descriptive statistical analysis was performed. ***Results:*** It showed that 80 (37%) participants stated that medical model should be used, 58 (26%) said no, while 80 (37%) were not sure. Also, 147 (67%) participants stated that social model be used, 11 (5%) said no and 62 (28%) were not sure. Combining both medical and social models, 180 (82%) participants stated yes, 2 (1%) stated no and 37 (17%) were not sure. ***Conclusions:*** In all, 37% of the participants supported the medical model, 67% supported the use of social model, and 82% of the participants' supported combining the medical and the social models of disability. Combining the models may help to provide access to holistic interventions thereby improving the quality of life and health outcomes of people with disability.

PNS150
DISABILITY AS DEFINED BY MARKET ACCESS AND HEALTH ECONOMICS AND OUTCOMES RESEARCH PROFESSIONALS: MIXED METHODS.

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Objectives: Disability is a term referring to the inability to carry out daily functioning expected of an average person often referring to as impairments. Disability is given different definitions by people based on their understanding of disability. This study examined the definition of disability as perceived by Market Access (MA) and Health Economics and Outcomes Research (HEOR) professionals. ***Methods:*** A questionnaire was administered at the International Society of Pharmacoeconomics and Outcomes Research (ISPOR) Baltimore 2018 conference. Two hundred and twenty-one (221) responses were collected, out of which 172 participants defined disability based on their understanding and experience. Responses were categorised as follows: impairment (any form of impairment), activity limitation (inability to partake in activities), social limitation (not been able to partake in social activities), functional limitation (inability to carry out daily living tasks) and physical appearance (body appearance). Descriptive statistics and thematic analyses were carried out. ***Results:*** Out of 172 responses, 43 (25%) participants were from pharmaceutical industry, 40 (23%) Academic, 57 (33%) Consultants, 3 (2%) Health Technology Assessment (HTA), 9 (5%) Healthcare Professionals, 3 (2%) Payers, and 17 (10%) Others. Their responses were categorised as follows starting with the most frequency theme to the least: Activity limitation 153 (89%) Functioning limitation 144 (84%), Impairment 129 (75%), Physical appearance 121 (70%) and Social limitation 67 (39%). ***Conclusions:*** The majority of the participants' defined disability in term of activity limitation, functioning limitation, impairments, physical appearance and social limitation in this order. This means that disability is perceived by this group as physical, sensory, cognitive, and intellectual limitations rather than in terms of social limitation. This suggests that social limitation is not as frequently thought of in association with disability and could be overlooked. MA and HEOR professionals may benefits from training programmes on disability to help them better understand the concept.

PNS153
THE PROVISION OF GATE-KEEPING PRACTICE TO MITIGATE THE ADVERSE EFFECTS OF LONG-TERM UNEMPLOYMENT DURING ECONOMIC CRISIS

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Objectives: The 2008 financial crisis raised concerns over the probability of rise in death, illness and disability in European OECD countries, with increased unmet health needs from 3.1 to 3.4 percent in 2008 – 2012. The concave relationship between income and health suggests that, effect of income on health and longevity is of greater magnitude among the poor. So, finding measures to address increasing unmet health needs is pivotal. This study aims to investigate the significance of gate-keeping practice in mitigating the adverse effects of long-term unemployment, during financial crisis. ***Methods:*** The data for 20 high-income European OECD countries (2006 – 2013), extracted from Eurostat, were analyzed using panel data analysis, and the variables for different cross-sections over a time span were observed using random effects and fixed effects model (s). F-test, calculated using R^2 values adjusted for number of covariates in different models, was used to test the nested models and results were analyzed using Stata-v11. ***Results:*** The long-term unemployment is associated, strongly and positively, with unmet health needs for all levels of income ($p < 0.05$ to $p < 0.01$). The gate-keeping practice is associated, strongly and negatively, with unmet health needs; decreasing from 0.52, 0.37, 0.29 and 0.24 percent across the first, second, third and fourth income-quintiles to 0.24, 0.14, 0.12 and 0.09 percent, respectively, compared to the countries without the practice of gate-keeping. However, the magnitude of mitigating effects of gate-keeping practice gradually decreases, with increasing income. ***Conclusions:*** During economic crisis, the gate-keeping practice can mitigate the adverse effects of long-term unemployment. The presence of General Physicians as the first point of contact controls the access to tertiary care, significantly, facilitating to meet most of the health issues at the primary level. However, such mitigating effects gradually diminish with increasing income.

