PUBLISHED COSTS OF MEDICATION ERRORS LEADING TO PREVENTABLE ADVERSE DRUG EVENTS IN US HOSPITALS

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OBJECTIVES: To quantify the financial impact of poor blood specimen quality on treatment and hospital costs in a healthcare facility in China, using institution specific data.

METHODS: The data were collected from six hospitals (beds >500) in Beijing, Shanghai and Guangzhou by interviewing institution staff, including operating departmental data such as total operating costs, medical treatment data such as probability of a low, medium or high impact of a rejection, laboratory data such as total number of blood tests. The patients were divided into three groups: critical patients, routine outpatients, and elective surgery inpatients, since the costs of an error vary greatly among the three categories. Finally, the data were entered into a model to calculate the possible financial impact of blood specimen rejection. RESULTS: The estimated average costs of a blood specimen rejection were $494, $422, accounting for 0.12% of total hospital costs. The financial impact of errors can be different defined in a health care facility, patient treatment costs represent the largest cost category at 92.18%, redraw costs at 3.21%, instrument downtime costs at 2.99%, lab investigation costs at 1.57%, and blood collection consumables 0.05%. CONCLUSIONS: Blood specimen rejection due to the poor pre-analytical quality increase operational costs and decrease the efficiency of hospitals, healthcare facility should monitor pre-analytical blood processes and use high-quality device to decrease pre-analytical errors.

THE FINANCIAL IMPACT OF BLOOD SPECIMEN REJECTION DUE TO THE POOR PRE-ANALYTICAL QUALITY IN HEALTHCARE FACILITY IN CHINA

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CURRENT ESTIMATES OF THE PUBLIC PHARMACEUTICAL EXPENDITURE IN MONGOLIA

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OBJECTIVES: To investigate regional variation in catastrophic health care spending in Pakistan.

METHODS: The data draws data from three rounds of Pakistan Living Standards Measurement Survey (PLSMS) conducted in both rural and urban areas of Pakistan in 2005-06, 2007-08 and 2010-11. A household is classified as incurring catastrophic health care expenditure if 10% or more of its annual expenditure is on health care. Household economic status is measured using household annual consumption expenditures and households are categorized into quintiles.

RESULTS: The proportion of households incurring catastrophic health care expenditure has declined from 7.5% in 2005-06 to 3.2% in 2010-11. The decline has been slightly more in case of rural households than in urban (4.9% urban and 9.1% rural households in 2005-06 vs. 2.0% urban and 3.8% rural households in 2010-11). The catastrophic expenditure is the same for both rich and poor households. However, there is an interesting pattern in the catastrophic health care expenditure compared to Sindh. There is regional variation across regions and remarkable decline in catastrophic health care spending. South Punjab had the highest proportion (13.6%) while south Sindh had lowest proportion (2.4%) of households incurring catastrophic health care expenditure in 2005-06. The highest proportion was in rural households whereas, north Sindh had lowest proportion (0.4%) whereas, north Punjab replaces south Punjab having the highest proportion (5.4%) of households incurring catastrophic health care expenditure in 2010-11. CONCLUSIONS: Pakistan has registered a decline in catastrophic health care spending over the period. It could be associated with a decline in morbidity over the period. However, cost of health care remains an important impediment to access health care particularly in rural areas.

A LITERATURE REVIEW AND MICRO COSTING APPROACH TO DETERMINE THE COST OF ONE HOUR OF OPERATING TIME IN CANADA

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OBJECTIVES: To determine the cost of operating time in Canada despite the fact that surgical care is provided by a single payer facing increasing cost constraints. The objective of the review was to analyze how OR costs are currently conceived of in Canadian hospitals. Additionally, a micro costing approach was used to determine the actual cost using a bottom-up approach. METHODS: A literature search was conducted to determine how Canadian hospitals perceived the value of one hour of operating time. Studies satisfying the defined criteria were summarized with respect to methodology and inclusion and exclusion of specific resources in their perception of their institution’s OR expenditure. All costs were adjusted to 2014 Canadian dollars. Additionally, we conducted an independent bottom-up micro-costing analysis of Canadian operating room time. Completion of the literature review prior to micro-costing ensured a robust and comprehensive approach was used. Costs were obtained using peer-reviewed literature and from a large Canadian hospital network. RESULTS: Specific search and inclusion criteria resulted in the inclusion of 5 studies in our analysis. The cost OR time ranged greatly from $621.60 to $2288.94 per hour. All studies obtained the cost of OR time using a top-down case-costing approach informed with data from their respective finance departments. Each study was conducted at a different Canadian hospital and OR costs were compared in a different years. Additionally, many of the studies lacked sufficient methodology details providing a challenge when comparing approaches. The bottom-up micro case-costing approach incorporated more than 30 individual costs and resulted in an OR hourly cost of $1200. CONCLUSIONS: In Canada, there is little consensus between institutions of how to capture the costs of OR time. A bottom-up micro costing approach allowed for a different perspective and a more detailed analysis.