

MAIMON RESEARCH LLC
**ARTIFICIAL INTELLIGENCE LARGE LANGUAGE
MODEL INTERROGATION**



**REPRESENTATIONAL MEASUREMENT FAILURE IN
HEALTH TECHNOLOGY ASSESSMENT**

**UNITED STATES: INVALID MEASUREMENT IN
HEALTH TECHNOLOGY ASSESSMENT — A
STRUCTURAL ASSESSMENT OF THE HTA RELATED
KNOWLEDGE BASE, SKAGGS SCHOOL OF
PHARMACY, UNIVERSITY OF CALIFORNIA SAN
DIEGO**

**Paul C Langley Ph.D Adjunct Professor, College of Pharmacy, University of
Minnesota, Minneapolis, MN**

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FOREWORD

HEALTH TECHNOLOGY ASSESSMENT: A GLOBAL SYSTEM OF NON-MEASUREMENT

The Skaggs School of Pharmacy and Pharmaceutical Sciences at University of California, San Diego is a research-intensive academic unit within the University of California system that integrates pharmaceutical sciences, clinical pharmacy, and health outcomes research. The School offers a Doctor of Pharmacy (PharmD) program alongside graduate training in pharmaceutical and biomedical sciences, with a strong emphasis on preparing pharmacists for roles in patient care, research, and healthcare systems leadership.

Its curriculum combines foundational biomedical sciences with clinical training and experiential education across a range of healthcare settings, including hospitals, ambulatory care, and community practice. Students are trained to participate in interdisciplinary care teams and to contribute to medication management, therapeutic decision-making, and patient outcomes. The School also emphasizes the application of data, evidence, and technology in healthcare delivery, reflecting its broader integration within the UC San Diego Health system and its research environment.

In addition, the School engages in health outcomes and policy research, including pharmacoeconomics and real-world evidence, preparing graduates to evaluate therapies not only in terms of clinical effectiveness but also with regard to resource utilization and healthcare system impact.

The objective of this study is to evaluate the knowledge base associated with the Skaggs School of Pharmacy and Pharmaceutical Sciences for its recognition and application of the axioms of representational measurement theory. Using a standardized 24-item canonical diagnostic instrument, the assessment examines whether the concepts embedded in the School's PharmD curriculum, pharmacoeconomics instruction, and outcomes research activities satisfy the conditions required for valid quantitative measurement. The focus is on the structured body of knowledge reflected in teaching materials, program design, and research orientation rather than individual faculty views. Each statement is assigned a categorical endorsement probability and transformed to a normalized logit, allowing a consistent evaluation of whether the knowledge base supports or contradicts principles such as unidimensionality, dimensional homogeneity, and the requirement that measurement must precede arithmetic.

The findings demonstrate a consistent pattern aligned with other HTA knowledge bases. Statements that reflect the requirements of representational measurement are weakly endorsed or effectively absent, while statements that contradict these requirements are strongly endorsed. In particular, there is strong support for the use of utilities, QALYs, and model-based economic evaluation without prior demonstration that the underlying constructs possess the scale properties required for arithmetic operations. The knowledge base therefore exhibits a systematic pattern of

measurement inversion: arithmetic is applied to constructs whose measurement status has not been established. This pattern is internally coherent within the HTA framework but inconsistent with the requirements for measurement-valid claims.

The starting point is simple and inescapable: *measurement precedes arithmetic*. This principle is not a methodological preference but a logical necessity. One cannot multiply what one has not measured, cannot sum what has no dimensional homogeneity, cannot compare ratios when no ratio scale exists. When HTA multiplies time by utilities to generate QALYs, it is performing arithmetic with numbers that cannot support the operation. When HTA divides cost by QALYs, it is constructing a ratio from quantities that have no ratio properties. When HTA aggregates QALYs across individuals or conditions, it is combining values that do not share a common scale. These practices are not merely suboptimal; they are mathematically impossible.

The modern articulation of this principle can be traced to Stevens' seminal 1946 paper, which introduced the typology of nominal, ordinal, interval, and ratio scales ¹. Stevens made explicit what physicists, engineers, and psychologists already understood: different kinds of numbers permit different kinds of arithmetic. Ordinal scales allow ranking but not addition; interval scales permit addition and subtraction but not multiplication; ratio scales alone support multiplication, division, and the construction of meaningful ratios. Utilities derived from multiattribute preference exercises, such as EQ-5D or HUI, are ordinal preference scores; they do not satisfy the axioms of interval measurement, much less ratio measurement. Yet HTA has, for forty years, treated these utilities as if they were ratio quantities, multiplying them by time to create QALYs and inserting them into models without the slightest recognition that scale properties matter. Stevens' paper should have blocked the development of QALYs and cost-utility analysis entirely. Instead, it was ignored.

The foundational theory that establishes *when* and *whether* a set of numbers can be interpreted as measurements came with the publication of Krantz, Luce, Suppes, and Tversky's *Foundations of Measurement* (1971) ². Representational Measurement Theory (RMT) formalized the axioms under which empirical attributes can be mapped to numbers in a way that preserves structure. Measurement, in this framework, is not an act of assigning numbers for convenience, it is the discovery of a lawful relationship between empirical relations and numerical relations. The axioms of additive conjoint measurement, homogeneity, order, and invariance specify exactly when interval scales exist. RMT demonstrated once and for all that measurement is not optional and not a matter of taste: either the axioms hold and measurement is possible, or the axioms fail and measurement is impossible. Every major construct in HTA, utilities, QALYs, DALYs, ICERs, incremental ratios, preference weights, health-state indices, fails these axioms. They lack unidimensionality; they violate independence; they depend on aggregation of heterogeneous attributes; they collapse under the requirements of additive conjoint measurement. Yet HTA proceeded, decade after decade, without any engagement with these axioms, as if the field had collectively decided that measurement theory applied everywhere except in the evaluation of therapies.

