

HTA methods review options.

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This submission is focused on the importance of the quantification of health equity impacts. Economics methods for this purpose and tools that we are developing for the Australian context are crucial for reducing health equity disparities through transparent decision making.

1.3. First Nations people's involvement and consideration in HTA

First Nations people partnership in decision making.

3. Sponsor submissions to require consideration/assessment of the impact on health outcomes for First Nations peoples to enable meaningful informed decision-making.

Response:

Health equity and accessibility of healthcare are important considerations in HTA, to help ensure that decisions regarding the adoption of interventions do not increase health inequalities of First nations Australians. Current HTA method guidelines do not require the quantification of the health impacts on Aboriginal and Torres Strait Islander people. A standardised approach to systematically quantify health inequities for First Nations Australians would enable the comparison of the impact across different interventions and health conditions and could facilitate HTA adopting a more transparent and rigorous strategy to ensure that health inequalities between Indigenous and non-Indigenous Australians are not increased.

Distributional cost-effectiveness analysis (DCEA) is a method that can provide quantitative information about the overall equity impact of funding new health technologies and the trade-offs that may arise between equity and efficiency (health maximisation). DCEAs can quantify the distribution of expected health benefits of interventions by Indigenous and non-Indigenous status. This methodology enables an intervention to be classified as being "Win-Win" (both cost-effective and reduced health inequality), "Lose-Lose" (not cost-effective and increases health inequality), "Lose-Win" (not cost-effective but decreases health inequality) and "Win-Lose" (cost-effective but increases health inequality). This will aid decision-makers confronted with equity-efficiency trade-offs, such as assessing the funding viability for a new medicine that is "Lose-Win" to address health inequality or contemplating additional investment in the redesign of a public health prevention program that is "Win-Lose" to enhance uptake among First Nations people.

There are two important ways the quantification of the health equity impacts could be used to inform HTA funding deliberations to ensure health inequalities of First Nations Australians are not increased. Firstly, this data has the potential to substantiate the development of supplementary delivery recommendations aimed to increase uptake of cost-effective interventions amongst Indigenous Australians. It could influence decisions around novel technologies with an unequal benefit in Aboriginal populations, due to inequality in the utilisation and adherence to existing technologies, such as more accessible medication for Aboriginal people with diabetes with suboptimal blood sugar control. Secondly, it may play a pivotal role in influencing definitive recommendations, either in favour or against, particularly in scenarios where the marginal cost per quality-adjusted life year (QALY) gained closely

approaches the relevant cost-effectiveness decision threshold. A considerable positive influence in lowering health inequality could sway a borderline decision from a 'no' to a 'yes.'

A publicly accessible tool, the Health Equity Impact calculator was developed in the UK to assess socioeconomic health inequality impact. It uses built in prevalence look up tables to estimate the social distribution of the population, based on hospital episode statistics and survey data for risk factors such as smoking. Inputs such as uptake and effectiveness can be varied by group. An Australian version could assess health equity impacts of Indigenous and non-Indigenous Australians and perform simple distributional cost-effectiveness analyses. We will begin to develop an Australian version in 2024. Indigenous experts and academics will be involved to make sure that the First Nations Australians health outcomes are accurately represented and that this tool is respectful to their cultural values and beliefs.

3. Methods for HTA for Australian Government Subsidy (technical methods)

3.1. Determination of the Population, intervention, Comparator, Outcome (comparator is also addressed under economic evaluation)

Updated guidance: Updated guidance to require the explicit consideration of health equity and priority populations for new treatments.

Response:

Updated guidance is required to measure the magnitude of the impact on health equity of interventions, explicitly and systematically, to ensure that funding decisions do not increase health inequalities and, where possible, reduce health inequalities for priority populations such as First Nations Australians. Potential health inequalities are rarely quantified or if considered are usually qualitative in nature. The type of equity information would vary, and quantitative analysis might focus on pre-existing health inequalities rather than expected impacts of interventions on health inequity. This makes comparing the health equity impact of different interventions difficult.

