CORRECTING FOR COMPENSATING MECHANISMS RELATED TO PRODUCTIVITY COSTS IN ECONOMIC EVALUATIONS OF HEALTH CARE PROGRAMS

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OBJECTIVES: In economic evaluation of health care programmes, productivity costs are often overestimated, because compensation of lost work is neglected. This study tested the conclusions of a small previous study (Severens et al. 1998) which indicated that short-term work absence often is compensated for during normal work hours, thereby leading to limited productivity costs. METHODS: We studied work absence and compensation of lost work in five different patient populations (psoriasis, low back pain, chronic fatigue syndrome, rheumatoid arthritis and persistent dyspepsia) and one employee population (workers of a pharmaceutical company). RESULTS: This study showed that only About 70–75% of lost work hours were compensated by the absentee or colleagues during normal working hours. Between 25–30% of the productivity costs as calculated by the classical method remained, if productivity costs were only calculated when extra efforts were needed. For 1 day absence only in 17–19% of the cases work absence resulted in productivity costs, while this was 35%–39% for absence of two weeks or longer. Measurement of the compensating mechanisms seemed to be valid, because the large since the agreement between the opinion of supervisors and their employees whether compensation takes productivity costs. The measurement of compensating mechanisms, seemed to be valid. Also, for different occupations different compensating mechanisms were reported in the expected direction. In our study populations, compensating mechanisms differed with occupational characteristics, like part-time work, managerial work and shift work. For example, higher educated workers more often compensate for lost work themselves. CONCLUSIONS: Including compensating reduces productivity costs due to absence from work to a considerable extent. Nevertheless, we advise researchers to take a broad range for correction, because for some compensation mechanisms the consequences for productivity costs may vary between settings.

QALYS LACK QUALITY IN PAEDIATRIC CARE: A CRITICAL REVIEW OF PUBLISHED COST-UTILITY STUDIES IN CHILD HEALTH

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OBJECTIVES: To critically appraise published cost-utility analyses of interventions in child and adolescent health care in terms of the methods used to estimate quality-adjusted life years (QALYs). METHODS: A comprehensive search of computerised databases (e.g., Medline, Embase) was undertaken to identify cost-utility studies published prior to April 2004. Studies were categorised according to the methods used to describe health status, the valuation technique and source of preferences. The methods were compared with the guidelines of the U.S. Panel on Cost-effectiveness in Health and Medicine and the National Institute for Clinical Excellence (NICE) in England and Wales which recommend the use of a generic health status classification system (e.g., HUI, EQ-5D), a choice-based valuation method (e.g., SG or TTO), and preferences of the general population. RESULTS: Fifty-four studies were reviewed, of which 34 (63%) were published in the latter 5 years. A generic health status classification instrument was used in 22 (35%) cases; the remainder developed study specific health state descriptions or elicited preferences directly from patients or proxies. In 7 cases (11%), sources were unclear. Utility values were elicited by using choice-based techniques in 28 cases (42%), either as tariffs for health status classification instruments (17 cases) or by directly valuing health state descriptions or patient health (11 cases). Community preferences were only used in 23 cases (37%). Four studies aggregated QALYs for mother/child or family/child pairs without giving any theoretical justification. CONCLUSIONS: Although the number of cost utility studies is increasing exponentially, the majority of studies did not adhere to standard recommendations with little improvement over time. Further research is warranted to develop appropriate methods to measure and value child health benefits within the QALY framework. In the interim, an expert panel is needed to provide guidance for cost-utility analysis of paediatric interventions to make studies more consistent.