Economic Evaluation

The Impact of Funding Inpatient Treatments for COVID-19 on Health Equity in the United States: A Distributional Cost-Effectiveness Analysis

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A B S T R A C T

Objectives: We conducted a distributional cost-effectiveness analysis (DCEA) to evaluate how Medicare funding of inpatient COVID-19 treatments affected health equity in the United States.

Methods: A DCEA, based on an existing cost-effectiveness analysis model, was conducted from the perspective of a single US payer, Medicare. The US population was divided based on race and ethnicity (Hispanic, non-Hispanic black, and non-Hispanic white) and county-level social vulnerability index (5 quintile groups) into 15 equity-relevant subgroups. The baseline distribution of quality-adjusted life expectancy was estimated across the equity subgroups. Opportunity costs were estimated by converting total spend on COVID-19 inpatient treatments into health losses, expressed as quality-adjusted life-years (QALYs), using base-case assumptions of an opportunity cost threshold of $150,000 per QALY gained and an equal distribution of opportunity costs across equity-relevant subgroups.

Results: More socially vulnerable populations received larger per capita health benefits due to higher COVID-19 incidence and baseline in-hospital mortality. The total direct medical cost of inpatient COVID-19 interventions in the United States in 2020 was estimated at $25.83 billion with an estimated net benefit of 735,569 QALYs after adjusting for opportunity costs. Funding inpatient COVID-19 treatment reduced the population-level burden of health inequality by 0.234%. Conclusions remained robust across scenario and sensitivity analyses.

Conclusions: To the best of our knowledge, this is the first DCEA to quantify the equity implications of funding COVID-19 treatments in the United States. Medicare funding of COVID-19 treatments in the United States could improve overall health while reducing existing health inequalities.

Keywords: cost-effectiveness, COVID-19, health equity, United States

Introduction

The burden of COVID-19 is far reaching and ubiquitous across communities and countries; nevertheless, the burden has not been equitable across the US population.1 Minority, low income, and socially vulnerable individuals/communities faced a disproportionate burden of COVID-19 cases, hospitalizations, and deaths.2-6 The disproportionate impact of COVID-19 on vulnerable communities has accelerated interest in understanding what steps can be taken to effectively mitigate disparities in health between more and less socially disadvantaged groups.7

To promote efficient resource allocation when budgets are limited, cost-effectiveness analysis (CEA) is being leveraged to inform decision making on funding and reimbursement for COVID-19 treatments in the United States.8-14 CEA focuses on the total costs and health effects across the whole population eligible for treatment. Nevertheless, CEAs rarely provide information on the distribution of costs and effects—that is, who gains and who loses—which depends on differences among people at various steps in the “inequality staircase” including differences in health risks (eg, who is at the highest risk), access (eg, who is most likely to receive treatment), capacity to benefit (eg, who benefits most from treatment), and who bears the opportunity costs of diverting scarce resources from other uses.15 Distributional CEA (DCEA) is an extension of CEA that provides information about these distributional questions, as well as the conventional question of cost-effectiveness.15

The equity impact of funding COVID-19 interventions in the United States has not yet been established.8,14 Given the disproportionate impact of COVID-19 on disadvantaged populations, it is essential to understand how decisions on the funding of treatments may affect health disparities. Building on previous work to outline a framework for estimating the cost-effectiveness of COVID-19 inpatient treatments,17 we conducted the first application of DCEA to evaluate how US Medicare funding of inpatient COVID-19 treatments for hospitalized patients might affect health equity in the United States.
Methods

The Original CEA Model

We adapted a published CEA model, described by Sheinson et al.13 This model was chosen for convenience and aligned with other COVID-19 CEAs developed in the United States in 2021.1,10 The model compared various treatments for hospitalized COVID-19 patients with standard of care as defined in clinical trials in 2020.10,17 including treatments with varying levels of impact on reducing mortality, use of mechanical ventilation, and length of hospital stay.

