linguistic differences between China and North America or Western Europe where PROs tend to be developed. The objective of this study was to identify some of the linguistic and cultural differences between English and Mandarin as well as cultural differences between North America and Western Europe and China. METHODS: Five questionnaires to assess health-related quality of life (HRQoL) were reviewed and the cultural and linguistic issues arising during different stages of the translation process were examined. RESULTS: Numerical and cultural linguistic issues became apparent throughout the review, including: 1) Mandarin does not employ superlatives so “the worst” was translated as “extremely bad”; 2) some patients did not understand how to complete aVAS although the words themselves were clear; 3) there is no specific benefit of “disability compensation” in China—this is a general benefit which can include pensions; 4) Private clinics where respondents receive acupuncture and massage are very common in China so additional categories had to be added to a resource utilisation measure; 5) in Mandarin questions cannot begin with “how often”; instead they are phrased “does it often?”; 6) with response options such as “never”, “sometimes”, appropriate responses can still be chosen; and 6) Low levels of obesity in China made recruitment for the linguistic validation of an obesity measure difficult. CONCLUSIONS: An increasing number of clinical trials take place in China. The issues raised above show some of the linguistic differences between English and Mandarin, and cultural differences between Western Europe / North America and China. These and other issues are important to consider when selecting, developing and translating measures for use in China.

OBJECTIVES: The purpose of this study was to explore the incremental cost-effectiveness of health interventions in Asia. Comparative studies with face-to-face TTO would be desirable, as the online approach seems an attractive solution to allow primary utility elicitation when time or cost constraints preclude a face-to-face survey.

RESULTS: A total of 3662 articles were originally identified from the planned searching strategy. 1466 among them were finally included to calculate ICER range after abstract review and full text review. Two independent reviewers worked to select relevant articles and extract data. Mean incremental cost per Quality-adjusted life-years-gained or Life-years-gained varied a lot. If we see the author’s judgment on cost-effectiveness, some interventions were recommended as cost-effective even in the case ICER were approximately US$80,000, US$75,000, US$200,000 for UK, Canada, and USA.

CONCLUSIONS: Use of EQ-5D utilities for means and variances comparison were equal to 0.0161 and 0.0060 respectively for means and variances comparison were equal to 0.0161 and 0.0060 respectively for chronic ICD-9 and CCC codes can be used to estimate QALYs in cost-effectiveness analyses in the UK. Although the preference function was derived from a UK population sample, there are limitations associated with using a US survey to develop the condition-specific questionnaire responses.