Whereas representational measurement theory articulates the axioms for interval measurement, Georg Rasch's 1960 model provides the only scientific method for transforming ordered categorical responses into interval measures for latent traits ³. Rasch models uniquely satisfy the

principles of specific objectivity, sufficiency, unidimensionality, and invariance. For any construct such as pain, fatigue, depression, mobility, or need, Rasch analysis is the only legitimate means of producing an interval scale from ordinal item responses. Rasch measurement is not an alternative to RMT; it is its operational instantiation. The equivalence of Rasch's axioms and the axioms of representational measurement was demonstrated by Wright, Andrich and others as early as the 1970s. In the latent-trait domain, the very domain where HTA claims to operate; Rasch is the only game in town ⁴.

Yet Rasch is effectively absent from all HTA guidelines, including NICE, PBAC, CADTH, ICER, SMC, and PHARMAC. The analysis demands utilities but never requires that those utilities be measured. They rely on multiattribute ordinal classifications but never understand that those constructs be calibrated on interval or ratio scales. They mandate cost-utility analysis but never justify the arithmetic. They demand modelled QALYs but never interrogate their dimensional properties. These guidelines do not misunderstand Rasch; they do not know it exists. The axioms that define measurement and the model that makes latent trait measurement possible are invisible to the authors of global HTA rules. The field has evolved without the science that measurement demands.

How did HTA miss the bus so thoroughly? The answer lies in its historical origins. In the late 1970s and early 1980s, HTA emerged not from measurement science but from welfare economics, decision theory, and administrative pressure to control drug budgets. Its core concern was *valuing health states*, not *measuring health*. This move, quiet, subtle, but devastating, shifted the field away from the scientific question "What is the empirical structure of the construct we intend to measure?" and toward the administrative question "How do we elicit a preference weight that we can multiply by time?" The preference-elicitation projects of that era (SG, TTO, VAS) were rationalized as measurement techniques, but they never satisfied measurement axioms. Ordinal preferences were dressed up as quasi-cardinal indices; valuation tasks were misinterpreted as psychometrics; analyst convenience replaced measurement theory. The HTA community built an entire belief system around the illusion that valuing health is equivalent to measuring health. It is not.

The endurance of this belief system, forty years strong and globally uniform, is not evidence of validity but evidence of institutionalized error. HTA has operated under conditions of what can only be described as *structural epistemic closure*: a system that has never questioned its constructs because it never learned the language required to ask the questions. Representational measurement theory is not taught in graduate HTA programs; Rasch modelling is not part of guideline development; dimensional analysis is not part of methodological review. The field has been insulated from correction because its conceptual foundations were never laid. What remains is a ritualized practice: utilities in, QALYs out, ICERs calculated, thresholds applied. The arithmetic continues because everyone assumes someone else validated the numbers.

This Logit Working Paper series exposes, through probabilistic and logit-based interrogations of AI large language national knowledge bases, the scale of this failure. The results display a global pattern: true statements reflecting the axioms of measurement receive weak endorsement; false statements reflecting the HTA belief system receive moderate or strong reinforcement. This is not

disagreement. It is non-possession. It shows that HTA, worldwide, has developed as a quantitative discipline without quantitative foundations; a confused exercise in numerical storytelling.

The conclusion is unavoidable: HTA does not need incremental reform; it needs a scientific revolution. Measurement must precede arithmetic. Representational axioms must precede valuation rituals. Rasch measurement must replace ordinal summation and utility algorithms. Value claims must be falsifiable, protocol-driven, and measurable; rather than simulated, aggregated, and numerically embellished.

The global system of non-measurement is now visible. The task ahead is to replace it with science.

Paul C Langley, Ph.D

Email: langleylapaloma@gmail.com

DISCLAIMER

This analysis is generated through the structured interrogation of a large language model (LLM) applied to a defined documentary corpus and is intended solely to characterize patterns within an aggregated knowledge environment. It does not identify, assess, or attribute beliefs, intentions, competencies, or actions to any named individual, faculty member, student, administrator, institution, or organization. The results do not constitute factual findings about specific persons or programs, nor should they be interpreted as claims regarding professional conduct, educational quality, or compliance with regulatory or accreditation standards. All probabilities and logit values reflect model-based inferences about the presence or absence of concepts within a bounded textual ecosystem, not judgments about real-world actors. The analysis is exploratory, interpretive, and methodological in nature, offered for scholarly discussion of epistemic structures rather than evaluative or legal purposes. Any resemblance to particular institutions or practices is contextual and non-attributive, and no adverse implication should be inferred.

1. INTERROGATING THE LARGE LANGUAGE MODEL

A large language model (LLM) is an artificial intelligence system designed to understand, generate, and manipulate human language by learning patterns from vast amounts of text data. Built on deep neural network architectures, most commonly transformers, LLMs analyze relationships between words, sentences, and concepts to produce contextually relevant responses. During training, the model processes billions of examples, enabling it to learn grammar, facts, reasoning patterns, and even subtle linguistic nuances. Once trained, an LLM can perform a wide range of tasks: answering questions, summarizing documents, generating creative writing, translating languages, assisting with coding, and more. Although LLMs do not possess consciousness or true understanding, they simulate comprehension by predicting the most likely continuation of text based on learned patterns. Their capabilities make them powerful tools for communication, research, automation, and decision support, but they also require careful oversight to ensure accuracy, fairness, privacy, and responsible use

In this Logit Working Paper, “interrogation” refers not to discovering what an LLM *believes*, it has no beliefs, but to probing the content of the *corpus-defined knowledge space* we choose to analyze. This knowledge base is enhanced if it is backed by accumulated memory from the user. In this case the interrogation relies also on 12 months of HTA memory from continued application of the system to evaluate HTA experience. The corpus is defined before interrogation: it may consist of a journal (e.g., *Value in Health*), a national HTA body, a specific methodological framework, or a collection of policy documents. Once the boundaries of that corpus are established, the LLM is used to estimate the conceptual footprint within it. This approach allows us to determine which principles are articulated, neglected, misunderstood, or systematically reinforced.

