behavior: diabetics and those with hypertension. METHODS: Analyses are based on a nationally representative sample from the Medicare Current Beneficiary Survey (MCBS) for the years 2000–2005. MCBS is a longitudinal survey and provide detailed information on prescription drug coverage, exercise, weight, diet, alcohol consumption, and smoking behavior. The analysis is restricted to non-institutionalized persons above 64 years of age with at least 2 years of data. We pay particular attention to the non-random nature of prescription drug coverage and the selection bias caused by it. Specifically, estimates are obtained using longitudinal data and multivariable regression models that control for observed characteristics and unmeasured person-specific effects (i.e., fixed effects). RESULTS: An average of 16% of the elderly switched coverage in any two consecutive years, providing sufficient variation in prescription drug coverage to conduct fixed effects analysis. In general, we find limited evidence of prescription drug coverage affecting health behaviors. The lone exception was for those in public programs, where one specification reflected that elderly in the public programs were 13 percentage points (30%) less likely to participate in physical activity than those with no prescription drug coverage after controlling for health status. CONCLUSIONS: Although, we did not find any evidence of ex ante moral hazard with employer-sponsored and HMO coverage, those in public program altered their behavior significantly upon gaining prescription drug coverage.

**PCV110**

THE POTENTIAL ECONOMIC IMPACTS OF RECONFIGURING TIA CARE IN THE UK

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OBJECTIVES: The experience of TIA patients in the UK NHS can be quite disparate. Patients presenting to primary care are often referred to a weekly clinic, creating a delay in access to effective treatments for this condition. The recent EXPRESS study by Rothwell et al. (Rothwell, Peter M., et al. Lancet. Online 9 Oct 2007 DOI:10.1016/S0140-6736(07)61448-2) clearly demonstrated that a greater focus on effectively managing TIA could have a significant impact on subsequent stroke rates. We wanted to examine how the implementation of the care pathway outlined in Phase 2 of the EXPRESS study could affect rates of stroke, and to explore the financial implications of such a shift in care. METHODS: We developed an economic model to estimate the costs and savings associated with setting up a rapid assessment and treatment clinic for patients with suspected TIA, in line with Phase 2 of the EXPRESS study. We used a local population of 500,000 people with an assumed annual incidence of TIA of 0.19%. Current management was based on national clinical guidelines and common clinical practice. We included all direct costs associated with care (medications, diagnostics and staff), and modeled the impact of changing management over a three-year time horizon, in line with NHS planning timeframes. RESULTS: For an assumed population of 500,000, changing the pathway of care for TIA management resulted in 295 future stroke events avoided over three years. As a result, the additional costs associated with changing the pathway of care for TIA were greatly outweighed by the savings generated through avoiding acute management costs associated with stroke. CONCLUSIONS: The model suggests that the implementation of the changes outlined in phase 2 of the EXPRESS study is cost saving for a local population of 500,000 with an assumed TIA rate of 0.19%.

**PCV111**

COST ANALYSIS OF DYSLIPIDEMIA TREATMENTS WITHIN THE SLOVAK REPUBLIC

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OBJECTIVES: The aim of this study was to collect comparable and reliable data on the lipid lowering therapy in Slovakia during the period 1996–2006. The special interest was paid to the trend of the statin and fibrate usages. METHODS: Data of wholesalers (following ATC/DDD), who are legally obliged to provide this information to the Slovak Institute for Drug Control, was used for the analysis. The results were expressed in the numbers of the packages, finance units (€) and defined daily doses per 1000 inhabitants per day (DDD). RESULTS: The collected data showed large increases in hypolipidemic consumption from 1996 to 2006 in term of DID (in 1996 (4.18), in 2001 (16.64), in 2006 (48.80). A significant increase in statin consumption (in 1996 (1.97), in 2001 (9.76) and in 2006 (39.66) and slight increase in fibrate consumption (in 1996 (3.59), in 2001 (6.76) and in 2006 (7.84) in term of DID can be seen from this analysis. From the reimbursement point of view, simvastatin (in 2000 was reimbursed at the level of €0.84 per DDD, in 2006 the reimbursement level was at €0.14), fluvastatin (in 2000 was reimbursed at the level of €0.75 per DDD, in 2006 the reimbursement level was at €0.46), atorvastatin (in 2000 was reimbursed at the level of €0.89 per DDD, in 2006 the reimbursement level was at €0.22). Financial expenditures were for statins (in 1996 (€989,000), in 2001 (€17,636,000) and in 2006 (€15,458,000) and for fibrates (in 1996 (€2,743,000), in 2001 (€5,570,000) and in 2006 (€3,517,000). CONCLUSIONS: Usage of generic drugs for the treatment of hypercholesterolemia brought about a dramatic increase in hypolipidemic consumption and the financial expenditures for health insurance funds have remained under control.

**PCV112**

STATINS USE IN PATIENTS WITH A RECENT ISCHEMIC STROKE: RESULTS FROM THE STROKE ANALYZER DATABASE

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OBJECTIVES: Assess the usage of statins in hospital after an acute ischemic event and identify differences across Europe. METHODS: Consecutive patients diagnosed for Ischemic Stroke were analyzed in 2006 and 2007 in Germany, France, Italy, Spain and UK using the Stroke Analyzer database. This was a retrospective study. RESULTS: A total of 4930 Ischemic Stroke cases were enrolled from July 2006 until July 2007. Data were reported from around 300 stroke specialists, neurologists, general medicine specialists. The most common treatments administered in hospital were: aspirin 73%, statins 55%, LMWH 48%, ACE inhibitors 46%, beta blockers 21%, clopidogrel 18%. The majority of the 2726 patients treated with statins in hospital received simvastatin 47%, atorvastatin 40% and pravastatin 8%. The most common simvastatin first doses used were: 40 mg (48%) and 20 mg (42%). The atorvastatin starting doses administered were mainly 20 mg (34%), 40 mg (27%) and 80 mg (16%) atorvastatin (Spain were leading with 25% of atorvastatin patients receiving a start dose of 80 mg). A total of 1023 patients (21%) were already receiving a long term treatment with a statin prior to hospital admission. Despite the fact that 36% of all ischemic stroke patients did not have dyslipidemia, 11% of them were already on statins before the stroke event. Almost 31% of patients already had a previous stroke or TIA event and 13% had a myocardial infarction more than 1 month before the current ischemic stroke event. Treatment with a statin was initiated on the same day of admission to hospital.