PHHP40

CLINICAL TRIAL TRENDS IN LATIN AMERICA: COMMUNICABLE VERSUS NON-COMMUNICABLE DISEASE
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OBJECTIVES: Following the recent economic growth in Latin America, this analysis was undertaken to analyse the corresponding shift in healthcare trends, by examining the number of clinical trials being conducted in the region and their changing focus on non-communicable and communicable diseases. METHODS: ClinicalTrials.gov was searched in March 2015 for all trials with a study start date from January 2000 to December 2014 in five Latin American countries: Brazil, Chile, Colombia, Mexico and Peru. Studies were classified as either communicable or non-communicable according to the World Health Organization International Classification of Disease-10 (WHICD-10), with studies that did not focus on disease or illness excluded. RESULTS: Between the five selected Latin American countries there were a total of 8,847 relevant studies identified, 46.3% of which originated from Brazil. Over the entire time period from 2000 to 2014, 89.3% of studies were concerning non-communicable diseases such as cancer, cardiovascular disease and musculoskeletal disorders, whilst 10.7% focused on communicable diseases. An analysis over time saw a trend of an increasing proportion of studies concerning non-communicable diseases and a fall in the proportion of studies in communicable diseases. In 2000, non-communicable diseases accounted for 77.8% of studies, compared with 22.2% in communicable diseases, however by 2014 these percentages were 91.4% and 6.6%, respectively. There were 711 unique studies across the countries in communicable disease, 24.9% of these were in HIV/AIDs, one of the most deadly, infectious diseases in the region, responsible for approximately 7.2 deaths per 100,000 people across the five selected countries. CONCLUSIONS: The healthcare trends in Latin American appear to be changing alongside the epidemiological changes in the region. Fewer clinical trials are being carried out in preventable, infectious diseases responsible for approximately 7.2 deaths per 100,000 people across the five selected countries. A focus on non-communicable diseases may reflect the region's economic growth and changing healthcare priorities.

PHHP41

GOVERNANCE, DECISION-MAKING, AND UNIVERSAL HEALTH COVERAGE: PERCEPTIONS FROM CHILEAN HEALTH DECISION-MAKERS
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OBJECTIVES: To explore health decision-makers’ perceptions on governance on decision-making process within the region de Los Rios integrated health delivery network. METHODS: A descriptive and exploratory qualitative study base on in-depth interviews with health decision-makers from region de Los Rios from June 2013 to December 2014 was conducted. A convenience sample of 11 health decision-makers was selected. A health decision-maker was defined as a health professional with a formal policy or managerial status whose primary responsibility would be formal leadership on decision-making (i.e. Health Service Director, and Directors Hospitals). The interviews were performed, recorded, and transcribed into the ATLAS.ti qualitative software. RESULTS: For the health decision-makers, a meaning of good governance was embedded within a system and services is not concerned in a technical approach. Moreover, governance is neither perceived as a concept related to health nor universal health coverage. Politics was perceived as a key issue at designing and implementing health decision-making processes. A governance perspective, politics of health policy is perceived as a strong root for health decision-making in Chile. CONCLUSIONS: the Chilean case highlights is the paradox that establishing good enough governance to implement central initiatives with effective integrity might involve accountability measures that interfere with good administration.

