

**Results.** The model outcomes predicted by each method (HR, FP and AFT) are presented and compared. Both deterministic and probabilistic results are presented, alongside a discussion around how the uncertainty in these structural assumptions may be captured in EE.

**Conclusions.** Structural assumptions in ES may lead to differences in model outcomes. The impact of these differences may be important in situations where decision uncertainty is high. Methods should be chosen and justified based on patterns of hazard present in the trial data.

## VP83 Health Economics Distance Learning For Healthcare Workers In Brazil

Ângela Bagattini ([angelabagattini@gmail.com](mailto:angelabagattini@gmail.com)), Adélia Marçal dos Santos, Juliana Juk, Renata Soares, Sergio Piola and Cristiana Toscano

**Introduction.** Despite increased healthcare systems costs, limited opportunities for health economics training are available to healthcare professionals. From 2016-2018, with a grant from the Brazilian Ministry of Health, the Federal University of Goias with 7 other universities, implemented the distance learning Postgraduate Certificate in Health Economics for Health Care Professionals (PCHE) aimed at enhancing technical capacity of professionals working in the Brazilian Public Healthcare System (SUS).

**Methods.** This is a descriptive and qualitative assessment of the PCHE implemented in Brazil 88 healthcare professionals working in SUS and involved in decision making in all levels of management were enrolled in a health economics training, through long-distance learning strategy. We present course metrics, describe its workload, content, modalities and structure of training.

**Results.** PCHE was structured with 3-day workshops introducing each of the modules, during which students were also evaluated regarding the previous module content. With a total workload of 360 hours, structured in four modules: Public Health and Epidemiology; Introduction to health economics and healthcare funding; Management of healthcare resources; and Healthcare economic evaluation. The module coordinator was responsible for supervision of course materials development, workshop, distance based tutoring activities, and evaluation. Course material included theoretical content and practical tools for economic evaluation and health technology assessment in the workplace, applying problem-based learning strategies. Certificates were granted to students with 75 percent presence and approved in all modules, and final papers approved by an examination board. Each module was completed in 8 weeks (90 hours/module). Within groups of 20 students, tutors performed communication with chats twice weekly and discussion forums by topic. A total of 88 students were enrolled. Drop-out rate was 35.2 percent (n = 31). Additional 10 students did not pass the exams. In total, 47 students completed the training.

**Conclusions.** Health economics training through distance learning is a more efficient use of resources with good results.

## VP89 A Preliminary Equity Checklist To Support The HTA Process

Maria Benkhalti ([maria.benkhalti.ciussse-chus@sss.gouv.qc.ca](mailto:maria.benkhalti.ciussse-chus@sss.gouv.qc.ca)) and Pierre Dagenais

**Introduction.** There is increased recognition of the need to include equity considerations in HTA. Despite this, a recent World Health Organization report has found that this is seldom the case. We developed a preliminary version of an equity checklist in the hopes that tangible guidance will increase such analyses in the future and contribute to smart capability building.

**Methods.** The checklist is based on the Equity Framework for HTA developed by Culyer & Bombard (2012). The elements presented in the framework were revised to follow the stepwise HTA process. A comprehensive literature search was used to update and complete the elements. The checklist was then piloted in an HTA in 2018 and subsequently further refined through a workshop during a national HTA conference in Canada.

**Results.** These steps resulted in a 27-item checklist leading to consider different aspects of the three major phases in the HTA process. The scoping phase brings questions relative to defining and contextualizing equity, such as highlighting potential minority groups and including vulnerability factors in the logic model. The development phase leads methodological approaches facilitating the analysis of inequities as well as considering contextual realities leading to inequities. The last phase, drafting of recommendations, aims to be aware of the evidence synthesis approaches as well as the various aspects to ensure recommendations consider existing inequities and avoid contributing to their development.

**Conclusions.** Given the essence of HTA to protect health by ensuring optimal technologies and interventions are adopted to the benefit of all system users, the consideration of inequities should constitute an integral part of its process. The use of a pragmatic and simple checklist to aid the planning of an HTA could contribute to greater consideration of inequities in the future. A movement in this direction could also lead to greater methodological developments for health equity analysis in HTA.

## VP90 Which Matching Adjusted Indirect Comparison Method Is Best?

Jonathan Alsop ([jonathan.alsop@numerus.com](mailto:jonathan.alsop@numerus.com)), Lawrence Pont and Martin Scott

**Introduction.** Matching adjusted indirect comparison (MAIC) methods are extremely useful when conducting ITCs, as they reduce baseline imbalances between studies, particularly upon patient characteristics that are confounded with treatment. The standard approach when conducting MAIC is that proposed by Signorovitch et al. (2010). However, there are newer, and potentially better, methods available.

**Methods.** Three different MAIC methods (Signorovitch, Entropy Balancing, Polynomial Weighting) were compared using multiple phase 3 RCTs conducted in Diabetic Retinal Edema. The