

Evaluation of Health Care Projects

EE 474 Health Economics
Semester 1/2012

Topics

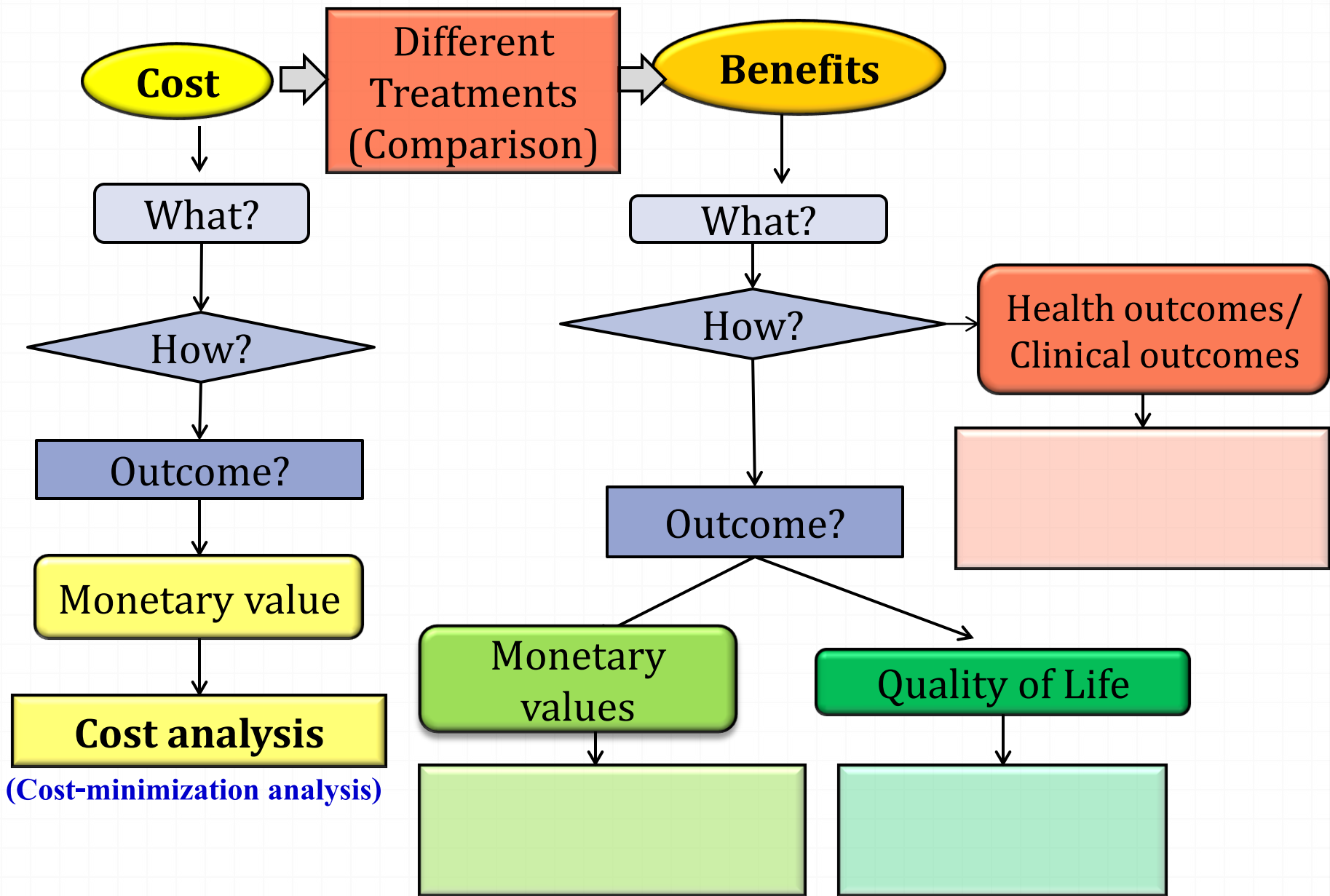
- Overview of Economic Evaluation
- Cost-Benefit Analysis
- Cost-Effectiveness Analysis
- Cost-Utility Analysis

