Health technology assessment in the cost-disutility plane

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Abstract
Currently, comparison of multiple strategies in health technology assessment is undertaken on the incremental cost effectiveness plane using 'efficiency' frontiers and cost effectiveness acceptability curves. This paper proposes shifting comparison of multiple strategies to the cost-disutility plane.

Evidence-based decision making requires comparison of all strategies against each other. Consequently, the origin in the incremental cost-effectiveness plane cannot be the appropriate reference point in comparing multiple non-dominated strategies. A linear transformation onto the cost-disutility plane allows equivalent comparison of net benefit and permits the use of standard efficiency measurement methods to estimate:

(i) degree of dominance (technical inefficiency) of dominated strategies; and
(ii) net benefit inefficiency, i.e., losses in net benefit relative to an optimal strategy.

In comparing strategies under uncertainty, comparison of loss in net benefit leads to the expected net loss frontier which, unlike cost effectiveness acceptability curves or the cost effectiveness acceptability frontier, directly identifies differences in expected net benefit (net loss) and the expected value of perfect information. Thus decision makers can be better informed about the choice of optimal strategy with given information and the potential value of future research. In conclusion, comparing strategies in the cost-disutility plane is suggested to better inform decision making and to provide a link between the cost-effectiveness literature and efficiency measurement methods.

Keywords: economic evaluation; health technology assessment; efficiency frontiers; dominance; net benefit maximisation; correspondence theorem, cost-disutility plane.

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Introduction

The emergence of bodies such as the Pharmaceutical Benefits Advisory Committee (PBAC) in Australia, the National Institute of Health and Clinical Excellence (NICE) in the United Kingdom and the Canadian Agency for Drugs and Technologies in Health (CADTH), reflect a growing awareness of the importance of cost-effectiveness evidence, particularly within publicly provided health systems [1-3].

In moving to the provision of evidence not just on effectiveness, but also on cost of interventions, it is natural to consider a two dimensional representation. To date, the incremental cost-effectiveness plane has become the most popular way of providing a geometric interpretation of cost-effectiveness results. The first presentations of this plane showed the difference in effectiveness on the vertical axis with cost difference on the horizontal axis [4]. This presentation coincided closely with the standard economic presentation of a production function – in particular with regard to the economic ‘law’ of diminishing marginal returns in outputs (effectiveness) to increasing inputs (cost). In practice, however, most analysts and commentators have preferred to plot the difference in effect on the horizontal axis with cost difference on the vertical axis [5] – chiefly because this allows the geometric interpretation of the slope of the line joining any two points on the cost-effectiveness plane as an incremental cost-effectiveness ratio.

In this paper, we argue for reframing measures of effects as measures of relative ‘disutility’ and presenting results on the cost-disutility plane. This provides a link between the literatures of efficiency in cost-effectiveness analysis and the broader framework of assessing efficiency with frontier methods.

We use a previously published probabilistic sensitivity analysis of management strategies for Gastro Esophageal Reflux Disease (GERD) [6, 7] to illustrate the principles of dominance,
extended dominance, the development of an efficiency frontier and comparison of net benefit
in the incremental cost-effectiveness plane. The following section then provides a formal
treatment of the ‘correspondence’ between net benefit on the incremental cost-effectiveness
plane and net loss on the cost-disutility plane. The GERD example is then presented on the
cost-disutility plane, demonstrating equivalent interpretation of frontiers, dominance and net
benefit, but the added ability to apply standard efficiency measurement methods [8-10].
Consequently, the proposed method is shown to allow estimation for each strategy of:
1. degree of dominance (technical inefficiency) relative to the efficiency
   frontier; and
2. economic (net benefit) inefficiency relative to the optimal (net benefit
   maximising) strategy at a given willingness to pay for health effects.
The natural consideration of loss in net benefit relative to an economically efficient (net
benefit maximising) strategy on the cost-disutility plane leads to construction of an expected
net loss frontier. This frontier has advantages over cost effectiveness acceptability curves both
in directly identifying differences in expected net benefit (expected net loss) and representing
the expected value of perfect information across strategies.

