

## EDITORIAL

# Should the cost perspective be integrated in clinical guidelines? On individual and societal perspectives in health research

In the evaluation of healthcare interventions, as input for developing and updating clinical guidelines, the choice of outcome measures is key. Of course, subjective and objective health outcome, daily functioning, and health-related quality of life will have central positions. Over the years, it has become clear that in operationalizing these outcomes, the patient perspective is the most important guide for clinicians to optimize individual care.

For society—from the perspective of tax payers, health insurance organisations, and policy makers who must prioritize both within health care and between health care and other societal investments—also (financial) cost is an essential outcome measure. Accordingly, in order to ensure evidence-informed policy decisions, the results of cost-effectiveness, cost-utility and cost-benefit analyses are increasingly requested. But should these results be also integrated in clinical guidelines?

Posing this question reveals an eye-catching but too often trivialized problem: using these two perspectives, patient health and cost, will not always point in the same direction, and might even lead to conflicting conclusions. First, integration of economic cost in addition to individual health in guidelines adds other interests and views than those of the individuals needing care. This becomes explicit when using methodologies such as determining utilities (e.g., based on either patient or community preferences) [1] and thresholds for the maximum cost per quality-adjusted life year: how much is society willing to pay for a certain amount of health gain? Second, generalizability of cost-effectiveness evaluations may be limited because of international differences in costs of one and the same intervention as a result of different remuneration systems or fees for clinicians, or because of differences in cost-effectiveness thresholds. Integrating such cost-related phenomena in clinical practice guidelines (CPGs) can result in (1) recommendations that in some cases favor reducing health care expenses rather than optimizing individual patient care or in (2) the clinically debatable situation that in country A certain intervention is recommended as good care while in country B it is not.

Can such conflicts of perspectives be resolved? Various options could be considered. For example, one could give priority to effectiveness from the patients' perspective, and use the cost(-effectiveness) perspective only if different

options are equally effective and safe. One could also develop two sets of guidelines: one based on effectiveness from the patients' perspective only, and another also integrating the cost(-effectiveness) perspective. This would make transparent that, when integrating cost input, serving the interest of the patient is not the only aim of the latter CPG type. Clinically less debatable is using the cost-related perspective only for negotiations with manufacturers and professional organisations, transparently showing the negative public health implications of too high prices and fees, with the aim to bring the cost-effectiveness ratios more in the direction of or even below the accepted threshold, in order to promote health care provision according to clinical effectiveness. This strategy has, for example, been followed in the Netherlands prior to introducing HPV vaccination in the national vaccination programme.

In fact, there can be different truths at different levels of decision making. At the microlevel, the perspective of individual patients and their doctors is leading, while at the macrolevel insurance companies and policymakers must fulfill their duties. Therefore, in promoting evidence-informed decision making, these levels should explicitly be distinguished as to content-related and methodological challenges in clinical, health economics, and health policy research. Such a multi-level research approach also allows the study of individual and societal ethical challenges being well targeted at those who are responsible at a specific decision level.

In this issue, the patient perspective is placed central by *Selvaet et al.*, who studied how colorectal practice guidelines (PGs) incorporate this. Based on a comprehensive search for colorectal practice guidelines, they included 28 PGs that contained almost 600 recommendations, 44% of which being potentially preference sensitive. Most of the PGs did not include patients in the development process, provide information about patients' perspectives, include recommendations in which the patient perspective was explicitly considered, nor recommend a discussion with the patient. Less than 10% of potentially preference-sensitive recommendations considered the patient perspective. When patients were involved in the development process, the patient perspective was more frequently incorporated in the relevant recommendations. The authors concluded that the incorporation of the patient perspective in colorectal cancer PGs is suboptimal, and call for efforts to better

incorporate this perspective, especially in preference-sensitive recommendations.

The cost perspective was considered by [Sanabria et al.](#), who reviewed available guidance from guideline organizations on how to incorporate resource use and cost (RUC) in clinical practice guidelines (CPGs). After searching various relevant sources, they included 77 documents from 67 organizations. Most organizations include information regarding RUC during the CPG development process, and report taking RUC into account when developing recommendations, but only a quarter of the organizations that explicitly consider RUC provide guidance on how to incorporate the RUC evidence when developing recommendations. While it was therefore concluded that CPG developers need more explicit guidance to incorporate RUC evidence in recommendations, in their discussion the authors emphasize the low transferability of results of the economic studies because of differences in populations, the costs included, or included options. They also emphasize that organizations need to be explicit not only about scientific but also social value judgments, for example about the balance of equity and efficiency, and about what they consider as acceptable trade-offs between costs and effectiveness. Also decisions to not consider economic aspects, need to be explicitly described and registered [2].

Against this background of potential conflicts between patients' and cost perspectives in research and guideline development, the commentary of [Moloney et al.](#), on the increasing complexity of the core outcomes (COS) landscape is especially recommended. Their analysis was informed by a multistakeholder meeting on challenges related to the uptake of COS in clinical research, with participation of patients, clinicians, payers, regulators, administrators, HTA experts, systematic reviewers, manufacturers, and academia. They argue that the broad recognition of the need for common, relevant outcomes has led to numerous initiatives and organizations intended to develop standardized outcomes and outcome measures in specific fields, but that these do not carry over to other sectors such as quality of care research. They call for better communication and collaboration among different initiatives, to ensure that COS standards align across contexts where possible and differ for understandable and transparent reasons.

The different perspectives of patients, professionals, public health, and policy makers can also be relevant in the discussion of the ethics of cluster randomized trials (CRTs), that can also be seen as a case of pre-randomization [3]. In response to a proposal by van der Graaf et al. for revision of the Ottawa Statement on the Ethical Design and Conduct of Cluster Randomized Trials [4,5], [Weijer et al.](#) disagree with van der Graaf's approach that, so long as the practice change is evidence-based and the clinician makes individualized patient care decisions, patient interests are not substantially affected, and that health providers who are research participants ought to be treated differently and should not be allowed to withdraw from a study too easily. In their view,

van der Graaf's position fails to weigh adequately the potential for coercion and harms that employees in research can face. In their reply, [van der Graaf et al.](#) argue that the two groups have different views on the moral and legal status of health care workers as research participants in cluster randomized trials, and that this is the main reason for the disagreement. But both teams of authors agree that the potential for bias may require blinding participants to allocation and study interventions in the consent process of a cluster trial. They also agree that further debate and guidance on informed consent and study bias is needed.

In another context, the relation between the individual and general interest in research is addressed by [Raymond et al.](#) They argue that medical ethics must include care research not only to find out what good practice will be in the future, when the results are available, but also to guide practice in the meantime, in spite of still existing uncertainty. They therefore propose a reconstruction of the care-research separation, where care research is reintegrated into care, as a "learning health system." Accordingly, the patient and societal perspective could simultaneously served.

Finally, for a scientific journal it is vital that members of the research community are available to serve the quality of scientific publishing in general. We are therefore extremely grateful to all JCE reviewers of all the 2019 articles for their crucial contributions to assure and further improve the Journal's quality. We especially compliment our [Reviewers of the Year](#), Annette M O'Connor and Tim Morris, for their outstanding, both critical and constructive reviews. Finally, we congratulate Ignacio Atal, the winner of The [David Sackett Young Investigator Award 2019](#), for his excellent work on divergence between the health needs and research efforts in low and middle income regions, as highlighted in this issue.

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