Drug Interaction Facts: RESULTS: A highly significant difference was observed between the prevalence of pDDIs in prescriptions from hospital (45%; 180 out of 400 prescriptions with at least 1 pDDO) and community pharmacies (29.1%; 17 out of 400 prescriptions with at least 1 pDDO). On the whole, out of total 543 pDDIs (hospital = 337; community = 206) majority of them were of delayed onset (hospital = 50.4%, 171 out of 337; community = 47.5%, 99 out of 206). Non-suspected type (hospital = 31.2%), suspected type (hospital = 27.6%) and possible documentation (community = 14.08%) were among the most frequent types of pDDIs in hospital and community pharmacies. Clinical practices must be standardized as rational prescribing practices.

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**UNMET HEALTH NEEDS OF IMMIGRANTS LIVING IN GREECE DURING THE ECONOMIC CRISIS: THE LONG-TERM IMPACT FOR THE HEALTH CARE SYSTEM**

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OBJECTIVES: To examine access of migrants in health care services, their unmet health needs, and the factors associated with these. METHODS: A cross-sectional pilot study among a community sample of 156 people was conducted in January to May 2013. The study consisted of 231 recent immigrants living in Greece. A questionnaire was developed including information about demographics, health status, difficulties in health services access etc. Statistical analysis included Pearson’s x2 test, x2 test for trend, student’s t-test, analysis of variance and Pearson’s correlation coefficient. RESULTS: 12.9% of the participants (n=115, 49.7%) used public health services in the last 12 months in Greece. Among them, 56.8% (n=131) used emergency department services. A considerable proportion of the participants (n=144, 62.3%) during the last year, needed at least one time to use health services but they could not afford it. The most important reasons for that were high cost of health care (n=80, 34.5%) and the long waiting times (n=92, 32.6%). More than half of the participants (n=122, 52.9%) reported that they had major difficulties in accessing health services. Increased monthly income was associated with decreased difficulties in access in health services (x2 test for trend: p<0.01). The use of preventive services has been limited since more than 60% of the women 60+ reported not having conducted a pap test or a mammography, while more than 30% of the respondents were not subjected to a blood test or a cholesterol test. CONCLUSIONS: Barriers to health services access for migrants may lead to decreased use of health services, especially primary and thus lead to increased hospitalizations and higher costs in the long run. A compilation of policies to improve access and use of health care services are necessary.

**P**H**P52**
**IMPORTANCE OF SUBGROUP ANALYSES FOR HEALTH TECHNOLOGY ASSESSMENTS**

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OBJECTIVES: Cost-effectiveness analyses can play a critical role in determining coverage of novel drugs and devices. Increasingly, payers are demanding subgroup analyses to determine indications which would be covered by the national health system or community pharmacies. Clinical practices must be standardized as rational prescribing practices.

**P**H**P53**
**CHRONIC PATIENTS’ ACCESS TO PHYSICIAN SERVICES IN TIMES OF ECONOMIC CRISIS**

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OBJECTIVES: To explore the magnitude of certain access barriers to physician services that chronic patients are in front of as well as which patients are more vulnerable to these barriers. METHODS: A national study was conducted in 1600 chronic patients suffering from diabetes, hypertension, COPD and Alzheimer. Logistic regression analysis was carried out in order to explore the factors related to economic and geographical barriers in access, as well as the determinants of barriers imposed by waiting lists. RESULTS: A total of 25% of chronic patients face geographical barriers while 63.5% and 58.5% of them are in front of economic and waiting list barriers respectively. More likely to face economic barriers in access are unemployed patients (OR 0.55; 95% CI [0.1, 1.1]) and patients with low income (OR 0.26; 95% CI [0.13, 0.45]) and lower educational level (OR 0.4; 95% CI [0.2, 0.8]). Women (OR 0.4; 95% CI [0.20, 0.42]), low-income patients (OR 0.13; 95% CI [0.02, 0.03]) and patients with lower health status (OR 1; 95% CI [0.02, 0.03]) are more likely to be in front of geographical barriers in access. Moreover, all occupational categories examined, demonstrate a statistically significant positive relationship with the probability of encountering difficulties in accessing health services. In addition, unemployed patients (OR 0.51; 95% CI [0.16, 1.5]), public or private sector employees (OR 4.5; 95% CI [0.09, 0.81]) and low income patients (OR 0.086; 95% CI [0.15, 0.02]) are more likely to deal with barriers attributed to waiting lists. CONCLUSIONS: Chronic patients face extensive barriers in access, which can mainly be explained by the fall of the income, the rise of unemployment and the policy of decreasing the supply of certain health services in order to reduce health expenditure. If such barriers won’t be minimized inequalities will be enlarged and the quality of chronic patients’ health care might lead to increased future costs and adverse effects on health expenditures.

