questionnaire. METHODS: Data from the Health Survey for England (HSE) of 1996 (n = 16,443) and 2006 (n = 14,142) were selected in order to assess variation in population health status over a 10 year period. Both surveys covered population aged 16 years and over living in private households. The sample is regularly drawn using a multistage stratified random sampling design. Postcode sectors are the primary sampling units.

Given that only the EQ-SD descriptive system is included to describe self-reported health in the HSE, a predicted EQ-SDVAS was estimated for each respondent based on a regression model developed from data of the 1993 York Measurement and Valuation of Health Project. RESULTS: Despite being older (2.59 years on average, p-value <0.001) and having a slightly higher proportions of women (0.8 percent, p-value 0.156), the 2006 HSE reflects that English population has significantly (p-value <0.001) reduced its prevalence of self-reported health problems in the last 10 years in those under the EQ-SD dimensions: usual activities, pain/discomfort and anxiety/ depression. Mobility and self-care dimensions, although higher in prevalence, did not reach statistical significance at 5% level when both years were compared. Health improvements over time were also reflected in the utility-weighted EQ-SDINDEX and predicted EQ-SDVAS (p-value <0.001), having the 16-44 age-group and women the highest health gains. CONCLUSIONS: EQ-SDV is a useful tool for monitoring population health. Our findings will assist local policymakers and public health authorities by improving their knowledge about trends in self-perceived health.

ASSESSING THE QUALITY OF CONJOINT ANALYSIS APPLICATIONS IN HEALTH: A PILOT EVALUATION OF THE ISPOR CHECKLIST FOR GOOD RESEARCH PRACTICE IN CONJOINT ANALYSIS

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OBJECTIVES: Increasingly, conjoint analysis, a stated-preference method, is applied in health outcomes research. Variation in method type and quality make it difficult to assess substantive findings. The ISPOR Conjoint Analysis Database Project was established to identify and evaluate empirical conjoint analysis applications in the literature using the 10-point ISPOR Checklist for Good Research Practice in Conjoint Analysis (the Checklist). METHODS: Multiple electronic databases published between 1980 and 2008 were searched to identify conjoint-analysis applications in human health studies. Only English-language publications were incorporated. Included studies were subject to detailed data extraction including descriptive information, methodological details on survey type, experimental design, survey format, attributes and levels, sample size, number of conjoint tasks per respondent, and analysis methods. Review articles and studies where there was a relative lack of descriptive data in multiple publications were excluded. The data extraction form was piloted to identify key elements to be included in the database using a standardized taxonomy and to test the Checklist as an evaluative framework for the methodological assessment of these studies. RESULTS: The search identified 2,363 citations – 264 met inclusion criteria. The number of applied studies increased substantially over time (1980 – 5 and 2007 – 42) in a broad range of applications, cancer being the most frequent. Based on the pilot results, discrete-choice experiments using fractional factorial designs were most common. Attribute number ranged from 3–6, choice tasks per respondent ranged from 8–16 and sample size ranged from 30–335. Studies generally reported key elements more than required by the 10-point ISPOR Checklist; especially concerning the translation process. CONCLUSIONS: Conjoint analysis in health is expanding to include a broad range of applications and methodological approaches. The Checklist provides a framework to assess their quality. The conjoint analysis Database project will complete the assessment of the quality and variability of these studies based on the pilot findings.