

SUPPLEMENTARY MATERIALS

Title: Use of the Visual Analogue Scale for health state valuation: A scoping review

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Despite yearly fluctuations, the number of articles published per year increased gradually from two in 1991 to 11 in 2021. The studies used data from 40 countries from the six continents Africa, Asia, Europe, Oceania, North and South America (Fig. S2 in Supplementary Material). A majority of the studies were from the United States (US) (n=83), the United Kingdom (UK) (n=55), the Netherlands (n=46), Canada (n=35), Germany (n=17), South Korea (n=13) and Spain (n=12).

For each characteristic, there were articles that did not report the specific information. In most studies (86%, n=266), the participants were aged 18 years and above. The sample size varied: 26% had a sample size of less than 100 participants and in 29% of the studies the sample size was greater than 500 participants.

The most common study settings were community-based (35%, n=109), healthcare facility-based (31%, n=96), followed by telephone or web-based (9%, n=28), and schools or universities (5%, n=15).

Specific patient populations were included in 120 (39%) of the articles and 114 (37%) sampled from the general population. The remaining articles included a mix of these populations and, e.g., health care personnel, students, teachers, parents and children.

The most common mode of administration for the VAS valuation was face-to-face interview (44%, n=136), followed by use of a questionnaire (24%, n=74). In addition, computer-assisted interview (n=13), web-based interview (n=3), telephone interview (n=4), web-based questionnaire (n=31), mailed questionnaire (n=19), computer-based questionnaire (n=12) have been employed. Secondary data was used in one study, panel session was used in another, and in eight other studies more than one method was used.

A VAS was used as a stand-alone valuation method in 96 articles (31%), whereas in 135 articles (44%) another valuation method, for example, TTO, SG, DCE or Ranking was used together with a VAS.

Table S1: Search Strategies for the Databases Medline (OVID), Web of Science (Clarivate) and PsycInfo (OVID)

No.	Search in Medline (OVID)
1	Visual Analog Scale/
2	((visual analog* scale or VAS or EQ-5D) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,kf.
3	or/1-2
4	Health Status/
5	Quality of life/
6	Quality-Adjusted Life Years/
7	((health stat* or quality) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,kf.
8	((HRQOL or QALY) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,kf.
9	or/4-8
10	3 and 9
11	limit 10 to english language
12	review.pt.
13	systematic review.pt.
14	review*.ti.
15	or/12-14
16	11 not 15
17	11 not 16

exp/ = exploded MeSH term

/ = non exploded MeSH term

.ti,ab,kf. = title, abstract and author keywords

adjx = adjacent within x words, regardless of order

* = truncation of word for alternate endings

No. Search in Web of Science (Clarivate)

- 1 TOPIC: (((("visual analog* scale" or VAS or EQ-5D) NEAR/5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)))
AND
 - 2 TOPIC: (((("health stat*" or quality) NEAR/5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*))) OR TOPIC: (((HRQOL or QALY) NEAR/5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)))
 - 3 Refined by: LANGUAGES: (ENGLISH) AND DOCUMENT TYPES: (ARTICLE OR REVIEW OR OTHER OR EARLY ACCESS OR CLINICAL TRIAL OR CASE REPORT)
-

TS/Topic = title, abstract, author keywords and Keywords Plus

NEAR/x = adjacent within x words, regardless of order

* = truncation of word for alternate endings

No. Search in PsycInfo (OVID)

- 1 ((Visual analog* scale or VAS or EQ-5D) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,id.
 - 2 health status/
 - 3 exp quality of life/
 - 4 "quality of life measures"/
 - 5 ((health stat* or quality) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,id.
 - 6 ((HRQOL or QALY) adj5 (adjust* or evaluat* or estimat* or experience* or rate* or rating or utilit* or valu*)).ti,ab,id.
 - 7 or/2-6
 - 8 1 and 7
 - 9 limit 8 to english language
 - 10 review*.ti.
 - 11 9 and 10
 - 12 9 not 11
-

exp/ = exploded controlled term

/ = non exploded controlled term

.ti,ab,id. = title, abstract and author keywords

adjx = adjacent within x words, regardless of order

* = truncation of word for alternate endings

Table S2: Reference List to Included Articles (n = 308)

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Table S3: Designs of the VAS used in the included studies (n = 308)

