

(CE) analysis to estimate the impact of this pricing policy on the CE of trastuzumab in Latin-America (LA). **METHODS:** Model structure and a common methodology for identifying costs and resource use were agreed with country teams. A Markov model was designed to evaluate life years (LY), quality adjusted life years (QALY) and costs from a health care sector perspective. A systematic search on effectiveness, local epidemiology and costs studies was undertaken to populate the model. A base case scenario using transition probabilities from trastuzumab clinical trials, and two alternative scenarios with transition probabilities adjusted to reflect breast cancer epidemiology in each country, were built to better fit local cancer prognosis. **RESULTS:** Incremental discounted benefits and costs of the trastuzumab strategy ranged from 0.87 to 1.00 LY, 0.51 to 0.60 QALY and \$24,683 to \$60,835 (2012 US dollars). Incremental CE ratios ranged from \$42,104 to \$110,283 per QALY, equivalent to 3-6 gross domestic products per capita (GDPc) per QALY in Uruguay to up to 35.5 GDPc per QALY in Bolivia. The probabilistic sensitivity analysis showed a 0% probability that trastuzumab is CE if the willingness-to-pay (WTP) threshold is one GDPc per QALY, and remains 0% at a WTP threshold of three GDPc except in Chile and Uruguay (probability 4.3% and 26.6% respectively). **CONCLUSIONS:** Despite its proven CE in other settings, trastuzumab was not CE in LA at its current price. Better cooperation between the public and private sectors is still needed to make innovative drugs available and affordable in DC.

CA2 NATIONAL SPENDING WITH SCREENING, DIAGNOSIS AND TREATMENT OF CERVICAL CANCER: ESTIMATES BASED ON HEALTH INFORMATION SYSTEMS, BRAZIL, 2006

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OBJECTIVES: To estimate national expenditure with procedures of the National Cervical Cancer Control Program. **METHODS:** A cost description study was conducted to develop estimates of expenditures related to care held under the National Cervical Cancer Control Program in Brazil. Health Information Systems of the Public Health System, SUS (SIH, SIA, APAC, SIAB, and SIGTAP SISCOLO), national survey (PNAD 2008), and guidelines of INCA/MS, and reference systems for payments of the private system were consulted to construct estimates of direct and indirect costs. The estimates were grouped by sets of procedures of the stages of cervical cancer care (screening, diagnosis, treatment of precancerous lesions of the cervix - CIN I and CIN II / III and treatment of cervical cancer). The study was conducted from the perspectives of the health care system and society. **RESULTS:** The total direct cost of SUS in 2006 was estimated at R\$ 227,167,515, ambulatory visits were responsible for 27% of spending. Screening represented the highest spending. The estimated total direct spending to the private sector in 2006 was R\$ 938,707,221, ambulatory visits were responsible for 68% of spending. The transport costs were estimated at R\$ 230,533,910. Lost productivity was based on the human capital approach and was estimated at R\$ 1,463,977,777. The final value of the direct and indirect costs estimated and adjusted for the year 2008 was R\$ 3,193,335,402. **CONCLUSIONS:** Spending with National Cervical Cancer Control Program is very significant. There is need for more costing studies in the country, alongside a greater structuring of official systems cost data available in order to contribute to the standardization and accuracy of the estimates of national costs.

CA3 ANÁLISIS DE COSTO-EFECTIVIDAD DE ESTRATEGIAS DE PREVENCIÓN PRIMARIA Y SECUNDARIA PARA CÁNCER DE CUELLO UTERINO EN COLOMBIA

