RESULTS: Each patient was asked whether or not he or she contracted fol-

cross-sectional design was conducted. Sample

OBJECTIVES: The US Valuation of the EQ-5D Health States was conducted to predict US societal preferences for the 243 health states described by the EQ-5D. The model used to generate these predictions (i.e., the D1 model) addressed a number of important conceptual and statistical issues. However, it has been criticized for being too complex and for failing to account for the non-normal distribution of health state preferences. Furthermore, the model’s developers have been faulted for applying an arbitrary transformation to the values for worse-than-death health states prior to estimation. This paper describes the development of an improved model for predicting US preferences for EQ-5D health states. METHODS: Model parameters were estimated using a probability-weighted least absolute deviations estimator. Variance estimation proceeded using a replication-based jackknife method. The resulting model predictions were contrasted with those of the D1 model. The fit of a median model for data collected in the Measurement and Valuation of Health study was also studied. RESULTS: When applying no transformation to the values for states worse than death, the best-fitting model included only fixed effects for moderate or severe problems in each of the 5 EQ-5D dimensions and excluded a constant. This specification yielded a squared rank correlation between observed and predicted values of 0.363, a median absolute error of 0.025, and a rank correlation between median observed and predicted values of 0.991. The predicted median preferences ranged from 1.00 for full health to −0.80 for the worst possible health state. CONCLUSION: The application of a linear model to the US valuation data cannot be justified given the non-normal distribution of health state preferences. A median model of preferences is superior to other available specifications. In applications requiring US societal preferences, it is suggested that the predictions of the model discussed here be used instead of those of the D1 model.

EFFECT OF CHRONIC DISEASES ON HEALTH SERVICES UTILIZATION

OBSERVATIONS: Little research concerning to the effect of co-morbidity on Health Service Utilization was conducted in field of General Practice. We aim to explore the effect of common chronic diseases on the Health Service Utilization of General Practice. We aim to explore the effect of common chronic diseases on Health Service Utilization. METHODS: Cross-sectional design was conducted. 750 Sample of patients was obtained via three stages of cluster sampling. Each patient was asked whether or not he or she contracted fol-

JUSTIFYING THE USE OF COST MINIMIZATION ANALYSIS: REPORTING COMPARATORS’ EQUIVALENCE

OBJECTIVES: Up to date in mainland China, no data has been shown the relationship between health-related quality of life (HRQOL) and health services utilization. This study is aim to confirm the hypothesis that the scale-score of the SF-36 is in linear relationship with health services utilization, and to quantify its linear relationship after the confirmation of above hypothesis. METHODS: Cross-sectional design was conducted. Sample was obtained via three stages of cluster sampling. We use both electronic version (based on QL-Recorder) and paper version of SF-36. Data process was conducted by the structured multiphase regression model. RESULTS: Firstly, in terms of monthly consultation rate, the scale-score of the SF-36 separately intercepted 5.1% contribution. Secondly, with respect to annual consultation rate, the scale-score of the SF-36 solely explained 2.7% contribution. Thirdly, referring to annual hospitalization rate, the scale-score of the SF-36 explained 4.7%. Beside, our research induces that there was gender difference of the scale-score of the SF-36 on Health Service Utilization, namely, the female are higher than the male. CONCLUSION: Our research proved, for the first time in Mainland China, that the hypothesis on linear relation between the scale-score of the SF-36 and Health Service utilization. We further calculated in quantification, the separate contribution rate of the scale-score of the SF-36 to Health Service utilization.