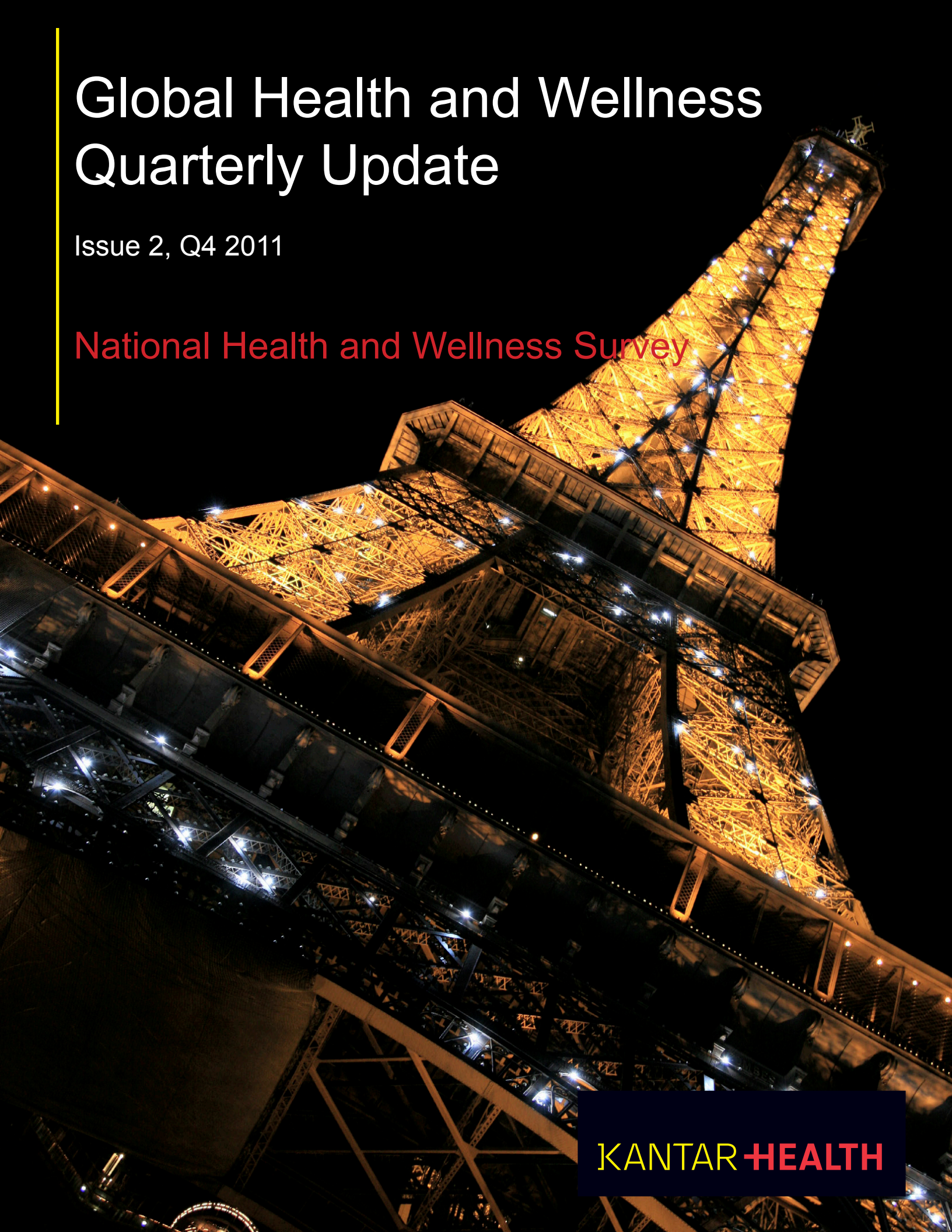
Global Health and Wellness Quarterly Update

Issue 2, Q4 2011

National Health and Wellness Survey



KANTAR HEALTH

Assessment Solutions for Type 2 Diabetes in Public Health

By Eveline Eschwège, MD

French Institute of Health and Medical Research (INSERM)

Measuring and monitoring a population's health status is a necessity and a challenge for health authorities, especially in our aging societies, where chronic diseases are becoming a major concern.

