OP80 Generating Patient Preference Evidence For Health Technology Assessment: A Sustainable Roadmap

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Introduction: Research with members of health technology assessment (HTA) bodies has uncovered key barriers to integrating patient preference (PP) data into HTA, including concerns about resources/time constraints and a lack of clarity around who is responsible for data generation. We sought to develop a roadmap that addresses these issues, outlining the roles and responsibilities of different stakeholders to foster more sustainable PP data generation.
Methods: Based on a forthcoming article to be published in *The Patient*, this roadmap consists of a step-by-step approach for PP evidence generation. Real-world case studies and literature will be used to illustrate each stage, from identifying priority treatment areas and evidence gaps, forming a steering committee and engaging HTA members, to securing syndicated funding and disseminating results with full transparency.
Results: In contrast to standard approaches to data generation, this roadmap focuses on proactive data collection, collaborating with those who will ultimately use the data (HTA), and pooling resources to mitigate costs and the risk of bias. The roadmap can be applied to all preference-sensitive treatment areas and across health systems/countries. It is designed to be a continuous process, whereby preferences are regularly updated to align with changes to the treatment landscape. A graphic summary of the roadmap is available for viewing at this link: https://cappre.info/images/HTAprocess.pdf
Conclusions: Patient preference data has the potential to make healthcare decision-making more informed, socially legitimate, transparent, and accountable to the patient community. However, current approaches to capturing PP data can be resource intensive with narrow applicability in their findings. The present roadmap offers an alternative, sustainable solution.

OP81 Experience Matters: A Discrete Choice Experiment Exploring Patient Preferences For Heart Valve Procedures

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Introduction: Treatment for heart valve diseases (HVD) typically involves surgery, but less invasive procedures are becoming more common. Although the two procedures have similar outcomes, the risk–benefit profiles differ, indicating patients should be included in treatment decisions so they align with their values/preferences. This study aimed to determine patients' preferences for HVD procedures, and the relative importance of treatment attributes.
Methods: An online survey with discrete choice experiment (DCE) was disseminated to patients with aortic stenosis, mitral valve regurgitation, and tricuspid valve regurgitation. Participants were presented with several choice sets, each comprising two hypothetical treatment procedures (labeled "invasive procedure" and "minimally invasive procedure") as well as an opt-out. DCE attributes were selected based on a literature review, qualitative interviews with patients and specialist doctors, and steering committee consultation (patients, patient organization representatives, and cardiac physicians). Responses were collected via healthcare recruiters, online panels, and patient organizations. DCE data from 143 Australian patients was analyzed using a mixed multinomial logit (MMNL) model.
Results: Results indicate an "experience effect" whereby patients preferred the same type of treatment they had undergone previously. For example, patients who had undergone a transcatheter procedure were more likely to choose the minimally invasive procedure in the experiment and vice versa for those who had undergone invasive procedures like open-heart surgery. Patients were willing to switch procedures based on its risk–benefit profile, and most patients preferred the minimally invasive procedure when it reflected the profile of transcatheter aortic valve replacement (TAVI), even if they had previous invasive procedures experience. Key attributes driving choice were valve durability and regaining independence.
Conclusions: There is a great deal of heterogeneity in HVD patient preferences, even when treatment outcomes appear similar. Patients preferred a minimally invasive procedure over an invasive procedure, irrespective of prior treatment experience with valve durability and independence driving choice. These results can inform healthcare decision-makers about what features of HVD procedures patients value most, taking into consideration patients' prior experiences.

Oral Presentations (online)

OD01 Delays In Funded Access To Medicines: A Global Perspective

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Introduction: There are significant delays in the funded access to medicines. Studies indicate that in many countries it takes more than a year for patients to have funded access to medicines after market authorization. This study aimed to understand the disparities in timelines for funded access to medicines across different countries and to identify underlying reasons for this access gap.