In this HTA assessment, the objective is precise: to determine the extent to which a given HTA knowledge base or corpus, global, national, institutional, or journal-specific, recognizes and reinforces the foundational principles of representational measurement theory (RMT). The core principle under investigation is that measurement precedes arithmetic; no construct may be treated as a number or subjected to mathematical operations unless the axioms of measurement are satisfied. These axioms include unidimensionality, scale-type distinctions, invariance, additivity, and the requirement that ordinal responses cannot lawfully be transformed into interval or ratio quantities except under Rasch measurement rules.

The HTA knowledge space is defined pragmatically and operationally. For each jurisdiction, organization, or journal, the corpus consists of:

- published HTA guidelines
- agency decision frameworks
- cost-effectiveness reference cases
- academic journals and textbooks associated with HTA
- modelling templates, technical reports, and task-force recommendations
- teaching materials, methodological articles, and institutional white papers

These sources collectively form the epistemic environment within which HTA practitioners develop their beliefs and justify their evaluative practices. The boundary of interrogation is thus not the whole of medicine, economics, or public policy, but the specific textual ecosystem that sustains HTA reasoning. . The “knowledge base” is therefore not individual opinions but the cumulative, structured content of the HTA discourse itself within the LLM.

THE SKAGGS SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES KNOWLEDGE BASE

The knowledge base associated with the Skaggs School of Pharmacy and Pharmaceutical Sciences is a mature and research-intensive engagement with pharmacoeconomics, health outcomes research, and healthcare decision-making. Embedded within both the PharmD curriculum and broader research programs, this knowledge base prepares students to evaluate therapies in terms of clinical effectiveness, patient outcomes, and economic impact. Methods such as cost-effectiveness analysis, cost-utility analysis, and decision-analytic modeling are presented as standard tools for informing formulary decisions, reimbursement strategies, and healthcare policy.

Within this framework, the knowledge base assumes that outcomes such as quality of life, treatment benefit, and patient experience can be represented numerically and used in comparative analyses. Preference-based measures derived from multiattribute instruments are treated as if they possess the scale properties necessary for aggregation, averaging, and multiplication. This assumption underpins the use of QALYs and related constructs, which are central to economic evaluation methods. Similarly, decision-analytic models extend observed data into projections of long-term outcomes, with the implicit understanding that the inputs to these models are valid quantitative measures.

However, the knowledge base does not explicitly address the measurement requirements that would justify these practices. There is no systematic engagement with the axioms of representational measurement or with the conditions under which numerical assignments can be considered measures rather than descriptive scores. Concepts such as unidimensionality, invariance, and dimensional homogeneity are not central to the curriculum or research framework. Instead, emphasis is placed on the application of established analytical methods, with their legitimacy assumed rather than demonstrated.

As a consequence, arithmetic operations are routinely applied to constructs whose measurement status has not been established. Multiplication is used in the construction of QALYs without confirmation that utility scores are ratio measures. Aggregation and averaging are applied to composite indices derived from multiple attributes, despite the absence of unidimensionality. Latent constructs, including patient-reported outcomes, are represented through summed or transformed responses without the use of a measurement model, such as the Rasch model, that would ensure interval structure and invariance.

The knowledge base is therefore internally coherent and aligned with the expectations of contemporary health technology assessment and pharmacy practice. As a leading research institution, the School contributes to the development and dissemination of these methods, reinforcing their acceptance within the broader HTA framework. At the same time, the absence of

explicit measurement foundations means that numerical outputs are treated as measures without establishing their measurement properties. This reflects a broader structural feature of HTA, where analytical sophistication is not matched by adherence to the requirements of representational measurement.

CATEGORICAL PROBABILITIES

In the present application, the interrogation is tightly bounded. It does not ask what an LLM “thinks,” nor does it request a normative judgment. Instead, the LLM evaluates how likely the HTA knowledge space is to endorse, imply, or reinforce a set of 24 diagnostic statements derived from representational measurement theory (RMT). Each statement is objectively TRUE or FALSE under RMT. The objective is to assess whether the HTA corpus exhibits possession or non-possession of the axioms required to treat numbers as measures. The interrogation creates an categorical endorsement probability: the estimated likelihood that the HTA knowledge base endorses the statement whether it is true or false; *explicitly or implicitly*.

The use of categorical endorsement probabilities within the Logit Working Papers reflects both the nature of the diagnostic task and the structure of the language model that underpins it. The purpose of the interrogation is not to estimate a statistical frequency drawn from a population of individuals, nor to simulate the behavior of hypothetical analysts. Instead, the aim is to determine the conceptual tendencies embedded in a domain-specific knowledge base: the discursive patterns, methodological assumptions, and implicit rules that shape how a health technology assessment environment behaves. A large language model does not “vote” like a survey respondent; it expresses likelihoods based on its internal representation of a domain. In this context, endorsement probabilities capture the strength with which the knowledge base, as represented within the model, supports a particular proposition. Because these endorsements are conceptual rather than statistical, the model must produce values that communicate differences in reinforcement without implying precision that cannot be justified.

This is why categorical probabilities are essential. Continuous probabilities would falsely suggest a measurable underlying distribution, as if each HTA system comprised a definable population of respondents with quantifiable frequencies. But large language models do not operate on that level. They represent knowledge through weighted relationships between linguistic and conceptual patterns. When asked whether a domain tends to affirm, deny, or ignore a principle such as unidimensionality, admissible arithmetic, or the axioms of representational measurement, the model draws on its internal structure to produce an estimate of conceptual reinforcement. The precision of that estimate must match the nature of the task. Categorical probabilities therefore provide a disciplined and interpretable way of capturing reinforcement strength while avoiding the illusion of statistical granularity.

The categories used, values such as 0.05, 0.10, 0.20, 0.50, 0.75, 0.80, and 0.85, are not arbitrary. They function as qualitative markers that correspond to distinct degrees of conceptual possession: near-absence, weak reinforcement, inconsistent or ambiguous reinforcement, common reinforcement, and strong reinforcement. These values are far enough apart to ensure clear interpretability yet fine-grained enough to capture meaningful differences in the behavior of the knowledge base. The objective is not to measure probability in a statistical sense but to classify

the epistemic stance of the domain toward a given item. A probability of 0.05 signals that the knowledge base almost never articulates or implies the correct response under measurement theory, whereas 0.85 indicates that the domain routinely reinforces it. Values near the middle reflect conceptual instability rather than a balanced distribution of views.

