Health policy

Value is in the eye of the beholder

The budget holder and systems for evaluation

Who pays for healthcare and how they pay are critical questions when presenting evidence of product value to any healthcare system. The answer can be diverse, complex and sometimes obscure. Even within a single healthcare system differences can emerge depending on the supply chain (retail or hospital use) or product class (vaccines versus oral pharmaceuticals versus intravenous forms).

Understanding who is at the centre of decision making and shaping the economic argument to meet their needs is critical. But achieving a well-rounded view of value may require a different perspective on some commonly held truths and targets.

In this era of value based assessment, valuation and perception of value is largely in the eye of the budget holder.

Willingness to pay and budgetary limitations

In the prevailing environment of high cost containment and shrinking real-terms budgets, the incremental value that new medicines bring to individual patients, patient subgroups and to society is a critical determinant in what new medicines receive funding.

The cost effectiveness and associated evaluation of new medicines relies on their perceived value – a tacit or explicit understanding of society's "willingness to pay", frequently expressed as the value of the incremental cost effectiveness ratio (ICER) below which interventions are considered cost effective. This manifests itself as willingness to pay thresholds – such as the magical £20,000-£30,000 per quality-adjusted life year (QALY) – which can themselves be both arbitrary and set a false hurdle for the pricing of new medicines.

In addition to the general concept of the threshold, value based assessments have taken alternative approaches to expanding the concept but largely rely on the application of modifiers to the willingness to pay threshold, for example end of life criteria applied to certain diseases by NICE, on the inclusion of wider benefits within cost effectiveness modelling, for example the addition of

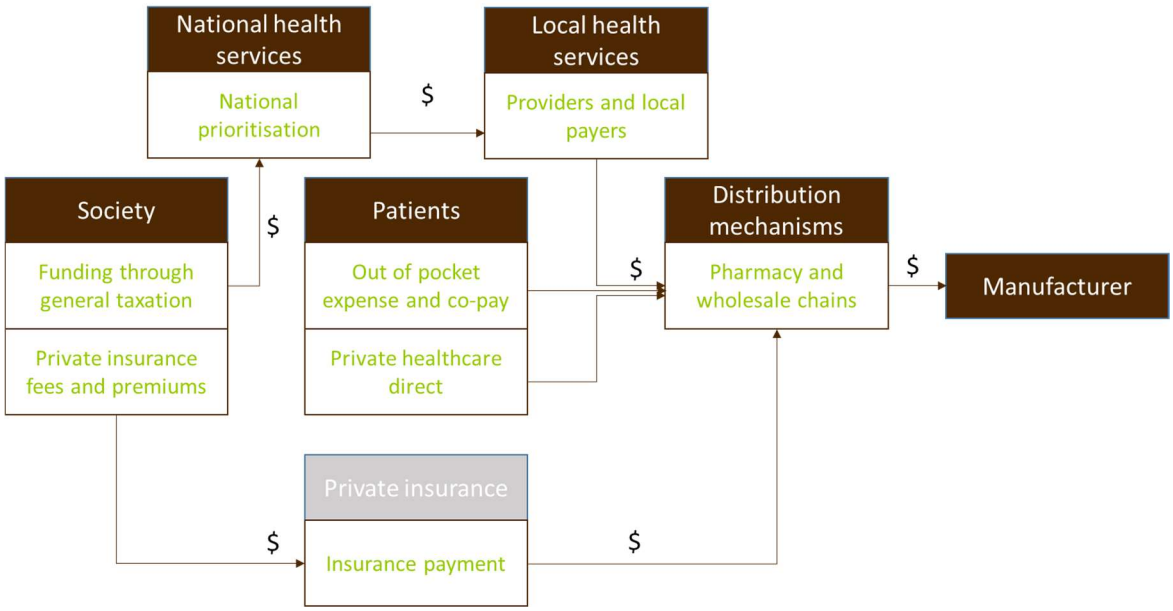
productivity and out of pocket costs in the Netherlands, or on more complex multi-criteria decision analysis which allows a much wider assessment of products but is seldom implemented.

These approaches may, however, hide a complexity around true willingness to pay as well as its ability to realise putative benefits. To get a complete picture of perceived value, policy makers need to understand the source of value and the differential perceptions of value according to where the value is accrued and how it is paid for.

Who is willing to pay?

The concept of willingness to pay in a standard consumer model is relatively straightforward. In any transaction there is a vendor who has a willingness to accept an offer and a purchaser who has a willingness to pay. If these two overlap, then a transaction can be successfully completed to the satisfaction of both parties.

