

**NATIONAL INSTITUTE FOR HEALTH AND
CARE EXCELLENCE**

**Modular update to NICE manuals
EQ-5D-5L value set**

Evidence review document

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1 Key messages

- 1.1 NICE is consulting on how we plan to implement the recently published EQ-5D-5L value set into our methods. We are doing this through our [modular update process](#) and we welcome feedback from all users and stakeholders.
- 1.2 The EQ-5D captures how someone's health affects their daily life and helps us compare the benefits of different treatments. A mathematical model called a 'value set' converts EQ-5D questionnaire responses to a utility value, which we use in economic models to estimate the cost effectiveness of a treatment. A value set is produced by collecting the public's views about what aspects of health-related quality of life matter most to them. A new value set for the EQ-5D-5L has recently been published (Rowen et al. 2026). It provides a more accurate picture of what matters to people today and will replace the value set used in NICE evaluations. We have worked closely with the researchers who developed the value set; our partners at Department of Health and Social Care (DHSC) and NHS England (NHSE); and EuroQol, the not-for-profit foundation that developed the EQ-5D instruments, to ensure that the new value set is robust and reliable. Adopting it will help NICE measure the health benefits of new treatments more precisely, which means we can better judge whether they offer good value for money.
- 1.3 Adopting the new EQ-5D-5L value set will affect cost-effectiveness results, and that will be determined by the balance between a treatment's effects on extending how long people live and improving health-related quality of life. In a small impact assessment using a sample of 39 decisions from 37 technology appraisals (Biz et al. 2026), cancer medicines became more cost effective with the EQ-5D-5L value set. For medicines that treat non-cancer conditions, the impact was mixed. Medicines that improved health-related quality of life but did not affect how long people with

non-cancer conditions live became less cost effective. Medicines that helped extend how long people with non-cancer conditions live mostly became more cost effective, but not in all cases.

1.4 Adopting the EQ-5D-5L value set is unlikely to change the severity weighting applied to most technology appraisal decisions. This conclusion is based on an analysis using the same sample of 39 technology appraisal decisions, plus 18 additional decisions (Wailoo et al. 2026).

1.5 Based on the results of our impact assessments, NICE recognises that some people, including those with certain chronic and disabling conditions, could potentially be negatively impacted by adopting the EQ-5D-5L value set, because treatments for their conditions may become less cost effective than under NICE's current approach of using the EQ-5D-3L value set. But, the new value set reflects an evidence-based methods improvement that will allow NICE to more accurately estimate the health benefits and cost effectiveness of new technologies consistently across our evaluations, regardless of the condition being treated. We will mitigate against any negative impact by promoting existing flexibilities in our methods. A [full equality and health inequality impact assessment \(EHIA\)](#) is provided as part of this consultation.

1.6 The methods update will affect NICE's [technology appraisal and highly specialised technologies guidance manual \(PMG36\)](#) and [developing NICE guidelines manual \(PMG20\)](#). We will amend these to stipulate that stakeholders preparing evidence submissions for NICE should use the EQ-5D-5L descriptive system and value set (Rowen et al. 2026) for reference-case analyses. If data has been collected using the EQ-5D-3L descriptive system, we will require it to be mapped onto the EQ-5D-5L value set. The EQ-5D-5L will also be required in any HealthTech evaluations that require cost–utility analyses. However, [NICE's HealthTech programme manual \(PMG48\)](#) does not require any updates

because it does not mention the EQ-5D and directs stakeholders to the technology appraisal and highly specialised technologies guidance manual for information on measuring and valuing health effects in cost–utility analyses.

- 1.7 The Decision Support Unit (DSU) has updated the instructions for implementing the mapping model and revised the relevant Technical Support Documents (Wailoo 2024, Wailoo et al. 2023). These resources are available to stakeholders as part of this consultation, for information purposes.