Health Economic Evaluation

- Cost-benefit analysis (CBA) is the general term for *economic evaluations* of new projects or intervention.
- CBA is based on the concept of **allocative efficiency**; it seeks to **determine the optimal quantity by comparing incremental costs and incremental benefits**.
- 3 commonly used tools for economic evaluation in health care:
 - Cost-benefit analysis (CBA)
 - Cost-effectiveness analysis (CEA)
 - Cost-utility analysis (CUA)

Overview of Economic Evaluation

		Outcomes			
		Consider either cost or benefit		Consider both cost and benefit	
		Consider cost	Consider benefit		
Compare among alternatives	No	Cost description	Outcome description	Cost-outcome description	Partial evaluation
	Yes	Cost analysis	Efficacy, Effectiveness analysis	Efficiency evaluation	Partial evaluation



Different Types of Economic Evaluation

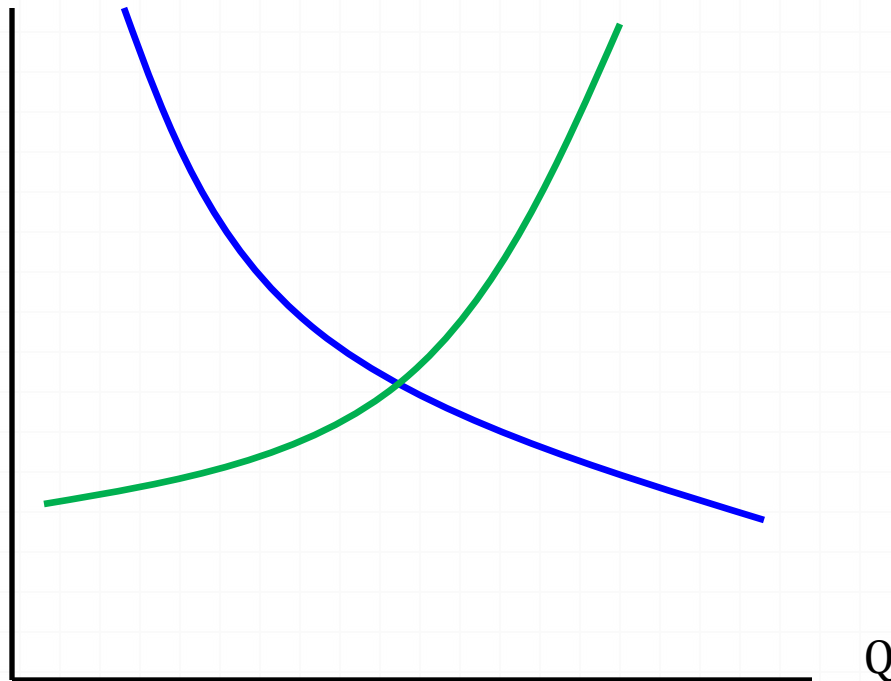
	Nominator (Cost)	Denominator (Benefit)
Cost-minimization	\$	-
Cost-benefit	\$	\$
Cost-effectiveness	\$	Health outcome in natural units (e.g. life-years gained, disability-days saved, points of blood pressure reduction, etc.)
Cost-utility	\$	Healthy years (e.g. QALY, DALY)

1. Cost-Benefit Analysis

- CBA is based on the idea that a project or policy will improve social welfare if its benefits exceed the costs.
- The benefits and costs that are counted must include not only direct benefits or costs of the project but also any indirect benefits or costs through externalities or other third-party effects.
- Let B represents all the benefits and C represents all the costs.
 - A project is worthwhile if

Marginal Analysis in CBA

MB, MC



Cost Measurement

- Costs are measured as **opportunity costs**.
 - Cost of the project itself.
 - Forgone costs associated with implementing the project.
- For **public investment**, the opportunity costs are difficult to measure because there is **no market to serve as a guide for pricing**.
 - Example: The costs of building a dam include the construction cost and the costs incurred from its negative impacts on animal habitat or historical landmark under water.
- Also, public investments may have **side effects** that create additional measurement difficulties.
 - Example: Immunization program, pollution abatement programs, etc.

