

## Emerging Health Policy Research Conference 2010

### Abstract Submission

#### **Presenter(s) Details**

**Name of Author(s) – asterisk the presenting author(s):**

Hideki HIGASHI\* for the ACE-Prevention Project Team

**Presenter(s) institution/organisation, address, email, and telephone:**

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**Short Biography of presenter (maximum 50 words):**

Higashi has spent most of his career in the field of international health and development in Asia and Africa. Currently he is doing PhD at the School of Population Health, University of Queensland. Areas of research include health economics and policy analysis in Vietnam, Thailand and Australia.

#### **Presentation Details**

**Presentation Title (up to 10 Words):**

Cost-effectiveness of kidney disease screening in Australia: general and Indigenous populations

**Keywords: (up to 5 to assist organisers in streaming papers):**

Economic evaluation, chronic kidney disease, Indigenous health, Australia

#### **Research Details (250 word limit)**

**Background:**

Kidney disease has significant impacts on quality of lives of affected people, mortality, and health resource use. It is estimated that the prevalence of chronic kidney disease (CKD) among Australians is about 14%. However, renal replacement therapy to treat end-stage kidney disease is expensive. Indigenous people are six times as likely as non-Indigenous people to receive renal replacement.

**Research Objectives:**

The study aims to provide evidence on the cost-effectiveness of screening and early treatment of CKD for general and Indigenous populations in Australia.

**Methodology:**

The intervention was a screening program for proteinuria (or albuminuria) among people aged 25-79 when they visit a general practitioner. People with and without diabetes mellitus were separately considered. Those identified with CKD were given subsequent therapy with angiotensin-converting enzyme (ACE) inhibitor to slow progression of CKD. The model employed a multiple cohort, multi-state life table approach. Health outcomes were measured in terms of disability-adjusted life years (DALYs) averted. Bootstrap was performed to account for uncertainties.

**Findings:**

Interventions for people with diabetes mellitus are cost-effective for both general and Indigenous population at all ages (between cost-saving and \$12,000 per DALY averted). Targeting Indigenous people without diabetes mellitus is also cost-effective at all ages. However, screening of general population without diabetes mellitus is less cost-effective, particularly those below the age of 40.

**Policy Implications\*\*\*:**

CKD screening is highly recommended for all Indigenous people and non-Indigenous people with diabetes mellitus. The inclusion of non-Indigenous people without diabetes mellitus may be limited to higher age-groups ( $\geq 50$ ).

**\*\*\*All presenters will be asked to include a final slide in their presentations that summarises the policy recommendations and/or implications that can be drawn from the research presented.**

## Emerging Health Policy Research Conference 2010

### Abstract Submission

#### **Presenter(s) Details**

##### **Name of Author(s) – asterisk the presenting author(s):**

Bonny Parkinson\*  
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##### **Presenter(s) institution/organisation, address, email, and telephone:**

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##### **Short Biography of presenter(s) (maximum 50 words):**

Bonny Parkinson, BEc(ANU) MSc(York University) is a Research Fellow at CHERE and has considerable experience in economic evaluation of healthcare interventions. Previously Bonny worked in the pharmaceutical industry in the UK, in an Australian consultancy, and at the Social Policy Evaluation and Research Centre at the Australian National University.

#### **Presentation Details**

##### **Presentation Title (up to 10 Words):**

Considering Consumer Choice in the Economic Evaluation of Mandatory Health Programmes

##### **Keywords: (up to 5 to assist organisers in streaming papers):**

Mandatory Programs, Economics, Public Opinion, Consumer Choice

#### **Research Details (250 word limit)**

##### **Introduction/Background:**

Governments are increasing their focus on mandatory health programmes (MHPs) following positive economic evaluations of their impact. Regardless of whether the programme enforces or bans consumption of a good, MHPs restrict personal choice and deny consumers the ability to readily substitute particular goods or services.

##### **Research Question:**

Should loss of consumer choice be included in economic evaluations of MHPs?

##### **Methodology:**

A systematic literature review was conducted to identify economic evaluations of MHP, whether they discuss the impact on consumer choice and any methodological limitations. The loss of consumer choice was then estimated for three case studies using discrete choice experiments (DCEs): fortification of bread making flour, mandatory influenza vaccination, and banning trans-fats.

