results show that cost-effectiveness studies constituted 15%, 12% and 7% of all abstracts presented at ISPOR, iHEA and HTAi respectively. Non-drug technologies with a traditional PPRS system to a value-based pricing (VBP) scheme in the UK was investigated with.

METHODS: The OFT VBP system has its aim to incentivise the industry and reduce reimbursement decision uncertainty. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness, a premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.

VALUE BASED PRICING IN THE UK: A PRICE-QUANTITY MODEL
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OBJECTIVES: Due to the financial crisis Greece was forced to implement hard cost containment measures almost in all fiscal sectors. The objective of the study is to investigate the economic impact emerging from the initiation of controls in prescriptions implemented in the Greek social security funds as of 1 January 2010 to 30th April 2010. METHODS: The data derive from the drug reimbursement database of the three biggest social security funds of Greece from January to April 2010 comparing with the same period of the previous year. The three security funds of the analysis cover about 90% of the Greek population with almost 10 million fully insured members. The security funds in scope were followed: IKA which covers the private sector with 6.3 million insured members; OPAD covering the public sector with 1.5 million insured members and OGA for agriculture with 2 million insured patients. RESULTS: In the first four-month period of 2010 form the initiation of the prescription control scheme the pharmaceutical expenditure was the following: for IKA €747 million in comparison to 716 million the same period in 2009. A difference of 4.3%, for OPAD 172 million for 2010 while in 2009 the expenditure was 203 million, with savings of 15% and for OGA in 2010 was 310 million and the same period in 2009 the amount reimbursed for medicines was €288 million with 7.6% growth. It should be highlighted that although for IKA and OGA the pharmaceutical expenditure is higher in 2010 in comparison to 2009, still the growth of expenditure follows a downward slope, 2008-2009 14.82% for IKA and 11.64% for OGA respectively. CONCLUSIONS: The new cost containment measures implemented in the Greek health care sector started presenting results. Other cost containment implemented measures were price cuts for all medicinal products in May 2010 and reduced supply prices for sanitary products.

VALUE BASED PRICING IN THE UK: A SURVEY-BASED APPROACH
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OBJECTIVES: In the wake of the 2007 Office of Fair Trading (OFT) Pharmaceutical Price Regulation Scheme (PPRS) market study there is a debate whether the UK should switch to a value-based pricing (VBP) scheme. The OFT VBP system aims to price pharmaceuticals in line with their clinical effectiveness. METHODS: The switch from the traditional PPRS system to a VBP scheme in the UK was investigated with regards to the two main PPRS objectives cost containment and value for money. The study was carried out by modifying and applying a price quantity setting model (Das, 1980) to fit the UK pharmaceutical market and investigate the capital-labour ratio of a firm. The quality of abstracts is not satisfactory for informed decision-making. A systematic literature review was also carried out for all the above mentioned topics. RESULTS: In the interviews the current PPRS system was seen as very beneficial with high transparency and stability, nevertheless lacking mechanisms promoting price competition when compared to the VBP system. The main concern with a switch to a VBP system was the risk of a global price lock-in. Since the UK is directly or indirectly influencing pricing decisions within about 25% of global pharmaceutical consumption, the industry might delay drug launch in the UK, to maintain global pricing flexibility (e.g. in the advartisement setting). Risk-sharing agreements were found to be one possible solution to maintain global price flexibility for the industry, whereas ensuring the NHS pays a fair price. The interviewed were unanimous about establishing an organization separate from any political influences needs to handle the pricing decision to avoid conflicting incentives. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness. A premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.

HAS THE QUALITY AND OUTCOMES FRAMEWORK INFLUENCED PRIMARY CARE DATA RECORDING?
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OBJECTIVES: The Quality and Outcomes Framework (QOF) was introduced in the UK in April 2004. The scheme financially rewards practices for providing quality care and this is evaluated based on electronic medical records. This study therefore evaluated whether data recording changed after QOF was introduced. METHODS: Patients were selected from The Health Improvement Network (THIN) database, which holds long-term anonymised primary care records from >450 UK practices. Patients were grouped according to whether they ever had 21 or 15 chronic QOF diseases. Percentages of patients with ≥1 general practice (GP) visit, smoking status, blood pressure (BP) and weight record were estimated throughout nine 12-month time periods (January 4, 2004-January 4, 2009). T-tests compared mean percentages before and after QOF introduction (January 4, 2004). RESULTS: Percentage of QOF patients ranged from 26.6% to 32.9% over time and non-QOF patients from 67.1% to 73.4%. The average percentage of QOF patients with a GP visit was 80.5% (standard deviation SD3.2) before QOF and 84.5% (SD0.9) after QOF (p = 0.036). These percentages were 57.5% (SD3.5) and 62.0% (SD0.6) (p = 0.082) for non-QOF patients. The average percentages for smoking recording were 26.8% (SD12.9) versus 55.9% (SD3.0) (p = 0.018) for QOF patients and 10.9% (SD4.8) versus 22.3% (SD2.9) (p = 0.001) for non-QOF patients. For BP recording, 53.6% (SD6.7) versus 68.1% (SD4.8) (p = 0.013) for QOF patients and 20.5% (SD2.9) versus 24.2% (SD0.9) (p = 0.084) for non-QOF patients. For weight recording, 25.5% (SD5.4) versus 40.4% (SD3.2) (p = 0.006) for QOF patients and 7.8% (SD1.7) versus 14.8% (SD1.7) (p = 0.001) for non-QOF patients. For QOF patients, 83.0% of QOF visits and clinical recording increased after QOF was introduced, although there was a evidence of a difference for GP visits or BP in non-QOF patients. This suggests that QOF influenced recording, especially the recording of the evaluated clinical measures for patients with chronic QOF diseases.