



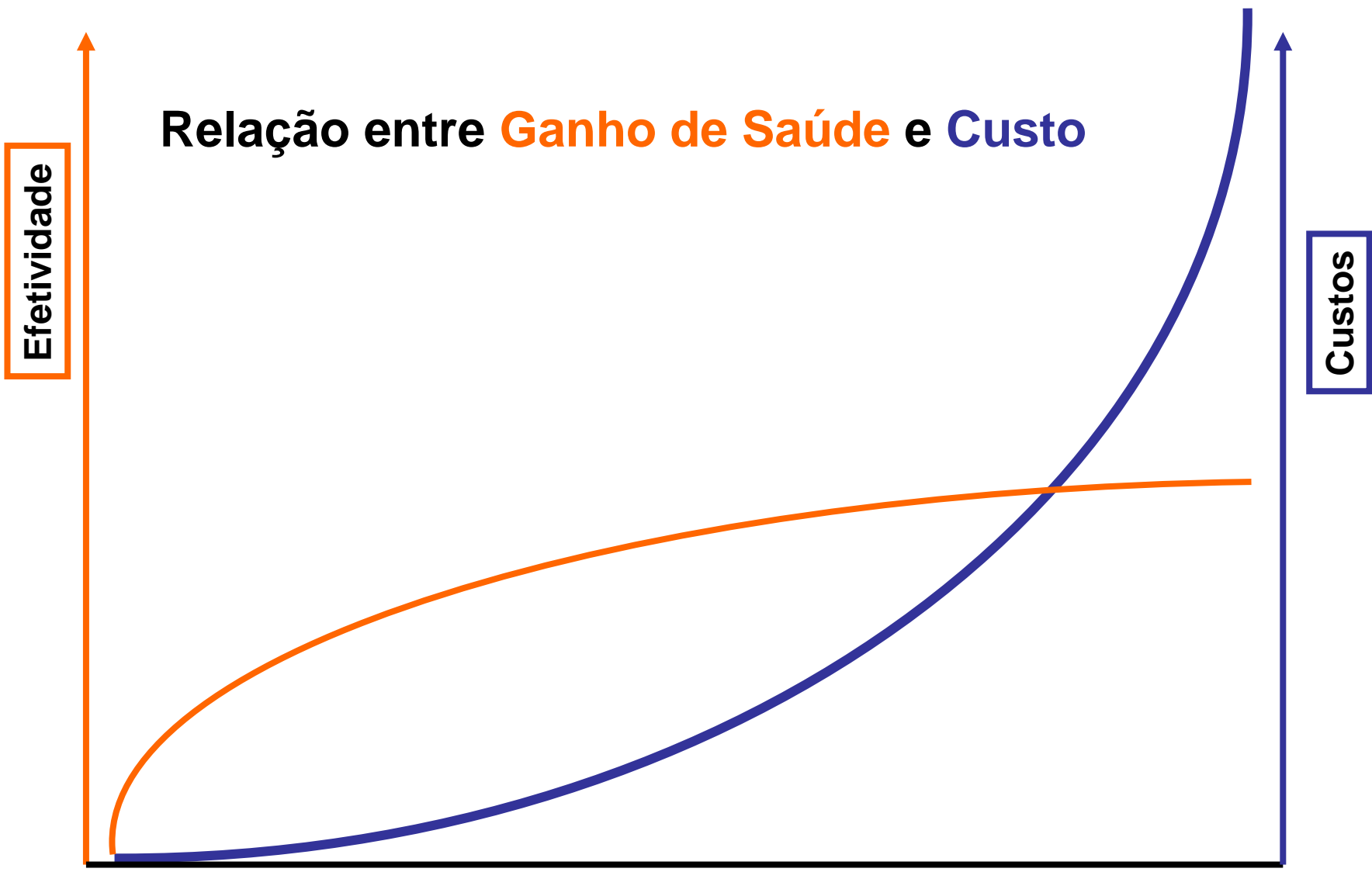
Universidade do Estado do Rio de Janeiro
Instituto de Avaliação de Tecnologias em Saúde



