Appendix 2 (as supplied by the authors)**:** Cost-effectiveness thresholds

When interpreting the incremental cost per quality-adjusted life-year ratio, one must consider the maximum that a decision maker is willing to pay for one quality-adjusted life year gained. In Canada, there is not a cost-effectiveness threshold per se, but rather a range of incremental cost per quality-adjusted life-year values, which, when considered in the context of a decision maker's priorities and the interventions' place in therapy, may be considered acceptable.

Consequently, cost-effectiveness thresholds may differ under different scenarios. For instance, decision makers may be more willing to accept a higher incremental per quality-adjusted life-year value for a new treatment for which no other treatments are available.[1] In contrast, interventions with a large budget impact may be subject to a lower threshold.[2] Use of cost-effectiveness thresholds in healthcare resource allocation decisions is controversial, as estimates are not based on empirical evidence.[3,4]

Nevertheless, use of cost-effectiveness thresholds to guide adoption and funding decisions on healthcare technologies is widespread.[1,5,6] The National Institute of Clinical Excellence (NICE) in the United Kingdom uses a cost-effectiveness threshold range of £20,000 to £30,000 per QALY gained.[1,5,6] Other estimates include a value of $50,000 per quality-adjusted life-year in the US,[8] a value of $52,400[9] per quality-adjusted life-year in the Australian benefits scheme, and a range of $20,000-$100,000[10] per quality-adjusted life-years reported in Canada. Some argue that these cost-effectiveness threshold estimates may be too high, and are contributing to escalating healthcare costs;[3,6,11] others argue that they are too low.[12,13]

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