An Analysis of Empirical Economic Studies from 1995 to 2015

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## The Value of (a Statistical) Life (Year)

Copyrighted Meterial Frank Ackerman & Lisa Heinzerling Health Economics Janusz R. Mrozek Laura O. Taylor Willingness to Pay for a Quality-adjusted Life Year: In Search of a Standard WEISSERT, PhD

Jystematic Review of Studies Eliciting

Willingness-to-Pay per Quality-Adjusted Life American Vear: Does It Justify CE Threshold?

Vachapon Nimdet<sup>1</sup>, Nathorn Chalvakurachat Ngorsurachee<sup>1</sup> On Knowing the Price of Everything and the Value of Nothing "A damning indictment of cost-benefit analysis applied to health and environmental protection." --- Robert F. Kennedy Jr.



### **Benchmarks for Cost Effectiveness**

### Examples of international de facto benchmarks:

¬ New Zealand (PHARMAC):

NZ-\$ 20,000 / QALY<sup>1</sup>

Australia (PBAC):
 AUS-\$ 42,000 / LYG to AUS-\$ 76,000 / LYG²

¬ England and Wales (NICE): £ 20.000 − £ 30.000 / QALY

¬ United States (some MCOs): US-\$ 50,000 − US-\$ 100,000 / QALY³

¬ Canada (proposed "grades of recommendation"): CAN-\$ 20,000 − CAN-\$ 100,000 / QALY<sup>4</sup>

¬ WHO (recommendation): 1-3 times GDP/capita / DALY⁵

#### No scientific basis

<sup>1</sup>C. Pritchard (2002); QALY: "quality-adjusted life year"; <sup>2</sup>George et al. (2001); LYG: "life year gained" <sup>3</sup>D.M. Cutler, M. McClellan (2001); <sup>4</sup>A. Laupacis et al. (1992); <sup>5</sup>DALY: "disability-adjusted life year"



### In Search of a Scientific Basis

### Demand-Side Analyses

- Health Care Programs (or Interventions):
   individual (or "social") WTP, holistic
- Characteristics of Health Care Programs (or Interventions):
   individual (or "social") WTP, attributes (and their interaction)
- Quality-Adjusted Life Years (Individual or Social WTP-Q):
   QALY maximization hypothesis; constant proportional trade-off...

### ¬ Supply-Side Analyses

- Efficiency Frontier Approach using PROs (CCA; e.g., IQWiG): flexible benchmarks, contingent on therapeutic area and rationality of prior pricing and reimbursement decisions
- Quality-Adjusted Life Years (CEA; Shadow Prices; e.g., York, 2013):
   universal benchmark, (in addition to assumptions above)
   also contingent on rationality of health care budget

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# **Answers Proposed by [Health] Economics**

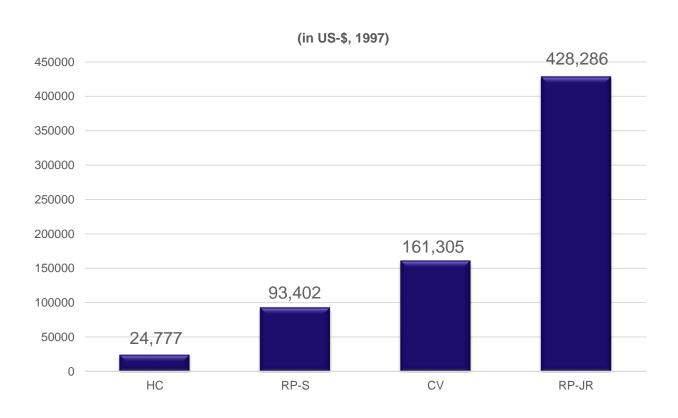
### A Typology:

- Value of a Statistical Life Year (VSLY)
  - Human Capital (HC) Approach:
     resting on productivity, rejected by modern welfare economics
  - Revealed Preferences (RP) Approach:
     observed human behavior (job risk or non-occupational safety)
  - Stated Preferences (SP) Approach:
     direct elicitation of preferences
    - ¬ contingent valuation (CV): direct or referendum style questions
    - discrete choice experiments (DCEs): choice alternatives,
       where the different goods or programs are defined by their attributes
- ¬ Willingness-to-Pay for a QALY (WTP-Q)
  - ¬ With adjustment for reduced average quality of life in later years, WTP-Q may be ~10% greater than VSLY (Hirth et al., 2000)
  - ¬ WTP-Q exists only if QALY maximization hypothesis is accepted and normative and empirical grounds for concern are disregarded



## In Search of a Standard (Hirth et al., 2000<sup>1</sup>)

## WTP-Q: Willingness-to-Pay for a QALY



<sup>1</sup>R. Hirth et al. (2000): median based on 35 estimates based on WTP approaches, US-\$ (1997) 265,345. A total of 37 studies (28 of which came from the U.S.) yielded 42 VSL estimates suitable for inclusion in the analysis.



