tion after hearing aid fitting. METHODS: The study consisted of a prospective study of fitting hearing aids in hearing impaired adults (N = 96), with 2 measurements: before hearing aid fitting, and 12 weeks afterwards. On both occasions the patients valued and described their actual hearing related health state. Descriptions of the health states before and after hearing aid fitting were used to obtain valuations in: 1) healthy persons without any illness experience; 2) persons with medical experience with visual impairment; and 3) persons with medical experience with hearing impairment (N = 26 each). Data were tested for between-group differences and influence of gender and education level using ANOVA. RESULTS: The valuations for the health states before and after hearing aid fitting differed between the groups (p = 0.001 and p = 0.011 respectively). The highest average valuations were observed in the group with medical experience with hearing impairment. The change in health state valuation after intervention was not different between the groups (p = 0.295). Gender and education level did not influence the results. CONCLUSIONS: The results confirm that illness experience influences health state valuations. Although the study groups were relatively small and hence the results should be interpreted with some caution, as opposed to earlier findings in this study persons with experience through medical knowledge had higher valuations than patients, and change in health state after intervention was not influenced by illness experience.

THE INFLUENCE OF ILLNESS EXPERIENCE ON VALUATION COMPRESSION
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OBJECTIVES: Objective was to investigate whether persons with illness experience (personally or through medical knowledge) use a smaller proportion of the VAS to value health states than persons without illness experience. METHODS: The study consisted of a survey in a patient group: 1) hearing impaired persons (N = 96), and in three groups without personal illness experience (N = 26 each); 2) persons without illness experience, 3) persons with medical experience with visual impairment, and 4) persons with medical experience with hearing impairment. All subjects were asked to value the hypothetical health states “asthma” (mild state) and “heart failure” (severe state) on a generic VAS. Results were tested for between-group differences and influence of gender and education level using ANOVA. RESULTS: The valuations for “asthma” varied from 0.46 (sd 0.18) in the group with medical experience with hearing impairment to 0.67 (sd 0.20) in the patient group. The valuations differed statistically significantly between the groups (p = 0.002). The valuations for the severe marker state “heart failure” ranged from 0.19 (sd 0.19) in the patient group to 0.24 (sd 0.17) in the group with medical experience with hearing impairment. The valuations did not differ statistically significantly between the groups (p = 0.603). The patient group used the largest proportion of the VAS (0.49), and the group with medical experience with hearing impairment the smallest proportion (0.21). These proportions differed statistically significantly between the groups (p = 0.002). Gender and education level did not influence the results. CONCLUSIONS: The result did not confirm that patients use a smaller proportion of the VAS than persons without illness experience. Since the valuations for “heart” were equal among the groups, this was largely because the patients had higher valuations for the mild health state, which is in concordance with earlier findings that personal illness experience leads to lower valuations for better health states.

ASSESSING QUALITY OF LIFE IN THE ELDERLY: A COMPARISON OF TWO UTILITY MEASURES
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OBJECTIVES: Accurately assessing changes in the quality of life of elderly people is becoming increasingly important. Generic instruments are the most popular method by which to assess quality of life; the EQ-5D in particular for economic evaluation. However, this instrument has been criticised as having insufficient dimensions, insensitive scales and concerns over completion rates. A possibly promising new alternative appeared to be the Assessment of Quality of Life (AQol) instrument developed in Australia. This purported to offer greater richness in dimensions, and sensitivity to small changes in quality of life. We describe a “head-to-head” comparison of the EQ-5D and AQol. METHODS: As part of a large trial investigating domiciliary medication review, the 2 instruments were used to assess changes in health status in 145 patients over 80 years old. Questionnaires were administered by researchers at baseline and by post at three months and six months. This study describes: (a) the practicality of using the questionnaires; (b) test performance, in terms of construct validity and internal consistency; (c) agreement of instruments, in terms of absolute utility scores and changes in scores over follow-up; and (d) sensitivity to changes in health status. RESULTS: The EQ-5D proved easy to administer with good response rates to postal follow-up (81%). 15% fewer AQol questionnaires were returned fully completed (95% CI 12–19%). The construct validity appeared to possibly favour the AQol. However, over 6-months follow-up the EQ-5D changed by 0.16 units versus AQol change of 0.12 units (95% CI –0.14 to +0.003). Whilst the EQ-5D showed moderate sensitivity (effect size of 0.52) the AQol appeared to be poorly sensitive (effect size of 0.34). CONCLUSION: The results of the analysis presented in this paper suggest that the EQ-5D is a practical and sensitive tool with which to assess quality of life within the elderly.