areas of the health care system. A critical appraisal was done covering the public HTA reports to assess the success of reimbursement of new therapies. RESULTS: The HTA implementation started in 2013, but the first model of a scorecard HTA was aborted in April 2014. From July 2014 the HTA responsibility moved at the National Drugs Agency and a new scorecard model was introduced. The Romanian HTA system is a quick-HTA based on a scorecard which sums up to 145 points, the criteria being: HAS (France) evaluation, NICE/SMEC (UK) evaluation, IQWiG/G-BA (Germany) evaluation, the number of EU countries with reimbursement, the RWD study and the Budget Impact Analysis. The thresholds were over 80 points for unconditional reimbursement and 60-79 points for conditional reimbursements. By the end of 2014 were evaluated 174 dossiers, including new INNs, new indications and new fixed dose combination. After the appeals done by MAHs, 23 new INNs were unconditionally included in the List and 15 INNs scored for conditional reimbursement, waiting for the cost-volume contracts to be signed in second semester of 2015. CONCLUSIONS: The introduction of the scorecard HTA in Romania created the possibility to access for new drugs, in a transparent and understandable manner, for the decision-makers. The scorecard model does not require any cost-effectiveness model and has a predominant budget impact perspective for unconditional reimbursement, but created the circumstances to access on the List using commercial arrangements.

**HT2 IMPACT OF HTA – AN IRISH CASE STUDY**
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OBJECTIVES: The Health Information and Quality Authority (HIQA), a statutory, government-funded agency in Ireland which monitors the safety and quality of the health and social care systems. HIQA has approximately 210 staff, with 7 contracts to be signed in second semester of 2015. HIQA working in HTA. Since 2010 we have completed 7 full HTAs and 25 rapid HTAs in addition to 6 national HTA guidelines. This study sought to evaluate the impact of a rapid HTA. METHODS: In 2013 the HIQA Health Information and Research Division examined the implications of establishing a national public access defibrillation (PAD) programme in Ireland to increase survival from out-of-hospital cardiac arrest. HIQA and the relevant healthcare/health-technology assessment (HTA) agencies were incorporated and weighted by HTA bodies. This research aims to develop a performance scorecard HTA capacity in different ways. In theory, a centralized approach offers the potential to pool the scarce resources devoted to HTA and national recommendations can be issued to encourage a uniform development of services across the whole country. On the other hand, a regional approach could help in tailoring recommendations to local needs. The study was to compare HTA practices in England (centralized approach) with Spain (regional approach). METHODS: We compared the assessments of the same cancer drugs in the two jurisdictions from 2000 to 2015, focusing on the availability of an HTA, the indication(s) studied, the comparator considered, the cost-effectiveness assessments produced and the reimbursement recommendation (recommended with no restrictions, optimized or denied use). RESULTS: The indications studied and the comparators considered were similar. However, the HTA systems differed in the number of HTAs produced, size of HTA bodies, and the number of HTA bodies involved. CONCLUSIONS: The systems are very different in terms of size, number of HTA bodies involved and the number of HTAs produced. Therefore we used data from two regional Governments (Andalucia and Catalonia) and a pharmacy scientific society (SFEH) where recommendations were more consistent and comparable. For the period of 2011-2014 a total of 4 indications were assessed in Catalonia: optimized (86%) exceptional use (14%). CONCLUSIONS: Due to a relative lack of central coordination, the approach to HTA in Spain leads to a less standardized approach for technology assessments of cancer drugs than in England. In addition, cost-effectiveness evidence is less frequently generated. However, a lower proportion of drugs receive a negative recommendation, which may reflect both the lower level of cost-effectiveness scrutiny and a relatively higher willingness-to-pay.

**PATIENT-REPORTED OUTCOMES STUDIES**

**PP1 EQUVALENCE OF PAPER AND ELECTRONIC ADMINISTRATION OF PATIENT REPORTED OUTCOMES: A COMPARISON IN PSORIATIC ARTHRITIS**
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OBJECTIVES: To evaluate whether scores from paper (P) and electronic tablet (E) versions of seven PRO measures [SF-36v2 Health Survey (Standard), Bath Ankylosing Spondylitis Disease Activity Index, Health Assessment Questionnaire, Dermatology Quality of Life Instrument, Patient Global Assessment of Disease Activity, Subject Assessment of Pain, and, Fatigue Visual Analogue Scale] are equivalent. METHODS: After public consultation, patients received P and E versions in similar ways. We used cognitive interviews, a crossover study was conducted in 53 patients (34 women) aged 18–83 years. A three-period design was used, with the first two periods being L and P in randomised order, the third period being F for all patients. This allowed both P and E and P-F reliability to be compared. Patients’ opinions on ease of use and acceptability of the electronic version were collected. RESULTS: Intracl ass Correlation Coefficients ranged from 0.75 to 0.97, all above the generally accepted threshold of 0.70. Correlations were in general similar for P–E (mode equivalence) and P–F (test-retest reliability for paper) T-tests revealed no significant mean difference between P and E scores. Mean score differences between P and E measures were small and within an acceptable limit of equivalence. The majority of patients reported that the electronic tablet was acceptable (99%) and ‘very easy’ (81.8%) or ‘quite easy’ (14.3%) to use. Few subjects (5%) reported problems using the tablet. The majority of patients (97.7%) preferred the tablet version to paper, while 12.4% had no preference, and 1% (2%) preferred paper. CONCLUSIONS: Results indicate that the PRO scores are equivalent when administered to patients with PsA via electronic and paper modes. The tablet versions were easy to accept and use, and preferred over paper versions in the results summary. The use of the electronic tablet versions of the PRO measures in PsA clinical trials.

**PP2 QUANTIFYING THE IMPACT OF HEALTH-RELATED QUALITY OF LIFE (HRQoL) ON MEDICAL EXPENDITURES IN ASTHMA, ARTHRITIS, DEPRESSION, DIABETES, AND MIGRAINE**
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OBJECTIVES: Understanding the meaning of differences in HRQoL scores is essential in communicating the value of treatment to stakeholders. This study translates differences in scores from a widely used HRQoL measure, the SF-12v2, into differences in future medical expenditures across 5 major conditions. METHODS: Data came from the Medical Expenditure Panel Survey (MEPS) (n=20,620), collected in 2006/2007. Conditions were identified by associated medical events, disability days or self-report. Medical expenditures (MEs) were calculated as the sum of payments for the condition, the medicines associated with the condition, and the office-based provider visits in the 6 months following administration of the SF-12v2. We modeled the effect of the physical (PCS) and mental (MCS) component summary scores on MEs using log-linear generalized linear models with different link functions, gender, marital status, comorbidity count and insurance status. RESULTS: A 5-point lower PCS score was associated with a 22% increase in MEs among men with asthma and diabetes, 18% increase in migraine, 17% increase in depression and 14% increase in arthritis. 5-point lower MCS was associated with a 23% increase in MEs among people with diabetes, 8% increase in migraine, 7% increase in arthritis and asthma and 4% in depression. The effect of PCS on MEs decreased with age in arthritis (P<0.0120) and similarly for MCS in depression (P<0.0365). A 5-point lower PCS was associated with a 25% increase in MEs in arthritis at age 45 but a 14% increase at age 50.