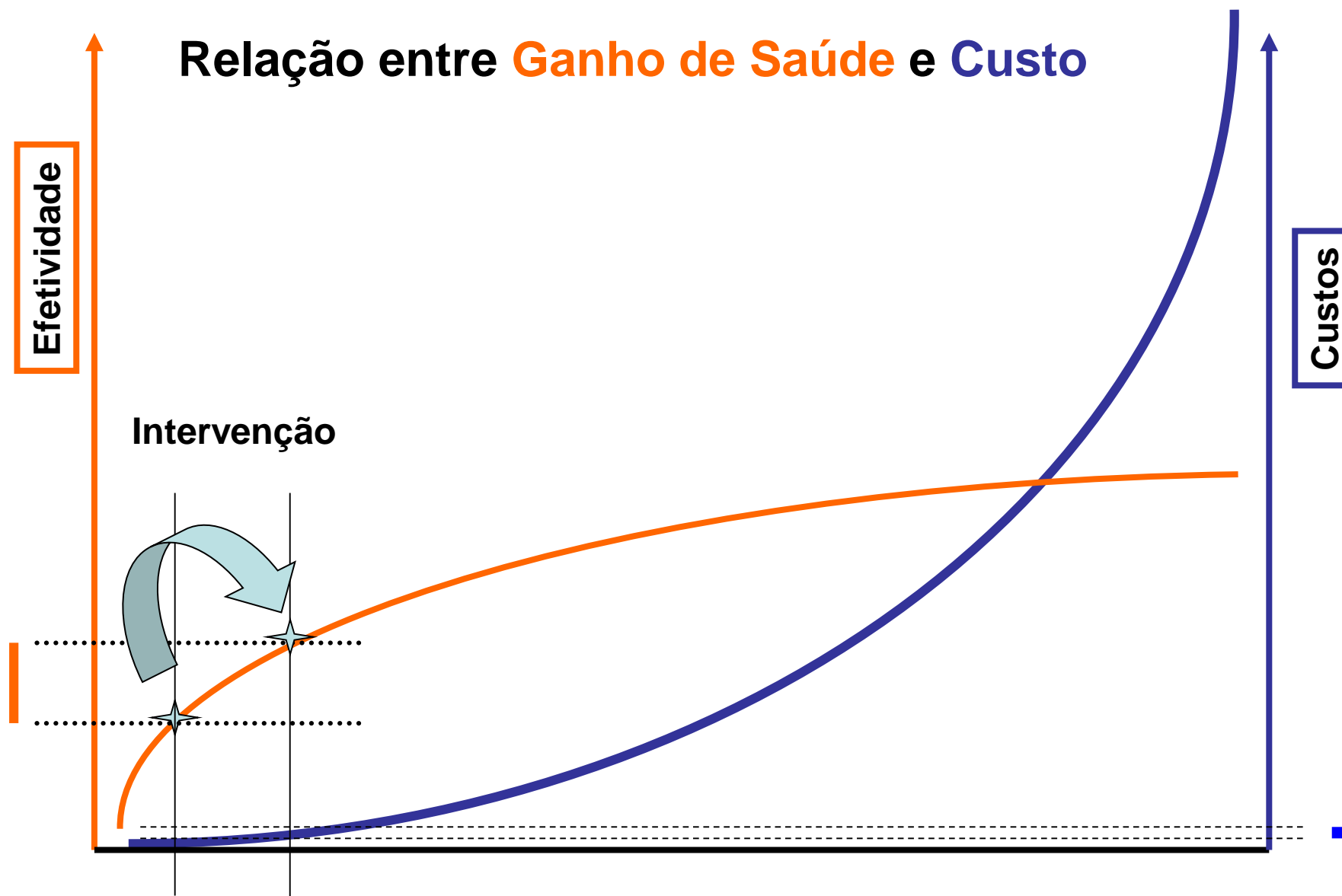
Avaliação de Tecnologia em Saúde no Brasil

