PODIUM SESSION I: ECONOMIC EVALUATIONS I

DISCRETE CHOICE EXPERIMENTS OF COMPLEX HEALTH CARE DECISIONS: DOES HIERARCHICAL INFORMATION INTEGRATION OFFER A SOLUTION?
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OBJECTIVES: Discrete choice experiments (DCE) are increasingly used to investigate preferences for health care products and programs. A limitation of DCE is the inability to handle large numbers of attributes. In hierarchical information integration (HII) attributes are categorized into meaningful subsets, and separate experiments are designed for each of the subsets. A HII-DCE was applied regarding potential barriers and facilitators to implementation of the guideline for breast cancer surgery in day-care. METHODS: A total of 1713 questionnaires were sent to three groups of health care professionals (anesthesiologists, surgical oncologists, breast care nurses). Random parameters logit modelling was used to estimate a choice model. Theoretical validity, construct validity, and internal consistency were assessed to investigate whether HII can be used to deal with the typical complexity of multi-faceted health care management decisions. Also, response rate and predictive ability of the model were assessed to study the feasibility of HII. RESULTS: Sixteen out of 17 attributes were significant at the 1% level and had the expected sign. Also all three decision constructs were significant at the 1% level, and were well defined by their attributes. The test-retest resulted in a Kappa statistic of 0.58 (p < 0.001). The overall response rate was 10%. The predicted frequency distribution and observed frequency distribution based on the full profile hold-out task did not differ significantly (Chi-square test; p = 0.088). CONCLUSIONS: Our study showed good theoretical validity, good construct validity and satisfactory internal consistency. Response rate was high and predictive ability of the model was satisfactory. In conclusion, HII can be successfully used to study complex health care decisions. The feasibility of HII in this particular context of an implementation decision seemed less favourable.

STANDARDIZED TYPE 2 DIABETES COMPLICATION COSTS FROM US COMMERCIAL PAYERS TO BE USED IN MODELING THE LONG-TERM ECONOMIC OUTCOMES OF DIABETES COMPLICATIONS
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OBJECTIVES: The American Diabetes Association (ADA) has estimated the annual cost of diabetes in the USA at $174 billion (ADA, Diabetes Care, 2008), using multiple and varied sources to derive cost estimates. This study used a single, multi-payer US database to derive private payer-specific estimates of average type 2 diabetes mellitus (T2DM) complication costs, which may be suitable for long-term economic modeling. METHODS: Private health insurance claims were taken from the PharMetrics Patient-Centric Database, which is comprised of adjudicated medical and pharmaceutical claims covering 55 million unique patients from over 90 health plans from across the USA. T2DM patients experiencing at least 1 of 24 major complications from July 1, 2003 through June 30, 2005, along with a T2DM diagnosis prior to or on the date of the index complication, were identified. T2DM complication costs were extracted from 64,536 patients who had a minimum of 12 months follow-up. Cost data for months 13–24 following the complication were taken from a subset of the full patient population who were continuously eligible for at least 24 months (n = 47,541). Direct medical costs were subdivided into charges and allowed amounts expressed in $US 2007. RESULTS: The average age of the population was 57 years and 51.8% were male. The most frequently reported complication was peripheral neuropathy (26.3%). First year charges for complications ranged between $272 for ketoacidosis to $38,588 for myocardial infarction, with corresponding allowed amounts of $174 and $14,394, respectively. Second year charges for complications ranged between $0 for ketoacidosis to $21,965 for peritoneal dialysis, with corresponding allowed amounts of $0 and $10,133, respectively. Among all complications, allowed amounts were significantly lower than charged amounts. CONCLUSIONS: Our study provides an important and representative source of T2DM complication costs for estimating the long-term economic impact of this prevalent and costly disease.
0.5, N = 2384), moderate (0.5 < APRI≤1.5, *=*, and=* (apri™ severe=™ n=377),*=*, N = 116). Per patient use and costs of HCV-related medical services and prescriptions were assessed over 12 months post-diagnosis. RESULTS: More than 23% of patients with severe HCV had a disease-related hospitalization compared to 12% and 16% of mild and moderate patients, respectively (both P < 0.05). Hospitalization costs were nearly 2.5 times higher in moderate patients ($3480) and approximately 4.7 times higher in severe patients ($6872) compared to those with mild disease ($1448; both P < 0.01). Severe patients also had a significantly higher mean number of hospital days (7.9) compared to moderate (6.7 days) and mild patients (4.1 days). There were no significant differences in encounters and costs for physician office and emergency department visits. Severe patients had slightly lower (but insignificant) HCV-related pharmacy costs compared to moderate (6.7 days) and mild patients (4.1 days).

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