2 Background

- 2.1 The EQ-5D is a generic health-related quality of life questionnaire, meaning it can be used across a wide range of diseases, conditions and populations, rather than being specific to one illness. It asks people to rate their degree of impairment in 5 areas ('dimensions'): mobility, self-care, usual activities, pain/discomfort and anxiety/depression. There are 2 versions used in adults: the original 3-level version (3L), introduced in 1990, and the newer, more sensitive 5-level version (5L), released in 2009 (Devlin and Brooks 2017). The levels refer to the number of multiple-choice options (indicating the extent of problems) for each dimension. For ease of reading, the terms 'EQ-5D-3L' and '3L' are used interchangeably, and 'EQ-5D-5L' and '5L' are also used interchangeably.
- 2.2 A mathematical model called a 'value set' converts EQ-5D questionnaire responses to a utility value, where 0 represents dead and 1 represents perfect health. A value set is produced by collecting the public's views about the relative importance of the 5 aspects of health-related quality of life measured by the EQ-5D questionnaire (also known as the 'descriptive system'), and what matters most to them, in a 'valuation study'. People's perceptions of health states vary across cultures and are affected by demographic differences, so value sets are country specific.
- 2.3 Utility values are used in economic models to combine estimates of health-related quality of life with length of life. We express this combination as quality-adjusted life years (QALYs). NICE looks at the extra cost of a new treatment compared with the extra QALYs it provides. This gives us the incremental cost-effectiveness ratio (ICER), which tells us how much it costs to gain 1 extra QALY. ICERs help us judge whether a treatment offers value for money for the NHS.

2.4 Through the severity modifier, NICE committees can give extra weight to the health benefits of a treatment when it is used for a particularly severe condition (referred to from here as ‘severity weighting’). A treatment qualifies for severity weighting if the condition it treats is expected to cause a large loss in a person’s future QALYs, compared with the future QALYs someone in the general population without the condition would be expected to experience. This loss may be measured as either total QALYs lost (absolute shortfall, AS) or a proportion of the QALYs the person would be expected to experience without the condition (proportional shortfall, PS). The treatment is eligible for severity weighting if either the AS or the PS reaches 1 of the cutoffs set by NICE (see table 6.1 of NICE’s [technology appraisal and highly specialised technologies guidance manual \[PMG36\]](#)). When this happens, the QALYs gained from that treatment are multiplied by either 1.2 or 1.7, depending on which cutoff has been reached. Increases in AS or PS, or both, can mean a treatment qualifies for higher severity weighting, which would make the treatment more cost effective (that is, it has a lower ICER).

3 Current approach in NICE manuals

3.1 The EQ-5D is NICE’s preferred measure of health-related quality of life in adults, so that evaluations are consistent. We do not recommend specific measures of health-related quality of life in children and young people. NICE’s [guidelines manual](#) and [technology appraisal and highly specialised technologies guidance manual](#) state that valuation studies for health-related quality of life instruments should be based on public preferences from a representative sample of the UK population using a choice-based method.

3.2 NICE’s manuals support using either the EQ-5D-3L or the EQ-5D-5L descriptive system to collect health-related quality of life data in adults. But these dictate that 5L descriptive system data should be

mapped onto the 3L value set to calculate utility values for reference-case analyses.

- 3.3 NICE does not recommend using the EQ-5D-5L value set for England published by Devlin et al. (2018a), because of concerns about the data and modelling approach raised during independent quality assurance by the National Institute for Health and Care Research Policy Research Unit for Economic methods of Evaluation in health and care interventions (EEPRU) (Hernández Alava et al. 2020). In a [position statement on use of the EQ-5D-5L value set](#), NICE recommended doing a new valuation study, with stricter governance and quality assurance built in throughout. This study, reporting an EQ-5D-5L value set for the UK, has now been published (Rowen et al. 2026).

4 Case for adopting the new UK EQ-5D-5L value set

- 4.1 Use of the EQ-5D-5L descriptive system has been increasing because it captures health-related quality of life more accurately and sensitively than the EQ-5D-3L (Buchholz et al. 2018, Devlin et al. 2018b). But in the absence of an accepted 5L value set for the UK, NICE's methods currently rely on mapping 5L descriptive system data onto the 3L value set. This approach, although unavoidable until now, has several limitations. First, the 3L value set is unlikely to reflect current societal preferences about health-related quality of life, because the data were collected in the early 1990s (Dolan 1997). Much has changed since then: the UK population demographics are different, healthcare has advanced, and public awareness of health issues has evolved. This means that what people consider important about their health is likely to be different now, and this is captured in the new 5L value set. Research comparing older and more recent EQ-5D value sets in other countries has demonstrated substantial changes in utility

