Evaluating value-based healthcare through HTA: Colombia’s Instituto de Evaluación Tecnológica en Salud

Colombia’s health technology assessment (HTA) agency, the Instituto de Evaluación Tecnológica en Salud (IETS), plays an important role in supporting a culture of technology and pharmaceutical evaluation, in which doctors make decisions based on objective information about outcomes and effectiveness. In emerging economies, value-based strategies are as crucial, if not more so, as in developing nations due to the need to allocate what may be limited resources efficiently. In 2017 Colombia’s government moved more towards this strategy, particularly by going into the more controversial area of value-based pricing for new drugs.
Colombia's healthcare system has seen significant and rapid progress in recent decades from a system in which inequalities predominated to one that offers broader, more accessible care. Since the 1990s out-of-pocket costs have fallen from 52% of national healthcare spending to just over 18% in 2015 and have remained one of the lowest levels in Latin America today. Waiting times have dropped and access to services has widened. In its report on Colombia published in 2016, the Organization of Economic Cooperation and Development (OECD) praised the country’s progress towards universal healthcare, describing it as a “regional leader” in key activities relating to healthcare reform and improvement.

IETS has played an important role in this process. By drawing on outcomes data and reviews in the literature, it is able to provide recommendations about pharmaceuticals and other treatments, developing 148 HTAs—on medicines (81%), diagnostic tests (14%), procedures (3%) and devices (2%).

The financial sustainability of the system has long been a concern, however. Total spending on healthcare crept up from 5.4% of GDP in 2004 to 7.2% of GDP in 2016, with rising financial pressures on the horizon. The OECD had previously cited inadequate control of prices and volume of services delivered, as well as the domination of the fee-for-service paradigm, among the catalysts for the financial stress. In addition, until 2017 Colombia had an “inclusion list” of services covered by the public system—the Plan Obligatorio de Salud—rather than a list of excluded services, as is common in countries like Germany and the UK. Patients who want to gain access to treatments outside the guaranteed basket of services could petition the courts, and were often successful, based on a legal concept of the right to health rather than on medical outcomes or cost effectiveness. Thus the government often paid for treatments of dubious value.

The result has been a significant outlay on a mix of proven and unproven treatments and costly procedures, at a time when a robust basic healthcare system is still in the process of being established. The uneven spending only increased already existing inequities, as Tatiana Andia, an assistant professor at Los Andes University in Bogotá, who spent three years advising the Ministry of Health, explains: “You get better care in Colombia if you are sick with a deadly cancer and have a very low life expectancy than if you are a regular person with needs as basic as access to water. It’s a completely non-rational way of spending your health money. It doesn’t make sense.”

**Introducing value-based pricing: a rocky road**

The introduction of value-based pricing for new pharmaceuticals has been a key part of the evolution of the Colombian health system in recent years, motivated by both political and economic factors, and serves as a good lesson for other countries trying to balance cost and care coverage. A statutory law came into effect in 2017 that declared health as a right. This strengthened citizens’ right of access to care and meant that they could demand treatments outside the standard benefits basket even more easily than...
before—without having to go through the courts. Some policymakers worried that the law would cause healthcare costs to rise exponentially and allow for the introduction of medicines of unproven quality or cost-effectiveness—covered at the public’s expense. But for health providers, the changes were seen as a way of strengthening medical autonomy.

At the same time, the government was looking to get even more value out of its Cuenta de Alto Costo, or "high-cost account", financial mechanism, under which a dedicated organisation collects funding from both general taxation and employee contributory schemes. It is dedicated to high-cost diseases such as HIV/AIDS, chronic kidney failure and hepatitis C. The organisation contracts with health insurance companies to allocate resources based on the demand from patients with these diseases, according to Jorge Alejandro Garcia Ramirez, a medical doctor and co-founder of Bive, a social enterprise in Colombia that enables low-income patients to gain access to specialist private healthcare. Over the past two years the government has pressured companies to be more cost-effective in the way they provide services to these patients, he adds.

Meanwhile, the former health minister Alejandro Gaviria Uribe, who departed in August following the election of a new government, was eager to slow the escalation of prices for medicines, and was willing to take on manufacturers and others in the health industry, Dr Garcia Ramirez observes.

For example, in early 2018 Colombia introduced Decree 433. Under the decree, in order to obtain market registration, pharmaceutical manufacturers would need to submit information on the safety, efficacy and effectiveness of new drugs. IETS would then classify the drug based on therapeutic value, which can include cost-effectiveness criteria and budget impact analyses. From there, Colombia’s pricing body would review the IETS evaluation to determine a price, with registration taking place simultaneously. However, a central point of conflict is that the decree stipulates registration be independent of the HTA and pricing processes. Colombia’s drug industry trade group, AFIDRO, has expressed concerns that by not making registration conditional on the HTA outcome, economic considerations could be prioritised over scientific criteria.

In 2016 Colombia’s government courted further controversy by cutting the price of the Novartis leukemia drug Glivec by nearly half after price negotiations with the Swiss pharmaceutical company broke down. A Reuters report noted that the government’s decision ‘stopped short of a so-called compulsory license declaration, which would have overridden Novartis’ patent and permitted other companies to make cheaper generic versions.’

Colombia is one of the few Latin American countries that has tried to control the price of medications, Dr Garcia Ramirez notes, adding that it has been “the third most active at regulating prices after Chile and México.” Yet, the political climate is likely to change with the arrival of a new government that wants to maintain Decree 433 but is “not as politically willing to continue the regulations of the Alejandro Gaviria legacy,” he said.
Lobbying from the US and Swiss governments in the wake of the Glivec decision could also test the new government’s commitment to reducing medical prices further, especially in the wake of Colombia’s admission to the OECD, according to Dr Garcia Ramirez.

“[Colombia] has had to adhere to specific policies in terms of restrictions to drug reimbursement and the public benefit of specific drugs,” he adds. “Even though the country has been progressive, the new introduction to the OECD club would impact the extent to which these decrees are applied.”

In theory, however, admission to the OECD could help improve Colombia’s system through health data benchmarking and collaboration with other countries on policies that will improve value-based outcomes.