The International Academy of Health Preference Research is proud to announce

The 2ND Meeting of the International Academy of Health Preference Research

Tuesday, 29 September 2015
8:00 to 17:30

Chaired by Emily Lancsar, PhD, Monash University

Cliftons Brisbane
Level 3, 288 Edward Street
Brisbane QLD 4000
Queensland, Australia

Held at Cliftons Brisbane—situated close to Central Station and the Queen Street Mall—this 1-day meeting will provide a forum to discuss innovative developments in the field of health preference research. Chaired by **Emily Lancsar, PhD,** the meeting will include approximately 13 presentations, coffee, lunch, and a business session. All are welcome to **register at**: www.iahpr.org.

Post-Meeting Dinner – 18:30 to 22:30

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After the meeting, IAHPR will host an offsite dinner for all meeting attendees. The post-meeting dinner is free for meeting attendees and includes a multi-course walking dinner menu and open bar. Tickets are available at the end of the meeting (no guests, please).

For more information, visit www.iahpr.org or email meeting2015@iahpr.org.

PROGRAM

Meeting, Tuesday, 29 September 2015, 8:00 to 17:30

8:00-8:30   **Arrival and Light Breakfast**

8:30-8:45   **Welcome and Acknowledgement of Sponsors**
                   Meeting Chair: Emily Lancsar[α]

8:45-10:15   **Session 1**

Specialist Training as an Incentive to Retain Doctors in Malawi: A Discrete Choice Experiment
Kate Louise Mandeville[β]
Eliciting Job Preferences of Dentists: A Discrete Choice Experiment of Job Choices in Australia
Elisabeth Huynh
Advances in Willingness-to-Pay Estimation Methods for More Informed Decision Making
Joel Hay[α]
How We Ask Matters: The Impact of Framing in Valuing Meta-Health Effects
Richard De Abreu Lourenco[β]

10:15-10:30   **Coffee Break**

10:30-12:00   **Session 2**

Examining the Value of Menopausal Symptom Relief among US Women
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The Valuation of the EQ-5D from the Perspective of US Patients with Cancer
Michelle Owens
A DCE to Value the QLU-C10D: Feasibility and Sensitivity to Presentation Format
Richard Norman
Developing SF-6Dv2 Utility Weights for the UK using a Discrete Choice Experiment with Duration
Brendan Mulhern

12:00-13:00   **Lunch**

13:00-14:30   **Session 3**

Eliciting Distributional Weights for QALYs
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Role of Parental Motivation, Situational Constraints and "Key Influencer" Views in Vaccine Decisions
Kirsten Howard[α]
Public Preferences around Prioritising Patients for Bariatric Surgery
Jennifer A. Whitty[α]
Caregivers' Treatment-Plan Preferences and Duration of ADHD Diagnosis: A Best-Worst Scaling (BWS)
John F. P. Bridges[α]

14:30-14:45   **Coffee Break**

14:45-15:45   **Session 4**

The Preferences of Recipients for Outcomes after Kidney Transplantation: A Best-Worst Scaling Survey
Martin Howell[β]
Open Discussion
Emily Lancsar[α]

16:00-17:30   **Business Meeting (All attendees are welcome)**

17:30-18:30   **Break**

18:30-22:30   **Post-Meeting Dinner – Moda Restaurant (attendees only)**

[α] indicates a member presenter
[β] indicates a student presenter

The 2nd Meeting of the International Academy of Health Preference Research

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Oral Presentations

8:45-10:15   Session 1

Specialist Training as an Incentive to Retain Doctors in Malawi: A Discrete Choice Experiment

Kate Louise Mandeville, BSc, MBBS, MSc, and *Mylene Lagarde, PhD,* London School of Hygiene & Tropical Medicine (LSHTM); *Adamson Sinjani Muula, MBBS, MSc, PhD,* and *Titha Dzowela, MBBS MSc,* University of Malawi; *Godwin Ulaya, MBBS,* Blantyre Malaria Project; *Lyson Gwesele, MBBS,* Queen Elizabeth Central Hospital; *Kara Hanson, PhD,* LSHTM

Context: Malawi is a low-income country with historically high emigration of doctors to high-income countries. To aid retention, a national medical school was established in 1991, followed by specialist training in 2004. Yet junior doctors continue to exit Malawi and the public sector, with four fifths of those abroad in specialty training. The limited specialty training available in Malawi paradoxically suffers from a poor uptake, particularly in a few priority yet unpopular specialties, suggesting that not all training is valued equally.

Purpose: To investigate the use of specialty training as an incentive to retain doctors in the Malawian public sector.

Methods: A discrete choice experiment (DCE) was designed to investigate the value of different types of training, presenting two generic job descriptions and an opt-out option. Attributes included specialty choice, time before training and location of training, as well as salary and location before training (urban/rural). The survey was administered to Malawian junior doctors within five years of qualification who had not yet entered specialist training. For the first time to our knowledge in health workforce DCEs, a latent class model was used to estimate preferences, willingness to pay and a novel "willingness to stay" measure. Simulations were carried out to investigate the effect of varying attribute levels for two policy objectives: (a) maximising public sector service in exchange for guaranteed training in a popular specialty; (b) increasing uptake of training in priority but unpopular specialties.

Results: 140 doctors participated out of 145 eligible, a response rate of 96.6%. Four classes with distinct preferences were identifiable from the latent class model: the rich rejecters (higher current salary, greater use of opt-out option); the money motivated (markedly higher preference for salary); the stubborn specialists (firm specialty preferences with little flexibility); and the poor patriots (lower current salary, no preference for training outside Malawi). Policy simulations showed that, by adapting job packages to these class preferences, service in the public sector can be increased in exchange for training in popular specialties. When training in unpopular but priority specialties is combined with favourable conditions such as shorter time before training, there is marked uptake across all classes except those with fixed specialty preferences.

Conclusions: There is considerable heterogeneity in the preferences of Malawian junior doctors for postgraduate job options. These preferences can be exploited to maximise the rate of return from medical training and support workforce planning.

Eliciting Job Preferences of Dentists: A Discrete Choice Experiment of Job Choices in Australia

Elisabeth Huynh, PhD, University of South Australia; *Emily Lancsar, PhD,* Monash University; *Joffre Swait, PhD,* University of South Australia

Purpose: This research elicits and models preferences of dental students and recent dental graduates for entry level jobs (more generally, work situations) using a DCE, with the objective of determining job characteristics important to young dentists in job screening and selecting. This study forms part of a larger project examining preferences for oral health care in Australia.