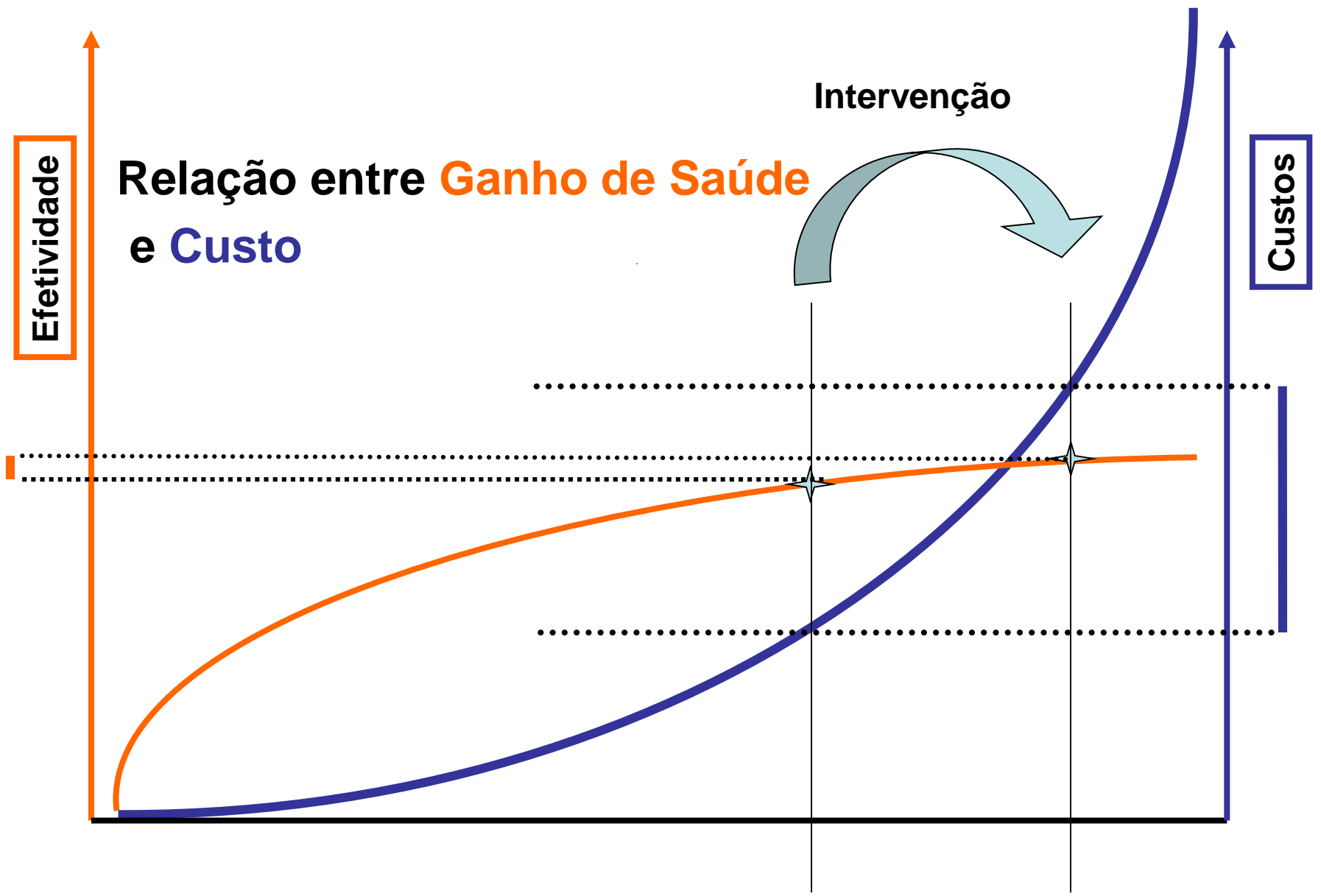
Denizar Vianna

Relação entre **Ganho de Saúde** e **Custo**

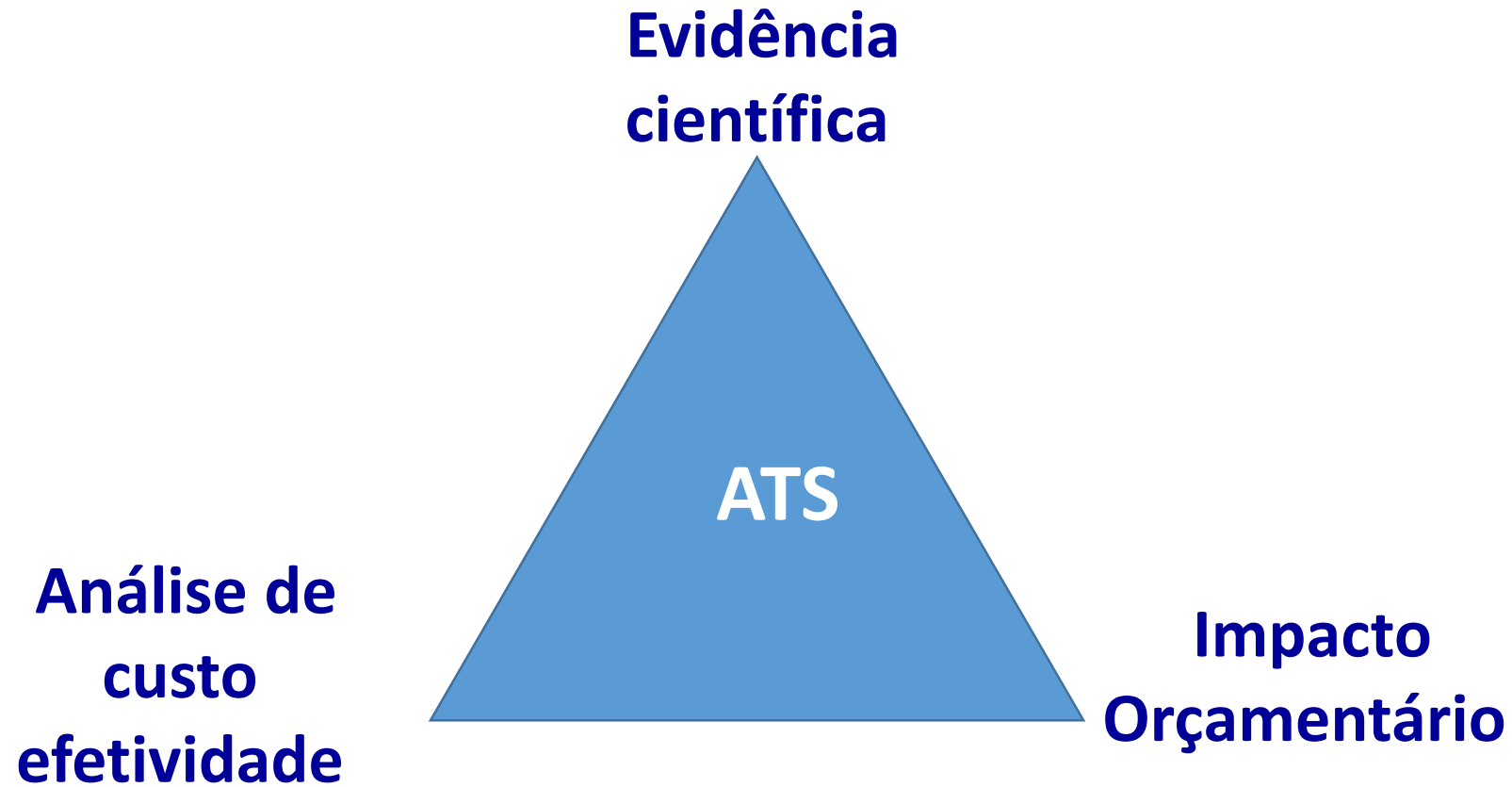


Relação entre Ganho de Saúde e Custo





Trilogia da Avaliação de Tecnologia em Saúde (ATS)



Análise de custo-efetividade relaciona custos com desfechos em saúde

“Custos” exemplos :

- hospitalizações,
tratamento, exames,
efeitos colaterais,
transporte, perda de
produtividade.



