analyses. The adoption of Sherlock 3CG® TCS was predicted to be more or less cost neutral per patient when compared with "blind" bedside in both the U.K. ($9.37) and the U.S. ($18.73). Further, Sherlock 3CG® TCS was predicted to be cost-saving per patient compared with fluoroscopy in the U.K. (£6,128 vs. SoC) and the U.S. ($3,275 with EVARREST® vs. SoC). The hospital analysis predicts further resource reduction with EVARREST® leading to cost impact of €608 per patient. In coagulopathic patients, the beneficial effect of EVARREST® was magnified, with the surgical and hospital analysis both showing cost-savings of €542 and £3,275 with EVARREST® vs. SoC respectively. CONCLUSIONS: In problematic bleeding situations, EVARREST® may result in important cost savings for hospitals, in addition to meeting an important unmet clinical need. EVARREST® may provide a more cost-effective type, with increased benefit seen in challenging (i.e., coagulopathic) bleeding patients. Further study is needed to confirm findings.

ECONOMIC ANALYSIS OF EVARREST SEALANT MATRIX COMPARED WITH STANDARD OF CARE IN SEVERE SOFT TISSUE SURGICAL BLEEDING: AN ITALIAN HOSPITAL PERSPECTIVE

Jamous N1, Socievole G2, Ferko N3, Hogan A4, Corral M4
1Ethicon Biosurgery, Berkshire, UK, 2Johnson & Johnson Medical Spa, Rome, Italy, 3Cornerstone Research Group Inc., Burlington, ON, Canada, 4Ethicon Biosurgery, USA, Somerville, NJ, USA

OBJECTIVES: Although several hemostats are available, drawbacks include limitations with efficacy and ease-of-use. Despite their use, uncontrolled bleeding still remains common and is associated with important clinical and economic burden. A study was conducted to estimate the economic impact of a novel fibrin sealant matrix (EVARREST®) versus standard of care (SoC) in problematic severe soft tissue surgical bleeding in Italy. METHODS: An economic model quantified 30-day cost impact of EVARREST® from a German hospital perspective. Severe soft tissue bleeding situations as they make decisions for their own. These data are likely to have a significant impact on how hospitals acquire and purchase medical devices and consumables. Other institutions, however, are not able to leverage the same purchasing power, resulting in higher prices and financial inefficiencies. The objective of this work was to measure the financial impact to a broad spectrum of hospitals using real-world German hospital purchasing and consumption data. METHODS: GIK Hospital Panel, a proprietary database for German hospital medical devices and consumables purchasing and consumption was evaluated. Ward care purchasing data was evaluated to see similarities in purchase patterns, acquisition costs, and utilization. Products used to promote infection control and healing in post-surgical sites were prioritized. RESULTS: The hospital purchasing and consumption data identified how specific products were used within and across hospitals. Differences in purchasing and consumption were being concentrated in different settings. Hospitals with greater buying power and those with access to group purchasing organizations paid less per unit price than other hospitals, however the mix of products used varied by setting. Advanced wound care products had the greatest variability in usage among hospitals within the sample.

CONCLUSIONS: Databases that provide detailed hospital purchasing data provide greater transparency to help hospitals make better purchasing decisions. Advanced wound care products had the greatest variability in usage among hospitals within the sample.
Khany-Manzi Autonomous Okrug – Yuga. METHODS: The study consisted of three steps: 1) selection of patients, who were trained in using the complex of telemedicine in chronic obstructive pulmonary disease (COPD) and asthma patients may be associated with a poor intake of medication and, consequently, in a reduction of adherence and worsening in pathology control. Aim of this analysis is to estimate the possible economic impact on Italian National Health Service (INHS) budget for patients with heart valve disease without adequate training. METHODS: An Italian observational study on patients with COPD and asthma, highlights higher healthcare resource consump- tion associated with heart valve disease, particularly signiﬁcantly higher rates of hospitalizations, emergency room (ER) access and pharmacological treatment (ster- oids and anticoagulants) were observed. These differences in resource consumption were monetized from the INHS perspective considering national DRGs tariffs for hospitalization and unit price for drugs and medical devices. RESULTS: Comparing a population of 100 COPD patients with at least a critical error in inha- lation with 100 COPD patients without errors in inhalation, the ﬁrst population is as follows: more hospitalization and hospitalization costs, more chronic obstructive pulmonary disease courses and 47 corticosteroids courses. In the same way, if we compare 100 asthma patients with at least a critical error in inhalation with 100 asthma patients without errors in inhalation, the ﬁrst population is associated with an increase in healthcare resource consumption and costs in COPD and asthma patients.

PMD145

TURKISH REIMBURSEMENT SYSTEM FOR MEDICAL DEVICES

Ozdemir AZ, Erdol S, Can H Medtronic, Inc., Istanbul, Turkey OBJECTIVES: A cost-consequence model (hospital perspective) of a recent study to elaborate on the Turkish medical devices (MDs) reimbursement system. METHODS: Health Implementation Communiqué (SUT), MD Reimbursement Guidelines and National Data Bank of Medicines and MDs (TITUBB) are analyzed. RESULTS: Ministry of Health (MoH) is responsible for reimbursement of MDs and their post-market follow-up (PMF), including safety issues. The study was performed for the years 2009-2013. RESULTS: A multi-year MDs reimbursement study was launched which will not allow manual reimbursement approval and all code-paths will be automated. Sensitivity analysis was performed to analyze changes in results when the application type: For a new code or a new title creation, health-economics and clinical evidence are required. For matching to an existing code and applying for minor technical changes like barcode and label name of a product basic clinical data and MoH approval is sufﬁcient. However C and D type are not processed currently due to existing TITUBB, joint data bank of MoH and SIS, allowing manufacturers to match products to existing SUT codes manually. A new system is planned to be launched which will not be automated in reimbursement because no code-matchings will be evaluated by SIS with respect to above-mentioned Guideline. As neither the timeline for new system activation nor the evaluation criteria of new system were listed up to now, reimbursement evaluation processes are not fully-transparent and predictable. CONCLUSIONS: MD reimbursement decisions are lim- ited to basic safety, efﬁcacy and clinical evidence. Due to existing generic listing practice, quality- or brand-based differentiation in reimbursement is not applied and price-differentiation for innovative and high-quality products does not prevail.

