modeling based corrections might be necessary for which the (re)-building of the study model is required. Univariate sensitivity analysis seems appropriate for identification of the most important adjustments. If not all relevant study parameters can be substituted with country specific ones, multivariate or probabilistic sensitivity analysis appears to be a promising way to quantify the uncertainty associated with a transfer. If study results cannot be transferred, the transfer of study models or designs should be investigated as this can save a substantial amount of time when conducting a new study.

CONCLUSIONS: The transferability decision chart is a transparent and user-friendly tool for evaluating and improving the transferability of economic evaluation results. For the assessment of transferability, a detailed method description in the original study is necessary. In addition, the relevant data should be presented in a non-aggregated manner for enabling modeling adjustment.

**ESTIMATING COST-EFFECTIVENESS IN THE ABSENCE OF HEAD-TO-HEAD CLINICAL TRIALS—EXAMPLES OF TWO RECENT TECHNOLOGY ASSESSMENTS FOR NICE**

**ME3**

**OBJECTIVES:** In making decisions about which health care interventions to reimburse, cost-effectiveness analyses should directly compare all relevant treatment alternatives based on all available data. “Head-to-head” clinical trials directly comparing all treatment alternatives are seldom available, requiring the use of indirect trial evidence to make the required comparisons. We illustrate the use of formal methods to make such comparisons using two recent cost-effectiveness analyses commissioned for the National Institute for Clinical Excellence (NICE).

**METHODS:** The clinical trial evidence available to inform the evaluations consisted of a mixed set of comparisons, such as drugs A vs. B, B vs. C, A vs. D. The model parameters required to perform the required direct comparison of the drugs (A vs. B, vs. C.) were estimated jointly from the available data using a generalized linear model in a Bayesian hierarchical framework. This was implemented using Markov Chain Monte Carlo techniques.

**RESULTS:** Direct comparisons of 9 anti-epilepsy drugs and 5 drugs for the acute-manic episode in bipolar disorder were undertaken based on data from 27 and 7 trials, respectively. In epilepsy, the analysis showed that, above a cost-effectiveness threshold of £20,000 per QALY, the newer adjunct therapies were likely to be cost-effective, although there was considerable uncertainty in these results. In bipolar disorder, olanzapine was cost-effective above a threshold of £7000 per responder. The use of this analytical approach avoided the need to restrict the analysis solely to the pairwise treatment comparisons made in existing trials. Cost-effectiveness acceptability curves were derived which incorporate the additional uncertainty associated with the observed heterogeneity between trials.

**CONCLUSIONS:** The use of formal analysis of mixed treatment comparisons is likely to play an important role in reimbursement decisions. Further research is needed into how additional uncertainty associated with unobserved heterogeneity can be incorporated into cost-effectiveness models.

**HOW FREQUENTLY ARE ECONOMIC EVALUATIONS USED IN DECISION MAKING?**

**ME4**

**Bloom BS**

University of Pennsylvania, Philadelphia, PA, USA

**OBJECTIVE:** To estimate actual use of benefit/risk and benefit/cost outcomes in health systems decision making.

**METHODS:** Respondents were selected from public and private payers, provider organizations, technology firms, regulatory agencies and universities in France, Sweden, UK and US. A survey questionnaire was developed and pre-tested with 15 people. After modification, the survey was administered to 116 selected people. We asked about actual use, and examples, by them and their organization of results from benefit/risk and benefit/cost evaluations in making decisions on acceptance or rejection of new, and delisting current, health care technologies.

**RESULTS:** A total of 104 (89.7%) respondents completed the survey. Every organization clearly used benefit/risk results in making decisions about accepting, using, rejecting and deleting technologies. Surprisingly, nearly every organization also used economic outcomes to help make decisions. Such results may not have always been formal benefit/cost evaluations (i.e., about 50% used budget impact primarily) but there was at the least the recognition about making trade-offs of benefits and costs among alternatives.

**CONCLUSIONS:** These results are contrary to other published studies, based mainly on opinions and perceptions that found little use of economic analysis in health care decision making. Post hoc studies of actual decisions made in UK, Australia of formal analyses, and in Canada of less formal methods, confirmed use of benefit/cost results. Measuring actual behavior on use of economic outcome evaluations in health care decision making provides different answers than soliciting opinions and perceptions of others’ use of these results.

**SESSION III**

**QUALITY OF LIFE OUTCOMES I**

**HEALTH-RELATED QUALITY OF LIFE IMPROVEMENTS IN AN EVIDENCE-BASED ASTHMA DISEASE MANAGEMENT PROGRAM**

**QL1**

**Muszbek N1, Szende A2, Kuntár A3**