“Desfechos” exemplos

- Sobrevida Global

- QALY

- DALY

“Razão de Custo-Efetividade Incremental (ICER)”
= Diferença nos custos dividido pela diferença dos desfechos entre
duas estratégias de tratamento

Razão de Custo-efetividade Incremental

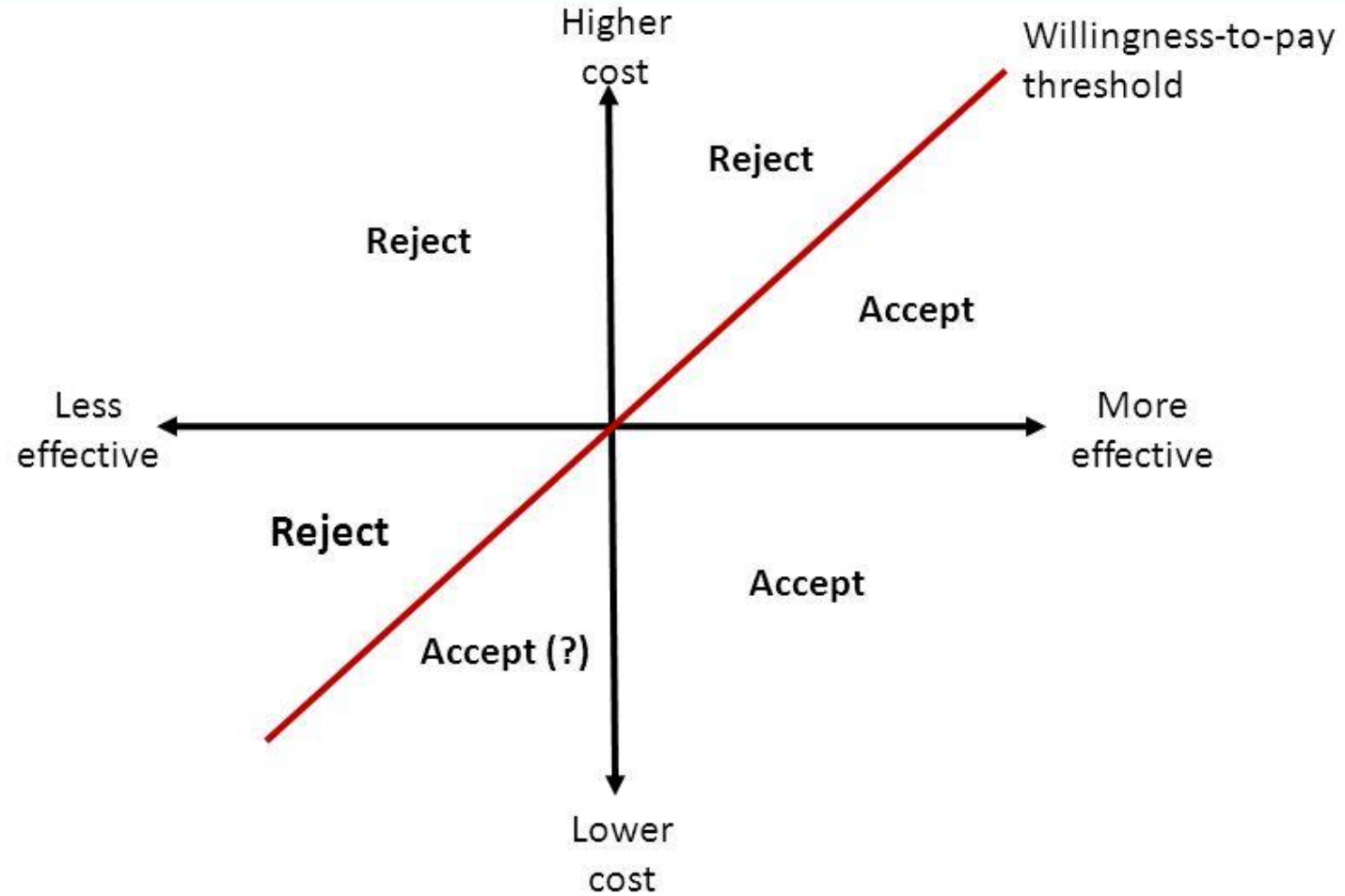
$$\text{RCEI} = \frac{\text{CUSTO INCREMENTAL}}{\text{EFETIVIDADE INCREMENTAL}}$$

CUSTO INCREMENTAL = Custo Intervenção A – Custo Intervenção B

EFETIVIDADE INCREMENTAL = Efetividade Int A – Efetividade Int B

RCEI = custo (\$) por ano de vida salva

Cost effectiveness plane





Contents lists available at [ScienceDirect](#)

