e Estatística). RESULTS: Our computed values vary across countries and across time. The average STP rate for the 167 countries in the sample is 6.8% and the standard deviation 3.9%. The figures ranged from −6.8% for Equatorial Guinea to 18.6% for Armenia. For Brazil, STP rates display a decreasing profile across time, with an average rate of 4.7%. Computed figures vary from 3.6% to 5.5%. CONCLUSIONS: The standardisation of the use and estimation of discount rates in the economic evaluation of health care programmes (EEHCP) is a core quest, especially with the increase of EEHCP as a tool for decision making. The variation of STR rate results indicate the need for country-specific discount rate estimation.

**PMC7**

**SELF-REPORT VERSUS CAREGIVER REPORT OF HEALTH CARE UTILIZATION: IMPACT ON COST AND COST-EFFECTIVENESS**

Hooijendoom M1, van Wetering CR2, Schols AM3, Rutten-van Mölken MP1

1Erasmus MC, Rotterdam, The Netherlands, 2Maxima Medical Centre, Veldhoven, The Netherlands, 3Maastricht University, Maastricht, The Netherlands

OBJECTIVES: This study aims to compare the impact of two different sources of resource use, self-report versus routine registrations, on incremental cost-effectiveness ratios (ICERs).

METHODS: Data were obtained from a cost-effectiveness study performed alongside a two-year randomized controlled trial evaluating the effect of an INTERdisciplinary COMMunity-based management program (INTERCOM) for patients with chronic obstructive pulmonary disease (COPD). The program consisted of exercise training, nutritional therapy, education and smoking cessation support offered by community-based physiotherapists and dieticians and hospital-based respiratory nurses. Data on caregiver visits, hospitalizations, diet nutrition, devices, (un)paid help, travel expenses and time lost from paid work over the two-year period were collected using a cost booklet. In addition, data on hospital admissions and outpatient visits, visits to the physiotherapist, dietician or respiratory nurse, diet nutrition and outpatient medication were obtained from hospital- and billing records and local pharmacies. The cost per QALY was calculated in two ways, using data from the cost booklet or registrations. RESULTS: In total 175 patients were included in the study. Agreement between self-report and registrations was good for hospitalizations (r = 0.96), diet nutrition (r = 0.91) and physiotherapist visits (r = 0.89), but above 0.58 for all other types of care. The total cost difference between the registrations and the cost booklet was €464 with the highest difference for hospitalizations 386 euro. Based on the cost booklet the cost difference between the treatment group and usual care was €2,444 (95% CI: −819–5,950), which resulted in an ICER of €29,100/QALY. For the registrations, the results were €2,498 (95% CI: −88–6,084) and €29,390/QALY, respectively. No differences were found in the cost-effectiveness planes and the acceptability curves between the two methods. CONCLUSIONS: This study showed that the use of self-reported data or data from routine registrations affected within group costs, but not between group costs or the ICERS.

**PMC8**

**DESIGN AND REPORTING TRENDS IN PIGGY-BACK ECONOMIC TRIALS**

Ubhadiya BS1, Gautam C1, Narvilkar P2, Singh N2, Bhanderi M2, Dimri S3

1Heron Health Pvt Ltd, Chandigarh, India, 2Heron Health Private Ltd, Chandigarh, India

OBJECTIVES: To assess trends in the prevalence and type of economic analysis alongside randomized controlled trials (piggy-back trials) published between 1997 and 2007. METHODS: We searched Medline for a total number of Randomized Controlled Trials published between 1997 and 2007. Economic studies alongside RCTs were searched by using the additional MeSH terms, costs and cost analysis. The abstract of each retrieved, English-language study was reviewed and economic studies alongside RCTs were identified. Included studies were categorized further by the type of analysis, perspective and interventions. RESULTS: Our search identified a total of 131,454 RCTs and 2820 economic analysis alongside RCTs. A total of 2077 studies met inclusion criteria and further analyzed. Only 1.58% of published RCTs included economic analysis. The prevalence of economic studies alongside RCTs as a proportion of RCTs was fairly constant over 1997–2007, except for the year 2000 where a higher prevalence (2.07%) was observed. Cost effectiveness analyses was most frequently reported (46.12%) followed by cost minimization (2.74%), cost benefit (2.6%) and cost utility (1.4%). More than one type of analyses was reported in 3.17% of studies. The remaining 44.05 % of studies were either cost analysis or cost-consequence analysis or were unclear. The interventions considered in the trials were drugs (36.3%), devices or surgical techniques (22.14%), behavioral studies (4.91%), preventive studies (3.9%), and others (30.8%). The perspective of economic analysis was stated in only 8.32% of studies. Federal, hospital, patient, payer, societal and state agency perspective were reported by 1.2%, 1.3%, 0.38%, 1.05%, 2.84%, and 0.52% of studies respectively. CONCLUSIONS: We observed an increase in the prevalence of economic analysis in randomized controlled trials than earlier years. Also, the number of drug trials and devices and surgical technique trials has increased from before 1997. The reporting of trial perspective was found very low. This could be because of external-validity problems with piggy-back trials."

**PMC9**

**DISCOUNTING COSTS AND BENEFITS OF HEALTH CARE PROGRAMMES: PROBLEMS OF THE SOCIAL TIME PREFERENCE APPROACH**

John J

Helmholtz Zentrum München, German Research Center for Environmental Health (GmbH), Neuherberg, Germany

OBJECTIVES: Economic evaluation of health technologies is increasingly used to inform decision-making in health policy. It is standard practice in cost-effectiveness analysis to discount future health benefits at the same rate as costs and to apply a baseline time preference approach for discounting health benefits at some rate. Public health advocates of prevention programmes often argue that devaluing future health gains through discounting is inappropriate. The purpose of this paper is to re-examine the arguments of the social time preference approach for discounting health benefits at some positive rate and at the same rate as the costs. METHODS: The paper is based on a systematic review of the literature on the foundations of discounting in the economic evaluation of health care programmes published during the time period 1989–2008. RESULTS: According to the social time preference approach the main arguments for discounting are the individual’s uncertainty about the returns of investment, diminishing marginal utility and pure time preference. None of these arguments convincingly supports a positive and distinct discount rate for health gains. Particularly the argument of pure time preference is challenged, e.g. by the problem of myopia, the divergence between private and collective decision behaviour, and the neglect of distributional concerns of public health policy. A more fundamental weakness of the welfarist framework is that it does not provide an appropriate conceptual basis for dealing with the question