recordatorios [call center] e interconsulta anual programada con Oftalmólogo y Cardiólogo). Complementariamente relevamos características fundacionales de estructura y procesos de gestión, del CAP y la red sanitaria. El análisis incluyó estadística descriptiva (media±desvío estándar o proporciones) e inferencial. Para las comparaciones se utilizaron pruebas paramétricas y no paramétricas considerando significativos p<0,05. **RESULTS:** Inicialmente no registramos diferencias significativas entre el GI (n=154) y GC (n=157). La deserción en el seguimiento fue significativamente mayor en el GC (48% vs. 28%; p=0.000). Finalizado el estudio (final vs. basal), el GI mostró descensos significativos en: HbA1c (7,18±1,4 vs. 7,65±2,1), presión arterial diastólica (77,8±9,4 vs. 80,7±10,8), glucemia (143,1±51 vs. 161±70), Colesterol total (182±36 vs. 196,9±46,3), c-LDL (107,8±30,9 vs. 117±38,1) y Triglicéridos (175,5±99 vs. 201,2±141). No registramos cambios significativos en el GC. Los cambios de mayor magnitud, correspondieron a las CAPs con peores características fundacionales. **CONCLUSIONS:** Estos resultados demuestran que la combinación de educación y cambios en el sistema de control/gestión de pacientes, mejora efectivamente la calidad de atención brindada a personas con DT2 y FRCV asociados.

HS3

ECONOMIC BURDEN OF HERPES ZOSTER ("CULEBRILLA") IN LATIN AMERICA

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OBJECTIVES: Evaluate the healthcare resource utilization (HCRU) and costs associated with herpes zoster (HZ) and postherpetic neuralgia (PHN) in Latin America. **METHODS:** We conducted a pooled-analysis of three prospective cohort studies of HZ patients ≥50 years of age in Argentina (n=96); Brazil (n=145) and Mexico (n=142). Patients were recruited during their HZ episode and were followed for six months. Incidence of PHN was defined as a worst ZBPI pain score of ≥3, persisting/appearing more than 90 days after rash onset. Work effectiveness was measured on a 100-point Likert scale where 100 was described as completely effective and 0 as not effective at all. Direct costs included costs from antiviral medication use and all medical services used to treat HZ. Indirect cost was based on forgone earnings from patients due to work loss and presenteeism, and work loss by family caretakers. All costs are reported in 2015 USD currency. **RESULTS:** 383 HZ patients were included and PHN incidence was 38.6%. The most commonly used resources were visits to the doctor's office (79.1% of patients), the emergency room (48.8%) and a specialist (37.9%). The overall direct cost per case was $763.19 USD, indirect cost was $701.40, for a total of $1,464.59 per HZ episode in Latin America. Total cost associated with HZ in patients with PHN was markedly higher compared to patients without PHN ($2,001.13 vs. $867.72, respectively) with indirect costs accounting for the most part of this difference. **CONCLUSIONS:** HZ and its sequelae impose a substantial economic burden in Latin America, which is expected to rise as the population ages and the number of HZ cases increases. The results support the need for preventative strategies and improved disease management to reduce the HZ-associated disease burden in Latin America.

HS4

FINANCIAMIENTO DE ENFERMEDADES HUÉRFANAS Y RARAS EN LATINOAMÉRICA

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Las enfermedades raras y huérfanas vienen siendo priorizadas por las políticas de países de Sudamérica desde hace más 10 años. A continuación, se elaboró una revisión comparativa de cuatro países de Sudamérica: Perú, Colombia, Chile y Brasil y los avances hacia la inclusión en sus planes de beneficios de salud la cobertura de enfermedades raras y huérfanas y los mecanismos de financiamiento de las mismas. Se realizó una revisión de la legislación en enfermedades huérfanas y raras en los cuatro países, evaluando los siguientes criterios: definición, políticas, mecanismos de financiamiento y acceso al diagnóstico y tratamiento. Dentro de las políticas en salud para, los cuatro países proponen un registro de pacientes con enfermedades huérfanas, es así Colombia hace un estimado de la población con enfermedades raras calculada en 13238, del resto de países no se conocen los datos precisos. Por otro lado, otra coincidencia es el listado de enfermedades huérfanas a atender, de cantidad variable de país a país, Perú con 399, Colombia con 1920. Otras estrategias particulares de cada país, son requisitos para la cobertura de una enfermedad rara como es el caso Chileno, especificados en la Ley Ricardi Soto del 2015. En Brasil, se viene implementando el tamizaje neonatal desde el 2001 de enfermedades raras y desde el 2009 una política nacional de atención integral de genética clínica. Respecto al financiamiento, Colombia, Perú y Brasil lo reciben como fracción del presupuesto asignado a sus respectivos sectores; Chile tiene un fondo autónomo con capacidad de generar rentabilidad. En general, muchos países han implementado una combinación de legislaciones, reglamentos y políticas para enfermedades huérfanos en las últimas dos décadas. Si bien éstos pueden permitir atención de Enfermedades raras y huérfanas, existen diferencias críticas entre los países en términos de alcance y tipos de legislaciones, reglamentos y políticas aplicadas.

