terms of observable characteristics such as age, gender, and comorbidities (p<0.001). Samples were balanced with nearest neighbor matching. Then segmented time-series models were applied. There was a significant association between the onset of intervention and the level of utilization of these drugs.

CONCLUSIONS: To determine the effects of guidelines, we need to control for three different factors: 1) baseline differences between the two groups; 2) stepwise differences at the intervention point; and 3) trend differences after the intervention. We showed that propensity score matching can be used for the first factor, and the latter two can be controlled with the interrupted time-series model.

PM5: THE BURDEN OF CAREGIVING: ASSESSING THE STATUS OF CURRENT CLINICAL RESEARCH

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OBJECTIVES: The burden of caregiving is high. In 2009 there were an estimated 65.7 million caregivers in the U.S. (29% of the adult population) and these numbers are expected to swell in the coming years with the ageing population. Caregiving impacts on the health, wellbeing and work productivity of the caregiver, therefore research aimed at assessing and reducing the burden of caregiving is warranted.

The objective of this study was to assess the status of current clinical research into the burden of caregiving. METHODS: Clinicaltrials.gov was searched for trials where caregiver burden (CB) was reported. Information on the care-recipients characteristics (CRC), the primary focus of the study, and the type of intervention being considered, was extracted from the included trials. RESULTS: 80 trials were identified that measured a reported outcome of CB. The most common CRC was Alzheimer’s disease and related disorders (34 studies), followed by cancer (14), frail elderly with or without comorbidities (7), Parkinson’s disease (7), brain and spinal cord injury (5) and ‘other’ (5). A range of questionnaire-based instruments were reported used across studies to elucidate the physical, emotional (psychological), social and financial impacts of caregiving. The role or burden of the caregiver was a key focus in 55% of the studies. trials involving care of cancer patients had the highest proportion of caregiver-focused studies (12/14, 86%). Behavioural and drug interventions were the most frequently investigated intervention type (38% and 25% of trials, respectively), although no studies investigating a ‘drug’ intervention evaluated the effect on caregivers as a primary outcome. CONCLUSIONS: Current clinical research into the burden of informal caregiving is concentrated in age-related CRCs. Research interventions aimed at relieving CB are mostly behavioural in nature. The growing number of caregivers means that research into effective methods of reducing CB will be of ever increasing importance.

Research on Methods – Cost Methods

PM6: WHAT IS IMPORTANT DURING THE PHARMACOECONOMIC EVALUATION OF CAM (COMPLEMENTARY AND ALTERNATIVE MEDICINES?) – A SURVEY RESEARCH

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OBJECTIVES: The increasing popularity of Complementary and Alternative Medicine (CAM) leading to an increasing interest of CAM assessment through pharmacoeconomic of TCM, and module two about the influencing factors of measuring the impact of CAM on economic of TCM. In Module 2, 4 common factors from 31 medical and research institutions of 8 provinces and cities in China giving a response rate of 91%, module 1 and 2 all passed the KMO and Bartlett’s test of sphericity test (kmo module 1=0.56, kmo module 2=0.66). Module 1 extracted 4 common factors after the Rotation Factor Analysis with cumulative variance of 69%, while Module 2 extracted 3 with cumulative variance of 70.6%. CONCLUSIONS: The common factors from Module 1 prompted us to pay attention to during the pharmacoeconomic of TCM, and to ascertain influencing factors of measuring HR-QOL in TCM. METHODS: A questionnaire (with 20 close and open-ended questions) was distributed to TCM practitioners who had been working in the field for at least 5 years and had published at least one related paper in the last 5 years. The questions were divided into two modules with module 1 about the issues of pharmacoeconomic of TCM, and module 2 about the influencing factors of measuring HR-QOL in TCM. Correlation and Partial Correlate test using age and professional title as control variable were used to module 1 and 2 respectively, non-related factors were excluded. Principal Component Analysis (PCA) was performed for remaining items. RESULTS: Of 429 questionnaires issued, 137 were recovered from 31 medical and research institutions of 8 provinces and cities in China giving a response rate of 31.9%. Module 1 and 2 all passed the KMO and Bartlett’s test of sphericity test (kmo module 1=0.56, kmo module 2=0.66). Module 1 extracted 4 common factors after the Rotation Factor Analysis with cumulative variance of 69%, while Module 2 extracted 3 with cumulative variance of 70.6%. CONCLUSIONS: The common factors from Module 1 prompted us to pay attention to during the pharmacoeconomic of TCM, and to ascertain influencing factors of measuring HR-QOL in TCM. The overall economic burden of patients. The common factors from Module 2 required us to note during the HR-QOL research. Acceptance level of the measurement scale by patients and physicians; disease complexity, and whether HR-QOL scale reflects the characteristics of TCM.

