with ADRs to oral anticoagulants. We selected data on hospital admissions due to ADRs or oral anticoagulants (the ICD-9-CM code E934.2: coumarin, phenindione, hepa-
rin, protrombin synthesis inhibitors, and warfarin sodium) from any diagnostic field during the study period. We calculated the number of hospitalizations per year, the mean length of stay, the Charlson comorbidity index, and the frequency of atrial fibrillation and thromboembolism. Robustness of study results were tested by comparing proportions of the conditions associated with ADRs to oral anticoagulants included atrial fibrillation (63.16%) and thromboembolism (2.45%). In 2013, the Charlson comorbidity index was 2.1 in 23.29% of patients. The median hospital stay was 8 days (IQR, 13), and 5,162 patients (10.32%) died during their stay in hospital. CONCLUSIONS: The overall number of hospitalizations increased with each 5-year period. For example, in colorectal cancer, clinical trial publications increased two-fold from 2,187 (1996–2000) to 4,838 (2011–2015). There was a 2.5-fold increase in diagnostic study publications from 2011 to 2015. Women accounted for 52.68% of patients admitted for colorectal cancer, and 51.62% admitted for atrial fibrillation.

OBJECTIVES: Our study aimed to analyze the use of the different types of criteria (Economics, Disease description, Prevalence, Evidence quality, Social and ethical factors and Other criteria) used in multi-criteria decision analysis (MCDA) studies in Central and Eastern European (CEE) countries. The aim of our study was to review published MCDA models to identify the key elements and challenges faced by policymakers and health-care payers when performing systematic literature reviews (SLRs). METHODS: A systematic approach was used to identify MCDA models. Two authors (first and last authors) searched Medline (via OVID) to identify the size of the literature, broken down by study design and time period (1996–2000, 2001–2005, 2006–2010, 2011–2015). The selection criteria were as follows: Studies that used MCDA models to support reimbursement decisions outside the CEE region were included. All studies that used MCDA models were included. Studies that analyzed new technologies in Hungary, a published MCDA framework for orphan drugs in Poland and the recently adopted regulation on the development of a National List of Essential Medicines in Ukraine. The national survey. RESULTS: 143 papers altogether were found in the search, out of which 24 dealt with the diseases of the nervous systems, out of which 12 (50%) were in English. The first study was launched in 1996, the latest studies from Hungary (54%) and none from Bulgaria, Romania and Slovakia. A total of 7,834 patients were involved (n=patients/studies: Parkinson’s disease 823/9, multiple sclerosis MS 6350/8, neuropathy 325/2, dystonia 401/1, essential tremor 24/1, Duchenne muscular dystrophy 4/1, epilepsy 10/1, and Huntington’s disease 25/1). The comparative medical costs for each disease were compared. N= samples and mean costs were calculated. The results showed that the potential utility of MCDA models to support reimbursement decisions in the CEE region in the countries in this study is promising.

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MCDA APPLICATION IN CENTRAL AND EASTERN EUROPE: SELECTION OF THE MOST IMPORTANT CRITERIA BASED ON EXAMPLES

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OBJECTIVES: Our study aimed to analyze the use of the different types of criteria in multi-criteria decision analysis (MCDA) models that are being used in the decision-making processes in Central and Eastern European (CEE) countries. The aim of our study was to identify the key elements and challenges faced by policymakers and health-care payers when performing systematic literature reviews (SLRs). RESULTS: 143 papers altogether were found in the search, out of which 24 dealt with the diseases of the nervous systems, out of which 12 (50%) were in English. The first study was launched in 1996, the latest studies from Hungary (54%) and none from Bulgaria, Romania and Slovakia. A total of 7,834 patients were involved (n=patients/studies: Parkinson’s disease 823/9, multiple sclerosis MS 6350/8, neuropathy 325/2, dystonia 401/1, essential tremor 24/1, Duchenne muscular dystrophy 4/1, epilepsy 10/1, and Huntington’s disease 25/1). The comparative medical costs for each disease were compared. N= samples and mean costs were calculated. The results showed that the potential utility of MCDA models to support reimbursement decisions in the CEE region in the countries in this study is promising.

