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VALUE IN HEALTH

What's in a Perspective?

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The history of pharmaceutical costing for use in cost-effectiveness studies has been marked more by convenience—what pricing data are readily available?—than by science—what opportunities are forgone when we use a particular drug? For too long, our field has relied on average wholesale price, when there is substantial evidence that it is an inappropriate measure [1,2]. Thus, the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) Task Force on Good Research Practices—Use of Drug Costs for Cost Effectiveness Analysis reports on drug costing [3–8] is commendable.

These reports describe in gory detail the intricacies of drug costing from five different perspectives: societal, managed care, US government, industry, and international. The documented complexity is magnified by the fact, well recognized by the authors, that much of the necessary information is proprietary and likely to be unavailable to researchers. The Task Force might have been better served giving as much thought to the objectives of published pharmacoeconomic studies as it did to the data needed for appropriate estimates for single payers/providers.

Do we expect that our published studies can individually inform each of the 50 different state Medicaid programs about whether an intervention is cost-effective in their state? How about individually informing each of the much larger numbers of managed care organizations? How overwhelmingly demanding would the information requirements be, particularly given that the necessary data would not be limited to identifying organization-specific drug costs, but would require organization-specific measures of both practice pattern and the other cost data used in the study? Although there is no consensus in our field about which is more important, organization-specific measures of practice pattern may have a greater impact on our recommendations to individual payers than do organization-specific price weights/unit costs.

The problem arises from the nebulous nature of some of the perspectives we hope to address: which payer? which provider? It is akin to the problem faced when transferring/generalizing economic data across jurisdictions [9]. If we make the results specific for an individual payer, we may lose transferability/generalizability to other payers; if we instead develop an average result across the pool of payers, all may be left wondering whether they are enough like the average that they should be confident that the study's recommendation applies to them.

If we actually want to publish a value recommendation directed specifically to the Pennsylvania Medicaid program or if we want to direct such a recommendation specifically to Independence Blue Cross in Philadelphia, the answer to the Task Force question is fairly obvious: use these organizations' price weights (and practice patterns). But it is rare that our published studies have such a narrow focus. These reports would have been more helpful had they spent more time helping us understand 1) whether and how we can more productively use average values for our price weights, and 2) the additional analyses we can perform to help payers understand how much variance can exist around these price weight estimates without their needing to worry about whether the value recommendation applies to them.

Having said that, these reports provide a good start at making us bring more rigors to a field that has relied preponderantly on the fictitious average wholesale price.

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