four with a significant increase in ARP, and two with a significant increase in OPC (p < 0.05). By comparison, Medicare Part D resulted in significant TRx increases for ten drugs (and no decreases), eight showed ARP increases and two had ARP decreases (p < 0.05). Interestingly, seen drugs decreased OPC while two increased (p < 0.05). CONCLUSIONS: NICE HTAs had mild effects on the prescription utilization and costs in the US, while Medicare Part D caused fundamental changes to the market parameters measured. The influence of NICE decisions on the US market should be monitored as HTAs are expected to play a more significant role in the advent of Medicare Part D Reimbursement.

HEALTH TECHNOLOGY ASSESSMENT PROGRAMS

PHP49

ANALYSIS OF FACTORS ASSOCIATED WITH REIMBURSEMENT DECISION MAKING IN HEALTH TECHNOLOGY ASSESSMENT AGENCIES (HTA)

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OBJECTIVES: Health technology assessment is used to inform reimbursement decisions for pharmaceuticals in many countries. The political and administrative contexts in which HTA is used vary considerably between countries, as do the decisions on individual products. The aim of this study was to investigate the influence of HTA and other factors on reimbursement decisions.

METHODS: A systematic search was conducted to obtain the documentation for reimbursement decisions on cancer and cardiovascular medicines. Where insufficient information was published, or reports were not available in English, decisions were excluded. The analysis was conducted using discrete response models and included methods of assessment, evidence included and stakeholder involvement.

RESULTS: Detailed information was obtained on 194 decisions from Australia, Belgium, Canada, England, France, Scotland and Sweden. The pooled analysis showed that 27% of medicines were recommended, 41% were recommended for restricted use and 32% were not recommended. The multinomial logistic regression showed that the number of RCTs, disease area, use of sensitivity analysis and public interest had a statistically significant impact upon decisions. The use of cost-utility analysis in the supporting HTA was found to reduce the probability of a positive recommendation. The analysis for those countries that included cost-utility analysis showed that the value of the ICER had a statistically insignificant impact upon the decision. However, a sub-analysis for decisions in England showed that this was found to be statistically significant.

CONCLUSIONS: These findings may reflect varying approaches to conducting economic analysis, differences in cost-effectiveness thresholds and variation in the weight given to economic evidence in informing decisions within countries. The individual product level factors explain some of the variation in reimbursement decisions across countries. Further variation may be explained by the health system and policy context in which decisions are made. The next stage of the work will investigate these factors directly.

PHP50

UNIVERSAL STEPS IN PERFORMING EARLY-STAGE MEDICAL TECHNOLOGY ASSESSMENT

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OBJECTIVES: Early-stage medical technology assessment (MTA) is sometimes conducted in an ad-hoc manner, if it is performed at all. Identification of universal steps in early-stage MTA would catalyze the development of valuable technology.

METHODS: Universal steps in early-stage MTA were developed following evaluation of a new stroke rehabilitation strategy targeting the urban Chinese population. Literature review, physician and patient interviews, and decision modelling were performed to appraise current stroke care and evaluate methods to improve it. Different rehabilitation strategies were recognised and described, and their costs and health effects were estimated and compared.

RESULTS: Certain universal steps in early-stage MTA could be identified. An important first step is the creation of a detailed study plan that includes evaluation criteria and may also discuss the value of a disease progression model. A second step consists of qualitative and quantitative descriptions of current treatments and new technologies. This step focuses not simply on acquiring quantitative estimates of costs, health effects and quality of care, but also on identifying areas for quality improvement. Since the literature review did not yield sufficient information, other methods (i.e., interviews) were needed to ascertain attitudes regarding usual care and behaviour. These methods provided extra insight into physician and patient preferences, insight that was used to modify the evaluation criteria. Subsequently, the new technology was described both qualitatively and quantitatively. Lastly, the costs and health effects of the treatments were compared using standard techniques (e.g., uncertainty analysis). These results identified where more information needed to be collected.

CONCLUSIONS: As with later-stage MTA, there is a need and an opportunity to develop universal steps for conducting early-stage MTA. They supplement, but do not replace, the steps and techniques applied during later-stage assessments. If properly formulated, they can be used to facilitate good internal decision-making during the development phase.
two years in many cases, and the fact that NICE does not cover middle ground therapies, other HTA organizations have a significant impact on funding, prescribing, and commissioning decisions in England. Their influence varies regionally, depends on their remit and focus, and need to be understood, and accounted for to ensure the appropriate uptake of technologies by health care providers in England, now, and in the foreseeable future.