Type 2 diabetes (T2D) is an increasingly prevalent condition. Its development is marked by a slow but inevitable deterioration of health, with non-specific complications such as heart conditions; specific complications such as retinal issues, including vision loss; and kidney failure, requiring dialysis or transplant. Understanding patients' experiences and the available treatments is essential for effective management at the individual and population level.

The methodology best suited for tracking diabetes is using repeated cross-sectional observational studies, i.e., successive images made with the same device, with the same constant and at the same angles. The study population may be exhaustive or a representative sample, but the conditions of choice remain the same over time. There should be no variability in definition or measurement, and the study should not be "contaminated" from one wave to another, meaning no changes to protocol, and no consent other than the use of information technology, which unlike conventional tracking cohorts of individuals can change their behavior and also the attitudes of physicians. The observational data collected can be from routine registration, general or targeted panels or ad hoc surveys.

Comprehensive data for reimbursed prescriptions in France are reported by the National Information System Inter Plan Health Insurance (SNIIRAM), which covers 88% of the population. However, general studies such as the National Health and Wellness Survey (NHWS), available for a number of countries globally, including since 2000 the five most populous markets in Europe, can provide valuable evolutionary and comparative information between countries. With a specific module for diabetes, this online study of consumers provides a means of following the characteristics of the disease year after year, as recorded and experienced by the patient.

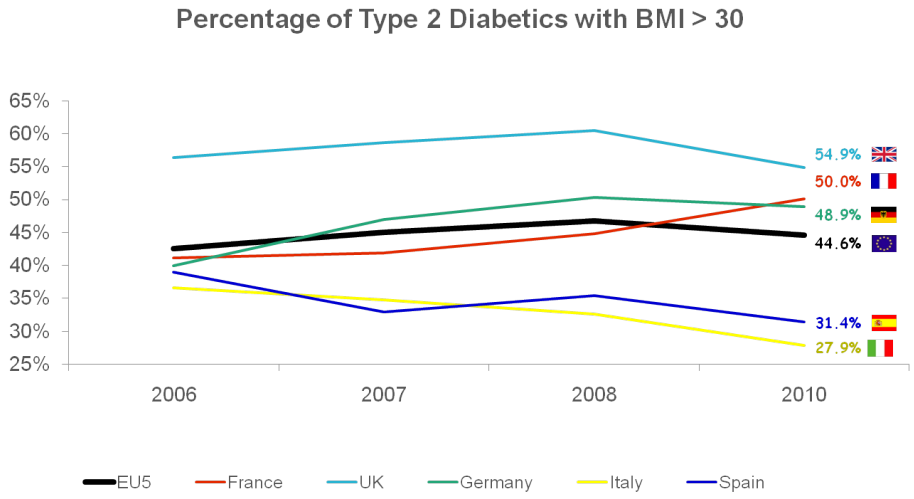
NHWS diabetes data for prevalence figures observed since 2006 have been validated with different data sources such as SNIIRAM[1]; ENTRED 2007[2], a randomly selected sample of diabetics; and the Panorama survey[3], a representative population of T2D patients using a randomized sample of physicians in nine European countries. For example, the prevalence of T2D in France was estimated for 2006, 2007, 2008 and 2010 as 4.4%, 4.0%, 4.5% and 4.7% from NHWS, and 3.8%, 3.9%, 4.2% and 4.4% (2009) from SNIIRAM, with both sources showing a similar increase over time.

To provide another example, the frequency of obesity (BMI ≥ 30) in T2D was compared across five European countries using data from NHWS between 2006 and 2010, Panorama in 2009 and ENTRED in 2007. The marked

differences in obesity observed between these countries are shown in the figure to the right. It should be noted that the prevalence of obesity in T2D is nearly three times greater than in non-diabetics. Obesity is associated with a worse quality of life and worse health outcomes[4-6] and therefore should be reflected in the indicators and recommendations for management of diabetes at a local level.

Through this consistent methodology, NHWS data can be assessed across five European countries, which can reconfirm that differences remain strong between these markets in terms of public health and provide an understanding of the rationale for the results.

