DECISION MAKING: CURRENT STATE OF PLAY

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2

Of them, only 4 countries (5.7%) accept consumer reports by phone
and 11 countries (15.7%) have a web-based electronic system for consumer reporting.

CONCLUSIONS: The consumers report relatively untargeted suspected reactions for many prescription and non-prescription drugs. Recent literature from these countries strongly stressed the WHO’s view in successful use of consumers as one of the valu-
able source of drug safety data. It is high time that the consumer reporting should be encouraged in all the countries, especially the developing nations, for better drug supervision. Proper educational interventions are required to the public generally towards active involvement in the respective National Pharmacovigilance Programs, which in turn improves the quality use of medicines.

PHP2

EVALUATION AND COMPARISON OF PHARMACOVIGILANCE SYSTEMS IN 70 DIFFERENT COUNTRIES FOR CONSUMER REPORTING OF ADVERSE DRUG REACTIONS

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Traditionally, the reporting of adverse drug reactions (ADRs) by health care profes-
sionals is recognized well. In the recent decades, the significance of consumer
reporting of ADRs have been give due attention in the developed nations. There are
documented reasons on the failure of health care professionals in reporting ADRs
communicated by the patients. OBJECTIVES: The present study aimed to evaluate and
compare the Pharmacovigilance systems in 70 different countries with regards to
consumer reporting of ADRs. METHODS: The official websites of regulatory/medicines agencies or National Pharmacovigilance Centres of selected 70 coun-
tries, which joined the World Health Organization’s (WHO) International Drug Monitoring Program between 1968 and 2010, were evaluated. RESULTS: In most of the countries, health care professionals are legally obliged to report ADRs to the re-
spective Pharmacovigilance agencies. Only 17 countries accept complaints directly from consumers. Of them, only 4 countries (5.7%) accept consumer reports by phone
and 11 countries (15.7%) have a web-based electronic system for consumer reporting.

CONCLUSIONS: The consumers report relatively untargeted suspected reactions for many
prescription and non-prescription drugs. Recent literature from these countries strongly stressed the WHO’s view in successful use of consumers as one of the valu-
able source of drug safety data. It is high time that the consumer reporting should be
encouraged in all the countries, especially the developing nations, for better drug
supervision. Proper educational interventions are required to the public generally
towards active involvement in the respective National Pharmacovigilance Programs, which in turn improves the quality use of medicines.

PHP3

INTEGRATION OF EVIDENCE ON PATIENT PREFERENCES IN HEALTH CARE DECISION MAKING: CURRENT STATE OF PLAY

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OBJECTIVES: Despite the increasing attention for active patient participation in
health care policy decisions, systematic use of the available evidence on collective
patient preferences (passive patient participation) is still limited. Objective of this study
was to explore opinions and ideas regarding the use of evidence on patient preferences in
coverage decisions and clinical practice guideline (CPG). 2) describe how and what type of evidence on patient preferences is considered in health care
policy decisions in 5 European countries. METHODS: A literature search was per-
formed to identify opinion papers on patient preferences in the context of CPG or
coverage decisions. A document search was performed on websites and databases of the responsible organisations of the Netherlands, England, Scotland, Germany and
France. Furthermore, a few coverage decisions and CPG were checked on the
subject. RESULTS: The debate on the integration of evidence on patient preferences concerns the definition and terminology of preferences, the question whether patient or public values should be used for policy-making, the different methods, quality and evidence synthesis of research on patient preferences, the relevance of including patient preferences, and the discussion on outcomes be-
yond the QALY. The procedures for coverage decisions do not mention the search for
or use of evidence on patient preferences, nor was information found in the
coverage decisions. Only in the Scottish CPG procedure a literature search on pa-
tient evidence (not necessarily patient preferences) is obligatory prior to the first
meetings. In the Netherlands this is optional. The selected CPG from Nether-
lands, England and Scotland mention the use of information on patient prefer-
dences in different conceptualisations. CONCLUSIONS: In coverage decisions evidence on patient preferences has no formal role yet. In CPG this role is limited.

Severalt reasons and possible barriers are under debate regarding the integration of evidence on patient preferences in health care policy making.

