and is substantial and therefore important in the context of informal care. Almost half of the caregivers (48.2%) derive positive utility from informal care and on average happiness would decline if informal care tasks were handed over to someone else. The multivariate analysis shows that process utility is significantly related to, amongst other things, age and gender of the caregiver. Male caregivers have lower process utility than female caregivers. Closer relationship (partner, parent, child) elicit lower process utility than others.

CONCLUSIONS: Process utility is important in the context of informal care. Our results strengthen the idea of supporting informal care, but also that of keeping a close eye on the position of carers.

METHODOLOGICAL ISSUES—Utility Studies

CALCULATING UTILITY VALUES FROM SF-36: A COMPARISON OF DIFFERENT ALGORITHMS

Svensson K
AstraZeneca R&D Lund, Sweden, Lund, Sweden

OBJECTIVES: This study aims to investigate if the results of four published algorithms for calculating utility values from assessments of SF-36 are in agreement with the responses of traditional efficacy variables assessed in a randomized clinical study with different treatments of asthmatic patients. METHODS: Data from a randomized clinical study of moderate asthmatic patients comparing treatment with budesonide alone (n = 114) with budesonide plus formoterol (n = 109) during 12 weeks are used in this investigation. Utility values from the four algorithms are calculated for the different treatment groups at randomization and at end of treatment, and both absolute values as well as change during treatment are correlated with efficacy variables assessed in the study: PEF Morning, FEV1, and the summary score SF-36 PCS from the SF-36 questionnaire. RESULTS: Mean Utility values at baseline range between 0.61 to 0.82 for the 4 algorithms but with no difference between the two treatment groups. Change during treatment varies between 0.08 and 0.11. While both PEF Morning and FEV1 are statistically significant when comparing the change during treatment between the two treatment groups, neither any of the SF-36 domains nor SF-36 PCS turns out to be. Two out of the four utility measures, both based on TTO, reaches statistical significance. Correlation for change during treatment shows moderate correlation with PEF Morning (0.28 to 0.32) and FEV1 (0.17 to 0.25). CONCLUSION: The two utility measures based on the SF-36 items (or a subset thereof) and evaluated through TTO show better response than the other two, one evaluated through a Visual Analog Scale as rating scale, and the other based on domain values and not item values from SF-36.

RELATIVE WEIGHTS ASSIGNED TO DRUGS AND BIOLOGICALS: OPPS METHODS AND CONCEPTS

Baker JJ
University of Rochester, Pickton, TX, USA

OBJECTIVE: The Centers for Medicare and Medicaid Services (CMS) assigns a relative weight to those high cost new technology drugs designated with a non-pass-through or expired pass-through payment status. This study examines the conceptual approach of relative weights for drugs and biologicals under the CMS Hospital Outpatient Prospective Payment System (OPPS) and compares this approach to the resource-based level of effort concept initially created for payment to physicians’ offices in the U.S. METHODS: The underlying intent of relative value units (RVUs) in the physician’s office was to create a hierarchy of resource-based level of effort involved in various types of office-based service delivery. The concept of hospital OPPS was also intended to reflect resource-based services. Thus the OPPS relative weights should be related to resource-based levels of effort. Non-pass-through high cost new technology drugs that are paid separately under OPPS are assigned a relative weight, implying that the payment includes level of effort resources. We postulate these relative weights contain no level of effort, but instead represent only the pure drug component. This use of the relative weight concept distorts its initial intent. RESULTS: Resource-based methods initially proposed for the hospital OPPS were collected and deconstructed. CMS rationale supporting treatment of non-pass-through high cost new technology drugs paid separately under OPPS were identified. CMS drug payment computation methods were likewise deconstructed and evaluated. The evaluation sought indications of resource-based level of effort applications. CONCLUSIONS: Many researchers and policy makers assume that relative weights equate to level of effort resource consumption in all instances. We cannot find this is so in the case of non-pass-through high cost new technology drugs paid separately under OPPS. It is necessary to draw CMS attention to this issue, as the volume of forthcoming new drugs and biologics means the issue will become increasingly important.