**Efficiency frontiers on the cost-effectiveness (CE) plane**
The GERD example compared six management strategies for patients presenting to their
physicians with endoscopically proven erosive esophagitis. The analysis modelled twelve-
month healing and recurrence rates based on a comprehensive review of the literature [7].
Expected costs and effects (weeks free of GERD symptoms) of the six strategies are plotted
on the incremental CE plane in Figure 1.

Improved performance on the incremental cost-effectiveness plane is indicated by south-east
movement (reduced costs, greater effect). Hence, an efficiency frontier can be constructed by:
1. rank ordering all interventions in terms of their effect;
2. excluding strictly dominated options (in this case option D is strictly dominated, being both more expensive and less effective than C, A or E);

3. excluding any extended dominated options (Option F in this case is ‘extended dominated’ [11] by combinations of E and B) and then;

4. linking adjacent non-dominated options to form a convex hull.

To ensure the efficiency frontier passes through the origin and relevant comparison is contained in the north-east quadrant, the origin can be set as the least cost strategy, rather than necessarily current practice. This is the approach presented in Figure 1, where the least cost intervention strategy, C (based on management of GERD with H2RAs), is set as the origin of the plane, rather than usual practice (option D based around a prokinetic agent [6]).

Geometrically, applying this process results in the illustrated frontier CAEB, where the slope of the frontier corresponds to the estimated incremental cost-effectiveness ratio (ICER) between adjacent non-dominated treatment options.

The use of the least cost strategy, rather than current practice, as the origin may seem arbitrary. However, more importantly, the origin cannot be used as a single reference point in the comparison of more than two non-dominated strategies because the appropriate point of reference shifts along the efficiency frontier. For example, in the base case for GERD, strategy A should be compared to C (implicitly for a value of 0 up to $10 per week GERD avoided), strategy E to A (from $10 up to $36) and strategy B to E (from $36 up to $243).

More recently, the net-benefit approach to cost-effectiveness analysis, which explicitly considers decision makers’ values for health effects, has become more popular in comparing strategies [12-14]. This approach offers particular advantages when comparing multiple strategies, as net benefit statistics allow a consistent ordering of strategies irrespective of comparator. Formally, at a given decision maker’s value for a unit of effect (k), the net
monetary benefit ($NMB$) of a strategy ($i$) is the monetary value of effects ($k \times E_i$) less costs ($C_i$):

$$NMB_i = k \times E_i - C_i$$  \hspace{1cm} (1)

and the incremental net monetary benefit ($INMB$) between two strategies $i$ and $j$ can be expressed as:

$$INMB_{ij} = NMB_i - NMB_j = (k \times E_i - C_i) - (k \times E_j - C_j)$$

$$= k (E_i - E_j) - (C_i - C_j).$$ \hspace{1cm} (2)

Alternatively, but equivalently, incremental net health benefit ($INHB$) can be calculated as incremental effect less incremental cost converted to equivalent health effects at a value per unit ($k$):

$$INHB_{ij} = (E_i - E_j) - (C_i - C_j) / k.$$ \hspace{1cm} (3)

In general, net benefit statistics, while conditional on monetary values for health effects, have the advantage over ratio measures in that differences are additively separable [15], a property of their linear form. Levels of net benefit at a given $k$, can be represented geometrically as iso-net benefit lines with slope $k$ on the incremental cost-effectiveness plane, where lines further south east represent higher net benefit at $k$. Figure 1 illustrates such iso-net benefit lines for $k = $100 per week of GERD avoided.

When comparison is restricted to two strategies (a new strategy and current practice) a net benefit line passing through the origin with slope $k$, defines acceptance and rejection regions, with the new therapy maximising net benefit where it is south east of this line. However, a line through the origin does not allow identification of the optimal intervention. For example in Figure 1, the iso-net benefit line passing through the origin (intervention C) can only establish that at $100 per week of GERD avoided, each of strategies A, E, F and B have higher net benefit than strategy C. The strategy maximising net benefit can be identified as that with an iso-net benefit line lying furthest south-east. Hence, the net benefit maximising
strategy will be at the point of tangency between this iso-net benefit line and the efficiency frontier. In Figure 1, at $k=100$, strategy E maximises net benefit at the point of tangency between the iso-net benefit line with INMB of 350, and the efficiency frontier CAEB.

