Except for one case, spearman's rank correlation coefficient between instruments was high (rho > 0.70). Furthermore, test-retest reliability in terms of ICC(3,1) was good for all instruments, i.e., 0.98 (95% CI, 0.82–0.99) for the BMJ check-list, 0.96 (95% CI, 0.75–0.99) for the CHEC list, and 0.95 (95% CI, 0.75–0.99) for the QHES instrument. Yet, they were poor agreement between the two examiners (kappa < 0.40 for most items and ICC(2,1) < 0.5). **CONCLUSION:** Findings highlight the subjective character of the assessment. Results are not influenced by the instrument used but more by the assessor. It is thus essential to perform quality analysis of economic evaluations by at least two experts and to base the final scoring on a consensus.

PODIUM SESSION I: PATIENT REPORTED OUTCOMES I

PR1

RECOMPUTING VALUES FOR EQ-5D IN ACCORDANCE WITH NICE APPRAISAL GUIDANCE

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OBJECTIVES: Measuring the QALY benefits of new health interventions is critically dependent on the values of the quality-adjustment index—putting the "Q" in QALYs. For many health-related quality of life indexes, including EQ-5D, there are multiple options when selecting the value set for use in a given application. For the purposes of health technology assessment in England and Wales the National Institute for Health and Clinical Excellence has published guidance that when conducting the appraisal of new health technologies the values of the relevant population should be applied. However, the standard set of values used to derive the $EQ\text{-}5D_{index}$ were collected from a national UK population survey that included Scottish respondents whose health care system is organised and funded separately from the NHS in England and Wales. This paper reworks the original UK survey data and presents a new set of weights for EQ-5D recalibrated using the appropriate population values. **METHODS:** The Measurement and Valuation of Health (MVH) survey methods have been fully described elsewhere. A total of 3395 individuals used ranking, rating and TTO methods to value a subset of 15 EQ-5D health states. A total of 360 of these respondents were citizens of Scotland. **RESULTS:** Scottish respondents reported similar health status compared to their English counterparts. However Scottish TTO values were systematically *higher* for 23/26 mild-moderate states and 16/17 states worse than dead were *lower* than English values. The Scottish data were removed from the MVH dataset and a new OLS regression model was constructed ($r^2 = 0.492$). 70% of values for EQ-5D health states in the revised model differ by more than 0.05 when compared with the original MVH values currently applied by NICE. The impact of applying these weights varies with the severity of the condition under review. **CONCLUSION:** The use of existing MVH weights appears contraindicated if English QALYs are required.

PR2

NON-PERSISTENT USE OF ORAL ANTIDIABETIC DRUGS LEADS TO 20% DECREASED CHANCE OF HBA1C GOAL-ATTAINMENT IN DAILY CLINICAL PRACTICE

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OBJECTIVES: Within the Dutch guidelines for treatment of Type 2 Diabetes Mellitus (T2DM), the target-value of HbA1c has been set at <7%. The aim of this study was to investigate the relationship between persistence with oral antidiabetic drug (OAD-)treatment and HbA1c goal-attainment in daily clinical practice. **METHODS:** From the PHARMO record linkage system, comprising among others, linked drug-dispensing, clinical laboratory, and hospital data for >2.3 million subjects in The Netherlands, new users of OADs were identified in the period 1999–2005. Patients who started on monotherapy with metformin, a sulphonylurea (SU), or a thiazolidinedione (TZD), or on combination therapy with metformin+SU, or metformin+TZD, with baseline HbA1c °Ý7% and at least one HbA1c-measurement in the period of 6–12 months after treatment-onset, were included in the study-cohort. Persistence with OAD-treatment in the first year of treatment was determined using the method of Catalan, and was defined as the duration of the first treatment-episode in days. In case the first treatment-episode overlapped with the date of a HbA1c-measurement, a patient was considered persistent at that measurement. Patients with HbA1c <7% were defined at goal. **RESULTS:** The study cohort included 2023 patients. Three-quarters (1512 patients) were persistent with any OAD at the time of first HbA1c-measurement in the time-period of 6–12 months after OAD-start: of these, 861 (57%) were at goal. Of the 511 patients who were non-persistent with any OAD at that time, 239 (47%) were at goal. Non-persistent patients were about 20% less likely to be at goal (RR-adj: 0.82; 95% CI: 0.74–0.91), compared to persistent users of any OAD. **CONCLUSION:** Non-persistent use of OADs leads to a 20% decreased chance of HbA1c goal-attainment in daily clinical practice. This effect of non-persistence seems modest, but represents a very large number of patients, in whom OAD-use might be better controlled.

PR3

PATIENTS', PARENTS', AND PHYSICIANS' RISK-BENEFIT TRADE-OFF PREFERENCES FOR CROHN'S DISEASE TREATMENTS

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OBJECTIVES: Compare the risk-benefit preferences of patients, parents of juvenile patients and gastroenterologists for Crohn's disease (CD) treatments. **METHODS:** Panels of CD patients, parents of juvenile patients and gastroenterologists completed a series of choice-format conjoint trade-off tasks with varying efficacy and risk levels. Parents evaluated treatments for their child, gastroenterologists evaluated treatments for three patients (young, middle-aged, elderly). Treatment attributes included daily symptom severity and activity limitations, potential for CD complications, time between flare-ups, systemic steroid use, and three SAE mortality risks: serious infection (SI), progressive multifocal leukoencephalopathy (PML) and lymphoma. Preference estimates were used to calculate the annual SAE-specific maximum acceptable risk (MAR) for various levels of clinical benefit. **RESULTS:** 342 patients, 105 parents of juvenile patients, and 315 gastroenterologists provided usable data for analysis. For all respondent groups improvement in daily symptom severity was the most important factor in treatment preferences and risk tolerance was greater for treatments with better clinical benefits. Physicians had lower MARs for young patients and higher MARs for the elderly. For middle-aged patients, gastroenterologists' MAR ranged from 0.16% to 0.76% for death or disability from PML, 0.24% to 0.58% for death from SI, and 0.13% to 0.81% for death due to lymphoma. Patients' preferences are similar to