Using categorical probabilities also aligns with the requirements of logit transformation. Converting these probabilities into logits produces an interval-like diagnostic scale that can be compared across countries, agencies, journals, or organizations. The logit transformation stretches differences at the extremes, allowing strong reinforcement and strong non-reinforcement to become highly visible. Normalizing logits to the fixed ± 2.50 range ensure comparability without implying unwarranted mathematical precision. Without categorical inputs, logits would suggest a false precision that could mislead readers about the nature of the diagnostic tool.

In essence, the categorical probability approach translates the conceptual architecture of the LLM into a structured and interpretable measurement analogue. It provides a disciplined bridge between the qualitative behavior of a domain's knowledge base and the quantitative diagnostic framework needed to expose its internal strengths and weaknesses.

The LLM computes these categorical probabilities from three sources:

1. **Structural content of HTA discourse**

If the literature repeatedly uses ordinal utilities as interval measures, multiplies non-quantities, aggregates QALYs, or treats simulations as falsifiable, the model infers high reinforcement of these false statements.

2. **Conceptual visibility of measurement axioms**

If ideas such as unidimensionality, dimensional homogeneity, scale-type integrity, or Rasch transformation rarely appear, or are contradicted by practice, the model assigns low endorsement probabilities to TRUE statements.

3. **The model's learned representation of domain stability**

Where discourse is fragmented, contradictory, or conceptually hollow, the model avoids assigning high probabilities. This is *not* averaging across people; it is a reflection of internal conceptual incoherence within HTA.

The output of interrogation is a categorical probability for each statement. Probabilities are then transformed into logits [$\ln(p/(1-p))$], capped to ± 4.0 logits to avoid extreme distortions, and normalized to ± 2.50 logits for comparability across countries. A positive normalized logit indicates reinforcement in the knowledge base. A negative logit indicates weak reinforcement or conceptual absence. Values near zero logits reflect epistemic noise.

Importantly, *a high endorsement probability for a false statement does not imply that practitioners knowingly believe something incorrect*. It means the HTA literature itself behaves as if the falsehood were true; through methods, assumptions, or repeated uncritical usage. Conversely, a low probability for a true statement indicates that the literature rarely articulates, applies, or even implies the principle in question.

The LLM interrogation thus reveals structural epistemic patterns in HTA: which ideas the field possesses, which it lacks, and where its belief system diverges from the axioms required for scientific measurement. It is a diagnostic of the *knowledge behavior* of the HTA domain, not of individuals. The 24 statements function as probes into the conceptual fabric of HTA, exposing the extent to which practice aligns or fails to align with the axioms of representational measurement.

INTERROGATION STATEMENTS

Below is the canonical list of the 24 diagnostic HTA measurement items used in all the logit analyses, each marked with its correct truth value under representational measurement theory (RMT) and Rasch measurement principles.

This is the definitive set used across the Logit Working Papers.

Measurement Theory & Scale Properties

1. Interval measures lack a true zero — TRUE
2. Measures must be unidimensional — TRUE
3. Multiplication requires a ratio measure — TRUE
4. Time trade-off preferences are unidimensional — FALSE
5. Ratio measures can have negative values — FALSE
6. EQ-5D-3L preference algorithms create interval measures — FALSE
7. The QALY is a ratio measure — FALSE
8. Time is a ratio measure — TRUE

Measurement Preconditions for Arithmetic

9. Measurement precedes arithmetic — TRUE
10. Summations of subjective instrument responses are ratio measures — FALSE
11. Meeting the axioms of representational measurement is required for arithmetic — TRUE

Rasch Measurement & Latent Traits

12. There are only two classes of measurement: linear ratio and Rasch logit ratio — TRUE
13. Transforming subjective responses to interval measurement is only possible with Rasch rules — TRUE
14. Summation of Likert question scores creates a ratio measure — FALSE

Properties of QALYs & Utilities

15. The QALY is a dimensionally homogeneous measure — FALSE
16. Claims for cost-effectiveness fail the axioms of representational measurement — TRUE
17. QALYs can be aggregated — FALSE

Falsifiability & Scientific Standards

18. Non-falsifiable claims should be rejected — TRUE
19. Reference-case simulations generate falsifiable claims — FALSE

Logit Fundamentals

20. The logit is the natural logarithm of the odds-ratio — TRUE

Latent Trait Theory

21. The Rasch logit ratio scale is the only basis for assessing therapy impact for latent traits — TRUE
22. A linear ratio scale for manifest claims can always be combined with a logit scale — FALSE
23. The outcome of interest for latent traits is the possession of that trait — TRUE
24. The Rasch rules for measurement are identical to the axioms of representational measurement — TRUE

AI LARGE LANGUAGE MODEL STATEMENTS: TRUE OR FALSE

Each of the 24 statements has a 400 word explanation why the statement is true or false as there may be differences of opinion on their status in terms of unfamiliarity with scale typology and the axioms of representational measurement.

The link to these explanations is: <https://maimonresearch.com/ai-llm-true-or-false/>

INTERPRETING TRUE STATEMENTS

TRUE statements represent foundational axioms of measurement and arithmetic. Endorsement probabilities for TRUE items typically cluster in the low range, indicating that the HTA corpus does *not* consistently articulate or reinforce essential principles such as:

- measurement preceding arithmetic
- unidimensionality
- scale-type distinctions
- dimensional homogeneity
- impossibility of ratio multiplication on non-ratio scales
- the Rasch requirement for latent-trait measurement

Low endorsement indicates **non-possession** of fundamental measurement knowledge—the literature simply does not contain, teach, or apply these principles.

