hospital characteristics, patterns of medication used, and outcome measures. Multivariate analyses such as general linear model (GLM) and logistic regression were performed. **RESULTS:** Logistic regression results show that hospital size (p < 0.0001), hospital type (p < 0.0472), type of procedure (p < 0.0001), and hospitals having a care-plan for surgical site infection (p < 0.0032) were significantly associated with the probability for patients to get the recommended prophylaxis. Based on the results from GLM regression analysis, older age is significantly associated with longer LOS (p < 0.0001) for all procedures. Scheduled operations (p < 0.0001) and receiving the recommended prophylaxis (p < 0.0214) were significantly related to a decrease in LOS. Also, a significant effect on LOS was observed, depending what kind of surgical procedure patients underwent and what hospital they were admitted. **CONCLUSIONS:** Compliance with practice guidelines may reduce LOS, which suggests improved patient outcomes and decreased health care costs.

**PHP28**

**COST-BENEFIT ANALYSIS OF A STATE POISON CENTER**

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**OBJECTIVE:** A cost-benefit analysis was conducted to compare the costs associated with operating a poison center to the benefits derived from center availability. **METHODS:** Costs were measured as the direct cost of operating the center, including personnel, reference sources for clinical information, equipment, and administrative overhead expenses. Benefits were measured as the opportunity cost of alternative treatment strategies had a poison center not been available to callers. Data were collected through a concurrent telephone survey of poison center callers at the time of the initial poison exposure call. Callers were asked a series of three questions regarding actions they would have taken if the poison center were not available. Follow-up calls were used to assess actions callers actually took after calling the center. Inputs and benefits were valued using average local prices for medical services from a state paid claims database. A decision analysis model was constructed to calculate the expected cost of poison treatments under two scenarios (poison center available or not). Model probabilities were derived from the percentage of callers indicating that they would pursue a particular course of action. **RESULTS:** A total of 1695 poison exposure cases were included in the analysis. The average cost per poison exposure associated with not having a poison center available was $62.40. This figure represents the benefit of having a poison center. The average cost of managing a poison call was $8.52, yielding a benefit per call ratio of $7.32. This ratio reflects the amount of additional health care expenditures avoided per dollar expended in a poison center consultation. A sensitivity analysis was conducted to assess the impact of changes in emergency service use on the model. **CONCLUSION:** Based on our analysis, the immediate information and treatment advice available through a state-run poison center has as a positive societal value.

**PHP29**

**WHERE DOES THE GERMAN HEALTH CARE SYSTEM WANT TO GO TO?**

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**OBJECTIVES:** The focus of present health political discussion in Germany is concentrated on financing as an instrument to meet the future needs of German population. Government wants to cut back benefits by offering alternative funding mechanism, which is tax financing and additional patient payments. The recent and significant changes to Health care funding in Germany is reviewed. **METHODS:** A literature review was conducted to analyze a number of strengths to the financing and funding arrangements in the German Health care system. The potential advantages for priorities, efficiency, and equity from this structure of financing are considered. The results will be compared to the design of the currently started plans for a further Health care reform in Germany with focus on financing. **RESULTS:** The current most important scheme of social health insurance (SHI) finance intended to mobilize resources for health care, to insure against risk, and to provide stable finance seems for the government not to be any longer the funding mechanism that helps to control costs and to secure access to broad priority services. Government intends to use finance mechanism to shift low priority services into SHI and put high priority services into finance mechanism of user charges. The level of priority services is—so far—not a result of discussions in the community. Financial fairness is best served by the cornerstone of more progressive prepayments as it is the case for SHI premiums instead of patient payments. Co-payments have the effect of rationing use health care services but does not effect in rationalizing its demand by insured. **CONCLUSIONS:** Currently risks are distributed according to ability to pay rather than to risk of disease. Financing fairness is best served by the cornerstone of progressive prepayments as it is the case for SHI premiums instead of patient payments.