(age 18+). The current analysis was limited to respondents from the UK. Individuals who reported having private health insurance were 1:1 matched with those who did not on age, gender and highest education level attained (college graduate vs. no college). Paired t-tests were conducted to assess if any differences existed for continuous variables. For dichotomous variables, odds ratios were calculated to determine the likelihood of an individual with health insurance experiencing comorbidities compared to those without health insurance, and significant differences were tested using McNemar’s chi-square. RESULTS: Of the 1944 respondents with private health insurance, 1925 were matched to controls without health insurance yielding a 99% match. Cases were generally healthier than controls. Cases had higher SF-8 physical summary scores (49.73 vs 47.79, p < 0.001) and SF-8 mental summary scores (49.72 vs 48.39, p < 0.001) than controls. Cases had a significantly decreased likelihood of experiencing angina, COPD, heart attacks, over-active bladder, abdominal bloating, anxiety, emphysema, depression, generalized anxiety disorder, pain, panic disorder and social anxiety disorder. Cases experienced less activity impairment than controls as measured by the Work Productivity and Activity Impairment (WPAI) Questionnaire (19.18% vs. 25.12%, p < 0.001). However, no significant differences were noted for resource utilization between those with and without private health insurance. CONCLUSION: Unique characteristics differentiate those with and without private health insurance in the UK. These differences have ramifications for health policy and health care spending.

**PHP31**

**EUROPEAN PRICING AND REIMBURSEMENT UPDATE: OPTIMAL MONETARY BENEFITS CAN DEPEND ON WHICH COUNTRY THE PROCESS IS INITIATED**

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OBJECTIVES: To demonstrate that in European pricing and reimbursement the benefits of the pharmaceutical industries can be optimised. METHODS: We have examined the reimbursement criteria and drug price establishments of 12 European countries: UK, The Netherlands, Germany, Sweden, Norway, Belgium, Italy, Spain, France, Austria, Denmark and Switzerland. Reimbursement systems were compared across six key reimbursement criteria (clinical efficacy, cost effectiveness, budget impact, foreign price reference, public medical need, value of treatment) and classified into three categories whether a Cost Effectiveness Analysis (CEA) is mandatory, optional or absent. In parallel, two types of pricing system were identified: no pricing reference and reference pricing. We have developed a network model to demonstrate the relative monetary benefits resulting from the pricing and reimbursement systems behaviour. RESULTS: We found that majority of countries determine drug price before the reimbursement decision in order to perform a CEA. However in other countries where CEA are optional or absent, reimbursement decisions generally precede price negotiations. The most important aspect of pricing for all countries except Germany and UK is the price in other reference countries (e.g. the price in France is the average of Spain, Italy, Germany and UK drug prices). Therefore a higher price obtained in Spain could increase the French drug price. Other countries (like Belgium or Italy) set price according to specific country. Pragmatically each country has its own fixed budget allocated to different diseases; therefore a reimbursement and price determination across Europe should be approached strategically to optimise margins and benefits. CONCLUSION: The applications of CEA for decision making have progressed in European countries constraining prices and costs to effectiveness. Nevertheless, in other countries drug prices are more sensitive to public health and are negotiated with public authorities. A European national pricing and reimbursement approach by disease network model could generate optimal monetary benefit for the pharmaceutical industry.

**PHP32**

**OBTAINING VALUE FOR MONEY FROM PHARMACEUTICALS: REFERENCE PRICING OR HEALTH TECHNOLOGY ASSESSMENT?**

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OBJECTIVES: The purpose of the study was to compare and contrast reference pricing with health technology assessment (HTA) as alternative strategies for obtaining value for money from pharmaceuticals. METHODS: The study focussed on decisions about the initial price and reimbursement status of innovative drugs. Four countries were studied: Germany, The Netherlands, Sweden and the UK. These countries have operated one, or both, of the two policies at certain points in time, sometimes in parallel. Drugs in four groups were considered: cholesterol-lowering agents, insulin analogues, biologics for rheumatoid arthritis and atypicals for schizophrenia. RESULTS: Where reference pricing schemes were in operation, all the drugs obtained reimbursement. In addition, all the drugs in the same group were placed in the same cluster. Prices were also similar, with the exception of cholesterol-lowering agents, where some generic agents were available. Where technology assessments had been performed, the use of some drugs (e.g. insulin analogues) was restricted more than the licensed indication. On occasions, technology assessments were used to assess whether a premium price was justified for a given product. CONCLUSION: Compared with HTA, reference pricing is a relatively blunt instrument for obtaining value for money from pharmaceuticals. It may have a role alongside HTA, in making reimbursement decisions about those drugs which, because of resource constraints, cannot be subjected to a technology assessment.

**PHP33**

**RESULTS AND OUTCOMES OF NICE SINGLE TECHNOLOGY APPRAISALS**

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OBJECTIVES: The new Single Technology Appraisal (STA) process introduced by NICE attempts to shorten the process of assessment. The purpose of this study was to review, summarise and critique all of the STAs published to date and to analyse themes and trends. METHODS: A database was developed to collate key data from the STAs completed to date with an initial focus on oncology submissions. Clinical and economic data as well as summaries of all key comments were extracted from the manufacturer submission, evidence review group report, expert submission and the final appraisal determination. Data were then analysed for associations between ICER values, clinical and economic evidence and submission outcome. RESULTS: Since the introduction of the STA process, six STAs have been completed for drugs in oncology. A further 27 STAs are in development, with 10 more in oncology. Three out of the six oncology submissions were considered to have resulted in positive guidance from NICE, recommending the use of the drug in the NHS.