Modular update: Equality and health inequality impact assessment (EHIA)

April 2026

1 General details

Name of modular update

EQ-5D-5L value set

Impacted manuals

- Developing NICE guidelines: the manual [PMG20]
- NICE technology appraisal and highly specialised technologies guidance manual [PMG36]
- NICE's position statement on EQ-5D-5L (corporate document that supplements the NICE manuals)

Impacted sections of the manuals

- NICE health technology evaluations and highly specialised technologies guidance: the manual [PMG36]
  - Section 4.2 'The reference case: framework', specifically table 4.1.
  - Section 4.3 'Measuring and valuing health effects in cost-utility analyses', specifically paragraphs 4.3.6–4.3.12 and 4.3.16, and figure 4.1.
- Developing NICE guidelines: the manual [PMG20]
  - Section 7.4 'The reference case', specifically table 7.1 'Summary of the reference case'.
  - Section 7.7 'Approaches to original economic evaluation', specifically the paragraph 'Measuring and valuing effects for health interventions'.
- NICE's position statement on EQ-5D-5L
  - This will be superseded by the manual updates and will be archived.

Person responsible for the EHIA

Tom Jarratt (Senior analyst, Science Policy team)

2 Development of EHIA

How was the EHIA developed?

This equality and health inequality impact assessment (EHIA) was informed by the conclusions of 2 impact assessments: 1 from the NIHR Policy Research Unit for Economic methods of Evaluation in health and care interventions (EEPRU), and 1 from the Decision Support Unit (DSU). EEPRU examined how the cost effectiveness of new medicines might be impacted by using the EQ-5D-5L value set instead of the EQ-5D-3L value set (referred to from here as the '5L value set' and '3L value set') to calculate utility values (Biz et al. 2026). The DSU looked specifically at the impact of adopting the 5L value set on the frequency with which the severity modifier would be applied in technology appraisal decisions (Wailoo et al. 2026). These analyses (described below) identified several conditions for which new interventions might become less cost effective after adopting the 5L value set, compared with if NICE continued its current approach of using the 3L value set. Based on these findings, we did a pragmatic review to identify other populations that could be negatively affected by adopting the 5L value set (that is, where the treatments for their conditions might become less cost effective) and explored the equalities and health inequalities considerations relevant to these conditions.

In assessing the impact of the proposed modular update, we have paid due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010 (HM Government 2010), and the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

Impact on cost-effectiveness estimates

NICE decides whether a new treatment offers value for money by calculating the incremental cost-effectiveness ratio (ICER). This compares the additional cost of a new treatment with the additional health benefits it provides compared with other available treatments. These health benefits are expressed as a combination of how long people live and the quality of those years of life, known as quality-adjusted life years (QALYs). To calculate QALYs we need a mathematical model called a 'value set' to convert data about people's health-related quality of life, collected using the

EQ-5D measure, into values that we can use in economic models (‘utility values’). EEPRU assessed how using the 5L value set instead of the 3L value set could affect estimates of QALYs and ICERs.

EEPRU purposively selected 39 decisions from 37 technology appraisals, published between 2016 and August 2024, that reported using EQ-5D-3L utility values in the economic model. The selected case studies broadly reflect the range of disease areas considered by NICE, but the sample was not formally designed to precisely mirror our portfolio of guidance topics. EEPRU found that all cancer medicines in the sample became more cost effective (based on 17 decisions from 17 technology appraisals). The impact on cost effectiveness of medicines for non-cancer conditions differed depending on whether the intervention's health benefits were driven by extending how long people live or improving health-related quality of life. For medicines that helped extend how long people with non-cancer conditions live the results were mixed, but most of these treatments became more cost effective (7 out of the 11 decisions reviewed by EEPRU). All of the medicines in EEPRU’s sample that did not affect how long people with non-cancer conditions live became less cost effective (based on 11 decisions from 10 technology appraisals). These included treatments for chronic diseases that can be classed as disabilities, and therefore are protected under the Equality Act 2010. Of the 37 technology appraisals included in EEPRU’s analysis, 10 treatments did not affect how long people lived and became less cost effective using the 5L value set. These 10 treatments covered the following 9 conditions:

- alopecia areata
- atopic dermatitis
- chronic sialorrhoea
- hidradenitis suppurativa
- migraine
- obstructive sleep apnoea
- plaque psoriasis
- prurigo nodularis
- ulcerative colitis.

We did a pragmatic review of a larger sample of published technology appraisals to identify additional populations that could be negatively affected by adopting the 5L value set, based on the trends observed in EEPRU's analysis. We reviewed the 214 most recently published technology appraisals (at the time of the analysis; published between 22 March 2023 and 8 October 2025) and identified 29 treatments that did not affect how long people lived (in addition to the 10 included in EEPRU's analysis), for the following conditions:

- allergic rhinitis
- anaemia in chronic kidney disease dialysis
- angioedema
- asthma
- CDKL5 deficiency disorder
- conjunctivitis
- COVID-19
- Duchenne muscular dystrophy
- endometriosis
- familial hypercholesterolaemia
- graft-versus-host disease
- haemophilia A and B
- hearing loss
- hidradenitis suppurativa
- insomnia
- Lennox–Gastaut syndrome
- multiple sclerosis
- optic neuropathy
- osteoporosis
- Parkinson's disease
- paroxysmal nocturnal haemoglobinuria
- Pompe disease
- uterine fibroids
- vitiligo.