Journal of Cancer Policy

journal homepage: www.elsevier.com/locate/jcpc



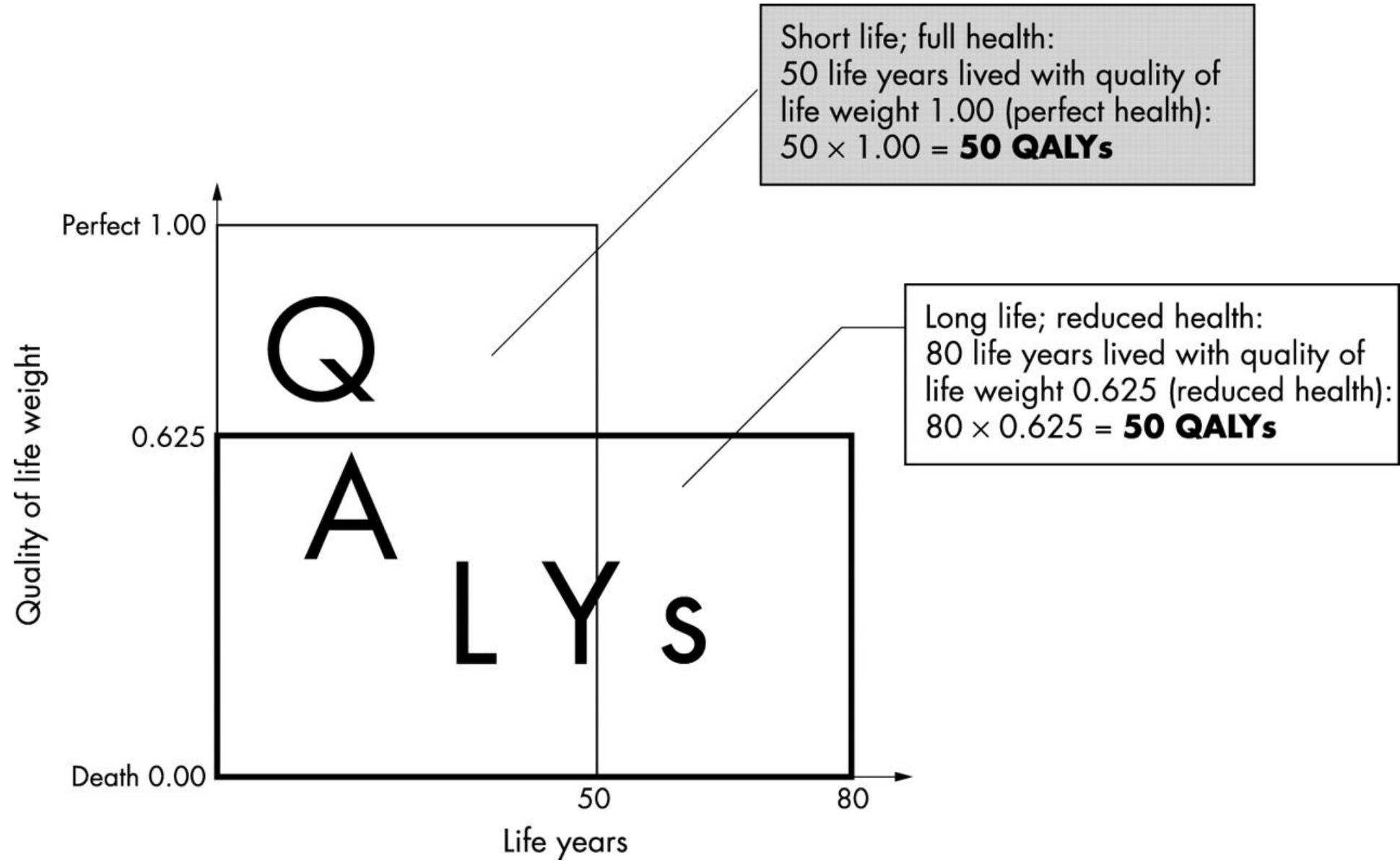
QALYs as a measure of value in cancer













Nancy J. Devlin*, Paula K. Lorgelly

Office of Health Economics, London, UK



Quality
Adjusted
Life
Years



Country	ICER	Cost effective
UK ¹ 	£7.893 per QALY gained	 YES - threshold for cost effectiveness £20-30.000 per QALY gained
France ² 	€15.382 per life-year gained	 YES - compares favourably with other accepted therapies
Switzerland ³ 	CHF16.178 per life-year gained	 YES - cost effective in increasing life-years in post-MI LVD
Spain ⁴ 	€9.759 per QALY gained	 YES - threshold for cost effectiveness €30.000 per QALY gained ⁶
USA ⁵ 	\$21.876 per life-year gained	 YES - threshold for cost effectiveness \$50.000 per life-year gained
Canada ⁷ 	\$19.902 per QALY gained	

MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT



REPORT OF THE COMMISSION ON
MACROECONOMICS AND HEALTH



Presented by JEFFREY D. SACHS, CHAIR
to GRO HARLEM BRUNDTLAND,
DIRECTOR-GENERAL OF THE
WORLD HEALTH ORGANIZATION
on 20 DECEMBER 2001

CRITICAL RATIOS AND EFFICIENT ALLOCATION

Milton WEINSTEIN and Richard ZECKHAUSER*

Harvard University, Cambridge, Mass., U.S.A.

