years old. There are alternations in the maximum values for gender in the 0 to 20 years old band. CONCLUSIONS: This study reflects the need to determine an optimum number of bands; that is, to add the information in some specific intervals that allow us to carry out an efficient analysis without losing the necessary perspective in order to obtain related conclusions with the aim of the study. It proves that a previous analysis is essential to evaluate the behaviour of the cost per inhabitant of a PHCT.

THE ORGANIZED REGISTER OF CANADIAN HEALTH INFORMATION DATABASES (ORCHID) PROJECT: A RESEARCHER INTERFACE

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OBJECTIVES: To organize and classify existing Canadian health information databases into a searchable repository that will assist in identifying and assessing Canadian data available for health outcomes and related research. METHODS: The identification of Canadian health information databases began with a structured search strategy involving Medline (PubMed, OVID); Internet search engines; web sites of a number of organizations, universities and government bodies; and personal communications. Canadian databases with data from the year 2000 onwards were included. Databases were assigned to one of four basic types (Administrative, Registry, Surveillance and Survey) and further classified in a hierarchical structure using categories, sub-categories and low-level terms. The three high-level categories were Medical Condition (MC), Population Health (PH) and Health Services Utilization (HSU). Approximately 20% of the identified databases were further profiled in detail, with recording of information on an additional 20 variable fields including sample size, data collection methods and data quality. RESULTS: The creation of a classification structure fully characterized the breadth and scope of the 255 unique databases initially identified. By database type, the largest proportion of databases was classified as surveillance (34%; n = 87), followed by administrative (28%; n = 72), registry (22%; n = 56) and finally surveillance (16%; n = 40). By non-exclusive database category, most were classified as PH (n = 140), followed by HSU (n = 116) and finally MC (n = 114). Canadian health databases were found to provide information across a wide range of clinical conditions, particularly those related to high disease burden areas. In addition, they provided health utilization and determinant data. Some data gaps were recognized, such as environmental exposure data, data identifying specific subpopulations, and information needed to fully assess data quality. CONCLUSIONS: Classifying existing Canadian health information databases within a single, organized register is expected to provide an effective research tool in the planning of health outcomes and related research.

PATHOLOGY RELATED DIFFERENCES IN VARIANCE OF DRUG INSURANCE COST IN HOSPITAL STAYS: FEASIBILITY OF FIXED FUNDING IN PATHOLOGIES WITH REDUCED COST VARIANCE

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OBJECTIVES: Parameters of central tendency (mean) are often estimated in budget impact assessment (BIA) with less emphasis on parameters of spread (variance); critical to fixed funding (FF) policies (e.g. envelope systems) is accuracy of the estimate and maximal precision. The complexity and diversity of the hospital pathology mix and its treatment are the main theoretical hurdles encountered. In this analysis, the variance of the drug treatment reimbursement cost was investigated on the Main Diagnostic Code (MDC) and the All Patients Refined Diagnosis Related Groups (APRDRG)-level. The aim was to select low cost variance diagnoses which would enhance precision in FF. METHODS: Belgian hospitals register admission data in minimum basic data sets (MBDS): we extracted anonymous data from stays of 21 peripheral Flemish hospitals (during 2002). MBDS contains ICD-9-CM codes, performed procedures, stay parameters (e.g. risk of mortality), patient characteristics (age, gender) and drug utilization data with the national insurance cost. Data were analyzed in SPSSWIN® 12.0. RESULTS: The database contained 368,618 unique stays. On MDC-level, the fit between mean cost and variance was merely a non-linear relationship; the MDC’s cardio-vascular (CV) disease, myeloproliferation & neoplasms, infectious disease and liver disease exhibited a linear relationship with r² > 0.90; in these MDC’s low mean cost pathologies also allow fixed funding. On APRDRG-level, increased cost variance probably reflects increased drug utilisation variation and/or heterogeneity in drug pricing. Illustrative examples: the ratio of mean cost for cesarean (95€) to vaginal (27€) delivery is about 4 but the ratio of variances exceeds 10. In the CV area, the corresponding ratios for heart failure (269€) to angina (104€) are respectively 2.5 and 8. CONCLUSIONS: Reducing mean cost is important to BIA but to FF reducing cost variance is essential in order for the funding to be in line with the resources used.
responses about actual acquisition cost methods currently in use, analyses revealed a significant differential between methods reported by hospital respondents and methods discussed in published CMS and GAO sources. CONCLUSIONS: Payment rates in 2006 for separately paid drugs will be derived, in large part, from the upcoming GAO survey. If the study design does not take existing variations of recording drug acquisition cost into account, the GAO survey will be significantly flawed and hospital providers may be well underpaid for drugs in 2006.