Benefits: Valuing Human Life

- o To **monetize the benefits** of a project or a treatment, one needs to place a value on human life.
- 1. The **human capital** approach:
 - o Estimates the **present value of an individual's future earnings**.
 - o Example: If a treatment can extend Mr. A's life for 1 year and Mr. A's potential salary is \$5,000 per month, the value of that treatment equals to the expected income Mr. A could earn during that extra year.

Benefits: Valuing Human Life

2. The **willingness to pay** or **willingness to accept** approach:
 - o Measures **what individuals are willing to pay (accept) to avoid (accept) additional risk** to life and limb.
 - o Example: Suppose people in the society are willing to pay \$10 to buy air cleaner that reduces the probability of death to 0.01%
 -
3. The **contingent valuation** approach:
 - o Elicits individuals valuation of alternative contingent risks.
 - o Example: If you face a 10% risk of heart attack, how much would you be willing to pay for a treatment that reduces the risk to 5%?

How Much Is One Life Worth?

Meta analysis of wage based studies	Years covered by the studies	Value of Life in 2009 dollars
Miller (2009)	1974–1990	5.2 million
Mrozek & Taylor 2002	1974–1995	2.0 to 3.3 million
Viscusi & Aldy (2003)	1974–2000	6.9 to 9.5 million
Kochi et al (2006)	1974–2002	11.1 million
Meta analysis of stated preference studies	Years covered by the studies	Value of life in 2009 dollars
Kochi et. al. (2006)	1988–2002	3.5 million
Dekker et al. (2011)	1983–2008	2.7 to 8.5 million
Lindhjem et al. (2010)	1973–2008	3.2 million

Note: These data are from Maureen Cropper, James K. Hammit, and Lisa A. Robinson, (2011), “Valuing Mortality Risk Reductions: Progress and Challenges,” Discussion Paper, Washington, DC: *Resources for the Future*.

Discounting

- Because benefits or costs that occur in the future are not equivalent to benefits or costs that occur today, the future benefits and costs must be discounted.
- Reasons for discounting:
 - A dollar today has opportunities other than the project of study.
 - People have a tendency to prefer the present when allocating spending.
- Present value of net benefits:

Other Issues in CBA

o Risk adjustment:

- o Due to differences in riskiness across projects, it is important that benefits and costs be discounted at a rate that accounts for the riskiness of the project being evaluated.

o Distributional adjustment:

- o when benefits are disproportionately distributed across the population, adjustments may need to be made in the analysis.

o Inflation:

- o Inflation can be accounted for by introducing an inflation factor into the discount rate used in the analysis.

Ex: Estimated Benefits and Cost for the Vaccination of College Students against Meningococcal Disease (m\$)

2 scenarios:

1. Students contract the disease at 2 times the national average rate.
2. Students contract the disease at 15 times the national average rate.

	Baseline x 2	Baseline x 15
Cost of the vaccination program	\$56.2	\$56.2
Total benefits	9.3	63.8
Direct medical benefits	0.5	3.1
Indirect benefits – value of lives saved	8.8	60.7
Net Benefits (Benefits – Cost)		

Source: Jackson et al. (1995). Cited in Santerre and Neun (2007)

Costs and Benefits of Medical Technology for a Lifetime

Time after MI	Revascularization		High Volume Hospital	
	Survival	Spending	Survival	Spending
1 Year	0.061	\$ 30,149	-0.009	\$ 4,065
2 Years	-0.029	\$ 27,339	-0.005	\$ 5,300
3 Years	-0.067	\$ 25,919	-0.004	\$ 5,993
4 Years	-0.043	\$ 26,820	-0.001	\$ 6,560
5 Years	-0.106	\$ 27,517	-0.005	\$ 7,296
6 Years	-0.119	\$ 29,662	-0.005	\$ 7,659
7 Years	-0.119	\$ 31,090	-0.005	\$ 7,953
8 Years	-0.108	\$ 32,919	-0.004	\$ 7,982
9 Years	-0.111	\$ 36,961	-0.006	\$ 8,087
10 Years	-0.119	\$ 38,028	-0.007	\$ 8,314
11 Years	-0.113	\$ 38,191	-0.006	\$ 8,532
12 Years	-0.120	\$ 40,804	-0.009	\$ 9,002
13 Years	-0.074	\$ 38,079	-0.006	\$ 9,161
14 Years	-0.064	\$ 38,708	-0.005	\$ 9,671
15 Years	-0.047	\$ 36,758	-0.005	\$ 9,524
16 Years	-0.041	\$ 37,200	-0.006	\$ 9,599
17 Years	-0.051	\$ 37,990	-0.007	\$ 9,770

