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Commentary

When Inaction Is the Costlier Error: Making Economic Evidence Feasible for Health Benefits Package Design

Comment on "Selecting Cost-Effectiveness Methods for Health Benefits Package Design: A Systematic Approach"

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Abstract

In many low- and middle-income countries (LMICs), the economic dimension remains the least-used input to health benefits package (HBP) design, even though these settings face the tightest budget constraints and the highest opportunity cost of misallocation. Nemzoff and colleagues offer a timely, structured way to select cost-effectiveness methods according to the time, data, and capacity available. I argue that the decisive question is not whether adaptive health technology assessment (aHTA) risks error, but error relative to what: in most LMIC decisions the comparator is not an ideal bespoke analysis but a choice made with no local economic evidence at all, and against that baseline an adequately safeguarded signal is a substantial gain, though a poorly adapted one can mislead. aHTA is often better understood as a probability signal than a verdict, and can help direct scarce analytic effort. Valid methodological critiques should drive guardrails and iterative improvement, not abstention.

Keywords: Adaptive HTA, Health Benefit Package, Cost-Effectiveness Analysis, Priority Setting, Opportunity Cost, LMIC

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Every year brings hundreds of new medicines, vaccines, and devices, and no health system, however wealthy, can fund them all. High-income systems have largely responded by building dedicated agencies that conduct full health technology assessment for the relatively small number of molecules and other health interventions they appraise each year, drawing on local cost, epidemiological, and clinical data; there, adaptive methods play a niche role, reserved for urgent or low-priority questions. Most low- and middle-income countries (LMICs) face the opposite situation: hundreds of technologies to assess when a health benefits package (HBP) is created or revised, limited analytic capacity, scarce local data, and budgets that permit full economic evaluation for only a handful of cases each year. Coverage decisions are made regardless — with or without evidence, and a price is paid either way.

In this setting the economic dimension is, paradoxically, both the most needed and the least used input to priority-setting. LMICs face the tightest resource constraints and thus the highest opportunity cost of a wrong decision, yet economic evaluation is frequently absent from the decisions that most need it.[1] Part of the reason is that economic evidence transfers poorly, and applying it across borders requires explicit assessment and, where warranted, local adaptation. Relative treatment effects and their certainty travel comparatively well across borders, and the magnitude of clinical benefit can usually be transferred too, though with more caution, since it also depends on local baseline risk. Cost-effectiveness is the least transferable, because it depends on local prices, resource use, epidemiology, health-system structure, and the opportunity cost embodied in a country's cost-effectiveness threshold.[2] Generating that evidence locally is hardest precisely where capacity, data, thresholds, and explicit decision rules are weakest.

Against this backdrop, Nemzoff and colleagues make a valuable contribution.[3] Theirs is the first systematic classification of the cost-effectiveness methods used in HBP design—expert opinion, review, model adaptation, and new modelling, sometimes used in combination and taking anywhere from one to thirteen months in the cases reviewed (reported experience, not expected completion times for each method)—together with the time, data, and capacity each demands, framed through adaptive health technology assessment (aHTA).[3] Here, aHTA denotes this family of lighter approaches—from rapid review of existing assessments to the adaptation of published economic evaluations—as distinct

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from a full economic evaluation conducted locally. Two features deserve emphasis. The selection is presented as a set of trade-offs rather than a hierarchy, so that a lighter method can be the right choice; and the authors insist that the choice remain driven by local decision-makers, not predetermined by whichever technical partner produces a given global public good. Building on their framework, I suggest three things: that the value of any selected method depends on the comparator it is judged against; that method selection should be governed by the decision each estimate must serve, not by feasibility alone; and that the time–data–capacity trade-off needs guardrails alongside it. Nemzoff and colleagues already flag assessment scope, uncertainty, bias, and additional prioritisation criteria as areas needing development; the extension offered here is to tie the choice of method explicitly to the consequences of decision error, and to locate that choice within the wider debate on how intervention-level assessment relates to package-level reform.[4]

The Comparator Is the Absence of Evidence

The paper's trade-off framing presupposes that some economic assessment will be done; its deeper importance is that, by making a feasible method available, it changes the real alternative facing a decision-maker. A recurring objection to adaptive methods is that lighter analyses risk biased or wrong estimates. The concern is legitimate, but usually posed against the wrong counterfactual. In most LMIC decisions the alternative to an imperfect aHTA is not a better bespoke evaluation commissioned instead; it is a decision taken on no local economic evidence at all: allocation by historical budgets, inertia, advocacy, or donor priorities. The proponents of aHTA frame it the same way, describing adaptive evidence as preferable to none and noting that, absent explicit methods, rationing simply proceeds implicitly.[5,6] The right test, therefore, is comparative: whether a selected method improves on the status quo it replaces. Treating estimation error as disqualifying while treating the unexamined error of the status quo as acceptable is not a neutral scientific stance; it is a choice that systematically favours inaction. Where opportunity costs are highest and the selected method clears basic guardrails, inaction is typically the costlier error; where those conditions fail, a poorly adapted estimate can itself worsen allocation, and the comparison must be made honestly in both directions.