Treatment effectiveness parameters remained unchanged from the published CEA model given that clinical data were not reported based on equity-relevant subgroups. In brief, effects were based on trials of inpatient treatments available at the time of model development (RECOVERY, ACTT-1).16,17 The intervention of interest was a hypothetical treatment with an impact on reducing mortality (relative risk [RR] 0.89 and 0.67 for patients on mechanical ventilation and oxygen support, respectively) and reducing progression to mechanical ventilation (RR 0.77), with an assumed treatment cost of $2500 (similar to the cost of monoclonal antibodies funded in 2021).10 Incremental cost-effectiveness ratio per quality-adjusted life-year (QALY) was used as a measure of cost-effectiveness. Base-case results for the healthcare payer perspective—when COVID-19 treatment was funded on top of the bundled episode-based care payments made to hospitals—found treatments to be cost-effective: incremental cost-effectiveness ratio of $28 651 per QALY gained (0.437 incremental QALYs, $12 527 incremental costs).

DCEA Framework: Estimation Tasks, Equity-Relevant Variables, and Perspective

Extending a standard CEA to conduct DCEA requires the estimation of 3 main distributional breakdowns, in addition to the information provided by standard CEA:

1. the baseline distribution of health in terms of quality-adjusted life expectancy (QALE);
2. the distribution of health effects; and
3. the distribution of opportunity costs.

All involve disaggregating an overall whole-population outcome by the same equity-relevant variables of interest. We focused on 2 equity-relevant variables: race and ethnicity (3 groups: Hispanic [H], non-Hispanic black [B], non-Hispanic white [W]) and county-level social vulnerability (5 quintile groups), yielding 15 equity subgroups for each distributional breakdown—as described later.

The perspective of our DCEA analysis is that of a single US payer: Medicare. We assumed that Medicare operates under a quasi-fixed budget whereby allocating funds to cover inpatient COVID-19 treatments would result in health opportunity costs from forgone health improving activities funded by either Medicare or other federal health programs. Although we recognize that the US landscape consists of many fragmented payers with limited continuous enrollment, Medicare perspective was adopted for this study because the vast majority of patients hospitalized in the United States for COVID-19 in 2020 were 65 years of age or older and covered by Medicare.18

Creation of Equity-Relevant Subgroups

Conventional CEA focuses on effects among the intervention recipient population only. DCEA considers the entire general population, including individuals who are not eligible for the intervention but could face opportunity costs from funding a cost-increasing alternative. To inform the creation of the subgroups and inputs for the DCEA, a targeted literature review was conducted to gather information on key risk factors for COVID-19 and COVID-19-related health outcomes of hospitalization and inpatient mortality (see Appendix in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010) available through February 28, 2021. Our race and ethnicity subgroups were chosen for inclusion based on the availability of data and review findings. The review identified many studies reporting increased risks of COVID-19 and death for Hispanic and non-Hispanic black communities relative to non-Hispanic white communities, although the magnitude and significance of race and ethnicity as a predictor of increased COVID-19 risks varied notably across geographies and analyses. Information on additional racial and ethnic subgroups beyond these 3 categories was not identified in the literature. We also used a deprivation index as a second equity-relevant variable, which interacts with some of the underlying causes of COVID-19 disparities across racial and ethnic groups.15,22

The social vulnerability index (SVI), a percentile-based measure routinely collected at the US census tract level to estimate the resilience of communities during times of public health emergencies, was used to group the populations into 5 quintile groups (from Q1 [least vulnerable] to Q5 [most vulnerable]).3,23 This resulted in 15 subgroups capturing important differences in COVID-19 risks and outcomes according to race and ethnicity and level of social vulnerability (see Appendix in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).

Establishing Baseline QALE Across the Subgroups

Suitable baseline data on QALE at birth across the whole US general population based on both social vulnerability and race and ethnicity were not available, and hence, we conducted a substantial de novo estimation exercise, which is reported in detail in the Appendix in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010. Using population, mortality,5,6,19-21 disability data (extracted from Centers for Disease Control and Prevention Wonder, American Community Survey, and County Health Rankings and Roadmaps program9), we first estimated disability-free life expectancy (DFLE) for each subgroup. DFLE was then converted to QALE, using a previously published mapping process outlined by Asaria et al.22 where the ratio of DFLE to life expectancy is used to adjust QALE estimates. QALE estimates for each subgroup used age-adjusted, sex-based QALY weights for the general US population (all races) from Sullivan and Ghushchyan17 (see Appendix Table 2 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).22 The conversion to QALE makes the analysis consistent with the standard QALY metric used in CEA.

