

# Preface to the second edition

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It is a decade now since the first edition was published and much research activity and policy application has taken place in the health care evaluation field that the reader needs to be aware of. This second edition expands the scope of the field by including the latest concepts and applications in an attempt to make the book more up to date and self-contained. To help accomplish these objectives, the book has many more applications throughout all regions of the world and covers more of the statistical requirements that are necessary to understand and carry out health care evaluations.

One of the main aims of the first edition was to build a bridge between the mainstream health care evaluation field, which is dominated by non-economists, and to link this with mainstream economics, in which CBA was first developed and has its roots. Economics has much to offer and it not useful to try to pretend that rational decision-making can be carried out without a firm understanding of basic economics principles. By focusing on applications, this book makes the theory accessible to economists and non-economists alike. CBA is inherently an applied economics discipline and this is demonstrated at all points in the second edition.

Unfortunately, the need to build a bridge between non-economists and economists is even more important today than a decade ago, when the first edition was written, as the general understanding of CBA in the health care field seems to have gone backwards. The majority of evaluators think that CEA and CBA are basically one and the same thing. More surprising still is the view that in some way cost-effectiveness is an improvement over CBA. At the iHEA Ninth World Congress on Health Economics in Sydney, the plenary speaker, in her summary of the history of the Health Economics field, stated that up to the 1980s CBA was used, but CBA has since been replaced by CEA. Although this may well summarize the thinking as well as practice in the field, this does make mean that this shift makes sense. A CEA is, at best, an incomplete CBA; it is not an improvement over CBA. The CEA threshold needs to be justified using CBA concepts. In the second edition we continue to make this point clear by starting off with CEA and showing how it can lead to CBA. Cost-effectiveness analysis cannot stand alone without CBA.

In the second addition, a fifth application is added to each chapter. For each application there is a theory section earlier in the chapter which serves to introduce and integrate the new application into the literature. Classics in the field have been retained provided they still have current relevance. Otherwise they have been replaced by more up-to-date applications. Each chapter also has an extra problem set. There are more cross-references of theories and practice which serve to reinforce the ideas presented. To make the text more unified there is a new, fourteenth, chapter that summarizes the whole text so that all the main conclusions can be seen in one place, using one area of application.

New to this edition is the emphasis given to health care evaluations for older adults. The greater emphasis on communicable diseases such as HIV/AIDS means that the text

gives a better balance between health care evaluations for developing as well as developed countries. To help make the book more self-contained, a number of chapters cover the UK's NICE system for evaluating health care technologies. The EuroQol is also now strongly featured together with newer instruments that have sought to extend and improve this way of measuring utilities for use in CUA. Many more ways of measuring benefits are covered, including a number of new methods for converting CUA into CBA. To make the text more self-contained in terms of the statistical concepts and techniques used in economic evaluations, the new edition has material on cost-effectiveness acceptability curves (CEAC), Markov chains, randomized control trials (RCTs) and the difference-in-difference estimator (DID). There is extended coverage of regression methods for estimating effects and value parameters, especially in revealed preference contexts.

I again want to thank all the students at Fordham University who have taken my health economics CBA courses and have given me feedback on the new material as it has been developed. William Cartwright was also very helpful in this regard by giving me detailed feedback on teaching the first edition and suggesting new material for the second edition. I also want to acknowledge the assistance I received in 2003 in terms of a Fulbright research award to carry out CBA of HIV/AIDS interventions in Tanzania. This award set the stage for all the subsequent CBA research I undertook in both developing and developed countries, and helped originate many of the new applications that are contained in the second edition. In particular, the final chapter would not have been possible without this assistance.