values over time, and researchers have highlighted the importance of periodically updating value sets (Liao et al. 2026, Norman et al. 2025, Roudijk and Jonker 2026). The change in population demographics also means the 3L value set may no longer satisfy NICE's requirement for valuation studies to reflect the general population. Finally, the methods for eliciting health state preferences, and the approaches to modelling preference data, have improved since the 1990s (Norman et al. 2025, Oppe et al. 2014, Ramos-Goñi et al. 2017, Rowen et al. 2022). These more reliable methods have been used to develop the new 5L value set, and the appropriate quality assurance of the data and modelling has been completed.

- 4.2 The EQ-5D-5L value set study was overseen by a steering group that included academics and representatives from NICE, NHS England, the Department of Health and Social Care (DHSC) and EuroQol (the international non-profit research foundation that develops, distributes and licenses the EQ-5D instruments). In addition, an independent quality control team, which included valuation and modelling experts not involved in the study team or steering group, reviewed the study protocol, quality assured the data at several predefined timepoints, and checked the modelling for errors and reproducibility (EuroQol 2020). Patients and members of the public also helped shape how the study was designed, carried out and interpreted. Their views were invited during several structured sessions between the study team and representatives nominated by NICE's people and communities involvement and engagement team. The study's quality control team and steering group concluded that the data collected was of high quality and that the modelling approach was appropriate and well justified. The study has been peer reviewed and published in *Value in Health* (Rowen et al. 2026).

- 4.3 In summary, the case for adopting the UK value set is strong. It represents a more accurate depiction of current societal preferences and will allow NICE to more accurately account for the health benefits of technologies and other interventions.

5 Proposed changes to the NICE manuals

- 5.1 Based on the evidence, our recommendation is that the [NICE technology appraisal and highly specialised technologies guidance manual \(PMG36\)](#) and the [developing NICE guidelines manual \(PMG20\)](#) require updating to stipulate that utility values in reference-case analyses should be calculated using the EQ-5D-5L descriptive system and the UK value set published by Rowen et al. (2026). It will state that data gathered using the EQ-5D-3L descriptive system should be mapped onto the 5L value set, using the mapping function and dataset recommended in the current manual (PMG36). [Appendix A](#) has details on the proposed amendments to the manuals' wording.
- 5.2 The EQ-5D-5L descriptive system and value set should also be used for any HealthTech evaluations that require cost–utility analyses. However, the [NICE HealthTech programme manual \(PMG48\)](#) does not require any updates because it does not mention the EQ-5D measure and directs stakeholders to the technology appraisal and highly specialised technologies guidance manual (PMG36) for information on measuring and valuing health effects in cost–utility analyses.
- 5.3 In line with NICE's modular updates framework, available as part of a [public board paper \(Word\)](#), the updated methods will be prospectively applied to NICE guidance. That is, for all topics for which the evaluation started after the publication date of the updated manuals. For technology appraisals and highly specialised technologies (HST) guidance this refers to the invitation to

participate, and for HealthTech evaluations this refers to the topic launch. For NICE guidelines this refers to topic selection.

- 5.4 Existing NICE recommendations using the EQ-5D-3L value set will not be reviewed solely to incorporate the EQ-5D-5L value set. Guidance will be updated only if there are changes to the evidence base, clinical pathway or economic case that are likely to have a material effect on the recommendations.

6 Impact of adopting the EQ-5D-5L value set

- 6.1 To understand the potential impact of adopting the EQ-5D-5L value set, we commissioned 2 projects:

- EEPRU examined the impact on quality-adjusted life years (QALYs) and incremental cost-effectiveness ratios (ICERs) (Biz et al. 2026).
- The DSU examined the impact on absolute and proportional QALY shortfall estimates, and the number of decisions qualifying for the severity modifier (Wailoo et al. 2026).

- 6.2 We have not assessed the impact of adopting the EQ-5D-5L value set on carer health-related quality of life because of the small number of evaluations that include estimates of carer health-related quality of life. A review of published technology appraisals and HST recommendations until 2022 showed that only 25 technology appraisals (4% of the total topics published) and 11 HSTs (65% of the total topics published) included carer health-related quality of life (Kanters et al. 2024). Only 14 of those 36 evaluations used EQ-5D utility values in the economic model, and some of these will have used the same published source of utilities.