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OBJECTIVOS: Evaluar la costo-efectividad de estrategias de prevención primaria (vacunación) y secundaria (tamización) para la prevención del cáncer de cuello uterino en Colombia. **METODOLOGÍAS:** Un modelo de Markov de la historia natural del cáncer de cuello uterino fue desarrollado para evaluar las siguientes estrategias: no tamización, tamización (citología convencional y en base líquida, pruebas ADN VPH, pruebas rápidas de ADN VPH y vía vilí), vacunación y tamización + vacunación. Las estrategias se evaluaron solas o combinadas, para un total de 32 estrategias evaluadas. Los años de vida ganados (AVG) fueron usados como medida de efectividad. El estudio tuvo la perspectiva del tercero pagador, solo se incluyeron costos directos. Se calcularon razones de costo-efectividad y costo-efectividad incremental, se condujeron análisis de sensibilidad determinísticos y probabilísticos. Se aplicó tasa de descuento del 3% a los costos y resultados en salud. **RESULTADOS:** Las estrategias que quedaron sobre la frontera eficiente fueron: la vacunación, la vacunación más las pruebas rápidas de ADN VPH cada 10 años desde los 35 - 50 años, la vacunación más la prueba de ADN VPH cada 3 años desde los 30-69 años con triage (vía vilí) y sin triage de las mujeres positivas a la prueba y la vacunación más la citología en base líquida en el esquema 1-1-1-3 desde 25-69 años. El costo por año de vida ganado para las estrategias arriba mencionadas fue de \$US 1.288, \$US 6.447, \$US 8.875, \$US 14.186 y \$US 94.503 respectivamente. El análisis probabilístico mostró que para umbrales de disponibilidad a pagar superiores a \$US 13.000 la tamización con prueba de ADN-VPH cada 3 años más vacunación es la estrategia más costo-efectiva. **CONCLUSIONES:** La tamización con prueba ADN-VPH cada 3 años más vacunación en mujeres de 12 años sería una alternativa costo-efectiva para Colombia.

CA4 EMERGING CARDIOVASCULAR EVENTS ASSOCIATED WITH TARGETED ANTICANCER DRUGS. PRELIMINARY RESULTS OF A CARE LINE'S PROGRAM BASED ON AUDIT VIGILANCE IN A PRIVATE HEALTH CARE IN BRAZIL

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OBJECTIVES: Retrospective study of oncology patients with cardiovascular event, in order to help an decision. There is evidence regarding the prognosis of cancer patients, which is seen as a carrier of a chronic disease that throughout its evolution may have acute decompensation, as cardiovascular manifestations. Progress in cancer treatment also resulted in increased exposure of patients to cardiovascular risk factors and chemotherapy with potential cardiotoxicity and sure for expenses in terms of adding costs of care. **METHODS:** We analysed 68 cases collected and registered by the time of cardiology and oncology audit, in 2012. Outcomes items used: Costs, cardiovascular events associated with cancer. **RESULTS:** Among 68 cases, Breast Cancer is the majority accounting 32 (47%). All of them were seen by cardiologist and the total amount spent were US\$15.000,00. Thirty one patients were characterized having a cardio - vascular event and the costs were comprise by echocardiogram, ergo-cardio test, angio tomography and coronary cardiac catheterization. The costs of oncology treatment range from \$1.500,00 to \$ 6.800,00 USD per cycle, each 21 or 28 days, that means \$18.000,00 to \$ 120.000,00 USD a year. It means that the provisional budget will range from \$ 1.224.000,00 to \$ 8.160.000,00 USD a year for the cohort of 68 patients in our institution. So, we will spend 0.18 % to 1.22 % in cardiac vigilance for the oncologic patients describe above. **CONCLUSIONS:** The costs still low, the price of the oncologic cure with an cardiology event needs more studies, details need for further recommendations.

