

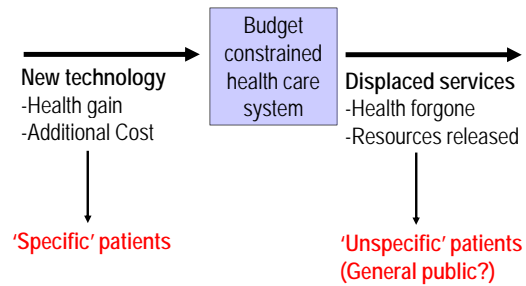
WHAT SHOULD BE THE ROLE OF PATIENT PREFERENCES IN MAKING HEALTHCARE RESOURCE ALLOCATION DECISIONS?

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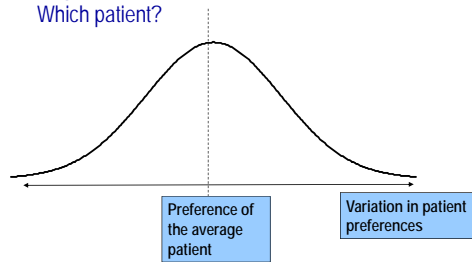
Defining our terms

What type of 'patient' are we talking about?

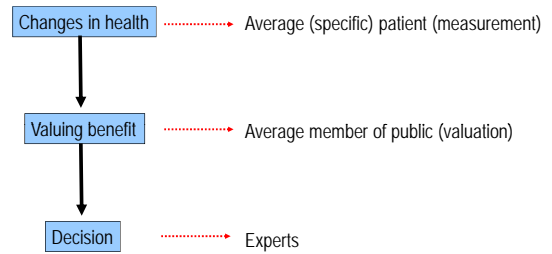


Defining our terms

Which patient?

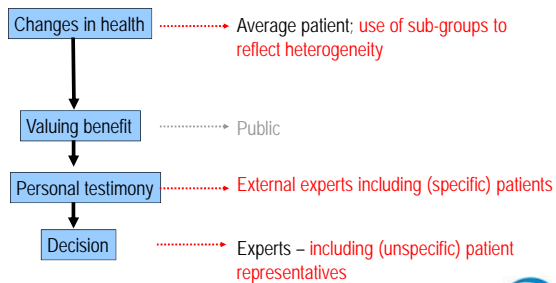


The 'patient-phobic' reimbursement agency



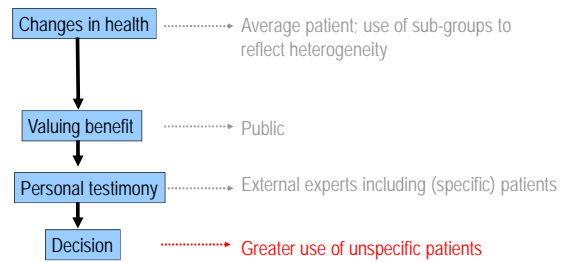
It's rather more nuanced than this

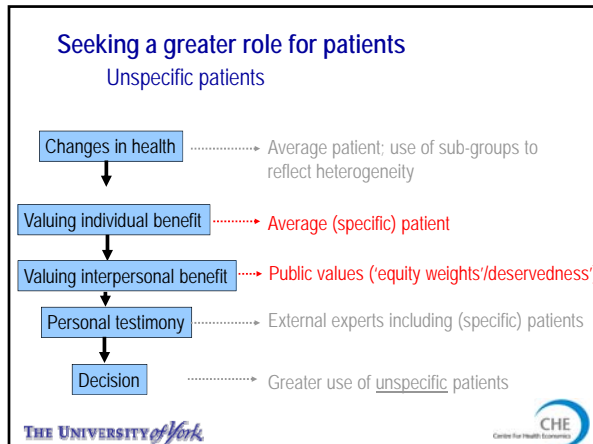
Example of NICE



Seeking a greater role for patients

Unspecific patients





Dealing with heterogeneity in patient preferences

Individualised cost-effectiveness analysis

Individualised CEA:

- Cost per QALY
- Individual patient preferences
- Access to treatment of < threshold
- Co-payment > threshold
- Co-payment only 'above threshold'

- Practicalities
- How is threshold determined?
- Equity implications of copayments

Sculpher. *Health Economics* 1998;7:129-142
Dowie. *Health Economics* 1998;7:93-103

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Dealing with heterogeneity in patient preferences

More pragmatic?

<p>Without copayments</p> <ul style="list-style-type: none"> • CEA used to identify whether new treatments added to available list • Patient preference can be exercised over the available list • No access to treatments not on list • Consistent with policy objectives on equity? 	<p>With copayments</p> <ul style="list-style-type: none"> • CEA used to identify whether new treatments added to available list • If not available, patient can pay for the treatment separately • Include full cost of care? • Implications for health inequalities
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Conclusions

- Specific patients have existing role in many systems (e.g. NICE)
- Strong argument for more role for unspecific patients
- Normative arguments for (specific) patient preferences to be used in valuing individual health
- Surely no role for (specific) patients to define distributional weights
- Challenge remains of dealing with heterogeneity in patient preferences
- Competing policy objective around health inequalities

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