treated with docetaxel-based chemotherapy. EQ-SD and FACT-P data were collected for a subset of patients at baseline and throughout the study until treatment discontinuation. The Rasch model was used to map three scales comparing the responses of patients’ EQ-SD index scores determined using the UK-tariff: (a) linear regression estimated by generalized estimating equation (GEE) algorithms; (b) two-part model (TPM) combining logistic and linear regression estimated by GEE algorithms; (c) separate mapping algorithms. The model is related to the health defined as the linear score.

To select the best model specification, four different sets of explanatory variables were compared. The models were fitted to the full dataset in cross-validated using a 10-fold in-sample cross-validation. The variance explained by the model was assessed by the marginal $R^2$. Model performance was assessed by comparing predicted and observed mean EQ-SD scores, the mean absolute error (MAE) and the root mean squared Error (RMSE). RESULTS: Values for both FACT-P and EQ-SD were available for 234 patients. The TPM model including the FACT-P sub-domain scores and demographic variables was the best performing model (marginal $R^2 = 0.689$ providing the most accurate predictions). The physical well-being and prostate cancer specific subscales in the logistic part and functional and emotional well-being subscales in the linear regression part had the highest explanatory power. CONCLUSIONS: The developed algorithms for mapping FACT-P to EQ-SD enable the calculation of appropriate preference-based HRQoL scores for use in cost-effectiveness analyses when EQ-SD data are missing or inadequate.

RASCH MODEL VALIDATION OF A PEER RELATIONS SCALE FOR PEOPLE TREATED FOR PSYCHOACTIVE SUBSTANCE USE DISORDER

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OBJECTIVES: Evaluation of the method for assessing self-rated somatopsychic health of alcoholic patients treated according to the Minnesota model, and changes during the five-month hospitalization. METHODS: Self-report questionnaire was used to assess well-being status, vegetative lability, sense of coherence, general health status and health behaviour. Health status was measured by the Optimal Living Profile (OLP) questionnaire on a scale regarding environmental, intellectual, spiritual, emotional, and social health questions, vegetative lability on the Hennenhofer-Heil scale (VLE), and Sense of Coherence on Antonovsky’s SOC scale. The results were assessed using descriptive methods as well as correlation analysis and Wilcoxon tests. RESULTS: The OLP scale minimized to 6 questions. Concurrent validity of the questionnaire was first assessed in a pilot study in alcoholic patients. Later patients receiving treatment at the Addictology Department of Szegvár Hospital (Hungary) were asked to fill out the questionnaire before and after the therapy. For a statistical analysis of the data we used descriptive methods as well as correlation analysis and Wilcoxon tests. RESULTS: When compared to the alphabetic index of Hennenhofer’s ($r = 0.75$, all correlations were significant), no significant difference was found in the matching sample of non-alcoholics (regarding sex, age and education). Sample of hospitalized patients included 51 patients (34 men, 17 women) with an average age of 46.1 years (SD 8.3, range 18–61). Compared to health and well-being status before the treatment there was a significant positive change which would be demonstrated both in dimensions of OLP and on VLE and SOC-scales. All cases showed $p < 0.001$ according to the Wilcoxon-test. CONCLUSIONS: The questionnaire was efficiently used for impact assessment of the Minnesota model – concerning somato-psychic status of alcoholic patients proved to be applicable. Results of the follow up were positive: somatopsychic and health status of the patients showed remarkable changes. Their intention to do more for their health has strengthened. Trust and belief in capabilities to improve health concerning issues of spiritual, social and physical health has become stronger.
tiple logistic regression models. As result of the very high correlation amongst MLHQ global score, physical and emotional dimensions we conducted three mod-
els, one for each MLHQ dimension. RESULTS: The alpha values were set based on the 49 participants, of which 27 were men (55%) and 22 were women (45%). The Cronbach’s alpha resulted in scores of 0.92 for the global scale, 0.90 for the physical scale, and 0.95 for the emotional scale. The test-retest reliability, calculated using intraclass correlation coefficients (ICCs), was excellent for all scales (ICC > 0.8). These results indicate that the MLHQ is a reliable tool for assessing health-related quality of life in patients with HIV.

**METHODS:**

We used the median values as the threshold for categorizing the HRQoL scores. The global score (MLHQ) and the physical and emotional dimensions (MLHQ-F and MLHQ-E) were used to calculate the median value. The results were then compared to the median values of the two subscales to determine if there was an association between the HRQoL and the presence of diabetes.

**RESULTS:**

The results showed that the median value for the MLHQ global score was 76.8 (10.7), and there were a 57.6% of men. At one year we observed 114 deaths (20.5%). Charlson index was divided into three categories, 0-1 (27.9%), 2-3 (38.8%) and greater than 3 (33.3%). The three multivariate models showed that both the total and individual Charlson index, on the basis of the models were significant predictors of mortality (p < 0.05). The models indicated that the higher the Charlson index, the greater the risk of mortality in the model.

**CONCLUSIONS:**

The results of this study indicate that the MLHQ is a reliable tool for assessing health-related quality of life in patients with HIV. The median value for the MLHQ global score indicates that the majority of patients have a good HRQoL.

**HEALTH SERVICES - Health Care Use & Policy Studies**

**PHS74**

**DOES DISEASE ADVOCACY IMPACT PRIORITY SETTING: EVIDENCE FROM THE NEEDS AND PRIORITIES FOR COMPREHENSIVE LIVER CANCER CONTROL IN 12 COUNTRIES IN EUROPE AND ASIA-PACIFIC**

**OBJECTIVES:**

To examine the impact of disease advocacy on the allocation of resources for liver cancer control in 12 countries in Europe and Asia-Pacific.

**METHODS:**

We used a cross-sectional survey design to collect data on the needs and priorities for liver cancer control in 12 countries in Europe and Asia-Pacific. The survey was administered online to healthcare professionals, patients, and advocacy organizations.

**RESULTS:**

The results showed that disease advocacy had a significant impact on the allocation of resources for liver cancer control. The countries that had higher levels of advocacy had a greater proportion of funds allocated to liver cancer control.

**CONCLUSIONS:**

Disease advocacy has a significant impact on the allocation of resources for liver cancer control in 12 countries in Europe and Asia-Pacific. Countries that have higher levels of disease advocacy allocate a greater proportion of funds to liver cancer control.