Each European country in effect retains specific characteristics such as lifestyle factors (i.e., diet, physical activity, etc.), standard level of care, screening policies and reimbursement terms. These factors can impact the prevalence of different conditions; the care received from physicians and other providers; and the use of different treatments. More specifically for T2D, in terms of treatment the use of insulin is later in France than in Germany (8.5 years vs. 5.4 years). In another example of diagnosis, the frequency of patients with undiagnosed diabetes is much lower in France than the UK, where



patients are diagnosed much later, often with complications, while in France screening for this condition is more systematic.

With regard to current prescribing, France is noted for a particularly high prevalence of patients receiving oral anti-diabetic medications with a gap of 10% compared with other countries regardless of the year both for NHWS and Panorama. However, Germany is leading the use of insulin, with nearly twice as much prescribed in T2D patients compared with France, Italy and Spain.

These examples show the consistency of NHWS data across EU countries and with other sources available in the literature. In addition, for NHWS in particular, the data can not only assess changes over time, but also characterize T2D populations in these countries – factors that should be considered in developing specific public health actions, which are unavoidably different for each population in Europe.

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3 Simon D., Eschewege.E., Andre.L., Amelineau E.,Geha S., Bradley C., 'Atteinte des objectifs glycémiques chez les patients diabétiques de type 2 : l'étude Panorama', Livre des Abstracts 2011 Diab & Metab 2011

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The Challenges of Conducting Research in Emerging Markets

By Ariella Dugan, MBA

Director of Business Management, Kantar Health

The emerging markets that make up BRIC and BRIC-TM are a focus of most business leaders today. Soon their attention will turn to CIVETS, the N-11 and MINT as well.

Offering products or services in these markets is imperative to compete in a global economy, but interpreting these markets is difficult for many companies. More often than not, the data needed are not available, and primary research must be done. However, conducting primary research, particularly with consumers, poses its own set of challenges in these markets. The tried-and-true practices used with Western consumers do not provide adequate results. Researchers must take a step back and approach each market differently, paying close attention to standards and customs. Throughout the three main stages of a primary research study – sample plan, survey design and data collection – researchers need to evaluate the best methods for each market.

Sample Plan

The basis of every sample plan is the question, "Whom do you want to contact?" Typically researchers evaluate this question based on inclusion requirements, such as gender, age or behavior. The methodology and feasibility of this methodology are typically assumed – internet survey, which has been common practice for years. It is economical, provides a fast turnaround, and is accessible for consumers.

Or is it? True, internet research offers those benefits for Western countries, but does it provide the same benefits for emerging markets? Internet penetration is approximately 80% in the US, UK and Japan and over 50% for the rest of Western Europe. Over 50% of the consumer internet panels are between the ages of 25 and 55. Conversely, in China and Brazil internet penetration is only 30% and panels are considerably younger—over 50% of members are between the ages of 15 and 35.

Computer access and comfort level should be considered. In Spain, over 25% of the population is over 55 years old, yet this age group represents less than 10% in internet panels. It is common to complete telephone screenings to recruit these consumers to an internet survey. However, this is almost impossible in Russia as there are no robust telephone databases and most Russians older than 55 either do not have access to a computer or do not know how to use one. Therefore, the internet would not be the best methodology to use if a representative sample across age groups is required. The National Health and Wellness Survey (NHWS) recruits to central locations where respondents can choose to complete the survey on a computer themselves or sit with an interviewer who will read the questions and input responses. This method allows the data to be captured within the same system, yet also provides a means to interview those 50 years of age and older within China, Brazil and Russia.

The concept of a representative sample can be vague. What is it representative of: age, gender, geography, income or a combination? In the US it is reasonable to conduct internet research and obtain a representative sample of some or all of these criteria. But can the same be said for all countries?

Our experience indicates it is not necessary to be representative of an emerging market's total population but to focus on the urban areas, where consumers have more disposable income and are more likely to adopt new products. For example, China has a five-tier evaluation system, while other countries rely simply on population size. The NHWS conducts its non-internet recruitment on Tier 1 and 2 cities and captures internet data from all three tiers. Income and education are factors for segmenting populations in many Western countries. But in Brazil,

Common Acronyms for Emerging Markets

***BRIC**: Brazil, Russia, India, China*

***BRIC-TM**: Brazil, Russia, India, China, Turkey, Mexico*

***CIVETS**: Colombia, Indonesia, Vietnam, Egypt, Turkey, South Africa*

***N-11**: Bangladesh, Egypt, Indonesia, Iran, Mexico, Nigeria, Pakistan, Philippines, South Korea, Turkey, Vietnam*

***MINT**: Mexico, Indonesia, Nigeria, Turkey*

the government classifies eight socioeconomic levels based on education and the number and type of household appliances owned, not income. It is important to view each country separately and determine the areas used for classification.