### **Research Question**

 What can we learn about the Economic Value of a Statistical Life Year ("VSLY")

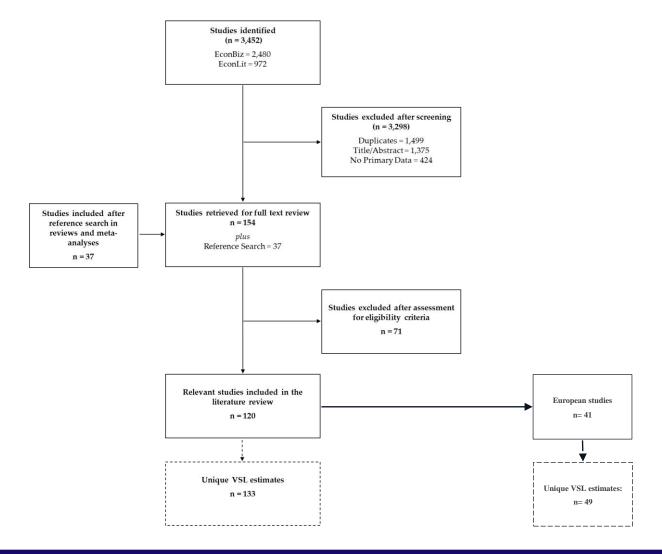
from empirical studies reporting original data on the Value of a Statistical Life ("VSL") over the last two decades (1995-2015)?

#### [Demand Side Perspective]

- Methodology of empirical studies over the last two decades
- Heterogeneity of estimates, by method and by area of origin
- No adjustment for health-related quality of life;
   no attempt to derive WTP-Q estimates from VSLY estimates
- No specific review of the Quality-Adjusted Life Year literature
- ¬ Two levels of analysis
  - 1. European data
  - 2. Worldwide data



# Literature Search: Worldwide & European Results



Division of Health Economics |

# Computing the VSLY from Reported VSL Data

### **Abbreviated calculation procedures:**

- VSL (base case or mean for each experimental setting) from study
- Currency reconversion from US-\$ (or else) to LCU (exchange rates)
- VSL inflated to year 2014 using country-specific CPIs
- GDP / capita from year of data generation, inflated as VSL
- Conversion of LCU values for 2014 to Euro (PPPs)

### **VSLY** computation:

- Calculation separately for men and women,
   residual life expectancy data from WHO Life Tables by country
- ¬ Base case discount rate 3% (for sensitivity analyses, 0% 10%)

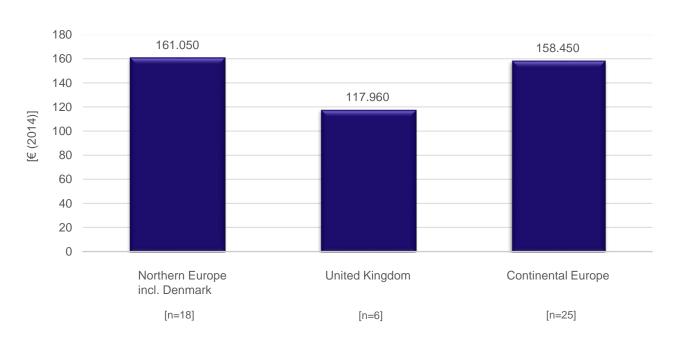
¬ Formulas: 
$$VSLY = \frac{VSL \cdot (1+r)^{t-1} \cdot r}{(1+r)^t - 1}$$
 or (for  $r = 0$ %):  $VSLY = \frac{VSL}{t}$ 

Calculating VSLY average (and range, if data were available),
 weighted by study population sex ratio



## Empirical Results from European Studies (n=41), 1995-2015

#### **Median VSLY Estimates by Region**



Differences n.s.

