Interferon beta treatment for multiple sclerosis (funded by DIHTA)

Danish Centre for Evaluation and Health Technology Assessment

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Authors' objectives
This report aims to include: 1) an analysis of the experience of interferon beta treatment for relapsing multiple sclerosis (MS), and 2) an account of the consequences of a possible widening of the range of patients being offered this treatment to include patients with secondary progressive MS.

Authors' conclusions
The clinical effect of interferon beta treatment of multiple sclerosis at the relapsing stage is now better documented than at the time when the therapy was introduced into clinical practice in 1996. The effect of the treatment is termed moderate. Clinical studies have shown that the number of relapses is reduced by one third and that the degree of severity of the relapses is reduced when treating relapsing MS by means of interferon beta. It is not yet known how many of the individual patients experience an improvement. The side effects are manageable for most patients.

Interferon beta moderates or slows down the progress of the disease for a cross-section of degrees of severity at the secondary progressive stage. The improved quality of life for this group of patients may be one of the essential benefits of the treatment. At the secondary progressive stage patients may also have relapses. The number of relapses is reduced when using interferon beta treatment. Clinical testing of interferon beta has shown that the progress of the disease is postponed by 6 to 12 months, and that the time when patients would have to use a wheelchair is postponed by approximately 9 months. The effect of the treatment is evident with patients with a moderately reduced as well as a highly reduced functional capacity. The side effects are considered to be manageable, while the duration of the effect of the treatment at the secondary progressive stage beyond a 3-year period is not known.

The increase in the number of patients resulting from a potential extension of the treatment to include the secondary progressive stage will be of great importance to the capacity and finances of the system.

If the treatment is offered to a wider range of patients, the majority of patients for a number of years will come from a potential group with secondary progressive MS of approximately 1,500 to 2,000 patients. The future increase in patients with secondary progressive MS is estimated to be modest, as the vast majority of patients in this group will already have commenced treatment at the relapsing stage. In the long term (after approximately 12 to 14 years), it is estimated that the number of patients receiving treatment in addition to the group which is offered the treatment today will stabilise at about 260.

Offering treatment to patients with secondary progressive MS undoubtedly will put pressure on the neurological departments, especially in the initial phase. As there are already too few neurological specialists at present and as certain other neurological diseases have also been targeted for special initiatives, it may become difficult for the neurological departments to meet the total demand while maintaining the required quality of the treatment. Restructuring and employment of more staff will be required. The home-care system and/or members of the patients’ families must be prepared to help the patient in connection with the administration of the medicine by injection and transport.

An overall assessment of the account given by DIHTA makes it seem realistic that the 15 neurological departments...
giving interferon beta treatment to patients will be able to extend the interferon beta treatment from the present approximately 700 to 800 patients to approximately 2,000 over the next 6 years or so. Such an extension depends, however, on the necessary finances being obtained and on the implementation of the required organisational restructuring.

At the same time, the HTA has made it clear that the group of patients concerned is vulnerable. Given the conditions and expectations for their lives, these patients will regard even small improvements in the course of their disease in a different and more positive perspective than healthy persons would normally do. Thus, when making decisions as to whether the range of patients being offered the treatment should be widened, aspects other than the purely clinical and financial aspects should be taken into account.

There may be factors other than those described in the report which individual county authorities might wish to consider when deciding whether or not to offer interferon beta treatment to more patients. In the light of the patients' freedom of choice over hospitals, DIHTA hereby recommends that the county authorities should coordinate their decisions in this field.

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