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OHE WHITEPAPER

The case for adopting a broader perspective on value in Health Technology Assessment

Priscila Radu
Conchi Biurrun
Meindert Boysen
Melanie Whittington
Chris Skedgel

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Priscila Radu

Office of Health Economics, London

Conchi Biurrun

Federación Española de Cáncer de Mama (FECMA)

Meindert Boysen

Independent HTA expert, formerly of NICE

Melanie Whittington

Leerink Center for Pharmacoeconomics, MEDACorp LLC

Chris Skedgel

Office of Health Economics, London

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Corresponding Author:

Chris Skedgel
cskedgel@ohe.org

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Executive Summary

Key points

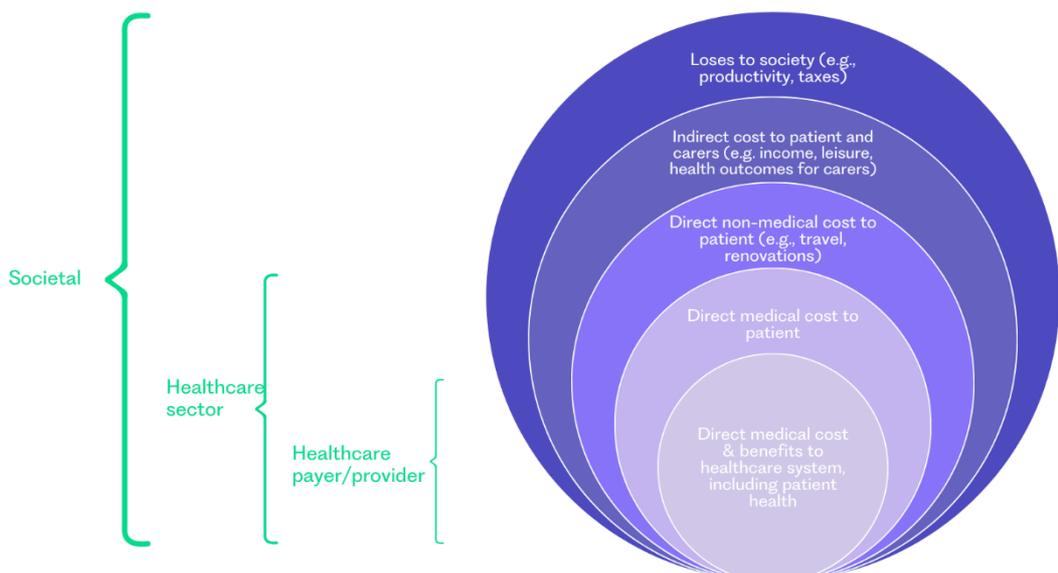
- Current HTA processes often adopt a narrow healthcare payer perspective, focusing on direct system costs and patient outcomes. While this simplifies decision-making, it systematically excludes indirect costs and spillover effects on carers, families, and society.
- Adopting a broader perspective on value, especially in conditions with clear spillover effects such as breast cancer, can better capture the full societal impact of disease and treatment, ensuring decisions target improved overall wellbeing, not just reduced costs for healthcare systems.
- While broader perspectives introduce challenges, such as data gaps and increased decision uncertainty, we recommend their routine adoption in cases with significant spillover effects. This targeted approach balances ambition with feasibility and incentivises data collection to reduce uncertainty over time.

In this Whitepaper, we describe different perspectives that can be adopted in Health Technology Assessment (HTA), and some of the advantages and disadvantages of these different perspectives. Drawing on a panel session at the 2024 European meeting of the International Society for Pharmacoeconomics and Outcomes Research (ISPOR), including patient, clinical, and health economics representatives, we argue for a broader perspective on costs and outcomes when assessing the value of new treatments, especially when a health condition or its treatment has significant health or economic impacts beyond the patient.

In the context of HTA, perspective refers to the ‘point of view’ or ‘scope of concern’ adopted when weighing outcomes and costs in an economic evaluation (Drummond et al., 2015). Several perspectives are recognised in HTA, and the appropriate perspective will depend on the context and objectives of an assessment (Sittimart et al., 2024):

- **Healthcare Payer Perspective** This narrow view focuses on direct costs to the healthcare system and patient outcomes, such as diagnosis, treatment, and hospitalisation costs. It is commonly used in publicly funded systems with strict budget constraints. This perspective simplifies evaluations and maximises potential health gains under a fixed budget, known as technical efficiency.
- **Healthcare Sector Perspective** A slightly broader view that includes direct (out-of-pocket) medical costs to the patient.
- **Societal Perspective** This perspective expands the scope of concern to consider all health or direct and indirect economic effects related to a patient’s illness. It may include indirect costs to the patient (lost productivity, leisure time), costs and health impacts to carers and family, and non-health impacts on sectors like education and justice. This perspective aligns with welfare economics in aiming to maximise societal welfare, known as allocative efficiency.

Figure 1 Overview of (especially cost) considerations by perspective (Sittimart et al., 2024)



Many health conditions have direct or indirect impacts beyond the healthcare system and can affect more than just the patient and the healthcare system. Indirect costs, not directly related to treatment, include monetary losses to the patient from time off work, or forgone education and leisure. Equally, "spillover effects" impact individuals beyond the patient, such as monetary and health impacts on carers, family, or the wider society (Basu and Meltzer, 2005; Wittenberg, James and Prosser, 2019; Mendoza-Jiménez, van Exel and Brouwer, 2024). The concept of spillover effects could even extend to consideration of 'unrelated healthcare costs' (Kearns, 2020). Depending on the perspective adopted, these indirect costs and spillover effects may or may not be considered in an HTA.