Impact on cost-effectiveness estimates

- 6.3 EEPRU purposively selected 39 decisions from 37 technology appraisals, published between 2016 and August 2024, that reported using EQ-5D-3L utility values in the economic model. The

selected case studies broadly reflect the range of disease areas considered by NICE, but the sample was not formally designed to precisely mirror our portfolio of guidance topics. They assessed how using the new 5L value set instead of the 3L value set would have affected estimates of QALYs and ICERs. HST decisions were excluded because of the relatively small number of published evaluations and because they are usually for childhood diseases, whereas the EQ-5D-5L measure and its value set were designed for use in adults only. Also, there is often uncertainty in utility estimates and other model assumptions and resulting cost-effectiveness estimates for HST topics because of the difficulties with evidence generation for rare diseases. HealthTech evaluations were excluded because utility estimates are usually sourced from the literature, where it is often unclear which version of the EQ-5D was used (3L or 5L).

6.4 EEPRU found that using the EQ-5D-5L value set increased the total QALY gains for both the intervention and the comparator in all appraisals reviewed. If the increase in QALY gains for the intervention was greater than the increase in QALY gains for the comparator, there was an increase in the incremental QALY gains and consequently a decrease in the ICER. When the increase in intervention QALY gains was less than the increase in comparator QALY gains, the ICER increased.

6.5 The impact on cost effectiveness differed between cancer medicines and medicines that treat non-cancer conditions. It also depended on whether the intervention's health benefits were driven by extending how long people live or improving health-related quality of life (table 1).

- Cancer medicines, which represent over half of NICE's technology appraisals portfolio (table 2), became more cost effective with the 5L value set: ICERs decreased by a median of 12%.

- Medicines that did not affect how long people with non-cancer conditions live, which represent approximately 20% of NICE's technology appraisals portfolio, became less cost effective: ICERs increased by a median of 59%. The technology appraisals in this category were treatments for migraine, chronic sialorrhoea, ulcerative colitis, obstructive sleep apnoea, prurigo nodularis, hidradenitis suppurativa, alopecia areata, atopic dermatitis and plaque psoriasis.
- For medicines that helped extend how long people with non-cancer conditions live, which represent just over 20% of NICE's technology appraisals portfolio, the results were mixed: some medicines became more cost effective and some became less cost effective. In most cases (7 of the 11 recommendations), ICERs decreased. Across all medicines in this category the median change in ICERs was a 9% decrease, based on 11 ICERs from 10 technology appraisals (1 topic included 2 separate populations, meaning 2 separate ICERs were reported).

Detailed methods and results are available in EEPRU's published report (Biz et al. 2026). Although we have not done any specific impact assessment on guidelines, we do not see any reason to expect that the impacts observed for medicines will be different for interventions included in NICE guidelines.

- 6.6 In EEPRU's analysis, the largest impacts of the 5L value set were seen for treatments that did not affect how long people lived: the ICERs for the medicines analysed increased by an average of 59%. We recognise that this is a substantial impact on cost-effectiveness estimates, but caution that the estimate for this category of medicines is uncertain because the sample size was small (11 ICERs from 10 published technology appraisals) and cannot be generalised to all quality-of-life improving interventions. The impact of using the 5L value set is likely to be different

depending on the size of the treatment benefit and which aspects of health-related quality of life are improved with treatment (as measured by the 5 dimensions in the EQ-5D). Medicines can improve health-related quality of life in many ways, so no sample would be able to fully represent all such medicines. It is also important to note that the incremental QALY gains were very small for most of the treatments in this category. This means that ICERs are very sensitive to changes in the costs included in the health economic model, such as the medicine’s price. Even a small reduction in medicine price, or other costs, could substantially reduce the ICER. Confidential commercial data held within NICE suggests the relationship between ICERs and prices is such that we do not anticipate a significant negative impact on NICE recommendations and patient access to these types of treatments.

