average age was 54 years (standard deviation + 11 years, range 17-85 years) with the majority being female (78%), white (87%), having a some college education or more (73%) and having health insurance (87%). Approximately 58% of patients reported medication nonadherence. No significant differences were observed between adherent and nonadherent patients with regard to age, sex, race, insurance status, condition, or number of medications taken. Reasons significantly associated with nonadherence were forgetting, being too busy, and the cost of medication, symptoms improved so stopped taking medication, side effects too severe, and poor knowledgeable about their medications. CONCLUSIONS: Medication nonadherence is common and patient reported reasons for nonadherence include over-optimism, lack of understanding or knowledge, and treatment-related characteristics. Interventions that motivate, educate and individualize drug therapy according to patients’ preferences and affordability may improve adherence.

P3H5
THE MEASUREMENT AND VALUATION OF HEALTH STATUS USING EQ-5D IN BRAZIL: A SYSTEMATIC REVIEW
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OBJECTIVES: The EQ-5D has been extensively used to assess health-related quality of life (HRQoL) and utility across different health condition worldwide. The aim of this study was to systematically review studies using EQ-5D in the Brazilian population. METHODS: A structured literature search was conducted using the text words related to EQ-5D and Brazil in Pubmed and Lilacs database. Original research studies that reported EQ-5D results among Brazilian patients or general population were included. RESULTS: Of 23 identified papers (PubMed=11, Lilacs=12, 3 duplicate citations), 4 met the selection criteria, with one study reporting confounding results from study patients (947, 184, 552, 747, 474, 407) and EQ-5D responses (index, VAS and self-classification) for caregivers of stroke patients (Carod-Artal 2009) and two publications of the same SF-3D study for rheumatoid arthritis (RA) patients in which EQ-5D was used as a comparison measure (Campolli et al. 2011). One study reported EQ-5D index scores (index, VAS and self-classification) for caregivers of stroke patients (Carod-Artal 2009) and two publications of the same SF-3D study for rheumatoid arthritis (RA) patients in which EQ-5D was used as a comparison measure (Campolli et al. 2011). Of 2695 patients, 56.99% were women, mean age 62 years (range 17-85 years) with diverse co-morbidities. CONCLUSIONS: The EQ-5D index scores range from 0.65 (SD 0.3) for RA patients and 0.7 (SD 0.2) for caregivers of stroke patients. The study which applied EQ-5D to stroke patients did not report the mean scores, only correlation coefficients with stroke severity and impairment on daily living activities scales. EQ-5D showed good correlation with SF-6D in the RA study and with NIH Stroke Scale and modified Barthel Index in the stroke study. Adequate convergent validity between EQ-5D and Zartt Caregiver Burden Interview was obtained. The scores of stroke patients were different from other disease states, The EQ-5D index scores range from 0.65 (SD 0.3) for RA patients and 0.7 (SD 0.2) for caregivers of stroke patients. The study which applied EQ-5D to stroke patients did not report the mean scores, only correlation coefficients with stroke severity and impairment on daily living activities scales. EQ-5D showed good correlation with SF-6D in the RA study and with NIH Stroke Scale and modified Barthel Index in the stroke study. Adequate convergent validity between EQ-5D and Zartt Caregiver Burden Interview was obtained. The scores of stroke patients were different from other disease states.

P3H6
THE QUALITY OF LIFE OF PATIENTS WITH THE TOP 5 DISEASES AND THE WAY TO REFLECT THE BURDEN OF DISEASES IN THAILAND: A COUNTRY-WIDE MULTICENTER EQ-5D MEASUREMENT STUDY
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OBJECTIVES: Thailand’s top 5 burden of diseases in 2004 (based on the protocol of global burden of diseases (GBD) 2004) were HIV/AIDS, traffic accident, stroke, diabetes mellitus, and liver cancer, accounting for 947, 718, 652, 524, 497, 440 DALYs. Adjusted Life Years (DALYs) per 1000 population, respectively. The technique used by GBD to calculate the disability weight (DW) is based on an expert panel summary. However, this study measured DW directly from the patients and compared the results. METHODS: The cross-sectional observational multicenter hospital health study was conducted in 2008-2009. The 2,695 sampling patients were selected based on epidemiologic disease data from outpatient, inpatient and primary-care unit in 5 major regional hospitals throughout Thailand. Selected patients were allocated in the quota slot and completed the EQ-5D questionnaires with their capabilities. The EQ-5D states were converted to utility weight (UV) using the Thai preference method and then changed into DW with linear regression function to then compare DALYs directly to the GBD result. RESULTS: Of 2695 patients, 56.99% are men and 43.01% are women. The quality of life was calculated to DW with: DW = 0.688 + (-0.688 x UV). The new DW differs from GBD weight from -47.21 to 53.27 percent and these changes will affect the YLD and change the DALYs to 2.83 to 4.84%. CONCLUSIONS: The new DW from the diseases and their complications differ from the GBD weight. This technique has the tendency to produce more DW that GBD’s. To establish the burden of diseases, we use the quality of life to reflect the true disability. The limitation that we have to improve is the way to calculate the disability weight from EQ-5D for the best prediction.