Given potentially important indirect costs and spillover effects, adopting an appropriate perspective is crucial for understanding the full impact of a disease and the value of its treatment. Systematically excluding indirect or spillover costs and health impacts can lead to suboptimal HTA recommendations. For example, early hospital discharge may seem cost-saving from a narrow payer perspective, but a broader view would consider the costs and health effects of shifting care to individuals outside the healthcare system. At the extreme, by disregarding potentially important impacts beyond the patient and the healthcare system, narrower perspectives on value have the potential to improve health outcomes to the patient or save costs for the system but ultimately reduce overall societal welfare in terms of wider costs and burdens (Brouwer, 2019). Conversely, adopting a broader perspective on value is more likely to ensure recommendations lead to overall societal welfare gains, particularly in cases where conditions or their treatments have clear spillover effects.

Concerns around a broader perspective in HTA may be overstated

Concerns have been raised around the feasibility or appropriateness of broader perspectives on value in HTA, but we suggest that these may be overstated or otherwise manageable:

CONCERN	RESPONSE
The primary objective of healthcare should be to produce (patient) health, not societal welfare.	An overly-narrow focus can mean that health gains to a patient come at the expense of unrecognised and unaccounted losses to others.
Including broader impacts requires additional effort to collect and analyse. As these impacts become increasingly removed from the patient or the health system, the uncertainty in these estimates increases.	Defining the scope of an evaluation based on <i>effort</i> rather than relevance is difficult to justify on a theoretical or practical level. HTA bodies may justifiably object that there is limited or uncertain data for broader value elements, but study sponsors may justifiably argue that they have little incentive to invest in the collection of such data until HTA bodies confirm their willingness to adopt a broader perspective in their appraisals.
Incorporating broader value elements will increase value-based prices or otherwise threaten the financial sustainability of health systems.	Where a new health technology provides a marginal gain in societal welfare, impact on a value-based price will be correspondingly marginal. However, in cases where a technology does provide a substantial improvement in societal welfare, these gains should be appropriately reflected in value assessment. We note, however, that adopting a different perspective on value will also likely require HTA bodies to adopt a different value threshold.

CONCERN	RESPONSE
Valuing people’s time would disadvantage unemployed or (typically older) retired individuals and those engaged in lower-paid or volunteer activities, leading to equity concerns.	It would be straightforward to assign a single, representative value of time to all individuals, regardless of their income or employment status. A representative value of time would be consistent with valuing all individuals’ ability to make choices about how they use their time, regardless of the activity.
Considering the monetary value of time gained or lost could lead to double-counting if people also consider time away from their usual activities as part of the health-related quality-of-life of a health state.	Empirical studies have consistently demonstrated that individuals do not consider time or income losses in their utility valuations, suggesting concern for double counting may be unwarranted, or at worst, minor.
A genuine societal perspective on welfare requires some transferability of resources between sectoral budgets as new opportunities to generate societal welfare arise, but such transferability is difficult or impossible under the current system of siloed budgets.	Adopting a broader perspective on value within healthcare would still be a step towards greater allocative efficiency and improved overall societal welfare, and transferability between healthcare budgets may be more achievable in the shorter term.

A pragmatic way forward: a broader perspective in the presence of spillover effects

We believe a broader perspective on value can lead to better societal outcomes than narrower perspectives, by allowing decision-makers to balance the burdens and benefits to everyone, not just the patient. However, we also understand that methods and interpretations are rapidly developing. For now, we suggest adopting a broader perspective in cases where there are clear spillover effects associated with a disease or its treatment. In these cases, an appropriately broad perspective is necessary to account for the full range of impacts beyond the patient and the healthcare system.

Breast cancer is one such example of a condition with clear spillover effects. As discussed in the ISPOR panel session, breast cancer is associated with substantial costs and burdens extending beyond the patient and the healthcare system. An analysis of chemotherapy for early-stage breast cancer patients in the UK diagnosed in 2018-19 found that costs to patients, carers, and wider society were 40% greater than direct treatment costs (Parsekar et al., 2021).

A survivor’s account given at an Educational symposium at the *2024 International Society for Health Economics and Outcomes Research (ISPOR) Europe conference* (ISPOR, 2024) also highlighted burdens of breast cancer and its treatment that would not be recognised within the narrow payer perspective. These include the need for support from paid or unpaid (informal) carers during treatment, the need for special diets, prosthetics, and clothing during and after treatment, and long-term effects that can impair survivors’ ability to return to work or make full use of their time.

We note that a limitation of this pragmatic approach is the need to define what constitutes “clear” spillover effects, and to appropriately estimate their costs. Any such definition will be intrinsically subjective, and it may be difficult to be consistent in the consideration of financial spillovers and more humanistic spillovers. Arguably, this supports routine adoption of a broader perspective, but in the shorter-term we suggest that continuing research on a ‘multiplier’ for relative spillover effects by condition may help to inform when spillover effects are likely to be more relevant to a HTA decision.