Survey Design

Once a methodology has been chosen a researcher can move into survey design. The most important aspect to consider when designing a survey for an emerging market is ensuring it reflects the local market, often referred to as "localization." An experienced linguist can ensure a translation is consumer-friendly, but even a good translation will not be meaningful if the topic does not accurately reflect the environment. A simple example is referring to a hospital. In the US consumers do not distinguish between hospitals, but some emerging markets have specific differences. In China consumers can readily identify three different hospitals: community, county and city. If a survey provided only the choice of "hospital" a respondent in China may be unsure of how to answer as this choice would not be meaningful.

A more complex example is the Western phrase "over-the-counter," referring to treatments purchased without a physician's prescription. It is common for consumers in Russia to receive branded prescriptions without a physician's script. A patient can simply go to a local pharmacist and explain his symptoms to a pharmacist, who can make a recommendation and sell the product. A consumer can even request the brand from the pharmacist based on a recommendation from a friend or family member. Therefore, the phrase "OTC" is not meaningful to Russian consumers, and a researcher would need to approach the line of questions differently.

Data Collection

Typically once a study has reached the data collection stage it is smooth sailing. This is not always the case in emerging markets. Many challenges are easy to avoid or plan for. The most common aspect overlooked during the data collection phase is holiday scheduling. Although the same holiday may be observed, the timing may be different. In Russia many consumers follow the Julian calendar and celebrate Christmas on January 7 rather than December 25. There are also many holidays specific to a country, such as the week-long holiday periods for Chinese New Year and Carnival in Brazil.

Another challenge that is easy to plan for is the length of interview. A problem often occurs when a researcher applies a survey previously conducted in the US or UK to a new country. Even without localization, the survey may take longer to complete due to translation. Romance languages, such as Portuguese, use more words to convey the same message compared with English. A survey that took 10 minutes in the UK may take 15 minutes in Brazil.

Another aspect to consider is a country's infrastructure. Western countries are used to very fast internet connection speeds and programs such as Java and Flash. Outside major cities in emerging markets, the infrastructure may not be in place to facilitate quick uploads. This is another reason targeting urban areas versus total population may be necessary.

Finally, researchers should expect incentives in emerging markets to differ from those in Western countries. Internet panel members typically receive the same points, sweepstakes or financial options, but incentives for other methodologies can vary greatly. In China, the NHWS respondents who complete the survey at facilities receive "gifts" such as soap, teas or candy. Conversely, cash incentive is used in Russia for the same interview and methodology because the mail system is not deemed reliable and respondents prefer not to have a check mailed to them. If Ethical or Institutional Review Board approvals are needed it is imperative that incentive information is determined early to avoid delays due to resubmissions.

Conducting primary research or purchasing research from an outside agency can yield extraordinary insights that can propel one's product or service. A successful venture into a new or emerging market is attainable with proper planning and assistance. Capitalizing on colleagues or affiliates in the local market or utilizing a partner or vendor with this expertise will provide long-term benefits and assurance that one's budget is well spent.

Do I Have Two Oranges or an Orange and an Apple?

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When utilizing outside data, it's important to find a source that is accurate and that you can trust. There is no one "best" source that serves all functions. In reality, estimates derived from different sources using varying methodologies provide valuable insight. Using a range of data sources offers a way of verifying results and gaining an understanding from diverse approaches.

However, when using multiple data sources it's also important to determine whether the data are indeed comparable, or whether you're comparing apples to oranges. This article presents a case study of two data sources in Brazil and how they complement each other.

In 2002, Brazil's Ministry of Health (MoH) created HIPERDIA to identify, monitor and follow patients with a diagnosis of hypertension and type 2 diabetes (T2D). Data from 2002-2010 was used from the HIPERDIA database to identify the general profile of T2D only and T2D plus hypertension patients to analyze geographical distributions, gender, age and overweight/obesity prevalence.

