ESTIMATING THE OPPORTUNITY COST BASED COST EFFECTIVENESS THRESHOLD - EMPIRICAL APPROACHES & THE POLICY CHALLENGES FOR PAYERS

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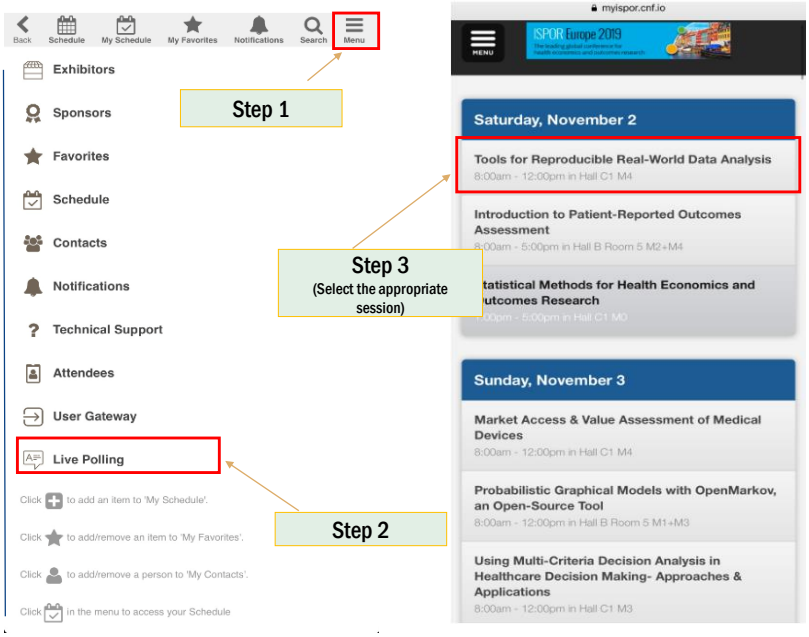

Estimating the opportunity cost based cost effectiveness-based cost effectiveness threshold: empirical approaches & policy challenges for payers

1. Why is this important?
2. The role of HTA bodies and payers/budget holders
3. Empirical challenges
4. Policy challenges
5. Aims of this workshop
6. Our speakers

1. Why is this important?

- Most ICERs are in N-E quadrant, so have no absolute interpretation. A decision rule is therefore required for these ICERs to truly 'inform' decision-making
- Two principal 'paradigms': society's WTP (MV of a QALY) or the NHS opportunity cost (MC of a QALY).
  - But no socio-political mechanism to reconcile the two!
- Given fixed budgets, opportunity cost is unavoidable - achieving allocative efficiency crucially relies on getting it (even roughly) right.
- But…
  - In practise, the ICERs are not independent of the threshold, once it is 'known': QALY gains will be priced up to the threshold by profit maximising suppliers.
  - static vs dynamic: There are also longer term consequences of choosing a threshold now – incentives to invest in R&D.

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2. The role of HTA bodies and payers/budget holders

- Thinking about this as a principal-agent relationship…
- HTA a highly technical process, so it makes sense for a health care system to delegate
- But inevitably, HTA entails both scientific and social value judgements
- HTA agencies are deciding (acting as 'agents') on behalf of health care systems ('the principal')
- Asymmetry of information? Are HTA bodies perfectly well informed about the preferences and budget constraints facing the principal?
  - Should HTA bodies be left to decide on the threshold?
  - What if the maximand assumed in HTA is out of keeping with the way resource are allocated in practise in the health care system?

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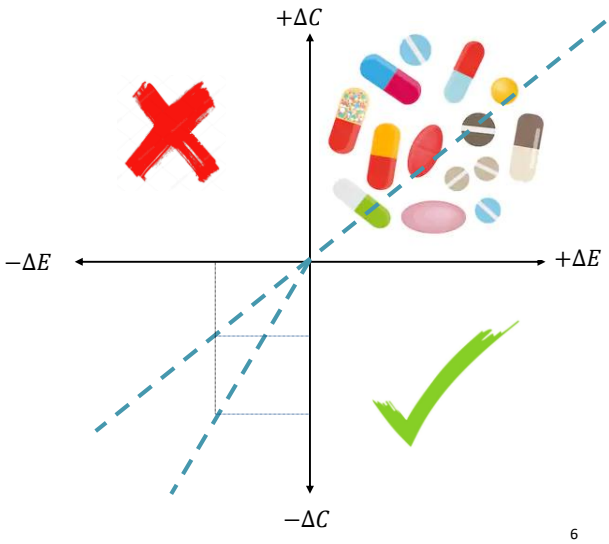
3. Empirical challenges

- Approaches that 'didn't work' eg identifying specific opportunity costs – largely because cost per QALY evidence isn't available/used!
- Approaches that 'work' eg. econometric approaches to identify average cost per QALY across the health care system.
- But: remaining challenges
  - Eg. asymmetric threshold for NE and SW quadrants – very little evidence on disinvestment



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4. Policy challenges

- Can we ever have 'perfect' evidence?
  - eg. the inevitable tension between national vs local evidence on opportunity costs
- If 'non-QALY' elements of value are to be considered in HTA, how are those also to be reflected in opportunity cost?
- Uncertainty and variability in evidence seems inevitable
- Suggests a key question to address is *how to triangulate* across competing evidence?
- And, ultimately, *who* then decides?

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Poll: 1. In the absence of perfect evidence, who should decide on the cost effectiveness threshold?

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Poll: 2. Given the inevitable variations in local costs, outcomes and other factors across a health care system, is it practical/useful to have a single national 'average' threshold? (ie in order to achieve efficiency across the system)

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Poll: 3. If we include other elements of value into HTA, should our measure of opportunity cost also reflect those other elements of value foregone/ other types of opportunity costs?

5. Aims of this workshop

- Illustrate how empirical work can inform cost-effectiveness thresholds based on opportunity cost
- Discuss the challenges for HTA bodies and payers in selecting a threshold

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6. Our speakers

James Lomas, Research Fellow, CHE, University of York, UK
Researcher using econometric methods to estimate Opportunity cost thresholds

Martin Henriksson, Senior Lecturer, Linkoping University, Sweden
Martin is both a researcher and a decision maker for TLV

Danny Palnoch, Head of Medicines Analysis, NHS England
Danny directly inputs into decisions about the ~ £17.4 billion spent on medicines in England

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