Conclusion

A narrow perspective on value simplifies the HTA process and may reduce decision uncertainty, but it excludes potentially important impacts on patients, carers, family members and wider society, and may lead to situations where HTA maximises health at the expense of broader societal welfare. A broader perspective on value may add some decision uncertainty but can better support decisions that can improve overall societal welfare beyond patient health.

In recognition of some of the challenges associated with broader perspectives on value, particularly the potential for greater decision uncertainty (at least in the short term), we recommend that HTA bodies routinely adopt a broader perspective on value in circumstances where there are recognised spillover effects associated with a condition and its treatment. As we have demonstrated here, including through the first-hand account of a survivor, this category includes breast cancer.

1 Background

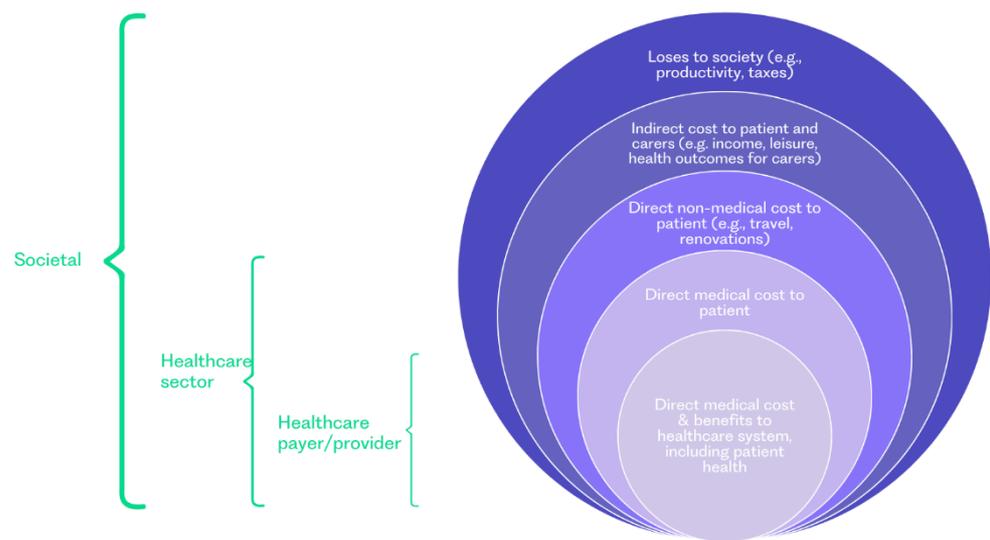
In the context of Health Technology Assessment (HTA), perspective refers to the ‘point of view’ or ‘scope of concern’ adopted when weighing outcomes and — especially — costs in an economic evaluation (Drummond et al., 2015). Different perspectives can influence the direction of the economic evaluation and the resulting decisions by including or excluding different categories of costs and outcomes (Sittimart et al., 2024). Critically, while there are several used and accepted perspectives within HTA, there is no one “right” perspective, and the appropriate perspective adopted is dependent on context (Drummond et al., 2015; Chalkidou, Culyer and Nemzoff, 2018; Kim et al., 2020).

In this Whitepaper, we describe different perspectives that can be adopted in HTA, and some of the advantages and disadvantages of these different perspectives. Using breast cancer as a case study, we argue for adopting a broader perspective on costs and outcomes when assessing the value of new treatments, especially when a health condition or its treatment has clear health or economic impacts beyond the patient.

1.1 Perspective in HTA

As illustrated in Figure 1, perspective in HTA can range from the narrow healthcare payer perspective, which limits itself to direct costs to the healthcare system, to the slightly broader healthcare sector perspective, which adds direct (out-of-pocket) costs to the patient to the evaluation, up to the broadest perspective considering costs and outcomes to society, regardless of their relationship to the patient or the healthcare system (Sittimart et al., 2024).

Figure 2 Overview of (especially cost) considerations by perspective (Sittimart et al., 2024)



The healthcare payer perspective is typically limited to patient outcomes and direct costs to the healthcare budget, such as costs of diagnosis, treatment, and hospitalisation. The healthcare sector perspective expands this slightly to include direct (out-of-pocket)

medical costs to the patient (Kim et al., 2020). These perspectives are widely adopted in publicly-funded systems like those in the United Kingdom, Canada and Australia, where funding decisions need to align with fixed budget constraints (Culyer et al., 2018; Wouterse et al., 2023). Focusing primarily on the healthcare budget simplifies the scope of the evaluation (Brouwer and van Baal, 2023; Sittimart et al., 2024) and can lead to an allocation of resources that maximises potential health gains to patients under a fixed budget, known as technical efficiency (Turner et al., 2021).

Broader societal perspectives expand the scope of concern to include — potentially — all health or direct and indirect economic effects associated with a patient's illness. There is some variation between countries in exactly which costs and outcomes are relevant under a societal perspective (see Figure 1), but they can include indirect costs to the patient, such as lost productivity, volunteering or leisure time; direct and indirect costs and health effects to informal carers and family members; and even non-health impacts on sectors such as education, environment, and justice (Avşar, Yang and Lorgelly, 2023). These broader perspectives on value are more closely aligned with welfare economics in seeking to maximise societal welfare rather than aggregate patient health gains (Culyer et al., 2018; Brouwer and van Baal, 2023; Wouterse et al., 2023). A broader perspective, though, by definition, requires consideration of costs and outcomes beyond those to the patient and the healthcare system, increasing the time and effort associated with an analysis and potentially delaying decision-making relative to a narrower and therefore simpler analysis (Sittimart et al., 2024; Brouwer and van Baal, 2023; Wouterse et al., 2023). A societal perspective is often adopted by the Netherlands and Sweden to recognise cross-sectoral cost-shifting and to promote equity and societal wellbeing (Wouterse et al., 2023; Geuzinge et al., 2025).