We reviewed NICE's published equality impact assessments for each of the 39 technology appraisals of treatments that did not affect how long people lived (from the sample of 214 recently published technology appraisals combined with those in EEPRU's sample). This was to identify potential equalities and health inequalities considerations for populations that EEPRU's impact assessment indicated could be negatively affected by adopting the 5L value set.

Impact on severity weighting

NICE committees can give extra weight to the health benefits of a treatment when it is used for a particularly severe condition (hereafter referred to as 'severity weighting'). A treatment qualifies for the severity weighting if the condition it treats is expected to cause a large loss in a person's future QALYs, compared with the future QALYs someone in the general population without the condition would be expected to experience. This loss may be measured either as total QALYs lost (absolute shortfall, AS) or as a proportion of the QALYs the person would be expected to experience without the condition (proportional shortfall, PS). The treatment is eligible for severity weighting if either the AS or PS reaches one of the cutoffs set by NICE (see table 6.1 of NICE's technology appraisal and highly specialised technologies guidance manual, presented in appendix A). When this happens, the QALYs gained from that treatment are multiplied by either 1.2 or 1.7 depending on which cutoff has been reached. Increases in AS, PS or both can mean a treatment qualifies for a higher severity weighting, which would make the treatment more cost effective (that is, it has a lower ICER).

The DSU assessed the impact of adopting the 5L value set on severity weightings using 2 samples:

- the sample of 39 decisions from 37 appraisals used in EEPRU's analysis, outlined above
- an additional 18 decisions from 12 appraisals deliberately selected because they either met one of the cutoffs to qualify for severity weighting or were just below one of the cutoffs.

The results showed that using the 5L value set led to a change in severity weighting for only 2 of the 57 decisions across the 2 samples. One decision was from an

appraisal of a treatment for spinal muscular atrophy in children and the other decision related to a treatment for metastatic colorectal cancer in adults. In both cases, the severity weighting fell from 1.7 to 1.2, meaning that a severity weighting would still be applied using the 5L value set, but not at the highest level.

Exploratory analyses looking at how the impact varied by technology type and population indicated that adopting the 5L value set had a very small effect on AS and PS estimates for cancer treatments (slightly higher AS and slightly lower PS using the 5L than using the 3L). AS and PS decreased for most treatments for non-cancer conditions (particularly those that did not affect how long people with non-cancer conditions live). Larger reductions in both AS and PS were seen in appraisals of treatments for patients with younger average starting ages in the cost-effectiveness models. This seems to suggest that adopting the 5L value set might be less favourable for younger people, although the evidence supporting this conclusion is limited because these reductions in AS and PS did not lead to lower severity weightings in the vast majority of cases.

Limitations of the EHIA

The impact assessments focus on technology appraisals for medicines, but the adoption of the 5L value set will affect all NICE recommendations for which the reference case requires a cost–utility analysis (including some HealthTech and guideline recommendations).

We have not been able to identify all the populations that might be negatively affected by adopting the 5L value set or all the ways in which equalities and health inequalities will be impacted. This is because EEPRU's impact assessment on cost effectiveness used a small sample of published technology appraisals. Regardless, it is not possible to predict in advance all the populations that might be negatively affected by the methods update. The impact of adopting the 5L value set depends on whether an intervention's health benefits are driven by extending how long people live or improving health-related quality of life. This would not be known until the cost-effectiveness analysis and committee evaluation has been completed.

The fact that some populations might have been negatively affected by adopting the 5L value set in the past does not mean that future appraisals of treatments for their

conditions will be affected in the same way, because new treatments may help extend how long people live where existing options had only improved health-related quality of life.

Although the assessment specific to the effects on severity weighting did not identify particular conditions at risk of being systematically disadvantaged by adopting the 5L value set, it is possible that such impacts could have been missed. This is because of the small sample size and the way the sample case studies were selected.

Summary of the information considered

- Results of EEPRU's impact assessment on ICERs (Biz et al. 2026).
- Results of the DSU's impact assessment on severity weighting (Wailoo et al. 2026).
- A review of 214 recently published technology appraisals (published between 22 March 2023 and 8 October 2025).
- NICE's published equality impact assessments for:
  - 39 technology appraisals of medicines that did not affect how long people with non-cancer conditions live (identified by EEPRU's impact assessment and the review of 214 recently published technology appraisals)
  - 2 technology appraisals of treatments that would have had a lower severity weighting using the 5L value set, based on DSU's impact assessment.

3 Impact and mitigation

Table 1 describes the impact of the EQ-5D-5L value set on populations with protected characteristics or wider determinants of poor health, and our proposed mitigations.

