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Head to Head

Should cost effectiveness analyses for NICE always consider future unrelated medical costs? No

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The objective of welfare economics is to maximise population health from a fixed healthcare budget. To achieve this objective, economic evaluations of different healthcare interventions should consider all consequences related to healthcare, including future medical costs unrelated to the interventions.(1)

The problem comes when trying to implement this approach in the real world. The utilitarian objective of maximising population health does not take into account whether health gains within the population are distributed fairly.

In some situations, inclusion of unrelated costs would preclude specific groups of people from having equitable access to care. In these cases, decision makers should consider cost effectiveness analyses that exclude unrelated costs.

A patient receiving dialysis

The classic example cited to justify the exclusion of unrelated costs is that of a life extending treatment in a patient receiving dialysis where the treatment does not alter the need for lifelong dialysis.(2) If dialysis is expensive, and the quality of life of patients receiving dialysis is low, then the value of the life years gained by the treatment may not outweigh the cost of dialysis during those additional life years. In this situation, the life extending treatment would not be cost effective even if it were provided at zero cost.(3)

Some health economists have argued that if the treatment being evaluated does not alter the need for lifelong dialysis, then the dialysis costs can be considered to be unrelated because the increased cost is driven solely by the increased longevity of the patient.(2) The exclusion of future dialysis costs on this basis allows cost effective prices to be identified for life extending treatments in this patient group.

This situation may apply among any group of patients with high ongoing costs that cannot be reduced by better care. In the UK this may include people with high social care needs because of disability, because NICE requires costs met by personal and social services to be included in cost effectiveness analyses.(4)

As a society we would never refuse to provide good preventive healthcare, such as flu vaccinations, to patients with disabilities purely because their high ongoing health and social care costs would mean that their early death would release funds that would generate more health gains elsewhere in the health system. A decision to do so would be unethical and would face legal challenges under the UK's equalities legislation.(5)

This same ethical argument can apply when considering interventions that are indicated only for groups of patients who need expensive ongoing care. It would be inequitable to fund technologies that are not themselves cost effective but to refuse to fund life extending treatments in populations receiving those cost ineffective technologies. The effect of such a decision would be to deny patients more of a treatment already prolonging their life when new patients would be able to receive it.(3)

Healthcare systems have more than one purpose

Some health economists might argue that more health would be gained by society as a whole if funding was removed from cost ineffective interventions and spent on cost effective interventions elsewhere in the healthcare system. However, the point here is that healthcare systems are not currently configured to maximise population health because that is not their only purpose.

Society also values providing compassionate care to patients who cannot currently be cured, with the aim of maximising the health that can be achieved during their individual lifetimes. If the societal value of providing such care is not currently captured in cost effectiveness analyses, then excluding

these costs as unrelated may be a means to appraise technologies in these populations in an equitable manner. It is for these reasons that NICE asks that unrelated future medical costs are omitted from cost effectiveness analyses.

REFERENCES

1. van Baal P, Meltzer D, Brouwer W. Future costs, fixed healthcare budgets, and the decision rules of cost-effectiveness analysis. *Health Econ* 2016;25:237-248.
2. Grima DT, Bernard LM, Dunn ES, et al. Cost-Effectiveness Analysis of Therapies for Chronic Kidney Disease Patients on Dialysis. *Pharmacoeconomics* 2012;30(11):981-9.
3. Davis S, Akehurst R, How do we evaluate technologies that are not cost effective at zero price. *Value and Outcomes Spotlight* 2016;2(4):6-8
4. The National Institute for Health and Care Excellence. Guide to the methods of technology appraisal 2013. London, UK: The National Institute for Health and Care Excellence 2013.
5. The Equalities Act 2010, c.15. Available at: <https://www.legislation.gov.uk/ukpga/2010/15/contents> (Accessed 29/09/2017)