PM7: DEEP DEVELOPMENT OF AN INCREMENTAL COST-EFFECTIVENESS RATIO WITH SOME EQUITY IMPLICATION

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OBJECTIVES: The conventional ICER (incremental cost-effectiveness ratio), which quantifies how many dollars are spent per QALY (quality-adjusted life year) gained from a specific health technology, has been criticized as unfair to the aged and/or physically challenged. METHODS: By taking the position that every life is equally important and every citizen is entitled to access health care services for the entire duration of his/her life expectancy, we replace the denominator of the conventional ICER, with the proportion of life, which is the quality-adjusted life expectancy (QALE) gained from the specific health technology divided by the QALE of the corresponding age- and gender-matched general population. The numerator is converted to the additional monetary cost spent over a lifetime after adjustment for annual discount rate. The new indicator quantifies how many dollars are spent to save the life of a person with a specific illness, and how much can be saved by preventing the occurrence of that illness. RESULTS: We have applied the estimation method to compare patients with liver cancer, breast cancer, acquired immunodeficiency syndrome, maintenance hemodialysis and peritoneal dialysis, and prolonged mechanical ventilation. CONCLUSIONS: Because the proposed indicator accounts for a fair opportunity for the aged and disabled more than the conventional ICER does, we recommend that this indicator be applied in future deliberations of health care resource allocation.

PM8: DRUG DEVELOPMENT AND PHARMACEUTICAL PRICING IN THE UNITED STATES: THE INFLUENCE OF DRUG INTENDED OUTCOMES OF DRUG PRICING

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OBJECTIVES: Determination of the price of a drug starts in its early developmental stages and it is driven by various competitive health market forces. The purpose of the study is to explore associations between pharmaceutical pricing and the value of drug outcomes. METHODS: Based on the data from Clinicaltrials.gov we have identified three different drug categories: life saving drugs, drugs that are not life saving but save lives over time, and drugs that only treat disease symptoms and affect QOL. We have investigated our theory of an association between drug intended outcomes and the price tag placed on a drug by performing a literature review of cost analyses for drugs selected in each category. The literature review included a combination of key words such as the name of the drug, cost-effectiveness, cost-utility, and QALY. We identified articles from the past 10 years published only in the English language. For each drug, studies reporting ICER/QALY values were selected. ICER/QALY data were recorded and the values of the three categories were compared among each other and with the published acceptable QALY threshold value of US$64,000. RESULTS: For the life saving drugs group the highest ICER/QALY value is US$150,843 and lowest is €105,599 among each other and with the published acceptable QALY threshold value of US$64,000. We have investigated our theory of an association between drug intended outcomes and the price tag placed on a drug by performing a literature review of cost analyses for drugs selected in each category. The literature review included a combination of key words such as the name of the drug, cost-effectiveness, cost-utility, and QALY. We identified articles from the past 10 years published only in the English language. For each drug, studies reporting ICER/QALY values were selected. ICER/QALY data were recorded and the values of the three categories were compared among each other and with the published acceptable QALY threshold value of US$64,000. RESULTS: For the life saving drugs group the highest ICER/QALY value is US$150,843 and lowest is €105,599 among each other and with the published acceptable QALY threshold value of US$64,000. For the life saving drugs group the highest ICER/QALY value is US$150,843 and lowest is €105,599.