Drug Interaction Facts. **RESULTS:** A highly significant difference was observed between the prevalence of pDDIs in prescriptions from hospital (45%; 180 out of 400 prescriptions with at least 1 pDDI) and community pharmacies (29.25%; 117 out of 400 prescriptions with atleast 1 pDDI). On the whole, out of total 543 pDDIs (hospital = 337; community = 206) majority of them were of delayed onset (hospital = 50.44%, community = 44.66%), moderate severity (hospital = 57.87%, community = 42.72%), suspected type (hospital = 27.6%) and possible documentation (community = 14.08%). Most of the prescriptions (hospital = 80%; community = 83%) contained 2-4 medicines. The interacting combinations such as aspirin-clopidogrel omeprazole-clopidogrel and digoxin-furosemide (in hospital); isoniazid-rifampin and tramadol-escitalopram were found to be frequently involved in major interactions. The findings showed that cardiovascular drugs were involved in most of the rapid pDDIs (in hospital = 32.46%; in community = 33.33%) and respiratory system drugs were associated with majority of established documented pDDIs (in hospital = 16.67%; in community = 42.86%). **CONCLUSIONS:** Drug-drug interactions in prescription medicines were observed in high percentage both in hospitals and community pharmacies. Clinical practices must be standardized as rational prescribing practices.

HEALTH CARE USE & POLICY STUDIES – Equity and Access

PHP51
UNMET HEALTH NEEDS OF IMMIGRANTS LIVING IN GREECE DURING THE ECONOMIC CRISIS: THE LONG-TERM IMPACT FOR THE HEALTH CARE SYSTEM

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OBJECTIVES: To examine access of migrants in health care services, their unmet health needs, and the factors associated with these. **METHODS:** A cross-sectional pilot study was conducted from January to May 2013. The study population consisted of 231 recent immigrants living in Greece. A questionnaire was developed including information about demographics, health status, difficulties in health services access etc. Statistical analysis included Pearson's x^2 test, x^2test for trend, student's t-test, analysis of variance and Pearson's correlation coefficient. **RESULTS:** Almost half of the participants (n=115, 49.7%) used public health services in the last 12 months in Greece. Among them, 56.8% (n=131) used emergency department services. A considerable proportion of the participants (n=144,62.3%), during the last year, needed at least one time to use health services but they could not afford it. The most important reasons for that were high cost of health care (n=80, 34.5%) and the long waiting lists (n=29, 12.6%). More than half of the participants (n=122, 52.9%) reported that they had major difficulties in accessing health services. Increased family monthly income was associated with decreased difficulties in access in health services (x2 test for trend=32.1, p<0.001). The use of preventive services has been limited since more than 60% of the women 40+ reported not having conducted a pap test or a mammography, while more than 30% of the respondents were not subjected to a blood test or a cholesterol examination. **CONCLUSIONS:** Barriers to health services access for migrants may lead to decreased use of health services, especially primary, and thus lead to increased hospitalizations and higher cost in the longer-run. Formulation of policies to improve access and use of health care services are necessary.

PHP52
IMPORTANCE OF SUBGROUP ANALYSES FOR HEALTH TECHNOLOGY ASSESSMENTS

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OBJECTIVES: Cost effectiveness analyses play a critical role in determining coverage of novel drugs and devices. Increasingly, payers are demanding subgroup analyses to determine indications which would be covered by the national health system or insurance agency. **METHODS:** To understand and review trends in the use of subgroup cost effectiveness analysis, we analyzed NICE HTAs for products approved between 2011-2012. Manufacturer submissions for CEA were compared to final review and decision by HTA agency. Analogs were identified and case studies were developed to further understand the use of subgroup analyses and cost effectiveness models. **RESULTS:** Decisions made by NICE in 2011-2012 show increasing trends towards the use of subgroup analysis for determining indications for coverage by national payer bodies. Between 2011-2012, 80% of the assessments included subgroup analyses. Approximately half of them included cost effectiveness analyses for various subgroups. Interestingly, the ICER values estimated by NICE for the same subgroups showed a large variation (1X-3X fold difference) compared to ICER values estimated by manufacturers. Selected case studies highlighted that for several products, NICE is recommending treatments only for subgroups whose ICER values are within the cost effectiveness threshold. **CONCLUSIONS:** New products need robust broader population and subgroup analyses for insurance coverage.