The main purpose of this database was to follow the effectiveness and national coverage of the HIPERDIA program. This in turn was used to help the government better plan and design health programs to assist this population in improving outcomes and life expectancy.

The National Health and Wellness Survey (NHWS) began collecting responses in Brazil in 2011 utilizing a mixed recruiting methodology (internet/CAWI) to ensure representativeness of the population. The age, gender and socioeconomic level quotas for Brazil are closely matched to the population breaks per the International Database (IDB) and the Ministry of Finance to ensure representativeness. The database offers a holistic view of the patient in Brazil, from the patient's point of view, and reports metrics that can only be captured from the patient perspective.

The 2011 Brazil NHWS was completed by 12,000 consumers. The survey reports on consumers' health status, attitudes, behaviors and outcomes among adults 18 or older. It also captures unique information specific to Brazil's healthcare market, including use of national health insurance (*Sistema Unico de Saude*); whether patients have paid out of pocket for a brand-name medication; where patients received their initial written prescription; and socioeconomic data.

For this case study we compared T2D only patients and patients with both T2D and hypertension using data from the HIPERDIA database and 2011 Brazil NHWS. From 2002 to 2010, a total of 2,199,972 people with T2D and T2D plus hypertension were registered in the HIPERDIA database, with 12.5% presenting T2D only and 87.5% having both conditions under the public

	NHWS T2D only % (95% CI) (n=245, weighted n=2,265,745)	HIPERDIA T2D only % (n=271,878)	NHWS T2D + Hypertension % (95% CI) (n=235, weighted n=2,445,794)	HIPERDIA T2D + Hypertension % (n=1,917,401)
Male	50.40% (39.01,61.80)	41.85%	51.08% (40.20,61.96)	32.15%
Female	49.60% (38.20,60.99)	58.15%	48.92% (38.04,59.80)	67.85%

CI = Confidence Interval

healthcare system. Out of 480 (projected n=4.7 million) T2D respondents from the NHWS, 51.9% reported as being diagnosed with hypertension as well.

For patients with T2D only the HIPERDIA data found that 41.8% were men and 58.2% were women. According to the NHWS, T2D only patients were 50.4% males and 49.6% female. For patients with both conditions, the HIPERDIA database found 32.1% men and 67.9% women and NHWS reported 51.1% men and 48.9% women.

Regarding age, in both databases the majority of patients with T2D only and T2D plus hypertension are between the ages of 40 and 70 years. The results in both datasets are fairly close. NHWS captures the pre-diabetic population, who are younger than the diagnosed diabetic population. This is a good indicator for what the market may look like in the future, with the prevalence of T2D likely to increase.

The results from the HIPERDIA database were within range of the 95% confidence intervals from the Brazil NHWS estimates in most instances. The HIPERDIA database reported slightly more females with T2D plus hypertension compared with the NHWS. The varying sample sizes and the different time periods of data collection across the databases may play an important role in the differences between these sources. Also, the methodologies of data collection for each source are distinct.

Every data source has its own limitations, with different degrees of accuracy and the ability to project to the actual real-world population. The prevalence of T2D only patients and T2D plus hypertensive patients varies from database to database. Each database is organized differently, created to address different issues, and has distinct data collection methods. Also, variation in results could be due to differences in the statistical design, in which the data are processed and analyzed.

Age (years)	NHWS T2D only % (95% CI) (n=243, weighted n=2,257,349)	HIPERDIA T2D only % (n= 271,878)	NHWS T2D + Hypertension % (95% CI) (n=235, weighted n=2,445,794)	HIPERDIA T2D + Hypertension % (n= 1,917,401)	NHWS Pre-diabetic patients (n=1,264, weighted n=13,393,794)
20-29	4.83% (2.39,7.27)	2.65%	1.46% (0.01,2.90)	1.16%	22.89% (19.08,26.70)
30-39	10.04% (4.25,15.82)	9.72%	5.74% (0.76,10.73)	4.42%	25.15% (20.90,29.41)
40-49	11.13% (7.10,15.15)	23.07%	25.10% (14.40,35.80)	14.48%	22.05% (18.09,26.01)
50-59	45.02% (32.98,57.06)	29.42%	31.01% (20.34,41.68)	27.99%	17.75% (14.01,21.49)
60-69	10.78% (5.89,15.68)	21.70%	17.93% (11.52,24.34)	28.88%	7.31% (4.68,9.94)
70-79	13.43% (7.10,19.76)	10.40%	13.74% (7.57,19.90)	17.66%	4.26% (2.73,5.79)
80+	4.76% (0.84,8.69)	3.04%	5.02% (1.14,8.91)	5.41%	0.59% (0.04,1.15)