Table 1 Impact and mitigation for protected characteristics

Protected characteristic or wider determinant of health	Impact	Mitigation
Comments across all equality strands	Adopting the 5L value set into NICE methods will affect all recommendations for which the reference case requires a cost–utility analysis. This is because cost–utility analyses require an assessment of health-related quality of life, and because NICE selected the EQ-5D as its preferred measure of health-related quality of life to ensure consistency across evaluations. The 5L value set will be applied equally across technology appraisals and highly specialised technology evaluations for adults, as well as HealthTech evaluations and guidelines that require a cost–utility analysis, regardless of the intervention under evaluation. But, we recognise that this is likely to have a disproportionate adverse impact on a group of people sharing the protected characteristic of disability (specifically, those with conditions for which treatments do not affect how long people live and might become less cost effective after adopting the 5L value set). Groups with other protected characteristics, as well as groups with wider determinants of poor health, may also be negatively affected by adopting the 5L value set, because treatments for conditions more common in these groups may become less cost effective. There is also some indication that adopting the 5L value set may be less	We recognise the disadvantage caused to some groups of people. We will provide committees with briefing materials and training**,** including information on the impact of adopting the 5L value set, drawing attention to the populations (and related equalities and health inequalities issues) that could potentially be negatively affected because treatments might become less cost effective. We will also explain the potential impact of adopting the 5L value set on the severity weightings applied in technology appraisal decisions. As part of these briefing materials and training, we will promote awareness of: • existing methods and processes for identifying and addressing equalities and health inequalities issues, and how the committee can apply flexibility in its decision making when considering these factors (described in this EHIA document) • existing flexibilities to accept evidence from other health-related quality of life measures when there is evidence that EQ-5D is not appropriate (described in this EHIA document). NICE's current processes ensure that equalities and health inequalities are considered and addressed during the development of every NICE evaluation and

Protected characteristic or wider determinant of health	Impact	Mitigation
	favourable for young people than for older people, although the evidence supporting this conclusion is limited. These impacts are discussed in section 2. Notwithstanding the impact assessment identifying the potential for indirect discrimination for some groups of people, adopting the 5L value set reflects an evidence-based improvement to NICE's methods and will allow us to more accurately estimate the health benefits and cost effectiveness of new technologies consistently across our evaluations, regardless of the condition being treated. The 5L value set reflects current societal preferences about what people consider important about their health. Much has changed since the 3L value set was created in the 1990s: the UK population demographics are different, healthcare has advanced, public awareness of health issues has evolved, and the methods used to develop value sets have improved significantly. Health technology assessment agencies in several other countries have adopted their local 5L value set. Some groups of people are also likely to be positively affected by adopting the 5L value set. These include people with cancer, which is classed as a disability under the Equality Act 2010, and conditions for which treatment benefits are driven by extending how long	guideline. Stakeholders and experts with relevant expertise are explicitly asked to identify relevant issues, and NICE publishes the outputs of our equality and health inequalities impact assessments for every evaluation, guideline and guideline update. Committees consider equalities issues and the health inequality impacts of a technology when making recommendations in technology appraisals, highly specialised technology evaluations and guidelines (see sections 6.1.2, 6.2.35 to 6.2.38, and 6.3.5 of NICE's technology appraisal and highly specialised technologies guidance manual [presented in appendix B] and section 9.1 of the developing NICE guidelines manual [presented in appendix C]). For interventions that reduce health inequalities, committees can apply flexibility to the range of ICERs normally considered a cost-effective use of NHS resources. To help address equality issues, committees can also make optimised recommendations (with different recommendations for specific groups) and recommendations for research. NICE manuals recognise that in some circumstances the EQ-5D may not be the most appropriate measure for capturing health-related quality of life. These include when evidence generation is difficult (for example, for rare diseases) or the nature of the condition means that the EQ-5D performs poorly and is not responsive to changes for

Protected characteristic or wider determinant of health	Impact	Mitigation
	people live. Based on the sample in EEPRU's analysis, treatments became more cost effective with the 5L value set for the following disabling conditions (references provide information about when the condition could qualify as a disability): • cancer (Equality Act 2010) • infections following stem cell or solid organ transplant (Anthony Nolan, 2021) • lupus nephritis (Lupus Trust UK, 2022) • pulmonary fibrosis (Action for Pulmonary Fibrosis, 2026).	particular people. Committees can accept evidence from other health-related quality of life measures, including generic or condition-specific measures, if evidence is provided to show that the EQ-5D is not appropriate (see sections 4.3.9 to 4.3.12 of NICE's technology appraisal and highly specialised technologies guidance manual, presented in appendix D).
Age	The EQ-5D is NICE's preferred measure of health-related quality of life for adults, and our manuals do not recommend specific measures of health-related quality of life in children and young people. The EQ-5D-5L measure and its value set are designed specifically for use in adults only, so this methods update does not cover children and young people. High-quality research examining methods for measuring and valuing health-related quality of life in children and young people is required to inform updates to our methods guidance. This will be identified and considered using NICE's published process for identifying and prioritising modular updates. Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's finding that	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people.

Protected characteristic or wider determinant of health	Impact	Mitigation
	treatments that did not affect how long people with non-cancer conditions live became less cost effective). People with some of these conditions are more likely to belong to certain age groups: • Parkinson's disease (NICE technology appraisal 934, 2023) and sialorrhoea (NICE technology appraisal 605, 2019) both predominately impact people over 65. • Multiple sclerosis is typically diagnosed in younger people between 20 and 40 (NICE technology appraisal 1053, 2025). • Vitiligo is typically diagnosed before the age of 30 years (NICE technology appraisal 1088, 2025). The DSU analysis identified a link between age and the impact of the 5L value set on the calculations that inform whether a treatment qualifies for the severity weighting. Using the 5L value set resulted in larger reductions in both AS and PS for populations with younger average starting ages in the cost-effectiveness models. This seems to suggest that adopting the 5L value set may be less favourable for younger people than for older people. That is, younger people may be less likely to receive the severity weighting. But, the DSU analysis did not identify any evidence that the severity weighting is systematically worse for younger patients when using the 5L value set. In the 2	Equalities issues related to age that are relevant to an appraisal or guideline will be identified and addressed using NICE's existing processes and methods, including consideration of whether any reasonable adjustments are needed. These will be captured in our published equality impact assessments and, where appropriate, in final NICE guidance.