PHP53
CHRONIC PATIENTS' ACCESS TO PHYSICIANS SERVICES IN TIMES OF ECONOMIC CRISIS

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OBJECTIVES: To explore the magnitude of certain access barriers to physician services that chronic patients are in front of as well as which patients are more vulnerable to such restrictions. **METHODS:** A cross-sectional study was conducted in 1600 chronic patients suffering from diabetes, hypertension, COPD and Alzheimer. Logistic regression analysis was carried out in order to explore the factors related to economic and geographical barriers in access, as well as the determinants of barriers imposed by waiting lists. **RESULTS:** A total of 25% of chronic patients face geographical barriers while 63.5% and 58.5 % of them are in front of economic and waiting list barriers, respectively. More likely to face economic barriers in access are unemployed patients [coef.0.55; 95% CI (0.1, 1)] and patients with low income [-0.2; 95% CI (-0.26,-0.13)] and lower educational level [-0.04; 95% CI (-0.08, 0)]. Women [0.22; 95% CI(0.02,0.42)], low-income patients [-0.13 ; 95% CI(-0.2, -0.06)], and patients with lower health status [-0.02 ; 95% CI(-0.02,-0.01)] are more likely to be in front of geographical barriers in access. Moreover, all occupational categories examined, demonstrate a statistically significant positive relationship with the probability of geographical barriers occurrence. In addition, unemployed patients [0.51; 95% CI (0.06, 1)], public or private sector employees [0.45; 95% CI (0.09, 0.81)] and low income patients [-0.086; 95% CI (-0.15, 0.02)] are more likely to deal with barriers attributed to waiting lists. **CONCLUSIONS:** Chronic patients face extensive barriers in access, which can mainly be explained by the fall of income, the rise of unemployment and the policy of decreasing the supply of certain health services in order to reduce health expenditure. If such barriers won't be minimized inequalities will be enlarged and chronic patients' health status will be worsened which might lead to increased future costs and adverse effects on health expenditures.

PHP54
QUALITY ASSURANCE OF FOURTH HURDLE CONCERNING TO DRUGS AND MEDICAL DEVICES

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OBJECTIVES: From 2011, there are basic thresholds (λ1=24 x average monthly salary € / QALY and λ2 = 35 x average monthly salary € / QALY) defined directly in the Slovak legislation reflecting the benefits displaced elsewhere in the Slovak health care system when funds are allocated to new medicines and medical devices. The objective of this study was to analyse the quality of submitted economic studies, related critical appraisals process and impacts of the new legislation on the access to medicines and medical devices. **METHODS:** We created a working group to review previously submitted economic evaluations and related critical appraisals in order to identify potential technical and methodological problems. The working group scrutinized previous submissions and critical appraisals, concerning to chosen ATC groups of drugs and groups of medical devices, published between June 2012 and June 2013 at the webside of MoH. **RESULTS:** Pharmacoeconomic evaluations of drugs and medical devices within decision making process concerning to reimbursement are mandatory but the quality of studies are very often rather poor. The concept "the QALY is a tool not a rule" was slightly modified in Slovakia. Our analysis shows that implicit thresholds included into the Slovak legislation have influenced decision-making process concerning to drugs and medical devices. In the defined time period 4 drugs exceeded the basic thresholds described in the Slovak legislation, however 108 drugs and medical devices were refused to include into the reimbursement list, because of the poor quality of provided pharmacoeconomic studies from the side of applicants. **CONCLUSIONS:** The transparent method of HTA can improve the consistency of reimbursement decisions making related to drugs and medical devices in Slovakia. However significant improvements in the quality of submitted pharmacoeconomic dossiers have to be the first step towards the better access to drugs and medical devices for the Slovak patients.

PHP55
THE HYBRID PURCHASER-PROVIDER SPLIT IN ENGLAND: SHOULD EUROPE FOLLOW SUIT?

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OBJECTIVES: Developed countries have embraced the purchaser-provider split as a mechanism to improve health resource allocation and outcomes. With the emergence of Clinical Commissioning Groups (CCGs) as both buyers and providers of health services a hybrid purchaser-provider model is being explored. This research explored the opportunities and challenges of this model and analysed the implications for NHS England and Europe. **METHODS:** Eighty influential regional and national payers involved in the NHS England reforms took part in 1-hour tele-depth interviews to better understand the changes and uncertainties before the reforms were implemented. This research was re-visited three months post implementation in an advisory board setting to externally validate our findings and identify case studies for further analysis. **RESULTS:** NHS payers stated that they were still 'broadly optimistic' about the re-allocation of purchaser responsibilities to CCGs. One case study illustrated that greater clinician involvement provided opportunities to redesign services like respiratory care and allocate funding more efficiently between acute and primary care. Initial success stories include the creation of primary care diabetes clinics and Pharma-NHS local partnerships to help reduce hospital activity. Within the advisory board, payers voiced concerns with this hybrid model. Questions raised from the meeting included: 1) How do we equip GP commissioners with the right skill set to draft and negotiate hospital contracts? 2) How can we help GP commissioners and GP providers to help minimise potential conflicts of interest? **CONCLUSIONS:** The purchaser-provider model implemented in England presents a new way to tackle reduced financial budgets and need to improve health outcomes. The results of this research suggest that the purchaser-provider model has the potential to make a difference for patient care. A number of challenges appear to still be present and it will be important to address these in order for the UK and other countries to further explore its benefits.

PHP56
CURRENT STATUS AND EVIDENCE OF EFFECTS OF E-PRESCRIBING IMPLEMENTATION IN UNITED KINGDOM, ITALY, GERMANY, DENMARK, POLAND AND UNITED STATES

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