Comment on: ‘The cost of a QALY’

Sir,

We were interested but bemused to read the paper from Kirkdale et al. ‘The Cost of a QALY’.1

There is much to agree on. For example, ‘...it is quite clear that the country’s purse is not deep enough to pay for every request and fund every need’. It is also easy to agree that the costs of drug development have to be recouped by companies, without whose continuing existence and financial viability, we would acknowledge, many effective new treatments would not emerge. We could not, however, agree that ‘many now feel that that NICE functions as a brake on Pharma profits and not solely to evaluate efficiency’. Nor could we agree that NICE’s use of a generic measure incorporating length of life with quality of life is misguided.

NICE processes can take time. Delays are often attributable to the many challenges to its decisions, but NICE’s activities should not be compared with those of the Food and Drug Administration which is a regulatory authority, akin to the European Medicines Agency. These bodies have the ‘simple’ job of assessing whether a drug has any proven clinical efficacy, not whether the magnitude of health gain it brings can justify the cost of achieving it, nor even whether a new drug is better than those it is targeted at replacing.

The paper states that ‘If a new treatment was safe and more effective than an older treatment, improving upon response and its duration, if it wasn’t toxic and wasn’t too costly, it would be recommended to patients’. We could not agree more. It sounds easy; but one can only admire doctors who are able to make a detailed and informed evaluation of that kind, especially in relation to costs, and when they do, are we sure that there is consistency of that decision? When NICE makes decisions it does so openly, in public, and most importantly can be held to account for those decisions. NICE committee decisions can be appealed against, and can and have gone to judicial review in the high court. With such intense debate, scrutiny and input from various rounds of consultation during the guidance development, it is perhaps not surprising that the discussion may be prolonged, and that interim decisions may be changed. That is surely a good thing, indicating that it is not just a matter of doing a few calculations and putting a tick or cross in the box.

Ignoring for the moment that the paper in places indicates that the QALY is a measure of cost (it is not); or that EQ5D scores are measured by visual analogue (they are not); or that patient scores are converted by heterogeneous patients (they are not; the general public does this); the QALY calculations are, sometimes, quite complex. However, as Kirkdale, Waxman and colleagues say, ‘It is essential that resources are fairly distributed across the population of the needy’ and the QALY is the best tool we currently have for measuring generic health benefit. We note with interest that the paper does not cite a better alternative.

The QALY is a refinement on just measuring extensions to length of life, although length of life remains its main element. The paper criticizes the QALY’s subjectivity and cites the decision on Sorafenib for Hepatocellular carcinoma (one of NICE’s relatively few ‘no’ decisions). But there was nothing subjective in NICE observing that the only HCC trial (‘SHARP’) found a 12-week median survival advantage. Nor was there anything subjective about Sorafenib’s cost. As regards to the relatively subjective element, that is the quality of life of patients before, during and after disease progression, this was calculated by the manufacturer in the same way as for other appraisals, and was not disputed by any of the participants in the process including the Committee, independent university assessment team, patient representatives or hepatic oncologists. Furthermore, for this treatment, as in all appraisals, the Committee scrutinized in immense detail all the clinical and cost effectiveness evidence in order to evaluate, in real terms, the actual patient benefit, and dissected all the underlying assumptions in the model used to calculate cost effectiveness. This is always done in the presence of clinical and patient experts, and the relevant manufacturer, all of whom contribute to the debate at all stages in the process.

There is also no evidence that this method ‘may discourage organisations such as NICE from authorising the treatment for a common condition when that for a rare condition may be endorsed’. This is actually one of the benefits of the use of cost per QALY. It takes no account of the overall cost or budget impact, just the cost per unit of health gain.

It is interesting that Professor Waxman and his colleagues call for a more rational method of assessing drug efficacy and indicate that this ‘is certain to require the input of healthcare professionals, health economic specialists and most importantly patients and carers’, all of whom are currently represented on NICE technology appraisal committees. Like them, we welcome any future developments in this important area, but cannot agree that the
QALY ‘can be manipulated to providing values that depend more on the weather than any objective parameter’. Nor should this method be abandoned unless and until a better alternative can be developed. And if it is developed, we wonder what it will comprise if not a measure of length of life and some assessment of quality of life?

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Reference


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