Designs of the VAS	n	%
EQ VAS		
EQ VAS	113	36.7
EQ VAS; vertical	14	4.5
EQ VAS; vertical, 10 cm	1	0.3
EQ VAS; vertical, 20 cm	14	4.5
EQ VAS; vertical, 50 cm	1	0.3
EQ VAS; horizontal	1	0.3
EQ VAS; horizontal, hashmarked, without numbers	1	0.3
EQ VAS; 10 cm	1	0.3
EQ VAS; 20 cm	3	1.0
EQ VAS; to give a number	2	0.6
EQ VAS and VAS PI	1	0.3
Unspecified VAS		
VAS	97	31.5
VAS; vertical	20	6.5
VAS; vertical, 20 cm	2	0.6
VAS; vertical, 25 cm	1	0.3
VAS; vertical, 50 cm	1	0.3
VAS; vertical, 55 cm	2	0.6
VAS; horizontal	4	1.3
VAS; horizontal, 10 cm	10	3.2
VAS; horizontal, 20 cm	1	0.3
VAS; 10 cm	14	4.5
VAS; 15 cm	1	0.3
VAS; 20 cm	1	0.3
VAS; 100 cm	1	0.3
EF-VAS	1	0.3

VAS Visual Analogue Scale; *EQ VAS* EQ Visual Analogue Scale; *VAS PI* Visual Analogue Pain Index; *EF-VAS* Erectile Function Visual Analogue Scale

Table S4: Types of anchoring for the VAS used in the included studies (n = 308)

Types of anchoring	n	%
Negative value or 0 to 100		
0 (worst imaginable health state) and 100 (best imaginable health state)	118	38.3
0 (worst imaginable health state) and 100 (perfect health)	2	0.6
0 (worst imaginable health state) and 100 (full health)	1	0.3
0 (dead/death) and 100 (perfect health)	49	15.9
0 (dead/death) and 100 (full health)	6	1.9
0 (death) and 100 (best imaginable health state)	1	0.3
0 (death) and 100 (best imaginable health state); 0 (worst imaginable health state) and 100 (best imaginable health state)	1	0.3
0 (death) and 100 (excellent or best health)	1	0.3
0 (death) and 100 (best health)	1	0.3
0 (death or worst possible health state) and 100 (best possible health state)	1	0.3
0 (very poor health state or death) and 100 (perfect health)	1	0.3
0 (immediate death) and 100 (normal, unburdened life)	1	0.3
0 (least desirable health state) and 100 (most desirable health state)	3	1.0
0 (least desirable health state) and 100 (most desirable health state; perfect health)	2	0.6
0 (least desirable health state) and 100 (perfect health)	1	0.3
0 (least preferred state) and 100 (most preferred state)	2	0.6
0 (worst possible health state) and 100 (best possible health state)	5	1.6
0 (worst possible health state) and 100 (full health)	2	0.6
0 (worst health state) and 100 (best health state)	4	1.3
0 (worst quality of life) and 100 (best quality of life)	1	0.3
0 (worst ranked state) and 100 (perfect health)	1	0.3
0 (no problems) and 100 (worst imaginable problems)	1	0.3
0 (really bad) and 100 (perfect)	1	0.3
0 and 100 (perfect health)	1	0.3
0 (death) and 100	1	0.3
0 and 100	3	1.0

0% (dead) and 100% (disease-free health)	1	0.3
0% (dead) and 100% (perfect health)	1	0.3
negative values (worse than death), 0 (death) and 100 (perfect health)	1	0.3

Negative value or 0 to 10		
0 (death) and 10 (perfect health)	1	0.3
0 (worst imaginable health state) and 10 (best imaginable health state)	1	0.3
0 (worst possible health or death) and 10 (perfect health)	1	0.3
0 (no quality of life at all) and 10 (optimal quality of life)	1	0.3
-10 (worst imaginable health), 0 (dead), 10 (full health)	1	0.3
0 to 1		
0 (death) and 1 (best imaginable health state)	2	0.6
0 (death) and 1 (best or normal health state)	1	0.3
0 (death) and 1 (perfect health)	5	1.6
0 (worst imaginable health state) and 1 (best imaginable health state)	4	1.3
0 (worst possible health state) and 1 (perfect health)	1	0.3
0 (worst possible health; as bad as or worse than death) and 1 (best possible health; perfect health)	1	0.3
0 (worst health state) and 1 (perfect health)	2	0.6
Anchors without numbers		
dead/death and perfect health	17	5.5
death and optimal health	1	0.3
worst imaginable health state and best imaginable health state	10	3.2
worst attainable health state and best attainable health state	1	0.3
extreme-level descriptors in each dimension	1	0.3
least important and extremely important	1	0.3
Not reported	42	13.6