First version received July 1972, final version received October 1972

“A second solution to the cost–effectiveness standard problem is to cite the cost–effectiveness of a benchmark intervention that has already been adopted in the relevant country and to use that as a threshold for acceptable cost–effectiveness”.

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EXPERT
REVIEWS

Assessing cost-effectiveness in healthcare: history of the \$50,000 per QALY threshold

Expert Rev. Pharmacoeconomics Outcomes Res. 8(2), 165–178 (2008)

Scott D Grosse

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Cost-effectiveness analyses, particularly in the USA, commonly use a figure of \$50,000 per life-year or quality-adjusted life-year gained as a threshold for assessing the cost-effectiveness of an intervention. The history of this practice is ill defined, although it has been linked to the end-stage renal disease kidney dialysis cost-effectiveness literature from the 1980s. The use of \$50,000 as a benchmark for assessing the cost-effectiveness of an intervention first emerged in 1992 and became widely used after 1996. The appeal of the \$50,000 figure appears to lie in the convenience of a round number rather than in the value of renal dialysis. Rather than arbitrary thresholds, estimates of willingness to pay and the opportunity cost of healthcare resources are needed.

KEYWORDS: cost-effectiveness analysis • cost-utility analysis • health policy • league tables • quality-adjusted life -year • willingness to pay

Interpreting the Economic Literature in Oncology

Patrick A. Grusenmeyer and Yu-Ning Wong

Table 3. League Table of Selected Interventions

Intervention v Comparator in Target Population	\$/QALY in 2002 US \$
Letrozole 2.5 mg v tamoxifen 20 mg daily in postmenopausal women with advanced hormone sensitive breast cancer who have not received first-line hormonal therapy in the advanced setting	8,700 ²⁸
Low-dose adjuvant interferon v testing with sentinel lymph node mapping in patients with clinical stage II malignant melanoma after surgical excision of their melanoma	58,000 ²⁹
Annual helical CT screening v no screening in a hypothetical cohort of current heavy smokers (> 20 pack-years) who were eligible for lung resection surgery	120,000 ³⁰
Annual helical CT screening v no screening in a hypothetical cohort of quitting heavy smokers (> 20 pack-years) who were eligible for lung resection surgery	570,000 ³⁰
Annual helical CT screening v no screening in a hypothetical cohort of former heavy smokers (> 20 pack-years) who were eligible for lung resection surgery	2,400,000 ³⁰

10 Common Chronic Conditions for Adults 65+

Quick Facts

 **80%** have at least 1 chronic condition

 **68%** have 2 or more chronic conditions



Hypertension
(High Blood Pressure)
58%



High Cholesterol
47%



Arthritis
31%



Ischemic Heart Disease
(or Coronary Heart Disease)
29%



Diabetes
27%



Chronic Kidney Disease
18%



Heart Failure
14%



Depression
14%



Alzheimer's Disease and Dementia
11%



Chronic Obstructive Pulmonary Disease
11%

Source: Centers for Medicare & Medicaid Services, Chronic Conditions Prevalence State/County Table, All Fee-for-Service Beneficiaries, 2015

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National Council on Aging

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How health economic evaluation (HEE) contributes to decision-making in public health care: the case of Brazil

Wie die Kosten-Nutzen-Bewertung zur Entscheidungsfindung im öffentlichen Gesundheitssektor beiträgt: am Beispiel Brasiliens