Distributional cost-effectiveness analysis (DCEA) is an economic method that can quantify the population distribution of expected health benefits of interventions by Indigenous and non-Indigenous status in quality-adjusted life years (QALYs). DCEAs provide quantitative information about the overall health equity impact of interventions and the trade-offs that may arise between equity and efficiency (health maximisation). Importantly, this method enables the comparison of the impact on health equity across various interventions.

While obtaining accurate subgroup data required for DCEAs can be difficult, a health equity impact calculator has been developed for socioeconomic position quintiles in the UK to facilitate this process. Developed in collaboration with the National Institute for Health and Care Excellence (NICE), the [Health Equity Impact calculator](#) allows a quick assessment of whether health inequality impacts are relevant for decision-making and whether further analysis is required. The development of Australian versions of the calculator for groups such as Indigenous/non-Indigenous, socioeconomic quintiles and Area of Remoteness Index of Australia, would allow quantitative estimates to be routinely used and would allow sensitivity analysis around alternative assumptions. We will begin to develop Australian versions in 2024. The calculators could be used in technology appraisal by industry analysts to generate

information as part of a submission, specifying the likely direction and magnitude of health equity impacts, allowing a transparent assessment to inform HTA deliberations.

3.2. Clinical Evaluation Methods

Develop an explicit qualitative value framework.

Informed by published research and public consultation, develop a checklist to assist HTA decision makers to integrate equity considerations into their deliberations in a more comprehensive and systematic way. Noting that some new health technologies may have a negative impact on health equity also. This could include explicit consideration of priority populations such as First Nations peoples.

Response:

Not only is an explicit qualitative framework required, a checklist of quantitative estimates of the impact of interventions on health inequalities is needed. The checklist would allow health economists to critically appraise quantitative estimates produced by external parties of the health equity impacts of interventions on priority populations such as First Nations people. Aboriginal and Torres Strait Islander input is required in the development of an explicit framework.

A checklist for ‘Critical Appraisal of Health Inequality Impact Estimates’ has been developed in the UK by expert health economists (Cookson et al, 2023). The checklist contains both quantitative and qualitative equity considerations that are important for HTA decision making. A similar checklist should be developed and tested for the Australian context in combination with health equity impact calculators that can quickly assess and check the likely direction and size of health inequality impacts.

5. Futureproofing Australia’s systems and processes

5.2. Establishment of horizon scanning programs to address specific informational needs within HTA and the health system

4. Develop a framework that includes an assessment of prioritisation of therapies after they have been identified through the scanning process to assist in informing the decision / action related to the identified therapy.

Horizon Scanning to meet priority areas (including addressing equity and high unmet clinical need HUCN)

Response:

Australia could become a world leader in the development of consistent processes to measure health equity considerations in HTA for priority populations such as First Nations people in all phases throughout the HTA decision-making process. A health equity impact calculator has been developed for the UK context for socioeconomic quintiles and can assess the likely direction and size of health inequality impacts of interventions under consideration. It allows a quick indication of whether health equity impact might be decision relevant, and whether further analysis is required. Calculators could measure the impact of interventions by Indigenous status, area of remoteness index and socioeconomic position. Development of these economic tools for priority populations in Australia will enable decision-makers to know the full picture of equity impacts; when health impacts are unfavourable and who gains the

largest benefits. We will begin to develop Australian versions of the health equity impact calculator in 2024.

The calculator could be used at the initial stage of scoping, assessment, and ultimately implementation support. It could be used for early assessment of new technologies where early scientific advice is being collected to guide discussions on the direction and significance of health inequality impacts. This economic tool should be part of a framework that will provide a transparent, rigorous evidence-informed approach to ensure that funding decisions do not increase health inequalities and where possible reduces health inequalities amongst priority populations.

If health care payers in other nations were to emulate this systematic approach to quantifying the health equity impacts in priority populations, the utilisation of this information might initiate a shift in global research and development incentives, encouraging innovation that enhances human health and longevity while also addressing the needs of priority population such as First Nations people. This shift could involve reallocating Research and Development investments towards conditions that disproportionately affect First Nations populations, such as mental illnesses, and exploring inventive strategies to reduce barriers to accessibility.

References

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