Commentary: COVID-19 cost-effectiveness research shows racial disparities

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A newly released study by the Institute for Clinical and Economic Review, a Boston-based nonprofit, attempts to answer a weighty question: How much should it cost to treat the novel coronavirus?

The study evaluated remdesivir, one of the most promising treatments for COVID-19 yet discovered. Its authors ultimately determined the drug warrants a price between $10 and $4,460.

This analysis is purportedly based on objective science and cold, hard statistics. But a closer look at ICER's methods reveals a deep bias against disadvantaged populations, particularly minorities.

This isn't surprising. For years, ICER has reduced the value of human life to dollars and cents and has done so in ways that systematically undervalue the well-being of those who are sick and disabled.

Central to ICER's cost effectiveness model is a controversial unit of measurement known as a quality-adjusted life year, or QALY.

This approach shows a drug that adds a year of perfect health to a patient's life provides one QALY. If it adds a year of less-than-perfect health, it might provide, say, 0.8 QALY. Using this metric, governments and insurers might determine a given drug isn't worth paying for based on the long-term health benefits to the patient — or lack thereof.

In ICER's new analysis of remdesivir, researchers used QALYs to determine how much the drug should cost in the first place. To get to its eventual ceiling of $4,460, ICER placed the value of each additional life-year gained by patients at just $50,000, far below the $150,000 standard ICER has used during other reviews.

Attempting to place a dollar value on human life is never a defensible calculation. But there's an even more onerous implication behind QALY analyses: They systematically undervalue certain populations.

Consider that many patients, particularly those with debilitating chronic conditions and disabilities, will never be in "perfect" health. QALY analyses might determine that extending the life of patients with blindness, heart disease, kidney disease, cancer, diabetes or paralysis isn't as worthwhile as extending the life of those who are healthier.

As a result, these analyses inherently undervalue future COVID-19 medications like remdesivir because many COVID-19 patients battle underlying health conditions and might never achieve perfect health.

The innate bias of these QALY calculations disproportionately affects minority Americans. These Americans are far more likely than white Americans to suffer from a range of underlying chronic diseases.

For instance, African Americans are 8.4 times more likely to be diagnosed with HIV, and 50% more likely to have high blood pressure. Meanwhile, Hispanic Americans have more than a 50% chance of developing type 2 diabetes, compared to 40% for the population as a whole.

COVID-19 has already ravaged minority communities. According to the Centers for Disease Control and Prevention, African Americans account for more than 26% of COVID-19 cases, despite making up only 13% of the overall population. Hispanics are also overrepresented among COVID-19 patients. This population comprises nearly 29% of cases, while constituting only 18% of the nation's population.

ICER's calculations devalue the very medicines that would deliver outsize benefit to our communities. And although the group is an independent entity, it has sway with federal and state policymakers. If government officials ever heed ICER's advice, the long-term implications would prove devastating.

But ICER takes it even further by putting a lower dollar figure on the health of minorities, chronic disease patients and those with disabilities. If it were up to groups like ICER, our nation's health care inequities will continue long after the coronavirus crisis is over.

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