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 treatments 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** - Does this treatment help you live longer and/or improve your quality of life?
2. **Health care costs** - How much 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 ways to evaluate a new treatment, such as:

- The impact on your family and caregivers
- The health risks you might face, depending on how severe your condition is
- Whether a treatment helps reduce health inequalities between different communities
- The peace of mind from getting a diagnosis

An independent group of experts from the United States, Canada and England examined whether benefits like these should influence HTA evaluations. For this paper, the group focused on **health benefits.**

How We Approached This

The group of experts created three key tests that any additional benefit must pass:

1. **Relevance** - Does this benefit align with what HTA organizations are responsible for considering in their evaluations?
2. **Measurability** - Can this benefit be measured clearly and used the same way across different treatments and conditions?
3. **"Opportunity costs"** - Health care budgets are limited. 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, they must consider both sides: does the money spent on the new treatment help underserved communities more than if that money went to treatments other communities might be helped by?

What We Found

One of the most important conclusions of the report was that the **health benefits** of treatments should be considered regardless of who receives them (i.e., the patient, caregiver, family member, or all of these). While there are clear ways to measure these benefits for patients, today there are challenges in getting the necessary information and measuring these benefits for caregivers, family members, and others.

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

1. Comfort with Risk

Some people are willing to try newer treatments even if the results are uncertain. Others prefer more established options with predictable results.

Our conclusion: We don't yet have enough reliable research on how to reflect people's preferences and comfort with risk in coverage and funding decisions. More research is needed before this can be included in HTA evaluations.

2. The Value of Knowing and Care Quality

This includes benefits like:

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

Our conclusion: Some of these benefits may already be included in current evaluation methods. For example, if a diagnostic test leads to better treatment *and* improved health, that health improvement is already counted. We should avoid counting the same benefit twice when doing evaluations to make sure that the results are as accurate as possible.

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:

- Clear explanation of which populations qualify
- Consistent way of doing this across all treatments and conditions

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

Should coverage decisions consider:

- Time missed from work or school
- Broader effects on work and the economy

Our conclusion: Unintentionally, including these benefits could shift the results of an HTA evaluation in ways that seem to help some patient groups more than others. For example, it might favor working-age patients over retirees or children. So, before an HTA organization includes these in their evaluations, they need:

- Clear evidence about these trade-offs
- Input from the public about whether these shifts are acceptable
- A way to do this consistently across all treatments

Bottom Line

Additional **health benefits** should only be included in economic evaluations for HTA when:

- They clearly fit within what HTA organizations are responsible for (for example, making recommendations for covering new treatments)
- They can be measured appropriately and consistently (for example, there is a clear way to measure a caregiver's time missed from work for any disease or condition)
- They are applied to both new and existing treatments

This ensures the process of evaluating treatments remains fair, transparent, and consistent.

What This Means

Understanding this framework helps you:

- Know what **health benefits** currently influence economic evaluations for HTA
- Understand why some proposed factors aren't currently included in economic evaluations for HTA

If You're Advocating for Change

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

- Demonstrate that the benefit can be measured reliably
- Show that it can be applied the same way across all patients
- Do research and provide decision-makers with evidence that this benefit reflects what's important to the public (for example, measuring a caregiver's time missed from work)

Moving Forward

Deciding to adopt a new treatment 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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