in 2010, being the fourth main cause of death. WHO estimated the prevalence of DM in Brazil is 10.2%, about 20 million people. **OBJECTIVES:** To measure the DM social cost based in earnings losses of Brazilian workers due to disease in 2008 using data from National Survey of Households (PNAD/IBGE). **METHODS:** A Binary Probit model to measure the participation in work force and a two-stage Heckman model to measure worked hours and productivity. Each model is estimated separately for both gender individuals, with and without disease, according three distinct definitions for DM: Restrict, Broad and Comorbidities. To capture the counterfactual effect, the model was calculated for ill and healthy individuals. The difference of both values exhibited the losses, which were aggregate to the whole population and the total cost was estimated. **RESULTS:** According each criterion, respectively, DM reduced the participation in the labor market in 0,97%; 4,60% and 7,06% for men and 0,14%; 4,79% and 6,44% for women, while reduced, respectively 1,51%; 6,40% and 9,15% in productivity and 6,44%; 15,23% and 17,58% in worked hours just for women. There was no impact of DM on productivity and in worked hours for men. The DM total cost was R$ 8,064 billion, or US$ 3,451 billion converted by current exchange rate. The losses reached 0,73% of total earnings and 0,27% of Brazilian GDP in 2008. **CONCLUSIONS:** DM generates significant losses in income of Brazilian workers, especially in relation to their participation in the labor market, since affects both of gender. The results indicate that public policies should be directed to disease diagnosis and prevention, since the development of comorbidities amplifies the effect of losses.

HEALTH TECHNOLOGY ASSESSMENT STUDIES

HT1

RAPID INCREASE OF HEALTH LITIGATION AS A MEANS OF MARKET ACCESS FOR INNOVATIVE MEDICINES IN COLOMBIA AND THE POTENTIAL ROLE OF HEALTH TECHNOLOGY ASSESSMENT

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OBJECTIVES: Reimbursement of high-cost medicines excluded from the Colombian mandatory healthcare plan (POS) through legal mechanisms known as 'tutela' and the Scientific Technical Committees (CTC) have significantly increased in the last four years. As the new healthcare statutory law (1751-2015) puts pressure on the healthcare budget, it is likely that these will increase further. This research analyses the "judicialisation" of the right to health in Colombia and the feasibility of a mandatory health technology assessment (HTA) evaluation as a policy to reduce reimbursement of non-POS medicines by litigation. **METHODS:** Secondary research of the main tutela decisions of the Colombian courts and CTC decisions related to non-POS medicines between 2011 and 2014 were conducted. A 2014 Ombudsman's Office report of detailed medicine-tutelas was also analysed, and cross-referenced with statistics from the Colombian Ministry of Health and the General Prosecutor. A lack of official data for 2014 is addressed using case-by-case tutelas, literature review and stakeholder interviews. **RESULTS:** Tutela and CTC decisions are predominantly in favour of protecting the fundamental right to health (80% of all decisions between 2011 and 2014), giving access to non-POS medicines irrespective of cost-effectiveness. According to the Ombudsman's Office, of the 115,147 tutelas presented in 2013, 34,099 (18.8%) were requests for medicines of which over half (22,685) were for access to non-POS medicine. The Colombian Fund of Solidarity and Guarantees paid health-promoting entities (EPS) over COP2 billion in 2012 and over 2.5billion in 2013 for the reimbursement of non-POS medicines following tutela and CTC decisions. **CONCLUSIONS:** Decisions over access to many high-cost medicines in Colombia are taken in courts based on infringement of fundamental rights rather than on cost and clinical-effectiveness assessments. This provides an important avenue to access new medicines, but also side-steps the formal reimbursement process. A more systematic, binding HTA system would likely reduce health litigation.

HT2

FROM LAW TO REALITY: MEASURING TIME-TO-ACCESS OF CONITEC APPROVED DRUGS IN BRAZILIAN PUBLIC HEALTH CARE SYSTEM (SUS) IN THE STATE OF PARANÁ

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OBJECTIVES: Brazilian Federal Law 12.401/2011 created the National Committee for Health Technology Incorporation (CONITEC) and defined criteria and deadlines for health technology (HT) incorporation in public health system (SUS). CONITEC advises the Brazilian Ministry of Health about HT incorporation or disinvestment in SUS and clinical guidelines development. After CONITEC appraises and recommends a technology, it should be available for the population in 180 days. The objective of this analysis was to evaluate the time between a technology was recommended by CONITEC and actually became available. **METHODS:** We reviewed all CONITEC's reports since 2012, and selected those regarding drugs. Reports were classified in not recommended and recommended, and publication date was retrieved for those recommended. Simultaneously, we evaluated the date a drug recommended by CONITEC was received by the Centro de Medicamentos Básicos do Paraná (CEMEPAR), which is responsible for buying and distributing medications in Paraná. The time between report publication and drug availability was then assessed. **RESULTS:** CONITEC published 125 reports since 2012, 93 on drugs and 42 classified as recommended. These 42 represented 62 drugs with different pharmacologic concentrations. From these, it was the Paraná state's liability to distribute 45, which were then selected for the analysis. The majority of cases (64.4%) were in non-conformity with established deadlines: 55.5% were unavailable at CEMEPAR before 180 days, and 8.9% were never bought until the day of this analysis (February 06th, 2015). The longest time between drug recommendation and its availability at CEMEPAR was 2 years and 73 days (salmeterol 50mcg) and the minimum was 13 days (adalimumab 40mg). Average time for a drug to be available for distribution was 315.3 days (135.3 days beyond the established deadline). **CONCLUSIONS:** This study shows that mere recommendation by CONITEC doesn't guarantee access for the population in the timeframe established. Reasons should be investigated.