##### **Findings:**

The loss of consumer choice has largely been ignored in economic evaluations, and when included the methodologies utilised were varied and had significant limitations. For example incorrect measurement of the marginal cost of compliance, unavailability of price elasticity estimates, ignoring the impact of income effects, double counting health impacts, biased willingness-to-pay responses, and “protest” responses.

535 participants provided a response to at least one DCE question. In all case studies the compensating variation was positive indicating that some level of compensation would be required for introducing the programme on a mandatory basis.

**Policy Implications\*\*\*:**

If a societal perspective is taken for an economic evaluation, measurement of the loss of consumer choice should be conducted for each MHP being evaluated. Excluding the loss of consumer choice from an economic evaluation may result in a sub-optimal or incorrect decision.

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## Emerging Health Policy Research Conference 2010

### Abstract Submission

#### **Presenter(s) Details**

##### **Name of Author(s) – asterisk the presenting author(s):**

Hideki HIGASHI\* and the Tobacco Cost-effectiveness Component, VINE Project

##### **Presenter(s) institution/organisation, address, email, and telephone:**

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##### **Short Biography of presenter(s) (maximum 50 words):**

Higashi has spent most of his career in the field of international health and development in Asia and Africa. Currently he is doing PhD at the School of Population Health, University of Queensland. Areas of research include health economics and policy analysis in Vietnam, Thailand and Australia.

#### **Presentation Details**

##### **Presentation Title (up to 10 Words):**

Cost-effectiveness of tobacco control policies in Vietnam: population vs. individual approaches

##### **Keywords: (up to 5 to assist organisers in streaming papers):**

Economic evaluation, tobacco control policy, international health, Vietnam

#### **Research Details (250 word limit)**

##### **Background:**

Tobacco smoking constitutes one of the leading public health problems in many countries. Vietnam has one of the highest smoking rates in the world, particularly among males. In the absence of effective interventions to control smoking, it will remain a major risk factor to the population health in Vietnam.

##### **Research Objectives**

The study aims to provide evidence on the cost-effectiveness of tobacco control interventions targeted at population and individual levels in Vietnam.

##### **Methodology:**

Nine tobacco control interventions were evaluated: tax increase; pictorial pack warning; mass media campaign; smoking bans in public and work places; physician advice; and three pharmacological therapies. The model employed a multiple cohort, multi-state life table approach which was constructed such that the interventions affect the smoking behaviours of the age-specific cohorts, and the resulting smoking prevalence defines their health outcomes. Health outcomes were measured in terms of disability-adjusted life years (DALYs) averted. Bootstrap was performed to account for uncertainties.

##### **Findings:**

All interventions targeted at population-level were “very cost-effective” according to the threshold level suggested by WHO (i.e., <GDP per capita). Pictorial pack warning was the most cost-effective option (VND 495 per DALY averted) followed by excise tax increase. Mass media campaigns and smoking bans were more costly. Individual approaches, except for brief advice, were not cost-effective unless pharmaceuticals would be locally produced at substantially lower costs.

##### **Policy Implications\*\*\*:**

Population-based approaches and physician advice should be positioned at high priorities for tobacco control in Vietnam, whilst pharmacological therapies may be considered only in the long-run.

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## Emerging Health Policy Research Conference 2010

### Abstract Submission

#### **Presenter(s) Details**

**Name of Author(s) – asterisk the presenting author(s):**

Jody Church\*, Richard Norman

**Presenter(s) institution/organisation, address, email, and telephone:**

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**Short Biography of presenter(s) (maximum 50 words):**

Jody Church is a research fellow at the Centre for Health Economics Research and Evaluation at the University of Technology Sydney.

#### **Presentation Details**

**Presentation Title (up to 10 Words):**

Modelling the costs and benefits of interventions to prevent and reduce obesity

**Keywords: (up to 5 to assist organisers in streaming papers):**

Obesity, Cost-effectiveness, Health Economics

#### **Research Details (250 word limit)**

**Introduction/Background:**

There is increasing concern, within Australia as in other countries, that the rising incidence of obesity will increase the future prevalence of chronic disease, increase premature mortality, and add to the costs of health service delivery. Governments are being lobbied to undertake population level interventions focused on overweight and obesity.

