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Yet another Ersatz World: The ICER Final Evidence Report for Additive Cardiovascular Therapies

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abstract

Previous commentaries in the Formulary Evaluation section of INNOVATIONS in Pharmacy have pointed to the lack of credibility in modeled claims for cost-effectiveness and associated recommendations for pricing by the Institute for Clinical and Economic Review (ICER). The principal objection to ICER reports has been that their modeled claims fail the standards of normal science: they are best seen as pseudoscience. The purpose of this latest commentary is to consider the recently released ICER report for Additive Cardiovascular Disease therapies. This report should not be taken seriously in its claims for cost-effectiveness and pricing in cardiovascular disease (CVD). The analytical framework applied by ICER fails to meet the standards of normal science in demarcating science from pseudoscience. Irrespective of the value judgements and recommendations of an ICER report, these lack credibility. They were never intended to be evaluable and replicable across treatment settings. The claims made are constructed, driven by assumption, and should be put to

one side by health system decision makers. In this review the focus is on to the ICER modeled estimates of utility scores in CVD, the insistence on utilizing a generic utility algorithm (the EQ-5D-3L) and the consequent quality adjusted life year (QALY) estimates. Two issues are raised that will be the subject of future commentaries: the lack of appreciation of fundamental measurement and (ii) the importance of the patient voice in benefit claims. Given the importance in the ICER methodology of QALYS, the ad hoc nature of the ordinal utilities introduced to the cardiovascular model must raise concerns over the role the ICER evidence report may play in health care decision-making. These concerns extend to the claim by ICER that, on ICER's own affordability threshold for individual new molecular entities, the anticipated uptake of these therapies may raise questions of overall affordability. Again, we are dealing with an arbitrary construct that may adversely impact patient access.

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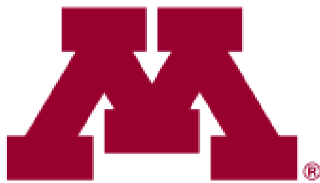

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