More generally, vertical distances between iso-net benefit lines represent differences in net monetary benefit ($INMB_y$) and horizontal distances between lines represent differences in net health benefit ($INHB_y$). For example, comparing strategies E and C at $100$ per week of GERD prevented in Figure 1, $INHB_{EC}$ is 3.50 weeks GERD prevented (intercepts of 3.5 and 0 on the horizontal axis) and $INMB_{EC}$ is $350$ per patient (intercepts of -$350$ and $0$ on the vertical axis). The constant distance between parallel iso-net benefit lines makes it clear that differences in net benefit are independent of choice of comparator.

A linear transformation allowing use of efficiency methods

Eckermann [16] identified a linear transformation that allows use of economic efficiency methods to compare performance consistent with maximising net benefit on the cost-disutility plane. To see how this transformation can be applied to compare multiple strategies, recall from Equations 1 and 2 that an option is preferred over another if it has a greater net benefit (the incremental net benefit is positive). Option $i$ is preferred to option $j$ if

$$k \times E_i - C_i > k \times E_j - C_j.$$  

(4)

Now, define the disutility of an option as the difference between the maximum health effect of the available options, $E^{MAX}$, and the health effect of the current option, that is

$$DU_i = E^{MAX} - E_i.$$

Rearranging gives an expression for effectiveness of:

$$E_i = E^{MAX} - DU_i.$$
Substituting this expression into Equation 4, noting that the $k \times E^{MAX}$ terms cancel, and multiplying through by minus one, we obtain:

$$C_i + k \times DU_i < C_j + k \times DU_j$$ (5)

For given $k$, the standard decision rule of maximising net benefit in Equation 4 corresponds to minimizing net loss in Equation 5. Effects on the cost-effectiveness plane are presented as reductions in morbidity or disability adjusted life years (DALYs [17]), or additional incremental survival, life years or quality adjusted life years (QALYs) relative to a comparator. Equivalent effects on the cost-disutility plane translate to incremental morbidity, DALYs, mortality and reduction in life years or QALYs, relative to the most effective strategy. To allow a standardised incremental framework for costs as well as effects framed from a disutility perspective (implicit in the definition of disutility as $DU_i = E^{MAX} - E_i$), the cost of each option can be similarly measured relative to that of the cheapest option, $C^{MIN}$, as illustrated in the following example for GERD.

**Comparing strategies on the cost-disutility plane – the case of GERD**

Figure 2 shows the GERD example plotted on the cost-disutility plane. The cost-effectiveness frontier is convex to a vertex (the origin) representing the lowest per patient cost across strategies, and the lowest disutility event rate per patient across strategies. Performance improves when moving directly towards this vertex (equi-proportionally reducing cost and disutility) and hence, ratio measures of performance can be estimated.

For example, the degree of dominance of a strategy can be calculated as the proportion by which costs and disutility can be simultaneously reduced by moving to the efficiency frontier. Graphically, degree of dominance of a strategy is the ratio of line segments from the strategy to the frontier (in moving towards the origin) and from the strategy to the origin, $ZX/Z0$ for strategy D in figure 3. Existing methods for efficiency measurement [8, 9] can be applied to...
calculate degree of dominance as technical inefficiency (1-technical efficiency) on the cost-
disutility plane, as described and illustrated for the case of GERD in Appendix 1. Degrees of
dominance for the six GERD strategies are presented in Table 1. Strategies B, E, A and C on
the frontier have 0 degree of dominance, while strategies D and F off the frontier have
positive degree of dominance (technical inefficiency). In summary, measuring technical
efficiency on the cost-disutility plane provides a simple and intuitive method for identification
of:

1. dominated strategies, where technical efficiency is less than 1 or equivalently
degree of dominance greater than 0 (strategies D and F in Figure 2); and
2. the efficiency frontier as combinations of non-dominated strategies with degree
of dominance of 0 (strategies B, E, A and C in Figure 2).

Comparing net benefit on the cost-disutility plane

Iso-net benefit lines representing equal levels of net benefit have a slope equal to $-k$ on the
cost-disutility plane. Lines closer to the vertex (origin) represent higher net benefit per
patient. Hence, the net benefit maximising strategy at a given $k$, is the strategy on the net
benefit line closest to the origin. For example, in the case of GERD, strategy E maximises net
benefit for $k=100$ with INMB of $350$, as illustrated in Figure 2.

