variability in CERs for some drugs for different indications, in some cases also varying by biomarkers. Primary care drugs had lower and less variable CERs than specialty drugs. Variations also exist in methodology used by different groups in modeling cost effectiveness, especially for time horizon and comparator. Majority of primary care drugs were modeled for a time horizon of 35-40 years or lifetime to demonstrate cost effectiveness. Among the top 10 drugs, quetiapine and etripaprazoprin had the highest variability across different studies, and atorvastatin, salmeterol/fluticasone and clopidogrel had the most consistent ICER values across studies. CONCLUSIONS: This analysis shows the range, variability and methods used for calculation of ICER values for these high budget impact drugs and provides lessons for executives and policy makers.

CONCEPTUAL PAPERS & RESEARCH ON METHODS – Patient-Reported Outcomes Studies

A COMPARISON OF THE DISCRIMINATIVE AND EVALUATIVE PROPERTIES OF THE SF-36 AND THE SF-6D INDEX

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OBJECTIVES: To examine whether the move from the SF-36 to the SF-6D entails a loss in discriminative or evaluative power, the magnitude of that loss, and how it matters. METHODS: The study used relative validity (RV); a ratio of two F statistics, and standardized response mean (SRM) to evaluate sensitivity and responsiveness of the SF-36 scales and SF-6D index. An RV of 1 reflected the most sensitive/responsive scale and the smaller the RV the less sensitive the measure would be. CORE results for interpreting effect sizes were used to interpret the SRMs. The data were used to identify the psychometric properties of the SF-6D index in any condition studied. Comparisons showed the SF-6D index was more discriminative with a mean RV difference of 0.09 (95% CI 0.07 to 0.12) and more responsive with a mean SRM difference of 0.08 (95% CI 0.01 to 0.16) than the SF-36 scales. However, based on longitudinal RVs the index was less discriminative with a mean RV difference of 0.07 (95% CI 0.01 to 0.15) than the SF-36 scales. CONCLUSIONS: Moving from the SF-36 to the SF-6D index entails a loss in evaluative strength and a gain in discriminative strength, a loss/gain too small to matter given the merits of either instrument.

A39

ELECTRONIC PRO VERSUS PAPER PRO: WHAT DO THE PATIENTS THINK?

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OBJECTIVES: To examine patients’ preferences and satisfaction on completing Patient-Reported Outcome (PRO) assessments by using alternative verb formations and formatting; 3) Though the new VAS mentions likening the scale to a thermometer as in the previous 3L VAS was necessary; 2) In some cultures ‘mark an X on the scale’ was difficult to render, and had to be amended by using alternative verb formations and formatting; 3) Though the new VAS mentions only ‘health’, in some languages, it was necessary to use ‘health state’ to avoid confusion, e.g. in Czech “health” alone means “good health.”; 4) In some languages the concepts of “health” and “health state” had different temporal associations. In Korean, “health” referred to a longer period of time, so “health today” had to be expressed by “health state today”; 5) Russian patients understood “health state” as the evaluation given by a doctor or test results, therefore “in your opinion” was added. CONCLUSIONS: The EQ-5D VAS has been translated and linguistically validated following a rigorous translation process. A number of cultural and linguistic issues became apparent and were resolved. The measure is now appropriate for use in multinational trials.

A40

DIMENSIONS CHARACTERIZING GOOD HEALTH BY CHINESE IN CHINA

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OBJECTIVES: Health-related quality of life (HRQoL) instruments used in China are mainly from Western countries. Such instruments may not cover all the important health dimensions relevant to Chinese people as health is a culture-specific concept. However, a paucity of empirical data on what good health is to Chinese people. The objective of the current study is to identify health dimensions with which Chinese people use to define health. METHODS: A convenience sample of 200 adult Chinese (67 healthy persons, 83 patients, 50 healthy seniors) were interviewed face to face. Open questions were used to elicit characteristics and life domains of good health. RESULTS: Fourteen health dimensions were identified. The 5 most frequently alluded dimensions were: mood (35.5%), absence of disease (33.3%), mobility (25.1%), ability to work (22.4%), and eating (17.5%). Other dimensions included vitality, pain or discomfort, physical fitness, sleep, freedom, self-care, social relationship, enjoyment, and cognition. More proportion of healthy persons than patients quoted mood and self-care as dimensions of health while more patients emphasized ability to work. Males regarded eating as a health dimension more often than females while females quoted self-care and social relationship more frequently than males. With regard to age, older persons valued ability to work more than younger people while more younger people thought freedom of pain or discomfort is a characteristic of good health. CONCLUSIONS: This study provides useful information for assessing the adequacy of HRQoL instruments developed in Western countries for the Chinese population in China.

A41

THE TRANSLATION AND LINGUISTIC VALIDATION OF THE EQ-5D VISUAL ANALOGUE SCALE (VAS)

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OBJECTIVES: The EQ-5D has been translated into many languages. The EuroQol group have recently altered and clarified the VAS scale. The objective of this study was to produce translations that are conceptually equivalent to the original and to other language versions, ensuring the relevance of the translations within the target culture. METHODS: A standard methodology was employed: 1) forward and back translation, review and developer review; or an in-country review and developer review; linguistic validation interviews with 8 subjects, a mix of healthy people and patients, a second developer review and 2 proofreadings. RESULTS: The translation process highlighted numerous cultural and linguistic issues including: 1) Cognitive interviews showed that there was no clear Dutch word for scale, so an explanation likening the scale to a thermometer in the previous 3L VAS was necessary; 2) In some cultures ‘mark an X on the scale’ was difficult to render, and had to be amended by using alternative verb formations and formatting; 3) Though the new VAS mentions only ‘health’, in some languages, it was necessary to use ‘health state’ to avoid confusion, e.g. in Czech “health” alone means “good health.”; 4) In some languages the concepts of “health” and “health state” had different temporal associations. In Korean, “health” referred to a longer period of time, so “health today” had to be expressed by “health state today”; 5) Russian patients understood “health state” as the evaluation given by a doctor or test results, therefore “in your opinion” was added. CONCLUSIONS: The EQ-5D VAS has been translated and linguistically validated following a rigorous translation process. A number of cultural and linguistic issues became apparent and were resolved. The measure is now appropriate for use in multinational trials.