behavior: diabetics and those with hypertension. METHODS: Analyses are based on a nationally representative sample from the Medicare Current Beneficiary Survey (MCBS) for the years 2000–2005. MCBS is a longitudinal survey and provide detailed information on prescription drug coverage, exercise, weight, diet, alcohol consumption, and smoking behavior. The analysis is restricted to non-institutionalized persons above 64 years of age with at least 2 years of data. We pay particular attention to the non-random nature of prescription drug coverage and the selection bias caused by it. Specifically, estimates are obtained using longitudinal data and multivariable regression models that control for observed characteristics and unmeasured person-specific effects (i.e., fixed effects). RESULTS: An average of 16% of the elderly switched coverage in any two consecutive years, providing sufficient variation in prescription drug coverage to conduct fixed effects analysis. In general, we find limited evidence of prescription drug coverage affecting health behaviors. The lone exception was for those in public programs, where one specification reflected that elderly in the public programs were 13 percentage points (30%) less likely to participate in physical activity than those with no prescription drug coverage after adjusting for health status. CONCLUSIONS: Although, we did not find any evidence of ex ante moral hazard with employer-sponsored and HMO coverage, those in public program altered their behavior significantly upon gaining prescription drug coverage.

PC110
THE POTENTIAL ECONOMIC IMPACTS OF RECONFIGURING TIA CARE IN THE UK
Jackson D1, Begg A2, Moshinsky J3
1GE Healthcare, Bucks, UK, 2Med axial Group, London, UK
OBJECTIVES: The experience of TIA patients in the UK NHS can be quite disparate. Patients presenting to primary care are often referred to a weekly clinic, creating a delay in access to effective treatments for this condition. The recent EXPRESS study by Rothwell et al. (Rothwell, Peter M., et al. Lancet. Online 9 Oct 2007 DOI:10.1016/S0140-6736(07)61448-2) clearly demonstrated that a greater focus on effectively managing TIA could have a significant impact on subsequent stroke rates. We wanted to examine how the implementation of the care pathway outlined in Phase 2 of the EXPRESS study could affect rates of stroke, and to explore the financial implications of such a shift in care. METHODS: We developed an economic model to estimate the costs and savings associated with setting up a rapid assessment and treatment clinic for patients with suspected TIA, in line with Phase 2 of the EXPRESS study. We used a local population of 500,000 people with an assumed annual incidence of TIA of 0.19%. Current management was based on national clinical guidelines and common clinical practice. We included all direct costs associated with care (medications, diagnostics and staff), and modeled the impact of changing management over a three-year time horizon, in line with NHS planning timeframes. RESULTS: For an assumed population of 500,000, changing the pathway of care for TIA management resulted in 295 future stroke events avoided over three years. As a result, the additional costs associated with changing the pathway of care for TIA were greatly outweighed by the savings generated through avoiding acute management costs associated with stroke. CONCLUSIONS: The model suggests that the implementation of the changes outlined in phase 2 of the EXPRESS study is cost saving for a local population of 500,000 with an assumed TIA rate of 0.19%.

PC111
COST ANALYSIS OF DYSLIPIDEMIA TREATMENTS WITHIN THE SLOVAK REPUBLIC
Tesar T1, Foltan V1, Ilavska A2
1Comenius University, Bratislava, Slovak Republic, 2Railway Hospital, Bratislava, Slovak Republic
OBJECTIVES: The aim of this study was to collect comparable and reliable data on the lipid lowering therapy in Slovakia during the period 1996–2006. The special interest was paid to the trend of the statin and fibrate usages. METHODS: Data of wholesalers (following ATC/DDD), who are legally obliged to provide this information to the Slovak Institute for Drug Control, was used for the analysis. The results were expressed in the numbers of the packages, finance units (€) and defined daily doses per 1000 inhabitants per day (DDD). RESULTS: The collected data showed large increases in hypolipidemic consumption from 1996 to 2006 in term of DDD (in 1996 (4.18), in 2001 (16.64), in 2006 (48.80)). A significant increase in statin consumption (in 1996 (1.97), in 2001 (9.76) and in 2006 (39.66) and slight increase in fibrate consumption (in 1996 (3.59), in 2001 (6.76) and in 2006 (7.84)) in term of DDD can be seen from this analysis. From the reimbursement point of view, simvastatin (in 2000 was reimbursed at the level of €0.84 per DDD, in 2006 the reimbursement level was at €0.14), fluvastatin (in 2000 was reimbursed at the level of €0.75 per DDD, in 2006 the reimbursement level was at €0.46), atorvastatin (in 2000 was reimbursed at the level of €0.89 per DDD, in 2006 the reimbursement level was at €0.22). Financial expenditures were for statins (in 1996 (€989,000), in 2001 (€17,636,000) and in 2006 (€15,458,000) and for fibrates (in 1996 (€2,743,000), in 2001 (€5,570,000) and in 2006 (€3,517,000)). CONCLUSIONS: Usage of generic drugs for the treatment of hypercholesterolemia brought about a dramatic increase in hypolipidemic consumption and the financial expenditures for health insurance funds have remained under control.

