ventilated with a median SOFA score of 6. The median cumulated time dedicated to one patient by physicians, nurses and caregivers was 10h20 over the 24-hour period (1h15 by physician, 6h08 by nurses and 2h57 by caregivers). CONCLUSIONS: The median time of more than 10 hours directly dedicated to a patient is a key information for the estimation of the real cost of one day stay in ICU.

METHODS AND IMPACT OF INCORPORATING MEDICATION COMPLIANCE INTO PHARMACOECONOMIC EVALUATIONS
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OBJECTIVES: This study aims to identify how medication compliance and/or persistence were assessed in the cost-effectiveness analysis, and what the impact was on ICER (Incremental cost-effectiveness ratio). METHODS: Pharmacoeconomic studies with compliance and/or persistence measures, had published from March 2005 to February 2010, were searched through MEDLINE. Articles were included if they integrated medication compliance and/or persistence into the economic analysis model. We reviewed the target diseases, the model designs, and the impact of non-compliance on the treatment costs and effects. After that, the results were compared with a previous review article of ISPOR MCP (Medication compliance and persistence special interest group) had conducted in 2007. RESULTS: The search identified 77 articles that were included, but only 12 of them were funded. Even though the overall kinds of target diseases were different, most of them were chronic diseases, which have remission and relapse as common characteristics. Variety of modeling techniques such as decision-analysis and Markov model, DES (Discrete event simulation) were used for the evaluations. In decision-analysis models, the branches of decision trees represented different level of compliance. In case of Markov models, transition probabilities assumed to be higher for those patients who were non-persistent or non-adherent to treatment. Finally, considering the effect of compliance and/or persistence, it may cause decrease of ICER for new intervention. CONCLUSIONS: We found that incorporating compliance and/or persistence into economic evaluations lead to favorable results to new intervention. However, there was a lack of methodological rigor and consistency in definition. Therefore, development of guidance is needed for measurement, analysis, interpretation, and application of compliance and persistence from variety of data sources.

DISCOUNTING HEALTH EFFECTS: A REVIEW OF THE SYSTEM
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BACKGROUND: Discounting health effects remains a matter of great debate these days. Currently, discussion focuses on whether health effects should be discounted at the same rate as costs or not. High discount rates for health effects are impacting negatively on the cost-effectiveness of screening and vaccination programs. Discounting health at a lower rate than wealth has however been argued to result in theoretical inconsistencies and practical unnecessary delays in implementation of health programs. Many authors have therefore assumed that there is a one-to-one relationship between health and wealth. OBJECTIVES: We investigate the rationality of several assumptions involved towards current discounting procedures. We especially investigated the assumption of a one-to-one relationship between health and wealth. METHODS: We performed a literature review to link the issues in current methods of discounting health effects with the assumptions involved. Furthermore, we analyzed other possible linkages of health rather than with wealth only. RESULTS: We noticed that although income might depict the marginal substitution between all commodities, it seems that externalities are not accounted for. Yet, research has shown that all forms of economic growth exert intrinsically negative population health effects among the poor. CONCLUSIONS: Although there might be a relationship between wealth and health, it appears that externalities may play an additional role on the quality of life. Therefore, it seems that we should regard the discounting problem of health effects as an interlinked system, rather than an equation with only health and wealth and allow differential discounting of, and potentially even within, health effects.

ASSISTANCE COST DEPENDING ON COMORBIDITY IN PRIMARY CARE: A SPANISH INTERREGIONAL LEVEL
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OBJECTIVES: The objective of the study is to obtain behaviour of the cost relative average weights of the assistance with the retrospective application of the Adjusted Clinical Groups (ACG’s) in 16 teams of Primary Care with an attended population in the clinical practice use. METHODS: Multicentre, retrospective study based on electronic records of patients seeking care during 2009 in the regions of Aragon, Baleares and Catalonia. Main measurements: universal variables (age, sex, health service-family practice/paediatrics) and dependent variables: episodes and total cost (visits, diagnostic test, referrals, drugs). The ACG case-mix System software (version 8.2, N = 106) classified subjects into a single category for a given annual resource consumption. The model of cost per each patient was established differenting the fix cost and the variable costs. Outlier patients were considered those surpassing T = 15.0(1.96) ± 177.86 for total cost expenditure. Log transformation of the dependent variable was carried out to reduce skewness of the distribution and make it close to normal. Exploratory power was calculated by coefficients of determination (R²). Statistical software SPSS, P < 0.05. RESULTS: The studied population was distributed into 10 ACG. The explanatory power of the ACG classification system was 59.6% (Ln: 41.2%), P < 0.001. A total of 6.2% of patients were considered Outliers (N = 14,066). CONCLUSIONS: The ACG are an acceptable system of classification of patients in situation of clinical practice use. Some ACG classification categories should be separated due to the high outliers number.