1.2

Perspective in the context of indirect costs and 'spillover effects'

As noted above, the narrow payer and sectoral perspectives focus on the direct impacts of a disease on healthcare systems and the patient. However, many health conditions can lead to direct or indirect impacts outside of the healthcare system and can affect more people than just the patient. Costs to the patient that are not directly related to costs of treatment are known as indirect costs and typically include indirect monetary losses due to time off from paid employment or associated with forgone education, volunteering or leisure activities (Sittimart et al., 2024). Impacts to individuals beyond the patient are known as "spillover effects" (Basu and Meltzer, 2005) and can include direct or indirect costs and health impacts to informal carers, family members, or wider society. This can include, for example, negative health effects on informal carers from physical exertions or anxiety associated with caring; direct monetary costs for caring aids; or indirect monetary losses as above. Similar spillovers can extend to other family members, even if they're not directly providing care, and even to employers and wider society to the extent they are unable to benefit from the contributions of the patient or their carer(s) in the form of lost productivity or tax revenues (Wittenberg, James and Prosser, 2019; Mendoza-Jiménez, van Exel and Brouwer, 2024). Arguably, the concept of spillover effects could even extend to consideration of 'unrelated healthcare costs' in HTA. In this view, future healthcare costs unrelated to the specific disease and treatment under consideration represent an additional cost to the healthcare system, especially in cases where treatment leads to survival gains and therefore future healthcare costs that would not otherwise have been incurred (Kearns, 2020).

The range of potential indirect costs and spillover effects means that adopting an appropriate perspective is critical to accounting for the full scope of the impacts of a disease and the value of its treatment. As Mendoza-Jimenez, van Exel and Brouwer (2024) note, a perspective that excludes relevant costs and health impacts will provide only a partial insight into the value of an intervention, and can lead to suboptimal decisions about

whether to fund particular interventions within the available budget. Brouwer (Brouwer, 2019) offers the example of early discharge from hospital. Under a narrow payer perspective, such a policy would be evaluated as unambiguously cost-saving, whereas a broader perspective would account for the wider costs and health effects of shifting care responsibilities to individuals outside of the healthcare system, supporting a more appropriate evaluation of costs and benefits across the health system, carers, and society. On this basis, he argues that narrower perspectives on value can improve *aggregate health outcomes* but potentially reduce *societal welfare* by excluding impacts that fall outside the healthcare system. A broader perspective is more consistent with maximising societal welfare by accounting for impacts on *all* stakeholders.

In the context of potentially substantial indirect costs and spillover effects associated with some diseases, including dementia (Lin et al., 2019) and infectious disease (Al-Janabi et al., 2016b), it is clear that adopting a narrower or broader perspective on impacts can lead to different estimates of value and therefore, different funding recommendations. We suggest that where there are likely to be substantial spillover effects, a broader perspective on value is likely to lead to a better understanding of the full scope of costs and benefits and thereby decisions that lead to better *societal* outcomes.

In the next section, we present a case study in breast cancer, based on a panel discussion at the 2024 International Society for Pharmacoeconomics and Outcomes Research (ISPOR) European Congress. We quantitatively and qualitatively illustrate indirect costs and spillover effects in breast cancer, and how narrower perspectives on value can overlook elements of value that are important to patients and clinicians.

2 Case study: spillovers and perspectives on value in breast cancer and its treatment

As noted in the previous section, many diseases can impose costs and burdens beyond the healthcare system. Breast cancer is one such example. An analysis of the costs of chemotherapy for early-stage breast cancer patients in the UK diagnosed in 2018-2019 (Parsekar et al., 2021) found that costs to patients and carers (£86.2m) and wider society (£141.4m), including societal losses (indirect costs) to patients and carers from lost productivity, leisure and volunteering opportunities, were 40% greater than the direct treatment costs. As illustrated in Figure 3, estimates that the total productivity losses, including out-of-pocket costs to patients and indirect costs to patients and carers were in the range of £145.6 million, compared to £102.7 million.

Figure 3 COST OF CHEMOTHERAPY ASSOCIATED WITH BREAST CANCER IN THE UK (Parsekar et al., 2021)



The topic of broader value in the context of breast cancer was explored in an Educational symposium at the 2024 *International Society for Health Economics and Outcomes Research (ISPOR) Europe conference* (ISPOR, 2024). The panel included Conchi Biurrin, member of the Federation of Spanish Breast Cancer Associations, and survivor of breast cancer, who described the patient experience from her own perspective; Dr Antonio Llobart Cussac, Head of Medical Oncology Service Hospital Arnau Vilanova, who provided insights into value from a clinical perspective; Meindert Boysen, an expert in HTA and previous director of the Centre for Health Technology Evaluation at NICE; and Melanie Whittington, Managing Director and Head of the Leerink Center for Pharmacoeconomics at MEDACorp and previous Director of Health Economics at ICER, who discussed different economic perspectives.