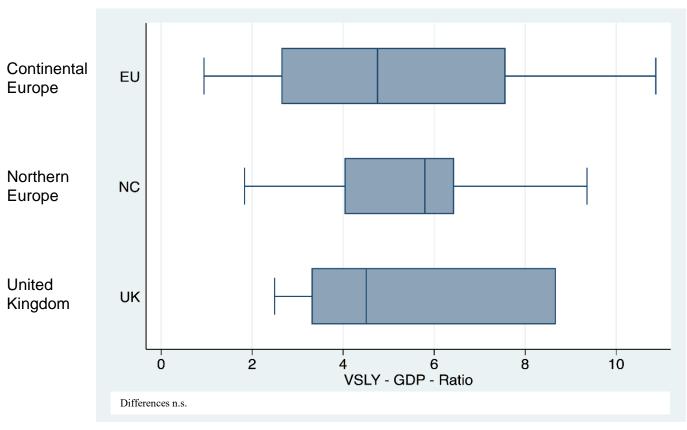
M. Schlander et al. (2017) - analysis based on 41 European economic VSL studies published from 1995 - 2015





#### Empirical Results from European Studies (n=41), 1995-2015

### VSLY / GDP per capita by Region



M. Schlander et al. (2017) - analysis based on 41 European economic VSL studies published from 1995 - 2015



# **Database for Analysis**

#### ¬ Worldwide data:

7 120 studies, yielding a total of 133 unique VSL estimates

Regional origin of studies yielding VSL estimates:

```
Asia (30);
Europe (49);
North America (45), including US (38) and CAN (7);
Other (9), including Africa (2), Oceania (2) and South America (5)
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Methodological basis of estimates:

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HC (0);
RP/WR (49);
RP/NO/Other (11);
SP/DCE (18);
SP/CV (55)
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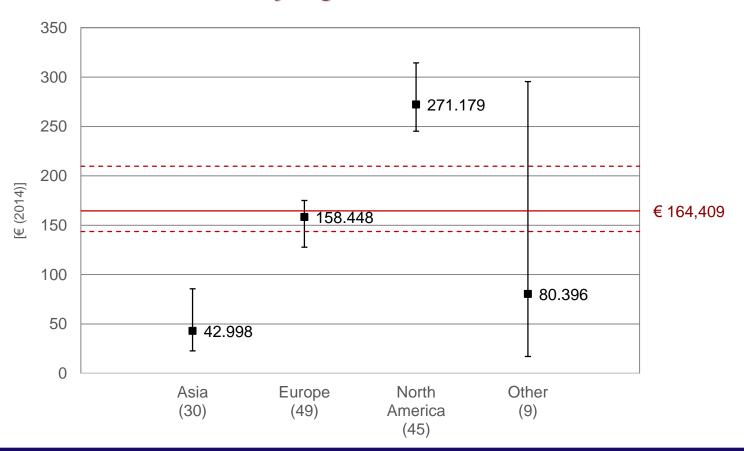
### Empirical Results from Economic Studies (WW, n=120), 1995-2015

	Mean	95% Confidence Intervals (nonparametric bootstraps)	
	[€ 2014]	Lower Bound	Upper Bound
VSL	€ 5,143,050	€ 4,270,455	€ 6,231,312
VSLY	€ 223,428	€ 182,042	€ 272,092

	Median [€ 2014]	95% Confidence Intervals (nonparametric bootstraps)	
		Lower Bound	Upper Bound
VSL	€ 3,827,509	€ 3,125,307	€ 4,847,382
VSLY	€ 164,409	€ 137,413	€ 204,121

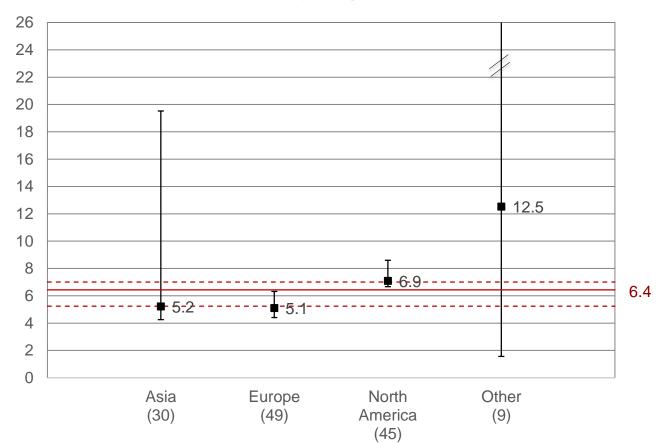
### Empirical Results from Economic Studies (WW, n=120), 1995-2015

#### **Median VSLY Estimates by Region**



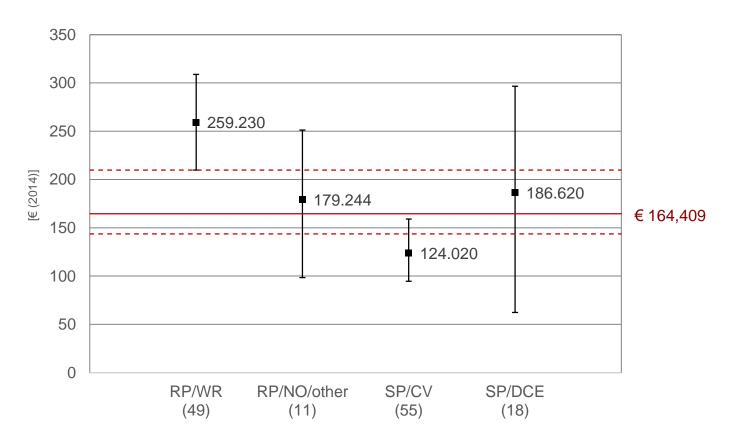
### Empirical Results from Economic Studies (WW, n=120), 1995-2015

#### Median VSLY per GDP/capita by Region



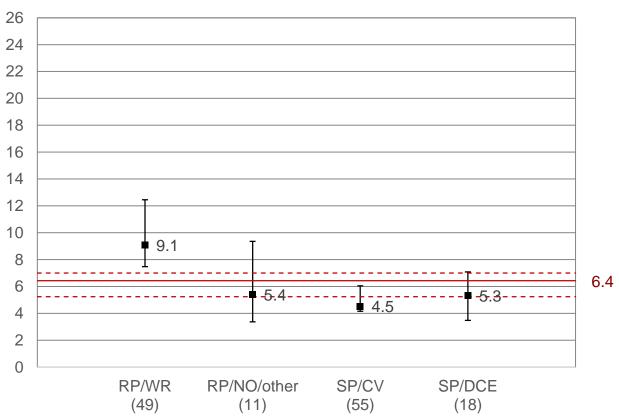
Empirical Results from Economic Studies (WW, n=120), 1995-2015

