Author has nothing to disclose with regard to commercial support.

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should: • Include no more than 500 words of text, three authors, and five references. • Type with double-spacing. • See http://jtcvs.ctsnetjournals.org/misc/ifora.shtml for detailed submission instructions. • Submit the letter electronically via jtcvs.editorialmanager.com. Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity of offering a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.

Challenges to Make Cost-Efficiency Studies Usable by Decision Makers

To the Editor:

I read with interest the editorial by Butterworth and Cassano1 and second most of their statements about cost-effectiveness analysis (CEA), especially with respect to the need to perform rigorous analyses with appropriate choices of comparators and outcomes. This is all the more important because these choices may bias the results and mislead decision making in health care in a context of hard budget constraints. This is well recognized by health economists and is a major point in various methodologic handbooks.2,3 In their enthusiasm to advocate this point, however, Butterworth and Cassano1 provide a list of references of questionable pertinence. Notably, the study by Poder and colleagues4 comparing drug-eluting stents with bare-metal stents for percutaneous coronary intervention is not especially pertinent where it is cited. Indeed, these devices are used for the same disease and the same type of revascularization. A more judicious use of this reference might have been to bolster the point made by Butterworth and Cassano1 regarding the need to redo CEA when a change occurs in the efficacy of the device or drug or in its associated costs. This was in fact the case in this study between patients who may have specific needs. This question should not either preclude the questioning of equity between patients who may have specific needs. This question has been largely debated10,11 and has led national agencies such as the National Institute for Health and Care Excellence in the United Kingdom or the Haute Autorité de Santé in France to consider not a fixed threshold but a range of costs per QALY life year, which can vary according to the category of disease. As an example, the National Institute for Health and Care Excellence considers a threshold for cost per QALY life year in a range of £20,000 to £30,000 for most diseases, whereas this range can go as high as £50,000 for end-of-life technologies and cancer and even as high as £300,000 for very rare diseases.12,13 Different thresholds are thus necessary to consider specific needs, but they should be strictly framed to avoid subjective decisions and reflect what is fair and reasonable in a society.

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References
Reply to the Editor:

Butterworth and Cassano1 highlight the importance of context and perspective when interpreting a cost-effectiveness analysis (CEA). The authors endorse a patient’s perspective when questioning whether all patients would place the same value on a gain in quality-adjusted life years (QALYs). We agree that patients would, undoubtedly, place different values on treatments and outcomes and, certainly, should not be prevented from paying for such interventions. Individualized CEA explores this perspective and the different conclusions it can lead to relative to population decision making. Because formal CEA are traditionally conducted from the perspective of society or the health care system, QALYs reflect community preferences for health states rather than individual patient preferences. However, the debate over community-based versus patient preferences in CEA continues.1

Similarly, the amount paid for a 1 QALY (ie, the willingness to pay [WTP]) will vary across individuals, but an estimate of the societal WTP is what is used in formal CEA. When considering the generalizability and value of CEA, we agree with Poder’s assessment2 of the risks associated with paying more for an equal number of QALYs gained in some contexts than in others. The value of a consistent standard is that interventions can be fairly compared based on normalized cost and effectiveness values.1 However, it has been suggested that a gain in QALYs is actually more highly valued for children, severely ill patients, disabled individuals, and those at the end of life.3,4 In the United States, there is no well-established WTP threshold and formal CEA have used estimates between $50,000 and $200,000 per QALY (Figure 1). This lack of a standard may be in part due to legislation prohibiting CEA in public payer health care decisions regarding treatment approval.5,6 The US Medicare program does utilize CEA when deciding on reimbursement for several preventive health care services.5

FIGURE 1. The intervention’s ICER should meet a specific WTP threshold.

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