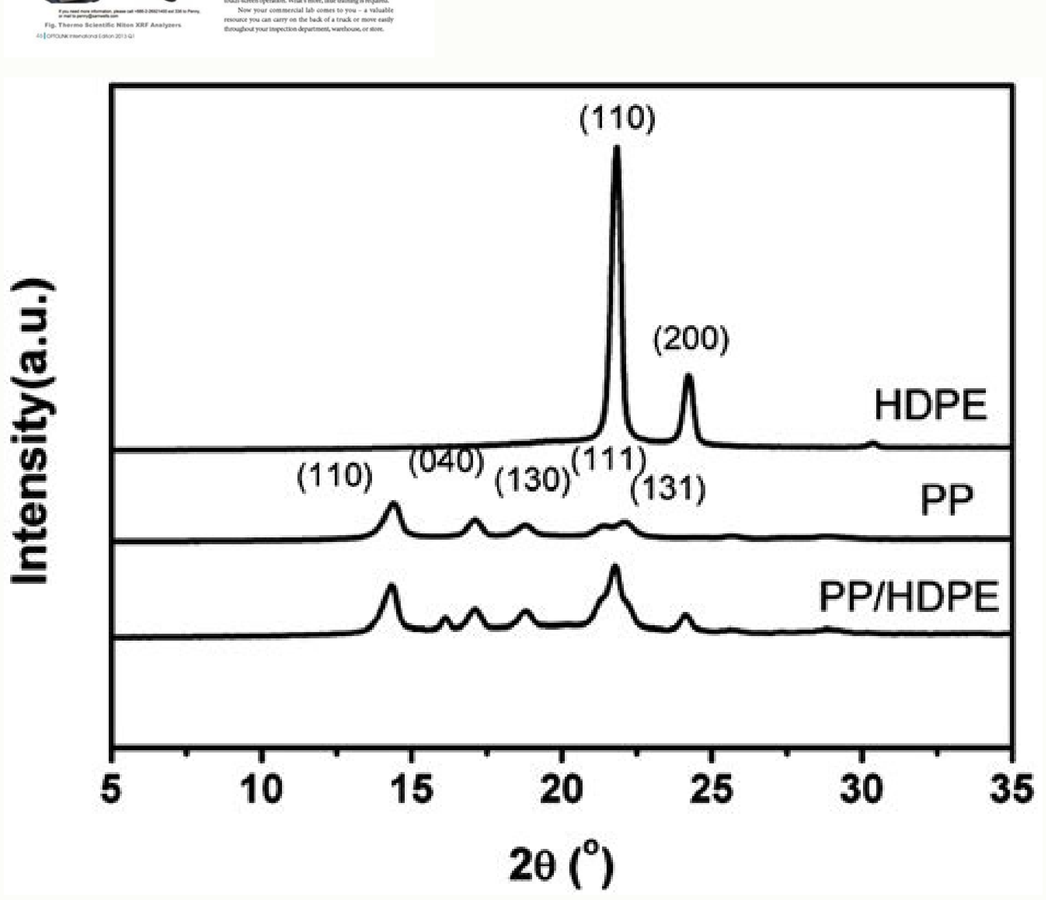


Next

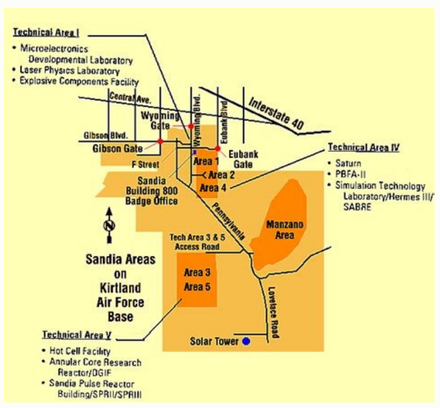
Article 23- a evaluation form











The quality-adjusted year of life (QALY) © routinely used as a summary measure of the health results for economic evaluation, which incorporates the impact on both quantity and quality of life. The main studies related to QALY and the utility measurement are the data sources. The a reas of agreement include the need for a standard measure of the health results to allow comparisons between different areas and populations of diseases, and the methods © all used to evaluate health status in utility measurement. The building areas © rsia include the limitation of the QALY approach in terms of the health benefits it can capture, its blindness in relation to equity concerns, the underlying theoretical assumptions and the utility measure based on preferences © Rich appropriate. There's a growing debate about whether a QALY © the same, regardless of who accumulates it, and also © m on the question of who should value the health states. © It would need to further improve the QALY approach to addressing equity-weighted utility maximisation challenges and test the validity of underlying assumptions. Questions concerning choice between specific measures of conditions and genetic instruments © rich too © They deserve a more thorough investigation. Decisions on relative prioritisation of health care resources in competing interventions involve assessing the impact on both costs and health outcomes. Health studies use many different measures of health outcomes to demonstrate the effect of one treatment. For example, one study can report survival rates, while another can focus on the incidence of pressure calculations and painless days. When confronted with such different types of result measures resulting from different interventions, the © It is difficult to determine where health care resources should be directed from more efficient. If only survival is © used to differentiate between different health interventions, any impact on the quality of life associated with an intervention is © ignored ignored health care, a © necessary a common measure. This measure should ideally encapsulate the impact of a treatment on a patient's lifetime and also the impact on their health©-related quality of life (HRQoL), which is © recognized as a key indicator of treatment outcomes. The quality-adjusted year of life (QALY) was developed in order to capture both impacts and © widely used in health economics as a measure of health © results, which can inform the decisions of assigning health resources. Valorization of health states: the concept of utilities When QALY are used as a result, the valuation is © known as a cost-utility anthanise (CUA). The use of QALYs is © required by the National Institute for Health and Clinical Excellence (NICE) in the UK to assess health technology. To generate QALYs, useful health uses (or HRQoL weights) are required. Utilities are weights of preference, where preference can be equated with value or convenience.1 Thus, utilities for health states should be based on preferences for the different health states, to the extent that the health states (i.e., more preferred) will receive greater weight and, therefore, they will be favored in the area.2 Utilities are measured on a cardinal scale of 0Ã¢1, where 0 indicates death and 1 indicates total health. Using anchors of 0 and 1, utility measurement is on a range scale, where the same change means the same regardless of the part of the scale that is to be considered (for example, a change in health from 0.2 to 0.3 A© equivalent to a change from 0.8 to 0.9). States worse than death can also ©, with such states assuming a negative value. Valorization of the years of life: the concept of a QALY The QALY Â© capable of combining "the effects of health interventions on mortality and morbidity in a single index , thus providing a "common currency" to enable comparisions between the different groves of disease. Over time, individuals experience different states of health, where health health should are weighted according to the utility scores associated with them. Qaly's concept of combining an individual's survival with his HRQOL can be seen in Figure 1. This demonstrates