Methods: An online survey including a DCE was sent to approximately 1500 graduating or newly graduated dentists (2012 to 2014). The conceptual model of job search underlying the survey encompasses three stages: 1) searching for jobs; 2) screening job postings to decide which to apply for; and 3) responding to

job offers from prospective employers. The first DCE combined the first two stages by mimicking an online job search site. Four jobs were presented at a time to subjects, each job's type drawn by design from up to six job types. Both within and between job type competition was permitted by design. Respondents were asked which job postings they would apply for, a pick-any choice task; subjects could also choose not to apply for any of the job postings. Jobs were described by key attributes including remuneration, location, practice staff size and composition, as well as other characteristics informed by the literature, previous qualitative work and an online pilot of early career dentists. Elicitation of Stage 3 involved a separate task that asked respondents to evaluate four specific job offers. Job offers were shown one at a time to subjects, with an accept/reject response option. Finally, to test for internal validity of the DCE and robustness of findings, participants completed a final choice task: presented with one list of job offers and asked to select the one they would most likely accept.

Results: Data is still being collected, a response rate of 20% is expected. Separate choice models for the two DCE tasks are under development. The first addresses the screening criteria used for job application and reflects the pick-any nature of the data. The second directly models job offer acceptance. Initial analyses reflect our a priori expectations that screening criteria and job offer evaluations are distinct; we also find substantial preference heterogeneity based on having been out of school for even a short while. Practice size, composition and location are found to be primary drivers for job search, with substantial heterogeneity in valence across screening attributes.

Conclusions: This study sets out to develop the core of a demand model for entry-level dentist career options. The elicitation is conceptualized to mimic the process of job search, application and offer evaluation, with the intention towards integrating the demand model within a dentist job market evaluation tool to examine the implications of certain public policy options that can lead to different distributions outcomes for oral health in Australia.

Advances in Willingness-to-Pay Estimation Methods for More Informed Decision Making

Shraddha Chaugule, B.Pharm.Sc, MS, PhD Candidate, and <u>*Joel W. Hay, PhD*</u>*, University of Southern California; Guy Young, MD, Children's Hospital Los Angeles; Oriol Andres, MS, Graduate School of Economics*

Purpose: Through this discrete choice experiment, first, we address several methodological gaps associated with the conventional approach of WTP estimation using random utility maximization (RUM) behavioral processes. Second, we empirically test whether and how the WTP estimate obtained for an alternative's attribute is affected by the relative importance of competing non-chosen alternatives in the choice set using alternative behavioral processes for estimation. Third, we conduct an experiment within our study to validate our results. Finally, we demonstrate how these empirically validated newer insights will help policy makers to make more accurate and informed decisions on subject preferences.

Methods: We conducted an experiment in a general US representative sample population in two phases. In phase one, 227 respondents completed an online discrete choice survey for hemophilia therapy preferences and in phase two, 344 respondents completed the same survey. An orthogonal main-effects design was used to generate 25 treatment profiles based on four treatment attributes and a cost attribute. We used RUM multinomial logit models (MNL) to estimate preferences using data from survey phase one. We then generated the WTP for treatment attributes using the conventional approach (i.e. the ratio of $\hat{\beta}$ estimate of an attribute to the negative of $\hat{\beta}$ estimate of cost). In addition, we used random regret minimization model (RRM) based MNL models to estimate preferences using R software. The RRM-based WTP measures showed that indifference across attributes becomes choice set-specific. We generated RRM MNL model-based WTP estimates for each of the choice scenarios in the survey. We used bootstrapped confidence intervals and parameter estimates and tested if choice set specificity gave statistically significantly different WTP estimates.

Results: The marginal WTP for the "no treatment related complications" attribute derived from the RUM-MNL model was $106 irrespective of the presence or the absence of treatment related complications for the chosen alternative. In the RRM-MNL model, the marginal WTP estimate became choice set-specific depending on the presence or absence of treatment related complications for the chosen alternative relative to competing alternatives in the choice scenario. There was heterogeneity across the choice scenarios in terms of RRM-MNL WTP estimates with a minimum WTP of $53 and maximum WTP of $344

across the survey. Bootstrapping each of the choice-set specific WTP estimates and averaging over all choice scenarios gave the mean WTP for RRM MNL model of $132 (95% CI: $91-$167). Non-parametric Wilcoxon-Mann-Whitney test and two sample Kolmogorov: Smirnov (K-S) test revealed that WTP estimates from the RUM and RRM models were statistically significantly different (p<0.001) and belonged to different distributions.

Conclusions: The study results demonstrate how choice-set specific willingness-to-pay measures allow for a richer interpretation of the trade-offs people make as a function of the composition of the choice set they face. This will allow policy makers to distinguish not only between segments of decision makers based on their socio-demographics or preferences for different attributes, but also on the choice sets different segments face.

How We Ask Matters: The Impact of Framing in Valuing Meta-health Effects

Richard De Abreu Lourenco, MEc (Hons), BEc (Hons); Marion Haas, PhD; Jane Hall, PhD; and Rosalie Viney, PhD, Centre for Health Economics Research & Evaluation, University of Technology, Sydney

Purpose: Convenience is the meta-health effect most often investigated in preference valuation studies. However, the values produced for convenience might be influenced by how information about convenience, or on other potential sources of value such as treatment efficacy or safety, is presented. The potential influence of these framing effects on the values derived for convenience is investigated in the context of chronic therapy for rheumatoid arthritis. This includes investigating whether preferences for convenience vary with different descriptions of who bears the cost of treatment.

Methods: A two stage community based DCE was used. Attributes and levels were developed based on a review of the literature and comprised: mode of delivery; frequency of delivery; efficacy; treatment discontinuation; and cost. The effects of framing were tested by comparing coefficient estimates and WTP values across three versions of the four blocks; a base version, a version in which efficacy effects were the same in the options presented, and a version in which more detail was provided on the mode of administration. A WTP efficient design was generated using Ngene, using 48 rows over four blocks and priors from the literature. Choice sets were unlabelled, forced choice and contained two options only. Stage one comprised an initial pilot phase using a purposive sample. Results were subsequently analysed using conditional logit. Following feedback, the cost attribute was redesigned and split into two: cost to the individual; cost to government. The sample design was re-estimated in Ngene using the priors from the pilot. The survey was implemented in a community sample of 450 individuals, who completed 12 choice sets. Results were analysed using mixed logit and GMNL. Estimates of WTP using individual and government cost attributes were compared to assess whether valuations for convenience and health effects differed depending on who paid.