PHP4

FINANCIAL PENALTIES FOR IMPROVING DRUG ADHERENCE

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OBJECTIVES: Drug non-adherence is associated with significant negative economic
and public health burdens. The objective is to contribute to the literature on neg-
ative monetary incentives (i.e., penalties) by developing a discourse for an innova-
tive approach that could be validated in further experimental studies. METHODS: A
comprehensive database search (PubMed, EcmLit) was conducted on economic
incentive programs to enhance adherence in drug therapy. Criteria for evaluation of the retrieved economic studies have been taken from the literature. RESULTS: Little evidence explicitly dealing with economic incentives in the form of monetary
sanctions in order to improve adherence or compliance was retrieved from the literature. Despite this, incentive-based health care designs including penalties if elements such as the standard of knowledge, social awareness, and
individual responsibility are well addressed and outweigh any profit orientation.

Transaction costs remain the main barrier in both institutional implementation and
on-rational enforcement of the contractual monitoring and settlement of penalties.

Hence, a multifaceted approach would be necessary to present a sustainable con-
cept fulfilling the aspects of equal access to health care, social equity, and eco-
nomic viability. CONCLUSIONS: Financial penalties for drug non-adherence are still
lacking a simple solution. This paper contributes to the widespread discussion by concentrating and aggregating widely scattered fig-
ures of dispute within a coherent argumentative discourse drawing on insights from
the field of health economics.

PHP5

USE OF HEALTH SERVICES AND MEDICINES AMONG STUDENTS IN SERBIA

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OBJECTIVES: The first real independence makes student population exposed to
various health risks. The aim of this study was to examine the health of students
and their using of health care services and medicines. METHODS: The cross-sec-
tional study was carried out at the three State Universities from February to May in
the academic year 2011/2012. and included 2285 students of both sexes. The stu-
dents filled in a questionnaire consisting of 30 questions referring to socio-eco-
nomic characteristics, life-style habits, health assessment, as well as some health
problems and use of health services. RESULTS: Half of all students reported having a
selected physician. Of the total number of students 59.8% of them had been to the
doctor and 63.8% of students used the services of a dentist at least once in the year
previously. The student respondents reported no or rare consumption of prescribed
drugs. Only 46.7% of the students used any non-prescribed drugs. Of those, 46.4% used
analgesics, 18.3% used sedatives, 17.2% used anti-allergic drugs and 4.9% used anti-
asthmatics. Only 1.3% of students used prescribed drugs in order to lose weight.

Among the students, 53.3% had used prescribed drugs at some time. Students in the
age group of 16-18 had used prescribed drugs in order to lose weight less frequently
than students in the age group of 19-23. CONCLUSIONS: Students should be encouraged to provide efficient, affordable counselling services for their students. Students must be encouraged to become actively involved in health promotion.

PHP6

COMPARING THE EFFECTIVENESS OF DIFFERENT EDUCATIONAL PROGRAMS FOR CHILDREN ON APPROPRIATE ANTIBIOTIC USE

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OBJECTIVES: The use of antibiotics is found to be irrational by patients as well as
prescribers and lack of knowledge and information about the adverse effects and
the increasing prevalence of resistant organisms are some of the important factors
in irrational antibiotic use. Clinical practice guideline programs show that the efforts of irrational antibiotic use should be the priority. Affecting these ideas in adults takes too much time and money, but education is more effective in children and its effect on a child becomes fixed in their beliefs. This study aimed to assess and compare the effects of 3 different sets of educational programs which the students took on their own initiative, where the
first stand pain medication, and then the drugs to strengthen the body (p < 0.001).

CONCLUSIONS: Universities should be encouraged to provide efficient, affordable counseling services for their students. Students must be encouraged to become actively involved in health promotion.

PHP7

HOW TO REIMBURSEMENT SYSTEMS ENCOURAGE OR INHIBIT ADOPTION OF INNOVATIVE MEDICAL DEVICES IN AN AMBULATORY SETTING?

