each country's department of health. Countries were reviewed under a range of headings including: current delivery models in place, institutions responsible for delivery and organisation of reimbursement system, incentive structures in place, basic bundle of health care covered, additional options for coverage, disease-specific resource use and health outcomes, government contribution to cost of health care and overall health care expenditure. RESULTS: By 2013 across countries with Universal entitlement ensures comprehensive medical care for everyone including GP services, access to tertiary care, post-natal care and maternity services.REFERENCES: A comparison of reimbursement fees across countries dependent upon the Universal delivery model in place. CONCLUSIONS: This review presents characteristics of Universal health care delivery systems across Europe. Basic bundles of health care provision and organisation of reimbursement across countries have been outlined. Thus provides a further wealth of clarity on the characteristics of and variation across Universal health care models.

PHP81 NATIONAL RARE DISEASE STRATEGIES: THE CURRENT STATE FOR ORPHAN DRUG MARKET ACCESS IN EUROPEAN UNION (EU) MEMBER STATES

Scholten J, Lie X, Kalnasko A, Maevort (1)
Quintiles Consulting, Hofstade, The Netherlands

OBJECTIVES: By 2013 all European Union (EU) member states were recommended to elaborate and adopt a national strategy for rare diseases. This study provides insights into the national rare disease strategies, in particular the status of the programmes, recent developments, and the congruencies and differences between the programmes regarding market access. METHODS: A literature and internet search was performed to identify national strategies for rare diseases published by member states. Key strategic policies and recent orphan drug introductions have been analysed to compare the rare disease strategies. RESULTS: All member states had a variety of approaches already in place before developing a national strategy. France is the leader in implementing rare disease policies as well as the member state with the highest number of marketed orphan drugs. Over the past five years, most member states finalised their national plans with a peak in publications late 2013-2014.METHODS on implementation of orphan drugs showed as off-label use, compassionate drug use and utilising cross-border health care. Member states with a decentralised market access model (e.g., Spain and Italy) commonly use national funds and decision-making to provide equity in treatment levels across the member states. There are few orphan drug specific pricing policies however special reimbursement criteria are common especially in countries with cost-effectiveness criteria. CONCLUSIONS: Increasing patient access to orphan drugs has been a focus point in the national plans for rare diseases. Congruencies in methods will aid the EU's ambition to align policies at European level. However the implementation phase has only recently been initiated for most plans and actual effects may be due to developments in their health technology can expect that tailored criteria need to be developed for orphan drug assessments.

PHP82 MEASURING THE EFFICIENCY OF HUNGARIAN HOSPITALS BY DATA ENVELOPMENT ANALYSIS

Csakvári T(1), Turcsányi K, Vajda F, Danku N, Agoston I, Bence I(2)
(1)University of Nöc, Cluj-Napoca, Romania, (2)University of Pécs, Pécs, Hungary, (3)Faculty of Health Sciences, University of Nöc, Pécs, Hungary

OBJECTIVES: Hospitals are important cost elements of the Hungarian health care system. In the last decade, several plans and procedures were taken to reduce the number of hospital beds in Hungary. The aim of our research is to analyse the efficiency of the Hungarian acute inpatient-care system. METHODS: Data derived from the Hungarian nationwide health insurance database was analysed by technical (TF) and scale efficiency (SE) of the Hungarian acute inpatient-care system (2003, 2006, 2010). The number of hospitals included into the study was 133 in 2003,125 in 2006 and 93 in 2010. We chose four inputs and two outputs: the number of active hospital beds, the number of discharged patients, the number of one- day cases, completed days of nursing (inputs), average length of stay, DRG cost weights (outputs). The method we used for our calculations was Data Envelopment Analysis. RESULTS: In 2003 both the technical and scale efficiency were high (TE: 96.9%; SE: 92.9%). To 2006 the situation deteriorated by some degree (TE: 96.6%; SE: 80.3%). By 2010 technical efficiency still did not show improvement (TE: 94.0%), although scale efficiency increased (SE: 88.2%). Usually the hospitals with higher number of beds are more efficient than the smaller units. CONCLUSIONS: The effects of the performance volume limit did not improve the two values; however, the capacity decrease of 2007 did improve the scale efficiency to some extent. The Hungarian health care system seems to reduce the number of hospitals and rethink their functions, but needs to improve the size of them.

