burden of disease in The Netherlands. METHODS: Review of the literature. To select which interventions to include, a two-step approach was followed. In the first step, a longest with possible interventions was created, based on a systematic search of the economic evaluations of relative new preventive interventions. In the second step, all interventions that a) were not systematically implemented in The Netherlands during the study; b) were relevant for the Dutch situation; and c) had at least three high quality economic evaluations with base case ICERs of around or below € 20,000 per QALY gained, were selected. For all included interventions a general appraisal of four aspects (effectiveness, cost-effectiveness, transferability and feasibility for implementation) was performed. RESULTS: Twenty-eight preventive interventions were included. Twenty-two of these were from the field of disease prevention, including eight vaccinations and seven screening programmes. Three interventions concerned health promotion, and three interventions concerned health protection. Remarkably, the majority of the included interventions lacked a convincing evidence-base for effectiveness. The results were generally not directly transferable to the Dutch context and there were considerable concerns with respect to implementation of these interventions in The Netherlands. CONCLUSIONS: Only 20% of the included preventive interventions were from the domain of health promotion or health protection. This proportion reflects the lack of economic evaluations in these domains of prevention, not that interventions in these domains are generally not cost-effective. Evidence of cost-effectiveness of preventive interventions in foreign countries can poorly support policy decision making at the national and local level.

LINKING HOSPITAL ADMISSION DATA INTO PRIMARY CARE RECORDS WITHIN THE GENERAL PRACTICE RESEARCH DATABASE

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OBJECTIVES: The General Practice Research Database (GPRD) is a premier data source for research but has limited detail on hospitalisations. UK Hospital Episode Statistics (HES) provide detailed health care resource use within secondary care. The aims of this project were to link primary care data with hospital admissions data at the patient level. METHODS: For contributing practices in England who gave explicit consent, GPRD patient data was linked to English HES data from April 2001 to March 2006 using NHS number, or using date of birth, gender and postcode; via a trusted third party (TTP) with full ethical and operational approvals. A descriptive analysis was conducted on the linked HES data including basic counts and univariate statistics. Analysis of concordance between data sets relating to disease diagnosis was undertaken on a fifty patient sample. RESULTS: Two hundred practices consented and provided linkage data to the TTP. There were 2,009,920 GPRD patients registered within the HES data, 99.3% with a valid NHS identifier. Of these, 1,242,242 (62%) had no record of hospitalisation during this period. The remaining 754,406 patients had 2,028,473 hospital spells comprised of 2,285,718 episodes. Mean duration of hospitalisation was 5.76 days (median = 2 days). Augmented care (ICU) stays were recorded for 2.6% of patients with mean duration = 4.97 days (median = 3 days). Hospital diagnoses were concordant for >75% of diagnoses reviewed. CONCLUSIONS: A very high proportion of eligible patients in GPRD were linked to HES using their NHS identifier. Initial descriptive analyses show a significant proportion of GPRD patients have one or more hospitalisation with good concordance of diagnosis between the two sources. The addition of HES data with duration and information on augmented care will facilitate the understanding of resource use in both hospitalisations and primary care which can result in more robust estimates for economic modelling and other research.

INVESTIGATING THE PROMOTION OF HEALTH BEHAVIOR AND HEALTH-RELATED QUALITY OF LIFE BY APPLYING SELF-DETERMINATION THEORY: USING “EXERCISE” AS AN EXAMPLE

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OBJECTIVES: In order to prevent chronic diseases, individuals should actively pay more attention to their own health conditions and not merely rely on the medical system passively. The purpose of this study attempted to investigate the impact of individual health behaviors, specifically the exercise behavior, to his/her health-related quality of life from “positive” viewpoints by applying Deci & Ryan’s self-determination theory (SDT). METHODS: Four hundred and thirty-two undergraduate students at National Taiwan University participated in this study. Four sets of questionnaires concerning the basic psychological needs in exercise, health motivation, exercise behavior, and quality of life (i.e., WHOQOL-BREF) were used in this study. The quantitative analysis of the questionnaires was conducted through descriptive statistics and structural equation modeling (SEM) in order to indicate any relationships between two latent factors or a latent factor and a manifested variable. RESULTS: Results of this study showed that there were stronger relationships between the basic psychological needs in exercise, the intrinsic health motivation, the exercise behavior, and the psychological domain of quality of life. Furthermore, the basic psychological needs in exercise were also linked directly to the psychological domain of quality of life. The results also indicated that the viewpoint of SDT can be used for predicting the health-related quality of the life. There was a relationship between the basic psychological needs in exercise and health-related quality of life. CONCLUSIONS: To conclude, the study shows that the satisfaction of three basic psychological needs can increase personal intrinsic health motivation, enable people to care about their own health more voluntarily, increase the possibility to do health behavior, and then lead to a better health-related quality of life.