de Kok et al. (1) recently reported a cost-effectiveness analysis of routine vaccination of women against the human papilloma-virus (HPV) in the Netherlands. The authors showed that the cost-effectiveness of HPV vaccination is less favorable in the Netherlands, which has a successful cervical cancer screening program, than
in other countries without such a well-organized screening program. However, their conclusion that HPV vaccination is not cost-effective seems to be inconsistent with the authors’ reported results.

This conclusion is based on the obtained cost-effectiveness ratio (CER) of £52,500 per quality-adjusted life-year (QALY) in the base-case analysis. This ratio indeed exceeds the informal Dutch willingness-to-pay threshold of €20,000 per QALY under which an intervention is generally labeled cost-effective in the Netherlands, but is still less than €80,000 per QALY, which has recently been proposed for the Dutch situation.

We feel, however, that the conclusion should not be based on the above-mentioned CER. In the “Results” section, authors validly argued that for health-care decisions in the Netherlands, costs and effects are discounted at 4% and 1.5%, respectively (2). The CER would decrease to £19,700 per QALY gained if these Dutch guideline–recommended discount rates are applied. As argued above, such a CER would definitely be labeled cost-effective for the Netherlands.

The reported decrease of the CER is not surprising considering that the immediate costs of vaccination are far removed from the health benefits obtained with HPV vaccination. There is much discussion about whether or not to discount health gains at different rates than monetary costs, especially in the case of preventive interventions including vaccination programs (3). Despite these ongoing discussions, we feel that economic evaluation should be performed according to existing country-specific guidelines for conducting pharmacoeconomic research (2).

There are two other issues that we would like to address here. First, the cost-effectiveness results reported by de Kok et al. (1) differ from those previously published by the same authors in a report of the Dutch Health Council (4). In that report, de Kok et al. (4) presented CERs that are essentially similar to those in the current publication with the exception of the results based on applying guideline–recommended discount rates for the Netherlands (£30,000 per QALY in the report by the Dutch health Council compared with £19,700 in the current article). How can this be explained?

Second, de Kok et al. (1) argued that the impact of vaccination on genital warts is expected to be relatively small. Jit et al. (5) showed that the cost of the bivalent HPV vaccine should be £13–£21 lower to be as cost-effective as the quadrivalent vaccine, which also protects against genital warts caused by serotypes 6 and 11.

The conclusion of de Kok et al. that HPV vaccination is not cost-effective is inconsistent with their own results and with previous scientific publications on the cost-effectiveness of HPV vaccination for the Netherlands (6,7).

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References


Notes

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