More generally, at a given $k$, the vertical distance between iso-net benefit lines represents
differences in net monetary benefit, while the horizontal distance between iso-net benefit lines
represents differences in net health benefit. In each case net benefit increases in moving
towards the origin. For example, comparing iso-net benefit lines at $100$ per week of GERD
avoided, strategy E has higher net benefit than strategy C by 3.5 weeks of GERD prevented
(intercepts of 2.18 and 5.68 measured on the horizontal axis) and $350$ (intercepts of $219$ and
$569$ on the vertical axis). These represent the same differences in net health and monetary
benefit shown in the incremental cost-effectiveness plane in Figure 1.
Economic (net benefit) efficiency on the cost-disutility plane

Calculation of degree of dominance (technical inefficiency) of a strategy does not rely on a decision maker’s choice of \( k \). However, if the \( k \) is known or conditioned on, then economic (net benefit) inefficiency can also be calculated in the cost-disutility plane.

Economic efficiency (EE) for each strategy \((i)\), is calculated for given \( k \) as the objective function (Equation 5) for the optimal (net loss minimising) strategy, divided by that for strategy \( i \):

\[
EE_i = (DU_i \times k + C_i) / (DU_* \times k_* + C_*)
\]

where * indicates the optimal strategy.

Now, loss in incremental net monetary benefit for strategy \( i \) relative to the optimal strategy can be expressed using Equation (5) as:

\[
INMB_{i_*} = NMB_* - NMB_i = (k \times DU_i + C_i) - (k \times DU_* + C_*)
\]

This loss in incremental net benefit can be represented as a function of economic inefficiency. Rearranging Equation (6) to substitute for \((k \times DU_ + C_*)\) into Equation (7) we obtain:

\[
INMB_{i_*} = (k \times DU_i + C_i) \times (1 - EE_i)
\]

Therefore, loss in net benefit (net loss) for any strategy \( i \) relative to an optimal strategy can be calculated as the product of economic inefficiency for strategy \( i \) and its objective function from Equation (5). For dominated strategies, \( EE_i \leq TE_i < 1 \), where TE stands for technical efficiency. Hence from Equation (8), net loss is greater than 0 for dominated strategies regardless of \( k \). This establishes a relationship between dominance and loss in net benefit, reminding us that only non-dominated strategies on the frontier (TE of 1) can optimise net benefit (have \( EE \) of 1) at any \( k \).
Reframing of the economic objective on the cost-disutility plane as minimising net loss relative to the optimal strategy provides a natural common reference point for comparison of multiple strategies. This natural common reference point is shown in the next section to be useful when comparing the expected net benefit of multiple strategies under uncertainty.

Comparing multiple strategies under uncertainty: The Net Loss Frontier

To model uncertainty for GERD, Briggs et al. [6] used a Bayesian approach, in which, for each variable in the model, a value is drawn from a probability distribution specified for that variable to reflect its second order uncertainty [17]. Costs and effects are re-calculated across strategies for each set of values to form a ‘realisation’ of the frontier and comparison of strategies. From these realisations cost effectiveness acceptability curves (CEACs) can be constructed for each strategy to represent the proportion of realisations for which the strategy maximises net benefit at each possible $k$ [6]. However, while allowing comparison of multiple strategies, CEACs do not tell the decision maker about the relative expected net benefit of strategies at any $k$ [18]. Conversely net benefit curves cannot represent the uncertainty associated with incremental net-benefit in the case of multiple strategies.

The net loss statistic (equation 7) provides an appropriate point of reference for comparison of the net benefit of multiple strategies. Applying Equation (7) to strategies across each realisation, the distribution and expected net loss relative to the optimal strategy is calculated for each strategy at any $k$. For example, Table 2 reports 95% confidence intervals and expected values across 1000 replicates of net loss relative to the optimal strategy for $k = \$100$. Strategy E minimises expected net loss for $k = \$100$, with an average loss in net monetary benefit of $4.90 per patient across 1000 replicates. This expected net loss for strategy E arises as there are a proportion of replicates (111/1000) where E is not expected to be the optimal strategy.
Table 2 compared expected net loss across strategies at $k=100$. Conditioning on $k$, an expected net loss curve for each strategy can be constructed as the expected loss in net benefit plotted against $k$. Figure 4 presents expected net loss curves for GERD strategies A to F. The lower bound of expected net loss curves across strategies, conditional on $k$, represents an expected net loss frontier. This frontier identifies the optimal strategy for a risk neutral decision maker across realisations at any $k$. For example, for the 1000 GERD realisations, expected net loss is minimised with: Strategy C from $k$ of $0$ to $10.26; Strategy A from more than $10.26$ to $35.02; Strategy E for more than $35.02$ to $265.79; and Strategy B for more than $265.79.$