Protected characteristic or wider determinant of health	Impact	Mitigation
	technology appraisal decisions that had a lower severity weighting with the 5L value set, 1 was in younger people (average starting age of 4 years) and the other was in older people (average starting age of 60 years). The DSU analysis concluded that changes in AS and PS resulting from using the 5L value set are unlikely to reduce the severity weighting in the vast majority of cases, so the risk of indirect discrimination based on age is low. We consider the risk of indirect discrimination to be justified for the reasons previously outlined. That is, adopting the 5L value set reflects an evidence-based methods improvement that will allow NICE to more accurately estimate the health benefits and cost effectiveness of new interventions consistently across our evaluations, regardless of the condition. It will be applied equally to all technology appraisals and other guidance requiring a cost–utility analysis.	
Disability	People are considered disabled under the Equality Act 2010 if they have a 'physical or mental impairment that has a "substantial" and "long-term" negative effect on your ability to do normal daily activities'. People diagnosed with cancer, HIV infection or multiple sclerosis automatically meet the disability definition under the Equality Act 2010. People with other conditions may also meet the definition, depending on the severity and duration of their condition.	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B)

Protected characteristic or wider determinant of health	Impact	Mitigation
	Several populations could be negatively affected by adopting the 5L value set (based on EEPRU's findings that treatments which did not affect how long people with non-cancer conditions live became less cost effective). Some of these conditions could be classed as disabling, depending on their impact on a person's ability to do normal daily activities. This includes people with multiple sclerosis, Duchenne muscular dystrophy and ulcerative colitis. Conversely, some conditions which are classed as disabling are likely to be positively impacted by adopting the 5L value set. In particular, treatments for cancer are likely to become more cost effective after adopting the 5L value set. We recognise that adopting the 5L value set could lead to indirect discrimination by placing some disabled people (those with conditions for which treatments do not extend how long they live and may become less cost effective) at a disadvantage compared with people who are not disabled. We consider that this risk of indirect discrimination is justified for the reasons previously outlined. That is, adopting the 5L value set reflects an evidence-based methods improvement that will allow NICE to more accurately estimate the health benefits and cost effectiveness of new interventions consistently across our evaluations, regardless of the condition. It will be applied equally to all technology	• when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some disabled persons. Equalities issues related to disabilities that are relevant to an appraisal or guideline will be identified and addressed using NICE's existing processes and methods, including consideration of whether any reasonable adjustments are needed. These will be captured in our published equality impact assessments and documented, where appropriate, in final NICE guidance

Protected characteristic or wider determinant of health	Impact	Mitigation
	appraisals and other guidance requiring a cost–utility analysis.	
Race or ethnicity	Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's findings that treatments which did not affect how long people with non-cancer conditions live became less cost effective). Some of these conditions are more common in people of certain races or ethnicities. These include the following: • Alopecia is more common in people of Asian family background (NICE technology appraisal 926, 2023). • Hidradenitis suppurative is more common in people of African-Caribbean family background (NICE technology appraisal 935, 2023). • Moderate to severe atopic dermatitis is more common in people of Black or Asian ethnicity (NICE technology appraisal 1077, 2025). Diagnostic and assessment tests for the following conditions can be less accurate for people with darker skin, and treatments for these conditions might become less cost effective as a result of adopting the 5L value set (based on EEPRU's finding that treatments that do not affect how long people live became less cost effective):	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people. Equalities issues related to race or ethnicity that are relevant to an appraisal or guideline will be identified and addressed using NICE's existing processes and methods, including consideration of whether any reasonable adjustments are needed. These will be captured in our published equality impact assessments.

Protected characteristic or wider determinant of health	Impact	Mitigation
	• atopic dermatitis (NICE technology appraisal 1077, 2025) • prurigo nodularis (NICE technology appraisal 955, 2025) • psoriasis (NICE technology appraisal 907, 2023) • skin manifestations in people with graft-versus-host disease (NICE technology appraisal 949, 2024).	
Gender reassignment	No impact identified.	–
Marriage and civil partnership	No impact identified.	–
Pregnancy and maternity	No impact identified.	–
Religion and belief	Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's finding that treatments that did not affect how long people with non-cancer conditions live became less cost effective). Some of these conditions disproportionately affect people from certain faith groups, as follows: • Treatments for haemophilia A and B (NICE technology appraisal 1051, 2025) and angioedema (NICE technology appraisal 1101, 2025) are sometimes not suitable for people because of their religious faith or beliefs. • Ulcerative colitis may disproportionately affect people from specific faith groups because the effects of active disease and surgery may interfere with religious	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and will remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people.