VAS Visual Analogue Scale

Table S5: Reported advantages of using a VAS in the included studies

Quotations from the studies about advantages of using a VAS	References
Administration	
VAS is easy to understand.	Ock (2016)
VAS scoring task is simple and straightforward.	Shmueli (2008)
VAS is described as simple, easy to administer and reduce cost and time in data collection.	Wu (2014)
VAS is the simplest and most practical method of health state valuation that can be generally understood and answered by most individuals, including older children and adolescents.	Dillman (2016)
VAS is a simple measure to obtain and as a preference value, it is risk-free for the patient.	Moore (1999)
VAS method is quickly administered and is the most understandable and consistent way to elicit social values in the general Korean population.	Kim (2017)
VAS is practicable for Parkinson's disease (PD) patients as it avoids writing, which may be severely impaired in PD patients.	Demeulemeester (2015)
Scoring may be a more intuitive approach to valuation than drawing lines to the VAS.	Devlin (2005)
Comparison with other valuation methods	
VAS was an easier to understand method than the TTO or SG, which were both considered difficult.	Khabibullina (2019)
The rating scale is associated with less random measurement error as it is considerably easier to administer and understand than the TTO and the SG questions.	Lundberg (1999)

Respondents found TTO valuations to be more difficult than VAS valuations.	Yusof (2012)
Self-rated is easier (than TTO) for children to value.	Wu (2014)
Both the VAS and the TTO proved to be feasible and reliable for use in this sample of the Spanish general population, with the VAS implying lower respondent burden and administration costs and providing slightly higher reliability than the TTO.	Badia (1999)
TTO is a more reliable valuation technique, but VAS is more practical in use and is therefore an accepted technique for preference value measurement.	Cleemput (2010)
The trade of life years in TTO is culturally unacceptable compared to VAS.	Yusof (2012)
VAS values had better model fit compared to TTO values.	Yusof (2012)
A model using the VAS scores as dependent variables showed a good predictive ability and goodness of fit comparable to those of the TTO model.	Cho (2015)
VAS appears to be more variable and sensitive to symptoms than the SG. VAS appears to be more suitable for studies that examine the impact of an intervention on the population with cirrhosis.	Foster (2020)
Applications	
VAS is feasible and acceptable.	Wu (2014)
VAS can serve as a feasible and reliable method to elicit patient values and is the predominant basis for generating an experienced health state-based value set.	Pickard (2017)
VAS method appears to be a more valid approach for valuation in the general population due to its greater simplicity and feasibility.	Wang (2020)

<p>That the rating scale method is most strongly related to the dimensions of quality of life could be used as an argument for using the rating scale method to measure health-state utilities.</p>	<p>Lundberg (1999)</p>
<p>VAS is not a multi-attribute, choice-based preference instrument, but it was included because it is sometimes seen as a more practical and equally valid alternative.</p>	<p>Langfitt (2006)</p>
<p>This study has demonstrated a high degree of acceptance by respondents and suggests that the VAS method can perform very successfully in generating health state valuations from the general public. These are powerful arguments for the serious consideration of VAS in a survey context, possibly alongside a choice-based method. Given its ease of use and low resource cost, it is time to reconsider the place of VAS (and other category rating methods) in the study of health.</p>	<p>Gudex (1996)</p>
<p>VAS gives a single score where health states lie compared to the best and worst imaginable overall health states.</p>	<p>Zrubka (2019)</p>
<p>VAS reflects the general health status of a patient with lupus.</p>	<p>Moore (1999)</p>
<p>VAS can be used as a “stand-alone” question, without any need for recall health data to be invoked.</p>	<p>Shmueli (2008)</p>
<p>Based on our findings, VAS captures the variability of utility across various pregnancy contexts and may be the most appropriate metric for use in assessing health utility among pregnant women.</p>	<p>Lundsberg (2017)</p>
<p>The stability found indicates that the VAS is quite robust with respect to growing exposure to health details.</p>	<p>Shmueli (2008)</p>
<p>The results of our study show that subject-reported VAS is sensitive to changes in HRQOL– health state.</p>	<p>Dillman (2016)</p>