Note: High Volume Hospitals are defined as hospitals that admit 75 or more heart attack patients in a year; these serve as comparisons and they are assumed to be high-quality hospitals in terms of heart care. High-quality hospitals do not necessarily have revascularization capability. "Survival" measures change in the risk of death compared to the hospitals that have neither high volume (quality) nor revascularization capability.

Source: Cutler, David, The lifetime costs and benefits of medical technology, *Journal of Health Economics*, 26 (2007), 1081-1100; data from his Table 5, p. 1094, with permission. Copyright © 2007 published by Elsevier B.V.

CBA: Pros & Cons

o Pros

- o Easy to compare the costs of a project with the benefits, because both are in monetary terms.
- o When there are diverse benefits, these benefits can be aggregated into one value.

o Cons

- o Must attach monetary values to health benefits or human life, which is not easy to do.

2. Cost-Effectiveness Analysis (CEA)

- CEA applies to problems where the goal is accepted at the start, and the problem is only to find the **best, most efficient, means** to achieve it.
- CEA compares the costs of achieving a particular **nonmonetary benefits**, including **health outcomes** or **clinical outcomes**.
- These benefits are measured in terms of '**natural units**', such as:
 - Decrease in the number of days being ill
 - Number of lives saved
 - Number of life expectancy
 - Clinical outcomes:

CEA Measurement

- Let the change in **social costs incurred** due to a particular project be $C_1 - C_0$, and let the **gain in health output** be $E_1 - E_0$.
 - C_0 and E_0 can be the cost and effectiveness of the original treatment, which could be **no health intervention**.
- Then the various projects are compared by the **incremental cost-effectiveness ratio (ICER)**:

○

CEA: Example

- Suppose there are two drugs to reduce LDL-cholesterol:
 - Drug A reduces 5 mg/dl of LDL cholesterol, and costs \$0.4/pill.
 - Drug B reduces 8 mg/dl of LDL cholesterol, and costs \$1/pill.
- Assume that there is *no previous treatment*. Which drug should be prescribed?

○ $ICER_A =$



○ $ICER_B =$



○

Use of CEA under Budget Constraints

Project	Cost (\$)	# Life Years Saved	Cost-effectiveness Ratio (\$/Life years saved)
A	1,000,000	80	12500
B	1,250,000	125	10000
C	2,500,000	125	20000
D	1,750,000	100	17500
E	1,950,000	100	19500

Question Suppose that the budget is fixed at \$4,000,000. Which project(s) should the policy maker choose to invest?

CEA: Another Example

- Suppose there are 2 alternative treatments: A and B
- Treatment A extends life expectancy by 3 years, compared with doing nothing, and treatment B extends it by 5 years.
- Treatment A costs \$20,000 and B costs \$50,000.
- Which one should be used?
 - $ICER = (C_B - C_A) / (E_B - E_A)$
 - ICER =
 - ICER =
 - If the value of a life expectancy is greater than, the use treatment B instead of treatment A.

CEA: Pros & Cons

○ Pros:

- CEA can be a useful first step toward undertaking a cost-benefit study. If the project is not cost-effective, it is unlikely that a CBA will be feasible.
- No need to convert health outcomes into monetary values.

