18.6 UKG (14.2–19.6) for patients undergoing urgent surgery, 22.3 UKG (19.2–24.4, n: 41) for patients with overdose. In 66%, a risk factor of overdose was identified: age >75 years (63%), comorbidity (15% like diabetes). The median cost of PCC treatment was 8898/patient ($92-8888) representing 9.3% of the total hospitalisation cost paid by national health insurance for those 91 patients. CONCLUSIONS: PCC was used according to the recommendations and in respect of the health care regulations for reimbursement. The high increase of prescription observed in 2008, mainly in the emergency department (48%), can be explained by a change of medical practices and prescribing behaviour since the new recommendations.

PSY56

SYSTHATIC REVIEW OF THE DIRECT COSTS RELATED TO OBESITY AND ASSOCIATED DISEASES IN POLAND

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OBJECTIVES: According to WHO data approximately 1.6 billion adults are overweight with at least 400 million being obese (BMI > 30). In Western Europe up to 4% of total expenditures on health care are spent on managing obesity and obesity dependent chronic diseases including diabetes, cardiovascular diseases and cancer. The aim of this systematic review was to find studies on direct cost estimates of obesity and its comorbidities in Poland. METHODS: Search and selection of data was based on a protocol developed before proceeding with the search and compilation of data. Two researchers independently assessed publications according to pre-defined inclusion and exclusion criteria regarding to methodological aspects. The review covered the following databases: MEDLINE, EMBASE and PBL. Last update of the search results have been made on May 10, 2009. RESULTS: In the result of the systematic review only 2 studies were found: Seaton et al. 2006 and Krzyza- nowa et al. 2008. In these studies direct costs of treating obesity and associated diseases have been estimated at between 20 to 30% of the total health care expenditures in Poland. Based on OECD data it gives the amount of 8.15 to 12.2 billion USD according to PPP in 2008. CONCLUSIONS: Economic burden of obesity and its comorbidities in Poland is undoubtedly significant. In 4 European countries with obesity prevalence similar to Poland (Portugal, Norway, Belgium, and Sweden), the cost of treating obesity and associated diseases has been estimated at around 0.32% GDP. If the cost of obesity and its comorbidities in Poland amounted also to 0.32% of GDP, total burden of disease could have been estimated at 1.98 billion USD. We conclude that specific Polish data from the two above mentioned studies can be significantly overestimated and there is an urgent need for further research in order to estimate the true value of these costs.

PSY57

REIMBURSEMENT OF INNOVATIVE DRUGS IN SLOVAKIA—PHARMACOECONOMICS OF USTEKINUMAB IN PSORIASIS

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OBJECTIVES: Although health spending is well below the OECD average when considered as a share of GDP, Slovakian pharmaceutical expenditure accounts 32% of total health care budget. The accessibility and availability of innovative drugs is good. Mandatory HTA (pharmacoeconomy) is incorporated in all relevant legislation, MoH set the official threshold by 2011 1 which equals 11% GDP. If the cost and obesity and its comorbidities in Poland amounted also to 0.32% of GDP, total burden of disease could have been estimated at 1.98 billion USD. We conclude that specific Polish data from the two above mentioned studies can be significantly overestimated and there is an urgent need for further research in order to estimate the true value of these costs.