P8: PRICING AND POLICY STUDIES

PR1

CONSULTA PÚBLICA COMO INSTRUMENTO DE DIÁLOGO E NEGOCIAÇÃO ENTRE INDÚSTRIA E GOVERNO

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OBJETIVOS: Identificar as tecnologias em saúde incorporadas ao SUS após a Comissão Nacional de Incorporação de Tecnologias no SUS (CONITEC) rever as recomendações iniciais contrárias à incorporação em decorrência de novas propostas de preço apresentadas pela indústria durante as consultas públicas. **MÉTODOS:** Estudo descritivo, de corte transversal. Foram levantadas, de janeiro de 2012 a março de 2017, todas as tecnologias incorporadas no SUS que haviam tido recomendação preliminar contrária à incorporação e que, após a consulta pública, a recomendação passou a ser favorável. Dessas, contabilizou-se quantas receberam novos estudos econômicos ou propostas de preço por parte da indústria produtora da tecnologia. **RESULTADOS:** Foram encontrados dez casos de mudança de recomendação após consulta pública. Desses, quatro (40%) receberam, entre outros subsídios e contribuições, novos estudos econômicos (impacto orçamentário e custo-minimização) ou propostas de preço por parte das empresas produtoras das tecnologias, fatores importantes para a mudança da recomendação, a saber: tofacitinibe para o tratamento de pacientes adultos com artrite reumatoide (2017), teriflunomida para primeira linha de tratamento da esclerose múltipla remitente recorrente (2017), rivastigmina via transdérmica (adesivo) para o tratamento de pacientes com demência leve e moderadamente grave do tipo Alzheimer (2016) e abatacepte subcutâneo para o tratamento da artrite reumatoide (2015). **CONCLUSÕES:** Durante as consultas públicas das demandas de incorporação de tecnologias em saúde no SUS, além de informações técnico-científicas, relatos de experiência e opinião sobre cada tema analisado, a CONITEC tem recebido novas propostas de preço e estudos econômicos da indústria, permitindo, em alguns casos, que essas tecnologias passem a ser competitivas e possam ser incluídas como alternativas em relação àquelas já disponíveis no SUS. Nesse sentido, para além de um importante mecanismo de participação social, as consultas públicas realizadas pela comissão podem ser vistas como instrumento de diálogo e negociação entre produtores de tecnologias em saúde e governo.

PR2

THE EFFICIENCY PATH TO UNIVERSAL HEALTH COVERAGE: DERIVATION OF COST-EFFECTIVENESS THRESHOLDS BASED ON HEALTH EXPENDITURES AND LIFE EXPECTANCY. UPDATED COUNTRY-LEVEL ESTIMATES FOR 194 COUNTRIES