Flávia Tavares Silva Elias^{a,*}, Denizar Vianna Araújo^b

^a Oswaldo Cruz Foundation, Brazil

^b State University of Rio de Janeiro, Brazil

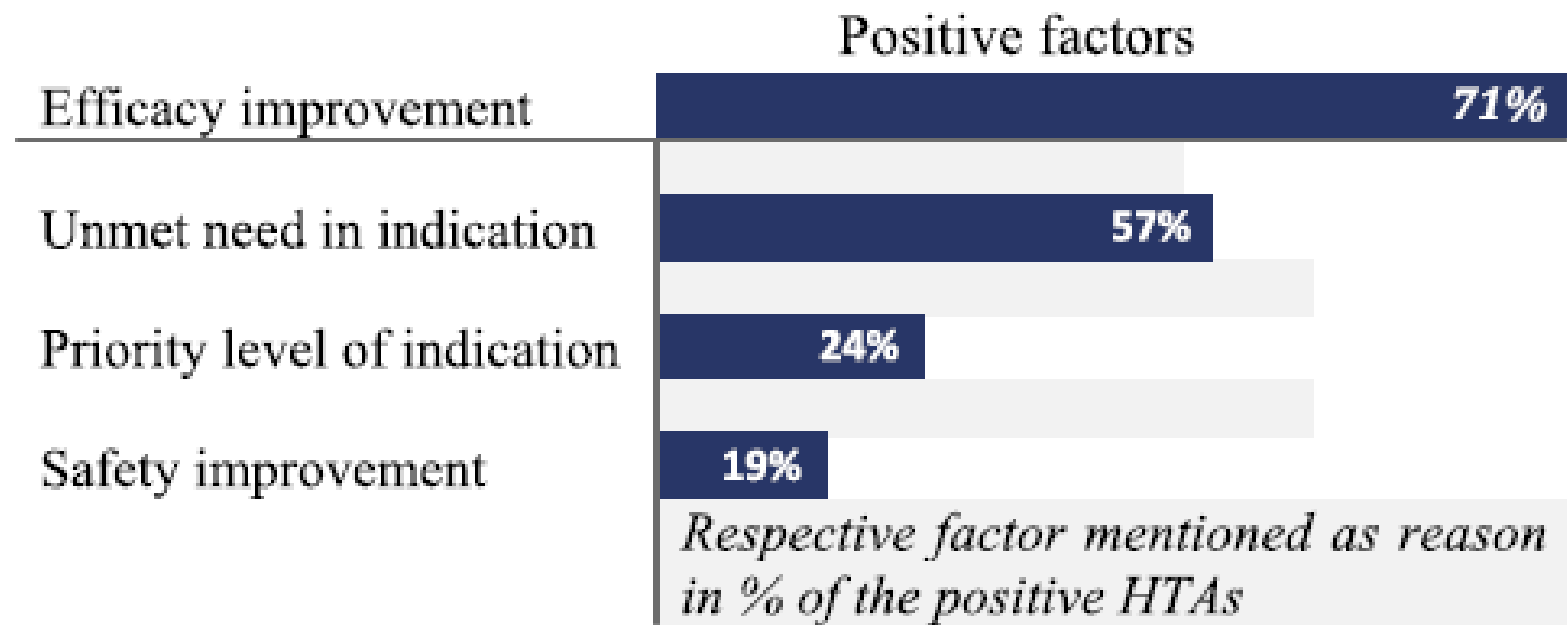


Figure 2 Clinical factors driving CONITEC decisions [23]

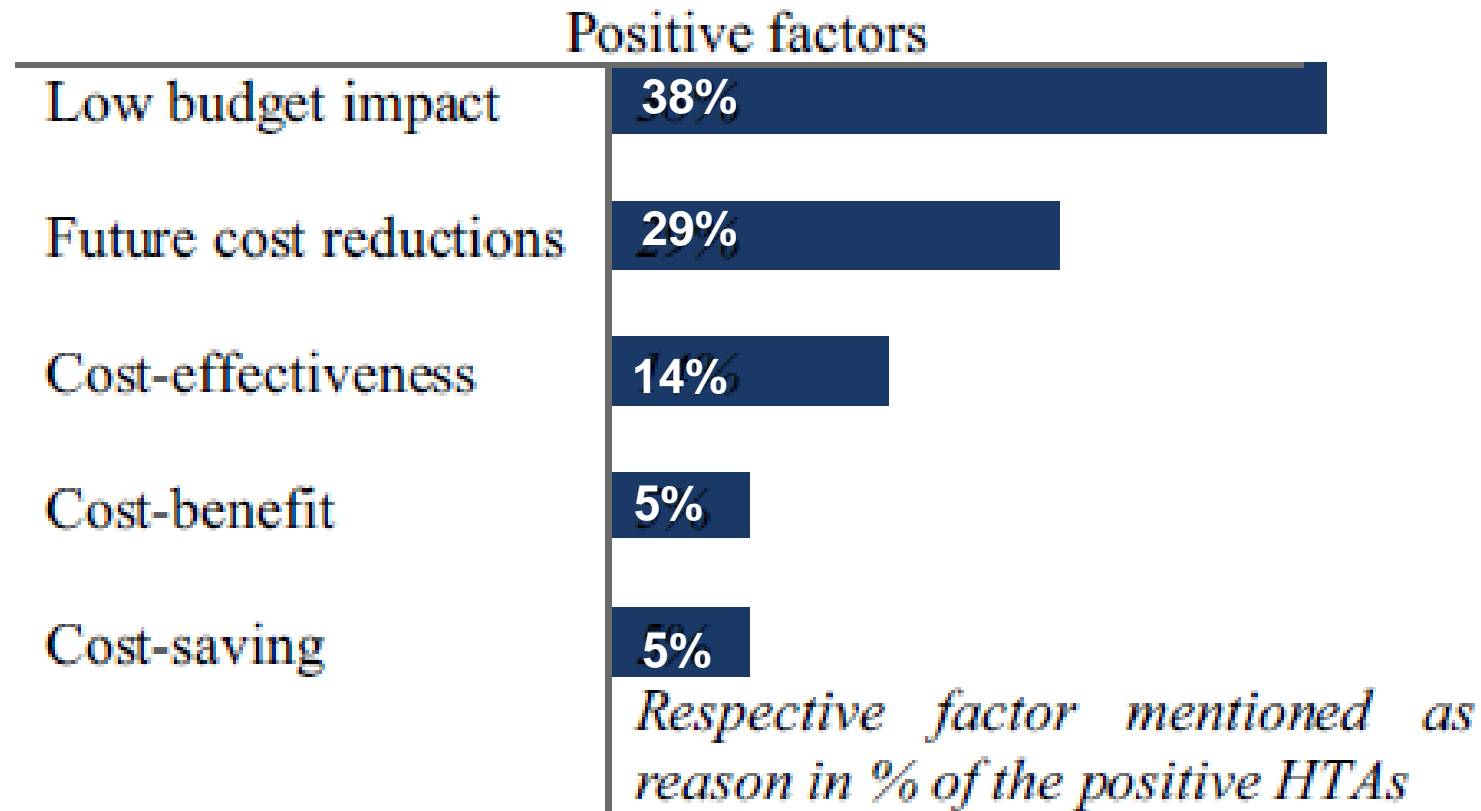
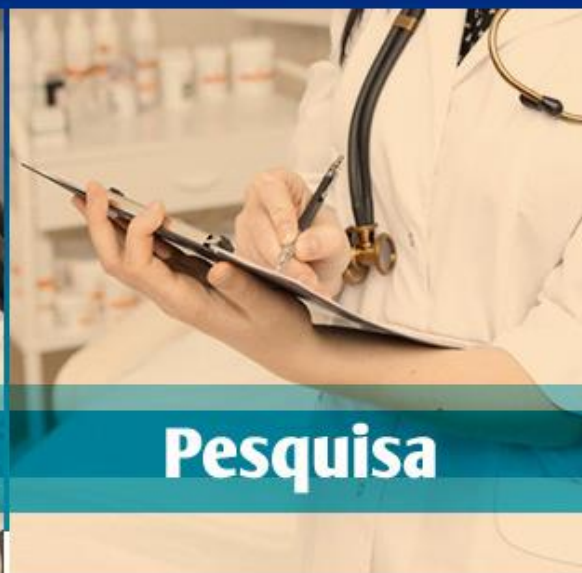


