

> (780) 448-4881  
# (780) 448-0018  
: webmaster@ihe.ca

#1200, 10405 Jasper Avenue  
Edmonton, Alberta  
Canada T5J 3N4

11773 6 FEB 22 19:55

February 13, 2006

Division of Dockets Management (HFA-305)  
Food and Drug Administration  
5630 Fishers Lane, Room 1061  
Rockville, MD 20852 USA

Telephone: (301) 796-0700

**RE: Comments on Statements About Preference-Based Measures in "Guidance for Industry Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims," February, 2006**

**Docket Number: 2006D-0044**

We have reviewed the document and congratulate the staff at the Food and Drug Administration and its consultants for producing and circulating the Draft Guidance document. The content of the Draft Guidelines represents an important step in promoting the use of reliable, valid, responsive, and interpretable measures of health-related quality of life for generating evidence about the effects of pharmaceuticals to assist in making evidence-based decisions on the appropriate use of pharmaceutical products.

Our comments are personal opinions and should not be understood to reflect the views of the organizations with which we are affiliated. Our comments focus on the exposition concerning preference-based measures of health-related quality of life (HRQL). As the Draft Guidelines note, preference-based measures include direct measures of the value that patients attach to the health states they are experiencing obtained using measurement instruments such as the standard gamble and time trade-off. Preference-based measures also include multi-attribute or indirect measures. In the multi-attribute approach, the patient completes a questionnaire reporting on self-perceived health status. The results are then scored using a multi-attribute scoring function based on community preferences. Prominent examples of multi-attribute measures include the EQ-5D, Health Utilities Index Mark 2 (HUI2), Health Utilities Index Mark 3 (HUI3), Quality of Well Being Scale (QWB), and Short-Form 6D (SF-6D). Reviews of evidence on the measurement properties of preference-based measures can be found in Feeny, 2005, Feeny, 2005, Horsman et al. 2003, and Torrance et al. 2002; copies are enclosed.

**Role of Community Preference Based Scores.** The Draft Guidelines note that "it is tempting to use those same weights [pre-determined community weights] in the clinical trial setting to demonstrate treatment benefit. However, this practice is discouraged unless the

2006D-0044

C1

relationship of the preference weights to the intended study population is known and found adequate and appropriate.” We feel that this statement might contribute to misunderstanding and confusion about the usefulness of preference-based measures with scoring systems based on community preferences. In particular, the statement might be interpreted to exclude the important contribution of such measures for applications to analyses about groups of patients such as those in clinical trials.

We see the important issue being the level of decision making for which the preference-based scores are to be used. If the preference-based score is to be used to assist a patient and his/her clinician to decide upon the best course of action, then indeed preference-based scores derived from multi-attribute instruments with scoring systems based on community preferences may not be appropriate. If the application is to an individual patient, then if at all possible, one would use the preference scores provided by that patient.

Our impression is that most applications of preference-based measures in the context of the regulatory affairs of the Food and Drug Administration rely on analyses conducted at the group level, for example comparing outcomes for the experimental and control groups in a randomized controlled clinical trial. For making group-level comparisons, it is indeed appropriate to use scores based on community preferences. Indeed one of the advantages of the approach is that one is able to obtain evidence on the extent to which patients in the experimental and control groups are “on net” (taking into consideration the improvements in some dimensions of health status but deterioration on others) better off (see page 5 of the Draft Guidelines). An additional advantage for a regulatory organization such as the Food and Drug Administration is that the use of carefully developed well-validated community preference based scores standardizes the analyses across different trials, thus leading to greater consistency and fairness in regulatory interpretations. Finally, the use of community preference based scores enables analyses required by other users of the data. In particular, the use of community preference based scores enables economic evaluations required or recommended by payers and funding organizations.

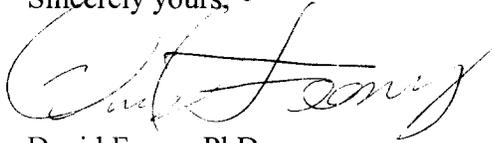
Gold et al. 1996 provide a review of the evidence on the relationship between preference scores provided by patients versus those provided by the general population. In general, the scores differ relatively little, although there are exceptions to this generalization. When scores do differ, patients tend to rate the same health state as more preferable than do members of the general population.