PC112
STATINS USE IN PATIENTS WITH A RECENT ISCHEMIC STROKE: RESULTS FROM THE STROKE ANALYZER DATABASE
Nasuti P1, Bellity J, Hamad B
1IMS Health, London, UK
OBJECTIVES: Assess the usage of statins in hospital after an acute ischemic event and identify differences across Europe. METHODS: Consecutive patients diagnosed for Ischemic Stroke were analyzed in 2006 and 2007 in Germany, France, Italy, Spain and UK using the Stroke Analyzer database. This was a retrospective study. RESULTS: A total of 4930 Ischemic Stroke cases were enrolled from July 2006 until July 2007. Data were reported from around 300 stroke specialists, neurologists, general medicine specialists. The most common treatments administered in hospital were: aspirin 73%, statins 55%, LMWH 48%, ACE inhibitors 46%, beta blockers 21%, clopidogrel 18%. The majority of the 2726 patients treated with statins in hospital received simvastatin 47%, atorvastatin 40% and pravastatin 8%. The most common simvastatin first doses used were: 40 mg (48%) and 20 mg (42%). The atorvastatin starting doses administered were mainly 20 mg (34%), 40 mg (27%) and 80 mg (16%) atorvastatin (Spain were leading with 25% of atorvastatin patients receiving a start dose of 80 mg). A total of 1023 patients (21%) were already receiving a long term treatment with a statin prior to hospital admission. Despite the fact that 36% of all ischemic stroke patients did not have dyslipidemia, 11% of them were already on statins before the stroke event. Almost 31% of patients already had a previous stroke or TIA event and 13% had a myocardial infarction more than 1 month before the current ischemic stroke event. Treatment with a statin was initiated on the same day of admission to hospital.
in 38% of ischemic stroke patients (46% in Germany vs 22% in Spain). CONCLUSIONS: These data are showing that statins are widely used in the acute setting with significant differences across Europe.

PCV113

PATIENTS WITH ACUTE STE-ELATION MYOCARDIAL INFARCTION: WHO ARE THE “UNTREATED PATIENTS” IN HOSPITALS WITH CATH LAB?

Hamad B, Nasuti PI, Bellity J

IMS Health, London, UK

OBJECTIVES: STEMI patients (pts) presenting <12 h since onset of symptoms should receive reperfusion therapy, which results in important mortality reduction. However, critical presentation timing is not the only factor that influences treatment choice for STEMI pts. In this study we assess the scale at which clinical guidelines are followed in the treatment of STEMI patients presenting within the timeframe of reperfusion therapy.

METHODS: This was a retrospective patient diary study using the IMS Health Acute Cardiovascular Analyzer. The study was conducted in 264 hospitals with Cath-Lab facilities in France, Germany, Italy, Spain and UK. They treated a total of 2553 patients diagnosed with STEMI, during the period of August 2006 and April 2007, with a mean of 10 patients per hospital. Hospitals were selected to be representative by geographic regions, size and facilities in each country. We analysed the data to determine factors associated with patients not receiving reperfusion therapy.

RESULTS: We found 2333 (91%) pts were admitted within 12 hours of onset of symptoms, where 49% had primary PCI, 16% received thrombolytics, 15% received thrombolitics and PCI, 8% had PCI outside the 12 hours reperfusion window, 9% didn’t receive PCI neither thrombolytics, 2% had CABG: We report data from 393 patients who didn’t receive reperfusion therapy and accounts for patients not receiving primary PCI or thrombolitics: 66% had dyslipidaemia, 63% hypertension, 37% CHF, 30% diabetes, 19% age >80, 12% stable angina and 11% with PAD. Also, it was noted that 40% of these patients experienced delay in hospital diagnosis, and thus haven’t received reperfusion therapy within the 12 hours window, 10% were contraindicated to thrombolitics, and 39% were scheduled to receive revascularisation. In-hospital mortality accounted for 14% of the total untreated population. CONCLUSION: This study concludes that 17% of STEMI patients admitted to Cath Lab hospitals within 12 hours of onset of symptoms in Europe don’t receive reperfusion therapy even when catheterization facilities are available.