**Research Question:**

Which interventions aimed to prevent and reduce obesity are the most effective and cost-effective, particularly in terms of lifelong health outcomes?

**Methodology:**

A decision analytic model will be built to capture causality from the intervention to final health outcomes using the best available clinical or epidemiologic evidence. Modelling lifestyle interventions are complex and the model will need to accurately reflect, i) how a change in exercise leads to a change in BMI; ii) which leads to a change in risk factors, such as blood pressure; iii) leading to a change in habits; iv) which lead to changes in risk factor profile; v) which result in lower incidence of symptomatic disease; vi) possibly resulting in less severe disease events; vii) and eventually reducing premature mortality.

**Findings:**

No economic model to date has been published that is flexible enough to capture long-term health benefits in disparate interventions. We will suggest modelling techniques that can resolve these shortcomings.

**Policy Implications\*\*\*:**

Organisations such as NSW Health or Department of Health and Ageing can use the results from the model to select potential cost-effective obesity prevention programs. Secondly, research organisations will be able to identify new, cost-effective areas of obesity research.

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## Emerging Health Policy Research Conference 2010

### Abstract Submission

#### **Presenter(s) Details**

##### **Name of Author(s) – asterisk the presenting author(s):**

Anh Tuan NGUYEN\*, Rosemary KNIGHT, Husna RAZEE, Andrea MANT, Quang Minh CAO

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##### **Short Biography of presenter(s) (maximum 50 words):**

Anh Tuan Nguyen is a lecturer and researcher of Hanoi University of Pharmacy, Vietnam. His background is pharmacy with qualifications of BPharm, MSc in Pharmacy, MSc in Pharmaco-economics and Pharmaceutical Management. Currently, he is doing his PhD in Public Health at the University of New South Wales, Australia.

#### **Presentation Details**

##### **Presentation Title (up to 10 Words):**

Root causes of high medicine prices in Vietnam.

##### **Keywords: (up to 5 to assist organisers in streaming papers):**

Medicine prices, pricing policies, corruption, transparency, qualitative.

#### **Research Details (250 word limit)**

##### **Introduction/Background:**

Medicine prices in Vietnam were unreasonably high. Adjusted for Purchasing Power Parity in 2005, the prices to patients in the public sector were 46.58 and 11.41 times the international reference price for originators and lowest-priced generic equivalents, respectively.

##### **Research Question:**

What are the main reasons for high medicine prices in Vietnam?

##### **Methodology:**

Semi-structured questionnaires were used to conduct 43 interviews with stakeholders including pharmaceutical companies' representatives, Ministry of Health officials, and prescribers in Vietnam from April 2008 to December 2009. The interviews were all recorded, transcribed and coded using NVivo8 software. Ethics approval was obtained from the University of New South Wales.

##### **Findings:**

According to participants' responses, originator medicines in Vietnam were too expensive due to a monopoly. Prices of generic medicines were set at around 80%, sometime even higher than those of corresponding originator medicines due to "informal payment" to authorities, commissions for prescribers, and kickback to hospital pharmaceutical departments. Pressures for survival arising from an imperfectly

competitive pharmaceutical market, among other reasons were believed to force pharmaceutical companies to be inextricably linked to healthcare providers. Salary pressures and the perpetual corruption in the absence of penalties in Vietnam were given as the main motive for healthcare providers to collude with the pharmaceutical industry. The magnitude of reported corruption varied across geographic regions, sectors, and prescriber's specialties.

**Policy Implications\*\*\*:**

Corruption was reported as a main driver for high medicine prices in Vietnam. While individual factors such as professional ethics and personal value influenced physician behaviours and their response to corruption, entrenched or intractable systemic issues including lack of transparency and accountability and poor legislation enforcement emerged as important factors perpetuating corruption. Addressing the widespread issue of corruption, both individual and systemic factors, is necessary in developing sound medicine pricing policies in Vietnam.

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