Healthcare funding and the multiple decision makers involved creates a complexity in which a true concept of willingness to pay can be confusing at best. Envisage the general situation for healthcare:



Even in this overly simplistic representation of a national healthcare system the interests of various players are noticeable and may conflict. Society, health services and patients are all payers and may have different willingness to pay depending on context and the point of value of the intervention.

Distributive funding and general taxation

Perhaps the best understood and most widely accepted sources of value are those that directly impact the public purse and contribute to reductions in, or at least more efficient use of, distributive funding (through general taxation).

While true public willingness to pay is poorly understood – even in this commonly applied setting – the concept of effective rationing of healthcare based on the available budget is well accepted and the use of comparable thresholds is commonly employed.

All elements of value relating to general taxation such as direct healthcare costs, social care costs and benefits tend to have high societal benefit and well established (if sometimes arbitrary) thresholds for willingness to pay.

Take one step below, however, to regional and local budget holders, and the sources of value become caught between a broad and national understanding of value and that of regional or local prioritisation and affordability.

Patient payments and out-of-pocket costs

In addition to sources of value that can be directly attributed to savings or more efficient use of tax, many interventions can have true impact on costs borne by patients and their carers. Such elements of personal value and costs that are paid for from the pocket of the patient and/or carers, such as travel costs can accrue when interventions shift the practical application of care.

For instance, a highly tolerable oral agent which enters to replace an intravenous infusion both can free up healthcare resources but also have direct and tangible impact on patients in terms of need to travel to hospital.

These costs and changes tend to have immediate and disproportionate impact on the patient and be subject to differential willingness to pay within wider society.

Productivity and wider societal benefit

The introduction of new and more effective therapies can also benefit individual patients, employers and wider society through the enhancement of patient engagement in the workplace.

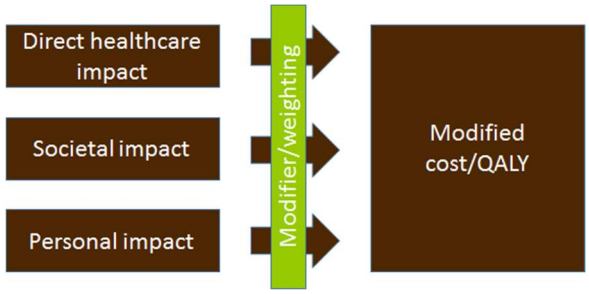
These costs and benefits may be difficult to realise fully and can be offset by other effects. In addition, lost educational and employment opportunities are difficult to value – particularly in systems without full employment.

Balancing different perspectives and sources of value

Most commonly economic models conflate sources of value into a single entity – the cost per QALY or a similar metric. While this brings some clarity and simple comparability to model outcomes, it

can hide a complexity and the different perceptions of value from different sources. This can lead to a potential overvaluing of a new medicine.

In contrast, the most common reaction of payers is simply to disregard all elements of value that do not comfortably sit within the direct healthcare budget – either since they have no responsibility for the wider benefits or because they distrust estimates of gain. This leads to an obvious underestimation in benefit and value.



An over-simplistic single threshold approach that values all sources of benefit equally may be inappropriate – undervaluing the impact of innovative medicines or being criticised for capturing broader societal benefits that are difficult to realise.

If we are to truly represent the value of benefits brought by new products, then our modelling and communication of these needs to begin with the perspective of all beholders, not just that of the decision making budget holder.

A modifier could be used for differential value of benefits and a scale of willingness to pay and should be accommodated in new product evaluation to capture these complex issues.

An approach that partitions benefit and considers each partition holistically and within context may come closer to truly describing and validating new product value

Conclusion

Assessment of new products needs to fully capture, while not overestimating, the value they bring to patients, carers and society and measures of willingness to pay need to fully account for sources of funding and type of benefit accrued. While multi-criteria decision making allows for a wider assessment of products, an optimal position requires multi-stakeholder multi-criteria decision making.

A clear methodological framework that allows the differentiation of benefit and cost by source of impact and cost is needed to allow for these differences and further research to establish alternative weightings and to validate a wider use of the findings in economic models is warranted.

Value based assessment is of clear advantage to societies and to all stakeholders involved in the process of deliberation on pharmaceutical pricing, reimbursement and access but careful weighting of benefits is needed together with a full understanding of societal benefit.

Author:
Eddie Gibson
Associate, Wickenstones
WICKENSTONES:
TEL: +44 (0) 7795 166 043
EMAIL: Wickenstones@wickenstones.com
WWW.WICKENSTONES.COM