Results: Preliminary analysis from the pilot phase indicates that exclusion of efficacy effects increases the relative value placed on convenience expressed as mode, not frequency (results from the full community survey are currently being collated and will be available for presentation at the conference). Providing respondents with more information reduces the importance of convenience gains in choices. Overall, while treatment mode (convenience) was important, respondents placed more emphasis on the role of efficacy and safety in making their choices. Convenience effects were more highly valued by those who did not report a history of chronic therapy use. Relative WTP for convenience relative to health effects was influenced by whether the data were analysed as continuous or categorical variables; the latter reducing the ranking of meta-health effects in value determination.

Conclusions: Values elicited for meta-health effects in DCEs are subject to framing effects in the presentation of the attributes. This relates to the amount of information presented on attributes describing those effects and possible sources of difference between choice options. Analytically, rankings of value expressed as WTP for meta-health effects are influenced by the method of assessment.

Examining the Value of Menopausal Symptom Relief among US Women

**Benjamin M. Craig, PhD,** _Moffitt Cancer Center;_ **_Sandra A. Mitchell, PhD, CRNP,_** _National Cancer Institute_

Purpose: Menopausal symptoms can cause significant distress to women, yet little is known about the value women place on these symptoms.

Methods: In April 2013, 3397 US women, ages 40 to 69, completed an online survey that included 30 paired comparisons. Specifically, respondents were shown two menopausal symptoms described using the Patient-Reported Outcomes Version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE) and asked, "Which do you prefer?" From their choices, we estimated a generalized linear model to assess values women place on symptom relief in terms of quality-adjusted life years (QALYs).

Results: Approximately half of the respondents (1753 of 3397; 52%) always preferred reduced lifespan (up to 90 days) instead of experiencing menopausal symptoms at their worst for 30 days. For a majority of the symptoms (248/263; 94%), including low-grade events, QALYs were significantly reduced (p-value<0.05). The value women placed on relief ranged widely by symptom domain: the relief of depression, problems with memory, headache, pain in abdomen, problems with anger, and vomiting were the most valuable.

Conclusions: Overall, the value women place on menopausal symptom relief is surprisingly high. As the first national study to directly ask women about their preferences and to estimate the value of menopausal symptom relief on a QALY scale, this work provides critical evidence for health outcomes research in mid-life women and can be applied in the evaluation of treatments that reduce or eliminate menopausal symptoms. This work also provides proof-of-concept for an approach to value PRO-CTCAE responses on a QALY scale.

The Valuation of the EQ-5D from the Perspective of US Patients with Cancer

Benjamin M. Craig, PhD, _Moffitt Cancer Center and University of South Florida;_ **_Michelle Owens, MA,_** _Moffitt Cancer Center_

Purpose: To value the EQ-5D-3L and EQ-5D-5L from two perspectives: (1) patients with cancer receiving chemotherapy and (2) men with metastatic prostate cancer prior to a physician appointment.

Methods: Based on the 2013 Measurement and Valuation of Health (2013 US MVH) study, a health preference study was designed to survey patients at Moffitt Cancer Center, which included the 3-level and 5-level versions of the EQ-5D instrument and a series of paired comparisons describing alternative losses in health-related quality of life (HRQoL) for 30 days. For this study, patients, ages 18 or older, were recruited from an infusion clinic (N=653) and men with metastatic prostate cancer (N=172) were recruited from a genitourinary cancer clinic waiting room. The two surveys were identical, except the men with metastatic cancer were not asked to trade off quality and quantity of life. Econometric analyses were performed for both samples to estimate the value of health described by each version (EQ-5D-3L, EQ-5D-5L) in terms of their equivalence in quality-adjusted life years (QALYs) and as compared to the 2013 US MVH, which included the same paired comparisons.

Results: Aside from producing preference-based weights from the EQ-5D-3L and EQ-5D-5L, three patterns in the paired comparison responses emerged that merit further discussion. First, men with metastatic prostate cancer placed a much greater value on avoiding "confined to bed" than the chemotherapy patients and the general population. A similar difference was not found for the EQ-5D-5L. Second, the patients receiving chemotherapy infusions placed a greater value on survival than on quality of life compared to the general population; however, men with metastatic prostate cancer were not asked these questions. Third, all 10 EQ-5D-3L and 20 EQ-5D-5L preference weights were nearly identical between the chemotherapy patients and the general population after adjusting for differences in survival preferences (mean absolute difference of 0.013 QALY on pits scale; Lin's concordance 0.976).

Conclusions: For decision scientists interested in decision aids or improving clinical care, this is the first EQ-5D valuation from the perspective of patients: the primary stakeholder for health technology assessments. For the field of health preference research, this is one of the first studies to use tablets to assess patient preferences on health outcomes in a clinical setting. In some sense, it is a negative study, because it did not

find many significant differences in health preferences between the two populations; nevertheless, further investigation is warranted.

A DCE to Value the QLU-C10D: Feasibility and Sensitivity to Presentation Format

Richard Norman, PhD, Curtin University; **Madeleine King, PhD,** and **Daniel Costa, PhD,** *University of Sydney;* **Rosalie Viney, PhD,** *University of Technology, Sydney*

Purpose: To explore the feasibility of using a discrete choice experiment to value health states within a new multi-attribute utility instrument for cancer based on the EORTC QLQ-C30.

Methods: The DCE was run in an Australian online panel. Respondents answered 16 choice pairs. Two presentation formats were tested, each in half of the choice pairs, with order of format randomised. In the "highlight" format, all domains were presented, and domains which differed in level between a pair of choice options were highlighted in yellow. In the "text and table" format, domains with the same levels in the two choice options were described in text, and only domains that differed were presented. Difficulty and clarity of the choice task was explored for each format using Likert scales, and a direct preference question was asked ("which format did you prefer?"). Conditional logit analysis was performed on responses for the pooled dataset as well as stratified by format. Semi-structured telephone interviews explored respondents' approaches to the choice task and their reasons for format preference.

Results: 449 individuals were recruited to the online DCE valuation task. 430 completed at least one choice set and 422/449 (94%) completed all 16 choice sets. Interviews conducted with 8 respondents revealed that they found 10 domains difficult, and most adopted simplifying heuristics to make the task easier. Most stated that the 10 domains adequately described health, but three suggested greater emphasis on mental health. Results for the clarity and difficulty questions were identical between presentation formats, but the "highlight" format was preferred by 68% of respondents. Conditional logit parameter estimates were monotonic within domains, supporting the structure of the health classifier and providing indirect evidence of the validity of a DCE approach.

Conclusions: A DCE can be used to value health states for a utility instrument with 10 domains. The "highlighted" presentation format is recommended for definitive valuations of the EORTC QLU-C10D which are planned throughout the world.

