demographic factors underlying the cost of GMS prescribing in Ireland are complex and inter-related. Alternative solutions to the question GMS coverage in the elderly may need to be found soon that prove fiscally and economically sustainable. The large gap in GMS prescribing costs between men and women in early adulthood requires further investigation.

**PHP69**

**THE TRANSPARENCY OF NATIONAL HEALTH CARE COSTS IN THE EUROPEAN UNION (EU): A MULTI CRITERIA DECISION ANALYSIS APPROACH**

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OBJECTIVES: Standard approaches to economic evaluations based on cost utility analysis are increasingly considered inadequate. While simple and intuitive, it is acknowledged that the QALY alone does not capture all aspects of health benefit. Multi Criteria Decision Analysis (MCDM) has been proposed as a way of incorporating multiple factors influencing the value of a health technology. The objective of this study was to analyse past reimbursement recommendations by the National Centre for Pharmacoeconomics (NCPE) in Ireland in order to identify factors which have been taken into consideration in the past. A targeted search and contact with country-specific representatives highlighted existing national documentation. A cross-sectional selection of costs were searched for including GP and nurse costs; hospital bed and outpatient costs; and true cost of hospital care HRU cost data through PSSRU. Italy was the least transparent however AIFA informed us a website reform will increase access to data in 2014. Where non-explicit, HRU costs can be indirectly derived from total procedure codes (for example through ATU, France). Spain and Italy's regional structure made sourcing national cost data challenging, resulting in wide ranges in input costs in published cost-effectiveness analyses. CONCLUSIONS: Whilst some nations provided transparent HRU cost data, others did not, causing inconsistent inputs across cost-effectiveness analyses. To minimise inconsistency we propose a hierarchy of evidence for use when sourcing costs: 1) Govt/health service official sources; 2) Official international websites (OECD/WHO); 3) Published economic studies; 4) Published non-economic studies; 5) National expert opinion, and 6) Unofficial websites/sources.

**PHP70**

**A RETROSPECTIVE ANALYSIS OF DRUG REIMBURSEMENT DECISIONS IN IRELAND: A MULTI CRITERIA DECISION ANALYSIS APPROACH**

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OBJECTIVES: Cost-effectiveness analyses play a key role in the reimbursement of health care technologies and require health care resource use (HRU) cost inputs. Inaccuracies in inputs can lead to potentially significant differences in results. Thus, the availability of HRU costs is vital for decision-making. This study’s objective is to assess and evaluate the impact of different HRU costs in France and Italy, Spain and the UK. METHODS: A targeted search and contact with country-specific representatives highlighted existing national documentation. A cross-sectional selection of costs were searched for including GP and nurse costs; hospital bed and outpatient costs; and true cost of hospital care. INITIAL OBSERVATION: The selection of costs were searched for including GP and nurse costs; hospital bed and outpatient costs; and true cost of hospital care. The objective of this study was to analyse past reimbursement recommendations by the National Centre for Pharmacoeconomics (NCPE) in Ireland in order to identify factors which have been taken into consideration in the past. A targeted search and contact with country-specific representatives highlighted existing national documentation. A cross-sectional selection of costs were searched for including GP and nurse costs; hospital bed and outpatient costs; and true cost of hospital care. RESULTS: DRG tariffs were identified for all countries, but the availability of other data varied. Drug prices were obtainable online (such as the website Medicin Prix, France), but others required paid registration (Giofis, Italy). The UK had the most accessible primary and secondary care HRU cost data through PSSRU. Italy was the least transparent however AIFA informed us a website reform will increase access to data in 2014. Where non-explicit, HRU costs can be indirectly derived from total procedure codes (for example through ATU, France). Spain and Italy's regional structure made sourcing national cost data challenging, resulting in wide ranges in input costs in published cost-effectiveness analyses. CONCLUSIONS: Whilst some nations provided transparent HRU cost data, others did not, causing inconsistent inputs across cost-effectiveness analyses. To minimise inconsistency we propose a hierarchy of evidence for use when sourcing costs: 1) Govt/health service official sources; 2) Official international websites (OECD/WHO); 3) Published economic studies; 4) Published non-economic studies; 5) National expert opinion, and 6) Unofficial websites/sources.

