OBJECTIVES: The study examined: a) the relationship between pharma care and healthcare expenditures by disease area, b) the influence of expenditure on drugs to the level of expenditure on other forms of care c) the impact of providers on the level of pharma expenditure. METHODS: We conducted linear multiple regression analysis with pharma expenditure as independent variable, and dependent variables such as clinician care expenditure of other categories. We then add all combinations of measures with numbers of physicians and pharmacists as independent variables and pharma expenditure as dependent. Analyses were conducted for all Eurozone countries and for each of the 10 GPNP countries. We also add controls for other factors. RESULTS: Increased total per capita outpatient pharma expenditure (in US $ PPP’s) by 10% was related to an increase in life expectancy: a) at birth for men by 0.41% (p=0.07), b) for men 65+ by 2.35% (p =0.004), and c) at birth for women by 0.37% (p =0.03). Moreover, increased public pharma expenditure as a % of total current public expenditure by 10% was related to a reduction of public current health expenditure (as a % of GDP) by 2.8% (p<0.01). 2. The increase of total pharmaceutical expenditure as a % of GDP was related to a reduction of total current health expenditure as a % of GDP by 3.3% (p< 0.0045). Finally, we ask: at the number of pharmacists/100,000 population by 10% was related to an increase of total current health expenditure as a % of GDP by 0.3%. The 10% increase in number of pharmacists/100,000 population was related to an 0.8% increase in life expectancy (p =0.02). We also add controls for other factors. OVERALL: the study found that there is a significant relationship between the number of pharmacists/100,000 population and life expectancy as well as public pharma expenditure as a % of total current public expenditure. Moreover, the study found that the increase of total pharma expenditure as a % of GDP was related to a reduction of total current health expenditure as a % of GDP by 3.3%. The 10% increase in public pharma expenditure as a % of GDP was related to a reduction of total current health expenditure as a % of GDP by 0.3%. CONCLUSIONS: The findings of the study support the need for more innovative medicines in order to ensure patient’s access to a patient’s pharmaceutical care. The primary objective of this study is to estimate the cost savings achieved by clinical pharmacists through the prevention of adverse drug events (ADE) as a hospital setting. Previous studies have estimated the benefit of these interventions over shorter periods of time and in specific hospital areas. This study will encompass a longer time period and a complete hospital system. METHODS: This was a retrospective analysis of a database containing pharmacist interventions on patients’ therapies at Cork University Hospital. Period examined was from January 2012 to December 2012 inclusive. Cost savings were calculated based on the probability that an ADE would have occurred and cost of pharmaceutical dispensing and the cost of the ADE event (A DE event). Input costs were calculated based on the time required for pharmacists (n=17) to enact interventions. One way sensitivity analysis incorporated published ranges for intervention time, pharmacist salary and probability an ADE would have occurred. Alternative sets for an ADE were also included in analysis. Cost savings are from the perspective of the health care institution. Costs are presented in 2012 € values. RESULTS: A total of 4,247 interventions were documented. Base case analysis resulted in net cost benefit of €590,000 per annum and a cost benefit ratio of 10.4:1. Cost savings of €550,000 were generated and the cost of providing the service was estimated at €60,000. Sensitivity analysis resulted in cost benefit ratio varying from 5.2 - 64.8 € (minimum - maximum). The most prevalent pharmaceutics were used to calculate the cost of interventions. The cost of pharmaceutical dispensing was calculated using the prices where available. Using a specific example (miifamurtide [Mepact, Takeda] for the treatment of osteosarcoma) the time to loss of health benefits for equal and different discount rates using a UK reference case was assessed. RESULTS: Like most of Europe, the UK National Institute for Clinical Excellence (NICE) has been using a discount rate of 3.5% for both costs and health effects. However, it has recently adopted a different reference case where health effects are sustained for a period of 30 years or more by 1.5% for health effects and 3.5% for costs. Taking the example of miifamurtide and using the original rate of 3.5% for health effects, all benefit would be discounted away after just 22 years. By adopting the lower rate, the effects will not be discounted away until 49 years after treatment. In this case, the discount rates used to for miifamurtide are particularly sensitive because all costs are borne in the first year, yet benefits of treatment can be over a patient’s lifetime. CONCLUSIONS: Assuming different discount rates affects the potential long-term benefits of new health care technologies. However, most European countries, with the exceptions of Belgium, The Netherlands and now the UK in specific circumstances, continue to use the same discount rate for costs and health effects, thereby potentially undervaluing the long-term benefits current and new treatments.

**PHP5**
ADVANCED BUDGET NOTIFICATION (ABN): IS THERE A WIN-WIN FOR MANUFACTURERS AND PAYERS GIVEN THE CURRENT AUSTRIAN MEASURES ACROSS THE EU

Access Partnership, London, UK

OBJECTIVES: The mature health economies across the EU are severely fiscally challenged, and yet manufacturers of innovative medicines are where the legislation permits expected to give a notifiable ‘warning’ of expected budget impact. A survey was undertaken amongst payers to ascertain their real world expectations in terms of advanced warning and how realistically a collaborative approach to access could be achieved. METHODS: Manufacturers of innovative technologies are where legislation permits advised to supply payers and budget holders with information that will assist the aforesaid bodies with sufficient information to decide on the level of managed entry of that technology. Historically manufacturers are in two minds about the value of this process. A study was undertaken with payers as to their perceived interest and interaction with manufacturers who willingly provide the information that will assist the aforesaid bodies with sufficient information to decide on the level of managed entry of that technology. RESULTS: There appears to be a dichotomy of opinion amongst payers as to the value of the legislation; ‘darned if you do, darned if you don’t’, however it clearly is in the interest of both parties to work together. Payers value the level of information that Manufacturers provide to consider, in order to seek to garner the approval of payers. CONCLUSIONS: The EU is in the worst economic depression since the 1930’s, affordability is the key watchword. New technologies need to continue to be presented to payers in a manner which allows them to plan for fiscal pressure and service redesign.