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**ARTIFICIAL INTELLIGENCE LARGE LANGUAGE
MODEL INTERROGATION**



**REPRESENTATIONAL MEASUREMENT FAILURE IN
HEALTH TECHNOLOGY ASSESSMENT**

**GERMANY: THE CINCH HEALTH ECONOMICS
RESEARCH CENTRE AT THE UNIVERSITY OF
DUISBURG ESSEN AND THE ENDORSEMENT OF
FALSE MEASUREMENT**

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FOREWORD

HEALTH TECHNOLOGY ASSESSMENT: A GLOBAL SYSTEM OF NON-MEASUREMENT

The CINCH Health Economics Research Center at the University of Duisburg-Essen is a multidisciplinary research center dedicated to the study of health economics and healthcare systems. Its work focuses on understanding how healthcare markets function, how resources are allocated, and how policy interventions influence health outcomes and system efficiency. The Center brings together economists and researchers to investigate the behavior of patients, providers, insurers, and regulators within national and international healthcare systems.

CINCH's research spans a wide range of topics, including healthcare financing, insurance design, competition among providers, physician behavior, and patient decision-making. A central aim is to generate evidence on how incentives and institutional structures affect access to care, quality of services, and overall system performance. The Center also conducts empirical and econometric analyses using large-scale administrative and survey data to evaluate healthcare policies and interventions.

In addition to applied research, CINCH contributes to methodological development in health economics, particularly in areas such as causal inference, policy evaluation, and data analysis. It is closely linked to academic teaching programs in health economics and collaborates with national and international research networks. Overall, CINCH represents a policy-oriented research environment focused on improving the understanding and performance of healthcare systems.

The objective of this study is to undertake a structured interrogation of the HTA-related knowledge base associated with the CINCH Health Economics Research Center and the Chair of Health Economics at the University of Duisburg-Essen using a standardized 24-item canonical diagnostic instrument grounded in the axioms of representational measurement theory. The purpose is to determine whether the conceptual framework that informs health economics and HTA-related research satisfies the minimum requirements for scientific measurement. This involves assessing whether the knowledge base recognizes the conditions necessary for admissible arithmetic operations, including unidimensionality, invariance, and the existence of a true zero, and whether it incorporates Rasch-conformant approaches to the measurement of latent constructs. By assigning categorical probabilities to each statement and transforming these into normalized logits, the analysis provides a structured profile of conceptual endorsement, allowing an explicit evaluation of whether the knowledge base supports evaluable, replicable, and falsifiable value claims.

The findings demonstrate a clear and consistent error pattern of measurement inversion. Statements that are true within representational measurement theory are weakly endorsed or rejected, while those that are false particularly those underpinning cost-utility analysis and the use of preference-based measures are strongly endorsed at or near maximum logit levels. Constructs

such as utilities and QALYs are treated as if they possess interval or ratio scale properties, supporting multiplication, aggregation, and modeled projection, despite lacking the required measurement foundations. At the same time, core principles such as the requirement that multiplication demands a ratio scale and that measurement must precede arithmetic are not recognized. Rasch measurement is entirely absent. The resulting profile confirms that the CINCH knowledge base does not meet the axioms of representational measurement and therefore supports the generation of non-evaluable claims.

The modern articulation of this principle can be traced to Stevens' seminal 1946 paper, which introduced the typology of nominal, ordinal, interval, and ratio scales¹. 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 traits³. 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.

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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 CINCH HEALTH ECONOMICS RESEARCH CENTER KNOWLEDGE BASE

The HTA-related knowledge base associated with CINCH and the Chair of Health Economics at the University of Duisburg-Essen is organized as a multidisciplinary academic framework focused on the economic analysis of healthcare systems and policy. Its activities encompass the study of healthcare financing, insurance design, provider behavior, and patient decision-making, with a strong emphasis on empirical and econometric analysis. Research within this knowledge base is directed toward understanding how incentives and institutional structures shape health outcomes, access to care, and system efficiency. While not always framed explicitly as HTA, many of its outputs contribute directly to the evaluation of healthcare interventions and policies, aligning it with broader HTA-related objectives.

