PriTec Tool: Adaptation for the selection of technologies to be assessed prior entry into the health care benefits basket

Spanish full text

Introduction: the following project, which has being developed as part of the 2015-2017 Working Plan of the Spanish Agencies Health Technology Assessment Network (RedETS), has been requested by the Spanish Provision, Coverage, and Financing Commission, which depends on the Inter-territorial Council of the National Health System (NHS). This project is focused on improving the procedure for prioritising technologies to be assessed by RedETS. The development of a systematic procedure that defines the steps, stages, and information requirements for the identification and prioritisation of technologies responds to the need to improve the objectivity, transparency, and acceptability of the selection process. Although different prioritisation models have been proposed in order to deal with topic selection, we have considered adapting the PriTec tool (http://www.pritectools.es/) for the purpose of implementing the prioritisation process at the national level. This automatic web tool makes it possible to rank different technologies based on the score given to a set of previously weighted criteria, distributed by domains.

Aims: To develop a tool that helps the Provision, Coverage, and Financing Commission to select and prioritise, in a systematic and objective way, the different healthcare technologies to be assessed by RedETS for the purpose of supporting decision making regarding their inclusion/exclusion or modification of conditions of use in the common service portfolio of the National Health System. The specific aims are: 1) to review the scientific literature in order to identify the prioritisation criteria and processes used to select healthcare priorities at national/international level, 2) to develop a prioritisation tool, based on the PriTec application, which makes it possible to classify and rank different technologies based on a series of commonly accepted criteria, which have been weighted by a multidisciplinary team of experts composed of managers from the macro, meso and micro level , clinicians, and patients' representatives, and 3) evaluate the use and application of the PriTec tool within the real context of prioritisation of the working plan of the Agency Network (RedETS).

Method: The criteria and domains were based on the results of a systematic search of the literature and two ad hoc working sub-groups were created in order to refine and validate the tool. The first was comprised of directors of the different agencies and units belonging to RedETS and representatives of the General Directorate for the Common Services Portfolio of the NHS and Pharmacy (SG1). The second (SG2) was integrated by various members of the Provision, Coverage, and Financing Commission coming from the health authorities of the different autonomous regions. The first working sub-group, which acted as a consultant, was responsible for developing the first proposal of criteria and domains, establishing the prioritisation process and approving the definitive proposal. The second sub-group was responsible for reviewing, testing and validating the tool, assessing the appropriateness and applicability of the criteria based on the results of a pilot study. This group and the technical group were also responsible for proposing potential panel members in their respective autonomous regions. This group of panel members, comprised of decision makers (hospital managers and directors of central services from local health departments, such as insurance, public health, etc.); clinicians (from primary and specialised care services, and representatives of scientific associations), and users of the system (patients' associations, consumers' and users' organisations), was responsible for assigning the definitive weightings for the prioritisation criteria. Following the formal prioritisation procedure establishedat the NHS level, the tool was used to prioritise the working plan for the Agency

Network for 2017. The applicability, reliability, and consistency of the tool were analysed. The reliability of the tool was analysed by calculating the intraclass correlation coefficient (ICC) with its respective confidence interval for each criterion. The main considerations resulting from the meeting were analysed and summarised, including the main ideas presented by the different participants.

Results: The preliminary proposal included 6 of the 8 domains identified as being critical in the systematic review. During the evaluation and pilot stage, the criteria relating to these domains underwent a series of changes and combinations, finally considering for the purpose of the definitive tool a total of 17 criteria grouped into 5 domains: 1) illness/clinical condition, 2) comparative results of the procedure, 3) comparative costs, 4) repercussion of implementation implications, and 5) dissemination issues. The weighting assigned to the criteria by the panel members did not differ significantly ($p<0.005$) between the decision makers (n=16), clinicians (n=12) or patients (n=12), with all of them giving greater relative importance to the domains of illness and comparative results, in this order (33 % and 25 %). The economic impact, repercussions of implementation and dissemination issies were respectively weighted at 20.5 %, 10.5 %, and 10.5 %.

A total of 13 autonomous regions tested the tool in 2017. Out of these, 8 (61.5%) scored all of the prioritisation criteria for all of the technologies being evaluated (n=44). The mean agreement defined by the mean ICC was good (ICC=0.712, CI95 % 0.623-0.877), showing that in general, the tool is reliable and consistent. It was observed that the level of agreement was good or very good for all of the criteria in the clinical illness/condition domain, indicating that there is little variability in terms of the score for these criteria. In the comparative results domain, the effectiveness criterion had a mediocre agreement, and the agreement was moderate in the rest. The agreement was poor for the non-healthcare costs criterion, and moderate for the rest of the criteria in this economic impact domain. Three of the aspects regarding dissemination also had moderate agreement. The evaluation group largely attributed the observed heterogeneity to the lack or unsuitability of the information, although they expressed that it would be important to review and simplify certain data, especially those referring to additional costs and non-healthcare costs, as they considered that the required information could be difficult to obtain. They also indicated that there is still room for improvement in the explanations and support material.

Discussion and conclusions: The prioritisation tool that was developed makes it possible to select options based on a systematic and transparent methodology. The tool allows for objectively ranking technologies according to a set of multiple universal prioritisation criteria, which have been adapted to the reality of the prioritisation process in place in our country. The criteria were weighted by decision makers, clinicians and patients/representatives, thereby ensuring the inclusion of the preferences of all of the key stakeholders in the system. The tool stands out for its simplicity and ease of application, although areas of improvement have been identified, especially with regard to the application form and support material. It should be noted that the PriTec tool was designed to help with the decision-making process, and is not proposed as a tool for establishing definitive priorities. The PriTec tool helps to organise technologies by including the opinions of different stakeholder groups, although it is important not to rule out other specific considerations or differences with regard to the importance of certain domains that may condition the final selection. For the purpose of its implementation, it is important to take into account the fact regardless of the procedure used or the thoroughness applied in defining the critical criteria, there will always be some degree of subjectivity in the evaluation process, meaning that a final value judgement will be required by the decision-maker.