randomised trial of general practitioner practices. Patients were over 74 years old, living in the community, in the UK. Costs and outcomes were discounted (3.5% recommended UK rate). Missing data for censored cases were imputed by survival analysis. Missing data due to missing observations were imputed by characteristic of patient. Data were adjusted for age, gender and cluster randomisation. Costs and LYGs were bootstrapped. Net benefit statistics were estimated. Cost-effectiveness acceptability analysis used willingness to pay thresholds (GBP0 to GBP50000). Sensitivity analysis assessed the impact of structural factors and assumptions. RESULTS: 109 GP practices were assigned to (a) assessment method: UA = 55 (21,762 patients) TA = 54 (21,457 patients); (b) management method: GM = 55 (22,216 patients); PC = 54 (21,003 patients). Preliminary analysis indicated a net cost to TA (GBP296; 2.5–97.5 percentile GBP140–GBP448) versus UA and a net saving to PC (−GBP41; 2.5–97.5 percentile −GBP192–GBP107) versus GM. LYGs were TA (0.006; 2.5–97.5 percentile −0.006–0.19) and PC (0.016; 2.5–97.5 percentile 0.004–0.28). The probability of net benefit was 0–0.50 for TA across the willingness to pay thresholds. The probability of net benefit for PC was 0.70–1.00. Sensitivity analysis indicated the results for targeted assessment, but not PC, were sensitive to method of imputing missing data and time-frame. CONCLUSIONS: The cost-effectiveness of targeted assessment is uncertain. PC management appears cost effective in the primary and sensitivity analyses. The small cost and effect differences between strategies indicate cost-effective configuration of services may be driven primarily by local considerations.

**PIH6**

**GRUMPY OLD MEN OR HAPPY YOUNG WOMEN: THE COMPARATIVE HEALTH STATUS OF SWEDEN AND THE UK**

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OBJECTIVES: Comparison of population health is a matter of concern for national governments and for international agencies. This paper reports on the analysis of data collected by in national surveys conducted in Sweden (S) and England & Wales (EW) using the same health status questionnaire, administered by post during 2002 and 2003. METHODS: Data were collected from 1945 respondents in Sweden and 1001 in England & Wales. Both datasets were weighted to be representative of their respective national populations. RESULTS: Age-standardised EQ-5Dvas was systematically higher for men than for women in both surveys, however this position is reversed for women aged 70+ in the EW survey. Differences in age/gender-standardised EQ-5Dvas between the 2 national surveys were small (typically <5). Despite this apparent convergence, the age-standardised rates of reported problem on the 5 EQ-5D dimensions varied significantly both by gender and by survey. The rates of problem on usual activities, for example, were 2.3% and 6.2% for men and women aged 20–44 in the Swedish survey. The corresponding rates in the EW survey were 12.1% and 13.1%. Within-survey regression models were constructed using EQ-5Dvas as the dependent variable and recoding the 5 dimensions to 0/1 dummy variables (no problem/any problem). Both models appear to fit the data reasonably well (r2 > 0.450) with roughly equivalent constants (87.9 and 89.5) however, the value decrements given by the beta coefficients indicate large differences in the importance associated with each dimension. The highest decrements in the Swedish survey are for mobility (15.7) and pain/discomfort (12.0). The highest decrements in the EW survey are for usual activities (11.4) and anxiety/depression (9.5). CONCLUSION: The study explores some possible causes of the differences (similarities) noted in the analysis and propose a series of standard tables for use in reporting data on comparative population health.