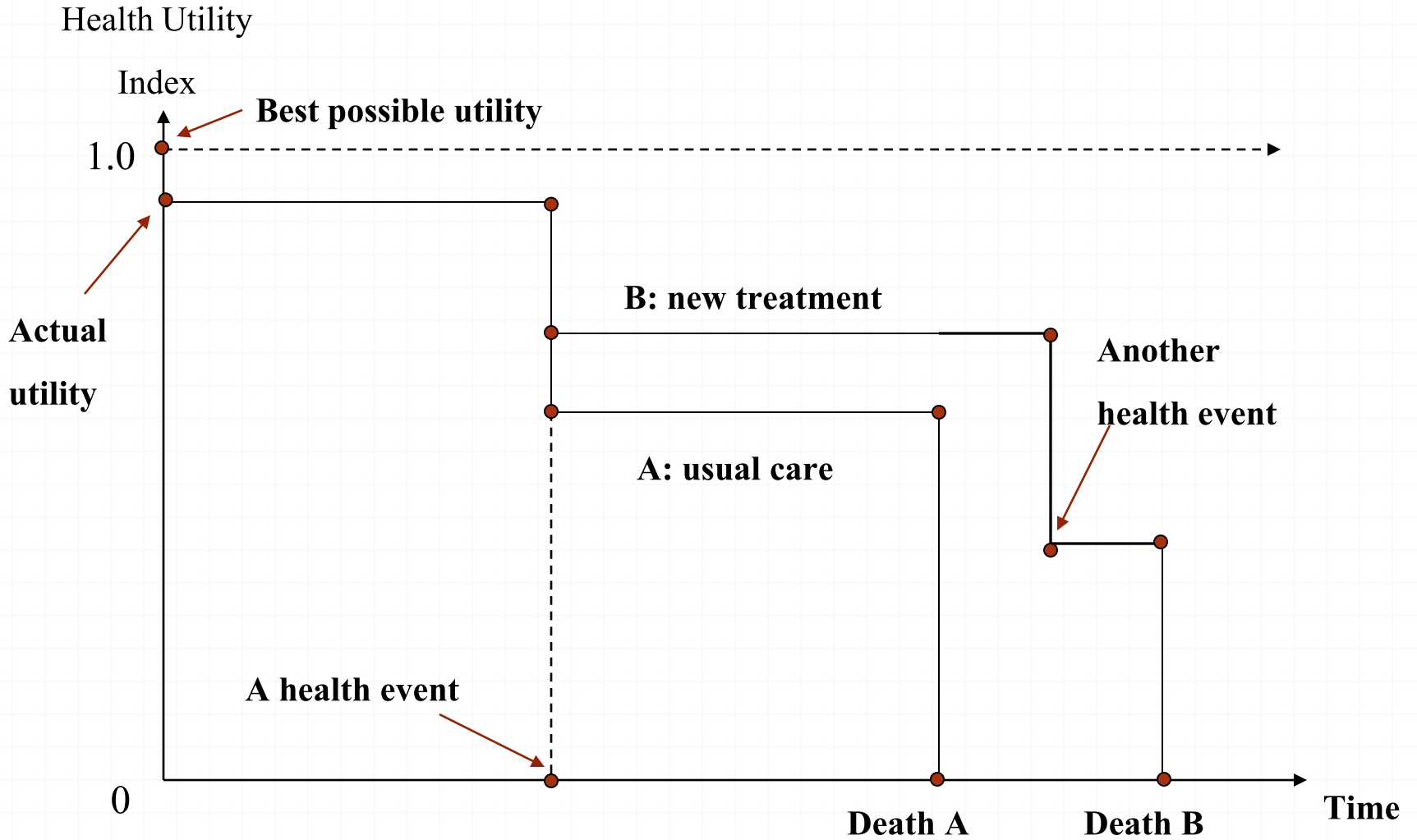
○ Cons:

- Effectiveness often has many dimensions.
- ICER is a relative information, not absolute.