More specifically, we have compared standard gamble scores provided by subjects evaluating their own subjectively-defined current health state to scores derived from HUI2 and HUI3 which were administered to the same subjects at the same point in time. (See Feeny et al. 2003, Feeny et al. 2004, and Feeny et al. 2004; copies are enclosed.) In these studies the mean HUI2 scores and mean standard gamble scores were virtually identical. At the group level, patient and community scores were in agreement. Mean HUI3 scores were a little lower than the mean standard gamble scores. However, at the individual level, agreement between standard

gamble and HUI scores was low. For group level analyses, instruments with scoring systems based on community preferences are much more practical and provide much the same information as can be obtained from direct preference elicitations from patients.

We hope that you find these remarks useful in your deliberations. We would be happy to clarify any of our comments.

Sincerely yours, -



David Feeny, PhD

Fellow, Institute of Health Economics; Professor, University of Alberta; Immediate Past-President, International Society for Quality of Life Research; Associate Editor, *Quality of Life Research*; Health Utilities Incorporated



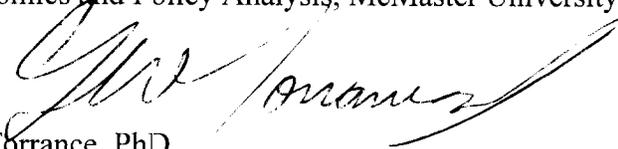
William Furlong, MSc

Research Associate, Department of Clinical Epidemiology and Biostatistics and Centre for Health Economics and Policy Analysis, McMaster University; Health Utilities Incorporated



John Horsman, BA

Research Associate, Department of Clinical Epidemiology and Biostatistics and Centre for Health Economics and Policy Analysis, McMaster University; Health Utilities Incorporated



George W. Torrance, PhD

Professor *Emeritus*, McMaster University; Vice-President for Scientific Affairs, Innovus Research Incorporated; Health Utilities Incorporated

## References

Feeny, David, Chris Blanchard, Jeffrey L. Mahon, Robert Bourne, Cecil Rorabeck, Larry Stitt, and Susan Webster-Bogaert, "Comparing Community-Preference Based and Direct Standard Gamble Utility Scores: Evidence from Elective Total Hip Arthroplasty." *International Journal of Technology Assessment in Health Care*, Vol. 19, No. 2, Spring, 2003, pp 362-372.

Feeny, David, William Furlong, Saroj Saigal, and Jian Sun, "Comparing Directly Measured Standard Gamble Scores to HUI2 and HUI3 Utility Scores: Group and Individual-Level

Comparisons.” *Social Science & Medicine*, Vol. 58, No. 4, February, 2004, pp 799-809.

Feeny, David, Lieling Wu, and Ken Eng, “Comparing Short Form 6D, Standard Gamble, and Health Utilities Index Mark 2 and Mark 3 Utility Scores: Results from Total Hip Arthroplasty Patients.” *Quality of Life Research*, Vol. 13, No. 10, December, 2004, pp 1659-1670.

Feeny, David, “The Roles for Preference-Based Measures in Support of Cancer Research and Policy,” Chapter 4 in Joseph Lipscomb, Carolyn Cook Gotay, and Claire Snyder, eds., *Outcomes Assessment in Cancer: Measures, Methods, and Applications*, New York, Cambridge University Press, 2005, pp 69-92.

Feeny, David, “Preference-Based Measures: Utility and Quality-Adjusted Life Years,” Chapter 6.2 in Peter Fayers and Ron Hays, eds., *Assessing Quality of Life in Clinical Trials*, Second Edition, Oxford, Oxford University Press, 2005, pp 405-429.

Gold, Marthe R., Donald L. Patrick, George W. Torrance, Dennis G. Fryback, David C. Hadorn, Mark S. Kamlet, Norman Daniels, and Milton C. Weinstein, "Identifying and Valuing Outcomes," Chapter 4 in Marthe R. Gold, Joanna E. Siegel, Louise B. Russell, and Milton C. Weinstein, eds., *Cost-Effectiveness in Health and Medicine*. New York: Oxford University Press, 1996, pp 82-134.

Horsman, John, William Furlong, David Feeny, and George Torrance, “The Health Utilities Index (HUI®): Concepts, Measurement Properties and Applications.” *Health and Quality of Life Outcomes* (electronic journal) (Vol. 1: 54, October 16, 2003); <http://www.hqlo.com/content/1/1/54>

Torrance, George W., William Furlong, and David Feeny, “Health Utility Estimation.” *Expert Reviews in Pharmacoeconomics Outcomes Research*, Vol. 2, No. 2, 2002, pp 99-108.