Estimating Health Effects for Each Subgroup

The outcome of COVID-19 treatments for a typical patient in each subgroup was estimated by incorporating distributional functionality within the CEA model. Appendix Figure 2 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010 shows the inequality staircase used for inpatients receiving COVID-19 treatments.
Trial data on differences in treatment effects across our subgroups of interest were not available, so we applied the same mortality RR reductions to each subgroup but different estimates of baseline risk based on real-world evidence on the link between social vulnerability and baseline risk of COVID-19 hospitalization and inpatient mortality. Areas with greater levels of social vulnerability were more likely to become COVID-19 hotspots and individuals in socially vulnerable communities were more likely to have poorer outcomes including COVID-19 mortality. A cross-sectional national study examining the relationship between SVI and COVID-19 outcomes showed that for every 0.1 increase in the SVI, a 14.3% relative increase in COVID-19 incidence and a 13.7% relative increase in COVID-19 mortality were observed.3

Estimates of COVID-19 hospitalizations for each subgroup were derived based on the underlying age distribution of the subgroup (Appendix Table 1 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010) and the age-based hospitalization rates.28 These initial estimates were adjusted to reflect the impact of county-level social vulnerability, based on each county’s deviation from the national average SVI score per the risk effect of increased SVI.3 It was assumed that the impact of SVI on the risk of COVID-19 incidence (14.3% increase per 0.1 increase in SVI) could be used to adjust SVI-based impact on COVID-19 hospitalizations. This county-level deviation from average SVI in our national sample was also used to adjust the baseline risk of death for the standard-of-care arm in our model, to reflect how different root causes drove inequality in initial COVID-19 mortality outcomes (13.7% increase per 0.1 increase in SVI) (Table 15,28) (Appendix Table 3 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).5

Patient-level average health effects for each subgroup were generated from the CEA and then converted to population-level subgroup effects based on the estimated number of hospitalized patients, considering the average SVI and underlying age distribution of the subgroup.

Assumptions About the Distribution of Health Opportunity Costs

Given that the assumed perspective was that of a single public payer (Medicare), we did not need to look at potential differences between subgroups in drug costs, inpatient reimbursement, or postdischarge costs. Instead we focused on differences in health opportunity cost based on subgroup, as described below. Outside of changes to baseline mortality related to average SVI score for each subgroup, all remaining model cost-effectiveness inputs remained unchanged from the published analysis for the base-case healthcare payer perspective.13 The Medicare healthcare payer perspective assumed that the cost of inpatient COVID-19 medicines would represent an incremental cost on top of bundled payments to hospitals for episode-based care.

When assessing population-level health equity impacts, standard DCEA methodology was used in which the average health of an individual based on subgroup was estimated after accounting for health losses due to inpatient COVID-19 mortality.15,22 Total opportunity costs were estimated by converting the total spend on COVID-19 inpatient treatments into health losses, expressed as QALYs, with an assumed opportunity cost threshold of $150,000 per QALY gained, with sensitivity analyses testing the impact of alternative ranges ($50,000-$150,000). Conceptually, the appropriate threshold for analyzing the distribution of health opportunity costs is an “opportunity cost” threshold, which estimates the marginal cost of producing 1 QALY from alternative uses of Medicare funding. Our estimate of $150,000 is at the high end of the best available estimate of the US opportunity cost of healthcare spending.20 In the absence of data on the distribution of this
Table 1. Summary of inputs for COVID-19 DCEA.

