A NEO-RICARDIAN APPROACH TOWARD DISCOUNTING

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BACKGROUND: The major focus of the history of economic thought has been devoted to defining a scientific theory of value. An even harder task entails formulating a theory of intertemporal value. Work on this theory dates back to the birth of modern economic thought. For example, some authors have argued that an intertemporal utility theory of value involves the explanation of a quantity which can be directly observed and measured in terms of a quantity which cannot. Major current economic thought. For example, some authors have argued that an intertemporal theory of value and allows extension of the classical framework of health and wealth with a 3rd dimension of externalities. Furthermore, by redefining the pure growth term in our 2 × 2 matrix with the Ramsey discount rate, our results simplify to current economic theory.

CONCLUSIONS: Although modern economic theory explains value from a utilitarian perspective, it lacks robustness when explaining intertemporal value. Therefore, we suggest that the Neo-Ricardian School of economic thought should also be considered when attempting to formulate a discount rate for health effects, within a concept of sustainable growth.

PMC11
ARE THRESHOLD RANGES FOR COST PER QALY A BARRIER TO RESEARCH FOR LIFE EXTENDING TREATMENTS

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As they are currently used thresholds for cost per QALY may provide a disincentive for companies to invest in research for therapies that prolong life in conditions with an already high treatment cost. Cost per QALY thresholds, not the sole basis for decision making are a major influence on whether a technology is considered cost-effective by NICE. Discussions have centred on the most appropriate threshold level and how its value should be determined. However a consequence of cost per QALY thresholds that is not discussed is the impact they may have on future health care research. The cost per QALY for renal dialysis has been estimated at £30,000, the higher end of what NICE considers acceptable. We have therefore reached the ceiling for the cost of treating renal disease. Assuming that utility is not improved a treatment that extends life will be at additional cost and have a cost per QALY greater than £30,000. Manufacturers of health care technologies may consider that the risk of not getting a product approved on cost-effectiveness grounds is not worth the financial investment in its development. As health care costs continue to grow the management costs of more conditions will exceed £20,000 per year and future research may be stifled as manufacturers seek to develop products that replace rather than add to current treatments. Since the background treatment cost would cancel out in an incremental analysis a treatment could be more cost-effective than the one it replaces, but conversely it can still be more cost-effective, however, if a cost which is lower than the cost per QALY of standard treatment above £20,000 or £30,000. As treatment costs for more conditions increase to threshold values (even if they are raised) manufacturers may be advised to consider realigning their portfolio and investment to other diseases.

PMC12
ASSESSMENT OF THE WORKLOAD REAL TIME DEDICATED TO EACH PATIENT IN INTENSIVE CARE UNITS (ICU); PRELIMINARY RESULTS OF THE CRRÉA STUDY

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OBJECTIVES: The objective of the CRRÉa study is to assess the real daily cost of a patient's stay in ICU in France. We present here preliminary results regarding the average time spent per patient by different health caregivers. METHODS: A prospec- tive multicentric health economic study was performed in 23 ICUs of different French hospitals randomly selected from the PMSI database (French National Hospital database) in a one day study, 5 adults patients were randomly selected among patients with a simplified severity score ≥ 15 in each ICU. Data on all the resources used, treatments administered, biological tests performed, etc. and time spent by different health caregivers to take care of each patient over a 24 hour period (direct and indirect interventions) were collected through data collection forms and elaborated by the professionals themselves. RESULTS: A total of 109 patients (median age = 66 years, 65% males) of 22 intensive care units (15 polyvalent, 3 surgical and 4 medical ICUs) were included. 104 of them were followed over 24 hours (there were 2 deaths and 3 early withdrawals). On the day of the study, 84% of patients were mechanically

demographic size of ACs) were calculated for selected tariffs. RESULTS: We observed lack of consistency in structure and contents of tariff lists and in tariff levels, as exemplified by: different categorization of services; incomplete listing of services; different terminologies; different levels of detail for common services (e.g. MRI: 2–127 options, by body part and/or complexity); wide ranges of tariffs for most procedures. There was a specialist visit: €56–€191, general ward per diem: €82–€4569, simple MRI: €120–€4634. Wide variations were also observed for other diagnostic investigations, (non-)surgical procedures, laboratory tests and DRGs. CONCLUSIONS: Wide ranges in tariffs for health resources commonly used in economic evaluations were identified across ACs with a difference between minimum and maximum values of at least factor 2. There exists no evidence on how tariffs are calculated and if they reflect real cost. Available AC tariffs should be used with caution and a simple or weighted average across AC tariffs combined may be used as a proxy for cost of health care. elaboration of a nation-wide list would avoid possible bias from analysts in the selection of cost values to obtain given results.

PMCE
BURDEN OF DISEASE AND ECONOMIC EVALUATION: ARE WE INVESTIGATING WHAT IT REALLY MATTERS?

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OBJECTIVES: We examined the association between economic evaluation studies performed in Spain in 1983-2008 and the burden of disease in the population.

METHODS: Cross-sectional observational study. Electronic databases (PubMed/ MEDLINE, SCOPUS, BI Web of Knowledge, CRD, IME, IBECS) and reports from public databases were systematically reviewed. Inclusion and exclusion criteria and a set of variables were defined to analyze the characteristics of the papers selected. Using the Global Burden of Disease (GBD) study classification the following measures were calculated: years of life lost (YLLs), years lived with disability (YLDs), disability-adjusted life-years (DALYs), and mortality by cause. Correlation and linear regression models were used.

RESULTS: Cardiovascular diseases (15.7%), infectious and parasitic diseases (15.3%), and malignant neoplasms (13.2%) were the conditions most studied in Spain. The disease sub-categories most prevalent in the studies were lower respiratory infections (5.7%), ischemic heart disease (5.7%), hepatitis B and C (3.3%) and HIV/AIDS (3.1%). For GBD categories the following measures were calculated: years of life lost (YLLs), years lived with disability (YLDs), disability-adjusted life-years (DALYs), and mortality by cause. Correlation and linear regression models were used.

CONCLUSIONS: Significant correlations were found between economic evaluation studies performed in Spain and the burden of disease in the population. Further work is needed to consider realigning their portfolio and investment to other diseases.