

Defining Appropriate Benefits for Economic Evaluation of Health Care Technologies: A Plain Language Summary

Why This Matters

When a new treatment, drug, or medical device becomes available, Health Technology Assessment (HTA) organizations need to make recommendations about whether the health system should pay for it, and if so, how much should be paid. These recommendations directly impact the availability of treatment and how much some patients will have to pay out of pocket.

The Question We Asked

HTA organizations have traditionally evaluated new treatments by looking at two main factors:

1. **Health benefits** - Will you live longer and/or have a better quality of life?
2. **Healthcare costs** - What does it cost the health system for doctor visits, hospital stays, and medications?

But many have asked: shouldn't there be more to the story? What about other factors such as:

- The burden on your family and caregivers
- Whether a treatment helps reduce health inequalities
- The peace of mind from getting a diagnosis
- The severity of the condition

An independent expert working group of international health economists convened by the Institute for Clinical and Economic Review (ICER) in the US, Canada's Drug Agency (CDA-AMC), and the National Institute for Health and Care Excellence (NICE) in England explored whether these factors should influence HTA evaluations. For this report, the group focused on **health benefits**; healthcare costs will be considered in a future report.

How We Approached This

The working group created three key tests that any additional factor must pass:

1. **Relevance** - Does this factor align with what HTA organizations are responsible for considering?
2. **Measurability** - Can this factor be measured appropriately and consistently across different treatments and conditions?
3. **"Opportunity costs"** - When HTA organizations evaluate a new treatment, they're not just asking "Does this help patients?" They're asking, "Does this help patients *more* than all the other ways we could spend this money?" For example, when evaluating whether a treatment improves health equity, you must consider both sides: does this new treatment help underserved communities more than the treatments other communities would have to go without to afford it?

What We Found

The group examined four types of factors that are often mentioned:

1. Comfort with Risk

Some patients are willing to try treatments with uncertain outcomes if there's potential for significant benefit. Others prefer more established options with predictable results.

Our conclusion: If preferences relating to risk are to be considered, we don't yet have enough reliable research on how to reflect public preferences in coverage and funding decisions. More research is needed before this can be included in HTA evaluations.

2. The Value of Information and Care Quality

This includes benefits like:

- Peace of mind from knowing the diagnosis
- The quality of the care experience itself

Our conclusion: If these other factors are to be considered, some aspect of these benefits may already be captured in traditional evaluations. For example, if a diagnostic test leads to better treatment *and* improved health, that health improvement is already counted. We need to avoid counting the same benefit twice.

3. Fairness and Health Equity

Should treatments that help disadvantaged or underserved communities receive special consideration in coverage decisions?

Our conclusion: This is possible, but only with clear guidelines:

- A transparent definition of which populations qualify
- Consistent application across all treatments and conditions
- Open communication about how much weight is given to equity concerns

4. The Burden on Patients, Their Families, and the Wider Economy

Should coverage decisions consider:

- Time missed from work or school
- Financial strain and other effects on the household
- Impact on productivity in the wider economy

Our conclusion: Including these factors could shift priorities in ways that help some patient groups more than others. For example, it might favor working-age patients over retirees or children. Before including these factors, HTA organizations need:

- Clear evidence about these trade-offs
- Input from patients and the public about whether these shifts are acceptable
- Consistent application across all treatments

Bottom Line

Additional factors should only be included in economic evaluations for HTA when:

- They clearly fit within what HTA organizations are responsible for
- They can be measured appropriately and consistently
- They are applied to both new treatments and existing alternatives

This ensures the process of making decisions remains fair, transparent, and consistent.

What This Means

Understanding this framework helps you:

- Know what factors currently influence economic evaluations for HTA
- Understand why some factors aren't yet included in economic evaluations for HTA
- Ask informed questions about how decisions are made

If You're Advocating for Change

If you believe coverage decisions should consider additional factors, this framework shows what needs to happen:

- Demonstrate that the factor can be measured reliably
- Show that it can be applied consistently across all types of patients
- Build evidence that including this factor reflects public values
- Consider how it might affect other groups

Moving Forward

Deciding to adopt a new health technology involves difficult trade-offs. Health systems have limited resources, so saying yes to one treatment can mean saying no to another (even though the link between the two may not be obvious). This framework helps ensure those decisions are made as fairly, transparently, and consistently as possible.

This summary is based on work by the Health Economics Methods Advisory (HEMA), which was convened by ICER (US), CDA-AMC (Canada), and NICE (England). More information: <https://hemamethods.org/>

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