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OBJECTIVES: To consider how reimbursement systems in 5 EU countries encourage
or inhibit adoption of medical device technologies that facilitate care in an ambu-
latory setting. METHODS: A literature review of payment systems for medical de-
VICES operating in England, Germany, Italy, France and Spain was undertaken. Examples of technologies that could be used in an out-patient setting, but which were predominantly being used in hospital were identified. Uterine balloon endo-
metrial ablation, low intensity pulsed ultrasound (LIPUS) and negative pressure wound therapy were investigated further, through interviews with country and product experts. RESULTS: Hospital and ambulatory sales could not be separated but some differences in total sales between countries were apparent. Where HTA processes existed they appeared to slow down access to new technologies. Several interviewees highlighted a lack of expertise on local purchasing groups where decisions are often based on in-year budget considerations which restrict access to some cost effective technologies. Even where new technologies are found to be cost effective, DRG based funding systems are insufficiently flexible to establish new out-patient fee levels. Hospitals have no financial incentive to treat patients in an out-patient setting if the procedure cost exceeds existing out-patient DRG fees. This prevents innovative technologies from being used in the most appropriate way and cost saving opportunities are missed. CONCLUSIONS: Health providers need to demonstrate new technologies are cost effective before commissioners agree to fund them. A classification based fee system can also be more efficient if commissioners pooled expertise for reviewing cost-effectiveness evidence and fed their conclusions directly to DRG code and Tariff setting authorities. New DRG codes and higher out-patient tariffs for cost effective technologies that enable a switch to ambulatory care could incentivise hospitals to care pathways. Benefits will include lower procedure costs than in-patient treatment or improved outcomes for patients.

HEALTH CARE USE & POLICIES STUDIES - Drug/Device/Diagnostic Use & Policy

PHPP1
A SURVEY OF “JOINT WORKING” BETWEEN THE PHARMACEUTICAL INDUSTRY AND THE NATIONAL HEALTH SERVICE IN THE UK
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OBJECTIVES: An increasingly high-profile policy initiative being driven by the Department of Health (DoH) of the Association of the British Pharmaceutical Industry (ABPI) and National Health Service (NHS) stakeholders, “joint working” encompasses a variety of forms of collaboration between the industry and the NHS in the UK. This study sought to characterise the current landscape for joint working in the types of projects undertaken by participating companies.

METHODS: Secondary research was conducted to establish a comprehensive list of joint-working projects; the websites of major pharmaceutical companies, the ABPI, the DoH and other NHS stakeholders were surveyed for any references to joint working. A classification system was created to segment projects by type of scheme, therapeutic area(s) and stakeholders involved. This segmentation was analysed to look for qualitative trends in the UK joint-working environment.

RESULTS: A key finding of the study is that many pharmaceutical companies are now active in joint working. Joint-working projects encompass a broad range of therapeutic areas, with most companies active in areas in which they have assets. These projects can be segmented into a number of different categories, including those centered on service (re)design, service appraisals in light of current guidelines, and techniques to better manage or educate patients. Pharmaceutical companies are also active in providing training or other types of support to health care professionals and managers within the NHS.

CONCLUSIONS: The joint-working policy initiative in the UK has resulted in a significant number of partnerships within the NHS in recent years. These projects, split in nature, are a reflection of the pharmaceutical industry and the health service cooperate in innovative ways. Increasingly, companies are willing to share their expertise and resources in projects which have indirect benefits for them in terms of the market access of their products.

HEALTH CARE USE & POLICY STUDIES - Drug/Device/Diagnostic Use & Policy

PHPP10
THE EFFECT OF LAW FOR ECONOMICAL USE OF MEDICATIONS 2006 ON THE AVERAGE Turnover of COMMUNITY PHARMACIES BETWEEN 2007-2010
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OBJECTIVES: In 2006 a law for the economical use of medications was introduced into the Hungarian legislative. This law – among others – facilitated the foundation of new pharmacies. The aim of our study is to analyse to that effect of legislation on the commercial turnover of community pharmacies.

METHODS: Data were derived from the pharmaceutical database of the Hungarian Health Insurance Fund Administration (OEIP), the only health care financing agency in Hungary. We analysed the 5 years period between 2006-2010. The main indicator of our analyses was the annual number of pharmacies per the number of population in different settlements. RESULTS: The average annual turnover – calculated on health insurance reimbursement – of a community pharmacy was 176.8 million Hungarian Forint (HUF) or 66011 EUR in 2006 with significant differences according to the size of population. Pharmacies located in small cities had a much lower average annual turnover (0.499 popu- lation: 105.6 million HUF, 500-999: 41.9 million HUF, 1000-1999: 63.2 million HUF, while the turnover of pharmacies located in bigger cities, was significantly higher (20000-499999 population: 217.6 million HUF, 50000-99999: 231.9 million HUF, over 100000: 241.6 million HUF). The average annual turnover of a community pharmacy was 135.4 million Hungarian Forint (HUF) or 491627 EUR in 2010, i.e. 76.6 % of 2006’s turnover. Between 2006 and 2010, the annual turnover of pharmacies in small villages (population 0-1999) remained the same; however, the turnover of bigger cities (population over 10000) changed to 66.9-76.5 %. CONCLUSIONS: The annual turnover of pharmacies in small villages was significantly lower than those of big towns during the study period 2006-2010. However, the annual turnover of small villages’ pharmacies decreased moderately compared to pharmacies located in bigger towns because new pharmacies were established in bigger towns.

