

# The Swiss Health Technology Assessment (HTA) Consensus: Guiding Principles

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## A Multi-Stakeholder Approach

Project Team	Scientific Steering Committee
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Stefan Kaufmann (santésuisse)	
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## Three Public Workshops

Retraite 1 (Muri, January 27/28, 2011)  
Retraite 2 (Hinterzarten, February 24/25, 2011)  
Retraite 3 (Bern, April 26, 2011)  
Retraite 4 (Brünen, May 31 / June 01, 2011)  
Retraite 5 (Solothurn, July 13, 2011)  
Retraite 6 (Bern, August 19 / September 02, 2011)  
Retraite 7 (Bern, October 19, 2011)



Brunnen / Vierwaldstättersee  
May 31 / June 01, 2011



Luzern / Vierwaldstättersee  
September 28/29, 2011

Swiss Workshop 2:  
Discussion of Consensus  
Draft with Stakeholders

Swiss Workshop 2: Discussion of Interim Results with Stakeholders

Kartause Ittingen  
November 05/06, 2011

Expert Workshop 1: Public Expectations & Societal Preferences;  
International Experience; Health Economic Evaluation Methods

Deliberation by Project Team

## Scope and Objectives

### HTA in Switzerland should

- provide effective support to health care decision makers in charge of reimbursement and pricing of interventions;
- regular reevaluation of any such decisions;
- identification of evidence gaps and research needs;
- provision of information supporting policies to ensure fair access of the Swiss population to high quality, effective and efficient health care interventions.

### Scope:

- both new and established (existing) technologies;
- selected following a transparent process according to criteria including cost of illness and budgetary impact, prevalence and burden of disease, ongoing controversy regarding effectiveness, or the wish to inform the imminent development of clinical guidelines in a specific field;
- HTAs should be conducted at the national level.

## Evaluation Criteria

### 1. A Prior Normative Commitment,

determining boundaries for a federal HTA framework derived from constitutional provisions as well as the principled, rights-based legal tradition of Switzerland (non-discrimination, including that of persons with disabilities, special protection of the autonomy and the development opportunities of children, and procedural justice, have all been part of that tradition);

### 2. Social Preferences of the Swiss Population,

a major input to an externally valid HTA framework; beyond pure efficiency goals, these include fairness objectives and equal access, preferences for reciprocity and altruistic motives (this best corresponds to the proposed concept of an "empirical ethics" with health care resource allocation being directed to best meet the expectations and the needs of the insured, which are believed to specifically include a priority for those worst off and for fair chances of access to effective health care, including access to innovative interventions);

### 3. Swiss "WZW" Criteria,

with explicit recognition of multiple criteria for decision making: W (Wirksamkeit: "effectiveness"), Z (Zweckmässigkeit: "appropriateness", i.e., "social desirability"), constrained by the prior normative commitment; W (Wirtschaftlichkeit: "economic viability")

## Clinical Effectiveness

"Levels of evidence" defined in line with the principles of evidence-based medicine (EBM):

### → Reasonable Evidence Expectations

incentives for the provider of a given health technology to produce evidence to the extent and quality that can "reasonably" be expected given the specifics of a technology in a given phase of its life cycle;

### → Expected Level of Evidence

application of the principles of EBM should be pragmatic in order to appropriately accommodate situational aspects inevitably influencing the level and quality of evidence of effectiveness that can be reasonably expected from a provider of a technology at a given time in the technology life cycle;

### → Full range of demonstrated health-related benefits

will be evaluated from an individual's perspective. Outcomes will be rated based on **relevance** and **magnitude of the effects** observed.

### → Judgments on the degree of confidence in the health-related benefits found in studies will primarily depend on the available level and quality of evidence. As a reference level for grading, Swiss HTA defines the best possible level of evidence that can be expected in a given context.

## Economic Viability

### 1. Budgetary Impact

Opportunity costs from a decision makers' perspective are defined by the overall budgetary impact of funding a specific health technology. The aim of these analyses is to establish transparency on the short, medium, and long term consequences of a decision from the perspective of payers.

### 2. Cost Benefit Evaluations

are considered most useful for technologies with a high budgetary impact, especially when there is reason to believe that social benefits conferred by their use are small or moderate only.

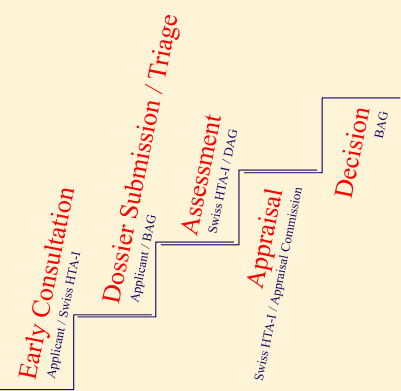
### 3. Technical and Allocative Efficiency

The evaluation of relative cost benefit ratios ("efficiency") should, for the time being, focus on issues of "technical efficiency", i.e., compare alternative ways to achieve the same clinical objective. Accordingly, the most appropriate evaluation method (cost minimization, cost effectiveness, cost utility analysis, etc., will depend on the specific research question. In other words, Swiss HTA Consensus recommends "methodological pluralism".

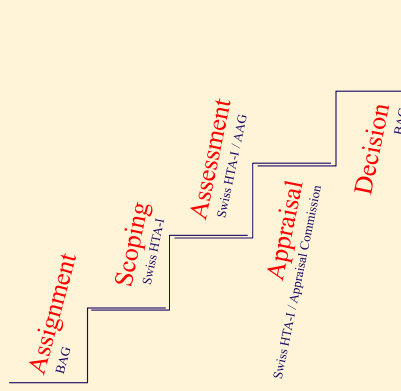
### 4. SwissHTA recognizes that the results of conventional cost benefit evaluations can be positively unethical when judged against the prior normative commitment.

Swiss HTA rejects the idea of uniform cost per QALY benchmarks.

## Rapid (r-)HTA Process



## Complete (c-)HTA Process



Four Key Documents were issued by the project team on October 19, 2011:

- Swiss HTA Consensus Project: Cornerstones for the Future Development of HTA in Switzerland (30 pages)
- Schweizer HTA-Konsensus-Projekt: Eckpunkte für die Weiterentwicklung in der Schweiz – Anhang“ (30 pages)
- Schweizer HTA-Konsensus-Projekt: Konsenterte Thesen, Gliederung des Referenzdokuments (Foliensatz) (13 pages)
- Dokumentation zum Thesenpapier (Eckpunkte des Schweizer Konsensus) (222 pages)

Five Implementation Papers are underway in 2012.

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