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Average SVI score</th>
<th>Total population</th>
<th>COVID-19 inpatient mortality adjustora</th>
<th>COVID-19 hospitalization (per 100,000)</th>
<th>Total number of hospitalizations</th>
<th>Percent hospitalized with COVID-19 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unadjusted COVID-19 hospitalization rateb</td>
<td>SVI-adjusted COVID-19 hospitalization ratec</td>
<td></td>
</tr>
<tr>
<td>HQ1</td>
<td>4143 362</td>
<td>0.145</td>
<td>0.61</td>
<td>537.2</td>
<td>325.6</td>
<td>13 493</td>
</tr>
<tr>
<td>HQ2</td>
<td>7473 781</td>
<td>0.352</td>
<td>0.80</td>
<td>529.1</td>
<td>421.0</td>
<td>31 462</td>
</tr>
<tr>
<td>HQ3</td>
<td>9992 513</td>
<td>0.531</td>
<td>1.01</td>
<td>567.1</td>
<td>570.2</td>
<td>56 979</td>
</tr>
<tr>
<td>HQ4</td>
<td>18 289 880</td>
<td>0.709</td>
<td>1.27</td>
<td>557.7</td>
<td>708.3</td>
<td>129 541</td>
</tr>
<tr>
<td>HQ5</td>
<td>14 018 354</td>
<td>0.897</td>
<td>1.62</td>
<td>599.0</td>
<td>972.6</td>
<td>136 348</td>
</tr>
<tr>
<td>BQ1</td>
<td>3251 954</td>
<td>0.145</td>
<td>0.61</td>
<td>664.3</td>
<td>402.7</td>
<td>13 096</td>
</tr>
<tr>
<td>BQ2</td>
<td>5 621 186</td>
<td>0.352</td>
<td>0.80</td>
<td>648.4</td>
<td>516.0</td>
<td>29 003</td>
</tr>
<tr>
<td>BQ3</td>
<td>8037 859</td>
<td>0.531</td>
<td>1.01</td>
<td>669.2</td>
<td>672.8</td>
<td>54 082</td>
</tr>
<tr>
<td>BQ4</td>
<td>12 066 135</td>
<td>0.709</td>
<td>1.27</td>
<td>681.7</td>
<td>865.7</td>
<td>104 459</td>
</tr>
<tr>
<td>BQ5</td>
<td>7 875 448</td>
<td>0.897</td>
<td>1.62</td>
<td>687.9</td>
<td>1117.0</td>
<td>87 972</td>
</tr>
<tr>
<td>WQ1</td>
<td>34 435 697</td>
<td>0.145</td>
<td>0.61</td>
<td>827.8</td>
<td>501.8</td>
<td>172 794</td>
</tr>
<tr>
<td>WQ2</td>
<td>34 445 350</td>
<td>0.352</td>
<td>0.80</td>
<td>830.1</td>
<td>660.5</td>
<td>227 527</td>
</tr>
<tr>
<td>WQ3</td>
<td>35 177 231</td>
<td>0.531</td>
<td>1.01</td>
<td>865.0</td>
<td>869.8</td>
<td>305 959</td>
</tr>
<tr>
<td>WQ4</td>
<td>31 837 920</td>
<td>0.709</td>
<td>1.27</td>
<td>855.2</td>
<td>1086.0</td>
<td>345 755</td>
</tr>
<tr>
<td>WQ5</td>
<td>14 803 158</td>
<td>0.897</td>
<td>1.62</td>
<td>860.7</td>
<td>1397.5</td>
<td>206 877</td>
</tr>
<tr>
<td>US Sample</td>
<td>241 469 828</td>
<td>0.527</td>
<td></td>
<td>915 345</td>
<td>1.12</td>
<td></td>
</tr>
</tbody>
</table>

Note. Average SVI score indicates fractional rank among all 810 US counties. B indicates non-Hispanic black; DCEA, distributional cost-effectiveness analysis; H, Hispanic; Q, quintile (1 = least socially vulnerable; 5 = most socially vulnerable); SVI, social vulnerability index; W, non-Hispanic white.

*aInpatient mortality adjustor: the difference between the subgroup SVI and the national sample SVI was used to create an adjustment factor for the baseline risk of COVID-19 mortality, based on the 13.7% increase per 0.1-point increase in SVI, per Karmakar et al7 (based on data from March 25 to June 29, 2020).
*bUnadjusted COVID-19 hospitalization rate: estimated rate of hospitalization based on the number of patients in the subgroup and the age distribution of patients within the subgroup, per Reesee et al28 based on data from February 27 to September 30, 2020 (see Appendix in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010 for detail on demographics based on subgroup).
*cSVI-adjusted COVID-19 hospitalization rate: estimated rate of hospitalization based on adjustments to baseline rate to reflect 14.3% increase in COVID-19 hospitalizations for every 0.1-point increase in SVI (relative to the national average SVI), per Karmakar et al7.