CI = Confidence Interval

Deriving $CHADS_2$ and CHA_2DS_2-VASc Scores

By Hillary J. Gross, MPA

Research Services Analyst, Kantar Health

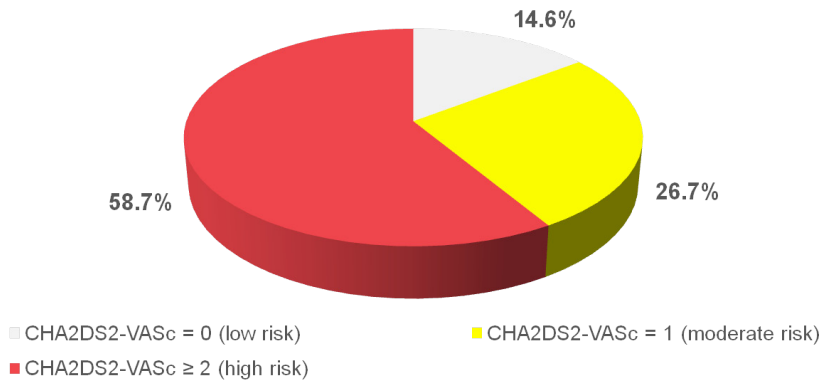
Atrial fibrillation (AF), the most common cause of sustained cardiac arrhythmia, carries a fivefold risk of stroke for sufferers. These strokes are often fatal, and survivors are more likely to suffer severe disability and have a recurrence of thromboembolism (TE) than patients with other causes of stroke. Therefore, identifying stroke risk in AF patients is vital so that the proper anticoagulant therapy (usually warfarin or aspirin) can be prescribed.

The $CHADS_2$ and CHA_2DS_2-VASc indexes were developed to assess the risk of stroke or TE in patients with AF. Using these scores, physicians can make decisions on whether to use anticoagulant therapy for the patient. $CHADS_2$ assigns a point each for congestive heart failure, hypertension, age 75 or older, and diabetes mellitus and two points for a previous stroke or transient ischemia attack (TIA). The CHA_2DS_2-VASc improves the predictive accuracy for TE by adding a point each for age 65-74, vascular conditions (myocardial infarction peripheral vascular disease or atherosclerosis), and female sex. In both scales, a score of zero indicates a low stroke risk, one a moderate risk, and two or more a high risk.

Patients considered low risk are recommended to use aspirin, while moderate- to high-risk patients are recommended to use warfarin. Because of the additional inclusion criteria, more AF patients are classified as moderate and high risk using the CHA_2DS_2-VASc schema. It is vital to keep this in mind because physicians are sometimes reluctant to prescribe warfarin to patients due to the need for close monitoring of blood levels and the many interactions of food and drugs with the therapy.

Due to the breadth of the National Health and Wellness Survey (NHWS), both scores can be accurately captured for all countries, which allows the AF population to be segmented by stroke risk. This is useful when considering the positioning and developing of thromboprophylactic therapies, especially given the market opportunity for an anticoagulation drug that doesn't require monitoring and has fewer food and drug interactions than warfarin. ◙

Stroke Risk among EU Atrial Fibrillation Patients



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KANTAR HEALTH

DID YOU KNOW?

Ensuring Representativeness in Observational Studies

By Marco DiBonaventura, Ph.D.