Figure 3 Economic factors driving CONITEC decisions [23]



Ensino



Pesquisa



Transferência de Conhecimento



Últimas Notícias

18/08/2017

Curso Metanálise de Rede de Evidências formou gestores e profissionais responsáveis pela incorporação de Tecnologias em Saúde no Brasil

Atividades ocorreram em Porto Alegre, de 7 a 11 de agosto, com a participação da professora Romina Brignardello-Petersen (Canadá). Durante o evento, ela destacou a necessidade permanente de capacitar pessoas para desenvolver ciência em um país

10/08/2017

Romina Petersen: É preciso treinar pessoas para desenvolver ciência

Últimas Resenhas IATS

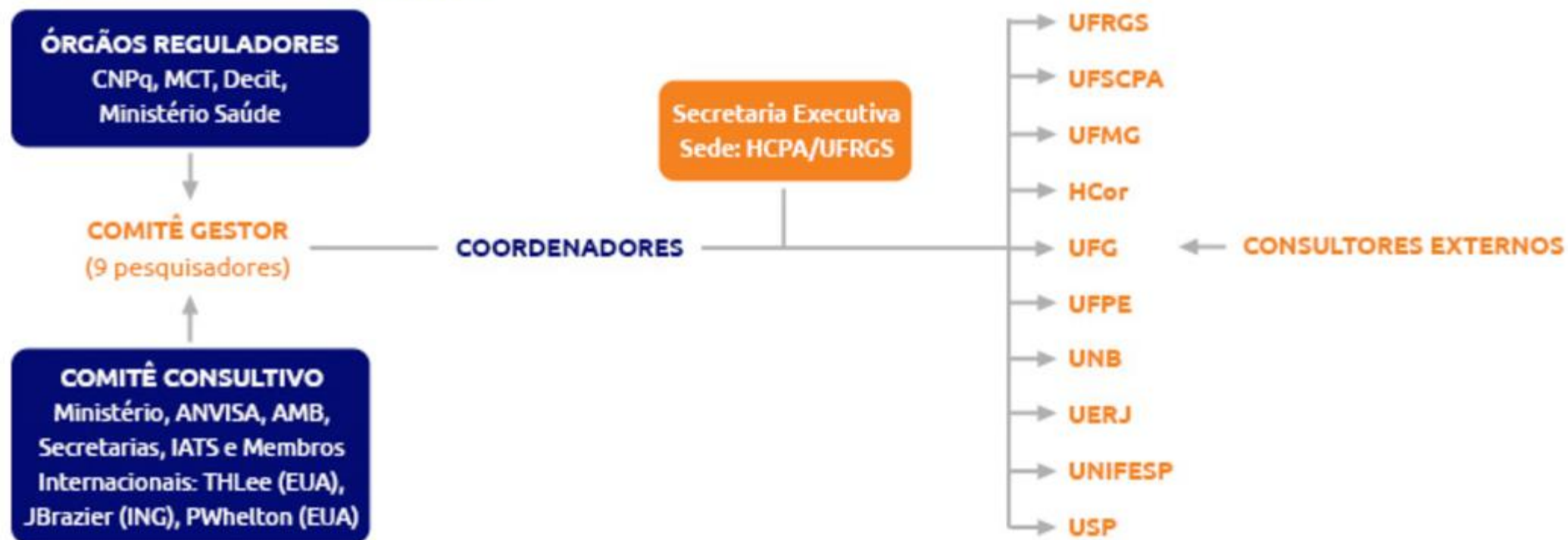
16/08/2017

Estimating the direct costs of ischemic heart disease: evidence from a teaching hospital in BRAZIL, a retrospective cohort study

Estimativa dos custos diretos da doença cardíaca isquêmica: evidência de um hospital de ensino no BRASIL, estudo de coorte retrospectivo

14/07/2017

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