PHPP11
AVAILABILITY AND PRICING OF INNOVATIVE PHARMACEUTICALS IN THE TOP 5 EUROPEAN PHARMACEUTICAL MARKETS
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OBJECTIVES: In an attempt to assess time to market and price levels of innovative drugs, we surveyed market availability and drug prices for a basket of drugs in the top 5 European pharmaceutical markets. METHODS: The market availability of 125 innovative drugs – approved between 2004 and 2010 – was calculated on the basis of information from European Medicines Agency – in France, Germany, Italy, Spain, and the United-Kingdom was analysed. Within this sample, prices of 10 drugs marketed in each of the market studied were compared. RESULTS: Most of the drugs included in our sample are marketed in Germany and the UK, 59% and 54% respectively. In France, Spain and Italy this figure drops to 39%, 33%, and 32% respectively. It should be highlighted that only 14% of the drugs was available in all the markets analysed. Prices are commonly the highest in Germany and lower in Italy or the UK. Additionally, while for an identical drug, most examples show significant price differences between the markets studied, a few showed that the price corridor was relatively narrow.

CONCLUSIONS: Our results show that Germany and the UK – where prices have not been directly controlled – are still prioritised, while market entry occurs at a later stage in France, Italy and Spain. The fact that large price differences are still observed in those countries means that there is still be separation between pricing strategies. The pricing procedure implemented in 2011 in Germany, has not had an immediate impact on prices - which are still the highest. However, an impact is already being felt on market access. Several innovative drugs were not launched in Germany when the price outcome was expected to be unsuccessful.

PHPP12
PATENTED DRUG EXTENSION STRATEGIES ON HEALTH CARE SPENDING: A COST-EVALUATION ANALYSIS
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OBJECTIVES: Drug manufacturers, facing patent protection termination, have developed strategies to maintain market share. These include marketing evergreening drugs (slow release formulations, single isomer chiral molecules, or structural analogues/combinations of original patented drugs) and offering high rebates to hospitals that use brand-name or evergreening drugs. Our objective was to assess the financial impact of evergreening drug prescriptions in the community, and to measure the impact of a hospital restrictive drug formulary (RDF) on health care expenditures. METHODS: We combined three administrative registries from the canton of Geneva, Switzerland to analyse all prescriptions between January 2000 and December 2008. We developed cost-minimisation models calculating evergreening drugs (slow release formulations, single isomer chiral molecules, or structural analogues/combinations of original patented drugs) and offering high rebates to hospitals that use brand-name or evergreening drugs. Our objective was to assess the financial impact of evergreening drug prescriptions in the community, and to measure the impact of a hospital restrictive drug formulary (RDF) on health care expenditures. RESULTS: General drug pricing system is set by Agency for medicines and medical devices of B&H. Prices are defined as maximal wholesaler price (WSP) and pricing is based on referral pricing. Referral countries are Croatia, Serbia, Slovenia, Austria and Italy. B&H price must be set at level of referral price with addition for patented drug (100%), originator (95%) and generics (90%). Prices are revised each year and published on Agency website. Maximal wholesaler margin is up to 8%, while retail margin is set by entity laws. In Federation maximal retail margin is 25% while in Republic of Srpska is 20% and on top of reimbursable price in Republic of Srpska is defined as lowest offered price for each INN and presentation. Price difference can be paid by patient depending on preferences. Reimbursed prices for drugs included into Federal reimbursement list is set by negotiation process with manufacturer and federal/ and state government. Results: Even there is intention to unify pharmaceutical market and drug prices in Bosnia and Herzegovina, there are still differences in price and related pricing regulations. Recently published Rule on price control by state Agency would contribute to equalisation of prices in Bosnia and Herzegovina.