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OBJECTIVES: To use a previously derived methodology to estimate cost-effectiveness thresholds (CETs) based on per capita health expenditures (pcHE) and life expectancy at birth (LE), and update empirically derived CETs for 194 countries. **METHODS:** We developed a conceptual framework to assess how the selection of a particular CET will affect the rate of increase of pcHE. When the cumulative effect of the new interventions has added one year of life to population LE, the pcHE will have increased at a ratio ("i") which can be quantified as: i=1+CET/pcHE*(LE+1), assuming that the mean cost-effectiveness of new interventions is equal to CET. This allows the definition of CETs based on a target increase in expenditures. The expected rate of increase in pcHE, according to countries' LE and income level, was estimated using WorldBank data to empirically derive the country-level indicative CETs that new interventions should not exceed in order to keep the increase in expenditures at the expected rate. **RESULTS:** The expected increase in pcHE was between 7.8% and 10.5% (low and high-income countries respectively) for each one-year increase in LE (an achievement that countries typically attain in 4-6 years). In order not to promote increases beyond this trend, CETs should be in a range between 5-8 pcHE per life-year and 7-11 pcHE per QALY/DALY. In 91.6% of the countries the estimated CETs were below one GDP per capita per life-year and in 80.0% were below one GDP per QALY/DALY. In none, CETs were above two GPD per capita. CETs per life-year ranged between 0.53-0.90, 0.45-0.71, 0.37-0.62 and 0.36-0.50 GDP in Brazil, Mexico, Peru and Bolivia respectively (0.62-1.05, 0.52-0.83, 0.43-0.72 and 0.42-0.58 per QALY). **CONCLUSIONS:** Our results show lower CETs than those promoted in the past by the WHO, and suggest that the adoption of higher thresholds would drive increases in pcHE beyond the current trend.

PR3

LIMITACIONES DE LAS EVALUACIONES ECONÓMICAS EN SALUD EN LA ASIGNACIÓN DE RECURSOS PARA MEDICAMENTOS PARA ENFERMEDADES RARAS: UN SCOPING REVIEW

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A la fecha, la mayoría de los países de la OCDE han incorporado cursos de acción para mejorar el acceso a Medicamentos para Enfermedades Raras (MER). No obstante, los Procesos de Decisión de Cobertura de Medicamentos (PDC-M) que emplean metodologías de Evaluación Económica en Salud (EES), aún representan un factor determinante. **OBJECTIVES:** Se llevó a cabo una revisión de literatura tipo scoping review para identificar las limitaciones de las EES en la asignación de recursos para MER. **METHODS:** La revisión consideró distintas bases de datos (MEDLINE, Embase, CINAHL, LILACS, Web of Science, EconLit), en las que se ingresaron las sinonimias identificadas por el Grupo de Interés de ER de ISPOR de la palabra clave "MER". Adicionalmente, se compararon los PDC-M y de MER puntualmente en los países de la OCDE con procesos de ETESA formales a nivel nacional. Para esto, se utilizaron los sitios web de autoridades sanitarias identificadas en el directorio ISPOR, y el navegador de google para explorarlos. **RESULTS:** Se identificó un total de 19 artículos relevantes, referidos principalmente a; la falta de representación de los elementos de valor relevantes en la evaluación de MER; la inconsistencia que se produce en el plano internacional entre las políticas de MER (con los incentivos correspondientes) y los PDC que restringen el acceso, basándose en lo discreto de los beneficios que estos importarían en términos de AVAC ganados, y; la elevada incertidumbre de los resultados de las EES de MER, por la calidad de la evidencia característica de estudios en poblaciones con ER. **CONCLUSIONS:** Se requiere avanzar progresivamente hacia

metodologías de EES que consideren los últimos hallazgos de la literatura respecto de la definición de los beneficios que se estiman y comparan en este tipo de análisis, y si estos realmente representan las preferencias de la población.

PR4

IMPACT OF USING EXTERNAL REFERENCE PRICING (ERP) AND HEALTH TECHNOLOGY ASSESSMENT (HTA) AS PART OF COST-CONTAINMENT POLICIES: COMPARISON OF PRICES IN LATIN AMERICA

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OBJECTIVES: Several Latin American countries have adopted ERP as a tool to bring the cost of medicines down. Brazil and Mexico are ERP users since 2004 and Colombia since 2006. In addition, Brazil has implemented HTA in the process of determining drug launch prices. This study explored the impact of ERP, HTA (when used) and other cost-containment policies in pricing determination in Brazil, Mexico, Colombia and Argentina (which allows free pricing). **METHODS:** The ex-manufacturer price (tax free; December 2016) of 24 drugs in Argentina, Brazil, Mexico and Colombia were analyzed. Of those, 12 were under direct control in Colombia (subject to ERP). **RESULTS:** Argentina reported the highest prices, followed by Mexico, except for drugs that were approved before ERP implementation in Brazil, demonstrating the impact of this cost-containment measure. Colombia and Brazil featured the lowest prices, with the cheapest country varying according to the specific drug (likely due to Brazil's inclusion in Colombia's basket). In certain cases, when the drug was considered of public interest in Colombia, such as Glivec and Kaletra, the price of the latter managed to be up to 10x cheaper in Colombia than in the next cheapest country (and 25X cheaper than in Argentina). Moreover, among the three ERP users, different parameters (eg basket countries) resulted in substantial price differences, varying up to 220% in the case of an out-of-pocket drug. **CONCLUSIONS:** The use of ERP as a successful cost-containment policy is immediately observed when comparing the prices in ERP-user countries to those in Argentina. The low prices in Brazil further reflect the impact of using a mix of ERP and HTA methodologies in price determination, which is also currently being adopted by Colombia and should bring drug prices further down in this country. Finally, Colombia achieves further reductions by using stricter ERP controls if there is public interest.