Table 1. Impact of adopting the EQ-5D-5L value set (Biz et al. 2026)

	Change in incremental QALYs (median)	Impact on ICERs	Change in ICERs (median)
Cancer medicines	+13.7%	Decreases (more cost effective)	-12.0% Based on 17 ICERs from 17 TAs
Medicines that did not affect how long people with non-cancer conditions live	-37.0%	Increases (less cost effective)	+58.8% Based on 11 ICERs from 10 TAs (1 TA included 2 decisions for 2 separate populations)
Medicines that helped extend how long people with non-cancer conditions live	+9.6%	Mixed	-8.8% Based on 11 ICERs from 10 TAs (1 TA included 2 decisions for 2 separate populations)

Abbreviations: ICER, incremental cost-effectiveness ratio; QALY, quality-adjusted life year; TA, technology appraisal. Medicines were categorised as helping to extend how long people live if they extended life by 1 day or more in the cost-effectiveness model.

Table 2. Analysis of recently published and ongoing topics in NICE’s portfolio

	Technology appraisals between 22 March 2023 and 25 June 2025 (n=188)	HealthTech evaluations up to 21 August 2025 (n=125)	Guidelines between 24 July 2013 and 18 June 2025 (n=223)
Cancer topics	56%	6%	9%
Topics for non-cancer conditions	44%	94%	91%
Non-cancer conditions: intervention did not extend life	20%	Not feasible to stratify interventions into this category	Not feasible to stratify interventions into this category
Non-cancer conditions: intervention extended life	23%	Not feasible to stratify interventions into this category	Not feasible to stratify interventions into this category

[Appendix B](#) has details on the methods used to inform the analysis of recently published and ongoing topics presented in table 2.

Impact on application of the severity modifier

6.7 The DSU used 2 samples to examine the impact of adopting the EQ-5D-5L value set on the application of severity weightings. The first sample (referred to from here as the ‘main sample’) was the same 39 decisions used in EEPUR’s analysis of the impact of the 5L value set on cost-effectiveness estimates. The distribution of AS and PS levels (the 2 criteria for qualifying for the severity modifier) across these 39 decisions was broadly representative of that seen in NICE’s technology appraisals decisions. The AS and PS distributions were similar to those of the sample used in the September 2024 review of the implementation of the severity modifier, as well as recent monitoring data on the uptake of the severity modifier (measured by the cumulative mean QALY weight used in technology appraisals published since January 2022). Ensuring representativeness was important, because a skewed sample could bias the estimates of the impact of the 5L value set on AS, PS or overall severity weightings. The DSU’s main sample

was supplemented by a second ('sensitivity') sample of 18 appraisal decisions, totalling 57 decisions. The additional 18 decisions were selected because they either met the criteria for the severity weighting or were close to the cutoffs for qualifying for the weighting. This sample contained a higher proportion of decisions for severe conditions than the main sample, as shown by the mean severity weights for each: the mean severity weight in the sensitivity sample was higher (1.267 compared with 1.133 in the main sample).

- 6.8 The DSU analyses showed that moving from the 3L to the 5L value set is unlikely to change the severity weighting in most technology appraisal decisions. This is because using the 5L value set appears to have a greater impact on AS than PS, but the severity weighting in most technology appraisal decisions is determined by PS. Although large reductions in AS can occur when using the 5L value set (the DSU identified 2 decisions with large AS decreases of 3 QALYs or more), such changes would not always alter the severity weighting used in decision making. This is partly because the cutoffs that determine whether a treatment qualifies for the severity weighting span broad ranges of AS and PS. A treatment will qualify for the lower severity weighting (where QALYs gained are multiplied by 1.2) if AS is anywhere between 12 and 18 QALYs. The higher weighting (where QALYs gained are multiplied by 1.7) is applied when AS is at least 18 QALYs, and no weighting is applied when AS is less than 12 QALYs. In only 1 of the 2 cases identified by the DSU did the large reduction in AS lead to a change in the severity weighting.
- 6.9 For cancer medicines, AS consistently increased when using the 5L value set (albeit by a relatively small amount: mean 0.55 QALYs), whereas PS was largely unchanged. The pattern for medicines that treat non-cancer conditions was less clear: both AS and PS usually decreased, with variable magnitude.