Protected characteristic or wider determinant of health	Impact	Mitigation
	practices (NICE technology appraisal 792, 2022). • Hair loss associated with alopecia can have more significance to people from certain faith groups (NICE technology appraisal 926, 2023).	Equalities issues related to religion or belief that are relevant to an appraisal or guideline will be identified and addressed using NICE's existing processes and methods, including consideration of whether any reasonable adjustments are needed. These will be captured in our published equality impact assessments and documented, where appropriate, in final NICE guidance
Sex	Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's finding that treatments which did not affect how long people with non-cancer conditions live became less cost effective). Some of these conditions are more common depending on biological sex. Some conditions more common in females are: • endometriosis (NICE technology appraisal 1067, 2025) • hidradenitis suppurativa (NICE technology appraisal 935, 2023) • migraine (NICE technology appraisal 973, 2024) • multiple sclerosis (NICE technology appraisal 1053, 2025) • prurigo nodularis (NICE technology appraisal 955, 2024).	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people. Equalities issues related to sex that are relevant to an appraisal or guideline will be identified and addressed using NICE's existing processes and methods, including consideration of whether any reasonable

Protected characteristic or wider determinant of health	Impact	Mitigation
	Haemophilia A and B primarily affect males (NICE technology appraisal 1051, 2025).	adjustments are needed. These will be captured in our published equality impact assessments and documented, where appropriate, in final NICE guidance
Sexual orientation	No impact identified.	–
Socioeconomic deprivation (This is not a protected characteristic under the Equality Act 2010, but is a determinant of poor health. It includes variation in deprivation by location such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status and income.)	Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's finding that treatments which did not affect how long people with non-cancer conditions live became less cost effective). This includes people with conditions linked to lower socioeconomic status, such as: • alopecia (NICE technology appraisal 926, 2023) • atopic dermatitis (NICE technology appraisal 1077, 2025) • COVID-19 in people with multiple comorbidities (NICE technology appraisal 900, 2023). People with some conditions need to travel to specialist centres to access treatments (see 'Geographical area variation' section). This may limit access to treatment for people from deprived backgrounds.	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities issues (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). In particular, committees can apply flexibility to the range normally considered a cost-effective use of NHS resources if there is robust evidence that a treatment substantially reduces health inequalities, which could relate to socioeconomic deprivation. These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people.

Protected characteristic or wider determinant of health	Impact	Mitigation
Geographical area variation (This is not a protected characteristic under the Equality Act 2010, but is a determinant of poor health. It includes geographical differences in epidemiology or service provision, for example urban or rural, coastal, north or south.)	Our review indicates that some populations could be negatively affected by adopting the 5L value set (based on EEPRU's findings that treatments which do not affect how long people live became less cost effective) because they need to travel to specialist centres for treatment. These include people with: • ulcerative colitis (NICE technology appraisal 792, 2022) • some treatments for COVID-19 (NICE technology appraisal 900, 2023) • insomnia (NICE technology appraisal 922, 2023) • multiple sclerosis (NICE technology appraisal 1053, 2025) • endometriosis (NICE technology appraisal 1067, 2025) • graft-versus-host disease (NICE technology appraisal 949, 2024) • spinal muscular atrophy (NICE technology appraisal 588, 2019) • vitiligo (NICE technology appraisal 1088, 2025).	As previously mentioned, we will brief committees on the impact of adopting the 5L value set and remind them of: • existing approaches for identifying and addressing equalities and health inequalities issues (see appendix B and appendix C) • how they can apply flexibility in decision making for interventions that reduce health inequalities (see appendix B) • when it would be appropriate to accept health-related quality of life evidence from measures other than the EQ-5D (see appendix D). In particular, committees can apply flexibility to the range normally considered a cost-effective use of NHS resources if there is robust evidence that a treatment substantially reduces health inequalities, which could relate to geographical differences in healthcare. These mitigations will act as reasonable adjustments to avoid the disadvantage caused to some groups of people.
Inclusion health groups and vulnerable groups (This is not a protected characteristic under the Equality Act 2010, but is a determinant of poor health. It includes vulnerable migrants, people experiencing homelessness, people	No impact identified.	–

Protected characteristic or wider determinant of health	Impact	Mitigation
in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking.)		

4 Sign-off

Signed off by: Koonal Shah, contact koonal.shah@nice.org.uk

Date: 24 March 2026

5 References

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Baricitinib for treating severe alopecia areata: Equality impact assessment (2023) NICE technology appraisal guidance 926

Belumosudil for treating chronic graft-versus-host disease after 2 or more systemic treatments in people 12 years and over: Equality impact assessment. (2024) NICE technology appraisal guidance 949

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Clostridium botulinum neurotoxin type A for treating chronic sialorrhoea: Equality impact assessment. (2019) NICE technology appraisal guidance 605

Daridorexant for treating long-term insomnia: Equality impact assessment (2023) NICE technology appraisal guidance 922

Deucravacitinib for treating moderate to severe plaque psoriasis: Equality impact assessment (2023) NICE technology appraisal guidance 907

Dupilumab for treating moderate to severe prurigo nodularis: Equality impact assessment (2024) NICE technology appraisal guidance 955

Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over: Equality impact assessment (2025) NICE technology appraisal guidance 1051

Filgotinib for treating moderately to severely active ulcerative colitis: Equality impact assessment (2022) NICE technology appraisal guidance 792

Foslevodopa-foscarbidopa for treating Parkinson's with motor symptom: Equality impact assessment (2023) NICE technology appraisal guidance 934

Garadacimab for preventing recurrent attacks of hereditary angioedema in people 12 years and over: Equality impact assessment (2025) NICE technology appraisal guidance 1101