HT4

PROCESO DE INCORPORACIÓN DE FÁRMACOS A LA LISTA POSITIVA DE MEDICAMENTOS (LPM) PARA LOS PRESTADORES INTEGRALES DE SALUD: EXPERIENCIA EN EL MINISTERIO DE SALUD PÚBLICA (MSP) DE URUGUAY

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OBJECTIVES: Describir el proceso para la de incorporación de fármacos al LPM en el marco del Sistema Nacional Integrado de Salud Uruguayo **METHODS:** El proceso comienza con la presentación de un formulario de solicitud al MSP al que se adjunta evidencia de alta calidad de su eficacia y seguridad comparado con las alternativas terapéuticas. Esta evidencia es analizada y complementada con una nueva búsqueda bibliográfica sistemática realizada por el evaluador. Se resumen los resultados de eficacia y seguridad obtenidos de estudios aleatorizados presentados y cuando hay más de uno y es metodológicamente adecuado se realizan meta análisis. Si no hay estudios de comparación cabeza a cabeza se realizan en ocasiones comparaciones indirectas. Los informes de eficacia y seguridad son posteriormente evaluados por un experto clínico quienes aportan su punto de vista en cuanto a la pertinencia de la inclusión. Finalmente en los casos candidatos a ingresar se realiza un análisis económico (impacto presupuestal o estudios de costo utilidad según el precio del tratamiento anual sea menor o supere un PBI per cápita). **RESULTS:** En 2011 solicitaron ingreso al FTM 123 fármacos, en 2012 fueron 37 fármacos, en 2013 fueron 30 fármacos y en 2014 fueron 51 lo que totaliza 241 solicitudes. De estas, todos fueron completamente revisados, 54 fueron rechazados por insuficiente evidencia presentada, 163 tienen informes de eficacia y seguridad completos y 24 están siendo evaluados en este sentido. De los 163 evaluados, 61 tienen pendientes evaluaciones clínica o económicas. **CONCLUSIONS:** El desarrollo de un sistema de evaluación de tecnologías para informar a los decisores sobre la incorporación de nuevos fármacos a las listas positivas de medicamentos de los sistemas únicos de salud, requiere de tiempo y pericia técnica, pero es posible en entornos de recursos limitados y representa un avance con respecto a modalidades anteriores.

PATIENT AND CLINICIAN PREFERENCES & QALY STUDIES

PP1

BARRIERS TO PARTICIPATION IN TRIALS OF CANCER: A SURVEY ON CLINICAL RESEARCH PERCEPTION

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OBJECTIVES: Clinical trials (CT) represent an important alternative treatment for oncologic patients. Also, CTs represent an important step to development of improved therapeutic strategies. On the other hand, little is known on Brazilian patient's perception regarding CT. Therefore, the aim of this survey was to describe the overall perception of clinical research in Brazil. **METHODS:** From April 2012 until October 2014, 254 respondents answered an internet-based survey related to knowledge related clinical research from Oncoguia Institute, an independent nonprofit cancer advocacy institution. **RESULTS:** Overall, about 85% of respondents would participate on oncology trial. Of all respondents, 99.9% believe that clinical research can contribute positively to advance of cancer treatment by increasing the scientific knowledge, improvement of treatment, finding a cure, to have a new treatment option, or improved quality of life. Among the respondents, 96% affirmed that have already had some information on clinical research, being internet the most used form of communication (69%), followed by physicians´ orientation (8%), magazines and newspaper (8%) and hospital hand-out material (7%). In addition, only 18 respondents reported previously participation on CT (6.9%), and about 10% answered that have someone known that participated in a clinical trial (e.g. friend, family or other). **CONCLUSIONS:** This survey demonstrates that respondents associate clinical research as an option in cancer treatment. However, only a small number of respondents have participated previously of a CT, besides that, internet was the main tool to learn about CTs. The data indicate that lack of available information, including low participation of physician on instructing their patients, are the current major barriers on CT in Brazil. Improvement of physician and patient awareness are potential solutions. Thus, strategies are needed to improve communication between patient and physician.

PP2

AN EQ-5D-5L VALUE SET BASED ON URUGUAYAN POPULATION PREFERENCES: REPORT OF THE FIRST EXPERIENCE IN LATIN AMERICA

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OBJECTIVES: To derive a value set from Uruguayan general population using the new five level (5L) EQ-5D instrument and report population norms. **METHODS:** We randomly assigned general population individuals to value 10 health states using composite Time Trade Off and 7 pairs of health states through Discrete Choice Experiments. Additionally, respondent provided sociodemographic information and rated their current health state. The sample was stratified using with quotas by location, gender, age and socioeconomic status in order to represent the Uruguayan population structure. Trained interviewers conducted face to face interviews using EuroQol valuation technology (EQVT) to administer the protocol, as well as to collect and store the data. Primary analysis used OLS and maximum likelihood robust regression models with or without interactions **RESULTS:** We included 794 respondents between 20 and 83 years. Their characteristics were