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ABSTRACT

The second section of our Special Task Force builds on the discussion of value and perspective in the previous article of the report by 1) defining a health economics approach to the concept of value in health care systems; 2) discussing the relationship of value to perspective and decision context, that is, how recently proposed value frameworks vary by the types of decisions being made and by the stakeholders involved; 3) describing the patient perspective on value because the patient is a key stakeholder, but one also wearing the hat of a health insurance purchaser; and 4) discussing how value is relevant in the market-based US system of mixed private and public insurance, and differs from its use in single-payer systems. The five recent value frameworks that motivated this report vary in the types of decisions they intend to inform, ranging from coverage, access, and pricing decisions to those defining appropriate clinical pathways and to supporting provider-clinician shared decision making. Each of these value frameworks must be evaluated in its own decision context for its own objectives. Existing guidelines for cost-effectiveness analysis emphasize the importance of clearly specifying the perspective from which the analysis is undertaken. Relevant perspectives may include, among others, 1) the health plan enrollee, 2) the patient, 3) the health plan manager, 4) the provider, 5) the technology manufacturer, 6) the specialty society, 7) government regulator, or 8) society as a whole. A valid and informative cost-effectiveness analysis could be conducted from the perspective of any of these stakeholders, depending on the decision context.

Keywords: cost-effectiveness analysis, decision context, perspective, value.

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In other words, the net value is what a consumer would be willing to pay to avoid losing access to the good. Second, because individuals vary in their preferences for health and other economic goods, the value they place on different health care interventions will also vary. Third, given that most medical care is purchased indirectly via health insurance, individuals do not directly face prices, and their agents (insurers and providers) acting on their behalf must assess value for money. Indeed, this is a large part of the motivation for payers and providers to develop value frameworks. Sometimes US payers have established price schedules (e.g., Medicare physician fee schedules or prospective payment by diagnosis-related groups), although their link to value is arguably tenuous.

The concepts of value and efficiency are related in economics, but the relationship can be complicated and nuanced with respect to health care technologies—and notably for innovative medicines. For economic assessment purposes, the net value of an action, a program, a treatment, or a technology reflects the willingness to pay (WTP) for the improvement in well-being minus the opportunity cost of resources used to produce that improvement. Broadly, achieving “economic efficiency” is obtaining maximum value for the money spent. In assessing value and economic efficiency from the perspective of society as a whole, both the well-being (utility) and the cost measures should include the consequences to all those affected by the action [2].

For well-known reasons, directly assessing benefits and costs of health care in strictly monetary terms using observed market prices is fraught with difficulty given the market distortions (such as insurance), as noted earlier. Cost-effectiveness analysis (CEA), by relating an intervention’s cost to its effectiveness (in terms of some change in health) as a ratio, is thus a standard approach to measuring the net value of a health care intervention. Economic efficiency is also sometimes considered in the short-term (static efficiency) and in the long-term (dynamic efficiency). Static efficiency means, for example, achieving the maximum expected health gain from a fixed annual budget; dynamic efficiency is about achieving the optimal rate of innovation. They are related in that paying for what people value provides the incentive to direct research and development to produce innovations that generate that value [3]. Because a simple comparison of market-based monetary benefits and costs is not feasible or useful for most individual health care technologies, health economists and outcomes researchers have developed a work-around that allows comparisons among technologies in terms of incremental cost-effectiveness ratios, and in comparison with a threshold of WTP or opportunity cost [4–6].

Empirical studies document what is known intuitively about heterogeneous preferences for health care. Our fellow citizens attach different values to health outcomes. Two patients might value the same health gain differently, and some of this variation is related to differences in incomes, but much of it is related to differences in preferences about spending on the health care versus other non-health-related goods that they value. There is also variation across people in the extent to which they are willing to trade off extensions in life expectancy against various aspects of the quality of life. Nevertheless, the larger concern in heterogeneity is the health gain delivered from the same intervention in different subpopulations. This heterogeneity of treatment effect implies that it is inappropriate to try to determine a single value for a medical intervention; rather, we should seek to know the distribution of values in a population. Payment and reward systems for medical products and services are, however, typically based on population averages, and hence cannot fully reflect this variation in value.

The theoretical foundations chapter of the recently published report [2] of the Second Panel on Cost-Effectiveness in Health and Medicine posits that alternative microeconomic approaches are variants of the general principle of “constrained optimization,” in particular, the maximization of health (a form of extra-welfarism) [7] or the maximization of individual well-being (traditional welfare economics) subject to a budget constraint [4]. Our STF follows a welfare economics approach in considering US value frameworks, recognizing that there is no fixed annual global budget for all of health care in the United States. At the same time, there are clearly more specific resource constraints and opportunity costs that apply over time in obtaining care for health plan members. Moreover, in public programs such as Medicaid or for public payers with short-term time horizons, there may effectively be a fixed annual budget.

Stakeholders, Perspectives, and Decision Contexts

Numerous guidelines for CEA emphasize the importance of clearly specifying from whose perspective the analysis is being undertaken [2,8]. In other words, from the standpoint of which key decision maker is the constrained optimization being undertaken: 1) the typical health plan enrollee, 2) the patient, 3) the health plan manager, 4) the provider, 5) the technology manufacturer, 6) the specialty society, 7) the payer (public or private), or 8) society as a whole. A valid and informative CEA could be conducted from the perspective of any of these stakeholders, depending on the purpose of the analysis.

Most published CEAs in the United States aim to support public or private health sector decision making about what technologies or strategies should be available to health plan members when those members become patients with a specific illness or condition.

The report of the Second Panel [2] is instructive in that the authors re-examined the past 20 years of the practice of CEA since the publication of the original panel’s report. They identified and defined four normative perspectives for consideration, ranging from the least to the most generally inclusive:

1. payer perspective;
2. health care sector perspective;
3. health care sector with time cost perspective; and
4. societal perspective.

Although any of these (as well as other possible perspectives) can be taken in CEAs and be scientifically valid and informative for certain decision makers, the Second Panel recommended—for the sake of consistency and comparability—that analysts should report “reference cases” from two perspectives—the health care sector perspective and the societal perspective.

The health care sector perspective includes “formal health care sector (medical) costs borne by third-party payers or paid for out-of-pocket by patients.” This includes “current and future health costs, related and unrelated to the condition under consideration [2].” Notably, it does not include patient time costs or the future benefits and costs of other types of consumption associated with increased longevity. In contrast, the more narrowly construed “payer perspective” does not include patient out-of-pocket costs because they are not borne by payers.

The Second Panel’s recommended societal perspective is very broad, adding time costs and effects on future productivity and consumption as well as relevant non-health-related impacts in other sectors, such as education and criminal justice. The panel recommended an “Impact Inventory” (reproduced here in Fig. 1), a structured table or checklist listing an intervention’s health-related and non-health-related effects, as a way of communicating to audiences the components included in a CEA and whether and how they were valued [9].
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