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MEDICAL DEVICES – BREAST FORMS. COST AND QUALITY CHARACTERISTICS OF MEDICAL DEVICES IN SLOVAKIA 2009 – 2013

Mariankova D, Malovecka I, Foltan V Comenius University, Bratislava, Slovak Republic OBJECTIVES: Reconstruction techniques after a mastectomy have improved greatly in recent years, with much more natural results. Even so, a third of women choose not to have reconstruction. They turn to breast forms medical devices (MDBF). MDBF are reimbursed from Health insurance funds, but for MDBF with higher functional properties, there is a presence of higher patient co-payment. METHODS: The target of the work was to analyse the data from paid databases of Slovak authority National Center for Health Information that collects the outputs of provided health care. The data were focused on totally or partly reimbursed medical devices (MD) from public health insurance funds. The selected group was medical devices for people after mastectomy – breast forms. The most recent data were from 1. 1. 2009 – 31. 12. 2013. It was used basic and advanced statistic processing by Microsoft Excel. RESULTS: Referring to the National Center for Health Information, in the observed period, the share of MDBF on total consumption of MD stapediated (MDBF/MDBF2009=0.0039%); MDBF increases from 2009-2013. – 0.02% in 2009-2013. – 0.02%; in 2009-2013. – 0.03%; in 2009-2013. – 0.04%; in 2009-2013. – 0.05%; in 2009-2013. – 0.06%; in 2009-2013. – 0.07%; in 2009-2013. – 0.08%; in 2009-2013. – 0.09%; in 2009-2013. – 0.10%; in 2009-2013. – 0.11%; in 2009-2013. – 0.12%; in 2009-2013. – 0.13%; in 2009-2013. – 0.14%; in 2009-2013. – 0.15%; in 2009-2013. – 0.16%; in 2009-2013. – 0.17%; in 2009-2013. – 0.18%; in 2009-2013. – 0.19%; in 2009-2013. – 0.20%; in 2009-2013. – 0.21%; in 2009-2013. – 0.22%; in 2009-2013. – 0.23%; in 2009-2013. – 0.24%; in 2009-2013. – 0.25%; in 2009-2013. – 0.26%; in 2009-2013. – 0.27%; in 2009-2013. – 0.28%; in 2009-2013. – 0.29%; in 2009-2013. – 0.30%; in 2009-2013. – 0.31%; in 2009-2013. – 0.32%; in 2009-2013. – 0.33%; in 2009-2013. – 0.34%; in 2009-2013. – 0.35%; in 2009-2013. – 0.36%; in 2009-2013. – 0.37%; in 2009-2013. – 0.38%; in 2009-2013. – 0.39%; in 2009-2013. – 0.40%; in 2009-2013. – 0.41%; in 2009-2013. – 0.42%; in 2009-2013. – 0.43%; in 2009-2013. – 0.44%; in 2009-2013. – 0.45%; in 2009-2013. – 0.46%; in 2009-2013. – 0.47%; in 2009-2013. – 0.48%; in 2009-2013. – 0.49%; in 2009-2013. – 0.50%; in 2009-2013. – 0.51%; in 2009-2013. – 0.52%; in 2009-2013. – 0.53%; in 2009-2013. – 0.54%; in 2009-2013. – 0.55%; in 2009-2013. – 0.56%; in 2009-2013. – 0.57%; in 2009-2013. – 0.58%; in 2009-2013. – 0.59%; in 2009-2013. – 0.60%; in 2009-2013. – 0.61%; in 2009-2013. – 0.62%; in 2009-2013. – 0.63%; in 2009-2013. – 0.64%; in 2009-2013. – 0.65%; in 2009-2013. – 0.66%; in 2009-2013. – 0.67%; in 2009-2013. – 0.68%; in 2009-2013. – 0.69%; in 2009-2013. – 0.70%; in 2009-2013. – 0.71%; in 2009-2013. – 0.72%; in 2009-2013. – 0.73%; in 2009-2013. – 0.74%; in 2009-2013. – 0.75%; in 2009-2013. – 0.76%; in 2009-2013. – 0.77%; in 2009-2013. – 0.78%; in 2009-2013. – 0.79%; in 2009-2013. – 0.80%; in 2009-2013. – 0.81%; in 2009-2013. – 0.82%; in 2009-2013. – 0.83%; in 2009-2013. – 0.84%; in 2009-2013. – 0.85%; in 2009-2013. – 0.86%; in 2009-2013. – 0.87%; in 2009-2013. – 0.88%; in 2009-2013. – 0.89%; in 2009-2013. – 0.90%; in 2009-2013. – 0.91%; in 2009-2013. – 0.92%; in 2009-2013. – 0.93%; in 2009-2013. – 0.94%; in 2009-2013. – 0.95%; in 2009-2013. – 0.96%; in 2009-2013. – 0.97%; in 2009-2013. – 0.98%; in 2009-2013. – 0.99%; in 2009-2013. – 1.00%.