

What Price for a Year of Life?

The Threshold Discussion in Health Technology Assessment

Executive Summary

Governments all over the world have tried to prioritise spending of taxpayers' money on healthcare in a variety of ways. The latest of these methods – and one which is on the rise – is known as Health Technology Assessment (HTA). All health systems engage in rationing but when health care expenditure decisions are based on HTA it becomes crucially important to understand how this process works, not least for to patients trying to find out what kind of access they can get to the latest medicines and treatment.

Specifically the question of spending limits (so-called 'thresholds') becomes significant. From the point of view of governments, the aim of HTA is to provide decision-makers with more accurate, evidence-based tools for prioritising healthcare treatments in terms of their utility, efficiency and cost-effectiveness. HTA institutions are charged, in other words, with checking which types of spending deliver 'value for money' to the public. In practice, however, it is not at all clear to what extent national HTA bodies - such as the National Institute for Health and Clinical Excellence (NICE) in the UK or the Institute for Quality and Efficiency in Health Care (IQWiG) in Germany - are able to state clearly what 'value for money' actually means. Typically, HTA institutions measure the 'benefits' of a treatment as the period by which a patient's life is extended and improved. But once this figure is known, up to what cost per year, month or day should a treatment be considered 'cost-effective'? Is there a monetary 'threshold' above which a new medicine should not be reimbursed (or, in other words, should be denied) in a given country?

These questions are far from being simple and straightforward. In fact they represent the significant complexities and built-in conflicts associated with the HTA process, not least in the context of determining the economic 'threshold' of a given medicine.

Moreover, due to the moral sensitivity of this topic – effectively announcing what a life is worth - no country in the world actually publishes an official threshold value above which it

declares a medicine to be 'unworthy' of public reimbursement. To date, only NICE has published what could be considered an approximate threshold.

Consequently, this paper concludes that HTA institutions have so far failed to live up to expectations of a scientific, fact-based alternative to politically determined rationing of health care spending. Instead, it seems that decision making has passed from one arbitrary body to another. No HTA institution in the world defines clearly what it means by 'cost-effectiveness', nor do they explain how they trade off cost-effectiveness against other variables. The UK model of HTA may currently be the most transparent one, but even this model suffers from such ambiguity that to call it a 'best-practice model' would be inappropriate.

The reasoning behind HTA failures remains a matter of speculation. Current rulings do not oblige HTA institutions like NICE to exercise more than a minimum degree of consistency and transparency.

The criticisms that are highlighted in this report refer to the current implementation of cost-effectiveness thresholds. Nevertheless the paper argues that, within the framework of government-funded health systems which ultimately focus on cost-containment, thresholds may still provide an improvement over purely politically determined cut-off points. By using thresholds more explicitly, HTA decisions may become more transparent and open for all interested parties who wish to monitor the process, to understand it better and to either support or challenge it. This would at least bring clarity and predictability for all those involved.

But to achieve this end, current practices would have to be substantially changed:

- Thresholds would need to be made more explicit and transparent, thus preventing the HTA institution or other political bodies from making decisions that are based on discretion and/or facing the criticisms that may be directed at these decisions.
- There would need to be greater transparency in decisions that 'trade' cost-effectiveness with other technically important variables, such as the quality of evidence or the expected cost-utility of new medicines over the longer term.
- HTA-related threshold figures should be much more aligned with government healthcare spending budgets as a whole, and specifically be adjusted to reflect the increase in healthcare expenditure over time, rather than being perceived as a constant, one-time, calculation.

Finally and most importantly, the paper notes that, even if it were to be greatly improved, the threshold concept would still reflect a very static and inflexible way of calculating the value of a given medicine to the public. This principle is arguably based on the model of 'one size fits all', in which the decision about the value of a medicine is based on a collective logic decided by the HTA body without taking into consideration the individual preferences and choices of patients and the public. Yet this does not necessarily have to be the case. By shifting to a model which is based on greater collaboration and partnerships between the public and the private sectors (such as by working with private healthcare providers and insurers), and by allowing consumers a greater degree of choice and say in the HTA prioritisation process (such as via the use of 'top-ups') the threshold concept, and indeed the HTA model as a whole, could become more flexible and ultimately more suited to the individual preferences and choices of the public.