This is also why the authors' insistence on local ownership of method selection matters more than it may first appear. A locally selected and locally owned estimate can be preferable to deferring to an external "gold standard," not only because transferability is imperfect, but because legitimate priority-setting requires that the choice of method and its assumptions be transparent and contestable by those who own the decision.[6,7] This is where local ownership becomes an accountable process rather than a slogan: widely endorsed principles for benefits-package design call for inclusive participation, nationally agreed criteria, evidence-informed and revisable decisions, and transparency, so that the basis for a choice can be examined by those it binds.[8]

Select the Method to the Decision, Not Only to the Resources

The framework selects methods by feasibility, considering aspects such as time, data, and capacity. I would add a second axis: the decision the estimate must serve. Much of the debate treats aHTA as a lighter machine for producing the same output as full evaluation, an incremental cost-effectiveness ratio and a verdict. Often, though, the decision needs only a signal of how likely a technology is to be cost-effective in context, or the price range at which cost-effectiveness becomes plausible, which is directly usable in negotiation.[6] When that is what is required, a lighter method is not a compromise but the correct choice. This logic is already familiar from the distinction between sectoral cost-effectiveness analysis, appraising many services together against a budget, and incremental analysis of a single technology against a threshold: the two suit different decisions, so choosing between them is itself a matter of matching analytic depth to the question.[9] The authors' companion scoping review makes it explicit in its account of "iterating" aHTA, where topics are routed to rapid or full assessment by certainty and budget impact, reserving intensive evaluation for uncertain, high-impact cases. A validation exercise in India reached the same conclusion, recommending aHTA to rule clearly cost-ineffective technologies in or out and to reserve full economic evaluation for those that are inconclusive or poorly studied.[5,10] Method selection and topic triage are, in this sense, aspects of the same decision: how much analytic effort a question warrants depends both on what a country can afford and on what is at stake. The efficiency at stake is real: over a decade of Ireland's rapid-review experience, roughly half of medicines avoided full appraisal, sparing an estimated 15 000 appraisal-days that could be redirected to the decisions that most needed them.[5,11] Understood this way, aHTA does not replace judgment; it helps a system decide where to invest it. One boundary is worth stating: matching method to decision operates on the individual estimate, whereas a package assembled from individually cost-effective interventions is not thereby affordable within the budget or deliverable within prevailing workforce and service-delivery constraints—distinctions that package-level design must address in their own right.[4,12]

Guardrails Alongside the Trade-off

Selecting a method by feasibility is necessary but not sufficient. For its results to be trusted in an actual decision, that choice must be paired with conditions that signal when a lighter method can be relied upon, guardrails that steer between adopting aHTA uncritically and rejecting it outright. Convergence is one such condition. When simple and more elaborate adjustments, applied to several source studies, point the same way, greater confidence is warranted. When they diverge, that disagreement is itself informative: it shows the decision hinges on assumptions that only a full evaluation can settle, and should prompt one. To be usable, the output should be reported not as a point verdict but as a probability of cost-effectiveness or a price range, with its

load-bearing assumptions and their likely direction stated, and with the trigger for escalating to a fuller evaluation agreed in advance rather than after the result is known. Budget impact should modulate this threshold, since the fiscal commitment scales the cost of a wrong decision. The transfer of costs deserves particular caution: a validation study adapting global evaluations to India found that adjusted cost estimates could diverge severalfold from a locally conducted reference, even where effect estimates transferred reasonably well.[10] This is a reminder that economic adjustment is not clinical transferability: rescaling a ratio does not repair non-transferable resource use, model structures, comparators, or care pathways, which must be assessed separately. Structured procedures for doing this work well already exist and continue to be refined.[13] These methods have real limitations. The thresholds used to translate an estimate into a likelihood of being cost-effective are as yet largely proposed rather than empirically calibrated, and the adjustments themselves remain unvalidated against locally conducted full evaluations in most settings. Such limitations point to the work still needed to strengthen these methods. When the aHTA literature first took shape, no study had compared an adaptive approach against a full one[6]; that gap is beginning to close,[10] and validation of this kind is how these methods earn greater decision weight. Valid criticism is a specification for improvement, not a warrant for abstention.

Conclusion

The case for this agenda is becoming more urgent, not less. LMIC systems already face more coverage decisions than they can analyse, and the pipeline of new interventions is likely to keep growing, making a bespoke economic model for every technology still less tenable and strengthening the case for the structured selection Nemzoff and colleagues propose. The paper lowers the barrier to entry and rightly keeps the choice in local hands; the task now is to build on it: developing local data and capacity, adopting opportunity-cost-based thresholds and explicit decision rules,[2] and validating adaptive methods in use. In the settings that most need economic evidence and least often use it, the greater risk is not an imperfect analysis but a decision made in the dark.

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Disclaimer

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