OBJECTIVES: To better understand the human benefits of maintaining or enhancing health, more research is needed to assess the impact of health status on individuals’ perceptions of their life satisfaction and quality of life. The purpose of this pilot study was to explore the relationship between health status and 1) satisfaction with life as a whole, and 2) overall quality of life. METHODS: A total of 314 participants were recruited from the general population of the Tucson Metropolitan Area to complete a touch screen computer-based questionnaire. The questionnaire included, among other items and scales, the EQ-5D and items assessing satisfaction with life in general (five-point scale from very dissatisfied to very satisfied) and overall quality of life (five-point scale from poor to excellent). Quadratic regression and ordered logit models were estimated to assess the potential impact of health status. RESULTS: The quadratic regression results suggest a curvilinear relationship between health status (EQ-VAS) and overall quality of life (β-coefficients: β1 = −0.022 and β2 = 0.004). Self-reported health status is positively related to quality of life, and health status is more influential when a person has better health. However, our estimates reject the quadratic relationship in favor of a linear relationship between health status and life satisfaction. CONCLUSIONS: Our results suggest that the contribution of health status to quality of life is not constant across health. Health status may be a more important factor when person is healthy. However, the impact of health status on life satisfaction appears constant across levels of health. These findings confirm that satisfaction with life as a whole and overall quality of life are related but are measuring different constructs. This suggests that the perceived value of outcomes, as opposed to satisfaction with the outcomes, may depend on the health of the person affected.

SELF-ASSESSED HEALTH STATUS IN THE UNITED STATES: EQ-5D FINDINGS FROM THE MEDICAL EXPENDITURE PANEL SURVEY
Craig BM1, Ramachandran S2, Coons SJ3
1University of Arizona, College of Pharmacy, Tucson, AZ, USA; 2University of Arizona College of Pharmacy, Tucson, AZ, USA; 3College of Pharmacy, Tucson, AZ, USA
OBJECTIVES: To measure population health in the United States. METHODS: We examine the EQ-5D responses from the 2000 and 2001 Medical Expenditure Panel Survey data. Under the EuroQol descriptive system, respondents assess their health on five dimensions (mobility, self-care, usual activity, pain/discomfort, and anxiety/depression), each of which has three levels. We further supplement the descriptive system by arranging the EQ-5D states into four categories (“Very Good”, “Good”, “Fair” and “Poor”) according to average self-assessed health status on 5-point and 101-point scales. RESULTS: In 2000, 45% of non-institutionalized adults in the United States had no problems on all 5 dimensions; 30% had no problems other than moderate pain or discomfort or being moderately anxious or depressed; and 6% of adults were in “Fair” or “Poor” EQ-5D states. Between 2000 and 2001, the prevalence of “Very Good” and “Poor” EQ-5D States increased which suggests that health inequality among the US adult population may have increased over this period. CONCLUSION: Using the EuroQol descriptive system, shifts and inequity in population health can be monitored for policy purposes, similar to a health gross domestic product.