HM Government (2010) Equality Act 2010 [online; accessed 25 February 2026]

Linzagolix for treating symptoms of endometriosis: Equality impact assessment (2025) NICE technology appraisal guidance 1067

Lupus Trust UK (2022) Is lupus a disability? [online; accessed 29 January 2026]

Nemolizumab for treating moderate to severe atopic dermatitis in people 12 years and over: Equality impact assessment. (2025) NICE technology appraisal guidance 934

Nusinersen for treating spinal muscular atrophy: Equality impact assessment (2019) NICE technology appraisal 588

Ruxolitinib cream for treating non-segmental vitiligo in people 12 years and over: Equality impact assessment. (2025) NICE technology appraisal guidance 1088

Secukinumab for treating moderate to severe hidradenitis suppurativa: Equality impact assessment (2023) NICE technology appraisal guidance 935

Tixagevimab plus cilgavimab for preventing COVID-19: Equality impact assessment (2023) NICE technology appraisal guidance 900

Vamorolone for treating Duchenne muscular dystrophy in people 4 years and over: Equality impact assessment (2025) NICE technology appraisal guidance 1031

Wailoo A, Biz AN, Hernández Alava M (2026) What is the impact of EQ-5D-5L vs 3L on NICE severity weights? NICE DSU report

Appendix A: Extracts from NICE technology appraisal and highly specialised technologies guidance: the manual

Decision modifiers: severity

Refer to NICE's technology appraisal and highly specialised technologies guidance manual (PMG36) for further information.

6.2 Decision modifiers: severity

6.2.12 The committee will consider the severity of the condition, defined as the future health lost by people living with the condition with standard care in the NHS (including use of other available treatments, diagnostics, or best supportive care). The extent of unmet health need is reflected within the severity definition. Initially, the severity modifier will not be applied to technology appraisals of HealthTech. Here the severity of the condition should be captured within the QALY benefits and then deliberatively within decision making. NICE is exploring approaches for how the severity modifier could be applied for technology appraisals of HealthTech.

6.2.13 When assessing the severity of the condition in technology appraisals, the committee will consider the associated absolute and proportional QALY shortfall.

6.2.14 Absolute QALY shortfall is the future health, including quality and length of life, that is lost by people living with a condition, compared with the expected future health without the condition over the remaining lifetime of the patients. Absolute QALY shortfall is calculated as the expected total QALYs that people living with a condition would be expected to have with current treatment over their remaining lifetime subtracted from the total QALYs that the general population with the same

age and sex distribution would be expected to have. The expected QALYs for the condition with current treatment is equivalent to the total QALYs gained with established practice in the NHS.

6.2.15 Proportional QALY shortfall represents the proportion of future health, including quality and length of life, that is lost by people living with the condition. Proportional QALY shortfall is calculated by taking the absolute QALY shortfall and dividing it by the remaining QALYs that the general population with the same age and sex distribution would be expected to have over their remaining lifetime.

6.2.16 The committee may apply a greater weight to QALYs if technologies are indicated for conditions with a high degree of severity. The data used to estimate both absolute and proportional QALY shortfall should focus on the specific population for which the new technology will be used and be based on established clinical practice in the NHS.

6.2.17 Absolute and proportional shortfall calculations include an estimate of the total QALYs for the general population with the same age and sex distribution as those with the condition. The population EQ-5D data and survival data used for the estimates should be based on a recent and robust source. Absolute and proportional shortfall calculations should include discounting at the reference-case rate.

6.2.18 The QALY weightings for severity are applied based on absolute and proportional shortfall, whichever implies the greater severity level. If either the proportional or absolute QALY shortfall calculated falls on the cut-off between severity levels, the higher severity level will apply.

Table 6.1 QALY weightings for severity

QALY weight	Proportional QALY shortfall	Absolute QALY shortfall
1	Less than 0.85	Less than 12
x1.2	0.85 to 0.95	12 to 18
X1.7	At least 0.95	At least 18

6.2.19 For diagnostics, a QALY weight for severity based on absolute and proportional QALY shortfall is unlikely to reflect the societal value and severity of disease in a way that is relevant to the diagnostics context.

6.2.20 For highly specialised technologies, the severity of the condition is already implicitly captured in the selection of technologies for evaluations. No additional QALY weighting for the severity of disease is applied.

6.2.21 Technologies recommended after applying the severity modifier will be considered as relevant comparators for future evaluations of new technologies introduced for the same condition. They must have been recommended for routine use and represent established practice in the NHS at the time of evaluating the new technology. Second and subsequent extensions to the regulatory approval for the same technology will be considered on their individual merits.

Appendix B: Extracts from NICE technology appraisal and highly specialised technologies guidance: the manual

Impact on health inequalities

Refer to NICE's technology appraisal and highly specialised technologies guidance manual (PMG36) for further information.

4.12 Impact on health inequalities

4.12.1 The benefits and costs of new health technologies may not be equally distributed across social groups, which can impact health inequalities. Distributional cost-effectiveness analysis (DCEA) is an economic evaluation framework for synthesising evidence on health inequalities. It determines how costs and benefits vary across population groups. It can be used to show the potential impact of a new technology on health inequalities and specifically the health inequality gap in the general population.

4.12.2 DCEA should only be included in a company submission if there is clear evidence of a significant burden of health inequalities in the eligible population. This should be supported by quantitative evidence (see the technology evaluation methods support document on health inequalities).