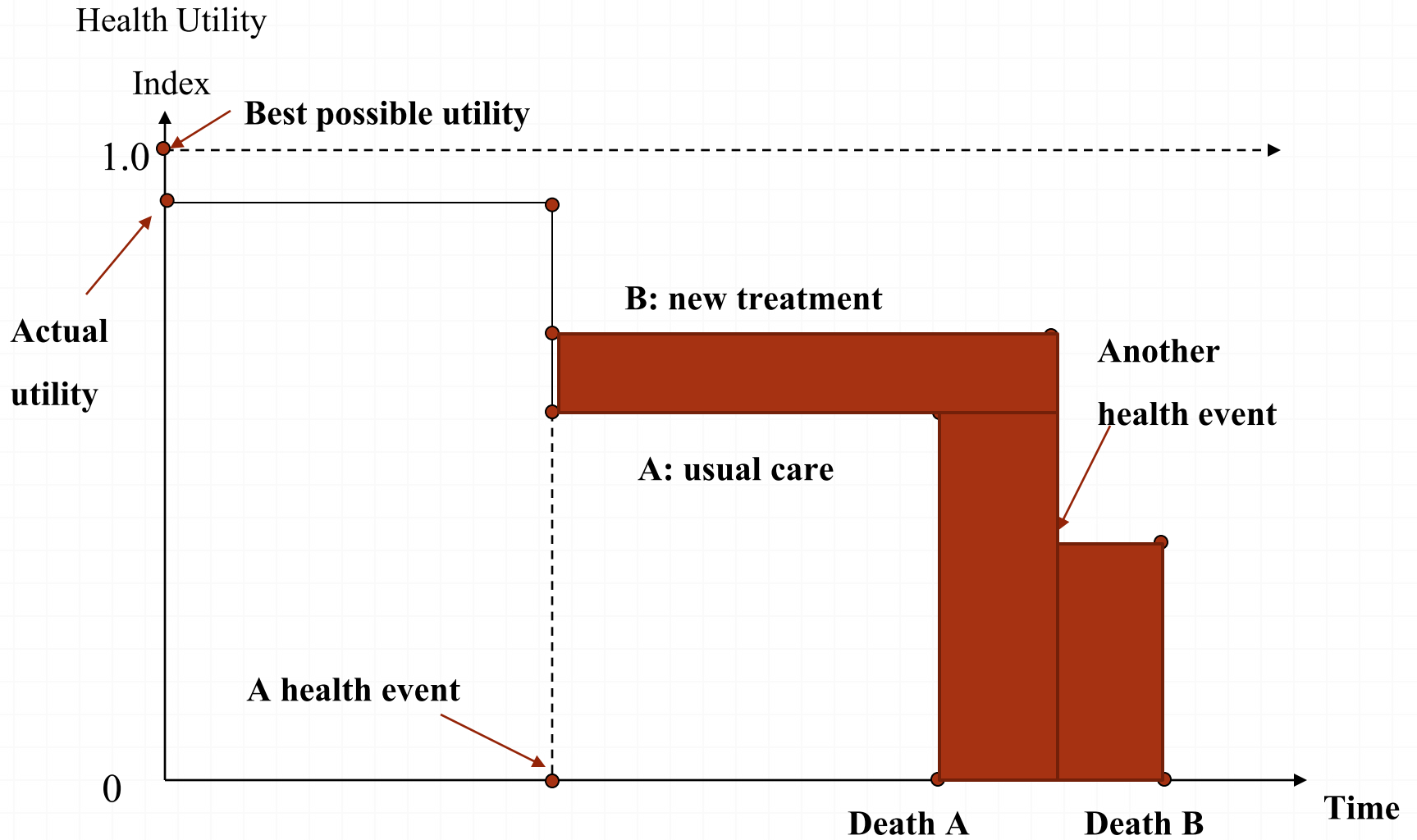
3. Cost-Utility Analysis (CUA)

- CUA is a special form of CEA, but the effectiveness is measured in terms of **quality-adjusted life years (QALY)**.
- QALYs measure the **aggregate effect of an intervention on health by combining its effects on mortality** (the number of years of life) **and morbidity** (the quality of life in each year of life).
- **Quality of life** is measured on a **0 to 1 scale**, with 1=perfect health and 0=death.
- Example:
 - Suppose an ill person's quality of life is equal to 0.5 and a healthy person's is equal to 1.0.
 - A person who lives an extra 5 years in a healthy state and extra 5 years ill would have a gain of

