

# Comments of Stephen Resch

Consumption value of health— what is it in LMICs, what are the determinants, can we reliably predict change over time.

How big of a research priority is it?

- Jim Hammitt went over theory and state of evidence regarding consumption value of health
- Raises familiar pain points:
  - VSLY vs. WTP for QALY (even BCA uses avg VSLY), RP vs SP,  $\lambda_{WTP} > \lambda_K$
  - There isn't one  $\lambda_{WTP}$  because not all QALYs are worth the same
- $\lambda_{WTP} > \lambda_K$  : clearly a huge problem, at least in medium term, to advise adoption of an intervention based on:  $\lambda_K < ICER < \lambda_{WTP}$ 
  - This was the big problem we identified with the way the 1x-3x GDPpc per DALY averted thresholds were being used as a de facto standard without much critical thought to recommend adoption of technologies that were clearly unaffordable in LMICs given their health budgets, even including temporary donor dollars.
  - But **neither is it right to immediately dismiss intervention as “not worth doing” because  $\lambda_K < ICER$ .**
- We are talking about this **now** because growth in the consumption value of health would affect **discount rates**.
- Earlier we were talking about Marginal Productivity of the health care system for the same reason.
- The two thresholds both matter. They may not grow for the same reasons or at the same rate. This might have implications for how we discount streams of effects,
- but for the business of helping LMICs allocate resources to health projects, **this is a very low priority**, except in some very interesting special cases (e.g. disaster preparedness).
- I find it hard to stay focused on discounting as opposed to thresholds.... But I think the reason is that figuring out the **value** of improving health in LMICs (and, likewise, figuring out if new interventions are going to crowd out more productive health spending) is really important and discounting for the most part, isn't.
- By all means we should learn more about consumption value of health and its determinants in the LMIC context. (and also the value of  $\lambda_K$ )... but not really for informing discounting. We should study it because it is central to the decision criteria (is it worth it or not).
  - This should include work on **VSLY**
  - VSL Small risk changes applying to health programs with big health changes
- Discount rate is usually dwarfed by other uncertainties. If I have limited time with policymakers to discuss allocating resources to some health program, its unlikely I'm going to spend much time talking about discount rate.