A central feature of the CINCH knowledge base is the use of quantitative methods to evaluate healthcare interventions and system performance. This includes the application of econometric techniques to observational and administrative data, as well as the use of modeling approaches to assess policy impacts. Preference-based measures and outcome indicators are frequently employed as inputs to analysis, supporting comparisons across interventions and populations. These measures are treated as if they possess the scale properties required for arithmetic operations, enabling their integration into models and the generation of comparative value assessments. However, there is no formal requirement within the knowledge base to establish the measurement properties of these constructs. Unidimensionality, invariance, and the existence of a true zero are not systematically demonstrated, nor is there any use of Rasch-conformant methods to transform ordinal observations into valid measures of latent attributes.

The knowledge base is embedded within a broader academic and policy-oriented research environment, with strong links to national and international research networks. Its outputs are intended to inform policy debates and contribute to the design and evaluation of healthcare systems. Methodological development is focused on improving the robustness of empirical analysis, refining econometric techniques, and enhancing the interpretation of results within policy contexts. This creates a research environment characterized by methodological sophistication and a strong emphasis on data-driven analysis.

Despite this sophistication, the CINCH knowledge base operates within a framework that assumes the validity of the quantities it employs rather than establishing it. Numerical values derived from preference-based measures, outcome indicators, and econometric models are treated as if they constitute measures, allowing arithmetic operations and comparative reasoning to proceed without addressing whether the underlying constructs meet the axioms of representational measurement. As a result, the knowledge base functions as a system of numerical reasoning in which values are assigned, manipulated, and interpreted without satisfying the conditions required for measurement.

While internally consistent within its own assumptions, it does not generate claims that are evaluable, falsifiable, or replicable in a measurement-consistent sense, limiting its capacity to contribute to the accumulation of objective knowledge within the standards of normal science.

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: CINCH HEALTH ECONOMICS RESEARCH CENTER

Table 1 presents each of the 24 diagnostic measurement statements with associated categorical probabilities and normalized logits. 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.

It is important to note that the convergence of probability–logit profiles across independently defined institutional knowledge bases is not an artifact of uniform assignment. Each interrogation is grounded in a separately specified corpus of institutional outputs and methodological commitments. The identical profiles reflect the fact that these institutions draw on a shared HTA framework, most notably the NICE reference case, QALY-based cost-utility analysis, and EQ-5D-derived utilities, which embeds a common set of assumptions regarding measurement. The results therefore demonstrate not independence, but epistemic replication.

THE REPRESENTATIONAL MEASUREMENT FAILURE OF THE CINCH HEALTH ECONOMICS RESEARCH CENTER

The interrogation of the HTA-related knowledge base at the University of Duisburg-Essen yields a profile that is both academically important and methodologically revealing. This is not a peripheral health policy environment. The university hosts CINCH, an internationally connected health economics research center, alongside an explicit Chair of Health Economics and a research-oriented master's program in health economics. Its stated mission is policy-relevant

research of high academic standard, directed toward the analysis of healthcare systems, competition, incentives, and resource allocation. That is precisely what makes it an appropriate knowledge base for interrogation. If the axioms of representational measurement were to find recognition in the German academic health economics environment, one might reasonably expect to detect them in a setting of this scale, visibility, and methodological confidence. The profile shows otherwise (Table 1).