the qalys that can be obtained by an individual from receiving treatment rather than no treatment. The area under the curve is equivalent to the total value of QALY. The lower path shows the health profile if no treatment is received; The HRQOL of the individual reduces over time, © die (death a). If a treatment is received, however, the individual follows the highest path; Your HRQL sits at a higher level for longer, besides© living longer (dying at death B). Thus, the total area between the two curves indicates the number of Qalys acquired by the treatment. Open in new tabebownload Slideqalys treatment gain.QALys is © calculated simply by multiplying the duration of the time spent in a health state by the weight of HRQOL (i.e. utility score) associated with this health state. Therefore, the two key elements - HRQOL and survival - are incorporated. For example, if an individual is in a healthy state for 10 years, where the health state has an associated utility of 0.6, this would generate six uncounted qalys (i.e., 0.6 multiplied by 10 years).Weinstein et al.1 summarize the underlying assumptions of the conventional QALY approach, some of which are listed below and are discussed in later sections. Qalys that occur in the future are deaxed to current values, to incorporate the idea that people prefer to receive health benefits now, rather than the future (this is ©, positive time preference). Nice's recommendation © Qalys should be discounted at a rate of 3.5% per year, in line with costs. For example, in our example above, six Qalys gained more than 10 years when debilled at 3.5%, © equivalent to 4.4 Qalys. However, the discount remains a matter of ©; For example, if must be deducted at a lower rate than the costs continue to be In addition, different people can have different time preferences for health outcomes. For example, a healthy person can rule out the future differently from a patient who actually has a particular health condition. Health is defined as value-weighted time (QALYs) along the relevant temporal horizon. The value is measured in terms of preference (desire). The preferences measured between individuals can be aggregated and used for the group. QALYs can be aggregated between individuals, i.e. a QALY is a QALY regardless of who wins or loses it. HRQoL weight assessment methods Measuring health services, or HRQoL weights, involves the first definition of health states of interest. The next step involves valuing these health states, that is, individuals evaluate the different health states and place a value in each of them. In order to generate HRQoL weights, there are direct or indirect methods (also called generic preferred measures). Methods of direct elition The direct methods that tend to be used more regularly for obtaining preferences include the analog visual scale (VAS), the time trade (TTO) and the standard bet (SG). Visual analogue scale The SAV (a notation scale form) is the simplest scale of direct methods and involves the use of a scale shown in a single line (Fig.Â HELL1602). The top of the scale indicates that priority15-2; better imaginary health for our customers, while the bottom of the scale indicates that a.Hah152; Individuals are asked to indicate on what scale they consider the state of health of interest. This method is generally considered inferior to SG and TTO, due to the involvement of a classification task rather than a task of choice, and also due to the biases scale1. The bias on scale include the end-of-scale bias, where participants are reluctant to put theof health at the extremes of the scale. However, the simplicity of SAV means that it is a useful tool often used as a hot maintenance exercise before other methods. Open in New Transfer tab TransferTime trade-off The ©whole TTO presents individuals with two alternative scenarios and asks what they prefer. The choice is © to live for the rest of your life (e.g., ten years, as in Fig.Ã, Bae160; 3a) in a state of debilitated health (e.g., type 2 diabetes), or live in full health for a shorter period of time. The period of time spent in full health © varied until © that the individual is © between the two choices. Thus, participants are asked how long they would be willing to sacrifice to avoid a state of impaired health. In The Figure ÂÃÃÃ