P3H7
THE ROYAL ROAD OR THE MIDDLE WAY? PUBLIC AND PATIENT PREFERENCES FOR HEALTH OUTCOMES
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OBJECTIVES: In economic evaluations of health care interventions, outcomes are often expressed in terms of Quality-Adjusted Life-Years (QALYs). Deriving QALY weights, operationalized as preferences for health states, requires important normative choices. One important choice is the question whose preferences we wish to capture. Currently, preferences are commonly derived from the general public, rather than from actual patients. This choice, which has large consequences on final outcomes of economic evaluations, is increasingly seen as problematic. In the current study, arguments for and against public preferences are discussed and alternatives are suggested. METHODS: We highlighted and critically assessed the different viewpoints put forward in the health economic literature regarding the public and patient perspective. Patient preferences are considered to reflect true patient experiences, but are troublesome because preference values elicited from patients are ‘unusually’ high due to adaption. Public preferences are argued to be less sensitive to adaption, but are troublesome because they do not adequately foresee preferences that will change over time. The arguments put forward in the literature do not provide straightforward support for assessing outcomes QALY weights derived the general public. The exclusion of patient values in public decision-making is not sufficiently argued. With patient preferences life saving interventions are likely to become too costly-effective. CONCLUSIONS: Arguments both positions represent different normative positions regarding the appropriate measure of outcome in health care decisions. To date, the debate seems to have focused on the question which of the two would be most appropriate. However, it seems unclear why such a dichotomy would be necessary or, in fact, useful. Both public and patient preferences appear to be important sources of information for the allocation of health care resources in society. Perhaps the question should be how to intelligently combine the two.

P3H8
SELF REPORTED HEALTH STATES AND QUALITY OF LIFE AMONG COASTAL RURAL POPULATION IN SOUTH INDIA
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OBJECTIVES: To assess the health status and health related quality of life among rural population residing in coastal region of South India. METHODS: Randomly selected population attending health awareness camp in rural village of South India was recruited for the study. The VAS version of EQ-5D was used to assess the health related quality of life. Both descriptive and VAS scores were used for assessment. The population recruited was having the age >18 years and ≤75 years having the family history of either diabetes, CVD or both. RESULTS: A total of 126 patients were recruited with the mean ± SE age of 45.9 ± 13.44. The descriptive scores range from 0.86 to 0.83 and anxiety score 2.07 to 1.86 and anxiety score 1.96 ± 1.01. Among the different health states, 11, 121 health state was found to be used for the VAS score of 0.86 ± 14.64. CONCLUSIONS: There was considerable impact of pain and activity on the health related quality of life among rural coastal population in south India who had the family history of diabetes, CVD or both. There is a need to study the risk factors and other quality of life indicators among the rural coastal population in India.

P3H9
HOW DO POSTMENOPAUSAL WOMEN DESCRIBE BREAST PAIN AND BREAKTHROUGH BLEEDING ASSOCIATED WITH HORMONAL TREATMENTS FOR MENOPausal SYMPTOMS: QUALITATIVE INTERVIEWS FOR MENOPAUSal WOMEN IN THE UNITED STATES, CHINA, MEXICO AND TAIWAN
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OBJECTIVES: More than postmenopausal women with a uterus for the treatment of symptoms associated with menopause. While successfully treating climacteric symptoms, the presence of progestin is necessary to prevent endometrial proliferation. Progestins contained in EPT and experienced breast pain and/or vaginal bleeding/spotting. The objective of this study was to conduct qualitative interviews with postmenopausal women to better understand the patient experience of breast pain and vaginal bleeding symptoms associated with EPT, and the language patients use to describe them, to inform the development of new measurement tools for these symptoms. METHODS: Fifty-nine postmenopausal women in the USA (n=14), China (n=15), Mexico (n=15) and Italy (n=15) aged 40-63 taking EPT and experiencing breast pain and/or vaginal bleeding/spotting (47/59 experiencing both) participated in in-depth interviews concerning their experiences of EPT and impact on quality of life. Thematic analysis was conducted to identify concepts describing the experiences of the participants using Atlas Ti. RESULTS: In all 4 countries, breast sensations experienced while taking EPT were described as ‘pain and tenderness’, ‘feeling swollen’ and ‘sensitivity’ to touch. Vaginal bleeding and spotting were commonly described in terms of frequency, volume, colour and consistency. Frequency of both symptoms ranged from ‘daily’ to ‘occasionally’. Both symptoms impacted on psychological well-being, activities of daily living and sex life. Items for new measurement tools were developed based on this qualitative data with clinical input from experts in menopause. CONCLUSIONS: In-depth interviews with a geographically diverse sample elicited common descriptors for the symptoms of breast pain and vaginal bleeding and allowed items to be developed that are applicable across cultures, conceptually consistent and easily translated. Accurately capturing descriptors used by patients is critical to ensure new outcome tools have content validity and cross-cultural reliability.