dures using devices to conventional open surgery. Indirect cost savings benefit patients, employers and society as a whole and therefore are important costs to consider.

**METHODS:** We searched the literature and identified studies in which “indirect cost”, “convalescence” or “work loss” were included in the analysis. All articles published since 1990 on menorrhagia (laparoscopic hysterectomy/endometrial ablation versus open hysterectomy), Gastroesophageal Reflux Disease (GERD) (laparoscopic versus open Nissen fundoplication), and coronary artery disease (Percutaneous Transluminal Coronary Angioplasty (PTCA) versus Coronary Artery Bypass Graft (CABG) surgery) were reviewed. Key information abstracted included: days of work lost, direct and indirect cost estimates, costing methodology, and follow-up period. The percentage impact, measured as the change in the difference between the total cost of open surgery compared to the less-invasive procedure due to the inclusion of indirect cost, was calculated. **RESULTS:** The review produced 11 articles on menorrhagia, 5 on GERD, and 5 on coronary artery disease. There were large differences in the average days of work loss between open surgery and less-invasive procedures; 21 days for laparoscopic versus 40 days for open hysterectomy, 15 days for laparoscopic versus 35 days for open fundoplication, and 27 days for PTCA versus 74 days for CABG. The percentage impact or difference in total cost due to the inclusion of indirect cost was on average 32.8% (4.4%–69.4%). **CONCLUSIONS:** Cost savings associated with minimally invasive surgery compared to open surgery are significantly increased when indirect costs are included in the assessment. Future economic outcome studies should attempt to include indirect cost measures to fully capture the benefits of devices and minimally invasive procedures.

**QUALITY OF LIFE & PREFERENCE-BASED MEASURES**

**DOES SOCIOECONOMIC STATUS AFFECT THE VALUATION OF HEALTH?**

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**OBJECTIVE:** The issue of whose values count in the evaluation of health interventions is central to decision-making in all health care systems. Within the health services research community there is a degree of consensus that population-based preference weights should be used as the quality-adjustment factor in determining the value of health outcomes. However, previous research indicates an inverse, graded relationship between socioeconomic status (SES) and an individual’s own health. If SES is also found to influence the valuation of hypothetical health states, then this could prove to have significant consequences for the evaluation of treatment. **METHODS:** Values for hypothetical health states defined by EQ-5D (a generic measure of health-related quality of life) were collected from a representative survey of the UK general population. 2,997 individuals used time trade-off (TTO) methods to value these EQ-5D health states. Information on each respondent included age, gender, social class and educational attainment. TTO values were bounded and non-normally distributed necessitating methods such as ordered logistic regression in addition to OLS to analyze these data. **RESULTS:** Education and social class as proxies for SES were significant predictors of the mean values for hypothetical health states. Their influence on health state valuation appears to act through their interaction with the mobility and self-care dimensions of the EQ-5D. This relationship persists after adjustment for respondent demographic characteristics. **CONCLUSIONS:** Valuation of hypothetical health states appears related to SES. This has implications for cost-effectiveness analysis since valuations from one population with a particular SES distribution may not be applicable for health policy and medical decision-making in other populations. The relationships between SES and health state valuation merit further investigation, in particular to examine the impact of non-health consequences such as income on values.