Director of Health Economics and Outcomes Research, Kantar Health

The rigorous design and execution of randomized clinical trials (RCTs) help eliminate sources of bias and give confidence to the researcher that their intervention causes a meaningful effect. However, the RCT is an artificial environment. The quality of medical care and the inclusion/exclusion criteria, among other factors, are often not representative of the broader patient population. Indeed, this lack of external validity is one of the major criticisms of RCT findings.[1]

Of course, external validity is important to all research studies, not just RCTs. Because the National Health and Wellness Survey (NHWS) uses a random stratified sampling framework based on US Census data (and other governmental sources for ex-US countries), the results can be used to project to the total country population, or the total therapeutic area population, maximizing its external validity. Several studies have demonstrated comparable findings between the NHWS and other governmental surveys (Current Population Survey, National Health Information Survey, and National Health and Nutrition Examination Survey).[2]

However, existing data sources are not always sufficient for answering particular research questions, and primary data collection may be required. The external validity of the results is an important consideration in these situations. How can a researcher be confident that respondents of their diabetes study are representative of the overall diabetes population? What if those who chose to respond are meaningfully different from those who did not?

Recontacting patients from the NHWS database allows for a thorough examination of differences between those who respond and who do not respond to the follow-up survey. Naturally, not all patients may decide to participate in a recontact study. However, even if they do not, we know quite a bit of information about them, including their sociodemographics, health behaviors, comorbidities, and healthcare attitudes. We can compare those who chose to complete the survey with those who did not to determine the extent of any differences between them.

But what if these patients are dramatically different? Because the NHWS is able to project to individual therapeutic area populations, we know the characteristics of, for example, the diabetes population. Perhaps the diabetes population consists of 55% males but our custom study is only 43% males. Under normal circumstances the extent to which the results generalize to the diabetes population would remain unknown. However, using NHWS data, we can calculate a custom set of sample weights (just like what is used by the US Census) to ensure that the males are proportionally overweighted in the results while the females are proportionally underweighted.

Designing the right study to eliminate sources of bias is of crucial importance. But, not to be overlooked, is the extent to which the results generalize to the population of interest. By using the NHWS data directly, or by using it as means to ensure a follow-up study is appropriately representative, researchers can be confident in the external validity of their findings.

References

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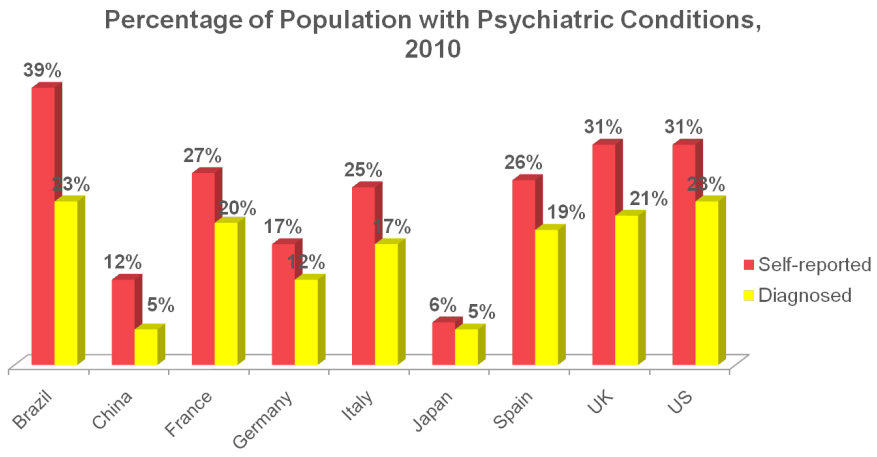
10 October Is World Mental Health Day.



Chinese adults who suffer from psychiatric conditions report the lowest medication use to treat their condition–56% are not taking prescription or over-the-counter medications.

German adults with psychiatric conditions report the highest activity impairment due to their condition –47%.

Japanese adults with psychiatric conditions report the highest work productivity loss due to their condition–46%.

ISPOR 14th Annual European Congress

The ISPOR 14th Annual European Congress will be held 5-8 November 2011 at the Hotel Auditorium Madrid in Madrid, Spain.

Kantar Health will be attending and exhibiting at this conference. Come visit us at **Booth 23** or see us at one of our podium or poster presentations.

For more information on ISPOR's 14th Annual European Congress or to register, please visit the event website: **http://www.ispor.org/Events/Index.aspx?eventId=36**.

Abstracts for ISPOR's 17th Annual International Meeting in Washington, DC, are due 19 January 2012.