TABLE 1: ITEM STATEMENT, RESPONSE, ENDORSEMENT AND NORMALIZED LOGITS CINCH HEALTH ECONOMICS RESEARCH CENTER

STATEMENT	RESPONSE 1=TRUE 0=FALSE	ENDORSEMENT OF RESPONSE CATEGORICAL PROBABILITY	NORMALIZED LOGIT (IN RANGE +/- 2.50)
INTERVAL MEASURES LACK A TRUE ZERO	1	0.25	-1.10
MEASURES MUST BE UNIDIMENSIONAL	1	0.20	-1.40
MULTIPLICATION REQUIRES A RATIO MEASURE	1	0.10	-2.20
TIME TRADE-OFF PREFERENCES ARE UNIDIMENSIONAL	0	0.95	+2.50
RATIO MEASURES CAN HAVE NEGATIVE VALUES	0	0.95	+2.50
EQ-5D-3L PREFERENCE ALGORITHMS CREATE INTERVAL MEASURES	0	0.95	+2.50
THE QALY IS A RATIO MEASURE	0	0.95	+2.50
TIME IS A RATIO MEASURE	1	0.85	+1.75
MEASUREMENT PRECEDES ARITHMETIC	1	0.20	-1.40
SUMMATIONS OF SUBJECTIVE INSTRUMENT RESPONSES ARE RATIO MEASURES	0	0.95	+2.50
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	0.95	+2.50
THE QALY IS A DIMENSIONALLY HOMOGENEOUS MEASURE	0	0.95	+2.50
CLAIMS FOR COST-EFFECTIVENESS FAIL THE AXIOMS OF REPRESENTATIONAL MEASUREMENT	1	0.10	-2.20
QALYS CAN BE AGGREGATED	0	0.95	+2.50
NON-FALSIFIABLE CLAIMS SHOULD BE REJECTED	1	0.50	0.00
REFERENCE CASE SIMULATIONS GENERATE FALSIFIABLE CLAIMS	0	0.95	+2.50
THE LOGIT IS THE NATURAL LOGARITHM OF THE ODDS-RATIO	1	0.80	+1.40
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	0.90	+2.20
THE OUTCOME OF INTEREST FOR LATENT TRAITS IS THE POSSESSION OF THAT TRAIT	1	0.05	-2.50
THE RASCH RULES FOR MEASUREMENT ARE IDENTICAL TO THE AXIOMS OF REPRESENTATIONAL MEASUREMENT	1	0.05	-2.50

The overall pattern is not mixed. It is stable and strongly aligned with measurement inversion. Statements that are false within the axioms of representational measurement are endorsed at very high levels, usually at the maximum logit. Statements that are true are weakly endorsed or rejected. This indicates a knowledge base in which numerical constructs are treated as though they automatically possess the properties required for arithmetic. That assumption is not a technical detail. It is the point at which the framework fails. If the quantities under analysis are not measures, then multiplication, aggregation, comparison, and model-based projection are invalid from the outset. The Duisburg-Essen knowledge base does not recognize this.

The most decisive indicators concern the QALY and the arithmetic that sustains cost-utility analysis. The statements that the QALY is a ratio measure, that it is dimensionally homogeneous, and that QALYs can be aggregated are all endorsed at the maximum logit. This is categorical commitment. The knowledge base treats QALYs as if they were lawful quantities capable of multiplication, addition, and comparison across persons and time. Yet this is precisely what representational measurement theory does not allow. A ratio scale requires a true zero and invariant

unit structure. Utilities derived from ordinal preference data do not satisfy these requirements. Multiplying them by time does not rescue them. It compounds the error. The central operation of cost-utility analysis fails at the first step.

That conclusion is reinforced by the treatment of preference-based measures and subjective response structures. The statement that EQ-5D preference algorithms create interval measures is endorsed at the maximum logit. So too are the propositions that summed responses to subjective instruments and Likert questions create ratio measures. These endorsements are not marginal slips. They show that the knowledge base does not preserve the elementary distinctions between ordinal, interval, and ratio scales. Once those distinctions collapse, any numerical label can be used arithmetically. Costs can be combined with QALYs, utility scores can be projected in models, and outputs can be treated as evidence. But none of this is admissible unless the underlying constructs are lawfully measured. They are not.

The negative side of the profile is equally revealing. The proposition that multiplication requires a ratio scale is strongly rejected. The proposition that measurement must precede arithmetic is also rejected. These are among the most important statements in the instrument because they define the scientific order of reasoning. One must first establish what kind of quantity exists, and only then determine what operations are permitted. In the Duisburg-Essen knowledge base, that order is reversed. The framework begins with the operations it wishes to perform and silently assumes the scale properties needed to justify them. This is the essence of measurement inversion. It is not simply an error inside the framework. It is the framework that supports false measurement.

The absence of Rasch measurement is complete. Every Rasch-related statement is placed at the lowest possible logit. This indicates effective non-possession of the only framework capable of transforming ordinal observations of latent constructs into invariant measures. Without Rasch, latent attributes remain classifications, rankings, or scores. They do not become quantities by being weighted, rescaled, or embedded in econometric analysis. The Duisburg-Essen knowledge base therefore lacks the only available route by which subjective therapy impact could be represented as a valid measure. This is decisive, because modern health economics does not merely rely on manifest variables. It repeatedly reaches for latent constructs while excluding the only measurement framework capable of legitimizing them.

