Commissioning Policy (EMSCG P026V1)

Use of cost-effectiveness, value for money and cost-effectiveness thresholds

1. Definitions

*Priority setting* is the task of determining the priority to be assigned to a service, a service development, a policy variation or an individual patient at a given point in time. Prioritisation is needed because the need and demands for healthcare are greater than the resources available.

*Treatment* means any form of healthcare intervention which has been proposed by a clinician and is proposed to be administered as part of NHS commissioned and funded healthcare.

*Guidance* issued to the NHS is non-binding advice which is intended to assist the NHS in the exercise of its statutory duties. It suggests steps which might be taken, factors which could be taken into account and procedures which could be followed to deliver specified steps of administration or policy.

*A service development* is any aspect of healthcare which the PCT has not historically agreed to fund and which will require additional and predictable recurrent funding. The term refers to all new developments including new services, new treatments (including medicines), changes to treatment thresholds, and quality improvements. It also encompasses other types of investment that existing services might need, such as pump-priming to establish new models of care, training to meet anticipated manpower shortages and implementing legal reforms. Equitable priority setting dictates that potential service developments should be assessed and prioritised against each other and other demands on increased funding within the *annual commissioning round*. However, where investment is made outside of the annual commissioning round, such investment is referred to as an *in-year service development*.

An *in-year service development* is any aspect of healthcare, other than one which is the subject of an individual funding request, which the PCT agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through
disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

*Singular decision making,* in the context of priority setting, occurs when a decision maker assesses a treatment in isolation from the budget and does not compare that proposal with other competing needs.

*Prioritisation* is decision making which requires the decision maker to choose between competing options.

*Effectiveness* means the degree to which objectives which have been identified in advance are achieved.

*Clinical effectiveness* is a measure of the extent to which a treatment achieves the pre-defined clinical outcomes in a target patient population.

A treatment is *efficacious* if it has been shown to have a beneficial effect in a carefully controlled and optimal environment. It not always possible to have confidence that data from clinical trials will translate in clinical practice into the anticipated or any meaningful health gain for the target patient population of interest. This is the difference between disease orientated outcomes and patient orientated outcomes. For example a treatment might have demonstrated a change in some physiological factor which is used as a proxy measure for increased life expectancy but this relationship might not be borne out in reality.

*Value for money* in general terms is the utility derived from every purchase or every sum spent.

*Cost effectiveness* is the same as value for money although, in health care settings, it tends to imply value for money determined by means of cost effective analysis. However here it is used synonymously with value for money.

*Cost effectiveness analysis* is a method which aims to provide information on value for money. It is not the only method. Cost effectiveness analysis particularly aims to compare very different types of healthcare interventions using a ratio of an intervention’s costs versus its benefit.

*Healthcare need* is a health problem which can be addressed by a specified clinically effective intervention.

*Opportunity cost* is the loss of healthcare gain for one group of patients which is forgone when a commissioner decides to invest in a healthcare intervention for another group of patients. If, for example, a commissioner can only afford to fund one of the following: a cancer treatment, a screening programme, or 6 more palliative care beds, then the opportunity cost of choosing the cancer treatment can be seen to be the loss of the benefit that would have been delivered by either the screening programme or the palliative care beds.

*Budgetary impact* means the total cost of providing a treatment or service. The greater the budgetary impact of a treatment, the greater the opportunity cost.

The *rule of rescue* is the observation that human beings, in situations where an individual’s life is at risk, have the proclivity to take action to rescue the individual regardless of the cost and the chances of success. In the healthcare setting the term
has been used in a number of ways. In this document the term refers to agreeing funding for treatments for patients whose prognosis is grave on the basis that their prognosis is grave and without regard to cost or ability to benefit.

*NICE* means the National Institute for Health and Clinical Excellence.

2. Background

The decisions which primary care trusts make about which treatments to commission are of a different nature from those made by patients, Acute Trusts or the National Institute for Health and Clinical Excellence. This document sets out key differences in approach and the policy approach of the PCT.

Details are set out in the Guidance Note published with this policy.

3. The policy

3.1 This policy applies to any patient for whom the PCT is the Responsible Commissioner.

3.2 PCT commissioners have a responsibility to make rational decisions in determining the way in which they allocate resources and to act fairly between patients.

3.3 The PCT will implement mandatory NICE guidance as directed by the Secretary of State. It reserves the right to take a different approach to treatments on which NICE has not reported or which NICE is not reviewing in its technology appraisal programme.

3.4 In assessing whether to make a policy variation so as to fund a treatment as part of the annual commissioning round, as a service development or when making an individual decision, the PCT will:

3.4.1 apply the principles set out in the Key Principles document; and

3.4.2 in making assessments about whether a treatment provides value for money, adopt a screening financial threshold. This will be set at £30,000 per QALY.

3.5 Where those who are proposing that a treatment be commissioned are unable to demonstrate that its cost per QALY is below the screening threshold, the treatment will not be routinely funded. There may, however, be exceptions where the proposed treatment will provide very substantial health gain (e.g. extension of life as measured in years, not months or weeks, or reversal of a major disease process), requires only a low number needed to treat and is affordable for the PCT.

3.6 Where those who are proposing that a treatment be commissioned are able to demonstrate that its cost per QALY is below the screening threshold, funding will not automatically be provided. The proposed treatment will still have to be prioritised against competing treatments, service needs and other demands.

3.7 The rule of rescue will not be practised.
3.8 The PCT has carefully considered the Richards Report and its proposal that preferential weighting be given to end of life treatments. The PCT has decided not routinely to adopt the Guidance because the PCT has taken the decision not to seek to increase its investment differentially in end of life care. The proposal in the Richards Report to provide a higher cost per QALY for end of life care is not accepted by the PCT.

4. Key principles supporting this policy

4.1 Primary care trusts have legal responsibility for NHS healthcare budgets and their primary duty is to live within the budget allocated to them.

4.2 PCT commissioners have a responsibility to make rational decisions in determining the way in which they allocate resources and to act fairly between patients.

4.3 All NHS commissioned care should be provided as a result of a specific policy or decision to support the proposed treatment. A third party has no mandate to pre-commit resources from PCT budgets unless directed by the Secretary of State.

5. Local documents which have a direct bearing on this policy

East Midlands Specialised Commissioning Group supporting documents
EMSCG Definitions (EMSCGN001V1), 2009
EMSCG Key Principles (EMSCGN003V1), 2009

Please refer to your PCTs documentation relating to:
Priority setting processes within the organisation
Individual Funding Procedures within the organisation
The principles guiding prioritisation

East Midlands Specialised Commissioning Group Commissioning Policy, Orphan Drugs (EMSCGP007V2), 2009.

Guidance Note (EMSCGN005V1): The role of commissioners in the evaluation of individual treatments and the funding of clinical research

6. Documents which have informed this policy


Regional leads for this policy

| Dr Tim Daniel |
| Dr Tim Daniel |
| Consultant in Public Health |
| East Midlands Specialised Commissioning Team |
| Malcolm Qualie |
| Malcolm Qualie |
| Head of Public Health Policy |
| East Midlands Specialised Commissioning Team |
| Email: Malcolm.Qualie@emscg.nhs.uk |
| Tel: 0116 295 0862 |

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As required – minimum 3 yearly

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