Asthma Control Questionnaire (ACQ) and with FEV1, were as expected ranging from −0.76 to −0.58 (RL −0.69) and −0.02 to 0.41 (RL 0.08) respectively. Similarly, correlations with change from baseline for ACQ and FEV1 ranged from −0.83 to −0.61 (RL −0.78) and −0.11 to 0.56 (RL 0.03). The AQLQ showed ability to detect changes in ACQ over time in all languages except Danish. CONCLUSIONS: The finding that internal consistency, construct validity and responsiveness were consistent across languages and similar to the RL provides evidence of the quality of these translations and supports the combining of data for analyses.

**PR23**

**IS THE EQ-SD RESPONSIVE TO RECOVERY FROM A MODERATE COPD EXACERBATION?**

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OBJECTIVES: To appreciate the effectiveness of treatments that reduce the frequency or severity of chronic obstructive pulmonary disease (COPD) exacerbations, the quality of life gains that result from this reduction should be adequately included. In the nary disease (COPD) exacerbations, the quality of life gains that reduce the frequency or severity of chronic obstructive pulmonary

To appreciate the effectiveness of treatments that reduce the frequency or severity of chronic obstructive pulmonary disease (COPD) exacerbations, the quality of life gains that result from this reduction should be adequately included. In the current study, we evaluated the ability of the EQ-SD to reflect the course of a moderate exacerbation. METHODS: The study was designed as a prospective cohort study in which the change in EQ-SD scores over a period of 6 weeks was studied. 59 US patients, 40 year or older visiting the clinic with a moderate exacerbation were seen 4 times, i.e. during the screening visit and approximately 8, 14 and 43 days thereafter. Patients completed the EQ-SD at each visit. ‘Baseline’ EQ-SD was defined as the lowest of EQ-SD scores at visit 1 and 2, to capture the point at which the impact of the exacerbation is most severe. Standardized Response Mean (SRM) was calculated as the change divided by the standard deviation of change. RESULTS: The mean EQ-SD-VAS and utility scores at baseline were 37 (SD 25; range 1–85) and 0.68 (SD: 0.21; range 0.17 to 1.00), respectively. Estimated improvements in VAS scores at visit 3 and 4 were 11.8 (p < 0.0012) and 13.9 (p < 0.0001), respectively. Estimated changes in utility scores were 0.1607 (p < 0.0001) and 0.1534 (p < 0.0001), respectively. SRM for EQ-SD utilities was 0.65, which was comparable with SRMs for symptoms (cough: 0.587, dyspnea 0.638). Patients with improvement in peak flow above the median had a larger improvement in utility (p = 0.030) and VAS (p = 0.012) than patients with improvement below the median. Based on curve estimation, an exacerbation results in average loss of 0.00188 QALY, compared to the same period with no exacerbation and 0.0286 compared to perfect health. CONCLUSIONS: EQ-SD VAS and utility are responsive to recovery from a moderate exacerbation, but changes are small.

**PR24**

**QUALITY OF LIFE RESULTS USING THE EUROQOL QUESTIONNAIRES AND DIRECT MEDICAL COSTS IN ASTHMATIC PATIENTS. CHAS STUDY**

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OBJECTIVES: To assess the association between the degree of asthma control and quality of life and to estimate the direct medical costs associated with asthma in real life practice. METHODS: An analytical, cross-sectional study. Study units are primary care users diagnosed of asthma from all over Spain, aged 18 years or older. A multistage cluster sampling has been used for sample selection: 230 participating primary care physicians. The Asthma Control Questionnaire (ACQ) was used to measure asthma control and EQ-SD / EQ-VAS were used to measure quality of life in asthmatic patients. The Spearman rank correlation coefficient was calculated in order to assess the relationship between asthma control and quality of life. Information regarding health care resources (hospitalization days, emergency room visits, primary care visits and absenteeism days) during the 12 months prior to the visit was collected, expressed as 2008 euros (according to public tariffs available and inflation rate). RESULTS: Overall, 2159 patients have been evaluated, 42.2% males, mean age 48.5 (95%CI: 47.7–49.2). Of these, 37.4% (95%CI: 35.3–39.4) were uncontrolled (score > 1.5) according to ACQ. EuroQol EQ-SD mean score was 0.82 (95%CI: 0.81–0.83). Spearman rank correlation coefficient between ACQ and EQ-SD scores was −0.48879 (p-value < 0.0001), and between ACQ and EQ-VAS scores was −0.54942 (p-value < 0.0001). Hospitalisations over the last year, resulted in a direct cost of €54.85 per year and patient. In the same way, emergency room visits €271.17, primary care visits €161.31 and absenteeism €322.89. CONCLUSIONS: Better asthma control is associated with better quality of life in asthmatic patients. Poor asthma control leads to a higher use of health care resources and therefore higher direct medical costs in asthmatic patients.

**PR25**

**THE PUBLIC’S WILLINGNESS TO PAY FOR A QALY IN THAILAND**

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OBJECTIVES: In Thailand, health care resource allocation is increasingly relying on economic analysis though the presentation of incremental cost per Quality Adjusted Life Year (QALY) is still arbitrary given a lack of consensus regarding the appropriate monetary value per QALY gained upon which to base resource allocation decisions. Using the societal perspective this study aims to explore the feasibility of establishing the monetary value per QALY gained for use in health resource allocation in Thailand. It also examined, if available, the differences in monetary value per a QALY gained for different disease severities, and between prevention and curative interventions. METHODS: Between March and June 2008 a random sampling household survey was conducted in eight provinces throughout the country where 1,080 participants aged between 15–65 years were interviewed face-to-face. Each respondent was randomly asked for the preferences of current health state and one of the following hypothetical states namely unilateral/bilateral blindness, hemi/quadric-paralysis, and mild/moderate-allergy using time traded off (TTO) and visual analogue scale (VAS). The willingness to pay (WTP) for prevention and treatment of a given scenario were elicited using the payment card method. RESULTS: The WTP per QALY ranged from 0.5–2.5 times of the average annual income. The relationship between the WTP per QALY and the severity of illness appears to be an inverted ‘U’ shape. The WTP per QALY were significantly higher for treatment than prevention. CONCLUSIONS: The participants highly valued the quality of life; however, the WTP was severely limited by the ability to pay especially when the program does not allow participants to gradually pay over a long period of time (paying all within three months in this case). It seems not possible to obtain a single value of WTP per QALY which clearly conflicts with the expected utility theory.