QALY Profile



QALY Profile



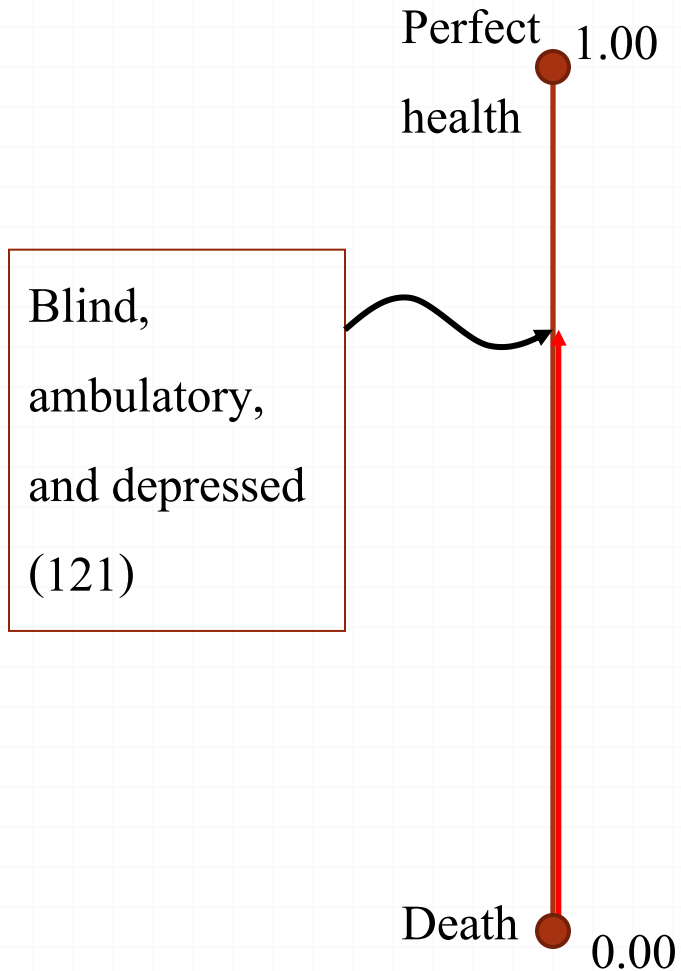
How to Determine Quality of Life Weight?

- Specify **health dimensions** that you think are important.
- Specify **health state** of each health dimension

Example:

- Sighted (2) vs. Blind (1)
 - Ambulatory (2) vs. Wheel Chair (1)
 - Good mental health (2) vs. Depressed (1)
-
- For each health state, determine **quality of life (QOL) weights**. Three methods are:
 1. Visual Analogue Scale (Rating Scale)
 2. Standard Gamble
 3. Time Trade-Off

Visual Analogue Scale

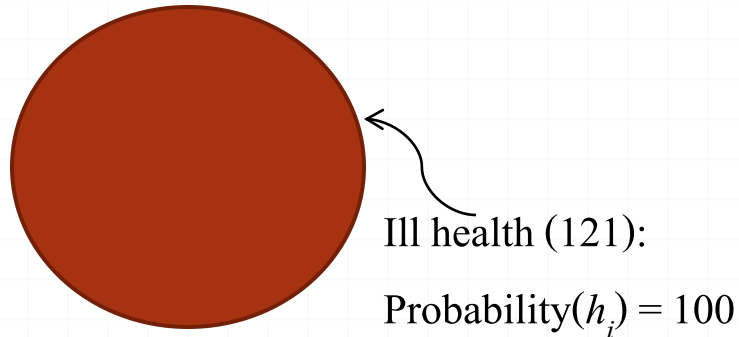


- Respondent is asked to draw a line on a visual analogue scale to represent the health state, where the value is between 0 and 1.
- The distance from 0.00 to that point is the QOL.

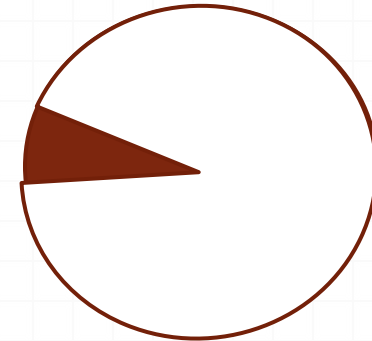
○

Standard Gamble

Option 1 (Do nothing)

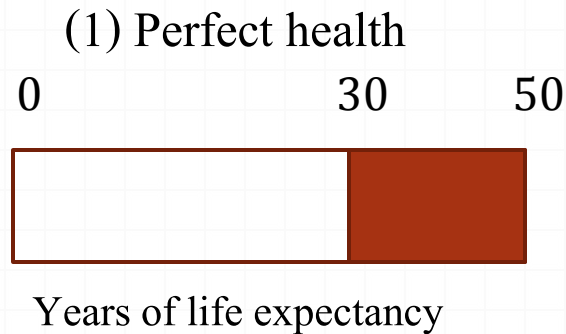


Option 2 (Treatment)

