LETTERS TO THE EDITOR

A Reply to Comment on the Use of Vignettes and the EQ-5D to Value Disease-Specific Health States

To the Editor – In this letter, we would like to address Kularatna et al.’s concerns about our recent study “Estimation and Comparison of EQ-5D Health States' Utility Weights for Pneumococcal and Human Papillomavirus Diseases in Argentina, Chile, and the United Kingdom” published in Value in Health. First, the authors of the letter express concerns about the use of vignettes. The approach we used is neither novel nor unusual (some recent examples can be seen in Janssen et al. [1] or Xie et al. [2]). Each vignette was designed to present a disease as close to clinical reality as possible. Typical clinical cases were depicted, and they were not oriented to map the EuroQol five-dimensional (EQ-5D) questionnaire (in fact, the variability we found in the scores for each condition as well as in the descriptive states shows this). Vignettes were indeed developed, as Kularatna et al. suggest, by clinicians who have access on an everyday basis to patients suffering from the studied conditions. Furthermore, the vignettes were first piloted with members of the general population. Because of space constraints, some of these details were not described in the article. We were confident though that interested readers would contact us to get more information about this process.

Then the authors of the letter make reference to the translation and linguistic validation of the vignettes, taking for granted that the vignettes were used in the United Kingdom, Chile, and Argentina. Unfortunately, this is a misunderstanding because, as is stated in the study article, the vignettes were administered only in Argentina: “…12 health state vignettes (…) were designed, pilot-tested, and administered to a convenience sample of subjects in Argentina.” We did it in only one country because the objective was to compare EQ-5D questionnaire health states' preference values "using the same health states' descriptive mix in the three countries” as is also described in the beginning of the article. Furthermore, this is emphasized in the discussion because it is a central aspect of our study, which shows that “utility coefficients for each condition differed significantly between the three analyzed countries even considering that the same health states' mix was valued in all three countries.” If this issue is not taken into consideration, the interpretation of the whole study will be flawed. Needless to say, translation and linguistic validation were not explained simply because they were not needed.

Regarding Kularatna et al.’s suggestions about alternative methods, preference elicitation methods were never the main objective of this study. Social preference values were already available, and so we were not interested in measuring them. On the other hand, obtaining a sample of patients for all health states in the three participant countries would have been ideal. If we collected data from patients in the three countries though, we would have missed the opportunity to compare EQ-5D questionnaire utility weights exclusively because in that case both the five-digit EQ-5D questionnaire numbers and the utility weights would have varied from country to country. Even if we did it in only one country, this approach would have required primary data collection from patients in each of the 12 disease states, and recruiting sufficient number of subjects for each state of each of the diseases was clearly out of our possibilities and plans.

Finally, the authors of the comment strongly advise not to repeat our approach but to use “sensible and scientifically valid methods” instead. Many still assume that utility values used in economic evaluations are transferable from place to place and use weights from other settings for quality-adjusted life-year calculations, but it has been consistently shown that there are systematic differences in social values among different countries-regions [3–9]. Therefore, we cannot emphasize enough the relevance of advancing in the field, even with low-resource-intensive approaches as the one we took. Because of the scarce research in this area in Latin America and the high contribution of the reported conditions to the regional burden of disease, we still think that our study has made a relevant regional contribution.

This was a small study, as is acknowledged from the very beginning, “[although this study was a substudy of a larger project…]” The fact that a study is small, however, is not related to its quality or the validity of its results. Health states could indeed be described in a different way, but this was not relevant in this practical exercise because what was tested was whether the country valuations were significantly different using the same set of health states. The fact that they are significantly different addresses the importance of using local and not foreign weights in context-specific analyses, and to show this with a realistic scenario was the rationale of the study.

We understand Kularatna et al.’s concerns given the incomplete flawed interpretation of the study. To indicate, however, that a study lacks scientific validity is a rather serious matter and should be soundly justified after a deep understanding of the objectives and methods used in the study being criticized. Contact details are included in every published article. Critics should evacuate all their doubts through this channel before making such strong and general remarks. Criticism in science is absolutely vital, but it should be as sensible and scientifically valid as the work that is being criticized.

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Comment on the Use of Vignettes and the EQ-5D to Value Disease-Specific Health States

To the Editor – We are concerned about the techniques used in an attempt to elicit utility weights reported in the recent article by Galante et al. titled “Estimation and comparison of EQ-5D health states’ utility weights for pneumococcal and human papillomavirus disease in Argentina, Chile, and the United Kingdom” in the July/August 2011 issue of Value in Health titled “3rd Special Issue: Pharmacoeconomics and Outcomes Research in Asia” [1]. That study aimed to estimate and compare the utility weights for health states associated with pneumococcal and human papilloma virus for Argentina, Chile, and the United Kingdom.

The investigators developed eight vignettes for pneumococcal health states and four vignettes for human papillomavirus states. After the vignettes were described to convenience samples, subjects completed the EuroQol five-dimensional (EQ-5D) questionnaire for each state described. Their responses were collated as five-digit numbers given for each EQ-5D questionnaire health state and paired with their available corresponding utility weights in each country.

The major shortcoming with this approach is that the responders “rate” the health state description on the EQ-5D questionnaire. If the health state was described by using the domains of mobility, personal care, usual activities, pain, and anxiety/depression (i.e., the EQ-5D questionnaire domains), then the respondents merely need to map the description to the EQ-5D questionnaire levels. The health states that are well described would result in all respondents scoring identical levels for each domain. For example, a health state could be described as “no problems walking around, some problems with washing or dressing, unable to perform usual activities, moderate pain or distress, and extreme anxiety” and all respondents would score this as 12323 on the EQ-5D questionnaire.

Rather than undertaking a poorly designed and flawed experiment, there were at least two alternative methods open to the authors [2]. One approach is scenario based using vignettes developed with patients and clinical experts. The vignettes, in turn, can be valued by subjects by using a preference elicitation technique such as the standard gamble or time trade-off where the value obtained for each vignette may differ with the desirability or the preference of each subject toward the given scenario [3]. The second more practical method available to the authors would have been, because all the three countries had already valued EQ-5D questionnaire utility weights, to obtain a sample of “patients” with different degrees of disease severity of pneumococcal and human papillomavirus in each country and to administer the EQ-5D questionnaire to the patients to describe the health state they were experiencing. Then the appropriate utility scoring algorithm for the respective country could be applied [4].

We cannot emphasize enough the need to use sensible and scientifically valid methods rather than repeating approaches such as those described by Galante et al.

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REFERENCES