Developing SF-6Dv2 Utility Weights for the UK Using a Discrete Choice Experiment with Duration

Brendan Mulhern, BSc, MRes, University of Technology, Sydney; **Nick Bansback, PhD,** *University of British Columbia;* **Richard Norman, PhD,** *Curtin University Perth;* **John Brazier, PhD,** *University of Sheffield*

Background: Recently, a new version of the SF-6D (SF-6Dv2) has been developed, which has the same dimension structure as the first version (physical functioning, role limitations, social functioning, pain, mental health and vitality), but includes changes for a number of the dimension descriptions. Utility value sets are required so that the SF-6Dv2 can be used in the economic evaluation of new health technologies, and a valuation protocol using a discrete choice experiment incorporating duration has been developed.

Purpose: The aim of this study is to test the methodological choices made in the development of the valuation protocol, and derive a value sets for the SF-6Dv2 based on the preferences of the UK general population

Methods: The d-efficient study design included 300 pairs of SD-6Dv2 health descriptions and an associated duration level (1y, 4y., 7y, or 10y), and 60 pairs including two health states with duration and a third "immediate death" option were. These were administered online to respondents recruited from a general population panel who completed 12 each. The order of the dimensions within each pair was randomised between respondents, who also completed a range of background and self-reported health questions including the EQ-5D-5L and SF-6Dv2. A minimum completion time of two minutes was imposed. Results were modelled using conditional logit regression, with the health dimension coefficients interacted with duration. This model was then used to estimate a preference index such that full health and death were valued at 1 and 0, respectively.

Results: In total, 3,060 respondents who were generally representative of the UK population in terms of age, gender and region fully completed the survey. The model including the 300 pairs without the immediate death option suggests that the dimension levels are ordered (so an increase in severity leads to a decrease in utility) apart from between vitality levels 2 and 3. The dimension with the largest decrement is pain, followed by mental health and physical functioning, and this is not confounded by the dimension order. The model characteristics do not change when including the pairs with the death option, but the range of the utility scale decreases.

Conclusions: The SF-6Dv2 valuation protocol produces valid utility values that can be used in the economic evaluation of health technologies, and the protocol is been used internationally to develop country specific values.

13:00-14:30   Session 3

Eliciting Distributional Weights for QALYs

Emily Lancsar, PhD, MEc, BEc, BA, and *Yuanyuan Gu, PhD, Monash University; **Cam Donaldson, PhD,** Glasgow Caledonian University; **Dorte Gryd-Hansen, PhD,** University of Southern Denmark; **Jim Butler, PhD,** Australian National University; **Julie Ratcliffe, PhD,** Flinders University; **Liliana Bulfone, MBA,** Deakin University*

Purpose: Countries around the world face the question of how best to set priorities in the allocation of scarce public resources. Within the health sector, the Quality Adjusted Life Year (QALY) has become the dominant measure of health gain for use in economic evaluation, particularly in health technology assessment. In such evaluations all QALYs are generally treated equally, regardless of how they are generated (e.g. by extension of survival, increase in quality of survival, or both) or to whom they are allocated (e.g. the young, elderly etc.). The investigation of comparative cost per QALY in such evaluations focuses on maximising health gain, or efficiency. However, in making resource allocation decisions, funders, tasked with managing scarce health care resources, are often faced with distributional or equity considerations that to date have been less readily quantifiable. This paper reports on the first of a series of DCEs undertaken as part of the "Values in Priority Setting (VIP)" study which harnesses a novel discrete choice experiment (DCE) framework to explore how members of the general public and "decision makers" (drawn from the population of current and past health technology assessment committee members) prioritise and trade off different types of health gain and their preferences around which factors should receive additional weight in priority setting and what weight they should receive. This paper focuses on results from the general public sample.

Methods: Focus groups with members of the general public were undertaken to generate attributes and inform the design of the DCE (n=42). A mixed methods approach including qualitative content analysis of open ended discussion combined with quantitative analysis of data generated from ranking and voting tasks generated two types of attributes for use in the DCE: those related to the characteristics of the beneficiary of the QALY gain (age, quality of life without treatment and life expectancy without treatment), and the QALY gain itself (size and type of QALY gains). DCE data collected via an online panel representative of the Australian population in age and gender and harnessed a split sample approach (n=1000 per arm) to test different decision-making framing in the DCE.

Results: Results from estimated choice models accounting for both observed and unobserved heterogeneity (conditional, mixed and generalized multinomial logit) were used to calculate distributional weights for QALYs via the Hicksian compensating variation.

Conclusions: This study empirically characterized the tradeoffs made by members of the general public between efficiency and equity criteria used in health care resource allocation and demonstrates the potentially important role for DCEs in eliciting preferences and associated distributional weights over such priority setting criteria.

Role of Parental Motivation, Situational Constraints and "Key Influencer" Views in Vaccine Decisions

Kirsten Howard, PhD, and ***Joffre Swait, PhD,*** *Institute for Choice, University of South Australia;* ***Andre Bonfrer, PhD,*** *Research School of Management, Australian National University*

Childhood vaccination decisions can be conceptualised as occurring along a continuum, with full adherence to officially recommended vaccination schedules at one end and no vaccination at the other. Between these poles, some parents may choose to delay scheduled vaccinations, to split combined vaccines, or to partly vaccinate, which has significant effects on population disease risk. Recent literature terms this continuum "vaccine hesitancy" (VH) (Larson et al. 2014). The Strategic Advisory Group of Experts on Immunisation Working Group dealing with vaccine hesitancy (SAGE) proposes a model of determinants of VH within three categories: vaccine/vaccination issues, individual/social group influences and context issues. Drawing on other literatures, specifically choice modelling literature, we expand this model to consider other factors, and estimate their relative influence on parental choice in a discrete choice experiment (DCE). We consider the impact of motivations or goals on choices, as well as situational constraints; and take a broader perspective of "social group influences" to consider the influence that comes from those beyond the immediate social network ("key influencers"). Existing DCEs of vaccine decisions do not account for these influences. Recent work in other choice contexts indicates the importance of considering motivations/goals and constraints as important influences on decision behaviour. Motivations establish antecedent volitions that determine the strategy of decision making in a given context. They encompass actions that help decision makers determine the relevant parameters of the decision process (Swait 2013), e.g. what alternatives are relevant (choice set formation); what information is relevant to the choice (attribute attendance (Hensher and Rose 2009)), or what decision rule to employ (utility maximisation, regret minimisation, habit (Adamowicz and Swait 2012)). We use a DCE to apply these methods to parental decision making concerning childhood vaccination to understand their influence on decision making. By presenting parents with choice sets containing three alternatives, 1) the official recommended vaccination schedule, 2) a deviation from that schedule involving delay of one or more components and 3) a no vaccination alternative, we can assess the influence of these factors on VH and on the impact of specific attributes. Attributes include individual consequences of the vaccine schedule (individual benefits/ possible harms for the child), societal consequences (herd immunity, risk of contracting disease) and consequences to the parent of, e.g. delaying vaccinations. Based on Swait and Marley (2013), we formulate and test an econometric choice model that explicitly 1) incorporates vaccine schedule characteristics, benefits and costs; 2) represents different identifiable reference influencers, allowing for the attribution of importance (and direction) of each influencer on the parent's decision to adhere to or reject vaccination; and finally, 3) allows for heterogeneous motivations (goals) and constraints across respondents. The model will be estimated based on a DCE embedded in a survey administered to an online panel. Respondents will be parents of one or more children (n=600) and stratified by state of residence. The survey will also include attitudinal scales, respondents' assessments of different key influencers (e.g., parents, teachers, child carers, physicians, government agencies etc.), as well as an elicitation of parental motivations and constraints with respect to vaccination.