4.12.3 DCEA should only be used as supporting evidence of the potential for a technology to impact health inequalities. Cost-effectiveness results by subgroups based solely on social characteristics should not be part of the base-case analysis or presented as non-reference case scenarios.

4.12.4 DCEAs will not be done in economic evaluations produced by EAGs on behalf of NICE for all appraisals of HealthTech and multiple technology appraisals for medicines. For these types of evaluations, DCEA evidence can be provided by companies as part of the information requested on the evidence base and their technology.

4.12.5 NICE's technology appraisals and highly specialised technologies recommendations do not include guidance on service delivery or to support implementation for disadvantaged groups. The committee can only recommend technologies as options for use in the NHS. Differences in uptake may determine health inequality impacts and be relevant to the committee's deliberations, but they cannot be addressed by the committee's recommendations.

4.12.6 The committee should be aware of the remit of their guidance programme and consider how any variations in modelled uptake would be addressed by the new technology.

4.12.7 The results of the DCEA should not weigh the costs or benefits of a technology differently based on the social characteristics of the people affected by the recommendation.

4.12.8 Health inequalities may be relevant to a range of technologies and diseases. So, it is important that DCEAs that support decision making are consistent. The key components of DCEAs and NICE's preferred methods are summarised in the technology evaluation methods support document on health inequalities. Other approaches can be presented if appropriate, but deviations from the specified methods must be clearly justified and supported by evidence.

6.1 Evaluation of the evidence and structured decision making

6.1.2 When forming its recommendations to NICE, the committee considers those factors it believes are most appropriate for each evaluation. In doing so, the committee takes into account the provisions and regulations of the Health and Social Care Act 2012 relating to NICE, and NICE's legal obligations on equality and human rights. The Act expects NICE, when doing its general duties, to be aware of:

- the broad balance between the benefits and costs of providing health services or social care in England.
- the degree of need of people in England for health services or social care.
- the desirability of promoting innovation when providing health services or social care in England.

Structured decision making: health inequalities

6.2.35 If robust evidence shows that the technology substantially affects health inequalities, the committee will consider how this impacts its decision on whether the technology is an effective use of NHS resources (see sections 6.2.37 and 6.2.38).

6.2.36 Consideration of the health inequality impacts of a technology is separate from NICE's legal obligations on equality and human rights, including under the Equality Act 2010.

6.2.37 When assessing the relevance of health inequality impacts on the value of the technology, the committee will consider any uncertainty associated with the health inequality evidence and analysis. If robust condition- or disease-specific evidence shows that uncertainty or biases in the health inequality evidence are caused by structural or social barriers to accessing care or participating in research, the committee may accept a higher level of uncertainty in the health inequality evidence and analysis.

6.2.38 When considering the relevance of health inequality impacts on the value of the technology, the committee can apply flexibility to the range normally considered a cost-effective use of NHS resources. But, it must consider the effects of healthcare displacement and opportunity cost and provide a rationale for stakeholders. This flexibility should be applied to the most appropriate acceptable ICER decided by the committee for the reference case analysis, as described in sections 6.3.4 to 6.3.8. It

should only be applied when the size of the health inequality impacts of a technology are substantial. It should not be used to justify restricting the population of interest to a subgroup based on cost effectiveness (see section 4.9). The committee will not use evidence on health inequality impacts to make optimised recommendations for subgroups based solely on social characteristics.

6.3 Decision making

Economic evaluations based on cost–utility analyses

6.3.5 Above a most plausible ICER of £20,000 per QALY gained, or £100,000 per QALY gained for highly specialised technologies, decisions about the acceptability of the technology as an effective use of NHS resources will specifically consider the following factors:

- the degree of certainty and uncertainty around the ICER
- aspects that relate to uncaptured benefits and non-health factors
- aspects that relate to health inequalities.

Appendix C: Extracts from Developing NICE guidelines: the manual

Factoring equalities and health inequalities into decision making

Refer to Developing NICE guidelines: the manual (PMG20) for further information.

Promoting equality and reducing health inequalities

The equality and health inequalities assessment (EHIA) form should document how the committee's responsibilities under equality legislation and our equality scheme have been discharged in reaching the recommendations (see the section on key principles for developing NICE guideline recommendations in the introduction chapter), and how the recommendations address equality issues and health inequalities.

The committee needs to consider whether:

- the evidence review has found evidence to support recommendations to address any equality issues and health inequalities identified during guideline development (if not, consider other sources of information for example expert testimony or health inequality briefings, if available)
- criteria for access to an intervention might be discriminatory (for example, through membership of a particular group, or by using an assessment tool that might discriminate unlawfully)
- any groups of people might find it impossible or difficult to receive or access an intervention.

Ideally, recommendations should be formulated to promote equality and reduce health inequalities (for example, by making access more likely for certain groups, or by tailoring the intervention to specific groups). If this is not possible, the committee should consider whether it is appropriate to make a research recommendation (for further details see the section on formulating recommendations for research**).**

Appendix D: Extracts from NICE technology appraisal and highly specialised technologies guidance: the manual

Measuring and valuing health effects in cost-utility analyses

Refer to NICE's technology appraisal and highly specialised technologies guidance manual (PMG36) for further information.