RESEARCH POSTER PRESENTATIONS – SESSION I

RESEARCH ON METHODS STUDIES

RESEARCH ON METHODS – Clinical Outcomes Methods

PRM1

CELEBRITY DEATHMATCH: BURDEN OF DISEASE VS RCTS IN THE SOUTHERN CONE OF LATIN AMERICA

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OBJECTIVES: It is not new that only a tiny percentage of the world's resources for health research and development (R&D) are spent on the health problems of developing countries, which represent almost all of the world's burden of preventable mortality. The south cone of Latin America (S-LA, Chile, Uruguay and Argentina) is not the exception. We aimed to compare the ranking and frequency of conditions that produce a greater burden of disease according to IHME's GBD and to compare it with the ranking of those same 10 conditions regarding registration of clinical trials in the ClinicalTrial.gov database for S-LA since inception until February 2017. Also to explore sources of funding and the evolution of trends in the las four five-year periods. **METHODS:** We manually reviewed the health condition or problem studied, the intervention and the primary sponsor by examining the registered record in CTGov database, for the countries above specified, and we then coded the data according to ICD-10 (Table 1). We retrieved GBD rankings of DALY-producing conditions from http://vizhub.healthdata.org/gbd-compare. We also included geographically relevant conditions such as Maternal causes, Chagas disease, Dengue and TB. Analyses were done in Stata® 14.1. **METHODS:** A total of 660 RCTs came from S-LAC considering the top DALY-producing conditions according to IHME's GBD, out of 2744 registered in CTGov from the database (24%, Table 2). 81% of trials were funded exclusively by the industry (Table 3). No important changes in patterns of frequency of conditions were observed in the last 20 years (Table 4). **CONCLUSIONS:** This landscape study confirms little correlation between burden of disease in S-LA and the distribution of topics addressed in clinical trial research, although RCTs may capture only a small proportion of all incident research in the countries, and this could vary according to the condition considered.

PRM2

IMPACTO ECONÓMICO DIRECTO DERIVADO DE LA ATENCIÓN DE PACIENTES TRAUMATIZADOS EN UN HOSPITAL DE MÉXICO

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OBJECTIVES: Identificar el gasto que generó la atención de pacientes politraumatizados en el servicio de Cirugía General en el Hospital General "Dr. Gustavo Baz Prada" en Nezahualcóyotl, Estado de México en un periodo de un año (1/enero 2015-31/diciembre 2015), en pesos mexicanos (PM). **METHODS:** Evaluación económica tipo estimación de costos. Población objetivo: Todos los pacientes atendidos en el servicio de Cirugía General. Fuente de datos: Registro de Pacientes Traumatizados, expedientes clínicos. Horizonte temporal: Se da seguimiento durante su estancia hospitalaria, máximo 5 meses. Perspectiva: Proovedor de servicios de salud. Estudio de costos tipo micro costeo donde se evalúan los costos médicos directos generados de la atención de pacientes traumatizados atendidos en el servicio de Cirugía General quienes ameritaron: manejo quirúrgico y/o hospitalización. Se analizan variables como: edad, sexo, días de estancia intrahospitalaria – y en la unidad de cuidados intensivos (UCI), costo de atención, cuota de recuperación e intencionalidad de la lesión. **METHODS:** Se contabilizaron 122 pacientes que requirieron manejo quirúrgico y/o hospitalario. 109 pacientes fueron masculinos (89.2%) con media de 28 años (22-37), 13 femeninas (10.7%) con mediana de 29 años (27-40). Se calculó un gasto global de $ 4, 261, 624. 60 PM el gasto medio por paciente fue de $ 24,430.3 PM ($ 18,427.2 - $ 37,100.00). La cuota global de recuperación fue de $ 235, 765.00 y la media de recuperación por paciente fue de $ 1,755.0 PM ($ 810.00 - $3,332.0). El 77% (n=94) de los pacientes atendidos presento lesiones relacionadas con sospecha de violencia generando un total de $ 3,339,054.9 (78% del gasto global). **CONCLUSIONS:** La atención de pacientes traumatizados genera un impacto económico considerable para las instituciones públicas del país. La atención de agresiones genera el mayor porcentaje de este gasto.