2.1 The survivor’s perspective¹

Señora Conchi Biurrin, a breast cancer survivor, provided a personal account of how her breast cancer and its treatment affected her health, daily life, and the people around her. She emphasised the need for continuing innovation in the treatment of breast cancer. Whilst she was grateful for treatments that helped reduce the burden of breast cancer, she highlighted that there is a still need for treatments that can reduce burdens on patients, their carers and wider society.

¹ This account reflects the patient’s personal perspective. The patient reviewed the manuscript and provided written consent for its inclusion.

Señora Biurrun outlined a series of issues that were particularly important to her, summarised below. Notably, these elements are currently not recognised under narrower perspectives, meaning that innovations in these areas would not necessarily be valued under conventional HTA approaches. Expanding perspectives on value could incentivise innovation and ensure that patients, carers and society are able to access and benefit from these innovations

Professional hurdles

Señora Biurrun was absent from work for a period of 18 months due to a combination of treatment and recovery time. Prolonged workplace absences can delay professional progress, create financial strain and lead to potential career setbacks. The potential for treatments to speed return to work, or other activities, are not traditionally considered by HTA but can have a profound impact on patients and their dependants.

Señora Biurrun also described how a specific issue associated with her treatment, lymphoedema, caused significant challenges. This condition characterised by fluid build-up in tissues (generally arms or legs) leads to swelling and discomfort. She observed that individuals who rely on dexterity or otherwise spend long periods on their feet, such as hairdressers, massage therapists, or sales clerks, would be particularly affected by such a condition. Although the discomfort associated with lymphoedema, and by extension, the benefits of treatments that could avoid it, would be captured by measures of health-related quality-of-life, any lost income or gains from avoiding such conditions would not.

Carer burden

Señora Biurrun emphasised the need she, and many other breast cancer patients, had for temporary assistance at home; in her case, particularly due to her lymphoedema which limited her ability to perform daily tasks.

Formal care, such as home nursing services, can impose financial burdens on the patient that may or may not be captured within conventional payer perspectives, while informal care, typically provided by family or friends, can strain relationships, disrupt the carer's home and professional life, and impact the carer's health and wellbeing. The time devoted to caregiving often comes at the expense of the carer's own physical, mental, or career-related needs. The impacts of informal caring are not well-captured within narrower perspectives, undervaluing potential innovations that could reduce caring needs.

Señora Biurrun also emphasised the impact of caregiving within romantic relationships on intimacy, particularly for breast cancer patients who have undergone a mastectomy. She noted that while breast cancer treatments often reduce libido, mastectomies also have a uniquely negative effect on sexual activity. These consequences can lead to emotional disconnection and deteriorating wellbeing. She noted the disproportionately high rate of relationship breakdowns due to carer burdens, further amplifying the emotional and financial challenges faced by both patients and their families.

Lifestyle changes associated with diagnosis and treatment

Señora Biurrun highlighted lifestyle changes that led to financial burdens which are often overlooked under narrower HTA perspectives. She explained that her medication caused a persistent metallic taste in her mouth, requiring major changes in her diet. For instance, drinking water exacerbated her nausea, requiring her to rely on alternative beverages, including when brushing her teeth. The swelling and discomfort from her lymphoedema necessitated changes to her wardrobe and the use of specialised hygiene and cosmetic products.

Many breast cancer patients experience alopecia, or hair loss, leading them to experience embarrassment and social stigma, and can be particularly distressing for children who may struggle to understand the situation. This can lead patients to have to purchase expensive wigs. As such, breast cancer and its treatment often lead to substantial out-of-pocket financial strains on patients that are not recognised by narrower payer perspectives.

Long-term cognitive and psychological effects

Señora Biurrun discussed the long-term cognitive impacts of chemotherapy, including brain fog and cognitive decline. She explained how these changes can make individuals feel unrecognisable to themselves, affecting their daily lives and relationships. Not being able to perform simple tasks, like reading a book due to increased forgetfulness, can take a significant toll on patients' wellbeing but also on their long-term productivity and career opportunities. These reduced prospects, and the value of innovative treatments that can minimise or reduce such effects, are not captured within narrower perspectives on value.

Narrower perspectives on value often overlook elements of value which are important to patients and those around them



Professional hurdles
Cancer patients often face prolonged absence from work due to medical treatment and recovery, leading to financial strain and career setbacks. Specific treatment side effects like lymphoedema can disproportionately impact manual workers, sometimes requiring costly career retraining.



Carer burden
The need for temporary home assistance as a result of treatment adverse events results in additional obstacles. While formal care adds financial strain, informal care can disrupt relationships, impact the carer's well-being, and even lead to relationship breakdowns, amplifying emotional and financial challenges.



Lifestyle changes
Lifestyle changes, triggered by medication can lead to significant financial burdens, including the need for specialised dietary, skincare, and hygiene products. These additional costs add substantial strain to patients' finances.



Psychological strain
Cognitive effects of chemotherapy, such as brain fog and forgetfulness significantly impact daily life and relationships. Treatment side effects like hair loss can cause particular distress, especially for young women and children who may not understand the situation.