What makes the Duisburg-Essen case particularly useful is that it is openly and self-consciously health economics driven. CINCH presents itself as a center of excellence in health economics research. The Chair of Health Economics and associated teaching structures reinforce this identity. This is not a methodological institute that merely touches HTA at the margins. It is a knowledge base explicitly devoted to health economics and policy-relevant analysis. If the axioms of representational measurement are absent here, then they are absent where one might most expect them to appear in German academic health economics. That strengthens the force of the critique. The problem cannot be dismissed as the accidental property of a peripheral or poorly specified unit. It is embedded in a flagship academic setting.

The treatment of falsifiability points in the same direction. The proposition that non-falsifiable claims should be rejected receives only neutral endorsement, while the claim that reference-case simulations generate falsifiable claims is strongly endorsed. This reveals a further confusion.

Model sensitivity and recalibration are mistaken for empirical testability. A model may be elaborate, responsive, and internally coherent, but if its core constructs are not lawfully measured, its outputs cannot count as falsifiable claims in any meaningful scientific sense. They are functions of assumptions applied to non-measurement. The Duisburg-Essen knowledge base, like so many others, appears willing to treat those outputs as evidence.

This is not a matter of insufficient statistical competence. On the contrary, the Duisburg-Essen environment is methodologically confident, quantitatively oriented, and internationally engaged. That is what makes the profile more damaging, not less. Methodological sophistication has been layered onto constructs that are not measured. Advanced econometric analysis, data work, and model construction deepen the appearance of rigor while leaving the foundational problem untouched. Arithmetic remains unauthorized. The numerical outputs remain non-evaluable.

The implications are direct. A knowledge base that endorses false propositions about scale, arithmetic, and latent constructs cannot generate evaluable value claims. Cost-effectiveness results derived from such a framework are not empirical findings. They are numerical artifacts. They cannot be replicated because there is no invariant quantity to reproduce. They cannot be falsified because the outputs are not grounded in measurable entities. They do not contribute to the accumulation of objective knowledge. They are not evidence. They are the institutionalized reproduction of invalid reasoning.

This is not a marginal deficiency. It is a categorical failure. The Duisburg-Essen HTA-related knowledge base does not fall short of ideal measurement standards. It is organized around their absence. It endorses the propositions required to sustain false measurement and rejects the propositions required to stop it. That is what makes this a gold-standard case of measurement inversion in German academic health economics.

The broader implication for Germany is clear as shown by other knowledge base interrogations. If Freiburg reveals measurement inversion inside a methodological institute, Hamburg reveals it in a distributed academic health economics environment, and IQWiG reveals it at the policy agency level, then the Duisburg-Essen case shows the same structure in an explicitly health economics-centered academic setting. Across institutional forms methodological, distributed academic, agency, and health economics flagship the same failure appears. This is not institutional accident. It is epistemic closure. There is no independent German HTA-related knowledge base that recognizes or applies the axioms of representational measurement. The result, unfortunately, of 40 years of measurement failure when the axioms of representational measurement had been formalized in 1971.

The final judgment is therefore straightforward. The HTA-related knowledge base at the University of Duisburg-Essen, centered on CINCH and the Chair of Health Economics, does not meet the axioms of representational measurement. It cannot support the arithmetic operations on which its evaluative claims depend. Its outputs are not empirically evaluable, not falsifiable, and not scientifically admissible. Once this is recognized, the status of the resulting claims is clear. They are not evidence. They are numerical storytelling under academic authority.

3. 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.

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.

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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/>.

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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REFERENCES

¹ Stevens S. On the Theory of Scales of Measurement. *Science*. 1946;103(2684):677-80

² Krantz D, Luce R, Suppes P, Tversky A. Foundations of Measurement Vol 1: Additive and Polynomial Representations. New York: Academic Press, 1971

³ Rasch G, Probabilistic Models for some Intelligence and Attainment Tests. Chicago: University of Chicago Press, 1980 [An edited version of the original 1960 publication]

⁴ Wright B. Solving measurement problems with the Rasch Model. *J Educational Measurement*. 1977;14(2):97-116