PHHP42

BRAZILIAN GUIDELINE FOR ACADEMIC DETAILING: A NEED TO IMPROVE HEALTH CARE
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OBJECTIVES: To develop a Brazilian guideline on Academic Detailing (AD) – educational outreach visits to prescribers. The overall aim is to enhance the rational use of medicines and devices provided by the Brazilian National Health System (SUS). METHODS: This document was based on an extensive search of the literature, the AD experience of international organizations and the experience of a pilot project conducted by the SUS Collaborating Centre in Belo Horizonte, Brazil. A team of 15 researchers, including facilitators and coordinators of AD Programs participated in the development of this Guideline. RESULTS: The Guideline provides an overview of the AD service that should be performed by a qualified and trained health professional (facilitator). To develop an AD Program a local team composed of specialists on the subject to be addressed, researchers and interns should be formed. It is recommended that at least one coordinator manage the process, orient staff members, and conduct the training of facilitators. The process to develop and conduct an AD Program involves ten stages: Stage 1: Prospection and identification of problems; Stage 2: Definition of the AD purpose; Stage 3: Budget estimate, elaboration of schedule and technical team designation; Stage 4: Elaboration and purchase of the support material; Stage 5: Selection of facilitators and organization of visitation goals; Stage 6: Recruitment of facilitators and workshop training; Stage 7: Prescribers’ visiting for AD; Stage 8: Release of the support material; Stage 9: Evaluation of results; Stage 10: Release of the results. CONCLUSIONS: A national Guideline is necessary to ensure the quality of AD service and the processes and outcomes that underpin it. The developed Guideline presents the main concepts of AD technique, examples of materials and forms necessary for documentation and evaluation of visits performance, and detailed information of each stage necessary to conduct an AD Program.

PHHP43

STATE AND PROSPECTS OF PHARMACOECONOMICS TRAINING IN UKRAINE
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OBJECTIVES: Reforming experience of health care in Western countries (Canada, USA, UK and other European countries) demonstrates the need for standardization of medical and pharmaceutical care for population, taking into account the results of pharmacoeconomic analysis, it can reduce health care costs by 10-20%. In Ukraine Prof. Ola Zaliz’ka conducted theoretical bases and pharmacoeconomic analysis and creation of educational and methodical system of pharmacoeconomics for pharmacists during 10 years. Pharmacoeconomics discipline “Pharmacoeconomics” was included in curriculum of pharmacists on specialty “Pharmacy” and “Clinical Pharmacy” and for postgraduate training of pharmacists in the specialty “Economy and management of pharmacy” and “General pharmacy management of health care systems”. From a governance perspective, politics of health policy is perceived as health professional with a formal policy or managerial status whose primary responsibility would be formal leadership on decision-making (i.e. Health Service Director, and Directors Hospitals). The interviews were performed, recorded, and transcribed into the ATLAS.ti qualitative software.

PHPP4

BENCHMARKING HEALTH TECHNOLOGY ASSESSMENT (HTA) AGENCIES FOR SETTING STANDARDS ON PHARMACOECONOMIC, PRICING, EVIDENCE, AND GENERAL SUBMISSION REQUIREMENTS: DEVELOPMENT OF A MULTIDIMENSIONAL RATING SCALE
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OBJECTIVES: To reliably and quantitatively benchmark Health Technology Assessment (HTA) agencies using a single global benchmarking system. METHODS: Literature search was conducted to identify surveys or reports evaluating different HTA processes. Using published literature, attributes deemed crucial for benchmarking HTA agencies were identified. In collaboration with clinical and actuarial experts, we developed a Likert scale to serve as the basis for comparing key attributes of HTA submission process, i.e. pharmacoeconomic, pricing, evidence, and general submission requirements. RESULTS: Few publications have benchmarked HTA agencies against good practice and processes, with no published scale quantitatively assessing HTA agencies for attributes of submission requirements. Using identified literature and expert opinion, a unique Likert scale was developed with 77 questions. Each question was marked on a scale of 0-5, with higher score (4 or 5) indicating lack of guidance or difficulty in accession. As a limitation, each category may not have all options from 0-5. These 77 questions form 18 best practice principles, and in turn six functional domains, i.e. transparency, process, technical, equity, speed and implementation. Each domain has a unique significance: transparency - clear unbiased process, process - delivers decisions in timely manner to meet innovation and timelines; implementation - performs clear audit to ensure guidance is followed. CONCLUSIONS: Our scale provides a new approach to benchmark HTA agencies in terms of adherence to best practice and ease of accession. Further research is required to consider individual market needs driving the HTA submission standards.