The expected net loss frontier also represents the expected value of perfect information (EVPI) across strategies at any $k$, given current uncertainty. For example at $k=100$ Strategy E minimises expected net loss at $4.90$ per patient (and hence maximises expected net benefit) across 1000 realisations. However, choosing Strategy E with current uncertainty we expect that in 111 of 1000 realisations another strategy would be optimal. If we had perfect information this loss of $4.90$ could be avoided by picking the optimal strategy in each realisation. More generally, the net loss curve tells us the EVPI at any $k$. In the case of GERD the expected value of perfect information is maximised at $44.20$ per patient at $k=265.79$, the point of indifference between Strategy E and B. However, the expected value of perfect information is less than $5$ per patient for $k$ between $100$ and $150$ where there is little uncertainty that strategy E is optimal. EVPI is minimised at $3.26$ per patient where $k=137$.

In summary, the expected net loss frontier enables identification of the optimal strategy for a risk neutral decision maker and the EVPI per patient at any $k$. Net loss curves therefore simultaneously address optimal strategies for risk neutral decision makers and the potential value of further research given current decision uncertainty.
Conclusion

A simple linear transformation from the cost effectiveness plane, to compare strategies on the cost-disutility plane, allows equivalent identification of the efficiency frontier, dominance and net benefit maximisation at a decision maker’s willingness to pay for health, $k$, but unlike the incremental cost effectiveness plane this transformation permits:

1. use of efficiency methods, with movement toward the origin representing better strategies;
2. ratio measures of inefficiency (degree of dominance and net benefit inefficiency at a given $k$).

Further, in comparing strategies under uncertainty, the common reference point of losses in net benefit relative to the optimal strategy in each replicate allows construction of expected net loss curves conditional on $k$, and the net loss frontier. This frontier directly identifies strategies that maximise expected net benefit (minimise expected net loss), and the expected value of perfect information across strategies.
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Appendix 1: Efficiency measurement methods on the cost-disutility plane

Standard efficiency measurement methods such as the linear programming method of Data Envelopment analysis (DEA) have been widely used in comparison of health care providers and other public service providers [10]. However, the application of such methods to aid with comparing multiple strategies for HTA has been prevented by the inability to formulate meaningful ratio measures of performance with the presentation of outcomes on the cost-effectiveness plane. This paper provides a missing link between efficiency methods and HTA, by a proposed reformulation of analysis onto the cost-disutility plane. In the cost-disutility plane a simple form of the linear programming method of data envelopment analysis (DEA [8-10]) can be used to identify:

(i) strategies on the efficiency frontier where no proportional reduction in cost and disutility is possible

(ii) the degree of dominance of strategies off the frontier as the proportional reduction possible in cost and disutility.

The DEA linear programming formulation required for this is simple, as constant returns to scale (CRS) are implicitly assumed in constructing the efficiency frontier as convex combinations of strategies. Under CRS, the linear programming problem simplifies to finding the proportion by which inputs of cost per patient and disutility (e.g. weeks with GERD) per patient can be reduced while remaining within the feasible set, defined by convex combinations of all strategies costs and disutility per patient.

Formally, for n strategies the preferred linear programming formulation of DEA to estimate technical efficiency, \( \theta \), under CRS is:

\[
\begin{align*}
\min_{\theta, \lambda} & \quad \theta \\
\text{st} & \quad \lambda \geq 1 \\
& \quad \theta x_i - X \lambda \geq 0
\end{align*}
\] (A.1)

Where:

- \( x_i \) is a vector of inputs for strategy \( i \) (\( i=1,...,n \)) of cost per patient in excess of the cheapest strategy and effects framed from a disutility perspective per patient (e.g. weeks with GERD);
- \( X = (x_1,...,x_n) \) and;
- \( \lambda \) represents a vector of weights for the n strategies, with \( X \lambda \) representing a convex combination of strategies for \( \lambda = 1 \).