**PHP71**

**MEDICAL CARDS DURING RECESSION: HOW MANY, FOR WHOM AND HOW MUCH?**

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OBJECTIVES: To model the age, gender and regional pattern of GMS coverage rates as they are key determinants of public spending on GMS medicines. METHODS: We used data from two healthcare units (National Centre for Pharmacoeconomics, Healthware Consulting Ltd., Budapest, Hungary) to estimate GMS coverage rates by age, gender and region in 2010 and 2011. Assuming log-normally distributed incomes we used CSO SILC data to estimate GMS coverage rates. RESULTS: Over 7 to 3, is highest for elderly age cohorts and in the South-East and South-West regions and is similar for males and females. Growing inequality generally increases GMS coverage, pushing some persons over 70 above the qualifying income threshold. Repeating 2010 average income in 2011 would increase the 2011 GMS costs medicine by around €110m; repeating the 2010 inequality changes would increase it by a further €150m, ceteris paribus. CONCLUSIONS: Fiscal cutbacks during recession induce intertemporal increasing returns to scale in the public cost of its medicines. These are the first systematic and detailed estimates – by age, gender and region – of whose medical access is affected and how much the offsetting public cost will increase.

**PHP72**

**THE BURDEN OF DISEASE ATTRIBUTABLE TO PHYSICAL INACTIVITY IN THE AUSTRIAN REGION OF BURGENLAND**

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OBJECTIVES: About 52.6% or 125,434 people of the population in Burgenland is physically inactive. As a risk factor for several chronic diseases like cardiovascular diseases, type 2 diabetes, osteoporosis, depression, back-pain, hypertension, breast cancer, osteoarthritis, diabetes and other chronic conditions, the impact of physical inactivity is a major public health burden. Furthermore, it is one of the greatest risk factors for global mortality. Hence, the aim of the analysis was to estimate the direct healthcare costs saved, the number of diseases and premature death saved each year attributable to a health promotion program focusing on walking (“1,000 steps” more). METHODS: The estimation of the health-economic impact was performed using a cost-of-illness analysis. We have used relative risk (RR) estimates from the literature to evaluate the effects of physical inactivity on the above mentioned diseases. Afterwards, the population-attributable fraction (PAF) for each illness to estimate the risk factor on the given disease was computed. Direct medical costs were considered from the health care service user perspective, HIA was conducted bottom-up for the year 2012. We have calculated effects of a reduction in inactivity level by 10,000 physical inactive people in Burgenland. RESULTS: Results show that physical inactivity causes 274,542 cases of ill health as well as 50 premature deaths in population of Burgenland, leading to a total cost-of-illness of 58.9 million Euro (6.3% of total health expenditure). Reducing the inactive group by 10,000 people, 2,221 cases of illness and cases of death will be reduced by four. Moreover, the cost of illness could be reduced by 6.4 million to 5.0 million Euro per year which is a decrease of 21% in total. The popu-

**PHP73**

**THE IMPACT OF THE BLIND BID PROCEDURE IN HUNGARY**

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OBJECTIVES: The modified reference price procedure, which was introduced in October 2011, caused significant savings in the Health Insurance Fund’s Pharmaceutical budget. In our analysis we aim to gain an insight into the effects of this measure on the drug consumption and on the sales of the pharmaceutical companies as well as measure the generated savings and losses on the side of the industry. In the course of the analysis we examine the change in the demand of the related drugs and in their composition, from the aspect of industry, financier and patients. We explore which are the price strategies of the companies and are they managed to increase the sales or decrease the losses with them. The proper knowledge of the effects of blind bid will support the decision making of the concerned market actors as well as the further rulemaking. METHODS: A retrospective evaluation of Firth Z.A., Smith T.A.

**PHP74**

**COST-EFFECTIVENESS OF AN INTERFACIAL GERIATRIC INTERVENTION: ACUTE MEDICAL UNIT COMPREHENSIVE GERIATRIC ASSESSMENT INTERVENTION STUDY (AMIGOS)**

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OBJECTIVES: Older people (>70) with high risk of future health problems discharged from hospital in 72 hours (Acute Medicine Unit, AMU) in England, were included in an RCT of an interfaccial geriatric intervention (IGI) comprising geriatrician assessment and further specialist management. The objective was to estimate the cost and cost-effectiveness of IGI compared to standard care. METHODS: In the trial-based economic evaluation, 417 participants (IGI: 205) were analysed at 90-day follow-up. Health (inpatient, day-case, outpatient), social care and IGI resource-use data were collected and with unit costs to estimate total cost. Quality-adjusted life years (QALY) were calculated from EQ-5D valuations at baseline and follow-up, were obtained for 254 (60.9%) participants. Multiple imputation by chained equations was applied to deal with missing QALY values. Cost and QALY's were adjusted by bivariate characteristics using regression methods, and probabilistic incremental cost-effectiveness ratios (ICER) were constructed. Sub-group analysis was carried out.