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PSY58

RIMONABANT IN CLINICAL PRACTICE (RCP). A SWEDISH MULTICENTER SURVEY IN PRIMARY CARE

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OBJECTIVES: To describe the prescription pattern of rimonabant in relation to the approved indications and the stated limitations of reimbursement. Secondly to compare the efficiency and adverse effects in rimonabant treated patients with the impact of conventional care in matched controls without rimonabant treatment during a follow up period of up to 12 months. METHODS: The survey was based on retrospective collection of data through a specified extraction and data management method, Pyrguraz Customized eXtraction Program (CXP) developed to extract patient data from an Electronic Health Record (EHR) system (Prodocis Journal III). Centres were selected with a wide socio-economic and geographical spread. RESULTS: Body mass index (BMI) was available in 922 patients out of 1477 (62%). Of those patients, 93% were prescribed rimonabant according to the indication and 79% within the reimbursement criteria. In reality, 97% of the total cohort obtained reimbursement. Patients prescribed rimonabant for at least 6 months showed a mean weight reduction of 6.0 kg after 12 months compared to 0.4 kg in controls. The mean decrease in HbA1c was 0.3% in patients with type-2 diabetes versus 0.0% in controls. More than half of patients and controls (54.4 vs. 54.3 %) had a documented psychiatric illness such as anxiety, depressive disorders or sleep disturbances at baseline. There was no increase in the co-prescription of anticoagulants /sedatives /anti-depressant over time comparing rimonabant treated patients with controls. CONCLUSIONS: The majority of patients were prescribed rimonabant according to the given rules for indication and reimbursement. Weight reduction in the total cohort and reduction of HbA1c in patients with type 2 diabetes during the follow up year, were of similar magnitude as reported in various clinical trials. The safety analysis did not signal any increase in adverse events including psychiatric illness in patients treated with rimonabant more than six months.

PSY59

REVIEW OF RECOMMENDATIONS OF HEALTH TECHNOLOGY ASSESSMENTS ON ORLISTAT AND SUBUTRAMINE

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OBJECTIVES: To review recommendations of Health Technology Assessment (HTA) reports on subutramine and orlistat in the treatment of obesity from France (HAS), UK (NICE, Sweden (TLV), Belgium (ICR) and Canada (CADTH). METHODS: HTA reports were identified by searching each HTA agency’s homepages using “subu- tramine” OR “orlistat” as keywords. Results were categorised as Recommended, Restricted recommended and Not Recommended in comparison to the indication for marketing authorisation given by EMEA. RESULTS: A total of eleven HTA reports were identified; six assessing orlistat and five subutramine. Four HTA-reports on orlistat gave a positive recommendation while the remaining HTA-reports did not recom- mend use/funding. Reasons for not recommending orlistat included; insufficient data to quantify obesity-related morbidity and mortality, uncertainties in compliance due to side effects, treatment effect was not maintained after discontinuation, lack of long term safety data, and poor definition of indications “metabolic syndrome”. For subu- tramine, three reports concluded Recommended, one Restricted recommended and one Not recommended. Reasons for a negative and restricted recommendation included; insufficient data to quantify obesity-related morbidity and mortality, and lack of long term safety data. CONCLUSIONS: Quantity of effect of weight loss on morbidity and mortality, defining an appropriate indication for initiating pharmaco- logical treatment and adequate provision of data on long-term safety and effectiveness appears to be main issues driving a negative recommendation. These issues must be addressed in the development of HTA of new pharmacological treatments of obesity. It is interesting to notice that similar evidences lead to very contradictory outcome reflecting broader way to scrutinize evidences for HTA decision making.

POSTER SESSION III

CONCEPTUAL PAPERS & RESEARCH ON METHODS – Clinical Outcomes Methods

PMC1

CORRECTING AN UNDERESTIMATE OF INCREMENTAL COST EFFECTIVENESS RATIO CONSIDERING STATISTICAL ERRORS AND PROBABILITY OF TRUTH

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OBJECTIVES: To clarify how the standard estimate of incremental cost-effectiveness ratio (ICER) theoretically changes, affected by the uncertainty accompanied with sta- tistical errors and probability of truth in evidence-based practice, and further to investigate how the ‘risk-adjusted ICER (r-ICER) could be used in the analysis of efficiency frontier by IQWiG. METHODS: A decision analysis was performed using: 1) probability of truth, 1 – p, for a null hypothesis (or p for the alternative hypothesis), 2) type I error (α), and 3) type II error (β). The decision tree modeled a patient facing the alternative decisions for treatment: evidence-based (Teb) or conventional (Tc), considering the choices: 1) Teb: if no evidence available about a new treatment A, then the patient takes a conventional treatment B, and 2) Teb: if positive evidence of a clinical trial available, then take the treatment A, whereas if the evidence is negative, take the treatment B. Given a pair of benefit and cost for the treatments A and B, respectively noted as (Ea, Ca) and (Eb, Cb) at the terminal node, then the operations