Results

CEA Results

The deterministic CEA results per average patient across each model subgroup are presented in Table 2. Differences in direct medical costs and incremental QALYs gained across subgroups are driven by changes to baseline mortality for the standard-of-care arm, per SVI adjustment. Increasing social vulnerability and the associated higher baseline mortality in the hospital result in greater absolute effects of treatment and hence greater incremental QALYs gained, which translated into a greater change in life-years after hospital discharge and higher incremental costs accumulated over a patient’s lifetime from increased survival (see Table 2).
DCEA Results

Through combining patient-level CEA outputs, information on incidence of COVID-19 hospitalization, and average starting patient QALE, the population-level results were determined (Tables 2 and 3). The total cost of inpatient COVID-19 interventions was estimated at $25.83 billion with an estimated 907,797 QALYs gained and health losses of 172,228 QALYs per the assumed $150,000 opportunity cost threshold. Net health benefits were generally higher in more socially vulnerable groups, because these patients had the highest mortality and therefore the greatest capacity to benefit (Fig. 2).

Comparing net health benefits across racial and ethnic subgroups, we see 2 competing factors driving the results. First, the non-Hispanic black and Hispanic subgroups had more patients in more deprived quintiles with higher baseline COVID-19 hospitalization and mortality risks and therefore increased health benefits (Table 3). Nevertheless, these gains were offset by the differences in age distributions of those groups relative to the non-Hispanic white subgroup. An average of 19.7% of the population was 65 years or older across non-Hispanic white subgroups compared with 10.8% and 6.8% in the non-Hispanic black and Hispanic subgroups, respectively (Appendix Table 1 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).

Given that COVID-19 incidence and hospitalization rate increase notably with age, these differences in population age mix result in a higher number of COVID-19 hospitalizations in the non-Hispanic white population (Table 1).3,28. Overall, nevertheless, SVI remained the dominant driver of results, with larger health benefits in socially disadvantaged groups.

Using the Atkinson index approach, we found that funding of COVID-19 treatments reduced the population-level burden of health inequality by 0.234%. Expressed in absolute population-level terms and using our base-case Atkinson parameter of 11,
### Table 3. Population-level DCEA outcomes.

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Total population within each subgroup*</th>
<th>Average starting patient QALE†</th>
<th>Health benefits from COVID-19 inpatient treatment (QALYs)§</th>
<th>Health losses (per opportunity costs) (QALYs)‡</th>
<th>Net health benefits (QALYs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HQ1</td>
<td>4143 362</td>
<td>71.22</td>
<td>4061</td>
<td>(2955)</td>
<td>1106</td>
</tr>
<tr>
<td>HQ2</td>
<td>7473 781</td>
<td>69.91</td>
<td>11641</td>
<td>(5331)</td>
<td>6310</td>
</tr>
<tr>
<td>HQ3</td>
<td>9992 513</td>
<td>68.76</td>
<td>25 014</td>
<td>(7127)</td>
<td>17887</td>
</tr>
<tr>
<td>HQ4</td>
<td>18 289 880</td>
<td>67.75</td>
<td>66 714</td>
<td>(13 045)</td>
<td>53 668</td>
</tr>
<tr>
<td>HQ5</td>
<td>14 018 354</td>
<td>65.90</td>
<td>82 082</td>
<td>(9999)</td>
<td>72 083</td>
</tr>
<tr>
<td>BQ1</td>
<td>3 251 954</td>
<td>70.26</td>
<td>3942</td>
<td>(23 19)</td>
<td>1622</td>
</tr>
<tr>
<td>BQ2</td>
<td>5 621 186</td>
<td>68.94</td>
<td>10 731</td>
<td>(4009)</td>
<td>6722</td>
</tr>
<tr>
<td>BQ3</td>
<td>8 037 859</td>
<td>67.87</td>
<td>23 742</td>
<td>(5733)</td>
<td>18 009</td>
</tr>
<tr>
<td>BQ4</td>
<td>12 066 135</td>
<td>66.84</td>
<td>53 796</td>
<td>(8606)</td>
<td>45 190</td>
</tr>
<tr>
<td>BQ5</td>
<td>7 875 448</td>
<td>64.98</td>
<td>52 959</td>
<td>(5617)</td>
<td>47 342</td>
</tr>
<tr>
<td>WQ1</td>
<td>34 435 697</td>
<td>70.45</td>
<td>52 011</td>
<td>(24 561)</td>
<td>27 450</td>
</tr>
<tr>
<td>WQ2</td>
<td>34 445 350</td>
<td>69.75</td>
<td>84 185</td>
<td>(24 568)</td>
<td>59 617</td>
</tr>
<tr>
<td>WQ3</td>
<td>35 177 231</td>
<td>68.00</td>
<td>134 316</td>
<td>(25 090)</td>
<td>109 226</td>
</tr>
<tr>
<td>WQ4</td>
<td>31 837 920</td>
<td>67.06</td>
<td>178 064</td>
<td>(22 708)</td>
<td>155 355</td>
</tr>
<tr>
<td>WQ5</td>
<td>14 803 158</td>
<td>65.19</td>
<td>124 540</td>
<td>(10 558)</td>
<td>113 982</td>
</tr>
<tr>
<td>Total/average</td>
<td>241 469 828</td>
<td>68.20</td>
<td>907 797</td>
<td>(172 228)</td>
<td>735 569</td>
</tr>
</tbody>
</table>

