2012 were analyzed for their ASMR ratings. Analysis were conducted to identify new trends and compare them for products in their indications, comparators and launch timing. **RESULTS:** Analysis of 2011-2012 assessments by TC showed that majority of products (73%) received an ASMR rating of IV (minor improvement). Approximately 27% of the products received an ASMR rating of III and V. A new trend in TC’s assessment is the assignment of two ASMR ratings for one product depending on type or projects. During last year 3 out of 11 products received two ASMR ratings. None of the products received ASMR ratings of I and II. The products that received ASMR rating of V (no improvement) were indicated for cardiovascular, epilepsy and bone metastases. All assessments included an analysis of intervention’s duration, one or more comparators.

**CONCLUSIONS:** France TC’s assessment trends show need for robust comparative effectiveness data to obtain better ASMR ratings, which affects both pricing and market access of new products. Future products would need subgroup analysis to obtain high ASMR ratings for all patient populations.

**PHP35**

**SYSTEMATIC REVIEW OF KEY ISSUES IN ENDOSCOPE REPROCESSING – GUIDELINE ADHERENCE, HEALTH OUTCOMES AND RESOURCE USE**

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**OBJECTIVES:** Safe endoscope reprocessing requires meticulous adherence to guidelines. Human error is a principal cause of deficient reprocessing. Approaches vary from fully manual processes, to semi-automatic reprocessors, or fully automatic reprocessors and others. We assessed issues in endoscope reprocessing related to guideline adherence, health and resource outcomes and staff burden.

**METHODS:** PubMed was searched from January 1, 2007 to March 7, 2012. Search terms: ((Endoscope OR endoscopy) AND (Reprocessing OR Cleaning OR Disinfection OR Bioburden OR Balancing OR Colo-ribal protocol)) were screened by 2 independent reviewers and included according to research areas: 1) adherence to endoscope reprocessing guidelines; 2) endoscope related adverse contamination outcomes and, 3) adverse effects of endoscope reprocessing on staff. Reference lists of key papers were searched. **RESULTS:** A total of 11 studies were included reporting on 60 abstracts. Most studies were conducted in North America (42%), Europe (23%), and Asia (12%). Adherence varied considerably with a trend for less developed health care systems to have poorer adherence. For study question 2, 19 articles reported 7 infection outbreaks, 6 pseudo-outbreaks and 4 toxic reactions related to endoscope procedures. The majority of events could have been prevented if standard reprocessing practices were followed. Eight studies (1 each from Canada, Japan and US and 5 from Europe) considered the impact of device reprocessing on staff health, time, or the associated costs. Two studies reported that manual reprocessing had a significant health impact on staff including respiratory ailments and physical discomfort. One study reported that in a single hospital reprocessing time was 6.2 hours longer per day with manual vs. automated procedures, this had a resultant impact on costs.

**CONCLUSIONS:** Effective reprocessing is vital to ensure safe use of endoscopes. Guideline adherence is variable, and poor standards can lead to adverse outcomes. Manual reprocessing is associated with considerable health burdens for staff. Automated reprocessing could improve guideline adherence and reduce the burden on staff, as well as reduce costs. Further studies in this area are warranted.

**PHP36**


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**OBJECTIVES:** Our goal was to analyze the Hungarian drug reimbursement decisions - through the reimbursement of new molecular entities (NME) in the period of 2007-2011. It was collected from the official drug reimbursement list published monthly on the website of the National Health Insurance Fund of Hungary (NHIF). Drugs with hospital reimbursement were excluded from the analysis, as their reimbursement process differs. There are two ways to reimburse an Rx NME in Hungary: Route A: NHIF is the final decision maker, there is no need for legislative change. Route B: In case of a new restricted indication or a new ATC category a request can be made from the industry to the NHIF. The NHIF will decide whether or not it will be reimbursed. The estimated model parameters differ across countries and products. To explain these differences, we conduct several expert interviews. The theoretical framework is based on the model of the diffusion of innovations by Everett Rogers and the Bass diffusion model.

**METHODS:** Published global POC HTA recommendations were identified and reviewed to provide insights into criteria scrutinized and concerns registered by HTA agencies. **RESULTS:** PCT HTA recommendations were identified included those for cardiovascular, oncologic, pulmonary/allergic, and infectious diseases, and those informing therapeutic or illicit drugs. In assessing PCTHTA, agencies scrutinized criteria generally fitting into four categories of evidence including Testing Logistics, Clinical Validity/Utility, Economic Value/Cost, and Ethical Concerns. For Testing Logistics: agencies scrutinized test turn-around time, platform accessibility and current acceptance, required resources, specimen collection and transport, and result/quality tracking. Clinical Validity/Utility: test performance (e.g., sensitivity, specificity, false positives/negatives) and agreement with/efficacy relative to lab-based tests, and impact on provider decision-making/patient outcomes. Economic Value/Cost: cost-offsets, cost-effectiveness, cost minimization, utility. Ethical Concerns: implications for quality assurance, results, and privacy issues. **CONCLUSIONS:** POC testing approaches hold potential to reduce health care costs while maintaining or improving patient outcomes. Evidence required to support POC HTA should be considered during development of new POC tests to increase the likelihood of achieving reimbursement and market access.

**PHP37**

**NEW CLASSIFICATION OF TRADITIONAL AND INNOVATIVE PHARMACEUTICAL PAYMENT METHODS**

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**OBJECTIVES:** To suggest a new classification of different pharmaceutical payment methods and to analyze the implementation of those methods in different health care settings of IQ Partners’ Countries. This division will facilitate the comparative analysis of the impact of different payment methods on health care costs, efficiency, quality and equity. **METHODS:** Data on pharmaceutical payment methods were obtained through a review of the available literature. The search included relevant economic and medical databases, journals and books, conference materials and reports on the development of pharmaceutical payment methods. A total of 12 studies were included, from publications (95 positions) and classified. The implementation of those methods in different countries was also described. **RESULTS:** The practical classification of pharmaceutical payment methods was based on two main categories: traditional (well established and used) and innovative (implemented in recent years, depending on the country). A sub-classification was also outlined, related to the regulatory mechanisms of the methods in question: market driven, administrative regulations and market mechanisms with administrative settings (mixed). The traditional and payment methods and schemes include: "free" or "payment less", fixed prices, flexible prices, fixed budget, reference pricing, margins, rebate agreements, bonus agreements and patient’s co-payment. The innovative payment methods include price volume agreements, cross-product agreements, risk-sharing, value-based pricing, framework agreements, cost-plus pricing, patient access schemes, portfolio deals, one price per patient, disease management. The second group was sub-sequently introduced in selected countries, including UK and US with a trend to be used in other countries (e.g. Poland). **CONCLUSIONS:** Innovative payment methods allow risk-sharing both related to costs and outcomes creating an additional platform for a dialogue between authorities and producers.