INTERPRETING THE MAGNITUDE OF SCORE DIFFERENCES IN THE SF-36 VITALITY SCALE: ASSOCIATION WITH CLINICAL CONDITIONS AND OUTCOMES
Wallenstein GY1, Bjorner JB1, Martin MC1, Mody SH2, Piech CT2
1QualityMetric Incorporated, Lincoln, RI, USA; 2Ortho Biotech Clinical Affairs LLC, Bridgewater, NJ, USA
OBJECTIVE: To evaluate the association between differences in scores of the SF-36 Vitality (VT) scale with clinical conditions and outcomes. METHODS: Analyses were performed on data from the Medical Outcomes Study (n = 3445) and the National Survey of Functional Health Status (n = 2909). The strategy for establishing the clinical and outcomes significance for the VT scale (0–100 scale) consisted of two components: 1) comparing VT scores in patients with and without clinical conditions with well-understood effects on VT/fatigue; and 2) investigating whether VT score differences of five-and ten-points predict outcomes. The first analysis used multivariate regression to evaluate the association between chronic disease conditions and VT. To approximate the impact of within patient VT differences, the second set of analyses used logistic regression models to examine the relationship between baseline VT scores and four outcomes: 1) inability to work due to health; 2) subsequent job loss; 3) subsequent hospitalization, all at one year; and 4) mortality at seven years. RESULTS: VT scores were significantly reduced in patients with anemia (five-six points), CHF (six points), and COPD (seven-ten points). Both five-and ten-point decreases in VT score were significantly associated with increased odds of negative outcomes, including inability to work due to health (OR(5) = 1.28, OR(10) = 1.62), job loss (OR(5) = 1.13, OR(10) = 1.28), hospitalization (OR(5) = 1.08, OR(10) = 1.17), and mortality (OR(5) = 1.08–1.28, OR(10) = 1.14–1.54, depending on VT level). Absolute risk for these negative outcomes increased nonlinearly with decreasing VT. CONCLUSIONS: VT scores are reduced in patients with serious medical diseases. Differences of five-ten points in the VT score were associated with significant increased risk of negative outcomes. A ten-point lower VT score was consistent with 62%, 28%, and 17% increased likelihood of inability to work, job loss, and hospitalization, respectively, by one year. Similarly, a lower VT score was associated with an increased risk of death by seven years.
illuminated and provided evidence for each domain discussed. Effectiveness was identified by patients as the most important consideration for satisfaction, irrespective of the patient's condition. Effectiveness comprised 1) consistency of effect; 2) time before onset of effect; 3) degree of symptom relief; and 4) duration. Side effects were also identified as among the most important considerations for satisfaction, and some patients, such as those on chemotherapy, identified it as the most important consideration. If two drugs have the same effectiveness, then side effects become most important. Convenience was found to be important because it impacts lifestyle and consists of three components: ease-of-use, drug form and/or mode of administration, and administrative characteristics. Finally, patients were greatly concerned about the impact their treatment would have on their ability to function in their daily activities. CONCLUSIONS: This study contributes to the understanding of medication treatment satisfaction from the patient's perspective. Rigorous qualitative methodology was used to assess the domain structure of a new instrument developed and validated to measure treatment satisfaction across therapeutic areas (TSQM®).

CONCLUSIONS: Linguistic validity of the US Spanish Work Productivity and Activity Impairment Questionnaire, General Health Version (WPAI:GH) was established among a diverse US Spanish-speaking population, including those with minimal education.

METHODS: A review of the concept and recommended use of perspective in theoretical literature and 31 economic evaluation guidelines was performed. The practical use of perspective was assessed in the 30 economic evaluations published in the Core25 Journals, Health Economics and Pharmacoeconomics in 2004. RESULTS: The use of societal perspective, including all relevant costs and outcomes, was unanimously recommended by the literature and the majority of the guidelines. No source mentioned the possibility and implications of using different perspectives for assessing both costs and outcomes in the same study. All articles reviewed used a different perspective for assessing both costs and outcomes. For assessing costs, the payer perspective was most preferred (22), followed by the societal perspective (4) and other (4). In the case of the outcomes, the patient perspective or outcomes for a patient or person at risk was used a majority of the time (29), followed by family perspective (1). CONCLUSIONS: The findings of different perspectives for assessing outcomes and cost in the same study contradict the conventional wisdom. This affects the interpretation of the results and implications of the study. We recommend the following: 1) explicitly state the perspective used for assessing both, costs and outcomes; 2) the use of the same perspective for both, costs and outcomes; and 3) the sum of individual patient perspectives should not be understood as the societal perspective because it excludes outcomes such as effects on the mental health of patients’ families.

METHODS: To evaluate the linguistic validity of the US Spanish version of the Work Productivity and Activity Impairment questionnaire, General Health Version (WPAI:GH), a bilingual (Spanish-English) interviewer debriefed subjects after self-administration of the US Spanish (N = 31) and English (N = 35) WPAI:GH. Subjects were stratified equally by educational level, with and without a high school degree. RESULTS: The item comprehension rate was 98.6% for Spanish and 99.6% for English. Response revision rates during debriefing were 1.6% for Spanish and 0.5% for English. Responses to hypothetical scenarios indicate that both language versions adequately differentiate sick time taken for health and non-health reasons and between absenteeism and presenteeism. CONCLUSION: Linguistic validity of the US Spanish translation of the WPAI:GH was established among a diverse US Spanish-speaking population, including those with minimal education.

OBJECTIVES: Perspective is the point of view from which costs and outcomes of an economic evaluation are evaluated. The results and interpretation of the evaluation depend upon the perspective used. This study evaluates the use of perspective in economic evaluation based on a review of literature, guidelines and current articles.