2.2

A clinical perspective

When discussing HTA in Spain, Dr Llombart Cussac highlighted that the process is more often concerned with ‘cost-minimisation’ than ‘value-maximisation’. It is often the case that a partial cost analysis is conducted without considering outcomes, and even when outcomes are considered, the analysis tends to focus on very narrow acquisition costs without considering other costs or savings to the healthcare payer. It is clear that such an approach will often fail to maximise patient health outcomes, let alone broader wellbeing or societal welfare.

Spain is not alone in putting a greater emphasis on cost than value: more ‘resource-constrained’ health systems tend to adopt narrower perspectives and a focus on direct cost-savings over welfare maximisation. Even among better-funded systems, there is an emphasis on costs to the healthcare system with less consideration of wider costs and impacts. A systematic review of health economic evaluations conducted between 1974 and 2018 (Kim et al., 2020) found that three-quarters of all appraisals adopted a healthcare payer or sector perspective. As we have discussed, this increases the possibility of recommendations that improve patient health but impose unrecognised burdens on carers, family members or society.

There are, though, notable differences in perspective between countries. Among the 5 countries that accounted for most economic evaluations (the United States [US], the United Kingdom [UK], Canada, Netherlands, and Australia), almost half (49%) of all evaluations conducted in the Netherlands adopted a societal perspective, compared to 14% in Australia and 10% in the UK. These proportions reflect HTA guidance for the conduct of health economic appraisals in these countries (excluding the US, which has no national HTA guidance). The Netherlands recommends a societal perspective whilst the remaining countries recommend a narrower payer or sector perspective in the base case (Kim et al., 2020). Arguably, the fact that almost half of all HTA evaluations in the Netherlands were conducted from a societal perspective demonstrates that such a perspective is feasible, and that many objections to such a perspective may be overstated. We explore some of these objections in the next section.

3

The way forward: improving outcomes through a broader perspective on value

A key advantage of the payer perspective is that it focuses on evidence that is generally high-quality and widely available, especially clinical trials and peer-reviewed studies. This facilitates timely decision-making based on reliable data. The payer perspective is also closely aligned with healthcare or pharmaceutical budgets allocated by political decision-makers, meaning it is straightforward to evaluate the outcomes generated within a defined budget (Sittimart et al., 2024).

Critically, however, the payer perspective's narrow scope often fails to capture the full impacts of a disease or its treatment. Omitting indirect costs and impacts outside the healthcare system can lead to decisions which reduce costs to the system or improve patient outcomes but impose even greater costs and burdens on carers, families and the wider society. A narrow perspective on system costs and patient outcomes would, for example, make routine early-discharge from hospital appear to be an unambiguous net gain, whereas in reality such policies redistribute costs and burdens across society, and gains within the health system may be offset by (unrecognised) losses elsewhere. Thus, it is possible that a narrow perspective on value could improve narrowly-defined health system outcomes but actually worsen overall societal welfare (Wouterse et al., 2023).

The advantage of a broader perspective on value is the consideration of a broader range of relevant costs and outcomes, whether or not these fall within healthcare budgets. This perspective allows for decisions that improve overall societal welfare, not just the healthcare system (Brouwer and van Baal, 2023).

Notwithstanding this advantage, though, the societal perspective may introduce challenges around practicality and transparency. Many of the elements included, such as lost productivity or caregiver burden can be difficult to collect and may rely on assumptions or incomplete information (Brouwer and van Baal, 2023). Methodologies for estimating broader cost elements, such as productivity losses or value of time, are also unsettled (Hanly, Ortega-Ortega and Soerjomataram, 2022; Miszczyńska, Krzeczewski and Stawska, 2025). Together, these can increase the uncertainty around estimates of costs and effects, increasing decision uncertainty, or the risk of making the 'wrong' (i.e. non-outcome-maximising) decision on the basis of incomplete or unreliable evidence (McCabe, 2019). The complexity of integrating diverse societal impacts will also tend to increase the resource requirements and analytical burden of evaluations, potentially delaying decision-making (Sittimart et al., 2024). Moreover, while this perspective provides a fuller picture of societal impacts, it may be less actionable for policymakers operating within rigid budgetary frameworks or 'siloes' (Brouwer and van Baal, 2023). Similarly, we note that adopting a different perspective on value is likely to lead to a different cost-effectiveness threshold by which to judge value, especially if a broader perspective includes wellbeing beyond health. This will require research to identify a relevant basis of the threshold, either in terms of societal willingness to pay for improved wellbeing, or the opportunity cost of spending on wellbeing.

3.1

Increased ambition but increased uncertainty?

Accounting for the broader impacts of medicines and technologies provides a fuller understanding of the value of new technologies to *society*, beyond just the *healthcare system*. As noted, this can promote greater societal welfare but may increase reliance on uncertain evidence, as well as require a revised value threshold. Both have the potential to

increase decision uncertainty. This leads to a tension between *maximising* societal welfare and *minimising* decision uncertainty.

In some cases, HTA bodies accept the possibility of greater decision uncertainty and broaden their perspective to include, in particular, caregiver effects (Pennington et al., 2022), but in most cases, they prefer to minimise decision uncertainty by limiting their objective to narrow technical efficiency in maximising (patient) health gains, arguing that concern for societal welfare is outside their mandate. Other approaches to reducing decision uncertainty, especially in the context of rare diseases or urgent unmet needs, include different versions of conditional or limited-time approval pathways subject to additional evidence generation (Mendell et al., 2023). Such pathways allow HTA bodies to make recommendations on the basis of uncertain evidence but retain the option to reverse these recommendations as new evidence emerges. Even in these alternative assessment pathways, though, HTA bodies typically adopt a narrow perspective on value.