Public Preferences Around Prioritising Patients for Bariatric Surgery

Jennifer A. Whitty, PhD, *University of Queensland;* ***Julie Ratcliffe, PhD,*** *Flinders University;* ***Elizabeth Kendall, PhD,*** *Menzies Health Institute Queensland;* ***Paul Burton, PhD,*** *Griffith University;* ***Andrew Wilson, PhD,*** *Menzies Centre for Health Policy;* ***Pete Littlejohns, PhD,*** *King's College London;* ***Paul Harris, Rachael Krinks,*** *and* ***Paul A. Scuffham,*** *Menzies Health Institute Queensland*

Purpose: Bariatric surgery is effective for the management of obesity. With the increasing prevalence of obesity, demand for surgery is growing. This leads to a need to develop criteria for prioritising access to bariatric surgery. This study aimed to (i) assess the relative importance of potential criteria and trade-offs the public would make when prioritising access to bariatric surgery for obese adults in Australia, and (ii) derive priority weights for access to bariatric surgery for obese adults, from the perspective of the public.
Methods: A Discrete Choice Experiment was administered to 1,994 adults in Queensland and South Australia. Respondents indicated which of two individuals with different characteristics should be

prioritised for surgery in each of 18 (from a total of 180) different hypothetical choices. Potential surgery recipients were described by seven attributes: BMI, presence of co-morbid conditions, age, family history, commitment to lifestyle change, time on the surgical wait list, and chance of maintaining weight loss following surgery. A multinomial logit model was used to evaluate preferences and derive priority weights, with a latent class model used to explore preference heterogeneity.

Results: A preference was observed to prioritise individuals who demonstrated a strong commitment to maintaining a healthy lifestyle as well as individuals categorised with very severe (BMI=50kg/m2) or (to a lesser extent) severe (BMI=40kg/m2) obesity, those who already have obesity-related co-morbidity, with a family history of obesity, with a greater chance of maintaining weight loss, or who had spent a longer time on the wait list. Lifestyle commitment was considered to be more than twice as important as any other criterion. There was little tendency to prioritise according to the age of the recipient across the sample as a whole. However, age was an important prioritisation criterion for some subgroups in the latent class model. Respondent preferences were dependent on their BMI, previous experience with weight management surgery, current health state, and education level.

Conclusions: This study extends our understanding of the publics' preferences for priority setting to the context of bariatric surgery. The priority weights that are derived could be used to assist healthcare services responsible for providing bariatric services.

Caregivers' Treatment-plan Preferences and Duration of ADHD Diagnosis: A Best-worst Scaling (BWS)

Susan dosReis, PhD, Alex Park, PharmD, and Xinyi Ng, BSPharm, University of Maryland; Emily Frosch, MD, Johns Hopkins University; Gloria Reeves, MD, University of Maryland; Charles Cunningham, PhD, McMaster University; John F. P. Bridges, PhD, Johns Hopkins University

Purpose: The evidence-base for pediatric attention-deficit/hyperactivity disorder (ADHD) supports pharmacologic management but many caregivers prefer not to use medication. To promote family-centered treatment planning, we sought to identify the ADHD treatment plans that caregivers most prefer and to determine if preferences differ by duration of child's ADHD.

Methods: Primary caregivers of a child diagnosed with ADHD were prospectively recruited through community clinics and family support organizations across the state of Maryland. Participants completed a computer-based survey that comprised child and family demographics, child clinical and treatment characteristics, and a best-worst scaling (BWS) (Case 2) instrument to assess ADHD care management preferences. Using a main-effects orthogonal array, 18 treatment profiles were developed with seven attributes (each attribute varying across three levels). In each profile, participants selected one "best" and one "worst" attribute among the seven attributes shown. Preferences were estimated as the mean of best-minus-worst scores and conditional attribute importance was calculated for the aggregate sample and stratified by the duration of child's ADHD.

Results: A total of 184 primary caregivers of children aged 4-14 years were recruited prospectively between January 2013 and March 2015. Participants were primarily the mother (84%) and college-educated (43%) with children with ADHD averaging 9.7 years old, 75% of whom were taking stimulants. Regardless of the duration of the child's ADHD diagnosis, evidence-based ADHD care management involving medication use seven days a week, therapy in a clinic setting, and an individualized education program (IEP) at school were most preferred (p<0.0001). Medication had a higher conditional attribute importance for participants of children diagnosed with ADHD for four or more years than it was by participants of children diagnosed with ADHD for less than four years.

Conclusions: Observed differences in stated preferences for an ADHD care management profile demonstrates that attributes are not valued equally and that the manner in which care is delivered is important. Future research will use latent class analysis to explore preference heterogeneity and will assess the relationship between stated preferences of actual treatment decision prospectively through follow-up surveys.

The Preferences of Recipients for Outcomes after Kidney Transplantation: A Best-Worst Scaling Survey

Martin Howell, PhD, and *Germaine Wong, PhD,* University of Sydney; *John Rose, PhD,* University of South Australia; *Allison Tong, PhD,* and *Jonathan C. Craig, PhD,* University of Sydney; *Kirsten Howard, PhD,* University of South Australia

Purpose: Patient preferences and values should underpin treatment decisions following kidney transplantation, however this is not reflected in current practice. Qualitative studies suggest that kidney transplant recipients have a strong focus on graft survival, an aversion to returning to dialysis, and a willingness to accept adverse outcomes associated with treatment after transplantation. However, transplant recipients' preferences and trade-offs elicited through structured, quantified methods are unknown. The aim of this study was to evaluate the preferences and trade-offs transplant recipients may be willing to make in order to minimise adverse outcomes of long-term immunosuppression.