- 6.10 Larger reductions in both AS and PS were seen in technology appraisals for people with younger average starting ages in the cost-effectiveness models. This seems to suggest that adopting the 5L value set may be less favourable for younger people than for older people. That is, younger people may be less likely to receive the severity weighting. But, the DSU analysis did not identify any evidence that the severity weighting is systematically worse for younger people when using the 5L value set. In the 2 technology appraisal decisions that had a lower severity weighting with the 5L value set, 1 was in younger people (average starting age of 4 years) and the other was in older people (average starting age of 60 years).

7 Equality and health inequality impact assessment (EHIA)

- 7.1 As part of our [equality and health inequality impact assessment \(EHIA\)](#), we reviewed the 214 most recently published NICE technology appraisals (at the time of the analysis; published between 22 March 2023 and 8 October 2025) to identify treatments that might have been less cost effective if the 5L value set had been used. We focused on medicines that did not affect how long people with non-cancer conditions live, because these interventions became less cost effective in the sample used for EEPRU's impact assessment, and found 39 appraisals. We also considered the limited evidence from DSU's impact assessment that adopting the 5L value set may be less favourable for younger people than for older people.
- 7.2 Assessing the equalities and health inequalities relevant to these 39 appraisals identified several populations that may be negatively affected by adopting the 5L value set and that could also qualify as disabilities under the Equality Act 2010. These include people with multiple sclerosis, Duchenne muscular dystrophy and ulcerative

colitis. We also identified groups with other protected characteristics, as well as groups with wider determinants of poor health, who may be negatively affected by adopting the 5L value set because treatments for conditions more common in these groups may become less cost effective. There are also some populations that are likely to be positively affected by adopting the 5L value set. These include people with cancer, which qualifies as a disability under the Equality Act 2010, and other conditions where treatment can extend how long someone lives. Full details are in the equality and health inequality impact assessment (EHIA) document provided as part of this consultation.

- 7.3 Notwithstanding the impact assessment identifying a disproportionate adverse impact for some groups of people, adopting the 5L value set reflects an evidence-based improvement to NICE's methods and will allow us to more accurately estimate the health benefits and cost effectiveness of new technologies consistently across our evaluations, regardless of the condition being treated. Recognising the disadvantage caused to some groups of people, we will provide committees with briefing materials and training, including information on the impact of adopting the 5L set. These will draw attention to the populations (and related equalities and health inequalities issues) that could potentially be negatively impacted because treatments become less cost effective. We will also explain the potential impact of adopting the 5L value set on the severity weightings applied in technology appraisal decisions. The briefing materials and training will also promote awareness of existing methods and processes for identifying and addressing equalities and health inequalities issues, how the committee can apply flexibility in its decision making when considering these factors, and provision for reasonable adjustments around requiring EQ-5D data (that is, accepting evidence from other health-related quality of life measures when there is evidence that the EQ-5D is not appropriate).

8 Key resources to inform stakeholder feedback

8.1 The following key resources are available to inform stakeholder feedback:

- the peer-reviewed journal publication of the UK value set for the EQ-5D-5L (Rowen et al. 2026), and the option to request the data used to develop the value set from [EuroQol's website](#)
- the impact of adopting the EQ-5D-5L value set on model-based cost-effectiveness estimates in NICE technology appraisals, available as a report on [EEPRU's website](#) and as a peer-reviewed journal publication (Biz et al. 2026)
- a [report from the Decision Support Unit](#) on the impact of adopting the EQ-5D-5L value set on the application of the severity modifier (Wailoo et al. 2026)
- an update to [Technical Support Document 22, 'Mapping to estimate health state utilities'](#) (Wailoo et al. 2023)
- an update to [Technical Support Document 23, 'A guide to calculating severity shortfall for NICE evaluations'](#) (Wailoo 2024)
- [software commands for mapping EQ-5D-3L health states onto the EQ-5D-5L value set](#) (for Stata, Excel and R)
- [software to support the calculation of QALY shortfall for assessing disease severity](#) ('shortfall calculators').

These resources are for information only. We are not inviting comments on the content of these supporting resources.