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Methods: We conducted a scoping review to examine the nature of health technology assessment (HTA) processes, current methods, and policies for medicines in ten jurisdictions. The jurisdictions included in this study are Australia, Canada, France, Germany, South Korea, the Netherlands, United Kingdom (divided into England, Scotland and Wales), and United States of America. The information was extracted from the websites of International Network of Agencies for Health Technology Assessment (INAHTA) member agencies in the selected jurisdictions, grey literature from governments' websites, and peer-reviewed literature.
Results: Overall median time from submission of the evidence dossier to HTA recommendations for most jurisdictions is 22 weeks. Although there are similarities in the time taken to reach a funding decision, there are considerable variations in the time taken for patients to have funded access to medicines after HTA recommendations. Only a few countries mentioned a specific timeline within which medicines approved for funding should be listed. Time taken for price negotiations and other arrangements (i.e., risk-sharing agreements) may contribute to varying timelines for listing medicines for funding. Mostly, such negotiations are confidential and may not be time limited.
Conclusions: There was surprising consistency, globally, in the time it takes for funding decisions after medicines registration. The causes of delays in the medicines' listing decisions are multifactorial and mostly occur after HTA recommendations. The parallel regulatory-assessment process and prioritization tend to reduce the time to a funding decision. However, transparency is needed in the listing process to improve overall timeliness.

OD02 Developing Components For A National Strategy For Heart Valve Disease In Canada

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Introduction: The research included a rapid review of current literature to describe epidemiology, management, and system impact of heart valve disease (HVD) in adult populations. Key issues were identified in consultation with expert focus groups and were framed across the continuum of care and systemic policy issues. The groupings were adapted and adjusted during deliberations.
Methods: A rapid literature review was conducted on HVD key interventions and evidence of effectiveness along with expert interviews to identify high-level themes for reform. This served as the evidentiary backgrounder. Two virtual policy engagements with clinical leaders, patients, and health system managers were conducted. The focus was their collective drafting of recommendations. These workshops identified nine thematic areas and developed associated recommendations for action under each theme. The success of the process is evident as the report has been taken up as a roadmap for ongoing research and policy work.
Results: A comprehensive grouping of recommendations for improving HVD detection, management, and treatment in Canada was produced. It was designed to be comprehensive to then allow more targeted work to proceed under an evidence-informed and clinically endorsed agenda.
Conclusions: Heart valve conditions are increasingly treatable, especially if detected early. Innovation in treatments as well as detection and management to address gaps in care were identified as the most urgent priorities. The key result was formation of formal working groups with a professional society to explore spoke–hub-and node models for care delivery and to launch awareness programs for early detection.

OD04 The EQ-5D-5L Value Set For Ghana

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Introduction: Ghana's reference case, developed to guide the conduct of economic evaluation as part of health technology assessment (HTA) guidelines, recommends the conduct of cost–utility analysis using outcomes such as quality-adjusted life years (QALYs). There is no national value set available for the Ghanaian population to be used in estimating QALYs. This study aimed to develop a value set for Ghana using the EuroQol 5-dimension 5-level questionnaire (EQ-5D-5L) instrument.
Methods: Face-to-face preference data were collected from 300 adults across three regions of Ghana using the adapted version of the EuroQol Valuation Technology (EQ-VT) standardized valuation protocol developed specifically for EQ-5D-5L valuation studies using composite time-trade-off (cTTO) and discrete choice experiments (DCEs). Different preference models were generated using both the cTTO and DCE data, individually or together to provide complementary results on respondents' utility preferences. Models explored include generalized least squares, tobit, heteroskedastic, logit, and hybrid. The best-fitting model was selected for the value set based on its logical consistency, ability to account for left-censored and heteroskedasticity data, and statistical significance of parameters.
Results: The 300 interviews provided 4,500 cTTO responses and 4,200 DCE responses. The demographic characteristics of respondents were representative of the Ghanaian population for religious background, level of education, and marital status. The preferred model chosen for the Ghana value set was hybrid tobit, random effect heteroskedastic, constrained model. The predicted value for the worst attainable health on the EQ-5D-5L (i.e., health state 55555) was −0.493 and that of the best health state (11112; except full health) was 0.969. The largest decrement was registered for level five mobility (0.369) followed by pain/discomfort (0.312), self-care (0.273), anxiety/depression (0.271), and usual activities (0.268).
Conclusions: This is the first Ghanaian EQ-5D-5L value set based on social preference derived for a nationally representative sample in Ghana. The value set will play a key role in the institutionalization of HTA in Ghana and the use of economic evaluation studies to inform priority setting where different health technologies can be compared. A planned findings dissemination to stakeholders is underway.

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