THE ASSESSMENT OF THE INFLUENCE OF AN EDUCATIONAL INTERVENTION ON PATIENT IMPORTANT OUTCOMES INCLUDING HEALTH RELATED QUALITY OF LIFE (HRQoL) AND MORTALITY USING A TIME-TO-EVENT SURVIVAL ANALYSIS IN PATIENTS WITH HEART FAILURE

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OBJECTIVES: Patients with HF can suffer from poor HRQoL particularly as their disease progresses. We wanted to determine whether HRQoL and mortality differences existed between patients following an intervention. We defined an event as either death or a drop from baseline of at least 10 points in the PCS or MCS summary scales of the SF-36 that was sustained on at least 2 consecutive intervals with no recovery prior to study termination. METHODS: This was an RCT (n = 134) with HRQoL collection from baseline every 3 months to 1 year. All data collection and outcomes assessment were done by study personnel who were blinded to patient treatment allocation. Complete SF-36 data were available on 114 patients. We did a Cox regression time-to-event survival analysis adjusting for Arm. RESULTS: According to our definition of events 14.9% of patients had a PCS event and 16.7% of patients had an MCS event. There was no significant effect of Arm. CONCLUSIONS: A 10-point drop in the PCS or MCS can be considered to be a minimal clinically important difference in patients with a sustained drop indicating no response to the intervention. The analytic techniques we used expand the interpretability of HRQoL changes and incorporate clinical outcomes.

WHAT IS THE WILLINGNESS TO PAY FOR FUTURE HEALTH BENEFITS AMONG HYPERTENSIVE PATIENTS—A PILOT STUDY IN POLISH SETTING

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OBJECTIVE: Although there is no final agreement on how willingness to pay (WTP) should be measured, it is increasingly used to value future health benefits. The objective is to measure the financial value of potential health benefits from antihypertensive treatment. METHODS: The study was carried out in 103 hypertensive patients in 3 centres in Poland. The WTP for theoretical antihypertensive agent (drug A) was measured assuming that it would reduce the risk of ischemic heart disease and strokes in the future. Patients were able to choose the treatment or non-treatment option, data obtained were confidential. Three types of potential benefits from the new healthcare intervention were measured: patient benefits, insurance/option value and altruistic value. RESULTS: The average WTP was €14,47 in terms of drug’s price (patient benefit), €3,16 as an insurance premium (private benefit) and €1,16 in additional taxes (societal benefit, all on monthly bases). Differences due to the regional level of development (wealth) were observed. A strong correlation between individual income and WTP was detected. The correlation between WTP and a level of education and occupational status is weaker. CONCLUSION: Patients are willing to pay more then twice as much as the average price of a drug available on the market, (if not reimbursed) and 3.7 times the amount of patient co-payment (if the drug is reimbursed). Patients are willing to allocate a substantial part of their income to avoid the complications of hypertension.

THE INFLUENCE OF COPAYMENTS ON THE DEMAND FOR DRUGS WITH THERAPEUTIC COMPETITORS: THE STATINS

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OBJECTIVES: Many prescription drug markets are inhabited by multiple patented drugs that perform similar functions at different effectiveness levels without generic competition. Little is known about the influence of drug benefits on drug choice in these markets. This paper employs a multinomial logit regression to estimate the influence of copayments on demand for statins for patients diagnosed with coronary heart disease (CHD). METHODS: Patients selected for inclusion in the study (N = 36,135) from the MarketScan Commercial Claims and Encounters database were required to have an ICD-9 diagnosis of CHD, use one of five statins (atorvastatin, fluvastatin, lovastatin, pravastatin, or simvastatin), and be continuously enrolled in an identified health plan. To estimate the influence of health plan benefits on usage, the average copayment for each patient’s statin over his relevant therapy period was calculated relative to pravastatin. Other explanatory variables used to control for variation in statin choice included demographic factors, clinical comorbidities, insurance type, and a proxy for primary CHD prevention. RESULTS: Most patients in the sample are treated with atorvastatin (N = 13,162) or simvastatin (N = 12,863). The copayment of the patient’s statin of choice has a highly significant influence on statin choice. An increase in the patient’s copayment relative to the copayment of pravastatin, over the patient’s therapy period, decreases the likelihood of receiving that statin by as much as 84% (lovastatin), and as little as 11% (atorvastatin). CONCLUSION: Findings suggest that insurers can influence a patient’s choice of one drug over another by varying a patient’s copayment level. Moreover, results...