EQ VAS may incorporate health information not reflected in the EQ-5D.	Chapman (2009)
In the EQ VAS assessment, participants included all important health aspects that they perceived were not covered by the EQ-5D-5L descriptive system, such as stress, well-being, relationships, job satisfaction, and fitness.	Ernstsson (2020)
VAS terms are also likely to be proxying for effects not otherwise represented in the model.	Dolan (2002)
VAS performs better in a predictive capacity in that those patients who require fewer visits have, on average, higher initial VAS scores.	Dolan (1999)
VAS is a simple and effective tool for economic evaluations.	Yu (2020)
VAS is easy to administer, quick and cheap, and can be easily used in decision-making models in everyday practice.	Loon (2017)
VAS might have an important role in familiarizing respondents with health states and with the idea that they can be expressed using a scale.	Dolan (2002)

VAS Visual Analogue Scale

Table S6: Reported disadvantages of using a VAS in the included studies

Quotations from the studies about disadvantages of using a VAS	References
Comparison with other valuation methods	
VAS measures attributes similarly to other generic health instruments (nonutility based), but TTO and SG incorporate preferences in a way that may better reflect decision-making processes.	Suarez-Almazor (2001)
Similar to the direct utility instruments (standard gamble and time trade-off) the Euro-thermometer VAS does not evaluate specific quality of dimensions but is not preference-based.	Huber (2021)
VAS is different from the SG, TTO, and WTP, in that it does not involve any tradeoffs or personal attitudes toward risk, time, or money.	King (2004)
An important consequence of the compression of VAS values is that the TTO is likely to discriminate better between health states at many points on the health continuum.	Badia (1999)
Only 3 of the instruments (the SF-6D, the Euro-thermometer VAS, and the time trade-off test) were responsive to CPAP treatment, while 2 (including the widely used EQ-5D and the standard gamble test) remained unchanged despite major improvements in breathing disturbances and symptoms.	Huber (2021)
The selection of VAS value set goes against the current preference of TTO based value sets in Asia.	Yusof (2012)
The VAS and SG-tool received similar difficulty ratings.	Yong and Shafie (2016)
Applications	
VAS rating scale represents a preference-based method but lacks the equivalent conceptual richness and does not reflect how people actually form their preferences.	Khabibullina (2019)

<p>The limitation of employing VAS-rated health states is that VAS methods are not regarded to measure preference on a cardinal scale.</p>	<p>Seidl (2015)</p>
<p>Responses to rating scales, including the VAS, tend not to have interval scale properties because no trade-offs are expressed.</p>	<p>Krabbe (2017)</p>
<p>VAS does not measure utilities, as only choice-based measurement techniques allow for the measurement of utilities.</p>	<p>Cleemput (2010)</p>
<p>VAS is not a choice-based method and there is a lack of choice under uncertainty.</p>	<p>Wu (2014)</p>
<p>VAS does not involve any sacrifice, and the severity of other health states being valued has been shown to influence the values produced.</p>	<p>Shafie and Thakumar (2020)</p>
<p>As the VAS does not incorporate a risk or a trade-off, it may lead to systematically lower scores.</p>	<p>Kiebert (2001)</p>
<p>Although the single-item VAS is convenient, utility preference scores from the VAS do not appear to be valid assessments of HRQOL in women with pelvic floor disorders.</p>	<p>Harvie (2018)</p>
<p>Although the single item VAS is convenient, utility preference scores from the VAS do not appear to be valid assessments of HRQOL in women with urinary incontinence.</p>	<p>Harvie (2014)</p>
<p>Although the single-item VAS appears to be convenient, it does not appear to produce scores that are valid assessments of utilities in women with fecal incontinence.</p>	<p>Harvie (2011)</p>
<p>Although median utilities for the CSG and VAS were higher, rather than lower, in the severe group, this was not significant, suggesting that the CSG and VAS did not have</p>	<p>Wang (2020)</p>

enough sensitivity to distinguish between these two levels of severity.