4.3 Measuring and valuing health effects in cost-utility analyses

4.3.4 The valuation of health-related quality of life measured by patients (or their carers) should be based on a valuation of public preferences from a representative sample of the UK population using a choice-based method. This valuation leads to the calculation of utility values.

4.3.5 Different methods used to measure health-related quality of life produce different utility values. Therefore, results from different methods or instruments cannot always be compared.

4.3.6 Given the need for consistency across evaluations, the EQ-5D measurement method is preferred to measure health-related quality of life in adults. Preference

values from the EQ-5D should be applied to measurements of health-related quality of life to generate health-related utility values.

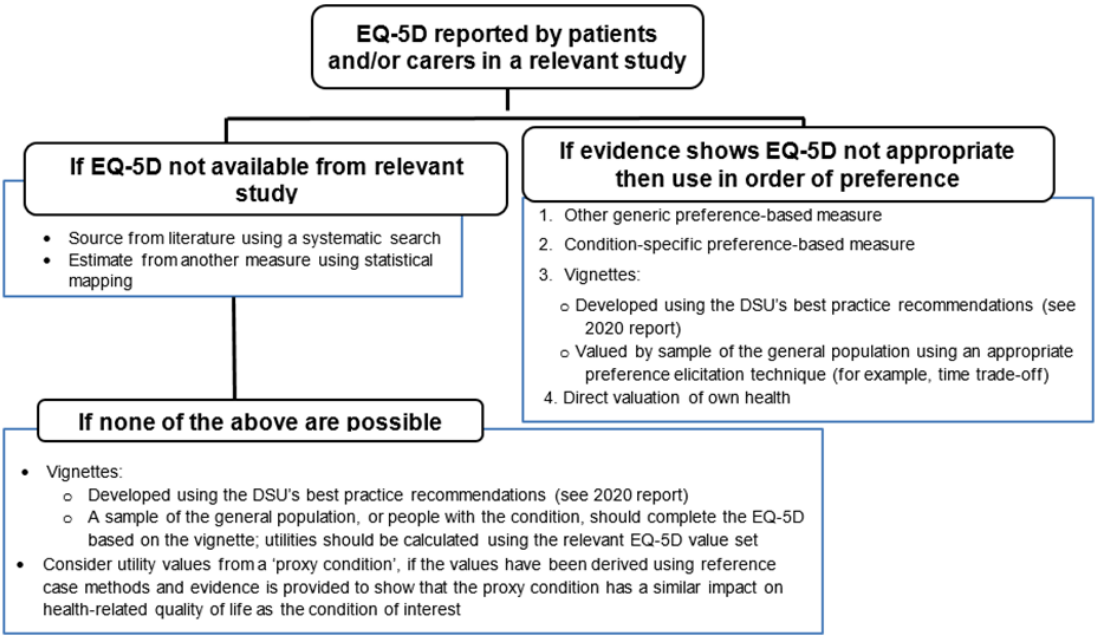
4.3.9 When EQ-5D data is not available, this data can be estimated by mapping other health-related quality-of-life measures or health-related benefits seen in the relevant clinical trials to EQ-5D. This is considered to be a departure from the reference case. The mapping function chosen should be based on data sets containing both health-related quality-of-life measures and its statistical properties. It should be fully described, its choice justified, and it should be adequately shown how well the function fits the data. Present sensitivity analyses to explore variation in using mapping algorithms on the outputs.

4.3.10 In some circumstances the EQ-5D may not be the most appropriate measure. To make a case that the EQ-5D is inappropriate, provide qualitative empirical evidence on the lack of content validity for the EQ-5D, showing that key dimensions of health are missing. This should be supported by evidence that shows that EQ-5D performs poorly on tests of construct validity (that is, it does not perform as would be expected) and responsiveness in a particular patient population. This evidence should be derived from a synthesis of peer-reviewed literature. In these circumstances alternative health-related quality-of-life measures may be used. These must be accompanied by a carefully detailed account of the methods used to generate the data, their validity, and how these methods affect the utility values.

4.3.11 In circumstances when evidence generation is difficult (for example, for rare diseases), when there is insufficient data to assess whether the EQ-5D adequately reflects changes in quality of life, evidence other than psychometric measures may be presented and considered to establish whether the EQ-5D is appropriate.

4.3.12 A hierarchy of preferred health-related quality-of-life methods is presented in figure 4.1. Use figure 4.1 for guidance when the EQ-5D is not available or not appropriate.

Figure 4.1 Hierarchy of preferred health-related quality-of-life methods


EQ-5D reported by patients and/or carers in a relevant study
If EQ-5D not available from relevant study
Source from literature using a systematic search
Estimate from another measure using statistical mapping
If evidence shows EQ-5D not appropriate then use in order of preference
1. Other generic preference-based measure
2. Condition-specific preference-based measure
3. Vignettes:
Developed using the DSU's best practice recommendations (see 2020 report)
Valued by sample of the general population using an appropriate preference elicitation technique (for example, time trade-off)
4. Direct valuation of own health
If none of the above are possible
Vignettes:
Developed using the DSU's best practice recommendations (see 2020 report)
A sample of the general population, or people with the condition, should complete the EQ-5D based on the vignette; utilities should be calculated using the relevant EQ-5D value set
Consider utility values from a 'proxy condition', if the values have been derived using reference case methods and evidence is provided to show that the proxy condition has a similar impact on health-related quality of life as the condition of interest