use and unit prices estimated from other sources. The level of detail collected in clinical trials varies and determines which resource costing methods can be used. Using hospital inpatient data, this study compares three resource costing methodologies that utilize varying levels of information about hospitalizations. METHODS: As part of project TrEAT, an alcohol-related intervention study, hospital primary discharge data were collected for HMO patients. Data from HCUP National Inpatient Sample (NIS) 2000 are used for estimating unit prices. Three resource costing methods are applied: 1) a per day unit price over all hospitalizations; 2) a unit price per day for each DRG; and 3) a unit price per day for each primary ICD-9-CM discharge diagnosis. Inpatient costs are calculated as the product of these unit prices and the observed inpatient days. Inpatient costs for the intervention and control groups are compared. RESULTS: For the 1-year period following study enrollment, method 1 yields control and intervention group averages of $485($2736) and $246($1458), respectively. Method 2 produced mean and standard deviations of costs that were approximately twice as large, $956($5695) and $543($3755) for the control and intervention group, respectively. Differences between the intervention arms may not be generalizable but is cause for concern because it suggests that the cost-effectiveness of an intervention may differ depending upon whether community or patient preferences are used.

COMMUNITY OR PATIENT PREFERENCES FOR COST-UTILITY ANALYSES: DOES IT MATTER?
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OBJECTIVE: To determine if it matters whether we use community or patient preferences in cost-utility analysis. METHODS: Patients were randomized within 6 weeks of acute myocardial infarction to a 2-month cardiac rehabilitation intervention (n = 99) or to usual care (n = 102). Data were collected at baseline and at 2, 4, 8, and 12 months. Community-based preferences for patients’ health states were measured using the Quality of Well-Being (QWB). Patients’ preferences for their subjectively-defined health states were measured using the Time Trade-off (TTO) technique. Agreement between QWB and TTO measures was assessed using intra-class correlation coefficient (ICC). Responsiveness of each measure was calculated as the standardized response mean (SRM). Quality-adjusted life years (QALYs) experienced by each patient were estimated separately using both QWB and TTO measurements. Costs, measured from the societal perspective for each individual patient, included those borne by the health-care system and the rehabilitation program and the patients. Incremental cost-utility ratios were estimated using mean costs and QALYs for the study groups. QWB-based and TTO-based cost-utility results were compared. RESULTS: Agreement between QWB and TTO scores varies from negligible (ICC = 0.069) at baseline to strong (ICC = 0.607) at 12-month assessment. TTO scores are higher than QWB scores (p < 0.01). QWB and TTO scores for both groups of patients improved (p < 0.05) between baseline and 12 months. SRMs are 0.64 for QWB and 0.34 for TTO. QALYs gained by rehabilitation are 0.011 using QWB and 0.040 using TTO, at a cost (US $ 2001) of $702 per patient. The cost-utility of rehabilitation is $62,000 per QWB-based QALY gained and $17,500 per TTO-based QALY gained. CONCLUSIONS: The QWB and TTO results are different. This may not be generalizable but is cause for concern because it suggests that the cost-effectiveness of an intervention may differ depending upon whether community or patient preferences are used.

SYSTEMATIC REVIEW OF ECONOMIC EVALUATION STUDIES OF MEDICAL TECHNOLOGY IN THAILAND
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OBJECTIVES: In Thailand, economic evaluation of medical technology has been increasingly used as a tool to aid decision making particularly since the economic crisis in 1997. Despite the increased number of economic evaluation studies, there has been no study evaluating their quality. The purpose of this study is to systematically identify all economic evaluation studies in Thailand and to assess their quality. METHODS: We performed a systematic search for economic evaluation studies through MEDLINE (1966–2002), Thai index Medicus (1918–2002), and Thai Thesis Online (1966–2002). In addition, we electronically searched for “research reports” or “theses” through 8 major university libraries to identify potential studies. Only Thai studies evaluating both cost and outcomes were included. All studies were evaluated using a standardized abstraction form, which was developed based on Drummond’s 10-item checklist. RESULTS: A total of 6488 studies was identified from the search but only 49 published and 57 unpublished studies met inclusion criteria. After complete assessments of pub-