possible significant external variable(s) separately or in combination. RESULTS: Twenty-five Chinese and 21 Indians (mean (SD) age: 45.0 (15.55) years, 55.6% female) were interviewed. Ethnicity was identified as the only independent variable causing significant difference in VAS (p < 0.05). RQoL, BTF, DOO, ITW were found to explain the variation of VAS of 26.5%, 27.2%, 23.2%, 17.1% respectively in separate MLR models (p < 0.05). Combining ethnicity together with the sum of AAs explained up to 27.3% of the variation in VAS, while a model with ethnicity alone only accounted for 10.7% (p < 0.05). When MLR was done to examine different predicting power of AAs by ethnicity, ITW failed to predict VAS of Indians (0.3%, p = 0.80) while the other 3 AAs moderately explained from 9.1% to 22.9% of the variation (p < 0.05). CONCLUSIONS: EVM may be helpful in explaining the variations in health preference and predicting important factors.

PREVAILING JUDGMENTS ABOUT SOCIETY’S WILLINGNESS TO PAY FOR A QALY: DO THEY VARY BY COUNTRY? HAVE THEY CHANGED OVER TIME? Greenberg D1, Winkelmayer WC2, Rosen AB3, Neumann PJ4

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OBJECTIVES: Great debate exists over appropriate cost/QALY thresholds. We assessed reporting of cost-effectiveness thresholds in the literature to examine prevailing judgements about society’s willingness-to-pay per QALY. We hypothesized that stated thresholds were directly related to an author’s home country GDP per capita and that they have increased over time to reflect economic growth. METHODS: We evaluated 573 cost-effectiveness analyses (CEAs) published between 1998–2003 and listed in the Tufts-NEMC CEA registry. We scrutinized authors’ judgments regarding appropriate cost/QALY thresholds (e.g., that an incremental cost/QALY ratio under $50,000/QALY represented “good value for money”), and examined whether thresholds differed by author’s home country GDP per capita (2000 listed in the Tufts-NEMC CEA registry. We scrutinized authors’ judgments regarding appropriate cost/QALY thresholds (e.g., that an incremental cost/QALY ratio under $50,000/QALY represented “good value for money”), and examined whether thresholds differed by author’s home country GDP per capita (2000 values). RESULTS: CEAs most frequently originated from the US (n = 320), UK (n = 68), Canada (n = 45), and The Netherlands (n = 35). Of 573 studies, 325 CEAs (57%) stated an explicit threshold. The most frequent thresholds used in the US were $50,000/QALY (52%), followed by the classification proposed by Laupacis (CAN$20,000–CAN$100,000) (16%), and $100,000/QALY (11%). Most Canadian studies (65%) used the Laupacis classification, and most UK studies (52%) used GBP30,000/QALY. The prevailing US threshold ($50,000/ QALY) corresponded to approximately 1.4 times US GDP per capita, whereas the UK threshold (GBP30,000/QALY) was approximately 1.9 times UK GDP per capita. The lower and upper limits of the Laupacis classification used in Canada corresponded to 0.6 to 2.9 times Canadian GDP per capita. Thresholds used by authors have not changed significantly over time and where not inflated to address inflation or economic growth. CONCLUSIONS: Thresholds used in the US, UK, and Canada do not appear to be related to GDP per capita, and have not increased over time. More research is needed to determine appropriate country-specific or disease-specific thresholds. Mechanisms for updating thresholds to reflect inflation rates or changes in GDP are warranted.

INTERNET-BASED UTILITY ELICITATION OF A GENERIC HEALTH STATE

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OBJECTIVES: The primary objective of this study was to determine the feasibility of an internet-based method for eliciting population based preferences for generic health states using the standard gamble procedure. METHODS: An internet-based standard gamble utilizing a chance board and a “ping-pong” search procedure was introduced to twenty-five respondents who were primarily recruited via e-mail solicitation. The respondents were asked to elicit their preference for an EQ-5D generic health state (21221). The same set of respondents were asked to elicit their preference for their current health state using an internet-based visual analog scale. RESULTS: Fifty-eight percent of the 25 respondents were male. Eighty percent of the respondents were either health care professionals or academic-based health service researchers, and the remainder were from the general population. The majority of the respondents were White. Four respondents were Hispanic and one was Asian. The mean age of the respondents was 39.7 years. Both the standard gamble and visual analog scale elicitation results were normally distributed (Kolmogorov-Smirnov, p > 0.05). The mean elicited preference for the generic health state using standard gamble was 0.8726 (s.d. 0.095), and the mean visual analog scale elicited preference for the respondents’ current health state was 0.8721 (s.d. 0.088). CONCLUSION: An internet-based approach for eliciting preference for a generic health state using a sophisticated standard gamble procedure appears to be an efficient means for performing such inquiry.

GENERAL HEALTH STATUS AND PATIENT SATISFACTION: ARE THEY MUTUALLY EXCLUSIVE OR CORRELATED OUTCOMES?

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OBJECTIVE: The objective of this study was to analyze the relationship between general health status and patient satisfaction by conducting a meta-analysis on two previously conducted studies. METHODS: Data collected from two cross-sectional studies performed in 1997 and 2001 were pooled. Data collected in 1997 was obtained from 737 patients taking a Selective Serotonin Reuptake Inhibitor selected randomly from a prescription claims database of a managed care company in Utah. Data collected in 2001 was obtained randomly from 443 patients filling prescriptions at 10 pharmacies located in the Houston, Texas. General health status was measured using the SF-12 scale. Patient satisfaction with the services provided by the health plan was measured using an eight item scale. The satisfaction scale across the two data sets was standardized to a 0–100 scale, where a score of 100 was considered highly satisfied. Data were coded and analyzed to report descriptive and correlation analyses. RESULTS: The pooled dataset resulted in 1180 observations. The mean age of the respondents was 47.02 ± 11.41 years (range 10 to 82) of which majority were females (72.6%). Data showed that the respondents had low physical composite scores (PCS) (48.34 ± 10.08) and mental composite scores (MCS) (46.39 ± 11.04) on the SF-12 scale. The mean patient satisfaction score was 71.18 ± 17.89. Correlation analysis indicated there was no association of either the PCS or the MCS with overall patient satisfaction scores (p > 0.05). However, there was a positive association of individual items like health coverage provided by the plan and out of pocket expenses paid by patient for health