### **Median VSLY Estimates by Method**



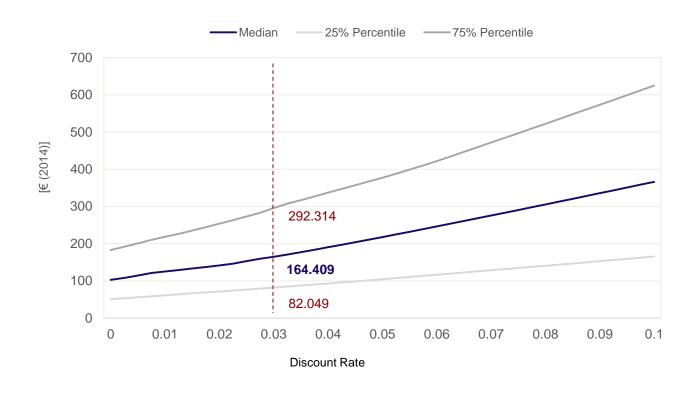
### Empirical Results from Economic Studies (WW, n=120), 1995-2015

### Median VSLY per GDP/capita by Method



### Empirical Results from Economic Studies (WW, n=120), 1995-2015

#### **Sensitivity Analysis**





**Empirical Results from Economic Studies (WW, n=120), 1995-2015** 

#### **Regression Analysis**

- Income (GDP/capita) in the country of study impacts VSLY estimates positively.
- ¬ Studies implemented with a revealed preferences wage risk (RP/WR) approach report higher VSLY estimates, relative to those with a stated preference / contingent valuation or DCE approach (SP/CV; SP/DCE).
- North American studies report higher VSLY estimates, compared to those from other regions (baseline), even after considering income effects.
- ¬ Size of (fatality) risk and study design (cross-sectional vs. panel data analyses) were not significant at conventional levels.



## **Implications**

Benchmarks for cost effectiveness (WTP/LYG, WTP-Q) widely used in the context HTAs and health economic evaluations appear to be much lower than the individual willingness-to-pay (WTP) for a life year (or "VSLY") in other sectors of life, as reported in the relevant empirical economic literature.

- Potential policy implications will be influenced by the type of health care system in question; for example, a National Health Scheme (NHS) with a politically determined health budget may respond differently compared to a bottom-up financed system.
- We do not intend to suggest a new benchmark for WTP-Q.
- ¬ In fact, we believe that there are compelling reasons to reject a universal WTP-Q benchmark on both normative and empirical grounds, unless health care policy makers were prepared to override prevailing social norms and preferences of citizens.