PNS155
VALUE-BASED CONTRACTING: DO PERSPECTIVES DIFFER BY PAYER TYPE?

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Objectives: Value-based contracts (VBCs) continue to receive attention as a mechanism for the shift toward value in the U.S. healthcare system. Under this model, stakeholders align drug payment and value to real-world performance metrics. Prior published payer research has not addressed VBCs according to payer type. ***Methods:*** An online survey assessing experience with VBCs, barriers to implementation, and elements required in establishing successful VBCs was completed by payers. ***Results:*** Respondents (N=47) represented health plans (HP; n=28), integrated delivery networks (IDN; n=10) and pharmacy benefit managers (PBM; n=9). At least one VBC was active or pending for greater than half of IDNs (60%) and PBMs (67%), while HPs (43%) had fewer active or pending VBCs. Clinical outcomes and compliance were the most common evaluation metrics for all payer types. The most common barriers to implementing VBCs were the ability to negotiate acceptable contract terms (HPs 71%; IDNs 40%; PBMs 78%), inability to obtain accurate/credible data to measure outcomes (HPs 57%; IDNs 70%; PBMs 78%), and implementing technology to collect data (HPs 54%; IDNs 50%; PBMs 78%). Simple and easily measurable outcomes, sufficient patient population, and reasonable timeframe for the contract were rated as the most important elements in establishing VBCs. IDNs may have more flexibility when considering each of these elements and place elevated importance on sharing risk (90%) compared to HPs (71%). Manufacturers' support of case management and adherence/compliance initiatives was endorsed by most IDNs (70%) and PBMs (67%), but fewer HPs (36%). Compared to HPs (32%) and PBMs (22%), IDNs (60%) reported the most interest in utilizing a mediator to analyze the risk before initiating VBC discussions. ***Conclusions:*** Surveyed payers are interested in VBCs, but utilization varies by payer type. Results indicate payer type should be considered as one element of a payer-manufacturer VBC partnership, and emphasis placed on flexibility.

PNS156
THE EFFECTIVENESS OF PERSONALISATION ON HEALTH OUTCOMES OF OLDER PEOPLE: A SYSTEMATIC REVIEW.

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Objectives: Personalisation/home care is used for people with long-term health conditions to receive support tailored to meet their individual needs. The support received is person centred to ensure independence, having total control/choice of services used daily. There is a shift from taking people to nursing home, as most people prefer to live and die in the comfort of their own homes. To date, no systematic review has examined the effectiveness of personalization. Hence, this systematic review examined the effectiveness of personalisation in older adults. ***Methods:*** A systematic review following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines was undertaken. Databases searched included: Science Direct and Medline (PubMed). Inclusion criteria were older people living in their own homes, receiving home care/rehabilitation/personalisation, and studies published in English language. Exclusion criteria were studies carried out in nursing and or residential homes. The Newcastle-Ottawa scale was used for quality of assessment and a narrative synthesis was carried out. ***Results:*** Search strategy yielded 151 results with titles and abstracts, 128 studies were excluded, the remaining 23 were judged against inclusion and exclusion criteria, following which 15 titles were excluded and remaining 8 were included. Four out of the 8 studies were randomised controlled trials. Older people with mean age ranging from 63 to 82.5 were included in the studies. All the 8 studies showed that quality of life (QoL) of older people receiving personalisation improved significantly with p = 0.001. Only one study examined resource utilisation and reported that personalisation was cost saving. ***Conclusions:*** The review found evidence of improvement in QoL in older people following personalisation intervention. It also showed that personalisation is cost saving. Practitioners, decision makers and social services are to be aware of these findings as they may help to improve QoL of older people and cost saving.

PNS157
IDENTIFICATION AND COST OF DIAGNOSTIC TESTS FOR INFECTION IN DIABETIC FOOT ULCERS, PRESSURE ULCERS, AND VENOUS LEG ULCERS

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Objectives: To understand the clinical drivers and incidence rates of culture and sensitivity testing for suspected wound infections. ***Methods:*** A retrospective analysis of the U.S. Wound registry was conducted for patients treated from 2005 through 2016 to examine the frequency of culture and sensitivity (C&S) testing in relation to prespecified patient- and wound-related variables. ***Results:*** The study comprised 82,624 patients with 239,746 wounds (diabetic foot ulcers [DFUs], venous leg ulcers