Methods: A Case 2 best-worst scaling survey (BWS) was used to assess preferences and trade-offs between graft duration and the risk of dying, cancer, cardiovascular disease (CVD), diabetes mellitus, serious infection, anxiety/depression, diarrhoea/nausea, and excessive weight gain. The survey used a d-efficient design, informed by a qualitative study and pilot BWS, with 4 blocks of 10 multi-attribute profiles. In order to limit survey fatigue respondents were asked to make four choices for each of 10 profiles, namely the "best", "worst", "next-best" and "next-worst" attributes. Attribute level coefficients were estimated using an MNL model assuming, sequential selection of choices, and symmetry of "best" and "worst" choices. Benefit/harm trade-offs for graft survival and the risk of adverse outcomes were estimated following the approach described by de Bekker-Grob, Rose and Bliemer (2013) for the estimation of marginal rates of substitution with confidence limits estimated using the Krinsky-Robb procedure.

Results: Ninety-three patients from two transplant centres and a community panel (18-69 years, transplant duration 0.9-31 years) completed the BWS. Using a normalised scale for attribute level coefficients of 1 (best) to 0 (worst) graft loss after 1 year was the least preferred outcome (0.0, 95%CI: -0.05,0.05) followed by a 100% risk of dying with a functioning graft (0.19, 95%CI: 0.13,0.24). Preferences varied with gender, age, comorbidities, dialysis and transplant duration, and number of transplants. To achieve a 0% risk of cancer, dying, CVD and anxiety/depression before graft failure participants were willing to trade 3.1 (95%CI: 2.10,4.69), 1.66 (95%CI: 1.12,2.51), 1.21 (95%CI: 0.82,1.83), 0.87 (95%CI: 0.59,1.32) and 0.81 (95%CI: 0.55,1.22) years graft survival respectively. The marginal rates of substitution declined exponentially as risk of adverse effects increased and with a willingness to trade less than 1 year graft survival to achieve a 10% risk for all outcomes.

Conclusions: Elicitation of preferences and trade-offs for outcomes after transplantation has demonstrated an almost singular focus on graft survival, so that the willingness to trade duration of graft survival to avoid serious adverse outcomes is contingent on achieving an unfeasible (zero) risk of these outcomes. The study has demonstrated the feasibility of using a BWS to elicit patient preferences for multiple serious adverse outcomes and side effects associated with a complex intervention where there is no clear choice between different treatment regimens, rather a process of adjustments, including withdrawal of treatment, to change the balance between benefits and harms.

Open Discussion
Emily Lancsar, PhD, MEc, BEc, BA, Monash University

Business Agenda

1. Opening and agenda: Emily Lancsar, Meeting Chair

2. Financial report

3. Membership report

4. Announcements of future meetings

5. Discussion on IAHPR logo

6. Discussion on book and manuscript opportunities

7. Collaborations with software vendors

8. Discussion on sustainability

9. Closing

Current IAHPR Members

Esther de Bekker-Grob

Kathleen Beusterien

Meenakshi Bewtra

Abhijeet Bhanegaonkar

John Bridges*

Derek Brown

Margaret Byrne

Benjamin M. Craig*

Terry Flynn

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Juan Marcos González

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Christine Kistler

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Ateesha Mohamed

Axel Mühlbacher

Mark Oppe

Jan Ostermann

Christine Poulos

Lisa Prosser

Shelby Reed

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Christopher Saigal

Elly Stolk

Jamie Studts

Jennifer Whitty*

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International Academy of Health Preference Research

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Biosketch

John is an associate professor in the Departments of Health Policy and Management and International Health at the Johns Hopkins Bloomberg School of Public Health, a Faculty Research Fellow at the National Bureau of Economic Research (NBER), New York, and a Senior Fellow at the Center for Medicine in the Public Interest. John's research is focused on the application of both qualitative and quantitative stated-preference methods to document the priorities and preferences of patients and other stakeholders in medicine. In addition to publishing over 80 peer-reviewed publications, he has made several important contributions to preference measurement in medicine. In 2008 he founded The Patient – Patient Centered Outcomes Research as the first journal in medicine to focus exclusively on the patients' perspective. John was also on the organizing committee for the first Conjoint Analysis and Health Conference (CHAC) in 2007, and went on to chair subsequent CHAC meeting in 2009, 2010, and 2012. At the International Society of Pharmacoeconomics and Outcomes Research (ISPOR) he founded the Patient Preference Methods/Conjoint Analysis working group (2006-2011), which led to the establishment of a series of methodological task-forces, including the "Good Research Practices for Conjoint Analysis Task Force" (2008-2010), which John chaired and which lead to the "ISPOR checklist for the application of conjoint analysis methods"; the "Conjoint Analysis Experimental Design Task Force" (2010-2012), and the "Conjoint Analysis Statistical Methods Task Force" (2013-). In 2006 he received ISPOR's Bernie O'Brien New Investigator Award and in 2011 received an ISPOR Distinguished Service Award for his leadership of conjoint analysis methods.

Areas of Interest:

☑ Preferences Between Health-Related Goods and Services

☑ Preference Methods (Elicitation Tasks and Econometrics)

☑ Preferences Between Health Outcomes

☑ Preference Tools and Technologies (Calculators, Decision Aids, and Tariffs)

International Academy of Health Preference Research

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Biosketch

Benjamin M. Craig, Ph.D., is an Associate Member in Health Outcomes and Behavior at Moffitt Cancer Center and Associate Professor of Economics at the University of South Florida. He received his M.S. in Economics at the University of Texas at Austin in 1999 and his Ph.D. in Population Health from the University of Wisconsin in 2003. His research focuses on health valuation and the economics of cancer prevention, detection, and control. Dr. Craig is currently the Principal Investigator for the PROMIS valuation project that will value PROMIS-29 v1.0 outcomes from both a societal perspective and a cancer survivor perspective. He is a member of the American Society of Clinical Oncology (ASCO), the International Health Economics Association (iHEA), the American Society of Health Economist (ASHE), the International Society for Pharmacoeconomics & Outcomes Research (ISPOR) and EuroQol Group.

Areas of Interest:

☐ Preferences Between Health-Related Goods and Services

☑ Preference Methods (Elicitation Tasks and Econometrics)

☑ Preferences Between Health Outcomes

☑ Preference Tools and Technologies (Calculators, Decision Aids, and Tariffs)

International Academy of Health Preference Research

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Biosketch

Joel W. Hay is Professor and Founding Chair in the Department of Pharmaceutical Economics and Policy in the School of Pharmacy and a Professor of Health Policy and Economics in the Leonard Schaeffer Center for Health Policy and Economics, with a joint appointment in the Department of Economics at the University of Southern California. He also serves as the USC Project Coordinator for the Rand Evidence-Based Medicine Practice Centers of Southern California funded by the US Agency for Health Research and Quality (AHRQ). He is a Health Economics Research Scholar at the UCLA Center for Vaccine Research. He is a founding member and founding Executive Board member of the American Society for Health Economics (ASHEcon) and of the International Society for Pharmaceutical Economics and Outcomes Research (ISPOR).