HEALTH CARE USE & POLICY STUDIES – Formulary Development

PHP83 EXPERIENCES WITH PRICE COMPETITION OF BIOSIMILAR DRUGS IN HUNGARY

Hornyák I(1), Nagy Z(2), Tálos Z(2), Agoston I(1), Endrei D(2), Csakvári T(1), Bence I(2)
(1)Csokány Ferenc Hospital, Veszprém, Hungary, (2)University of Nöc, Pécs, Hungary, (3)University of Pécs, Pécs, Hungary, (4)Faculty of Health Sciences, University of Nöc, Pécs, Hungary

OBJECTIVES: The aim of our study is to analyse the biosimilar bids of the Hungarian price competition bid of biosimilar products showed a minimal decline in the number of patients under treatment by both colony-stimulating factor and erythropoietin products while the health insurance reimbursement of these drugs significantly decreased.

PHP84 IMPACT OF PRIOR AUTHORIZATION RESTRICTIONS ON RESOURCE UTILIZATION AND COSTS IN US HEALTH PLANS: A REVIEW OF LITERATURE

Shah D, Tongrum V, Faly P
ECOM PI, Morristown, NJ, USA

OBJECTIVE: Prior authorization (PA) restrictions have been implemented by US health plans to ensure appropriate utilization and control costs. A review of published peer-reviewed literature was conducted to evaluate the impact of such PA restrictions on resource utilization and costs.

METHODS: A targeted review of literature was conducted in Medline from 2009 onwards using keywords including: “PA”, “impact”, “economic”. 14 articles, non-English language studies, non-US studies, were excluded and studies evaluating the effectiveness of formulary policies of which PA may be a component were excluded. Impact of PA policies on health care utilization and costs was qualitatively assessed.

RESULTS: Fourteen studies were identified which met our inclusion criteria. Majority (57%) of the studies were conducted on Medicaid plans (Medicaid: 8, commercial: 4, Medicare: 1, not clear: 1). Majority (57%) of studies evaluated the impact of mental health medications (anti-psychotics, anti-depressants bipolar medications, antipsychotics), two studies were conducted on anti-diabetics, one on a multiple sclerosis drug, one for a lipid-lowering drug, one on an antiepileptic drug and one on a vaccine. Few studies were industry-sponsored. 12 studies were retrospective data analyses and only 2 studies were decision-analytic models. Overall, the trends showed that PA restrictions were effective in reducing health care costs. PA restrictions had raised concerns on patient safety and quality of care outcomes due to PA policies.

CONCLUSIONS: Although PA restrictions may result in cost-savings, patient safety and quality of life concerns must also be evaluated while imposing these restrictions. Further research including studies assessing impact of PA administration costs as well as indirect costs due to lost productivity should be conducted to better assess the overall economic impact of such restrictions.

PHP86 DO NICE DECISIONS AFFECT DECISIONS IN OTHER COUNTRIES?

Nemendő: Villafuerte K, Garau M, Devin N
American Management, London, UK

OBJECTIVE: The objective is to test the hypothesis whether NICE recommendations on the use of a new drug affect recommendations from other bodies in countries outside England and Wales. To our knowledge, “this is new”, “use”, “upto and to”, “cost”, “impact”, “economic”. Review articles, non-English language studies, non-US studies, were excluded and studies evaluating the effectiveness of formulary policies of which PA may be a component were excluded. Impact of PA policies on health care utilization and costs was qualitatively assessed.

RESULTS: Fourteen studies were identified which met our inclusion criteria. Majority (57%) of the studies were conducted on Medicaid plans (Medicaid: 8, commercial: 4, Medicare: 1, not clear: 1). Majority (57%) of studies evaluated the impact of mental health medications (anti-psychotics, anti-depressants bipolar medications, antipsychotics), two studies were conducted on anti-diabetics, one on a multiple sclerosis drug, one for a lipid-lowering drug, one on an antiepileptic drug and one on a vaccine. Few studies were industry-sponsored. 12 studies were retrospective data analyses and only 2 studies were decision-analytic models. Overall, the trends showed that PA restrictions were effective in reducing health care costs. PA restrictions had raised concerns on patient safety and quality of care outcomes due to PA policies.

CONCLUSIONS: Although PA restrictions may result in cost-savings, patient safety and quality of life concerns must also be evaluated while imposing these restrictions. Further research including studies assessing impact of PA administration costs as well as indirect costs due to lost productivity should be conducted to better assess the overall economic impact of such restrictions.