**P**H**P54**
**QUALITY ASSURANCE OF FOURTH HURDLE CONCERNING TO DRUGS AND MEDICAL DEVICES**

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OBJECTIVES: From 2011, there are basic thresholds (1-24 x average monthly salar y = r / QALY and 2.5 – 3.5 x average monthly salary = r / QALY) defined directly in the Slovak legislation reflecting the status of the National health care system when funds are allocated to new medicines and medical devices. For example, the main objective of this study was to analyse the quality of submitted economic studies, relative cost effectiveness appraisals and predictions of the needs and access to medicines and medical devices. METHODS: We created a working group to review previously submitted economic evaluations and related critical appraisals in order to understand the use of subgroup analyses and the use of the new legislation to access new medicines and medical devices. RESULTS: A high number of the European countries which have the potential to make a difference for patient care. A number of challenges appear to still be present and it will be important to address these in order for the new legislation to be effective. The concept “the QALY is a tool not a rule” was slightly modified in Slovakia. Our analysis shows that implicit thresholds have been included into the Slovak legislation have influenced decision making process concerning to drugs and medical devices. In the defined time period 4 drugs exceeded the basic thresholds described in the Slovak legislation, however 108 drugs and medical devices were refused to include into the reimbursement list because of the poor quality of provided phase III and IV double blinded studies. CONCLUSIONS: The transparent method of HTA can improve the consistency of reimbursement decisions making related to drugs and medical devices in Slovakia. However significant improvements in the quality of submitted pharmacoeconomic dossiers have to be the first step towards the better access to drugs and medical devices for the Slovak patients.

**P**H**P55**
**THE HYBRID PURCHASER-PROVIDER SPLIT IN ENGLAND: SHOULD EUROPE FOLLOW SUIT?**


OBJECTIVES: Countries have embraced the purchaser-provider split as a mechanism to improve health and care by allowing competition and introducing the performance of Clinical Commissioning Groups (CCGs) as both buyers and providers of health services a hybrid purchaser-provider model is being explored. This research explored the opportunities and challenges of this model and analysed the implications for NHS England and the four devolved nations – England, Wales, Scotland and Northern Ireland. METHODS: The study utilized a comprehensive review of the peer-reviewed and grey literature, a scoping review of previous submissions and critical appraisals, concerned to chosen ATC groups of drugs and groups of medical devices, published between June 2012 and June 2013 at the website of MoH. RESULTS: Pharmacoeconomic evaluations of drugs and medical devices were a common methodology used. Double blinded studies – Prescribing within a defined time period 4 drugs exceeded the basic thresholds described in the Slovak legislation, however 108 drugs and medical devices were refused to include into the reimbursement list because of the positive critical appraisals of subgroup differences, the poor quality of submitted studies – Prescribing within a defined time period strategies are mandatory but the quality of studies are very often rather poor. The concept “the QALY is a tool not a rule” was slightly modified in Slovakia. Our analysis shows that implicit thresholds have been included into the Slovak legislation have influenced decision making process concerning to drugs and medical devices. In the defined time period 4 drugs exceeded the basic thresholds described in the Slovak legislation, however 108 drugs and medical devices were refused to include into the reimbursement list because of the poor quality of provided phase III and IV double blinded studies. CONCLUSIONS: The transparent method of HTA can improve the consistency of reimbursement decisions making related to drugs and medical devices in Slovakia. However significant improvements in the quality of submitted pharmacoeconomic dossiers have to be the first step towards the better access to drugs and medical devices for the Slovak patients.