 His previous positions include: Senior Research Fellow, the Hoover Institution, Stanford University (1985-1992); Senior Policy Analyst, Project HOPE (1983-1985); Asst. Professor, Dept. of Behavioral Sciences and Community Health, and Dept. of Economics, University of Connecticut (1980-1984); and Asst. Research Professor, University of Southern California (1978-1980). . He received his B.A. summa cum laude from Amherst College in 1974 and his M.A. (1975), M. Ph. (1976) and Ph.D. in economics (1980) from Yale University.

 Dr. Hay has authored or coauthored over 400 peer-reviewed scientific articles, abstracts, editorials and reports in the fields of pharmaceutical economics, health economics, outcomes research, disease management, statistics, econometrics, epidemiology and health care in journals including more than 170 peer-reviewed scientific articles in journals such as: American Journal of Cardiology, American Journal of Health-Systems Pharmacy, American Journal of Managed Care, American Journal of Public Heath, Archives of Neurology, Cancer, Community Dentistry and Oral Epidemiology, General Dentistry, Haemophilia, Health Care Financing Review, Health Economics, Health Policy, JAMA, Journal of AIDS, Journal of the American Geriatrics Society, Journal of Business & Economic Statistics, Journal of Clinical Gastroenterology, Journal of Health Economics, Journal of Health Politics, Policy and Law, Journal of Human Resources, and more.

Areas of Interest:

☑ Preferences Between Health-Related Goods and Services

☑ Preference Methods (Elicitation Tasks and Econometrics)

☑ Preferences Between Health Outcomes

☑ Preference Tools and Technologies (Calculators, Decision Aids, and Tariffs)

International Academy of Health Preference Research

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Biosketch

Kirsten Howard joined the Institute for Choice in January 2015 as a Research Professor in Health Economics. Kirsten's research focuses on methodological and applied health economics research predominantly in the areas of patient and consumer preference assessment using discrete choice (DCE) methods as well as in economic evaluation, and decision modelling; her publications in leading international clinical journals have included studies in clinical areas such as kidney disease, falls prevention, cancer screening, perinatal services, aged care services, exercise interventions for older people and organ donation and allocation policy. She is also a member of the Economics Sub Committee of the Australian government's Pharmaceutical Benefits Advisory Committee (PBAC).

Areas of Interest:

- ☑ Preferences Between Health-Related Goods and Services

- ☑ Preferences Between Health Outcomes

- ☑ Preference Methods (Elicitation Tasks and Econometrics)

- ☑ Preference Tools and Technologies (Calculators, Decision Aids, and Tariffs)

International Academy of Health Preference Research

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Biosketch

Emily is an economist whose research is in the broad areas of choice modelling, preference elicitation, and welfare analysis, particularly using discrete choice experiments (DCEs). Her work has addressed both methodological and empirical issues in these areas with applications in health, environment and safety/physical risk. Areas of methodological interest include appropriate analysis of data from DCEs and Best-Worst Choice Experiments, particularly to estimate models for single individuals and the elicitation of welfare measures from such experiments, the use of eye tracking technology to explore and better understand choice behaviour in DCEs along with ongoing research on appropriate methods to elicit social values in the context of health care resource allocation. Emily currently holds an ARC fellowship in which she is harnessing choice and laboratory experiments to explore the role of behavioural economics in the area of obesity, is leading an NHMRC funded project harnessing a novel DCE approach to elicit distributional weights for QALYs and is a co-investigator on a number of other ARC, NHMRC and NIHR funded projects.

Emily is an Associate Professor in the Centre for Health Economics at Monash University. Joining Monash in 2011 represented a return to Australia for Emily after spending more than 7 years working at Newcastle University in the UK where she held Senior Lecturer and Lecturer positions in the Department of Economics and, in addition to teaching undergraduate and postgraduate economics, was a member of the Economics of Safety Health Environment and Risk research group and the Institute of Health and Society. During this time Emily was also the recipient of an ESRC/MRC/NIHR Early Career Fellowship in the Economics of Health and a member of the EU funded European Value of a QALY (EuroVaQ) team which investigated the social value(s) placed on quality adjusted life years across ten European countries. Prior to that she was also part of the UK Department of Health funded Social Value of a QALY (SVQ) project which estimated distributional weights and monetary values for QALYs in the UK. Prior to moving to the UK Emily worked at CHERE at University of Sydney/UTS and at the Federal Department of Health.

Areas of Interest:

☑ Preferences Between Health-Related Goods and Services

☑ Preferences Between Health Outcomes

☑ Preference Methods (Elicitation Tasks and Econometrics)

☑ Preference Tools and Technologies (Calculators, Decision Aids, and Tariffs)

International Academy of Health Preference Research

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Biosketch

Dr Jennifer Whitty is Associate Professor of Health Economics, Pharmacoeconomics and Quality Use of Medicines with the School of Pharmacy at The University of Queensland, and holds as adjunct position as Associate Professor of Health Economics with the Centre for Applied Health Economics, School of Medicine, Griffith University, Australia. As a pharmacist who has specialised in health economics, she has considerable research leadership and consultancy experience in health economics and health services research, including in pharmacoeconomics, economic evaluation, and health technology assessment.

Jennifer leads a multidisciplinary program of research at the University of Queensland evaluating patient and public preferences, choices and values around health and healthcare delivery. Her research is developing methods for measuring preferences, valuing quality of life and other outcomes from healthcare, and incorporating social values in decision-making. She is an expert in the application of choice-based stated preference approaches such as the discrete choice experiment. Jennifer's preference-based research is supported by funding from competitive and industry sources, including the Australian Research Council (ARC), the National Health and Medical Research Council (NHMRC), and the Australian Government Department of Health. She has published in numerous peer-reviewed journals and is a member of the Editorial Board for the international journals "Medical Decision Making" and "Applied Health Economics and Health Policy". She makes strong contributions to professional development in the preference elicitation field through research student supervision, delivery of courses and seminars, and invited membership of the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) Distance Learning Faculty.

