broadly similar to the Uruguayan population. Forty percent of the subjects reported regular smoking. The problem of the five domains included. Older respondents reported more problems in all dimensions. Mean self-reported VAS was 79.63 (SE 0.58); it decreased with age and was lower in women. As OLS model showed logical inconsistencies, robust modelling was chosen to derive social values. Values on the 0-100 scale were created as the mean value for all dimensions in Uruguay, using the final main effects Uruguay EQ-5D-5L value set, is 0.895. In general, older people had worse values and males had slightly better values than females. 

**Conclusions:** We derived the EQ-5D-5L Uruguay value set, the first in the region. Further work will help inform decision-making using economic evaluations for resource allocation decisions.

**PP3**

**COST-EFFECTIVENESS ANALYSIS FOR CERVICAL CANCER SCREENING USING HPV TESTS IN BRAZIL**

Francisco Figueredo S, Cachoeira CV, Pestana Hagesasse AC, Kano BY, Souza FH, Paulos N

**Methods:** A Markov model captured the outcomes of 1,000 non-hysterectomized women ages 25 years and older who transitioned annually across possible health states and were screened over a 45-year period in Brazil. This model was used to compare three strategies: (1) cytology alone every 3 years; (2) HPV with reflex genotyping and reflex cytology, from a payer’s perspective. The one-way and probabilistic sensitivity analyses were performed. Additionally, the screening and cancer treatment costs were calculated according to DATASUS (Departamento de Informatica do Sistema Único de Saúde - Brazil) public data, in Brazilian Real (BRL) and discounted at an annual rate of 5%. **Results:** The primary screening with the strategy (3) HPV with reflex genotyping, reflex cytology and the general population in Brazil due to the ICER ≤ 3 Brazilian GDP per capita, according to the World Health Organization’s recommendations.

**PP4**

**AN UNDEVELOPED PICTURE: THE AVAILABILITY OF UTILITY VALUATIONS IN LATIN AMERICA – HOW WILL THEY AFFECT QALYs?**

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**Methods:** Using PubMed, a structured search was conducted to identify the generic, preference-based instruments that had valuations for Latin America. The instrument was selected if the sample included data from at least five Latin American countries and if the general population was assessed. The selected instrument was HUI4 (Health Utilities Index Mark 4). This instrument was used in 1998 to provide a unique health-related quality of life measure. **Results:** While the instrument covers all possible health states and is easy to use, this is the first study to report on the valuation of QALYs in Latin America. **Conclusions:** The HUI4 may be a useful instrument for measuring QALYs in Latin America. Further work is needed to validate the instrument in this region.

**RESEARCH ON METHODS STUDIES**

**RM1**

**STANDARDIZATION PROCESS OF RAW DATASUS AND CONSUMPTION ANALYSIS OF ONCOLOGY THERAPIES IN THE BRAZIL PUBLIC HEALTH CARE SYSTEM: A COMPARISON BETWEEN RAW AND STANDARDIZED DATASET IN COLORECTAL AND LUNG CANCER**

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**Objectives:** To compare results of oncology drugs consumption extracted from DataSUS raw data with those obtained after standardization and cleaning data base files. **Methods:** We used the SUS database available from DataSUS ITP and standardized the oncology treatment fields available in the specific oncology data banks. All included reimbursed drugs were identified according to the same name used for the same drug name (i.e., cetuximab, cetux, cetuximab and ketuximab), including generic and brand names. We also converted acronyms use in NCNN and MOC Brazil guidelines to the generic name (i.e. fluoracil and 5FU; irinotecan and CIM; and carboplatin and MM). Treatment was defined with the new standardized table with additional fields (regimen name, drugs used, adjudicated therapy and a high/low cost flag). For this analysis we filtered by APAC (High complexity procedures approval) code for colorectal cancer (CRC) and lung cancer (LC) drugs. Results: From 2012 to 2014. All blank or not identified regimens were excluded from this analysis. The final sample was composed by 50,792 CRC and 23,525 LC records. **Results:** It was compared the total number of regimens available at raw data and those standardized. Regarding CRC regimens we found 6,691 vs 3,590 treatments in the raw database and 82 in the standardized dataset, a considerable reduction. In raw data, the most frequent regimen was FOLFOX representing 7.9% of all records, in contrast to standardized dataset where FOLFOX represented 33.6% of all records. The mean value for the general population in Brazil due to the ICER ≤ 3 Brazilian GDP per capita, according to the World Health Organization’s recommendations.

**RM2**

**EXTRACTING AND USING DATA FROM ELECTRONIC MEDICAL RECORDS (EMR) TO MONITOR QUALITY OF CARE AND PRESCRIPTION PATTERNS FOR DIABETES PREVENTION AND CONTROL IN OUTPATIENT CLINICS OF LOW AND MID RESOURCES COUNTRIES: THE CASE OF COIMA, MEXICO**

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**Objectives:** Evaluate the feasibility of extracting data from the EMR used by the Health Services of Colima, Mexico and use it to assess the quality of care and prescription patterns for Diabetes prevention and control in outpatient clinics. **Methods:** A copy of the electronic medical records database, including clinical information, was obtained from the Health Services of Colima. A data verification and validation process was carried out including checking for EMR duplicity using Structured Query Language (SQL) and phonetic algorithms. A flat table for each patient’s encounter with the health services was constructed in order to have a longitudinal record along with vital signs, diagnostic and control tests as well as drugs prescribed. Each encounter was then coded to reflect in a single character string the main variables of diabetes: number of visit after diagnosis, glucose measurement, drugs administered, as well as eye and feet examination. **Results:** The EMR in Colima initiated its operation in 2005 as a pilot in 3 clinics, in 2010 it covered about 50% of the state’s clinics (SS) and in 2013 reached 100%. In 2013. A total of 393,398 records were extracted and consolidated with 2,271,251 data points and covered about 50% of the state’s clinics (55) and in 2013 reached 100%: 117 clinics. **Conclusions:** Differences of TTO values between the Metropolitan Region (MR) and the rest of the country are of interest on this topic.