*Total population based on subgroups: the total US population modeled is based on the remaining 810 US counties in our sample (see Methods).

†Average patient QALE: this estimate represents the average population before considering inpatient COVID-19 interventions. Given the lag in reporting of mortality data and the large observed impact of COVID-19 on mortality, estimates of QALE (in years) derived from US data were further adjusted to reflect QALY losses owing to COVID-19 by estimating average years lost due to COVID-19 for hospitalized patients (based on age and setting of care) multiplied by the number of hospitalized patients in the subgroup. This was done by calculating the expected total QALYs of an individual under standard-of-care treatment in the hospital by taking a weighted average between the subgroup-specific disability-free expected life expectancy and the average age of patients in the CEA model.

‡Health benefits from COVID-19 inpatient treatment: estimate reflects the incremental QALY gains per COVID-19 patient treated inpatient that are scaled based on the estimated number of hospitalized patients in the subgroup.

§Health losses (opportunity costs): the model base-case scenario assumes that opportunity costs are borne equally across the full population. Estimates above were based on the total opportunity costs per a $150 000 opportunity cost threshold, distributed across subgroups based on relative population sizes.

This represents a reduction of more than 130 000 QALYs in the population-level burden of health inequality across the whole US general population (see Appendix Fig. 3 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).

Plotting the individual-level net monetary benefit per recipient of COVID-19 treatment on the y-axis and the change in population-level health inequality burden (estimated via the Atkinson index) on the x-axis, the relationship between cost-effectiveness and equity impact can be visualized in an equity-efficiency impact plane (Fig. 3). Inpatient COVID-19 treatments fall into the upper right-hand quadrant, indicating that funding COVID-19 treatments not only increases population health overall but also decreases health inequality.

