but these laws are neither universal nor consistent. This study estimates the hospital-wide prevalence, cost, and mortality of CLABSI-associated discharges for all US community hospitals. Hypotheses are that CLABSI prevalence and mortality are increasing. METHODS: Data for the study was extracted from the National Inpatient Sample Database (NIS). CLABSI was defined as a discharge with an ICD-9-CM procedure code for a central line procedure (38.92, 38.93, and 38.95) and an ICD-9-CM diagnosis code for a BSI (24 codes). SAS Proc Surveyreg was used to estimate (log of cost) and, Surveylogistic was used to estimate mortality and CLABSI prevalence. NIS weights were used to make national estimates, charges were adjusted using cost-to-charge ratios, and costs were adjusted to 2006 US dollars using the hospital service CPI. RESULTS: Average cost of a CLABSI-related hospitalization was $31,879 in 2006 dollars. Presence of CLABSI had a positive significant effect on cost ($0.128, p < 0.001) and female had a significant negative effect (−$0.227, p < 0.001). The time variable was not significant (−$0.036, p = 0.032). OR for CLABSI increased over time (1.196, p < 0.001) when controlling for gender, LOS, number of procedures, liver disease, and renal failure. Mortality significant ORs (p < 0.001) were time (0.761), female (0.875), LOS (0.928), age (1.026), number of procedures (1.204), liver disease (1.184), and CLABSI (2.348). CONCLUSIONS: CLABSI-related hospital mortality in the US is decreasing as is the cost of treatment. However, the prevalence of CLABSI is increasing.

THOUGHTS ON THE LABORATORY CULTURES REIMBURSED BY THE SOCIAL SECURITY IN AUSTRIA (OUTPATIENT SECTOR IN PHYSICIANS' CARE AND INSTITUTES, BUT NOT HOSPITAL OUTPATIENT CARE) Wohlbach J, Endel G, Klenner E Main Association of Austrian Social Security Institutions, Vienna, Vienna, Austria OBJECTIVES: If a patient shows an infection, the physician has to decide which kind of anti-infective substance has to be prescribed. One method to figure this out is to order laboratory cultures. We want to find out whether there is a correlation between the frequencies of cultures reimbursed and the number of prescriptions of anti-infective agents. METHODS: Claims data (2006) from physicians in free practice and institutes for laboratory medicine data for laboratory cultures were conducted out of different reimbursement catalogues in Austria. RESULTS: The rate of reimbursed cultures per prescription was 11% (for bacterial cultures and antibacterial medication J01, J04, J06, 63% (for mycotic cultures and antymycotic medication J02), 24% for viral cultures and antiviral medication J03) and 25% (for parasitic cultures and antiparasitical medication PO1, PO2, PO3). If just those infections verified by cultures had a prescription rate, the time variable and gender targets efficiently in the 0.001 level. We have found that the number of all medications had been based on a culture, the prescription costs would have been 7.5 times higher. There are price differences for cultures due to various contract partners. If the lowest fee had been paid for each test we would have saved 33% of the current turnover for bacterial, 37% for mycotic, 38% for viral, and 6% for parasitic infections. The highest price had been paid we would have paid 7.5% (bacterial), 46% (mycotic), 164% (viral) and 33% (parasitic) more than the current turnover. CONCLUSIONS: Our further research will focus on the different categories of prescription for anti-infective agents, testing and also the guideline conformity of its use.

A true determination of cost-effectiveness of palivizumab has been conducted using a pair-wise comparison instead of multiple comparisons (i.e. different vaccines for a certain disease are compared only to no vaccination strategy). Advanced methods to characterize uncertainty, such as cost-effectiveness acceptability frontiers and bootstrap of information analyses, have not been applied. Also, no specific cost-effectiveness threshold for new vaccines has been set in Finland although international references and Finnish home dialysis and bypass surgery thresholds have been cited in the evaluation reports. However, the literature revealed that setting a threshold may be inappropriate. Thus, we present an ideal EE process that enables value-based threshold pricing for manufacturers and decisions that can lead to efficiency. CONCLUSIONS: There is a discrepancy between the scientific principles and objectives of EE and real life in terms of national EE of vaccines and tender calls in Finland. The current practice does not necessarily lead to optimal decisions based on cost-effectiveness. Particularly, multiple comparisons with valid prices should be encouraged.

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Safeguarding the health of children from Haemophilus influenzae type b disease (Hib) and Haemophilus influenzae type a disease (Hi) and reducing the burden of disease from invasive pneumococcal disease (IPD) are priorities for many countries. The conjugate vaccine PHiD-CV (23-valent pneumococcal, 5-typeable Haemophilus influenzae type b, 5-typeable Haemophilus influenzae type a, 5-protein D, bivalent Hib, 3-component pneumococcal) provides cost-effective protection against both Hib and IPD. The impact of PHiD-CV on the health system was estimated in a three-year, cohort, nationwide, population-based model of Italy. The model was populated with hospital discharge data, and general practitioners and hospital admission data, and included the direct costs of hospitalization, doctors and medications. Two PHiD-CV vaccine roll-out scenarios were studied: a base-case scenario (2010–2012) and a worst-case scenario (2021–2023). The base-case scenario assumed that PHiD-CV was administered to all children in 2011 and 2012. The worst-case scenario assumed the introduction of the vaccine in 2021 and observed the vaccine coverage until 2023. The projected impact of PHiD-CV vaccination in Italy was estimated using the WHO Health Impact Modelling Framework (HIMF) software. The health impact of PHiD-CV was assessed using life years gained (LYG) and disability-adjusted life years (DALYs) averted as health outcomes. The model estimated that PHiD-CV vaccination would result in 660 million life years, with an equivalent of 575 million years in disability-adjusted life years were averted in Italy. A 13% reduction in hospitalization was expected. The economic impact of PHiD-CV vaccination was estimated. A reduction of 700 million euros was estimated in the health care sector and 170 million euros in the Gini index. The cost-effectiveness of PHiD-CV vaccination was higher in the worst-case scenario. The potential cost-effectiveness may make PHiD-CV vaccination a relevant cost-effective policy for children who are at risk of IPD in Italy.

**Conclusions:** PHiD-CV vaccination can provide a significant health and economic impact on the health system of Italy. The health impact of PHiD-CV vaccination in Italy was cost-effective in the base-case scenario and cost-saving in the worst-case scenario.