**PHP52**

**EVALUATION OF CURRENT ASSESSMENTS OF WORLDWIDE AGENCIES FOR HEALTH TECHNOLOGY ASSESSMENT**

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**OBJECTIVES:** To evaluate the information about current activities of worldwide agencies for Health Technology Assessment (HTA) and assess whether the information disseminated by the agencies is sufficient to ensure timely and effective information sharing with stakeholders. **METHODS:** Targeted searching of the websites of all members of the International Network of Agencies for Health Technology Assessment (INAHTA) was conducted to retrieve relevant information. Secondary research was supplemented with a survey administered directly to target organizations in each country. **RESULTS:** The results of these searches totalled 815 references to on-going assessments. They fall into some broad categories, which include HTA, systematic reviews, primary research, clinical guidelines, observational studies and registries. About 5% of the references identified were assessing medical devices, 18% assessing drugs (pharmaceuticals, biologicals, vaccines), and 76% other technologies (medical or surgical procedure, organization or administrative system, support system or others). Agency’s key communication form is Internet; in one out of five cases not available in English. About 50% of the agencies (24 out of 46) have a section about current assessments on their website. Out of the 22 agencies without information on the internet, 68% were readily responsive to requests for information; 36% providing full project details (e.g., application name, assessment process, stage and timeline). **CONCLUSIONS:** Health care agencies routinely use centralized assessments for (new) medicines and other health technologies. While ISPOR Special Interest groups have gathered insights on the current methods and applications of technology assessments across worldwide HTA agencies, the access to on-going assessments is limited. The examples above show the lack of transparency and inconsistency in the information disseminated by the agencies. This complicates early access to information needed to get insights in recent developments and trends in health policy. This not only negatively impedes on the industry but one might question the impact on patient care.

**PHP53**

**EXPANDING THE PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI): MEASURES GROUPS AND REGISTRY-BASED REPORTING**

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**OBJECTIVES:** In mid 2007 the U.S. Centers for Medicare and Medicaid Services (CMS) implemented a Medicare quality incentive program for physicians and other professionals paid under the Medicare Physician Fee Schedule (PPS). This study examines the development and expansion of that program in to 2008 and beyond and illustrates its growing emphasis on disease management. **METHODS:** PQRI regulatory guidance was reviewed and analyzed for changes from the 2007 program. Criteria for successful compliance were arrayed according to the method of participation: claims-based, measures groups and registry reporting. A list of current PQRI resources was compiled. **RESULTS:** The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted on December 29, 2007 (Pub. Law 110–173), authorized the continuation of the Physician Quality Reporting Initiative (PQRI) for 2008 and 2009, and authorized CMS to establish greater flexibility within the program. In addition to the original claims-based reporting, new options include: 1) alternative reporting criteria and periods for the reporting of measures groups, and 2) submission of quality data through clinical data registries. For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data will earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during the 2008 calendar year. Financial incentives earned for 2008 reporting will be paid in mid-2009 from the Federal Supplementary Medical Insurance (Part B) Trust Fund. For 2008 PQRI consists of 119 quality measures, a 61% increase over 2007. **CONCLUSIONS:** During 2008 PQRI requirements have diversified and expanded, allowing providers more choices in how they participate. The expanded options for data submission tend toward a more comprehensive, disease management perspective than did the initial 2007 process, and also include a measures group for preventive care.

**PHP54**


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**OBJECTIVES:** A review of the cost and usage for all medicines and antibiotics in Serbia in 2004–2007, as well as the data on medicines usage for these two groups. The importance of collecting data on antibiotics consumption is in correlation with rational use. **METHODS:** Medicine and Medical Devices Agency of Serbia is authorised for collecting and processing data on medicines consumption. Data on medicine consumption in 2004–2007 was gathered from obliged entities, processed by the DDD/at Canton classification, and the analyses of financial indicators is done as well. **RESULTS:** It was established that the total medicines marketing in Serbia in 2004 was €340 million (20% for antiinfectives for systematic use—J group), in 2005 it was €380 million (19% for J group), in 2006 it was €510 million (18% for J group) and in 2007 it was €690 million (17% for J group). By processing consumption data as DDD, from 2004–2007 consumption of J group was 34.74, 36.38, 34.21 and 46.51 DDD/1000 inh/d, respectively. Expenditure of subgroup penicillins with extended spectrum was at the first place (12 DDD/1000 inh/d in 2004 and 2005, 11 DDD/1000 inh/d in 2006 and 15 DDD/1000 inh/d in 2007), then tetracyclines (6 DDD/1000 inh/d in 2004, 5 DDD/1000 inh/d in 2005–2007) and first-generation cephalosporins (around 5 DDD/1000 inh/d in 2004–2007). The consumption of amoxicillin was the highest in all four years, around 9 DDD/1000 inh/d, at the second place was doxycycline (6 DDD/1000 inh/d in 2004 and around 5 DDD/1000 inh/d in 2005–2007). **CONCLUSIONS:** Data useful for the improvement of pharmacotherapy and its realisation are generated through processing and analysing the structure of medicines, and getting the insight of all other factors necessary for the health care.