

## Letter to the Editor

**The opportunity cost of funding new medicines: an attempt to measure the invisible****El coste de oportunidad de financiar nuevos medicamentos: un intento de medir lo invisible**

To the Editor:

A recent study published in *The Lancet*<sup>1</sup> estimates that funding decisions for new medicines over the past two decades have resulted in a net negative impact on the health of the English population. The authors show that the health losses caused by diverting resources to fund new medicines have exceeded the health benefits generated by these treatments—a conclusion that may be hard to accept.

In a context of finite resources, spending more in one area inevitably means spending less in another. We know this to be true when we make decisions about our own household expenditures, and the same is true when decision makers allocate limited public healthcare resources. We cannot directly observe the displacement that arises from every funding decision, as these impacts are indirect, subtle, and diffuse—which often make them invisible. It is hard to prove that spending on a specific new drug directly causes staff reductions elsewhere in the system, or longer waiting times for other treatments, or a decline in engagement efforts for preventive programs. But these displacements inevitably happen, and their consequences can be devastating.

Naci et al.<sup>1</sup> seeks to quantify this reality. According to their estimates, drugs approved by the National Institute for Health and Care Excellence (NICE) between 2000 and 2020 generated 3.75 million quality-adjusted life years (QALY), but the displacement of resources to fund them (what economists refer to as the ‘opportunity cost’) led to the loss of 5 million QALY for other patients, resulting in a net loss of 1.25 million QALY. This value is nearly three times larger than the health lost as a direct result of the first year of the COVID-19 pandemic in England, albeit accrued over a longer period.<sup>2</sup>

The analysis of Naci et al.<sup>1</sup> is based on an empirical estimate that one QALY is lost for every £ 15,000 reallocated away from current services provided by the English National Health System (NHS).<sup>3,4</sup> Similar empirical studies have provided evidence about this effect in Spain.<sup>5,6</sup> In the United Kingdom, this £ 15,000 per QALY estimate is used by the Department of Health and Social Care to quantify the health losses resulting from reductions in NHS spending. However, NICE maintains a range of £20,000 to £30,000—and will continue to do so under an agreement between the United Kingdom Government and the pharmaceutical industry.

Criticism of Naci et al.<sup>1</sup> may focus on the uncertainty around the actual opportunity costs of the analysed funding decisions. It is possible that disinvestment during the period under study was partly on interventions with higher cost-effectiveness ratios, leading to somewhat smaller health losses than estimated. But, conversely, funds may have been diverted from highly cost-effective alternatives, meaning the net health loss could be underestimated. The assumption underpinning their calculations was that interventions being displaced were ‘marginally’ cost-effective, which is likely to provide a conservative estimate of the expected net loss.

We cannot hope to precisely estimate the invisible, but we can approximate it with the best available evidence. And while we cannot undo the past, we can certainly aim to reduce the harm in the future. A renewed effort by decision makers in the United Kingdom, Spain, and other countries to take into account these health opportunity costs when making funding and price-setting decisions is needed to avoid future health losses, and to ensure equal consideration for every patient—whether visible or invisible.

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