identify the PRACs main concerns relating to the methodology. METHODS: All PSDs published between July 2005 and November 2012 where the primary evidence was based on an indirect comparison, either as simple or a mixed treatment comparison, were reviewed. Data relating to comparator, clinical claim, economic analysis, and PRAC concerns were extracted and analysed. RESULTS: PSDs relating to 105 products using indirect comparisons as the primary analysis were reviewed. A total of 79 (67%) submissions were recommended; the remaining submissions were rejected (32-30%) or deferred (3, 3%). An indirect comparison was used to support a non-inferiority claim in 84 (80%) submissions and superiority in 21 (20%) submissions. Of those claiming non-inferiority, 60 (71%) submissions were recommended by the PRAC. Of those claiming superiority, the PRAC accepted the clinical claim for 10 (48%) submissions, 6 (29%) received a price premium. The PRAC expressed concerns relating to the indirect comparisons in 56 (53%) PSDs. The key issues related to the extrapolation of the trials as a consequence of different patient populations (25%), quality of tri- als (24%), and dosing (18%). CONCLUSIONS: Clinical comparisons based on indirect evidence are associated with chronic patients’ choices. The PBAC usually accepts evidence to support a claim of non-inferiority, but rarely the same in regards to superiority.

PHP99 INVESTIGATING THE ECONOMIC IMPACTS OF NEW PUBLIC PHARMACEUTICAL POLICIES IN GREECE
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OBJECTIVES: Since 2010, cost containment efforts in Greece focused on the reduction of public pharmaceutical expenditure. Changes in cost sharing levels (dementia/alzheimer, depressive disorders, hypertension, osteoporosis & COPD etc.), reduced prices for generics substitution are some of the measures implemented after the second quarter of 2012. The aim of the study is to investigate the economic impact of the above measures, their impact on public expenditure, implementation on price premiums and preferred drugs for prescribed drugs for each therapeutic category and cost sharing level were derived from EOPYY, the main reimbursement agency (95% of population). The periods compared were January to February 2012 vs. January to February 2013. RESULTS: During 2009-2014, generics substitution was a key measure aiming at reducing cost of generics. In 2009-2010 the decline is projected at 61%. During 2013, 2014 targets are 2-4 billion per month. Major savings for generics substitution are some of the measures implemented after the second quarter of 2012. 69% of them stated that they were aware of the trials. The PBAC usually accepts evidence to support a claim of non-inferiority, but rarely the same in regards to superiority.

PHP100 CHRONIC PATIENTS’ RESPONSE TO THE IMPLEMENTATION OF INTERNATIONAL NON-PROPRIETARY NAME (INN) PRESCRIBING IN GREECE
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OBJECTIVES: Under the pressure of fiscal consolidation and pharmaceutical spending decrease in Greece, mandatory generic substitution and compulsory prescription by INN were recently introduced as reimbursement drivers in Greece. This study aims to investigate the implications of INN implementation regarding chronic patients’ choices and their willingness to switch to an alternative pharmaceutical treatment. METHODS: A cross-sectional study was carried out among 1600 patients from four chronic disease groups (HIV, Diabetes, COPD and Alzheimer). Logistic regression analysis was used to investigate the factors associated with chronic patients’ choices. RESULTS: Out of 1600 patients approached, 1594 responded to the survey (99.6%). 69% of them stated that they were aware of the new reimbursement system. After the implementation of INN prescribing, only few (11%) have changed their usual drug, 43% were totally certain that the original drug is more effective than a generic while 67% have not used generics in the past. Most (82%) preferred to be prescribed their usual medicine, despite of the extra cost they had to bear. This choice was a co-decision with their physician as 58% of them stated. The average additional amount that they would be willing to spend in order not to switch to another medicine was estimated at £17.8. These results showed a significant statistical correlation with patients’ income, educational level and occupation category. CONCLUSIONS: According to this study chronic patients are not willing to change their usual drug and switch to a generic, despite the cost decrease associated with INN prescribing may decrease public expenditures on pharmaceuticals but it will lead to higher private expenditure. Given that due to economic crisis incomes are continuously decreasing and unemployment rate is rising, this study's findings may eventually result in lower adherence to medication and consequently in adverse effects on patients' health status and future public expenditure for treating possible complications.

