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The use of absolute shortfall in prioritizing in health care (between drugs)

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Recent years' more effective but also expensive treatment options make prioritizing increasingly challenging. Patients are to a greater extent denied access to treatment options with known good effect, with reference to the fact that the added health benefits do not come at a reasonable cost.

An economically correct allocation of the resources in the health service is not the one that maximizes the population's health, e.g. expressed as the number QALYs. Although the amount of good years of life is obviously a goal in itself, the distribution of these good years of life is also important in order to obtain the highest possible health-related welfare level. This means that all approaches to priorities in the health service involve dilemmas. Everyone can't be as satisfied.

In 2018 absolute shortfall was introduced in Norway as a measure of severity, and is closely related to the concept of alternative costs of introducing new an expensive treatment into a given health care budget.

What are the pitfalls of absolute shortfall and what distributional effects can the application of the concept have? To what extent will proportional shortfall give markedly different effects.

Biography

Eivind Jørgensen holds an M.Phil in economics from University of Oslo. He has been working in the field of health economics and market access since 2000. He is Managing Director of his own consulting company Oecona AS.

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