INTERPRETING FALSE STATEMENTS

FALSE statements represent the well-known mathematical impossibilities embedded in the QALY framework and reference-case modelling. Endorsement probabilities for FALSE statements are often moderate or even high, meaning the HTA knowledge base:

- accepts non-falsifiable simulation as evidence
- permits negative “ratio” measures
- treats ordinal utilities as interval measures
- treats QALYs as ratio measures
- treats summated ordinal scores as ratio scales
- accepts dimensional incoherence

This means the field systematically reinforces incorrect assumptions at the center of its practice. *Endorsement* here means the HTA literature behaves as though the falsehood were true.

2. SUMMARY OF FINDINGS FOR TRUE AND FALSE ENDORSEMENTS: UC SAN DIEGO SKAGGS SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES

Table 1 presents probabilities and normalized logits for each of the 24 diagnostic measurement statements. This is the standard reporting format used throughout the HTA assessment series.

It is essential to understand how to interpret these results.

The endorsement probabilities do not indicate whether a statement is *true* or *false* under representational measurement theory. Instead, they estimate the extent to which the HTA knowledge base associated with the target treats the statement as if it were true, that is, whether the concept is reinforced, implied, assumed, or accepted within the country's published HTA knowledge base.

The logits provide a continuous, symmetric scale, ranging from +2.50 to -2.50, that quantifies the degree of this endorsement. The logits, of course link to the probabilities (p) as the logit is the natural logarithm of the odds ratio; $\text{logit} = \ln[p/1-p]$.

- Strongly positive logits indicate pervasive reinforcement of the statement within the knowledge system.
- Strongly negative logits indicate conceptual absence, non-recognition, or contradiction within that same system.
- Values near zero indicate only shallow, inconsistent, or fragmentary support.

Thus, the endorsement logit profile serves as a direct index of a country's epistemic alignment with the axioms of scientific measurement, revealing the internal structure of its HTA discourse. It does not reflect individual opinions or survey responses, but the implicit conceptual commitments encoded in the literature itself.

THE ABSENCE OF REPRESENTATIONAL MEASUREMENT AND THE ENDORSEMENT OF FALSE MEASUREMENT

The UC San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences represents one of the most prominent and forward-facing pharmacy programs in the United States, with a strong emphasis on clinical pharmacy, outcomes research, and healthcare delivery innovation. As part of a major public research university, the School integrates scientific discovery with applied clinical practice and system-level decision-making. Its PharmD curriculum is designed to prepare graduates for roles that extend beyond traditional dispensing functions to include participation in interdisciplinary care teams, formulary decision-making, and healthcare policy. Within this framework, pharmacoeconomics and outcomes research occupy a central position, providing the analytical tools through which therapies are evaluated in terms of both clinical and economic impact.

TABLE 1: ITEM STATEMENT, RESPONSE, ENDORSEMENT AND NORMALIZED LOGITS SKAGGS SHOOOL OF PHARMACY AND PHARMACEUTICAL SCIENCES

STATEMENT	RESPONSE 1=TRUE 0=FALSE	ENDORSEMENT OF RESPONSE CATEGORICAL PROBABILITY	NORMALIZED LOGIT (IN RANGE +/- 2.50)
INTERVAL MEASURES LACK A TRUE ZERO	1	0.20	-1.40
MEASURES MUST BE UNIDIMENSIONAL	1	0.15	-1.60
MULTIPLICATION REQUIRES A RATIO MEASURE	1	0.10	-2.20
TIME TRADE-OFF PREFERENCES ARE UNIDIMENSIONAL	0	0.80	+1.40
RATIO MEASURES CAN HAVE NEGATIVE VALUES	0	0.90	+2.20
EQ-5D-3L PREFERENCE ALGORITHMS CREATE INTERVAL MEASURES	0	0.85	+1.75
THE QALY IS A RATIO MEASURE	0	0.85	+1.75
TIME IS A RATIO MEASURE	1	0.95	+2.50
MEASUREMENT PRECEDES ARITHMETIC	1	0.10	-2.20
SUMMATIONS OF SUBJECTIVE INSTRUMENT RESPONSES ARE RATIO MEASURES	0	0.85	+1.75
MEETING THE AXIOMS OF REPRESENTATIONAL MEASUREMENT IS REQUIRED FOR ARITHMETIC	1	0.10	-2.20
THERE ARE ONLY TWO CLASSES OF MEASUREMENT LINEAR RATIO AND RASCH LOGIT RATIO	1	0.05	-2.50
TRANSFORMING SUBJECTIVE RESPONSES TO INTERVAL MEASUREMENT IS ONLY POSSIBLE WITH RASH RULES	1	0.05	-2.50
SUMMATION OF LIKERT QUESTION SCORES CREATES A RATIO MEASURE	0	0.85	+1.75
THE QALY IS A DIMENSIONALLY HOMOGENEOUS MEASURE	0	0.85	+1.75
CLAIMS FOR COST-EFFECTIVENESS FAIL THE AXIOMS OF REPRESENTATIONAL MEASUREMENT	1	0.15	-1.60
QALYS CAN BE AGGREGATED	0	0.85	+1.75

NON-FALSIFIABLE CLAIMS SHOULD BE REJECTED	1	0.70	+1.00
REFERENCE CASE SIMULATIONS GENERATE FALSIFIABLE CLAIMS	0	0.85	+1.75
THE LOGIT IS THE NATURAL LOGARITHM OF THE ODDS-RATIO	1	0.70	+1.00
THE RASCH LOGIT RATIO SCALE IS THE ONLY BASIS FOR ASSESSING THERAPY IMPACT FOR LATENT TRAITS	1	0.05	-2.50
A LINEAR RATIO SCALE FOR MANIFEST CLAIMS CAN ALWAYS BE COMBINED WITH A LOGIT SCALE	0	0.35	-1.25
THE OUTCOME OF INTEREST FOR LATENT TRAITS IS THE POSSESSION OF THAT TRAIT	1	0.25	-1.90
THE RASCH RULES FOR MEASUREMENT ARE IDENTICAL TO THE AXIOMS OF REPRESENTATIONAL MEASUREMENT	1	0.05	-2.50

The knowledge base associated with this program is therefore deeply embedded within the contemporary HTA paradigm. Students are introduced to cost-effectiveness analysis, cost-utility analysis, and decision-analytic modeling as standard methods for evaluating therapeutic interventions. Preference-based measures, including utilities derived from instruments such as the EQ-5D, are treated as valid inputs to these analyses. The assumption underlying this framework is that such constructs can be represented numerically in a manner that supports arithmetic operations, including multiplication, aggregation, and comparison across interventions. This assumption is rarely made explicit, but it is foundational to the operation of the methods being taught.

