

but not across intervention types. The majority of published ICERs are falling in or below the £20–30,000 range. The highest ICERs were found to come from publicly funded studies of technologies, which had yet to be generally adopted within the NHS. In the non-pharmaceutical group an association was found between lower ICERs and adoption into routine practice. **CONCLUSIONS:** The results indicate some degree of consistency in decision-making. However, the results must be treated with caution. The selection of technologies for evaluation is neither comprehensive nor representative of technologies used in the NHS. Large areas of routine practice remain unevaluated. The methodology and the quality of CE studies remain variable, and the definition and assessment of routine use remain problematic.

**HP2****HEALTH ECONOMIC EDUCATION IN ALLOCATION DECISIONS: A PRE-TEST POST-TEST STUDY**Evans CJ

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**OBJECTIVE:** To determine the impact that an educational intervention has on students' perception of the relative importance of efficiency and equity in the rationing of health care. **METHODS:** Over two years, a survey was provided to students in a graduate health economics class. The survey asked the students ( $n = 54$ ) how they would allocate organs amongst patients who had varying chances of benefiting from them. Participants were asked to complete the survey at two points in time: the first day of class and prior to receiving the final examination on the last day of class. Responses were anonymous. Between the 2 administrations the subjects received a 3-hour lecture on health economics once a week for 13 weeks. The lectures included: pricing, cost-minimization, effectiveness, utility, and benefit analyses, the use of pharmacoeconomic data, and the Oregon experiment. **RESULTS:** Prior to receiving instruction in health economics, the students weighed equity and efficiency equally: 32% of respondents allocated organs regardless of the patient's prognosis compared to efficiency arguments that stated that the organs should be allocated to the group with the greatest chance of survival (36%). After completion of the course most respondents (50%) allocated organs so as to maximize health outcomes; however, many (30%) still felt that organs should be allocated based on principles of fairness to all. After the course was completed there was evidence to suggest that nearly all students understood the trade-offs and the implications of non-health maximizing behavior better. **CONCLUSIONS:** Previous research has indicated that equity considerations in allocation decisions are important to members of the general public. This study provides preliminary evidence that an educational intervention may change this perception, although there is still a high value placed on equity concerns. Equity arguments

should be incorporated formally in cost-effectiveness evaluations and medical decision making.

**HP3****A RISK-ADJUSTED LEAGUE TABLE OF EXPECTED RETURNS**Sendi P<sup>1</sup>, Al MJ<sup>2</sup><sup>1</sup>University of Basel, Basel, Switzerland; <sup>2</sup>Erasmus University, Rotterdam, Netherlands

**OBJECTIVES:** The league table approach to rank ordering health care programs according to the cost-effectiveness ratio is a common method to guide policy makers in setting priorities for resource allocation. The league table approach, however, has so far been described from a deterministic perspective. The objective of the present study is to propose a risk-adjusted method to ranking health care programs. **METHODS:** In the presence of uncertainty, ranking programs is complicated by the degree of variability associated with each program. Confidence intervals for cost-effectiveness ratios may be overlapping. Moreover, confidence intervals may include negative ratios and the interpretation of negative cost-effectiveness ratios is ambiguous. We suggest ranking health care programs according to their rate of return, which is defined as the net monetary benefit over the costs of the program. However, how does a program with a higher expected return but higher uncertainty compare to a program with a lower expected return but lower risk? **RESULTS:** We borrow methods used in portfolio theory. Financing a health care program is treated as an investment in a risky asset. The risky asset is combined with a risk-free asset in order to construct a combined portfolio. The weights attributed to the risk-free and risky assets are chosen in such a manner that all programs under consideration exhibit the same degree of uncertainty. **CONCLUSION:** The proposed method can be used to compare the performance of the individual programs by constructing a risk-adjusted league table of expected returns.

**ADHERENCE (COMPLIANCE) STUDIES****CP1****CROSS-CULTURAL DIFFERENCES IN NON-ADHERENT ATTITUDES**Bolge SC, McDonnell DD, Eschmann B, Annunziata K, Donohue JA

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**OBJECTIVE:** To examine cross-cultural differences in non-adherent attitudes among people across four countries. **METHODS:** Analyses are based on self-administered questionnaires mailed to adults in 2001. A total of 40,269 responses were received from France, Germany, Great Britain, and the United States. Results are weighted and projected to the national population of each country. Weighting is based on gender, age, and