PCV114

SEARCHING THE OPTIMAL TREATMENT MIX STRATEGY WITH A TREATMENT MIX CHART APPROACH—THE CASE OF CHOLESTEROL LOWERING IN SWEDEN

Martikainen JA1, Soini EJ1, Paulsson T2

1ESiOR Oy, Kuopio, Finland, 2AstraZeneca, Södertälje, Sweden

OBJECTIVES: Different statin dose titration and treatment switching strategies of atorvastatin, rosuvastatin, and simvastatin were compared in the Swedish setting. The objective was to find the optimal treatment mix strategy (i.e. a mix that provides the greatest benefits in terms of cost (£ in 2008 value) per patient treated to target (PTT)) in high-risk patients with elevated LDL-cholesterol (LDL-C). METHODS: A decision-analytic model with Monte Carlo simulation was developed to estimate the expected net benefits of different statin treatment mix strategies. Since it has been demonstrated that the optimal option may not always have the highest probability of being cost-effective for a given value of cost-effectiveness threshold (λ), a new approach, named the optimal treatment mix chart (OTMC), was developed. The OTMC is based on cost-effectiveness acceptability frontiers (CEAF). RESULTS: In the base case (LDL-C = 4.42 mmol/l) and when λ < £350/PTT, the optimal option was to initiate treatment with simvastatin 10 mg and to titrate dose up to the assumed maximum tolerated dose (40 mg) until the treatment target (LDL-C ≤ 2.5 mmol/l) was reached. When £350 < λ < £775, the optimal option was to initiate a treatment mix, where simvastatin was up-titrated to 40 mg and then switched to a higher-potency statin (here rosuvastatin), when needed. When λ > £775 the optimal option was to initiate a treatment with simvastatin 20 mg and then directly switch to rosuvastatin, when needed. CONCLUSIONS: The selection of the optimum treatment mix is conditional on baseline assumptions. OTMC provides a natural and practical graphic tool for presenting the optimal treatment mix at different λ-values under different baseline assumptions (e.g. different baseline LDL-C levels). The majority of Swedish patients will, currently and in real-life, not generally experience dose titration and/or change of statin after treatment initiation. Therefore, rosuvastatin has a central role in a treatment “mix” for high risk patients with the LDL-C exceeding 4.2 mmol/l.

PCV115

ASSESSING THE POTENTIAL BENEFITS OF CHANGING REIMBURSEMENT CRITERIA FOR LIPID LOWERING THERAPY IN KOREA

Kang HY1, Liew D2, Ko S3, Kim J4

1Yonsei University, Seoul, South Korea, 2The University of Melbourne, Melbourne, Victoria, Australia, 3Pfizer Korea, Seoul, South Korea, 4Konyang University, Chungnam, South Korea

OBJECTIVES: To contain health care expenditure, the Korean National Health Insurance (NHI) sets reimbursement criteria for lipid-lowering therapy that are quite strict. We assessed the potential health and economic effects of relaxing the criteria for lipid-lowering treatment in Korea to align with NCEP-ATPIII recommendations. METHODS: A microsimulation Markov model was constructed with yearly cycles and the health states ‘Alive without cardiovascular disease (CVD)’, ‘Alive with CVD’, ‘Dead from CVD’ and ‘Dead from non-CVD causes’. It was populated with CVD-naïve subjects aged ≥55 years from the nationally-representative 2005 Korean NHANES. Follow-up until death or age 99 years was simulated. An Asian-specific risk equation (Wu 2006) was applied to estimate cardiovascular risks. Sex-and-age-specific mortality risks were drawn from national health statistics. Decision analysis compared treatment according to the two sets of criteria. Eligible patients were all prescribedatorvastatin, the lipid-modifying efficacy and costs of which were drawn from a meta-analysis and current drug pricing schedules, respectively. CVD cost estimates were provided by the Korean Health Insurance Review and Assessment Services. A five percent annual discount rate was applied. RESULTS: Nearly three times more Koreans aged ≥55 years would qualify for lipid-lowering therapy if NCEP-ATPIII instead of NHI criteria were to be applied (43.1% vs 15.0%). Compared to treatment under NHI criteria, the treatment of 1000 Koreans aged ≥55 years under NCEP-ATPIII criteria would lead to 38 less cardiovascular events (447 vs 409) and 3195 more QALYs (10,843 vs 7648) over a lifetime. There would be saving of 845 million KW in net costs (9876 vs 10,721 million). CONCLUSIONS: Current criteria for lipid-lowering therapy in Korea are conservative. If NCEP-ATPIII criteria were to be adopted, as in many other countries, significantly more patients would qualify for treatment, but the strategy would represent a more effective and cost-effective way of preventing CVD.