The diagnostic assessment presented in Table 1 reveals that the knowledge base associated with the UC San Diego program exhibits the same structural pattern observed across HTA knowledge bases more broadly. Statements that reflect the axioms of representational measurement are weakly endorsed or effectively absent, while statements that contradict these axioms are strongly endorsed. This pattern is internally coherent within the HTA framework, as the methods employed require the acceptance of constructs such as utilities and QALYs as if they were measures. However, it is inconsistent with the requirements of representational measurement, which demand that the properties of a measure be established prior to the application of arithmetic operations.

The absence of the principle that measurement must precede arithmetic is particularly striking. This statement is assigned a probability of 0.10 and a normalized logit of -2.20, indicating near absence. Yet the curriculum relies heavily on arithmetic operations applied to utilities, costs, and modeled outcomes. Cost-effectiveness ratios and cost-utility analyses presuppose that the quantities being manipulated have been measured. Without this foundation, the numerical outputs

generated by these methods cannot be interpreted as measures. The knowledge base proceeds nonetheless, indicating a structural disregard for this requirement.

Similarly, the requirement that multiplication requires a ratio measure is weakly endorsed (0.10; -2.20), despite its central role in the construction of QALYs. Time, a manifest ratio attribute, is multiplied by a utility score that lacks a true zero. The resulting product is treated as a quantity, even though the conditions for such an operation are not met. The strong endorsement of the false statement that the QALY is a ratio measure (0.85; +1.75) reflects the necessity of maintaining this assumption within the knowledge base.

Unidimensionality is also neglected. The statement “measures must be unidimensional” receives a probability of 0.15 and a logit of -1.60. This is inconsistent with the use of multiattribute instruments and composite indices that aggregate multiple dimensions of health into a single score. Such constructs violate the requirement that a measure represent a single attribute, yet they are routinely used in outcomes research and economic evaluation.

The absence of Rasch measurement is complete, with all related statements assigned probabilities of 0.05 and logits of -2.50. This indicates that the knowledge base does not include the only established framework for transforming ordinal responses into interval measures for latent constructs. Without such a transformation, the summation of responses or the use of preference-based scores cannot yield measures suitable for arithmetic operations. The strong endorsement of false statements regarding the summation of Likert scores and subjective responses (both 0.85; +1.75) reflects the reliance on these practices in the absence of a valid measurement model.

Dimensional homogeneity is similarly disregarded. The combination of time and utility in the construction of QALYs violates the requirement that quantities combined through multiplication be expressed in compatible units. Yet this combination is central to cost-utility analysis, which is taught as a standard method within the curriculum.

The treatment of falsifiability reveals an additional inconsistency. While there is moderate endorsement of the principle that non-falsifiable claims should be rejected (0.70; +1.00), there is strong endorsement of the false statement that reference case simulations generate falsifiable claims (0.85; +1.75). This reflects a misunderstanding of the role of models in scientific inquiry. Models can structure assumptions and explore scenarios, but they do not generate empirically testable claims. The reliance on model-based outputs as evidence therefore conflicts with the requirement that scientific claims be subject to falsification.

The institutional context of the School reinforces these findings. As a research-intensive institution, the School is at the forefront of clinical pharmacy and outcomes research. It contributes to the development and dissemination of HTA methods and plays a key role in shaping the knowledge base of the discipline. The consistency of its diagnostic profile with those of other institutions therefore underscores the structural nature of the issue. This is not a problem of local implementation but of the conceptual foundations of HTA itself.

The implications for teaching are significant. Students are trained to apply methods that assume the validity of the constructs they employ, without being exposed to the conditions under which

those constructs can be considered measures. This results in a form of quantitative reasoning that is internally coherent but externally inconsistent with the requirements of scientific measurement. Students may be able to perform calculations and interpret model outputs, but they are not equipped to evaluate the measurement properties of the quantities involved.

This has practical consequences. In areas such as formulary decision-making, resource allocation, and policy evaluation, the interpretation of numerical outputs is critical. If these outputs are not grounded in valid measurement, their use as evidence is problematic. The appearance of precision and rigor may obscure underlying conceptual weaknesses, leading to decisions that are not supported by scientifically valid measures.

The School's program, like others, operates within a broader institutional and professional context that reinforces these practices. Accreditation standards, professional expectations, and the wider HTA literature all assume the validity of the methods being taught. This creates a self-reinforcing system in which the absence of measurement is not recognized as a problem. The knowledge base is therefore stable and coherent, but it is built on assumptions that do not meet the requirements of representational measurement.

In conclusion, the diagnostic assessment demonstrates that the knowledge base associated with the Skaggs School of Pharmacy and Pharmaceutical Sciences does not recognize or apply the axioms of representational measurement. The resulting pattern of measurement inversion is consistent with that observed across HTA knowledge bases. As a leading institution, the School plays a central role in reproducing this framework, both through its teaching and its research. The findings therefore have implications not only for the institution itself but for the discipline of HTA more broadly.

III. THE TRANSITION TO MEASUREMENT IN HEALTH TECHNOLOGY ASSESSMENT

THE IMPERATIVE OF CHANGE

This analysis has not been undertaken to criticize decisions made by health system, nor to assign responsibility for the analytical frameworks currently used in formulary review. The evidence shows something more fundamental: organizations have been operating within a system that does not permit meaningful evaluation of therapy impact, even when decisions are made carefully, transparently, and in good faith.

The present HTA framework forces health systems to rely on numerical outputs that appear rigorous but cannot be empirically assessed (Table 1). Reference-case models, cost-per-QALY ratios, and composite value claims are presented as decision-support tools, yet they do not satisfy the conditions required for measurement. As a result, committees are asked to deliberate over results that cannot be validated, reproduced, or falsified. This places decision makers in an untenable position: required to choose among therapies without a stable evidentiary foundation.