FORMULARY DEVELOPMENT AND PUBLICATION OF COST STUDIES

FD1

RESULTADOS DE LA ENCUESTA "CHANGE PAIN" LATINOAMERICANA: DIAGNOSTICO Y TRATAMIENTO ACTUAL DE LOS PACIENTES CON DOLOR CRÓNICO

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OBJECTIVOS: La "Change Pain Survey at EFIC 2009- Physician's perception on management of severe chronic non-cancer pain" realizada en países europeos, confirma la falta de conocimiento para el dolor neuropático y las variedades de enfoques del tratamiento del dolor crónico sin utilizar una guía consistentemente. Aplicando la misma encuesta a médicos generales y especialistas en países de América Latina, se exploró la percepción y comprensión de la forma de manejo del dolor crónico en América Latina. **METODOLOGÍAS:** Se realizaron 2130 encuestas vía electrónica de octubre 2012 a marzo 2013, en forma aleatoria a médicos generales y especialistas a través de sociedades médicas, fuerza de ventas o aplicadas en congresos médicos de 15 países de América Latina, poniendo énfasis en la percepción del tipo de dolor para elección del tratamiento. **RESULTADOS:** El porcentaje por especialidad fue: 18% traumatólogos, 12% médicos generales, 12% de rehabilitación, 13% anestesiólogos, 10% algólogos, y otras especialidades menores a 5%. Clasifican el dolor crónico muy heterogéneamente, desde nivel 4 al 9, en una escala del 1-10. Sus objetivos del tratamiento del dolor son reducción del dolor (30%) y calidad de vida (27%). La elección terapéutica para el dolor la deciden por eficacia (19.28%), tolerabilidad (21.83%), eficacia/equilibrio de efectos adversos (24.69), calidad de vida (18.19%) y costo (15.99%). Perciben un conocimiento limitado de las opciones terapéuticas y sobre la diferencia fisiológica entre dolor nociceptivo y dolor neuropático. **CONCLUSIONES:** La encuesta muestra una ausencia de estandarización en el tratamiento de dolor crónico y desconocimiento de las opciones terapéuticas ideales para el dolor crónico. Existe una necesidad de contar con un mejor conocimiento sobre el dolor crónico para lograr un adecuado manejo multimodal para su seguimiento y control.

FD2

ESSENTIAL MEDICINE LIST (CUADRO BÁSICO) EN MÉXICO. IS IT A GUIDELINE FOR DECISION MAKING ON THE CURRENT AND FUTURE HEALTH NEEDS?

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OBJECTIVES: Cuadro Básico is a list of minimum medicines needed for a basic health care system, listing the most efficacious, safety and cost-effective medicines for priority conditions. The importance is to ensure availability of drugs for current and future public health relevant diseases. The objective is to describe the characteristics of National List in Mexico and compare it with the Instituto Mexicano Seguro Social (IMSS) List in order to hypothesize the relevance of the drugs included on both Lists versus current and future health needs in the country. **METHODS:** It was performed a descriptive analysis of the two lists organized by therapeutic area. The description includes number of total codes, and number per therapeutic area. The information was compared to find the gaps on the number of codes between the two Lists. In addition it was identified the top health priorities and prevalence. **RESULTS:** National list has 1631 codes; the therapeutic areas with the majority of codes are infectious diseases (222) and Oncology (150). IMSS List has 1145 codes. The biggest relative difference between the two lists come from codes available for neurology, dermatology and ophthalmology; 57%, 56% and 45% codes are not available at IMSS, respectively. The top mortality causes in Mexico are heart disease, diabetes, cancer, accidents, liver diseases, stroke and COPD. If the analysis is made by disease, it worth mention that COPD only have 3 codes at IMSS and 7 codes at National Listing, while Alzheimer disease do not have any code at IMSS. **CONCLUSIONS:** A more extensive analysis (already available) brings information about the gaps between health needs and the drugs available. Mexico has an increased number of an aging population, which requires access to different drugs. The Essential list of WHO has 315 compounds versus Mexican which has 1631 codes. Is it a good guideline for decision makers?

FD3

¿PUEDE UN CAMBIO DEL 2003 EN EL REGLAMENTO EN EL CUADRO BÁSICO (CBM) EN MÉXICO IMPACTAR LA CANTIDAD DE ESTUDIOS CIENTÍFICOS PUBLICADOS DE EVALUACIÓN ECONÓMICA COMPLETOS DE MEDICAMENTOS (EEM) EN LOS ÚLTIMOS 10 AÑOS?

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