PRM3

INVESTIGATION OF DRUG THERAPY PROBLEMS IN TYPE 2 DIABETES OUTPATIENTS WITH COMORBID HYPERTENSION IN A TERTIARY HOSPITAL IN SOUTHEAST NIGERIA

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OBJECTIVES: Drug therapy problems (DTP) are undesirable events, which involves drug therapy and could potential or actual prevents a patient from realizing the full benefits of pharmacotherapy. They arise in the course of medical treatment and compound problems being treated. This study identified DTP among diabetes outpatients with hypertension, and document evidence-based data for intervention studies. **METHODS:** A retrospective cross sectional study of prescriptions for type 2 diabetes (T2DM) patients comorbid with hypertension was conducted using randomly selected prescriptions. Eligible prescriptions with at least an antihypertensive and antidiabetes agent written between January 2012 and December 2015 were used and results were analyzed with descriptive statistics. Study lasted from February to October 2016. **METHODS:** A total of 307 patients prescriptions were studied with 306 DTP were identified. The mean age of patients was 61.4±12.8 with female population of 196 (63.8%). Patients with glycosylated hemoglobin below 7% were 116 (38%). Adverse drug reaction was the leading DTP 108 (35.3%), followed by wrong drug 73 (24.9%), and non-adherence 55(18.0%). Unnecessary drug was the least DTP encountered. The high severity and potentially inappropriate medications identified based on Beer Lamberts criteria was 120 (39.1%) while the presence of low severity potentially inappropriate medications was 56 (18.2%). **CONCLUSIONS:** High incidence of DTP was evident in this study, an indication of poor clinical, economic, and humanistic outcomes. It underscored the need to promote pharmaceutical care at all level of health care especially in chronic disease management to eliminate DTP and improve treatment outcomes.

RESEARCH ON METHODS – Cost Methods

PRM4

ECONOMIC BURDEN ON FAMILIES OF CHILDREN RECEIVING INPATIENT CARE

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OBJECTIVES: Economic evaluations typically do not include family effects. Our goal was to explore the feasibility of evaluating the economic burden to families of children receiving inpatient care and the magnitude of this burden. **METHODS:** Surveys aimed to capture four categories of family economic burden: (1) healthcare out of pocket (OOP) costs (surgery-related, other inpatient, outpatient, ER, medication, caretaker and other OOP costs to the patient's family), (2) non-healthcare OOP costs (transportation, lost wages, caregiver costs, food, accommodation, and other, (3) Non-monetary burden (work and activity impairment for caregivers and lost school days), and (4) HRQL (EQ-5D) of the primary caregiver. The survey was tested and emailed to primary caregivers of children receiving surgery at Boston Children's Hospital. **RESULTS:** Response rate was 60.3% resulting in 44 complete surveys. Total healthcare OOP costs were $182, mostly driven by the copays and deductibles for surgery ($94) and outpatient care ($48). Non-healthcare OOP costs were $166, mostly driven by lost wages among primary caregivers and other family members ($69), accommodation ($50) and transportation costs ($33). Non-monetary burden included 38% work impairment, 26% activity impairment, and 1 missed school day. HRQL was 0.84 - lower than 0.91 reported for the US population of similar age - and mostly driven by the high proportion (26%) of problems with the anxiety/depression. **CONCLUSIONS:** Study demonstrates the **feasibility** of capturing a wide range of economic impacts on families of children receiving inpatient care. Inpatient care is associating with **tangible impacts** on families, in terms of healthcare, non-healthcare cost, non-monetary impacts and likely, HRQL. Study provides evidence for **spill over economic impacts on family members.** Family impacts should be routinely incorporated into economic evaluations in order to calculate the full societal cost of inpatient care and to avoid overestimation of the cost-effectiveness of interventions.

PRM5

COST-EFFECTIVENESS THRESHOLD IN BRAZIL THROUGH A LEAGUE-TABLE APPROACH: SYSTEMATIC REVIEW

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