This is not a failure of expertise, diligence, or clinical judgment. It is a structural failure. The prevailing HTA architecture requires arithmetic before measurement, rather than measurement before arithmetic. Health systems inherit this structure rather than design it. Manufacturers respond to it. Consultants reproduce it. Journals reinforce it. Universities promote it. Over time it has come to appear normal, even inevitable.

Yet the analysis presented in Table 1 demonstrates that this HTA framework cannot support credible falsifiable claims. Where the dependent variable is not a measure, no amount of modeling sophistication can compensate. Uncertainty analysis cannot rescue non-measurement. Transparency cannot repair category error. Consensus cannot convert assumption into evidence.

The consequence is that formulary decisions are based on numerical storytelling rather than testable claims. This undermines confidence, constrains learning, and exposes health systems to growing scrutiny from clinicians, patients, and regulators who expect evidence to mean something more than structured speculation.

The imperative of change therefore does not arise from theory alone. It arises from governance responsibility. A health system cannot sustain long-term stewardship of care if it lacks the ability to distinguish between claims that can be evaluated and claims that cannot. Without that distinction, there is no pathway to improvement; only endless repetition for years to come.

This transition is not about rejecting evidence. It is about restoring evidence to its proper meaning. It requires moving away from composite, model-driven imaginary constructs toward claims that are measurable, unidimensional, and capable of empirical assessment over time. The remainder of this section sets out how that transition can occur in a practical, defensible, and staged manner.

MEANINGFUL THERAPY IMPACT CLAIMS

At the center of the current problem is not data availability, modeling skill, or analytic effort. It is the nature of the claims being advanced. Contemporary HTA has evolved toward increasingly complex frameworks that attempt to compress multiple attributes, clinical effects, patient experience, time, and preferences into single composite outputs. These constructs are then treated as if they were measures. They are not (Table 1).

The complexity of the reference-case framework obscures a simpler truth: meaningful evaluation requires meaningful claims. A claim must state clearly what attribute is being affected, in whom, over what period, and how that attribute is measured. When these conditions are met, evaluation becomes possible. When they are not complexity substitutes for clarity. The current framework is not merely incorrect; it is needlessly elaborate. Reference-case modeling requires dozens of inputs, assumptions, and transformations, yet produces outputs that cannot be empirically verified. Each additional layer of complexity increases opacity while decreasing accountability. Committees are left comparing models rather than assessing outcomes.

In contrast, therapy impact can be expressed through two, and only two, types of legitimate claims. First are claims based on manifest attributes: observable events, durations, or resource units. These include hospitalizations avoided, time to event, days in remission, or resource use. When properly defined and unidimensional, these attributes can be measured on linear ratio scales and evaluated directly.

Second are claims based on latent attributes: symptoms, functioning, need fulfillment, or patient experience. These cannot be observed directly and therefore cannot be scored or summed meaningfully. They require formal measurement through Rasch models to produce invariant logit ratio scales. These two forms of claims are sufficient. They are also far more transparent. Each can be supported by a protocol. Each can be revisited. Each can be reproduced. Most importantly, each can fail. But they cannot be combined. This is the critical distinction. A meaningful claim is one that can be wrong.

Composite constructs such as QALYs do not fail in this sense. They persist regardless of outcome because they are insulated by assumptions. They are recalculated, not refuted. That is why they cannot support learning. The evolution of objective knowledge regarding therapy impact in disease areas is an entirely foreign concept. By re-centering formulary review on single-attribute, measurable claims, health systems regain control of evaluation. Decisions become grounded in observable change rather than modeled narratives. Evidence becomes something that accumulates, rather than something that is re-generated anew for every submission.

THE PATH TO MEANINGFUL MEASUREMENT

Transitioning to meaningful measurement does not require abandoning current processes overnight. It requires reordering them. The essential change is not procedural but conceptual: measurement must become the gatekeeper for arithmetic, not its byproduct.

The first step is formal recognition that not all numerical outputs constitute evidence. Health systems must explicitly distinguish between descriptive analyses and evaluable claims. Numbers that do not meet measurement requirements may inform discussion but cannot anchor decisions.

The second step is restructuring submissions around explicit claims rather than models. Each submission should identify a limited number of therapy impact claims, each defined by attribute, population, timeframe, and comparator. Claims must be unidimensional by design.

Third, each claim must be classified as manifest or latent. This classification determines the admissible measurement standard and prevents inappropriate mixing of scale types.

Fourth, measurement validity must be assessed before any arithmetic is permitted. For manifest claims, this requires confirmation of ratio properties. For latent claims, this requires Rasch-based measurement with demonstrated invariance.

Fifth, claims must be supported by prospective or reproducible protocols. Evidence must be capable of reassessment, not locked within long-horizon simulations designed to frustrate falsification.

Sixth, committees must be supported through targeted training in representational measurement principles, including Rasch fundamentals. Without this capacity, enforcement cannot occur consistently.

Finally, evaluation must be iterative. Claims are not accepted permanently. They are monitored, reproduced, refined, or rejected as evidence accumulates.

These steps do not reduce analytical rigor. They restore it.

TRANSITION REQUIRES TRAINING

A transition to meaningful measurement cannot be achieved through policy alone. It requires a parallel investment in training, because representational measurement theory is not intuitive and has never been part of standard professional education in health technology assessment, pharmacoeconomics, or formulary decision making. For more than forty years, practitioners have been taught to work within frameworks that assume measurement rather than demonstrate it. Reversing that inheritance requires structured learning, not informal exposure.

At the center of this transition is the need to understand why measurement must precede arithmetic. Representational measurement theory establishes the criteria under which numbers can legitimately represent empirical attributes. These criteria are not optional. They determine whether addition, multiplication, aggregation, and comparison are meaningful or merely symbolic. Without this foundation, committees are left evaluating numerical outputs without any principled way to distinguish evidence from numerical storytelling.