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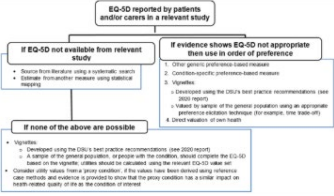
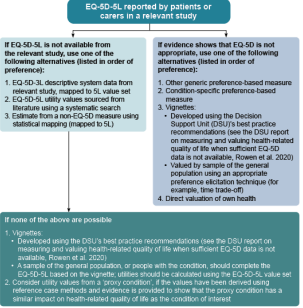
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Appendix A: Proposed changes to NICE manuals

Table A1. Proposed changes to NICE technology appraisal and highly specialised technologies guidance manual (PMG36)

Section	Current wording	Proposed change
4.2.2, Table 4.1	Health effects should be expressed in quality-adjusted life years (QALYs). The EQ-5D is the preferred measure of health-related quality of life in adults.	<p>Replace with new text:</p> <p>Health effects should be expressed in quality-adjusted life years (QALYs). The EQ-5D-5L is the preferred measure of health-related quality of life in adults.</p>
4.3.6	Given the need for consistency across evaluations, the EQ-5D measurement method is preferred to measure health-related quality of life in adults. Preference values from the EQ-5D should be applied to measurements of health-related quality of life to generate health-related utility values.	<p>Replace with new text:</p> <p>Given the need for consistency across evaluations, the EQ-5D-5L measurement method is preferred to measure health-related quality of life in adults. Companies, academic groups and others preparing evidence submissions for NICE should use the EQ-5D-5L descriptive system and value set (Rowen et al. 2026) for reference-case analyses.</p> <p>Add new section 4.3.7:</p> <p>In some cases, data may only be available from the EQ-5D-3L descriptive system. If data was gathered using the EQ-5D-3L descriptive system, utility values in reference-case analyses should be calculated by mapping the 3L descriptive system data onto the 5L value set. If analyses use data gathered using both EQ-5D-3L and EQ-5D-5L descriptive systems, the 5L value set should be</p>

Section	Current wording	Proposed change
		used to derive all utility values, with 3L mapped onto 5L when needed. The mapping function developed by the Decision Support Unit (Hernández Alava et al. 2017), using the 'EEPRU dataset' (Hernández Alava et al. 2023), should be used for reference-case analyses.
4.3.8	If not available in the relevant clinical trials, EQ-5D data can be sourced from the literature. When taken from the literature, the methods for identifying the data should be systematic and transparent. Clearly explain the justification for choosing a particular data set. When more than 1 plausible set of EQ-5D data is available, sensitivity analyses should be done to show the effect of the alternative utility values.	Replace with new text (now 4.3.9): If not available in the relevant clinical trials, EQ-5D-5L data can be sourced from the literature. When taken from the literature, the methods for identifying the data should be systematic and transparent. Clearly explain the justification for choosing a particular data set. When more than 1 plausible set of EQ-5D-5L data is available, sensitivity analyses should be done to show the effect of the alternative utility values.
4.3.9	When EQ-5D data is not available, this data can be estimated by mapping other health-related quality-of-life measures or health-related benefits seen in the relevant clinical trials to EQ-5D. This is considered to be a departure from the reference case. The mapping function chosen should be based on data sets containing both health-related quality-of-life measures and its statistical properties. It should be fully described,	Replace with new text (now 4.3.10): When EQ-5D data is not available (from either the EQ-5D-3L or EQ-5D-5L descriptive systems, or from the literature), this data can be estimated by mapping other health-related quality-of-life measures or health-related benefits seen in the relevant clinical trials onto the EQ-5D-5L value set. This is considered to be a departure from the

Section	Current wording	Proposed change
	<p>its choice justified, and it should be adequately shown how well the function fits the data. Present sensitivity analyses to explore variation in using mapping algorithms on the outputs.</p>	<p>reference case. The mapping function chosen should be based on data sets containing both health-related quality-of-life measures and its statistical properties. It should be fully described, its choice justified, and it should be adequately shown how well the function fits the data. Present sensitivity analyses to explore variation in using mapping algorithms on the outputs.</p>
<p>4.3.12</p>	<p>A hierarchy of preferred health-related quality-of-life methods is presented in figure 4.1. Use figure 4.1 for guidance when the EQ-5D is not available or not appropriate.</p> <p>Figure 4.1 Hierarchy of preferred health-related quality-of-life methods</p> 	<p>Replace with new text (now 4.3.13) and amended figure 4.1:</p> <p>A hierarchy of preferred health-related quality-of-life methods is presented in figure 4.1. Use figure 4.1 for guidance when the EQ-5D-5L data is not available, or the EQ-5D measure is not appropriate.</p> <p>Figure 4.1 Hierarchy of preferred health-related quality-of-life methods</p>  <p>NICE National Institute for Health and Care Excellence</p>