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A CROSS-NATIONAL COMPARISON OF THE EFFECT OF AGE AND GENDER ON HEALTH-RELATED QUALITY OF LIFE (HRQOL)

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OBJECTIVES: The aim of this study was to conduct a cross-national comparison of HRQOL data from the US, France, Germany, Italy, Spain, and the UK. The impact of age and gender on HRQOL was modelled for each year using multivariate regression with SF-12v2® physical (PCS) or mental (MCS) component score as the outcome and country, age centered (18-39), gender (0=Female, 1=Male), and 5-year increments as explanatory variables. RESULTS: Women tended to have lower PCS and MCS scores compared to men (<p<0.01), with more pronounced differences in the majority of EU countries (PCS: 0.9 to 1.5; MCS: 1.7 to 2.9), while in the US and UK these differences were lower (PCS: 0.1 to 0.5; MCS: 0.3 to 1.4) and often not statistically significant. In all countries, age had an impact on HRQOL by decreasing PCS by 1.3-1.5 points and increasing MCS by 1.6-2.0 points, with every 10 year increment, statistically significant differences between countries generally indicated small decreases in both scores from these values, representing an additional 0.25 decrement in PCS and 0.40 in MCS, on average. CONCLUSIONS: This large broad-based study consistently showed significant impacts of age and gender on HRQOL, with greater differences on mental health compared to physical health. Variation in the magnitude of these differences across EU countries was consistent across years. This study presents robust findings on the need to apply age and gender adjustments when comparing HRQOL scores.

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EQ-5D STUDIES IN NERVOUS SYSTEM DISEASES IN EIGHT CENTRAL AND EASTERN EUROPEAN COUNTRIES

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OBJECTIVES: Guidelines for economic analyses of health care technologies require local input data for reimbursement decisions in the Central and Eastern European (CEE) countries. The aim of our study was to systematically review and analyse the available EQ-5D literature in neurology, a clinical area with increasing economic importance. METHODS: To identify studies using EQ-5D a systematic literature search was performed using PubMed, EMBASE, Web of Science, CINAHL, PsycINFO, the Cochrane Library and the EuroQol Group database up to July 1, 2015. Local journals were hand searched. The countries included were Austria, Bulgaria, Czech Republic, Hungary, Poland, Romania, Slovakia and Slovenia. Original articles reporting on EQ-5D was used, cross sectional studies, national surveys, and 3 other studies. Only 1 study used EQ-5D-SL. EQ-5D utility scores were reported in 18 (75%) papers but the tariff used was not specified in 15/18 (83%). The lowest utility score was modelled for each year using multivariate regression with SF-12v2® physical (PCS) or mental (MCS) component score as the outcome and country, age centered (18-39), gender (0=Female, 1=Male), and 5-year increments as explanatory variables. RESULTS: Women tended to have lower PCS and MCS scores compared to men (<p<0.01), with more pronounced differences in the majority of EU countries (PCS: 0.9 to 1.5; MCS: 1.7 to 2.9), while in the US and UK these differences were lower (PCS: 0.1 to 0.5; MCS: 0.3 to 1.4) and often not statistically significant. In all countries, age had an impact on HRQOL by decreasing PCS by 1.3-1.5 points and increasing MCS by 1.6-2.0 points, with every 10 year increment, statistically significant differences between countries generally indicated small decreases in both scores from these values, representing an additional 0.25 decrement in PCS and 0.40 in MCS, on average. CONCLUSIONS: This large broad-based study consistently showed significant impacts of age and gender on HRQOL, with greater differences on mental health compared to physical health. Variation in the magnitude of these differences across EU countries was consistent across years. This study presents robust findings on the need to apply age and gender adjustments when comparing HRQOL scores.

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HOW TO SELECT THE BEST COMPARATOR? AN INTERNATIONAL ECONOMIC EVALUATION GUIDELINES COMPARISON

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Cost Effectiveness Analyses (CEA), including cost-effectiveness and cost-utility evaluations need to respect international methodological guidelines to provide reliable information in different countries. Cost-effectiveness is a relative concept so if the comparator is inappropriate, then the results will be unsuitable for decision-making purposes. Therefore, one of the most important structural choices of a CEA is the comparator choice OBJECTIVES: The objective of this study was to identify a standard way to define the most appropriate comparators in a CEA according to international guidelines. METHODS: We analyzed 29 country-specific economic evaluation guidelines available online, in Chinese, Dutch, English, Portuguese and Spanish, on the ISPOR website section, “Pharmacoeconomic Guidelines around the World” in June 2016. The parts related to the comparator choice were identified by the words “comparator”, “compare”, “alternatives”, and “intervention”. After a thorough analysis, the following criteria were identified to define the appropriate comparators. RESULTS: In the 29 countries, the most commonly used comparator was the “standard of care for local practice”, heterogeneity in the definition of a relevant comparator choice. The “therapy that prescribers would most replace with the proposed drug” was cited to be a good comparator in 38% (N=11) of the guidelines. The “lowest cost alternative” was a comparator of choice in 54% (N=17) of the guidelines. The comparator choice. CONCLUSIONS: Even if the most commonly advised comparator was the “standard of care for local practice”, heterogeneity in the definition of a relevant comparator to consider for a CEA was identified among countries. Further analyses

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