Comparison of hospital at home and hospital care. The outcome is based on QALYs formed from a five dimension quality of life scale. The cost of treating the patient in the hospital at home was £1200 more than in hospital and made little difference to the mean number of QALYs gained (0.02), where QALYs combine information about mortality and quality of life. This results in an incremental cost per QALY gained for hospital at home of £60 000 (£107 000, £87 000). Using the cost effectiveness acceptability curve (figure), decision makers would estimate their maximum willingness to pay for a QALY. If, for example, this was £30 000, the probability that hospital at home is more cost effective is slightly less than 20%, but if their willingness to pay for an additional QALY was as high as £80 000, the probability that hospital at home is the more cost effective option would be more than 80%.

The table shows a simplified version of the cost-consequences analysis. A full table might additionally include: anxiety and depression, pain control, carer quality of life, costs to social services, accessibility to the service. Decision makers would use the information provided in the table to make decisions or, if desired, they could also use monetary valuation or discrete choice experiments to obtain utility values for the different elements. The relative efficiency of different options would depend on the implicit or explicit values attached by decision makers to the different elements of cost and outcome.

A cost-consequences approach would more closely meet the needs of decision makers than current practice and avoid extensive use of inadequate assumptions. Such an approach may not earn researchers the respect they deserve but it may be closer to a true trade-off analysis. It has the additional benefit of being easier to understand and use.

Summary points

- Cost effectiveness analysis is based on achieving an assumed societal objective of maximising health
- Little evidence exists that this is the desired objective of the public or decision makers
- Use of QALYs as a single outcome measure for economic evaluation means that important health consequences are excluded
- Complex technical presentation makes the findings difficult to understand and use
- Cost-consequences analysis would better approach the objectives of decision makers and be easier to understand

Corrections and clarifications

Safety of antipsychotic drugs for pregnant and breastfeeding women with non-affective psychosis

The authors of this editorial, Louise Howard and colleagues, have asked us to point out that the opening sentence was incorrect (25 October, pp 933-4). It should read: “About 0.2-0.3% of women of childbearing age [not “Around 2% of women”] develop a non-affective psychotic disorder.”

Use of rapid 24-hour testing and estimation of clinical probability in the diagnosis of deep vein thrombosis: systematic review

In the full version (on bmj.com) of this paper by Tonya L Fancher and colleagues, some data in table 3 (which shows cohort characteristics of management studies) are wrong (9 October, pp 821-4). In the second row (the study by Schugens et al) the mean age should read 59 years [not “unknown”]; male sex, 54% [not “unknown”]; and total number of cases lost to follow up, 1 [not “15”]. The table is not included in the abridged version of the paper.