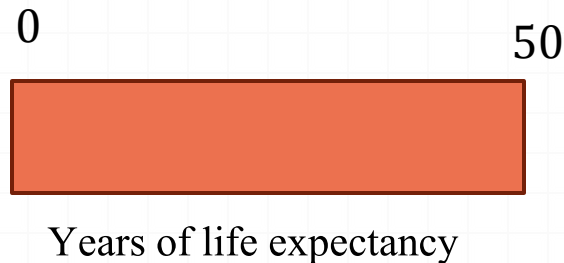


- o Respondent is asked: “There is a treatment that has a **P chance of painless death**, but a **(1-P) chance of total cure to perfect health**. What is the largest **P** that you would accept to try this treatment?”
- o If the health state 121 is really bad, you might have said 0.4 is the largest chance of death that would tolerate.
-
- o The quality of life weight =

Time Trade-Off



(2) Blind, ambulatory, &
depressed



Suppose there are two alternatives:

1. X years of life expectancy with perfect health
2. Y years of life expectancy with ill health (e.g. health state 121), where $Y > X$

Ask: How many years (X years) of best possible health would be equivalent to Y years in health state 121?



Ex:
QOL for health state 121 =

CUA Measurement

- Once the weights (q) are agreed upon and the QALYs are acceptably calibrated, then the measure becomes:

$$QALY = \sum_{t=1}^{t=T} \frac{F_i q_i}{(1+d)^t}$$

where F_i is the probability that the person is still alive at age i ; d is the time discount factor; and the value q_i is the quality weight

- Example: A treatment can extend life by one year with Prob of 0.9 and by two years with Prob of 0.5. The patient will die within two years, and $q_1 = 0.8$ and $q_2 = 0.6$. ($d = 5\%$)
 - QALY =
- Projects are evaluated on the basis of their **incremental costs per extra QALY** delivered to the patients or other subjects (Garber and Phelps, 1997; Ried, 1998).

Cost-Utility Ratio

- **Costs per QALY** (Cost-utility ratio) can be used to compare alternative intervention.
- This cost-utility ratio is one type of ICER, except that the denominator is QALY.
- The project or intervention with lower costs per QALY are preferred.

Example: League Table

Health Project	Cost per QALY gained (£)
1. GP advice to stop smoking	170
2. Pacemaker in heart block	700
3. Hip replacement	750
4. GP control of total serum cholesterol	1,700
5. Kidney transplantation	3,000
6. Breast cancer screening	3,500
7. Heart transplantation	5,000
8. Hospital haemodialysis	14,000

**Total Budget
= £5,000**

Compare CEA and CUA

Treatment option	Cost	Life-years gained	QOL	QALY
Current procedure	\$20,000	2 years	0.7	1.4
New procedure	\$110,000	8 years	0.4	3.2

Source: Santerre & Neun (2007)

CEA: ICER = per life years gained.

CUA: ICER = per QALY gained.

CUA: Pros & Cons

○ Pros:

- Provides another technique for judging public projects.
 - Can compare many diverse interventions
- Consider capabilities in terms of health and function when evaluating alternative treatments.

○ Cons:

- Like CEA, CUA is based on a relative information.
- QALYs tend to place a reduced value on older or handicapped people when evaluating a medical intervention.
- The method's linear valuation of medical interventions (the simple sum of quality gains times life-years saved times the number of people treated) is questionable.

Comparison of Economic Evaluation Tools

Tools	Outcomes	Evaluation
1. Cost-minimization analysis	Assume the exact same outcome.	Evaluate in terms of costs only .
2. Cost-effectiveness analysis	Require outcomes to be one type and be in the same unit.	Evaluate in terms of (i.e. clinical outcomes or health outcomes)
3. Cost-benefit analysis	Outcomes need not be the same.	Evaluate in terms of (monetary values)
4. Cost-utility analysis		Evaluate in terms of