results show that cost-effectiveness studies constituted 15%, 12% and 7% of all abstracts presented at ISPOR, IEHA and HTAI respectively. Non-drug technologies ranged from 11% at ISPOR to nearly 30% for HTAI and were excluded. 32% of analyses used best standard of care as comparator and 10% did not specify the comparator. Approximately 29% of abstracts did not report point estimates. 28% of the nature of costs included in analysis and 10% the time horizon. A total of 52% of analyses reported results as a point estimate of cost per QALY. 15% of abstracts submitted to ISPOR were not co-authored by the industry, 30% at HTAI and above that at IEHA. Analyses which judged the assessed drug to be cost-effective, cost-saving or dominant made up 82%, 70% and below 50% at ISPOR, HTAI and IEHA respectively. CONCLUSIONS: ISPOR is a congress preferred by the industry and a high proportion of abstracts reported favourable conclusions. This trend diminished for HTAI and further for IEHA. The quality of abstracts is not satisfactory for informed decision-making.

**PHP63**

The economic impact of the initiation of prescription control in the Greek social security funds

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OBJECTIVES: Due to the financial crisis Greece was forced to implement hard cost containment measures almost in all fiscal sectors. The objective of the study is to investigate the economic impact emerging from the initiation of controls in prescriptions, implemented in the Greek social security funds as of 1 January 2010 to 30th April 2010. METHODS: The data derive from the drug reimbursement database of the three biggest social security funds of Greece from January to April 2010 compared with the same period of the previous year. The three security funds of the analysis cover about 90% of the Greek population with almost 10 million fully insured members. The security funds in scope were the following: IKA which covers the private sector with 6.3 million insured members, OPAD covering the public sector with 1.5 million insured members and OGA for agriculture with 2 million insured patients. RESULTS: In the first four-month period of 2010 form the initiation of the prescription control system the pharmaceutical expenditure was the following: for IKA €747 million in comparison to 716 million the same period of 2009 a difference of 4.3%, for OPAD 172 million for 2010 while in 2009 the expenditure was 203 million, with savings of 15% and for OGA in 2010 was 310 million and the same period in 2009 the amount reimbursed for medicines was €288 million with 7.64% growth. It should be highlighted that although for IKA and OGA the pharmaceutical expenditure is higher in 2010 in comparison to 2009, still the growth of expenditure follows a downward slope, 2008–2009 14.82% for IKA and 11.64% for OGA respectively. CONCLUSIONS: The new cost containment measures implemented in the Greek health care sector started presenting results. Other cost containment measures implemented were price cuts for all medicinal products in May 2010 and reduced supply prices for sanitary products.

**PHP64**

Value based pricing in the UK: A price-quantity model assessment

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OBJECTIVES: In the wake of the 2007 Office of Fair Trading (OFT) Pharmaceutical Price Regulation Scheme (PPRS) implementation in the UK some are a debate whether the UK should switch to a value-based pricing (VPB) scheme. The OFT VPB system has its aim to price pharmaceuticals in line with their clinical effectiveness. METHODS: The switch from the traditional PPRS system to a VPB scheme in the UK was investigated with regards to the two main PPRS objectives cost containment and value for money. This was carried out by modifying and applying a price quantity setting model (Das, 1980) to fit the UK pharmaceutical market and investigate the capital labour ratio of a firm. The model uses the assumptions that Von Neumann-Morgenstern utility axioms are to fit the UK pharmaceutical market and investigate the capital labour ratio of a firm.

**PHP65**

Value based pricing in the UK: A survey-based approach

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OBJECTIVES: A survey was carried out to investigate the economical impact of a switch from the traditional Pharmaceutical Price Regulation Scheme (PPRS) system to a value-based pricing scheme (VPB), as proposed by the Office of Fair Trading (OFT). The OFT VPB system has its aim to price pharmaceuticals in line with their clinical effectiveness. METHODS: Interviews were carried out with experts from the industry, academia and the government comparing the traditional PPRS with the proposed VPB system. The interviews focused on the regulatory effectiveness, competition, launch delays, pharmaceutical pricing, risk-sharing agreements and uncertainty premium of the two systems. A systematic literature review was also carried out for all the above mentioned topics. RESULTS: In the interviews the current PPRS system was seen as very beneficial with high transparency and stability, nevertheless lacking mechanisms promoting price competition when compared to the VPB system. The main concern with a switch to a VPB system was the risk of a global price lock-in. Since the UK is directly or indirectly influencing pricing decisions within about 25% of global pharmaceutical consumption, the industry might delay drug launch in the UK, to maintain global pricing flexibility (e.g. in the adjudgent setting). Risk-sharing agreements were found to be one possible solution to maintain global price flexibility for the industry, while ensuring the NHS pays a fair price. The interviewees were unanimous about establishing an organization separate from any political influences needs to handle the pricing decision to avoid conflicting incentives. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness. A premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VPB system in the UK.

