ing considered on each criterion in the preference structure; 4) Normalize and average the preferences for each drug agent; 5) Create a statistic that indicates consistency in quantifying the preferences; 6) Determine the preference of each criterion relative to every other criterion in the preference structure (normalize, average, and check consistency); 7) Determine summary preference "score" for each drug agent; 8) Choose the drug agent having the greatest summary preference.

RESULTS: The optimal drug identified by the AHP was the same drug agent identified by the Formulary Steering Committee for inclusion in the formulary. However, the AHP achieved this result with a comparable reduction in inconsistency, greater efficiency and the ability to perform a sensitivity analysis of the outcome.

CONCLUSIONS: The analytical hierarchy process can be used to successfully identify appropriate drug agents for formulary placement in managed care settings. Use of this method allows formulary members to quantify their subjective preferences among competing drug agents.

EVALUATION OF THE STRUCTURAL VALIDITY OF THE SF-12

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OBJECTIVE: The purpose of the present study was to validate the structural model of the SF-12 with data from the 1990 National Survey of Functional Health Status (NHS).

METHODS: We used Confirmatory Factor Analytic (CFA) to evaluate the structure of the MOS SF-12. CFA is ideally suited for examining self-report survey tools, in that the proposed structural characteristics are statistically evaluated by comparing the estimated population covariance matrix, estimated from the proposed parameters, to the sample covariance matrix.

RESULTS: There was substantial support for the hypothesized structure of the SF-12; however, it was not a statistically adequate fit ($r^2 = 1672.27$; fit indices were well below 0.9 [CFI = 0.85]). The model was significantly improved by adding a covariance path between Physical Health and Mental Health, adding an additional link between General Mental Health and Physical Health, and the addition of two covariances among the item errors. This revised structure represented a good fit to the data ($r^2 = 338.26$; fit indices were well above 0.9 [CFI = 0.97]). This suggests that there are some commonalties between self-reported Physical and Mental Health. This was supported by the strong correlation between Physical Health and Mental Health ($r = 0.838$; 70% shared variance).

CONCLUSION: While there was some support for the hypothesized structure, there was substantial evidence to support the dependencies between Physical and Mental Health. These findings are very similar to our previous work with the SF-36 that suggests that a substantial portion of these two constructs, Physical and Mental Health,

reflect a common construct. The SF-12 appears to be relatively free of correlated errors, unlike the SF-36, and may have fewer problems with systematic measurement error or idiosyncratic interpretation of item content.

DEVELOPING A QUALITY ASSESSMENT SCORING SYSTEM FOR ECONOMIC EVALUATIONS

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OBJECTIVE: In recent years, a number of primers, standards, and guidelines have appeared in the pursuit of promoting "good practice" and improving the overall quality of economic evaluations. However, none of these contain the logical next step: a scoring system that evaluates and summarizes the quality of the studies. This research investigates whether a scoring system can be developed for published economic evaluations, and discusses how such a system can assist in clearly identifying studies of a better quality, which in turn would provide the evidence to allow priorities to be set in a more explicit manner. We construct a scoring system based on an adaptation of the BMJ Working Party 35-point checklist, and illustrate its application to a case study of schizophrenia.

METHODS: A comprehensive literature search was conducted for the period 1966–1997. The inclusion criteria were: 1) the study considered both the costs, and cost or health consequences of alternative health programs for schizophrenia; 2) the study was published in English; 3) the majority (i.e., >50%) of the patients sampled had a diagnosis of schizophrenia or related psychoses. The studies were scored according to the maximum total which could be achieved for each study. Selected items (e.g., perspective) were given more weighting according to their importance as determined by a recent survey of health economists.

RESULTS: Thirty studies met the inclusion criteria (17 US, 7 UK, 6 elsewhere). The studies either considered alternative methods of service delivery or the use of novel antipsychotic drugs (e.g., clozapine or risperidone). The quality scores ranged from 43–88%.

CONCLUSIONS: It is shown that our scoring approach may be one reasonable method of summarising methodological quality. Further research needs to be performed on the development of economic quality scoring methods and the link between the quality of economic information to their effects on decision-making.

MINIMAL STANDARDS FOR THE VALIDATION OF QUALITY OF LIFE INSTRUMENTS USED IN CLINICAL TRIALS

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