PHP101 MARKET ACCESS RISK SCORING: A UNIFIED FRAMEWORK FOR CROSS COUNTRY COMPARISON OF DIVERSE MARKET ACCESS SYSTEMS AND PROCESSES
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OBJECTIVES: To define and develop risk - and more specifically market access risk - scoring frameworks and evaluating stability in market access systems at an individual country level. METHODS: We created a combination model of rating quantitative and qualitative variables which affect a country’s ability and willingness to pay for new drugs. The criterion for selection of variables is based on the economic crisis incomes are continuously decreasing and unemployment rate is rising, this study's findings may eventually result in lower adherence to medication and consequently in adverse effects on patients' health status and future public expenditure for treating possible complications.

PHP102 CAN VARIATION IN HOSPITAL PROCEDURE RATES IDENTIFY CANDIDATES FOR HEALTH TECHNOLOGY REASSSESSMENT AND DISINVESTMENT?
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OBJECTIVES: The process of disinvestment from inefficient health care involves identification and prioritisation of candidates, a health technology reassessment (HTR) framework for Cross Country variations might lead to NHS savings and disinvestment or discontinuance of inefficient countries identified as distinct clusters – such as BRICS (Brazil, Russia, India, China and South Africa), BRICS-MT (Brazil, Russia, India, China, South Africa, Mexico and Turkey), and Emerging Europe (Czech Republic, Hungary and Poland) – for easier targeting of candidates and implementing strategies. Market Access Risk ratings could serve as a starting point for crafting tailored strategies to fully capitalize new opportunities. These ratings could also serve as a benchmark for a country to improve its overall access to pharmaceutical products and improve quality of care.

PHP103 CAN VARIATION IN HOSPITAL PROCEDURE RATES IDENTIFY CANDIDATES FOR HEALTH TECHNOLOGY REASSSESSMENT AND DISINVESTMENT?
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OBJECTIVES: The process of disinvestment from inefficient health care involves identification and prioritisation of candidates, a health technology reassessment (HTR) framework for Cross Country variations might lead to NHS savings and disinvestment or discontinuance of inefficient countries identified as distinct clusters – such as BRICS (Brazil, Russia, India, China and South Africa), BRICS-MT (Brazil, Russia, India, China, South Africa, Mexico and Turkey), and Emerging Europe (Czech Republic, Hungary and Poland) – for easier targeting of candidates and implementing strategies. Market Access Risk ratings could serve as a starting point for crafting tailored strategies to fully capitalize new opportunities. These ratings could also serve as a benchmark for a country to improve its overall access to pharmaceutical products and improve quality of care.

PHP104 INFLUENCE ONINCREMENTAL COST EFFECTIVENESS THRESHOLDS INFLUENCING NICE DECISIONS: A BAYESIAN ANALYSIS
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OBJECTIVES: NICE has been issuing health technology guidance based on cost-efficacy evidence alongside other factors since 2000. Previous studies have shown that technologies with higher incremental cost-effectiveness ratio (ICER) were more likely to be rejected, however none drew direct inference on the ICER threshold(s). Our aim is to directly estimate the ICER threshold(s) as well as the possible range. METHODS: Data were abstracted from the technology appraisals (TA) published from 03/2000 to 12/2012. For each decision to ‘recommend’ or ‘reject’ a technology we collected: ICER, publish date, disease area, technology type, comparator, reason for rejection if rejected, population and end of life (EOL) criteria (applies only to TAs after January 2009). Cancer related technologies which were evaluated for EOL criteria were classified as satisfying or not satisfying the criteria. A Bayesian hierarchical model was implemented to estimate the overall threshold as well as the thresholds in different technology categories. RESULTS: A total of 270 TAs were evaluated. After excluding those updated or terminated, a total of 187 appraisals with 323 decisions entered the final analyses. The unadjusted estimate of the ICER threshold was £64,850 (95% CI: £40,420-£55,570). After adjusting for disease area, cancer related technologies had an estimated threshold of £48,550 (95% CI: £36,550-£63,200) compared to non-cancer related technologies’ estimated threshold of £43,430 (95% CI: £35,440-£52,300). Among the 37 technologies evaluated for end of life criteria, the estimated ICER threshold was £56,160. (95% CI: £39,020-£79,970) and £33,100 (95% CI: £19,180-£49,620) for satisfying and not satisfying the criteria respectively. CONCLUSIONS: Preliminary assessment of NICE appraisals and associated ICER indicates that a likely ICER threshold exceeds the £20K-£30K quoted in the NICE Methods Guide. Additional analyses are needed to assess the impact of other factors on the likely variability of ICER thresholds.