**PHP66**

An assessment of the variation in accepted ICERs by disease type: results from four HTAs

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OBJECTIVES: HTAs are frequently required to assess different treatment regimes for different disease types. Frequently, technology appraisal decisions are based on the ICERs estimated from economic models. The aim of this study was to identify any trends in accepted ICER thresholds by disease type. METHODS: All published technology appraisals since April 2005 were identified from PHAC, SMC, CADTH and NICE websites. Appraisals were categorised by disease type according to BNF categories. The manufacturer’s base-case ICERs were extracted and compared across accepted submissions by disease type. RESULTS: Eighteen CADTH, 122 SMC, 81 PHAC and 122 NICE appraisals were identified. For PHAC and SMC, the accepted ICER level (<£75,000 and £30,000, respectively) was consistent across >90% of the disease categories. However, accepted ICERs for malignant disease at a higher level (up to £200,000 for PHAC and up to £63,000 for the SMC). Additionally, age related macular degeneration for PHAC and severe osteoporosis, Lennox-Gastaut syndrome, plaque psoriasis, and hypothyroidism for the SMC have treatments with accepted ICERs outside the typical range. Data is limited for CADTH, although Crohn’s disease and hepatitis B are exceptional in having treatments with accepted ICERs <£80,000. Complex data from NICE is qualitatively assessed in light of data from the other HTAs. While most accepted ICERs were below £30,000, selected submissions for malignant disease were accepted above this commonly assumed threshold. CONCLUSIONS: Across disease types, accepted ICERs tend to cluster beneath a common threshold. However, submissions for treatments of malignant disease and immunosuppression have a greater chance of acceptance at higher ICERs than submissions for other disease categories. Rare diseases may also have a higher limit for ICER acceptance.

**PHP67**

Has the quality and outcomes framework influenced primary care data recording?

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OBJECTIVES: The Quality and Outcomes Framework (QOF) was introduced in the UK in April 2004. This scheme financially rewards practices for providing quality care and this is evaluated based on electronic medical records. This study therefore evaluated whether data recording changed after QOF was introduced. METHODS: Patients were selected from The Health Improvement Network (THIN) database, which holds longitudinal anonymised primary care records from >450 UK practices. Patients were grouped according to whether they ever had ≥1 of 15 chronic QOF diseases. Percentages of patients with ≥1 general practice (GP) visit, smoking status, blood pressure (BP) and weight record were estimated throughout nine 12-month time periods (January 1, 2004 to January 1, 2009). T-tests compared mean percentages before and after QOF introduction (January 1, 2004). RESULTS: Percentage of QOF patients ranged from 26.6% to 32.9% over time and non-QOF patients from 67.1% to 73.4%. The average percentage of QOF patients with a GP visit was 80.5% [standard deviation (SD):3.2] before QOF and 84.5% [SD:0.9] after QOF (p = 0.086). These percentages were 57.5% [SD:3.5] and 62.0% [SD:0.6] (p = 0.082) for non-QOF patients. The average percentages for smoking recording were 26.8% [SD:12.9] versus 55.9% [SD:3.0] (p = 0.018) for QOF patients and 10.9% [SD:8.35] versus 22.3% [SD:2.9] (p = 0.030) for non-QOF patients. For BP recording, 53.6% [SD:6.7] versus 68.1% [SD:4.8] (p = 0.013) for QOF patients and 20.5% [SD:2.9] versus 24.2% [SD:0.9] (p = 0.084) for non-QOF patients. For weight recording, 25.5% [SD:5.4] versus 40.4% [SD:3.2] (p = 0.006) for QOF patients and 9.8% [SD:1.7] versus 14.8% [SD:1.7] (p = 0.004) for non-QOF patients. CONCLUSIONS: Over the nine year period QOF visits and clinical recording increased after QOF was introduced, although there was no evidence of a difference for GP visits or BP in non-QOF patients. This suggests that QOF influenced recording, especially the recording of the evaluated clinical measures for patients with chronic QOF diseases.