guidelines, health prevention / monitoring, strategies involving coordinated actions between primary care and pharmacies, are valuable resources to consider.

PCV150 A REVIEW OF THE APPLICATION OF INTERNATIONAL REFERENCE PRICING IN UKRAINE'S PILOT HYPERTENSION REIMBURSEMENT SCHEME

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The Ukrainian government has been considering ways to improve the population’s access to medicines by offering limited reimbursement access. For this purpose, the government has expressed its interest in implementing International Reference Pricing (IRP). The pilot hypertension programme, which introduced a system of IRP for certain hypertension drugs, was introduced in mid-2012. The government is currently looking to revise the pricing and reimbursement mechanism and to expand the list of drugs eligible for reimbursement under the scheme. This study examined the pilot hypertension programme (VTP) and its role in achieving its objectives so far.

METHODS: Second-level research focused on analysing the current pharmaceutical market and health care situation in Ukraine, with a specific focus on the hypertension market. The study then assessed the pricing and reimbursement mechanisms up to the most recent modifications, and the impact of the VTP on volume and value of the antihypertensive market.

RESULTS: Hypertension was chosen for the pilot programme due to the high prevalence of the condition in the country. While, for the full year 2012, the weighted average cost per package in the antihypertensive drug segment decreased by 1.4% compared to the previous year, the volume of retail sales increased 16.8%. Furthermore, as of January 2013, the prices of these drugs had been falling every month from July till December 2012 by 12.7%. The total sum spent on antihypertensive drugs was increased by 2012 compared to the corresponding months of 2011.

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OBJECTIVES: To determine the attitude of physicians in three family medicine centers (FMCs) at the National Guard Health Affairs (NGHA) toward the implementation of the Shared Medical Appointment (SMA) approach compared to the current individual appointment approach. METHODS: A cross-sectional survey study was conducted by distributing a structured questionnaire among the 79 FMCs’ physicians at NGHA in Riyadh, Saudi Arabia. The first part of the questionnaire was an introduction, the second part had requested socio-demographic information, and the third part consisted of 12 statements that physicians’ attitude toward implementing SMA and the current individual appointment approach. Responses were measured using a 5-points Likert Scale. Seventy-nine self-administered questionnaires were distributed to physicians and were collected from mail-boxes at each clinic. Data collection was done from December 10 to 15, 2011.

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Re-hospitalizations were taken into account if they occurred after one month following the initial hospitalization. The benefit of the local treatment was similar to the national results. Alternatively, all re-hospitalizations rates regardless of the related diagnosis were also assessed. Inpatient costs were valued based on reference tariffs according to French National Social Health Fayer perspective. RESULTS: Around 1750 patients were followed in 2009 and 2010. Four-hospital-stay rate from 2009, 2010, 2011 and 2012 one-year re-hospitalization rates for ST and TI ranged from 2.9% to 7.1%. The median time to re-hospitalization ranged between 1.5 to 9.3 months. Two-year re-hospitalization rates for ST and TI ranged from 4.5% to 10.4%. Two-year re-hospitalization rates regardless of related diagnosis in acute and/or rehabilitative settings ranged between 45.5% to 65.1%. Mean costs (+/- SD) per inpatient stay for ST and TI were €4'645 (+/- €3'821) in acute setting (2013 EUR). When excluding TI, mean costs were €5,294 (+/- €2'956). Hospitalization costs varied depending on sub-type of stroke, severity, co-morbidities and also year of costing. CONCLUSIONS: Such short term data on recurrence rates and inpatient costs might be useful when estimating potential benefits of any secondary prevention intervention aiming at reducing stroke relapses.

PCV156
STATINS IN CANADA: THE CASE FOR DISINVESTMENT
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OBJECTIVES: We examined the economic consequences of generic switching within the statin market for public plans in Canada between 2000 and 2012.
METHODS: We extracted data (number of units, costs, and claims) for all statins reimbursed by Canadian public drug plans for the period 2000–2012 (sources: IMS Brogan and Canadian Institute for Health Information). RESULTS: Public plans paid $11.2 B to reimburse statins for 2 MM patients between 2000 and 2012. The annual cost of reimbursing statins peaked at $1.3 B in 2009. Generic atorvastatin was listed by public plans in 2010, and the proportion of statin reimbursement attributable to generics increased from 1% in 2010 to 79% in 2012, reflecting a 76% increase in generic switching during the same period. The unit cost of brands and generics fell by 25% and 49%, respectively. The combined effect of increased generic switching and lower unit costs resulted in a drop of the total cost of statins from $3.8 B in 2006 to $1.1 B in 2012. Annual savings attributable to generic switching increased 10-fold between 2000 and 2012, from $7 to $709 MM. The efficiency at which potential savings has been captured through generic switching increased from 8% to 74% from 2000 to 2012; we projected this will generate savings of $800 MM annually through 2015. Increasing generic switching to 100% could generate up to an average of $135 MM annually in additional savings. CONCLUSIONS: Although substantial savings have been generated by generic switching within the statin class, increasing generic switching could generate additional savings. One strategy to capture these additional savings would be disinvestment: if branded statins were de-listed from public plans if a generic version were available, this would increase generic switching, increase the efficiency at which potential savings are captured, and increase total savings.