Areas of Interest:

☑ Preferences Between Health-Related Goods and Services

☑ Preference Methods (Elicitation Tasks and Econometrics)

☑ Preferences Between Health Outcomes

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Upcoming IAHPR Meetings

3rd Meeting of the International Academy of Health Preference Research

Sunday, 18 October 2015, 8:00-17:30, chaired by Derek Brown
Charles F. Knight Executive Education & Conference Center
1 Bookings Drive
St. Louis, Missouri, USA 63130
www.acc-knightconferencecenter.com

4th Meeting of the International Academy of Health Preference Research

Wednesday, 13 July 2016, 8:00-17:30, chaired by Mandy Ryan and Elly Stolk
Nord Event Panoramadeck, Emperio Tower, Dammtorwall 15, Hamburg, Germany

5th Meeting of the International Academy of Health Preference Research

Friday, 2 September 2016, 8:00-17:30, chaired by Kirsten Howard and Mark Oppe
hosted by the Center for Health Services and Policy Research (CHSPR) at the Saw Swee
Hock School of Public Health (SSHSPH) and the National University Hospital System
of Singapore (NUHS), Tahir Foundation Building, National University of Singapore, Singapore

6th Meeting of the International Academy of Health Preference Research (Tentative)

Friday, 7 July 2017, chaired by Juan Marcos González and Joel W. Hay
TBD, Boston, Massachusetts, USA

7th Meeting of the International Academy of Health Preference Research (Tentative)

November 2017, chaired by Karin Groothuis-Oudshoorn and Terry Flynn
TBD, Glasgow, Scotland, UK

8th Meeting of the International Academy of Health Preference Research (Tentative)

September 2018, chaired by Brendan Mulhern and Jennifer Whitty
TBN, Australia

9th Meeting of the International Academy of Health Preference Research (Tentative)

13 October 2018, chaired by TBN
Fairmont The Queen Elizabeth, Montréal, Québec, Canada

10th Meeting of the International Academy of Health Preference Research (Tentative)

September 2019, chaired by TBN
TBN, Europe

CALL FOR ABSTRACTS

THE 4TH MEETING OF THE INTERNATIONAL ACADEMY OF HEALTH PREFERENCE RESEARCH

DINNER & POSTER SESSION: 18:00 TUESDAY, 12 JULY 2016
MEETING: 8:00 - 17:30 WEDNESDAY, 13 JULY 2016

NORD EVENT PANORAMADECK
AT THE EMPERIO TOWER
DAMMTORWALL 15
20355 HAMBURG
GERMANY

Held at the Emperio Tower—with 360° views over the Alster and city—this meeting (and its pre-meeting dinner and poster session) will provide a forum to discuss innovative developments in the field of health preference research. Chaired by **Mandy Ryan**, **PhD**, and **Elly Stolk**, **PhD**, the meeting will include approximately 14 oral presentations, lunch, and a business session. The pre-meeting dinner and poster session will showcase the achievements of students engaged in health preference research.

CALL FOR ABSTRACTS

The International Academy of Health Preference Research (IAHPR) is soliciting abstracts for oral presentations and posters to be presented at the 4th Meeting in Hamburg, Germany, on 12- 13 July 2016.

IAHPR welcomes submissions on a variety of health preference topics, including, but not limited to conjoint analysis in health, valuation of health outcomes, preference methods, and preference tools and technologies (e.g., advanced directives and decision aids). There will be time for approximately 14 presentations. Speakers will present their research in a 15-minute format, followed by audience discussion. The poster session will take place at the pre-meeting dinner. Attendees and IAHPR members may view the presentations in-person or via live webinar. All presentations must be in English.

Submissions will be accepted until 15 April 2016. Notifications and comments will be provided by mid-May. All submissions will be reviewed by all IAHPR members.

Interested researchers should submit online at www.iahpr.org
For more information, visit www.iahpr.org or email admin@iahpr.org

Call for Abstracts
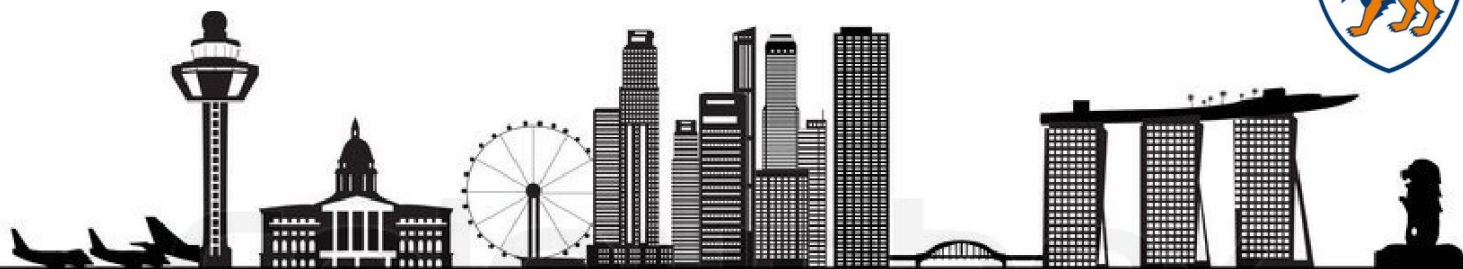
The 5th Meeting of the International Academy of Health Preference Research

Meeting: 8:00- 17:30 Friday, 2 September 2016
Post-Meeting Dinner: 18:00 Friday, 2 September 2016

**Tahir Foundation Building at the National University of Singapore
21 Lower Kent Ridge Rd
Singapore 119077**

Held at the Tahir Foundation Building—located at the National University of Singapore and hosted by the Center for Health Services and Policy Research (CHSPR) at the Saw Swee Hock School of Public Health (SSHSPH) and the National University Hospital System of Singapore (NUHS)—this meeting will provide a forum to discuss innovative developments in the field of health preference research. Chaired by **Kirsten Howard, PhD**, and **Mark Oppe, PhD**, the meeting will include approximately 14 oral presentations, lunch, and a business session. After the meeting, IAHPR will host an offsite dinner for all meeting attendees.

Call for Abstracts

The International Academy of Health Preference Research (IAHPR) is soliciting abstracts for oral presentations and posters to be presented at the 5th Meeting in Singapore, on 2 September 2016.

IAHPR welcomes submissions on a variety of health preference topics, including, but not limited to conjoint analysis in health, valuation of health outcomes, preference methods, and preference tools and technologies (e.g., advanced directives and decision aids). There will be time for approximately 14 presentations. Speakers will present their research in a 15-minute format, followed by audience discussion. Attendees and IAHPR members may view the presentations in-person or via live webinar. All presentations must be in English.

Submissions will be accepted until 1 June 2016. Notifications and comments will be provided by early-July. All submissions will be reviewed by all IAHPR members.

Interested researchers should submit online at www.iahpr.org
For more information, visit www.iahpr.org or email admin@iahpr.org