polisena (osteba7-san@euskadi.eus), Leonor Varela-Lema, Iñaki Gutiérrez-Ibarluzea, Brian Godman

INTRODUCTION:

Candidate health technologies identified for disinvestment will require prioritization depending on the system's capacity for dealing with the assessments or for further considerations. Compilations of low value lists, such as the National Institutes for Health and Clinical Excellence's, "Do not do recommendations", can serve as databases for prioritization topics. Prioritization processes can also be triggered by experience or event-based regional requests and decisions; new evidence on safety, effectiveness and cost-effectiveness, variations in clinical practice, patient or consumer voicing, discrepancies between practice and guidelines; and or time-based mechanisms, such as approval of new health technologies and reassessment five years after introduction.

METHODS:

A search of the published and grey literature was conducted to identify the current methods or tools used to prioritize potential health technologies and services for disinvestment. The description of the methods and tools identified, the prioritization criteria, and the stakeholders involved in the process were reviewed and summarized.

RESULTS:

The methods and tools used for prioritization that were identified in the literature include the PriTec Prioritization tool, nominal group technique, Program Budgeting and Marginal Analysis, consensus building, and online surveys. Further, common criteria for prioritization centered on the disease burden, possible risks and benefits, costs and cost-effectiveness, utilization, and time-based criteria. Prioritization can be conducted by health care professionals, decision makers, patients or patient groups and representative community members.

CONCLUSIONS:

The prioritization process for disinvestment candidates should be transparent and guided largely by evidence. It is highly recommended that the list of predefined criteria be developed with input from all relevant stakeholders to meet the objectives of the specific health care setting. The commonly cited basic requirements include clinical parameters, economic measures, and social, ethical or legal considerations.

VP02 Real-World Evidence (RWE) And CADTH Pan-Canadian Oncology Drug Review

AUTHORS:

Dolly Han (dollyh@cadth.ca), Missale Tiruneh, Alexandra Chambers, Adam Haynes

INTRODUCTION:

The pan-Canadian Oncology Drug Review (pCODR) program was established by Canada's provincial and territorial Ministries of Health (except Quebec) to assess cancer drug therapies and make recommendations to guide drug reimbursement decisions. The pCODR Expert Review Committee (pERC) makes reimbursement recommendations, providing a rationale for the recommendation and next steps for stakeholders. The objective of this analysis was to identify reviews and reasons pERC has requested real-world evidence (RWE) data collection.

METHODS:

A retrospective analysis of pERC Final Recommendations (January 2012 – May 2017) was conducted. pERC Final Recommendations include drug information, reimbursement recommendation, rationale for recommendation following pERC's Deliberative Framework (clinical benefit, patient-based values, economic evaluation, and adoption feasibility), next steps for jurisdictions to consider to support their funding decisions, summary of deliberations, and

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evidence in brief. Reviews were included if there was a next step advising the collection of RWE to reduce uncertainty in the drug under review.

RESULTS:

Out of eighty-four reviews, forty-one (forty-eight percent) included a next step to collect RWE to address a gap in the available evidence. Reasons for RWE data collection, in descending order of frequency, were to inform: sequencing of available therapies; magnitude of clinical benefit and cost-effectiveness or the true cost-effectiveness; duration of treatment and cost-effectiveness; defining the population or disease progression; quality of life; and dosage.

CONCLUSIONS:

In almost half of pERC's recommendation there is an indication that there is a gap in the existing evidence that could potentially be addressed through the collection of RWE. This reflects the rising number of new cancer drugs, limited evidence supporting submissions (for example non-comparative studies), and newer drugs such as immunotherapies which may not have a fixed treatment duration. Further research includes development of mechanisms for RWE data collection to help inform pERC recommendations and assist stakeholders with adoption feasibility of reviewed drugs.

VP06 The Effectiveness And Ethics Of Prenatal Testing For Cystic Fibrosis

AUTHORS:

Sharon Kessels (sharon.kessels@adelaide.edu.au), Skye Newton, Drew Carter, Tracy Merlin

INTRODUCTION:

Cystic fibrosis (CF) is the most common autosomal recessive disorder in Caucasians, occurring in one out of every 2,500–2,800 births worldwide, and is associated with a high burden of disease. In Australia, prenatal testing for CF is indicated for pregnant couples identified as carriers or when a fetus is found to have an 'echogenic bowel' (FEB). We aimed to determine the effectiveness of prenatal CF testing and to assess ethical dimensions. A key challenge in assessing a prenatal test is selecting appropriate endpoints to indicate clinical effectiveness.

METHODS:

A systematic review was conducted and a linked evidence approach was used to answer the effectiveness question. The literature on ethical considerations relating to prenatal testing was also reviewed.

RESULTS:

No studies were identified on the direct effectiveness of prenatal CF testing or downstream consequences. Linked evidence showed good diagnostic performance with a test failure rate of 4.5 percent. Termination of pregnancy occurred in the majority of cases where two mutations were identified in a fetus of carrier parents (155/163; 95 percent), indicating testing impacts clinical management. In FEB cases with CF, termination occurred in around sixty-five percent of pregnancies. Both terminating a pregnancy and having a child with CF were associated with poor short term parental psychological outcomes. Evidence indicates prenatal testing leads to a decreased number of CF-affected births. However, ethical analyses indicated that 'informed decisions' should have been the primary outcome of interest.

CONCLUSIONS:

Proper counselling prior to testing ensures that the aim of prenatal testing is informing reproductive choices in a non-directive way, rather than decreasing the number of CF-affected births (which is ethically problematic). These results suggest that for health technology assessments undertaken on contentious topics, ethical analysis should be undertaken first so appropriate endpoints are selected for the subsequent systematic review of clinical evidence and for the economic model.

VP08 Description Of A Strategy To Face Judicialization Of The Right To Heal

AUTHORS:

Ana Perez Galán, Alicia Aleman (aaleman@unicem-web.org), Magdalena Irisarri, David De Sosa, Ana Deminco, Daniel Pedrosa

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