patients with T2DM in the UK had significantly lower (p < 0.001) physical summary scores than other EU countries. Patients experiencing depression symptoms were more likely to visit the ER (OR = 1.74; 95% CI[1.33, 2.23]; p < 0.0001), be hospitalized (OR = 1.43; 95% CI[1.11, 1.84]; p < 0.005) and had more physician visits in the last six months (r = 0.57, p < 0.0001). Patients in Spain had significantly more provider visits (p < 0.05) and ER visits (p < 0.0001) than UK patients, while patients in France were hospitalized more often than UK patients (p < 0.05). CONCLUSIONS: Comorbidity depression in patients with T2DM greatly decreases physical and mental summary scores of the SF-12, and increases resource use. Further research is needed to clarify associations between the two conditions, including geographical and cultural influences on health outcomes in this cohort.

PODIUM SESSION II: UTILIZATION MEASUREMENT STUDIES

VALUING EQ-5D USING TIME TRADE-OFF IN FRANCE

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OBJECTIVES: The EQ-5D questionnaire has been developed and validated in France but the utility function has not been elicited. The main objective of the present study is to provide a French value-set for the EQ-5D health states using the Time Trade-Off (TTO) method. METHODS: A total of 452 respondents aged over 18 were recruited for a French valuation study. They were chosen to be representative of the French population with regard to age, gender and socio-professional group. Twenty four EQ-5D health states were selected to be directly valued. Three groups of 300 respondents were set up and each group valued 17 of 24 EQ-5D health states using the time trade-off (TTO) method. The TTO valuations were linearly transformed to be on the interval [0,1]. Exclusion criteria used were the same as in other valuation studies. We also investigated logical inconsistencies. Several alternative models specifications were investigated to estimate the values of the remaining non direct valued EuroQol health states. The analysis was conducted at an individual level to make the maximum use of the data and we estimated random models with variables. Models were compared using different goodness of fit measures: the Akaike’s information criterion (AIC), the Mean Absolute Error (MAE) and the Pearson correlation between the observed and the predicted value. RESULTS: After exclusion, 443 respondents take part in the study. Fifty three respondents (12%) present more than 10 logical inconsistencies in their responses. The model presenting the smaller Akaike’s information criterion include the same variables as the N3-model used in UK. This model yield a good fit for the TTO data with a mean absolute error of 0.04 and a Pearson correlation coefficient of 0.99. CONCLUSIONS: This study will provide the first EQ-5D value-set for France.


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OBJECTIVES: The choice of quality-adjustment factor, as stipulated by health economics and as required by regulatory agencies, dictates that the “Q” in QALY should be a utility (choice-based preference) measure. This requirement has led to a state of chaos in which multiple utility elicitation methods are permitted and in which no test of their relative performance has been documented. This paper reflects the current status of utility measurement as applied in QALY calculations and conclusively demonstrates its fallibility. METHODS: The paper is divided into two parts, the first of which re-examines the basic measurement requirements for any viable metric used as a quality-adjustment scalar and deals with the impossibility of permitting mutually incompatible utility elicitation procedures. It concludes with a novel test of uniqueness that can be applied to competing sets of utility weights. The second part is based on empirical evidence generated in the MVH study in which both TTO and VAS ratings were used to calibrate EQ-5D for use in economic evaluation conducted in the UK (n = 3,395). Analysis compares the within-respondent ordinal preferences captured through VAS rating with those inferred by TTO utilities. RESULTS: Nearly 50% of respondents had a Spearman’s rho below 0.8, corresponding to a mean difference in rank of around 4 between VAS and TTO scores. Twenty-six percent of respondents assigned a utility of 0.0 (full health) to 3 or more health states with differing degrees of dysfunction. More than 40% of respondents fail to distinguish between full health and the 5 mildest health states. CONCLUSIONS: The demonstrable frailty of utility elicitation methods is well-known. Research scientists in general and health economists in particular should be wary of encouraging others to accept QALY metrics of this type. The continued requirement for utility measures in social decision-making compromises both the science and the scientists who tolerate its misuse.