The linear programming problem needs to be solved n times, once for each strategy (\( i=1 \) to \( n \)). The value of \( \theta \) obtained in each of these n programming problems is the technical efficiency...
score for the $i$th strategy. In the case of GERD, for each of the six strategies (A to F) there
were inputs of cost per patient and weeks with GERD per patient, as shown in Table 1. The
technical efficiency for strategies A, B, C and E of 1 indicate these strategies were on the
frontier, as shown in figure 2. The technical efficiency score ($\theta$) of 0.897 for strategy D and
0.319 for strategy F reflect the proportion of their original value to which both costs and
effects for these strategies can be reduced in radially moving onto the frontier (target point) in
figure 2. Hence, inefficiency (1-efficiency), or degree of dominance, is 0.103 and 0.681 for
strategies F and D, respectively. In the case of strategy D the target on the frontier was a
linear combination of strategies A ($\lambda_1 = 0.680$) and E ($\lambda_5 = 0.320$), while for strategy F it was
a linear combination of strategies B ($\lambda_2 = 0.561$) and E ($\lambda_5 = 0.439$). Explicitly, applying
the formulation in Equation (1.A) the technical efficiency of strategy D of 0.319, is the
target for strategy F a linear combination of strategies A and E this can be further
simplified to:

$$\begin{align*}
\text{min}_{\theta, \lambda} \theta \\
st \\
\lambda_1 + \lambda_2 + \lambda_3 + \lambda_4 + \lambda_5 + \lambda_6 \geq 1 \\
\begin{bmatrix}
297 \theta & -28 \lambda_1 + 438 \lambda_2 + 147 \lambda_3 + 87 \lambda_5 + 297 \lambda_6 \\
0.72 \theta & -3.04 \lambda_1 + 5.69 \lambda_3 + 7.81 \lambda_4 + 1.32 \lambda_5 + 0.72 \lambda_6
\end{bmatrix} \succeq \begin{bmatrix}
0 \\
0
\end{bmatrix}
\end{align*}$$

While in the case of GERD effects were measured with a single effect framed from a
disutility perspective, more generally multiple effects framed from a disutility perspective can
be included as additional input vectors. Defining disutility event rates as incremental to the
most effective strategy and costs as incremental to the cheapest strategy ensures that
dominated strategies can be equi-proportionally reduced (radially contracted) to a target on
the efficiency frontier in the incremental cost-incremental disutility plane. This simplifies data
envelopment analysis results, by preventing slacks in estimating technical efficiency scores
[9].
Figure 1
GERD base case in the incremental CE plane
Figure 2
GERD base case in the incremental cost-disutility plane
Figure 3:
Technical and economic efficiency for strategy D in GERD base case
Figure 4:
Expected net loss curves and acceptability frontier for GERD strategies
Table 1: Comparisons of efficiency for the GERD management options

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Incremental ($) cost per patient</th>
<th>Additional weeks with GERD</th>
<th>Technical Inefficiency (degree of dominance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>28</td>
<td>3.04</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>438</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>0</td>
<td>5.69</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>147</td>
<td>7.81</td>
<td>0.682</td>
</tr>
<tr>
<td>E</td>
<td>87</td>
<td>1.32</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>297</td>
<td>0.72</td>
<td>0.103</td>
</tr>
</tbody>
</table>
Table 2: Ninety five percent confidence intervals and expected value for loss in net benefit, $k=100/\text{week GERD}$

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Median value (95% CI) for loss in NB, relative to optimal strategy</th>
<th>Expected loss in NB ($/patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>113 (0,285)</td>
<td>115.8</td>
</tr>
<tr>
<td>B</td>
<td>225 (124, 328)</td>
<td>223.9</td>
</tr>
<tr>
<td>C</td>
<td>353 (284,452)</td>
<td>355.6</td>
</tr>
<tr>
<td>D</td>
<td>717 (561,866)</td>
<td>715.2</td>
</tr>
<tr>
<td>E</td>
<td>0 (0,65)</td>
<td>4.9</td>
</tr>
<tr>
<td>F</td>
<td>155 (44,257)</td>
<td>154.2</td>
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