Podium Presentation: Monday, 7 November, 11:30-12:30

AD4	Assessing Effect of Medication Adherence and Persistence on Cost-Effectiveness

Poster Session II: Monday, 7 November, 8:00-19:30

PGI27	Sleep Disturbance and Quality of Life Among Hepatitis C-Infected Individuals
PSY39	Predictors of Health Utilities among Patients with Rheumatoid Arthritis in Europe
PIH44	Health-Related Quality of Life for Patients with Chronic Conditions: Revealing the Profile of Burden Associated with Comorbid Physical and Mental Conditions in Respondents from Five European Countries
PCV111	Economic Burden and Health-Related Quality of Life in European Patients with Peripheral Arterial Disease
PCV116	The Impact of High Risk of Stroke Patients Diagnosed with Atrial Fibrillation on Health-Related Quality of Life and HealthCare Use in the 5EU
PHP88	Societal Unmet Needs Within Spain

Poster Session III: Tuesday, 8 November, 8:00-16:00

PDB67	Treatment Patterns and Health Outcomes among Type 2 Diabetes with Comorbid Obesity in France, Germany and the UK
PDB83	The Epidemiology and Burden of Obesity and Diabetes in France

NHWS Data Now Available in Brazil

Kantar Health is pleased to announce the expansion of the National Health and Wellness Survey (NHWS) database in Brazil. NHWS is the largest international self-reported patient database in the healthcare industry.

"Brazil has the largest economy and population in Latin America, making it an attractive growth opportunity for pharmaceutical companies," says Dave Pomerantz, Senior Vice President of Business Development with Kantar Health. "However, this is not a market to enter into without deep knowledge of the market and its patients. NHWS's data helps global pharma companies gain an understanding of the Brazilian patient as well as the Brazilian healthcare market, which is different from the typical U.S. or EU market."

The survey was completed by 12,000 Brazilian consumers. Topics covered include health status, attitudes, behaviors and outcomes among adults 18 or older. The survey also captures unique information specific to Brazil's healthcare market, including:

+ Which of the following conditions are you aware of?
+ Which of the following conditions have you ever experienced?
+ Which of the following conditions have you experienced in the past 12 months?
+ Vaccinations
+ Which of the following types of medical insurance do you currently have?
  - Public/national health insurance (*Sistema Unico de Saude*)
+ In the past six months, have you paid out-of-pocket for a brand-name medication instead of a generic medication?
+ Where did you receive your initial written prescription to treat your [condition]?
  - Public hospital, private hospital, private clinic, physician's office, public emergency room, private emergency room
+ Do you use any of the following to treat your [condition]?

Brazil's government has developed a classification of socioeconomic levels (A1, A2, B1, B2, C1, C2, D and E) based on education and consumer durable goods, which is included in the survey as well.

For more information on the National Health and Wellness Survey in Brazil please **download a copy of our fact sheet** or contact Dave Pomerantz at **dave.pomerantz@kantarhealth.com** or +1 267 419 8139 to find out how NHWS data in Brazil can be used to address your needs.

Visit www.kantarhealth.com at the end of October to hear our podcast on the importance of conducting research in Brazil and to download our supplement to the **2011 Global Health and Wellness Report** containing Brazilian data.

About NHWS

The National Health and Wellness Survey (NHWS) database provides disease-specific measures that help healthcare clients size market opportunities, measure direct and indirect costs, gain insight into disease-specific segments and develop marketing and publication strategies directed at specific consumer or patient segments. It provides broad coverage of healthcare, with results that are projected to the population to deliver prevalence information in more than 165 conditions. NHWS includes information for patients who are diagnosed, undiagnosed yet symptomatic, untreated and for patients treated with prescription and/or over-the-counter medications. Access to data-mining patient information is delivered through a 12-month subscription service and includes a First View Therapeutic Condition report covering:

- Epidemiology of the condition
- Patient diagnosis and treatment choices
- Demographic and health profile of sufferers
- Patient compliance and satisfaction
- Utilization of healthcare resources
- Patient attitudes and approaches to healthcare
- Patient-reported outcomes
- Condition-specific questions

As part of our ongoing efforts to expand the geographic coverage of the NHWS, Brazil and Russia have been added to the survey for 2011. NHWS data is available for the following countries:


Brazil **NOW AVAILABLE**


China


France


Germany


Italy


Japan


Spain


United Kingdom


United States


Russia COMING IN 2012

Contacts

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