Editorial: Pursuing Efficiency: A Dead End for HTA?

J. Jaime Caro, MD CM

United BioSource Corporation, Lexington, MA, USA

Keywords: efficiency, HTA cost per QALY, utilitarianism.

The papers in this *Value in Health* Special Issue document the process of health technology assessment (HTA) in various countries very well and the opening and closing editorials draw important lessons from these that should help the development of HTA and related policy setting in countries with less well-developed systems. Two themes seem to weave throughout the issue: that a full HTA should include consideration of efficiency ("cost-effectiveness") and that despite methodological developments, we have not been very successful at persuading stakeholders outside the HTA community to see the value in our activities and adopt our procedures wholeheartedly. Perhaps, these two are closely related—our audiences are reluctant to embrace our approach because they reject at some fundamental level our focus on efficiency.

Our current focus on efficiency stems from the two ideas that are said to form the very rationale for health economic evaluation: that the goal of the health-care system is "maximizing health" and that this must be accomplished with limited resources. It seems obvious that if this is the problem, then the solution must involve assessing efficiency—how much health one buys per monetary unit—and that this requires a universal unit of health in order to have a common measure that allows comparisons across interventions. As presented didactically, this appears to work: set the budget, start with the most efficient intervention, and continue adding others in order of decreasing efficiency until the budget is spent. The trouble is that this idea fails entirely, from practice, to concepts, to fundamentals.

The practical failures are many. None of our health-care systems are open to designing from scratch—we cannot follow the didactic prescription. Instead, we have an existing set of interventions that are covered, most of which have never been evaluated. We have no idea what their efficiency is, so we do not know what the lowest covered efficiency is. When faced with assessing a new intervention for coverage within the budget, we can establish its efficiency but it is not clear what the decision-makers are supposed to do with that information. So, we invent a threshold efficiency and propose that the new intervention's efficiency be compared with it: if it is worse, do not cover; otherwise, go ahead and reimburse. But that, of course, does not respect the budget limit—on the contrary, it forces an increase as no "inefficient" interventions are identified and removed.

Even if we did take pains to identify less efficient interventions, basing the trade-off on efficiency would still not be very helpful as the new intervention might command a much larger share of the budget than the one proposed for withdrawal. This would still be the case even if we made an effort to establish what the insured citizens think the minimum efficiency should be (assuming such a question can be meaningfully asked and answered). The concept of comparing efficiency as a means to making coverage decisions for new interventions within a particular budget does not work because it does not address the trade-offs that are required.

What if we could redesign the system, perhaps in stages, so that eventually we would be covering only the most efficient interventions up to the budget limit? Would such a system achieve what the insured citizens want? That depends on whether citizens generally want their health-care system to yield the highest aggregate health regardless of how that total is obtained. This is clearly not the case as it matters to people what illnesses are treated. Health gained by removing minor complaints is not as valuable as that obtained by dealing with severe or life-threatening diseases. No one would accept to prioritize headache treatment over cancer removal no matter how much more efficient the former is or how much greater its total health gain might be. The fundamental idea that we should maximize aggregate health is not tenable.

Instead, what our health-care systems need to do with their limited budgets is maximize value and no dimensions of health (e.g., the quality-adjusted life-year) will be a good measure of value because people consider other aspects in their evaluations. It is difficult, of course, to assess value, but choosing to measure something else because it is easier to do will not produce HTAs that are persuasive to the stakeholders.

So, is there a role for efficiency? There is, but it is much more limited. Efficiency is important when purchasing a particular benefit. If one wants to cover treatments for headache, then it is desirable to purchase the most relief with a given budget and this requires that efficiency be estimated in these terms. More efficient pain relievers should be preferred for coverage. Whether one should cover headache treatments, or to what extent, is a whole other matter, and is not informed much by efficiency.

In my view, then, HTA will fail to gain traction with stakeholders so long as overall efficiency is viewed as its ultimate output. Providing competent review and summary of the evidence, as well as estimates of the possible health impact of a proffered intervention together with its budgetary implications, should be very useful to decision-makers. In therapeutic areas with multiple available interventions, estimation of their efficiency at providing the specific benefits in that area should also be useful. If we want our HTAs to go beyond that without leaving our audiences behind, we will need to get into the much more difficult business of weighing the values our citizens place on different health benefits. We must back out of the dead end that is pursuing overall efficiency.

Address correspondence to: J. Jaime Caro, United BioSource Corporation, 430 Bedford Street, Suite 300, Lexington, MA 02420, USA. E-mail: jaime.caro@unitedbiosource.com

10.1111/j.1524-4733.2009.00559.x

Source of financial support: ISPOR provided a modest honorarium.

J. Jaime Caro has no conflicts to declare.

 1098-3015/09/S49 S49