costs calculation in economic evaluations, measures used to calculate indirect cost, and difficulties while performing indirect costs estimation. Questionnaires were handed out to participants of the 3rd International Symposium Evidence-Based Health Care in Cracow, mailed to the Polish Pharmaceutical Society members and distributed directly to providers, health economists and decision-makers returned completed questionnaires. Mean age of respondents 33,3 ± 7,6 years; mean experience in health economics 4,7 ± 5,2 years; 43% (23/54) of responders had no economic background, 41% (22/54) reported government as a work environment. The best method to estimate cost from societal perspective identified. Indirect cost could be calculated in pharmacoeconomic studies (strongly agree 58%, agree 40%). Experts pointed out that indirect cost were calculated in only 24% of reports and presented on average 22% of total costs. Twenty three (i.e. 43%) responders indicated human capital approach as the best method to estimate cost from societal perspective. The cost method came second best 11% (6/53); 42% (22/53) responders had no opinion. The doers of economics evaluations pointed to GDP per capita (11/18), average salary (11/18), and costs of sick pay or injury benefit (11/18) as measures which should be used to calculate productivity losses. CONCLUSION: Indirect costs are considered important but seldom executed component of economic evaluations of health care interventions in Poland. The lack of consensus and widely accepted methods for indirect cost evaluation support further research.

ANALYSIS OF TRANSFERABILITY TOOLS FOR COST-EFFECTIVENESS DATA AND CONSIDERATION IN KOREA SETTINGS

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OBJECTIVES: Through the increase of economic evaluation studies in Korea, the question of transferability from different settings is becoming more and more important. However, there are some factors that may limit the transferability of studies such as variations in the epidemiology, relative pricing and the availability of health care resources. Already published by Welte, Boulenger and Udahl, transferability tools are useful and easy to check the transferability among countries. This study assessed the transferability with these tools from other settings to Korea settings.

METHODS: With three selected articles conducted in Belgium, Sweden and USA, we evaluated the transferability to Korean settings using 3 methodologies (Welte, Boulenger and Udahl) and then identified those factors that can be appropriate to adapt in Korea settings. RESULTS: In case of Welte, Belgium and US study showed low correspondence for disease incidence like 0.4% vs. 0.01% in THR. And Sweden study showed different case-mix that the average age of TKR patients were higher than THR but Korea case was opposite. According to Boulenger method, the scores for Belgium, Sweden and US studies were 51.5, 51 and 75% respectively. Low scores came from the discount and cost mainly due to insufficient description. With Udahl method, three studies well expressed for decision maker, but Belgium and Sweden studies did not describe the clinical research enough. The United States study explained in detail for the transition probabilities and modeling but the unit price and resource use were not related to Korea setting directly due to different pricing system. CONCLUSIONS: Through this evaluation, disease incidence, unit price and resource use showed low transferability in order to transfer to Korea. We could find out that data and methods should be presented in a transparent way to improve transferability.

EVALUATING AN ONLINE INCREMENTAL COST-EFFECTIVENESS CALCULATOR STRUCTURED AS A DECISION ANALYTIC TREE THAT IMPLEMENTS MONTE CARLO SIMULATIONS OF KEY VARIABLES

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OBJECTIVES: To evaluate an online, freeware, incremental cost-effectiveness calculator that generates and plots results from a decision tree that utilizes Monte Carlo simulations.

METHODS: An online cost-effectiveness calculator and plotter were developed that incorporates a decision tree structure with Monte Carlo simulations to compare two interventions. This decision analysis calculator is available at www.healthstrategyst.com. This online tool uses JavaScript algorithms and was based on an MS Excel model description published by Hughes D. His spreadsheet can be downloaded from www.liv.ac.uk/pg/model.xls. For this evaluation, the spreadsheet structure was modified slightly to match the more basic online tree. Log-normal and beta distributions are generated from variable inputs that can be modified in the web-based software that cover costs, utilities and probability of both success and failure for two treatment alternatives. RESULTS: The online calculator functions on most computer operating systems with JavaScript enabled browsers. The web-based tool creates a scatter plot of incremental costs versus incremental utilities in cost-effectiveness quadrants, and also graphs a cost-effectiveness acceptability curve. Although the min-max range of incremental costs versus incremental utilities in cost-effectiveness quadrants, and also graphs a cost-effectiveness acceptability curve.

IMPLEMENTING A BENCHMARKING MODEL FOR EXPENDITURES OF PRESCRIPTION DRUGS IN AUSTRIA

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OBJECTIVES: Since 2005 Austrian regional sickness funds have been facing an increase in drug prescription costs of 7–8 % per year. In order to analyze these costs we developed a benchmarking system comparing drug prescription costs for 2007 of the regional sickness funds including two ratios split into a price and a volume measurement. To estimate the ratios at the high level ATC level revealed problems: The total savings potential seemed unrealistically high and could not be traced back to a specific field of action. Therefore, the need for a re-design of the benchmarking system was more than necessary. METHODS: Since the cost-function is interpreted as a function of the distribution of prescriptions, price effects can be shown by adjusting the distribution. This is equivalent to shifting prescriptions from specific drugs to others within a cluster. To legitimize this new method, the volume component of each sickness fund is normalized to the average level of prescriptions per beneficiary (ATC level 2), considering the fund’s distribution of prescriptions in lower ATC levels. The process of clustering starts with substitutable drugs according to the national eco-list. After that these clusters are combined to groups at first ATC level 5 and then ATC level 4. Within these groups the distributions of the funds’ costs are adjusted to the benchmark fund’s distribution. RESULTS: In case of Welte, Belgium and US study the min-max range of incremental costs versus incremental utilities in cost-effectiveness quadrants, and also graphs a cost-effectiveness acceptability curve. Although the min-max range of incremental costs versus incremental utilities in cost-effectiveness quadrants, and also graphs a cost-effectiveness acceptability curve. Although the min-max range of incremental costs versus incremental utilities in cost-effectiveness quadrants, and also graphs a cost-effectiveness acceptability curve.