Section	Current wording	Proposed change
4.3.16	<p>The EQ-5D-5L is a new version of the EQ-5D, with 5 response levels. NICE does not recommend using the EQ-5D-5L value set for England published by Devlin et al. (2018). Companies, academic groups and others preparing evidence submissions for NICE should use the 3L value set for reference-case analyses. If data was gathered using the EQ-5D-5L descriptive system, utility values in reference-case analyses should be calculated by mapping the 5L descriptive system data onto the 3L value set. If analyses use data gathered using both EQ-5D-3L and EQ-5D-5L descriptive systems, the 3L value set should be used to derive all utility values, with 5L mapped onto 3L when needed. The mapping function developed by the Decision Support Unit (Hernández Alava et al. 2017), using the 'EEPRU dataset' (Hernández Alava et al. 2023), should be used for reference-case analyses. We support sponsors of prospective clinical studies continuing to use the 5L version of the EQ-5D descriptive system to collect data on quality of life.</p>	<p>Delete section 4.3.16 (updated guidance on value set and mapping moved to section 4.3.6)</p>

Table A2. Proposed changes to [developing NICE guidelines manual \(PMG20\)](#)

Section	Current wording	Proposed change
7.4, table 7.1	<p>Measuring and valuing health effects: Quality-adjusted life years (QALYs): the EQ-5D-3L is the preferred measure of health-related quality of life in adults (See our position statement on the EQ-5D-5L)</p>	<p>Replace with new text: Measuring and valuing health effects: Quality-adjusted life years (QALYs): the EQ-5D-5L is the preferred measure of health-related quality of life in adults. The UK value set for the EQ-5D-5L (Rowen et al. 2026) should be used to generate utility values.</p>
7.7, subsection 'Measuring and valuing effects for health interventions'	<p>As outlined in NICE technology appraisal and highly specialised technologies guidance: the manual (2022) and the accompanying NICE position statement on use of the EQ-5D-5-level (5L) valuation set for England (updated October 2019), we do not currently recommend using the EQ-5D 5L valuation set. Guideline development teams should use the 3-level (3L) valuation set for reference-case analyses, when available.</p>	<p>Delete this paragraph</p>
7.9 references	<p>–</p>	<p>Add reference: Rowen D, Mukuria C, Bray N, et al. (2026) A UK value set for the EQ-5D-5L. Value in Health (forthcoming)</p>

Appendix B: Analysis of recently published and ongoing topics in NICE's portfolio

The information in table 2 was based on a review of recently published and ongoing topics in NICE's portfolio.

The sample for technology appraisals was based on a review of the 200 most recently published technology appraisals (at the time of the analysis; published between 22 March 2023 and 25 June 2025), excluding 41 withdrawn or terminated and 27 cost-comparison topics, plus 56 ongoing technology appraisals (for which an external assessment group report was available to ascertain whether the treatment is life extending). The number of technology appraisal topics, not the number of decisions, was analysed. If multiple relevant comparators were presented, a main comparator was chosen for this analysis (based on explicit reasoning in the final guidance document where possible, otherwise a judgement was made based on the committee reasoning). A limitation of the analysis is that some interventions may have been classified differently (life-extending against non-life-extending) if another comparator had been selected, this would have affected only 2 technology appraisals.

The sample for HealthTech was based on a review of all published evaluations up to 21 August 2025 that were categorised as HealthTech or MedTech on the NICE webpage. One technology was counted twice because it had clear applications in both cancer and non-cancer conditions.

The sample for guidelines was based on a review of the last 200 published guidelines or guideline updates (24 July 2013 to 18 June 2025). For pragmatic reasons, topics were categorised as cancer or non-cancer conditions based on the guideline's title alone.

Medicines were categorised as helping to extend how long people live if they extended life by 1 day or more.