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LETTER FROM THE EDITOR

"It's the season for value assessment frameworks" was the common refrain at a recently convened stakeholder conference organized by ISPOR as part of its Initiative on US Value Assessment Frameworks. No less than five such frameworks have been developed and are now being used with some regularity in the United States, including three different ones focusing specifically on oncology. Not surprisingly, the frameworks are similar in some respects but fundamentally different in others, geared towards different stakeholders, encompassing different dimensions of value, using different costing methodologies, and so on. But what's important is that these frameworks are being put out there for public scrutiny and debate—because open and transparent health care decision making is certainly better than the alternative.

It's interesting to note that value assessment frameworks are not new. Younger members of our Society may not realize that in its original formulation cost-effectiveness analysis was developed as a method of value assessment and budget-constrained resource allocation all in one—in other words, as a value assessment framework. If you read some of the earliest methods pieces published in the 1970s and '80s, you'll find instruction on how to construct incremental cost-effectiveness ratios (ICERs) in much the same way we do today, but you'll also find material on how to arrange the interventions in descending order of cost-effectiveness, and systematically allocate resources by going down the list selecting ones to adopt until an externally imposed budget constraint is reached. This approach guarantees obtaining the greatest health benefit from a fixed level of health care spending. At least in theory.

But in practice most of us have never used cost-effectiveness analysis in this way. The health care system is too complex, and numbers of interventions too vast, to ever be able to use the method for budget-constrained resource allocation. There was one notable quasi-attempt to do so, in the state of Oregon in the early 1990s, but this fell victim to methodological challenges and data limitations, and gave rise to a political firestorm that left cost-effectiveness analysis with a lasting stigma throughout the US of being a technocratic form of rationing, never to be trusted by patients in waiting rooms or voters at the ballot box.

Instead of using the constrained optimization part of cost-effectiveness analysis, the fall back approach initially was to assess the relative standing of a medical intervention by comparing its ICER to those of others (remember league tables?), judging it favorably if it was in the mix of currently accepted and reimbursed treatment modalities. The informality of this soon gave way to use of cost-effectiveness thresholds, which remain in place to this day even though they have generated their own share of controversy.

So the need for explicit and rigorous value assessment in the US has existed for a long time and ISPOR is doing something about it. A new Special Task Force has been convened and work is underway on a white paper to help sort through the five existing frameworks and make recommendations for a path forward. In addition to the one-day stakeholder engagement event, which drew more than 250 attendees, there will be an Issue Panel at the upcoming European Congress in Vienna devoted to potential learnings from European systems, and certainly more to come in 2017.

A developing story that *Value & Outcomes Spotlight* will be watching closely as it continues to unfold.

Sincerely,

David Thompson, PhD
Editor-in-Chief, *Value & Outcomes Spotlight*

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