We suggest that this is a short-sighted approach. As Brouwer (2019) notes, consciously adopting a narrow perspective on value means that, "...decision makers are systematically left ignorant of the broader consequences of their decisions." In this context, it is difficult to justify a valuation process that systematically excludes relevant aspects of the decision problem and consciously disregards the possibility that some HTA decisions could *reduce* overall societal welfare.

Put another way, decision makers may be forced to choose between the possibility of making the 'wrong' (non-outcome-maximising) decision as a result of the additional uncertainty inherent in some broader value elements or making the 'wrong' decision as a result of deliberately excluding broader aspects of value that are relevant to societal welfare but may be more uncertain or difficult to measure.

In the next section, we suggest that consistently adopting a societal perspective in HTA ensures that HTA decisions have the potential to improve overall welfare and will incentivise data collection that, in the medium-term, will reduce the uncertainty around estimates of many broader value elements.

3.2

A pragmatic way forward

We advocate for a broader perspective on value but also recognise the tension between the certainty of the evidence and the scope of the ambition. Adopting a broader perspective on value is more likely to optimise societal welfare but, in the short to medium term at least, is also likely to rely on more uncertain evidence than a narrower perspective. Therefore, we suggest that the appropriate breadth of perspective in any appraisal should be guided by anticipated spillover effects. The potential for systematically excluding important elements of value under a narrower perspective is greatest for conditions where there are clear spillover effects. Treatments for such conditions, therefore, should routinely be evaluated under a broader perspective, whereas treatments for conditions without clear spillover effects can more justifiably be evaluated under a narrower perspective. Indeed, this would be aligned with NICE's existing guidance that carer effects (i.e. spillovers) should be considered "when relevant" (NICE, 2025), but would expand the perspective to include more than just carer health effects.

Such an approach is still likely to be 'second-best' in terms of societal welfare gains relative to routine adoption of a broader perspective on value but could improve societal welfare while recognising the opportunity costs of more comprehensive appraisals. A similar approach has been suggested in the context of carer spillovers, where inclusion of carer burden would be guided by an understanding of the likely intensity and duration of caring (Bourke et al., 2024). The greater these factors, the more relevant (and arguably, *necessary*) a broader perspective on value becomes. Whichever perspective is adopted,

though, it is essential that it is explicitly stated *prospectively*, prior to beginning data collection or the appraisal. Adopting or changing the perspective partway through an appraisal inevitably suggests some ‘opportunism’, or adopting a particular perspective because it will favour a particular outcome.

One challenge to this approach will be understanding the likely scale of spillovers prior to conducting an appraisal. In most cases, though, it should be possible to anticipate the *likelihood* of spillovers, even if their precise magnitude is unknown in advance. Future research could also inform the development of ‘spillover multipliers’ by disease area (Al-Janabi et al., 2016a), whereby estimates of spillover effects would be based on estimates of the relative relationship between patient and family effects across different disease areas. Estimates of relative spillover effects by disease area would also speed-up data collection and analysis, limiting any delays in decision-making associated with adopting a broader perspective.

3.3

Balancing concern for *health* and *welfare* in a broader perspective

As we have argued, a broader perspective on value, including carers, family members, employers, and wider society, would facilitate consideration of factors beyond health, and ultimately move from technical efficiency in maximising health towards allocative efficiency in maximising societal welfare.

We recognise, however, that there are arguments in favour of a narrower focus on health. These include, explicitly or implicitly, 1) the (intuitive) idea that the primary objective of *healthcare* should be to produce *health*; 2) concerns around the analytic complexity and decision uncertainty associated with broader perspectives; 3) concerns that incorporation of broader value elements would threaten the sustainability of health systems; 4) inequities, including discrimination by age or socioeconomic status, associated with consideration of societal elements such as productivity, and 5) practical barriers to reallocating resources between sectors to promote allocating efficiency. However, drawing on the discussions from the ISPOR panel, and overarching arguments from papers cited, specifically, Brouwer (2019) and McCabe (2019), we suggest that many of these concerns may be overstated and otherwise inconsistent with seeking to maximise the overall welfare of *society* rather than specific subgroups within society.

First, whilst a focus on patients in healthcare decision-making may seem intuitive, an overly-narrow focus can mean that “...decision makers are systematically left ignorant about the broader consequences of their decisions” (Brouwer, 2019). This means that health gains to a patient may come at the expense of unrecognised and unaccounted losses to others, and as Brouwer (2019) notes, an evaluative approach based on systematic and wilful ignorance is difficult to justify. Furthermore, such an approach would seem to violate the ‘distributional indifference’ of the principle that ‘a QALY is a QALY is a QALY’, as it prioritises some QALYs (to patients) over others, such as carers or family members. In this context, we note that many HTA bodies are expanding their perspective to allow more routine consideration of carer effects in appraisals (Pennington et al., 2022), but such consideration typically remains limited to a single primary carer, and wider family effects are not typically included, nor are the impacts on leisure, education, employment or volunteer activities.

