Q3

DOES COST-EFFECTIVENESS ANALYSIS DISCRIMINATE AGAINST PATIENTS WITH SHORTER LIFE EXPECTANCY?

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OBJECTIVES: The UK’s National Institute for Health and Clinical Excellence (NICE) has been accused of discriminating against patients with shorter life expectancy by embracing the use of quality-adjusted life years (QALYs) within cost-effectiveness analyses (CEA). The basis of this claim is that patients with shorter life expectancy have fewer QALYs to gain from treatment and so NICE’s guidance inherently discriminates against such patients. Such criticisms may also be directed at similar decision making agencies. Our objective was to formally identify the circumstances under which CBA-based decision-making discriminates on the basis of life expectancy.

METHODS: We developed a simple model of a CEA-based decision making process in which a technology is considered cost-effective for a particular patient cohort only if the ICER for that cohort lies below a fixed cost-effectiveness threshold. For such decision making to discriminate on the basis of life expectancy, the ICERs for two hypothetical cohorts of patients – identical in all ways except life expectancy – must lie on either side of the threshold.

RESULTS: We find that CEA does not inherently discriminate on the basis of life expectancy but that scope for discrimination arises in the case of specific technologies having identifiable characteristics. Such discrimination may in fact favour those patients with shorter life expectancy. In all cases the use of discounting is shown to reduce the likelihood of discrimination on the basis of life expectancy – this is particularly relevant in light of the recent discussion around NICE’s discounting practices.

CONCLUSIONS: It is recommended that agencies such as NICE consider the possibility of discrimination arising from their use of CEA. Accusations of inherent discrimination, however, appear to be misplaced. It is argued that these claims are founded upon a fundamental misunderstanding of the role of QALYs in CEA, particularly within the decision rules adopted by policy makers.

Q4A

IS THE AIM OF THE HEALTH CARE SYSTEM TO MAXIMISE QALYS? AN INVESTIGATION OF ‘WHAT ELSE MATTERS’ IN THE NHS

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OBJECTIVES: It is often assumed that the objective of health care is solely to maximise health using available resources. This is the principle underpinning NICE’s use of cost-effectiveness analysis based on incremental cost per QALY gained. Yet research by the Office of Health Economics and others shows that cost per QALY is far from the only consideration. Similarly, many national NHS policy initiatives are driven primarily not by QALY gain, but by ‘process-of-care’ and other considerations. The DH is required to undertake and publish impact assessments (IA) identifying the costs and benefits expected from all new policy implementation. We analyse all IAs carried out in 2008-2009 to identify the benefits considered by the DH as relevant to its decision making.

METHODS: The stated benefits of each policy were extracted from the relevant IA. A combination of methods was used to categorise these.

RESULTS: 51 IAs were analysed, 8 of which mentioned QALYs as a benefit. 162 benefits other than QALY gains were identified. Apart from improving health outcomes, common types of benefit included reducing costs, improving quality of care, and enhancing patient experience and empowerment.

CONCLUSIONS: Many of the policies reviewed were implemented on the basis of benefits unrelated to health. ‘Other’ benefits should be used to apply a monetary valuation to QALY gains (in IA cost-benefit calculations) are not consistent across IAs, or with NICE’s stated threshold range. We consider the implications for NHS decision making and NICE guidance, and the meaning of allocative efficiency in the NHS.

POSTER SESSION 1: HEALTH CARE USE & POLICY STUDIES

Health Care Use & Policy Studies – Consumer Role in Health Care

PHP1

USE OF STRUCTURAL EQUATION MODELING TO EXPLAIN CONSUMER BEHAVIOR TOWARDS GENERIC DRUG DISCOUNT PROGRAMS

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OBJECTIVES: The study attempts to assess the robustness of constructs with the Theory of Planned Behavior (TPB) in explaining intention to use generic drug discount programs (GDDPs). METHODS: A self-administered questionnaire was distributed to consumers filling a prescription at pharmacies in Houston (Texas, USA) that offered GDDPs. Constructs of TPB, namely, consumer’s attitude towards GDDPs, perceived behavioral control (PBC), subjective norms (SN), and intention to use were measured using a pre-validated 5 point likert scale. The questionnaire also measured consumer’s demographic characteristics and their perceived value towards GDDPs.

RESULTS: The correlation coefficient value was tested using Pearson’s correlation method. Significant correlation was found between attitude and PBC (r = 0.60, p<0.01). Significant relationship was also found between attitude and intention (r = 0.37, p<0.01). The overall model had a goodness of fit of 0.803 and explained 30% of the variance in the intention to use GDDPs. The SEM showed that the model fit the data well (χ² = 28.3, df = 15, p<0.05).

CONCLUSIONS: The study established that TPB is a useful theoretical framework in the explanation of intention to use GDDPs.