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REFERENCES

1. O'Malley SP, Jordan E. Horizon scanning of new and emerging medical technology in Australia: Its relevance to Medical Services Advisory Committee health technology assessments and public funding. *Int J Technol Assess Health Care*. 2009;25:374–382.
2. Kearney B. The Horizon Scanning Network. Emerging Technology Bulletin. Issue 1, January 2007. <http://www.horizon-scanning.gov.au/internet/horizon/publishing.nsf/Content/anzhs-newsletter-1> (accessed August 1, 2010).

ICER is good for us—Possibly not for you, he or she

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To the Editor:

Cleemput et al. make a point that the incremental cost-effectiveness ratio (ICER) alone is not a sufficient criterion to guide decision making in health care, and needs many other supplementary inputs. This is nothing new, it has been well known for years to researchers and decision makers alike. ICER serves as an important ingredient to guide decision making, at least in some healthcare systems.

The authors' main argument is that ICER is not applicable in insurance-financed healthcare systems, with major patient co-payments or co-insurance, where "it is unclear which amount of money needs to be allocated efficiently." It is much easier in NHS-type systems where "Patients' out-of-pocket expenditures are relatively small compared with public expenditure. The budget to be allocated efficiently is therefore clearly defined."

It appears that the authors have fallen in a quite common (payers') trap and focused only on the payers' perspective. Usually CEA and ICER adopt societal perspective and analyses costs and outcomes irrespective of who pays the costs and receives the benefits. The societal perspective includes all payers, and costs and benefits can be attributed to different parties.

In practice, CEA is often performed from the healthcare sector's perspective (and thus does not necessarily cover effects to social services or patient's family and friends, etc.). The healthcare perspective in these analyses covers all costs

irrespective of the funding party, that is, includes costs borne by the government, local authorities, insurers, employers, patients, etc. This is often an adequate perspective for national healthcare decision makers.

It is obvious that the ICER is different if only costs to a single payer (e.g., insurance) are included, and costs to other parties are excluded. In NHS-type systems, with minor co-payments, the healthcare perspective produces roughly the same ICER as the payers' perspective. In insurance-based systems, the healthcare perspective and payers' perspective may lead to greater deviance, in particular if there are several payers (insurers). In this case, it is normal to perform a CEA from a societal or healthcare perspective which produces an ICER that can be used to assess if an intervention (procedure, treatment, medicine, appliance, etc.) is worth adopting for the society, irrespective of who is paying it. This analysis is then supplemented with a budget impact analysis indicating financial consequences to different payers.

In summary, the authors' argumentation is about right if the question is asked from a single payers' perspective: Is one single ICER useful for all payers—when they consider only effects falling on them and not to other parties involved?

The authors may be less right if the question concerns the societal or healthcare perspective, asking: Is the ICER a useful ingredient in decisions judging whether an intervention provides sufficient health benefits allowing for the costs it incurs to health care (or to society at large)—irrespective of who eventually covers the costs?

CONFLICT OF INTEREST

The author reports having no potential conflicts of interest.

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REFERENCE

1. Cleemput I, Neyt M, Thiry N, De Laet C, Leys M. Using threshold values for cost per quality-adjusted life-year gained in healthcare decisions. *Int J Technol Assess Health Care*. 2011; 27:71-76.