PCV157
ATRIAL FIBRILLATION’S BURDEN OF DISEASE IN PORTUGAL
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OBJECTIVES: To estimate the Disability Adjusted Life-Years (DALY) attributable to Atrial Fibrillation (AF) during 2010 in Portugal, including both AF and AF related strokes.
METHODS: To estimate the DALY’s we used the Russian setting. Intervention scenarios of achieving SBP control rates (defined as BP <140) of 30%, 40%, 50%, and 60% were simulated by modifying adherence rates of an antihypertensive medication combination and compared with current care (23% BP control rate). An extensive simulated individuals were modeled over a 30 year time horizon. Outcomes of major adverse cardiovascular events, stroke, myocardial infarction (MI) and CV death were reported. Direct health care costs of strokes and MI were derived from official Russian statistics and price lists.
RESULTS: To achieve SBP control rates of 30%, 40%, 50%, and 60%, adherence rates to the antihypertensive treatment program were 11.1%, 29.4%, 47.6%, and 65% respectively. CV death relative risk reductions were 5.0%, 13.2%, 21.4%, and 29.6%, respectively. For the simulated scenarios, the modeled 43,855,000 Russian hypertensive population was estimated to averted 398,097, 1,050,715, 1,703,334 and 2,355,952 CV deaths, and a reduction of 458,781, 1,210,881, 1,962,981, and 2,715,081 stroke/MI deaths. Averted direct costs from current care (225,781) were 12,834, 38,811, 117,542, and 358,550 million Rubles, respectively. CONCLUSION: Our simulation implies that a clinically significant number of CV events in the Russian hypertensive population may be prevented by achieving BP control through an antihypertensive medication combination. Averted costs may be re-allocated to strengthen evidence-based, preventive interventions.

PCV159
WHAT FACTORS PREDICT THE DECISION TO TREAT ACUTE CORONARY SYNDROME INVASIVELY? EVIDENCE FROM CLINICAL PRACTICE
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OBJECTIVES: To describe UK patients with acute coronary syndrome (ACS) who received an in-hospital coronary intervention (PCI) or are medically managed only (MM) and evaluate factors affecting approaches to treatment. METHODS: Patients registered with a general practice participating in the Cardiology Practice Research Database (CPRD), Framingham Study and Health Survey Statistics (HSS) from 2001 to 2010 were included if they had an ACS-related hospitalization (January 2008-December 2009). Logistic regression analyses were used to assess what characteristics at ACS-related hospitalization (MM or PCI) are associated with in-hospital PCI. RESULTS: A total of 10,753 ACS patients were identified (60% male, 67% aged ≥ 65, 81% had NSTE or UA at index date); 30DHD, 74% were MM and 26% had PCI. Factors associated with receiving PCI were STEMI at hospitalization (OR 0.63, CI 0.54, 0.75), previous PCI pre-hospitalization (OR 1.29, CI 1.07, 1.55) and current smokers (OR 1.16, CI 1.02, 1.32). Patients less likely to receive PCI included women (OR 0.67, CI 0.60, 0.75), those with previous ACS hospitalization (OR 0.69, CI 0.60, 0.80), those previously diagnosed with congestive heart disease (OR 0.54, CI 0.42, 0.71), atrial fibrillation (OR 0.5, CI 0.54, 0.83), stroke/TIA (OR 0.77, CI 0.63, 0.93) or renal disease (OR 0.82, CI 0.71, 0.95). Age and BMI were significant as continuous variables with non-linear effects. CONCLUSIONS: This is the first large-scale UK study using real-world data to assess socio-demographic and clinical predictors for PCI in ACS, and indicates that NSTE-ACS patients and those with comorbidities are more likely to be MM. This will be discussed in light of current treatment of STEMI and NSTE-ACS in the EU.

PCV160
THE PHARMACOECONOMICS OF CARDIOLOGY IN RUSSIA
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OBJECTIVES: To analyze the current state and the trends of pharmacoeconomic research in cardiology in Russia. Literature searches were conducted using databases of scientific publications (PubMed, eLibrary.ru etc.) as well as individual journals, conference abstracts and web-sites for the period 2007–2013.
RESULTS: It was found that cardiology becomes one of the most popular topics for pharmacoeconomists, partly because of its significance for public health and the growing amount of state funding for the prevention of CVD in recent years. Cardiovascular problems make up 16–25% of congress abstracts and 26% of publications for Da Signa, the only award in pharmacoeconomics in Russia. Most publications in our analysis dealt with arterial hypertension (44%), coronary heart disease (16%) and chronic heart failure (7%). A wide range of original and generic drugs were included into these researches, however in most cases there was a prevalence of cost-efficiency analysis and modeling methods based on the results of non-Russian clinical trials and meta-analyses. Overwhelming majority of the results were published in Russian and therefore are not available for the non-Russian-speaking reader.
CONCLUSIONS: During the last five years, a great number of pharmacoeconomic research in cardiology have been performed and published. However, there is a need of clinical trials that would consider the Russian specifics and health care standards. Pharmacoeconomic analysis should become an integral part of clinical trials, especially in case of drug therapy of myocardial infarction, stroke and other conditions, where the differences exist between the Russian and foreign practice. Some of the analyzed publications should be updated because of the recent changes in health care standards.

PCV161
THE VOLUME-OUTCOME RELATIONSHIP AND MINIMUM VOLUME STANDARDS – NALEDI’s IMPACT ON CORONARY BYPASS GRAFT SURGERY IN SOUTH AFRICA
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OBJECTIVES: To analyze the volume-outcome relationship for patients with intact abdominal aortic aneurysm (AAA) and hip fracture (HIP) and define hypothetical minimum volume standards to assess changes in access. METHODS: The analysis is based on administrative data coming from the German system of diagnosis related groups of about 18–26 million hospital cases of 176 General hospitals for the year 2007. The data includes detailed information on patient characteristics used for

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