NICE National Institute for Health and Care Excellence

Economic plan

This plan identifies the areas prioritised for economic modelling. The final analysis may differ from those described below. The rationale for any differences will be explained in the guideline.

1 Guideline

Chronic pain: assessment and management

2 List of modelling questions

Review question by scope area	**What is the clinical and cost effectiveness of exercise interventions for the management of chronic primary pain?**
Population	Adults with chronic primary pain
Interventions and comparators considered for inclusion	• Exercise • No exercise It was assumed that both groups receive the same other care.
Perspective	Interventions with health outcomes in the NHS setting (UK NHS and PSS costs)
Outcomes	Cost per QALY gained
Type of analysis	Cost-utility analysis
Issues to note	Incremental lifetime costs and QALYs per person for exercise compared to no exercise were calculated based on studies identified by the systematic review of the clinical evidence that reported appropriate quality of life (QoL) data that could be mapped to EQ-5D (like the SF-36). Differences in QALYs between exercise and no exercise in the model were driven by differences in QoL alone. Data on the difference in utility between exercise and no exercise were combined with assumptions about what was likely to happen to QoL beyond the follow-up in the trials, an alternate base case did not extrapolate beyond the trial data. The key difference in costs were agreed to be those related to delivering an exercise programme. All types of exercise were pooled together. Most were supervised group exercise. The approach taken aimed to give an indication about whether exercise in general was likely to be cost effective. However, the pooling of all types of exercise created a lot of heterogeneity due to differences in the studies in terms of the types of exercise, the intensity (i.e. frequency, duration, and total number of sessions), the staff delivering the exercise, and usual care may have also differed between studies. This heterogeneity in the underlying evidence base should be taken into consideration when interpreting the results of the analysis.

Review question by scope area	What is the clinical and cost effectiveness of acupuncture interventions for the management of chronic primary pain?
Population	Adults with chronic primary pain
Interventions and comparators considered for inclusion	• Acupuncture • No acupuncture It was assumed that both groups receive the same other care.
Perspective	Interventions with health outcomes in the NHS setting (UK NHS and PSS costs)
Outcomes	Cost per QALY gained
Type of analysis	Cost-utility analysis
Issues to note	Incremental lifetime costs and QALYs per person for acupuncture compared to no acupuncture were calculated based on studies identified by the systematic review of the clinical evidence, that compared acupuncture to usual care, and reported appropriate data that could be mapped to the EQ-5D (quality of life (QoL) scales like SF-36, or pain scales where sufficient QoL data was not available for mapping). Usual care studies were used because the committee decided this was the best way to determine treatment effect in a real world scenario. Differences in QALYs between acupuncture and no acupuncture in the model were driven by differences in QoL alone. Data on the difference in utility between acupuncture and no acupuncture were combined with assumptions about what was likely to happen to QoL beyond the follow-up in the trials, an alternate base case did not extrapolate beyond the trial data. The key difference in costs were agreed to be those related to delivering acupuncture. All types of acupuncture were pooled together. The approach taken aimed to give an indication about whether acupuncture in general was likely to be cost effective. However, the pooling of the studies created a lot of heterogeneity due to differences in the studies in terms of the types of acupuncture, the intensity (i.e. frequency, duration, and total number of sessions), the staff delivering the acupuncture, and usual care may have also differed between studies. This heterogeneity in the underlying evidence base should be taken into consideration when interpreting the results of the analysis.