### Sensitivity Analyses

Overall conclusions remained robust across scenario and sensitivity analyses. These include the use of alternate opportunity cost thresholds ($50 000, $100 000) for estimation of health losses, alternative Atkinson inequality aversion parameter values, and changes to the assumed cost of the inpatient COVID-19 treatment. Lower thresholds reduced the total population net health benefits from COVID-19 treatments from 735 569 QALYs (base-case 150 000 QALYs threshold) to 391 114 and 649 456 for the 50 000 and 100 000 QALYs thresholds, respectively, because lower thresholds assume that more QALYs are forgone owing to the use of resources for funding the new COVID-19 intervention (see Appendix Table 4 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010). At thresholds of $100 000 and lower, we observed a small negative change in net health in the least deprived subgroups for Hispanics and non-Hispanic whites who had the highest baseline QALE in the sample, but overall population health gains and inequality reduction remained. Results for the relative reduction in health inequality were also consistent across levels of inequality aversion, consistently remaining close to 0.23% when testing inequality aversion levels between 0.5 and 20 at the 150 000 QALYs opportunity cost threshold (see Appendix Table 3 and Appendix Fig. 3 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010). When the assumption was made that opportunity costs were faced by the most or least socially disadvantaged, this had very minor effects on overall health benefits but affected the estimated level of relative inequality reduction in the population (decrease to 0.032% if the most deprived face all opportunity costs and increases to 0.350% if the least deprived face all opportunity costs; see Appendix Table 5 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010). Scenarios exploring the impact of changing...
inpatient COVID-19 treatment costs (from $1500 to $3500) did not notably change conclusions from the base case, and threshold analyses revealed that net population health benefits would remain positive as long as the COVID-19 treatment cost was less than $60 100 (see Appendix Table 6 in Supplemental Materials found at https://doi.org/10.1016/j.jval.2022.08.010).

Discussion

A novel DCEA evaluated the equity effects of funding COVID-19 inpatient treatments. First, current levels of health equity were estimated across the United States at all levels of social vulnerability and race and ethnicity to create a nationally representative sample. Next, a previously published CEA for COVID-19 treatments was updated reflecting the impact of underlying social vulnerability and population age demographics on the risk of COVID-19 hospitalization and inpatient mortality. Considering the net health gains and losses across each subgroup at an opportunity cost threshold of $150 000/QALY gained, we found that funding of COVID-19 treatments increased overall population health and reduced inequality. At population level, this translates into 735 569 QALYs gained and a 0.234% reduction in the population-level burden of health inequality. As of 2019, the United States spent approximately $3.8 trillion annually on healthcare. With a total intervention cost of $25.83 billion, funding of inpatient COVID-19 treatments would use approximately 0.68% of the healthcare budget.32

To the best of our knowledge, this is the first DCEA conducted in the United States following methods outlined by Cookson and colleagues15 and the only DCEA to examine COVID-19 treatments.8 Although the reporting of results aligns with DCEAs conducted in other settings, direct interpretation and comparison are difficult given the many unique features of the US population and healthcare system. For example, we found that more socially vulnerable groups experienced more health benefits from inpatient COVID-19 treatments across all subgroups. Nevertheless, the ethnicity and race differentials are more complex due to
Figure 3. Equity impact plane. Equity impact in equity-weighted QALYs is calculated as the equity-weighted QALY gain of the intervention divided by the standard, unweighted QALY gain. This shows how much the equity impact is worth, in terms of equity-weighted QALYs. This equity impact is plotted on the x-axis and the total net monetary benefit per patient is plotted on the y-axis to clearly demonstrate the impact on both cost-effectiveness on health equality.

QALY indicates quality-adjusted life-year.
role in healthcare decision making to ensure that we do not further perpetuate underlying system inequalities.

Conclusion

DCEA of inpatient COVID-19 treatments in the United States suggests that Medicare funding of COVID-19 treatments may improve overall health while reducing existing health inequalities, given the disproportionate impact of COVID-19 hospitalizations on vulnerable communities. To the best of our knowledge, this study represents the first analysis to quantify the equity implications of funding COVID-19 treatments in the United States. To further support application of DCEA in the US context, future research needs to

1 address data suppression to include all geographies and racial and ethnic groups to establish the social distribution of health for the entire United States. Additionally, nationally representative QALY data across age, sex, and race and ethnicity should be generated to replace the need to create proxy mapped estimates, and this will require new national surveys or improved use of historic estimates;

2 survey the US general population to establish benchmark health inequality aversion parameters that can be used in social welfare functions that underpin DCEAs, such as the Atkinson index; and

3 analyze healthcare expenditure patterns across equity-relevant subgroups to better inform the true distribution of opportunity costs from increased health spending.

In addition to filling the research gaps mentioned earlier, US decision makers need to align to endorse their preferred equity-relevant priorities, which will guide the development of consistent generic equity measures (like the SVI) and the creation of core subgroup definitions to be used across settings and research questions.

Supplemental Material

Supplementary data associated with this article can be found in the online version at https://doi.org/10.1016/j.jval.2022.08.010.

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