Second, the inclusion of broader impacts requires additional effort to collect and analyse, and as these impacts become increasingly removed from the patient or the health system, the uncertainty in these estimates increases. At some point, the effort of collecting additional information cannot be justified by its impact on the decision. However, as with limiting the scope of concern to the patient, defining the scope of an evaluation based on *effort* rather than *relevance* seems difficult to justify on a theoretical or practical level. As

McCabe (2019) notes, “...these are challenges for the implementation of economic evaluations in specific contexts, not principles that would exclude such factors from its scope.”

With respect to uncertainty in estimates of broader impacts, HTA bodies may justifiably object that there is limited data on such impacts, and where data may exist, it is highly uncertain. Indeed, the need for better estimates of spillover effects on carer quality-of-life was recently highlighted by Pennington *et al* (2022). Equally, however, study sponsors may justifiably argue that they have little incentive to invest in the collection of such data until HTA bodies confirm their willingness to adopt a broader perspective in their appraisals. Arguably, the first step in resolving this ‘chicken-and-egg’ problem is for HTA to signal their willingness to accept such data where it is important to understanding the value of a medicine or technology, especially in the assessment of treatments for conditions with clear spillover effects.

Third, there is arguably a concern that incorporating broader value elements into HTA would increase value-based prices or otherwise undermine the ability of HTA processes to limit access to products with ‘genuine’ value, threatening the financial sustainability of health systems. We suggest, however, that this concern may be exaggerated. As with conventional payer value elements, any broader value elements would be assessed on an *incremental* basis. Where a new health technology provides a marginal gain in societal welfare, any impact on a value-based price or value assessment will be correspondingly marginal. However, in cases where a technology does provide a substantial improvement in societal welfare, these gains should be appropriately reflected in value assessment. If two technologies deliver similar patient health gains, but the second is also associated with a substantial reduction in spillover effects or a dramatic increase in productivity, it seems intuitive that the second technology provides additional value to society that should be appropriately recognised.

Fourth, critics suggest that consideration of the value of people’s time in HTA would disadvantage unemployed or (typically older) retired individuals, as well as those engaged in lower-paid or volunteer activities. We suggest that it would be straightforward to assign a single, representative value of time to all individuals, regardless of their income or employment status. Using a representative value of time would be consistent with valuing all individuals’ ability to make choices about how to use their time, regardless of any salary or tax revenue associated with the activity (Verbooy *et al.*, 2018). Others may make a contrary argument: that true allocative efficiency requires discriminating by economic productivity. In this argument, prioritising more productive workers maximises tax revenue and, in turn, societal resources that can be used to contribute to societal welfare. We do not accept this argument. Although we suggest that the value of people’s time, or more specifically, *the value of allowing people use their time in the way they prefer*, can be represented by some monetary value, it does not follow that it is necessary to value some people’s freedom to use their time more highly than others based on their current productivity.

There are also objections that considering the monetary value of time gained or lost could lead to double-counting if people also consider lost productivity or time away from their usual activities as part of the health-related quality-of-life, or utility, of a health state. However, empirical studies have consistently demonstrated that individuals do not consider time or income losses in their utility valuations (Krol, Sendi and Brouwer, 2009; Tilling *et al.*, 2012), suggesting concern for double counting may be unwarranted, or at worst, minor.

Finally, adopting a genuine societal perspective on welfare requires some transferability of resources between sectoral budgets as new opportunities to generate societal welfare arise. A technological breakthrough in housing or nutrition, for example, might be more efficient at generating welfare gains than currently available in the health sector, implying that some of the health budget should be transferred to the other sector in pursuit of

allocative efficiency. The reverse could also be true, implying in-flows to the health budget. Such flexibility between budgets is not, however, the norm; most governments adopt a system of earmarked or siloed budgets. Indeed, in addition to silos *between* sectors, there is most often a second layer of silos *within* sectors. Most health systems, for example, earmark funding for pharmaceuticals, hospitals, physicians, public health, and so on, generating ever more silos, and ever more barriers to reallocation.

We do not suggest that eliminating silos across all sectors of the economy would be simple, or even possible. We do suggest, however, that starting by adopting a broader perspective on value within healthcare would be a step towards greater allocative efficiency (Liu, 2003) and improved overall societal welfare. It would also represent a step towards the idea of health as an 'investment' that provides benefits across society and not just to the patient. Transferability between healthcare budgets may be achievable in the shorter term but will require consideration of a fuller range of the impacts of health conditions and their treatment, ensuring that the allocation of healthcare resources improves societal welfare as well as patient health.

4

Conclusion

A narrow perspective on value simplifies the HTA process and may reduce decision uncertainty, but it excludes potentially important impacts on patients, carers, family members and wider society, and may lead to situations where HTA processes maximise health at the expense of broader societal welfare. A broader perspective on value may add some decision uncertainty but can better support decisions that can improve overall societal welfare beyond patient health.

In recognition of some of the challenges associated with broader perspectives on value, particularly the potential for greater decision uncertainty (at least in the short term), we recommend that HTA bodies routinely adopt a broader perspective on value in circumstances where there are recognised spillover effects associated with a condition and its treatment. As we have demonstrated here, including through the first-hand account of a survivor, this category includes breast cancer.

5

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