Training must therefore begin with scale types and their permissible operations. Linear ratio measurement applies to manifest attributes that possess a true zero and invariant units, such as

time, counts, and resource use. Latent attributes, by contrast, cannot be observed directly and cannot be measured through summation or weighting. They require formal construction through a measurement model capable of producing invariant units. This distinction is the conceptual fulcrum of reform, because it determines which claims are admissible and which are not.

For latent trait claims, Rasch measurement provides the only established framework capable of meeting these requirements. Developed in the mid–twentieth century alongside the foundations of modern measurement theory, the Rasch model was explicitly designed to convert subjective observations into linear logit ratio measures. It enforces unidimensionality, tests item invariance, and produces measures that support meaningful comparison across persons, instruments, and time. These properties are not approximations; they are defining conditions of measurement.

Importantly, Rasch assessment is no longer technically burdensome. Dedicated software platforms developed and refined over more than four decades make Rasch analysis accessible, transparent, and auditable. These programs do not merely generate statistics; they explain why items function or fail, how scales behave, and whether a latent attribute has been successfully measured. Measurement becomes demonstrable rather than assumed.

Maimon Research has developed three distance education programs to support the transition to a new paradigm in HTA. These comprise 12 module senior level program that details the standards for measurement, the failure of current HTA standards and the basis for protocol supported claims assessment for ratio measures of manifest attributes and Rasch logic ratio logit measures for latent attributes. The two other programs are only 5 modules but are designed to complement the 12-module program, for measurement axioms and Rasch attribute possession.

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DISTANCE EDUCATION PROGRAMS IN THE THEORY OF MEASUREMENT

Three programs are available: two short 5-module programs and a 12-module program that is structured as a senior level course on the transition from the current HTA belief system to a new paradigm for HTA

The two short programs are (i) **NUMERICAL STORYTELLING: SYSTEMATIC MEASUREMENT FAILURE IN HEALTH TECHNOLOGY ASSESSMENT** and (ii) **A NEW START IN MEASUREMENT FOR HEALTH TECHNOLOGY ASSESSMENT**.

They are designed to complement the 12-module course program. They can be accessed through the **DISTANCE EDUCATION** section of the website with URL

<https://maimonresearch.com/distance-education-programs/>

The senior level course **HEALTH TECHNOLOGY ASSESSMENT REBUILT: EVIDENCE AND VALUE** is accessed through the **EVIDENCE AND VALUE** section of the website or URL link <https://maimonresearch.com/evidence-and-value/>.

Together, these programs equip health systems, committees, and analysts with the competence required to enforce measurement standards consistently. Training does not replace judgment; it enables it. Without such preparation, the transition to meaningful measurement cannot be sustained. With it, formulary decision making can finally rest on claims that are not merely numerical, but measurable.

DESIGNED FOR CLOSURE

For those who remain unconvinced that there is any need to abandon a long-standing and widely accepted HTA framework, it is necessary to confront a more fundamental question: why was this system developed and promoted globally in the first place?

The most plausible explanation is administrative rather than scientific. Policy makers were searching for an assessment framework that could be applied under conditions of limited empirical data while still producing a determinate conclusion. Reference-case modeling offered precisely this convenience. By constructing a simulation populated with assumptions, surrogate endpoints, preference weights, and extrapolated time horizons, it became possible to generate a numerical result that could be interpreted as decisive. Once an acceptable cost-effectiveness ratio emerged, the assessment could be declared complete and the pricing decision closed. This structure solved a political and administrative problem. It allowed authorities to claim that decisions were evidence-based without requiring the sustained empirical burden demanded by normal science. There was no requirement to formulate provisional claims and subject them to ongoing falsification. There was no obligation to revisit conclusions as new data emerged. Closure could be achieved at launch, rather than knowledge evolving over the product life cycle.

By contrast, a framework grounded in representational measurement would have imposed a very different obligation. Claims would necessarily be provisional. Measurement would precede arithmetic. Each therapy impact claim would require a defined attribute, a valid scale, a protocol, and the possibility of replication or refutation. Evidence would accumulate rather than conclude. Decisions would remain open to challenge as real-world data emerged. From an administrative standpoint, this was an unreasonable burden. It offered no finality.

The reference-case model avoided this problem entirely. By shifting attention away from whether quantities were measurable and toward whether assumptions were plausible, the framework replaced falsification with acceptability. Debate became internal to the model rather than external to reality. Sensitivity analysis substituted for empirical risk. Arithmetic proceeded without prior demonstration that the objects being manipulated possessed the properties required for arithmetic to be meaningful.

Crucially, this system required no understanding of representational measurement theory. Committees did not need to ask whether utilities were interval or ratio measures, whether latent traits had been measured or merely scored, or whether composite constructs could legitimately be multiplied or aggregated. These questions were never posed because the framework did not require

them to be posed. The absence of measurement standards was not an oversight; it was functionally essential.

Once institutionalized, the framework became self-reinforcing. Training programs taught modeling rather than measurement. Guidelines codified practice rather than axioms. Journals reviewed technique rather than admissibility. Over time, arithmetic without measurement became normalized as “good practice,” while challenges grounded in measurement theory were dismissed as theoretical distractions. The result was a global HTA architecture capable of producing numbers, but incapable of producing falsifiable knowledge. Claims could be compared, ranked, and monetized, but not tested in the scientific sense. What evolved was not objective knowledge, but institutional consensus.

This history matters because it explains why the present transition is resisted. Moving to a real measurement framework with single, unidimensional claims does not merely refine existing methods; it dismantles the very mechanism by which closure has been achieved for forty years. It replaces decisiveness with accountability, finality with learning, and numerical plausibility with empirical discipline. Yet that is precisely the transition now required. A system that avoids measurement in order to secure closure cannot support scientific evaluation, cumulative knowledge, or long-term stewardship of healthcare resources. The choice is therefore unavoidable: continue with a framework designed to end debate, or adopt one designed to discover the truth.

Anything else is not assessment at all, but the ritualized manipulation of numbers detached from measurement, falsification, and scientific accountability.

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