The VAS method is not considered a real preference-measurement instrument because it does not require participants to consider the potential downsides of therapy. Faris (2018)

VAS is prone not only to end-aversion but also to context or reference bias. Krabbe (2017)

VAS does not appear to add very much to the explanatory power of the model. Dolan (2002)

VAS showed lower correlation with other generic HRQOL instruments (HUI-3, EQ-5D, and SF-6D) as well as condition-specific symptom severity and quality-of-life instruments (the PFDI and PFIQ). Harvie (2011)

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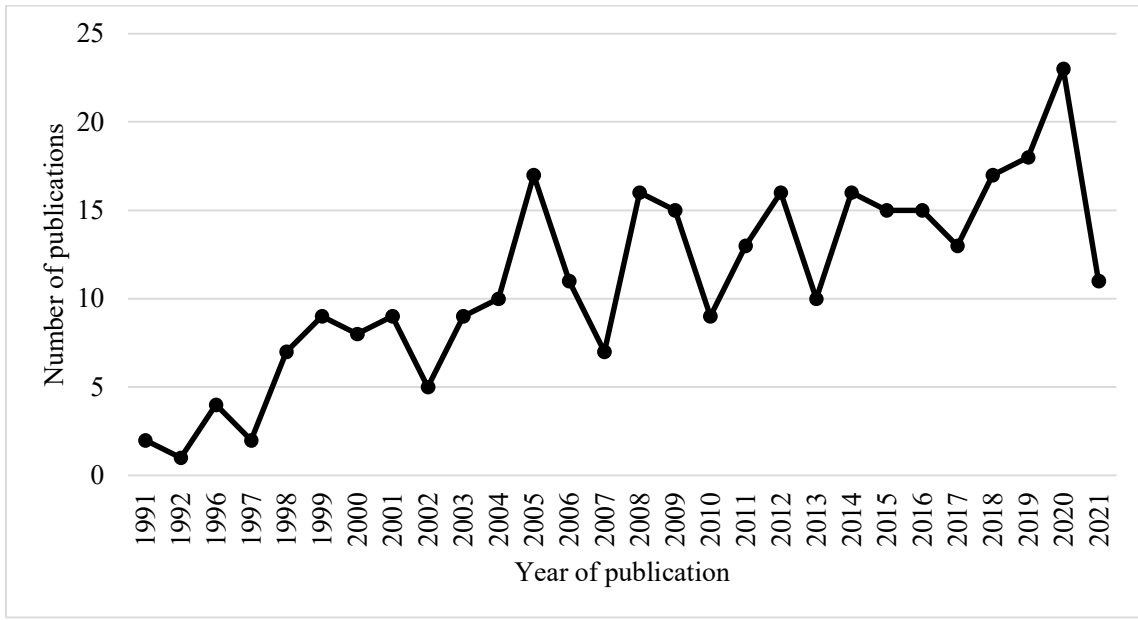


Figure S1: Number of Included Studies by Publication Year (n = 308)

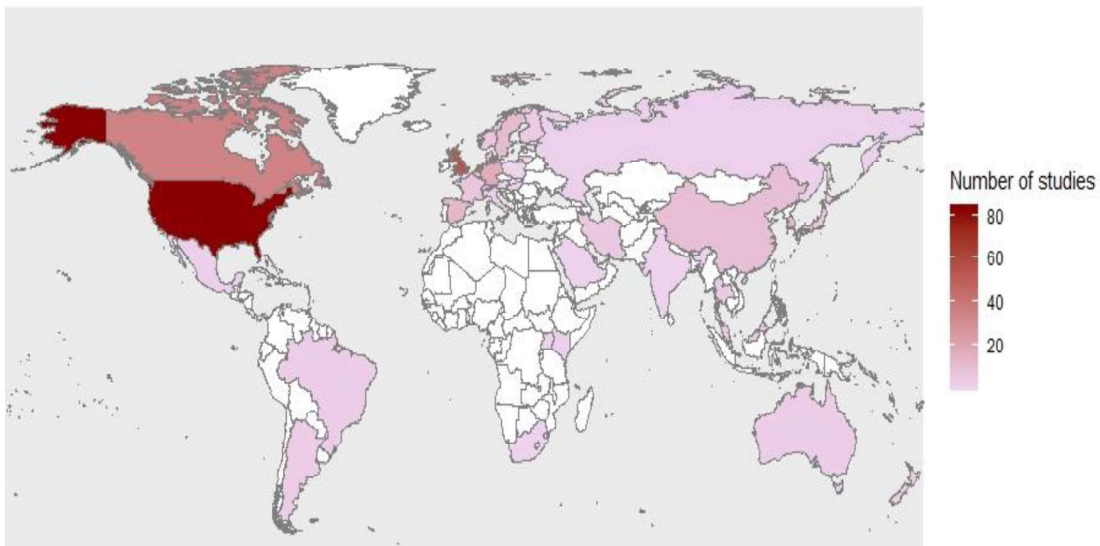


Figure S2: Countries Where the Included Studies Were Conducted (n = 308)