attitudes of physicians in Germany towards telemonitoring. METHODS: In the first step, questions about the entire programme of acceptance were identified using a systematic literature review and transferred to a theoretical effect model. This model was used to create a quantitative questionnaire which was then used to interview online 201 outpatient and inpatient physicians from different fields of medical practice in all German federal states. Pharmacoeconomic aspects (84.8% male, mean age: 57 years) were empirically based economic attributes of telemonitoring regarding its implementation. RESULTS: The results show a lack of information regarding the financial risks of using telemedical technology, as only 14% of those interviewed said they felt sufficiently informed about the subject. Barriers to using telemedicine technology include missing arrangements for reimbursement, uncertain financial advantages and missing business models. In addition, the cost of implementation are indispensable for a broad majority of physicians. On the other hand, physicians reported dimensions the user see a potential financial benefit due to telemedicine. The positive effects expected from telemonitoring were rated much higher by those who already used telemonitoring than the one set by the manufactures, is considered as the official list price since April 1st 2014. The objective of this study is to evaluate the potential impact of this new list price on important economic factors. A simulation model, developed for the European Commission, was used to simulate ERPs impact on Boceprevir and Telaprevir prices after five years, following the discount’s inclusion on the official list price in Germany. ERP impact on price was evaluated in Belgium, France, Germany, Luxembourg, Norway, Slovakia, Slovenia, Sweden, Switzerland, The Netherlands and UK for Boceprevir and in Belgium, Finland, France, Germany, Luxembourg, Norway, Poland, Slovakia, Slovenia, Sweden, Switzerland, The Netherlands and UK for Telaprevir. National policy inputs were obtained from a literature review and consultation of international organisations’ representatives. Prices used at the start of the simulation were obtained from IMS. RESULTS: After five years, the relative price variation of Boceprevir between the same groups is expected to be higher, the first and second years after the discount is integrated in the list price was null in Belgium, Luxembourg, Sweden and UK, of -81% in the Netherlands, -9.2% in Norway, nearly -10% in Czech Republic, France, Slovakia and Switzerland, and -14% in Slovenia. For Telaprevir, the price variation was null in Belgium, Finland, Luxembourg, Slovenia and the UK, of -0.8% in Slovakia, -2.5% in the Netherlands, -2.9% in France and -8.6% in Switzerland. CONCLUSIONS: Integrating AMNOG discount in the list price impacts significantly the price in European countries due to ERPs.

PHP112
EXTERNAL REFERENCE PRICING IMPACT OF THE INTEGRATION OF THE AMNOG DISCOUNT IN THE LIST PRICE

Thielert 1, Getinoisy L1, Vatalier A2, Rémytsz C1, Brunet JF, Korsnfeld A1, Toury M3
1Creation-Creatif, Paris, France, 2Assistance Publique des Hôpitaux de Marseille, Marseille, France, 3Aix-Marseille Université, Marseille, France

OBJECTIVES: In Germany, the AMNOG law replaced free pricing by the early benefit assessment (EBA) since 2011. Manufacturers are free to set new drugs’ prices for up to one year after which the price is negotiated between manufacturers and insurers based on the EBA. The negotiated price, that is consistently lower for up to one year after which the price is negotiated between manufacturers and insurers based on the EBA. In the first four years, the AMNOG discount model was implemented for the European Commission, was used to simulate ERPs impact on Boceprevir and Telaprevir prices after five years, following the discount’s inclusion on the official list price in Germany. ERP impact on price was evaluated in Belgium, France, Germany, Luxembourg, Norway, Slovakia, Slovenia, Sweden, Switzerland, The Netherlands and UK for Boceprevir and in Belgium, Finland, France, Germany, Luxembourg, Norway, Poland, Slovakia, Slovenia, Sweden, Switzerland, The Netherlands and UK for Telaprevir. National policy inputs were obtained from a literature review and consultation of international organisations’ representatives. Prices used at the start of the simulation were obtained from IMS. RESULTS: After five years, the relative price variation of Boceprevir between the same groups is expected to be higher, the first and second years after the discount is integrated in the list price was null in Belgium, Luxembourg, Sweden and UK, of -81% in the Netherlands, -9.2% in Norway, nearly -10% in Czech Republic, France, Slovakia and Switzerland, and -14% in Slovenia. For Telaprevir, the price variation was null in Belgium, Finland, Luxembourg, Slovenia and the UK, of -0.8% in Slovakia, -2.5% in the Netherlands, -2.9% in France and -8.6% in Switzerland. CONCLUSIONS: Integrating AMNOG discount in the list price impacts significantly the price in European countries due to ERP.
OBJECTIVES: Hospital readmissions have been an important issue, as they reflect suboptimal quality of medical care and incur high health care expenditures. However, limited information is available on the patterns of hospital readmission in the entire population to support a thorough planning to prevent hospital readmissions. Therefore, this study aimed to examine the patterns and economic burden of hospital readmission in Taiwan, and identify predictors of hospital readmissions.

METHODS: This study used the National Health Insurance Research Database of insured persons randomly selected from those enrolled in the National Health Insurance program in 2005. Individuals who were admitted to acute hospitals in 2005 were selected and their readmission patterns one-year after discharge were examined. Cox proportional hazards regression model was adopted to identify predictors of hospital readmission.

RESULTS: The 30-day, 6-month and one-year readmission rates were 11%, 25%, and 34%, respectively. During the one-year follow-up, 52% of total health care expenditures were due to hospital readmissions. Of those who were readmitted to hospitals, 56% were readmitted once and took up 29% of the cost of rehospitalization. However, those readmitted for more than three times (5%) accounted for 30% of the cost. The major disease category of the highest 30-day and one-year readmission rates was neoplasms. The disease of the highest 30-day and one-year readmission rates were cancer of bronchus and lung (36%) and cancer of liver and intrahepatic bile duct (74%), respectively, and the most frequent reason for readmission was the disease itself. Age, gender, place of residence, previous hospital readmissions, administration errors and human error were identified as risk factors of hospital readmissions.

CONCLUSIONS: This study identified diseases of higher short-term and long-term readmission rates, causes of short-term and long-term readmissions, and predictors of hospital readmission. The information is of importance for planning interventions to reduce hospital readmission rate.