

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, don't like to take pills/give injection, 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 motivational factors, 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.

PIH35

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 free 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 evidence on validity for stroke patients (Pinto 2011), one study reporting EQ-5D responses (index, VAS and self-classification) for caregivers of stroke patients (Carod-Artal 2009) and two publications of the same SF-6D study for rheumatoid arthritis (RA) patients in which EQ-5D was used as a comparison measure (Campolina 2009 and 2010). All 3 studies reported EQ-5D index, 2 of them used the UK tariff and Carod-Artal 2009 did not inform the conversion method. Mean EQ-5D index scores were 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 Zarit Caregiver Burden Interview was observed among caregivers of stroke patients. **CONCLUSIONS:** Although the EQ-5D is the most widely used generic preference-based measure of health-related quality of life, studies reporting results for Brazilian samples are still scarce. Normative reference data for the general population are not available in the published literature which makes interpreting disease-specific scores a complex task.

PIH36

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, 2010

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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, 474, 407 Disability-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 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 (UW) 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 male, and the age is between 1 to 100 years old. The quality of life was calculated to DW with: $DW = 0.688 + (-0.688 \times UW)$. 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 -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 than 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.

PIH37

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 topic of debate. In the current study, arguments for and against public preferences are discussed and alternatives are suggested. **METHODS:** We highlight and critically assess 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 adaptation. Public preferences are argued to be less sensitive to adaptation, but are troublesome because they do not adequately forecast experience. **RESULTS:** 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 more cost-effective. **CONCLUSIONS:** Arguments for and against 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.

PIH38

SELF REPORTED HEALTH STATUS 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 were recruited for the study. Kannada version of EQ-5D5L questionnaire 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 \pm SD age of 45.95 \pm 13.44. The descriptive scores ranging between minimum 1 and maximum 5 for different health related quality of life indicators were, mobility score 2.11 \pm 0.88 (mean \pm SD), self-care score 1.55 \pm 0.83, activity score 2.07 \pm 0.94, pain score 2.38 \pm 0.86 and anxiety score of 1.96 \pm 1.01. Among the different health states, 11,121 health state was found as more common (mode). The VAS score found to be 67.56 \pm 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.

PIH39

HOW DO POSTMENOPAUSAL WOMEN DESCRIBE BREAST PAIN AND BREAKTHROUGH BLEEDING ASSOCIATED WITH HORMONAL TREATMENTS FOR MENOPAUSAL SYMPTOMS: QUALITATIVE INTERVIEWS WITH POSTMENOPAUSAL WOMEN IN THE UNITED STATES, CHINA, MEXICO AND ITALY

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OBJECTIVES: Estrogen plus progestin therapies (EPT) represent the current standard of care for 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 are associated with side effects such as breast pain/tenderness and vaginal spotting/bleeding. The objective of this study was to conduct qualitative interviews with menopausal 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 were 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 or contact. 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 using 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.