**PHP31**

SENSIBLE FLEXIBILITY OR UNNECESSARY DUPLICATION? THE USE OF DECISION MODELLING IN NICE APPRAISALS

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**OBJECTIVES:** To track and categorise the use of decision modelling in the NICE appraisal process. Does it meet the needs of the Appraisal Committee and is it an efficient use of time and resources by all stakeholders? **METHODS:** A review was undertaken of the appraisals completed by NICE up to the end of October 2003. All available documentation from NICE (published and on the NICE website) was accessed and previous published commentaries were reviewed. Information was extracted from the use of decision models by: 1) manufacturers and sponsors in their submissions; 2) by the independent review groups assessing submissions; and 3) by NICE staff and the Appraisal Committee. The final NICE guidance to the NHS was reviewed to identify the importance of the model results in reaching a decision. **RESULTS:** Of 71 appraisals reviewed, only 5 (7%) involved no modelling. Manufacturers used models in their submissions in 87% of appraisals, and the independent review group developed its own additional model in 46%. In 30 appraisals (42%) both the review group and the manufacturers developed separate models. This was more likely to happen in recent appraisals. In the majority of cases, the review groups were critical of manufacturers’ models and in several appraisals the Appraisal Committee did not use the results of the review group’s own model. **CONCLUSIONS:** The timing of NICE appraisals makes modelling essential if the full range of costs and outcomes of a technology are to be considered. In appraisals of multiple products five different models may be produced. The potential for confusion and duplication of effort in the current process was highlighted by the recent review of NICE by WHO. The explicit and implicit cost of this duplication is considerable and alternative approaches to modelling should be considered.

**PHP32**

LOSS PROFILES DERIVED FROM ACTIVITY OF DAILY LIVING SCORES ATTRIBUTABLE TO HANDICAPS

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**OBJECTIVES:** The purpose of this analysis was to characterize handicaps according to activity of daily living (ADL) scores issuing from a general questionnaire aimed at measuring handicap, incapacity and dependency. **METHODS:** A nationwide representative sample of 16,943 French citizens living in the community were interviewed. A 30-item questionnaire documented the ability to perform ADL, including washing, dressing, food, excretion, mobility, changing position, moving inside and outside, shopping, house chores and management, distance communication and orientation. The need for nursing assistance and the intensity required were documented qualitatively (from none to full help). Handicaps were documented as visual impairment (low vision (LV), blind), motor, brain, visceral and audition. A principal component analysis identified six scores from the questionnaire: hygiene and meals, physical capacity, transport and housework, ability to move, behavioral problems, and autonomy. Individual coordinates were estimated after Varimax rotation scores were adjusted on age, number of subjects in the household and number of handicaps, using a weighted global linear model. Comparisons with control were used to estimate attributions to handicap. **RESULTS:** Subjects were 37.9 years old (average) and 12.9% declared a motor handicap, 2.0% visual impairment, 7.1% audition, 8.7% a visceral and 6.4% a brain handicap. The hygiene and meals score was most affected by blindness, followed by motor handicap. Physical capacity was limited by LV, blindness and motor handicap. The transport and housework score reflected LV, blindness and brain handicap. The ability to move score was reduced in citizens with blindness and brain handicap. The behavioral problem score was higher in citizens with brain handicap or LV. Only three handicaps were associated with a diminished autonomy score: LV, blind and brain handicap. **CONCLUSIONS:** Visual impairment was the sole handicap associated with high ADL loss attributable to all dimensions.

**PHP33**

SATISFACTION AMONG GERMAN PHYSICIANS—A REPRESENTATIVE EMPIRICAL STUDY

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All over Europe, health care systems are currently scrutinized for their efficiency. Solutions that maintain the best possible care for patients and lead at the same time to substantial reduction of costs are looked for at all levels and domains of the existing health care systems. This quest often enough leads to constant changes in the daily practice work with patients and—at least on the political level—to claims that the professional dissatisfaction among medical doctors is constantly increasing. For Germany we tried to get an empirical perspective of this situation. **OBJECTIVES:** It was our aim to analyze the complex health system from the physician’s point of view and provide data for a problem oriented political discussion and reform strategy. **METHODS:** A questionnaire was mailed to a random sample of 7000 German medical doctors across specialties. The final sample consists of 1094 institutional employed medical doctors and 1071 general practitioners. Measures included (among others) personal and job characteristics, perceived working conditions, research and teaching activities, life satisfaction, organisation and management, continuous medical education. Statistical analysis was performed using Analysis of Variance (ANOVA), t-test, regression analysis, and chi-square test. An alpha level of 0.01 was considered significant. **RESULTS:** The average working time, including on-call service is 66.7 hours/week, excluding on-call service 51.3 hours/week. Over-time is not monitored at all in 54.6%. Issues related to organisation and management were seen and interpreted significantly different among directors and chiefs versus residents and attendants. Issues related to research and teaching, life satisfaction and income presented statistically different results between male and female, formerly eastern and western Germany and different hierarchical positions. **CONCLUSIONS:** The high response rate in this empirical study allows for further analysis of specific subgroups (i.e. Urologists, family doctors, surgeons etc.) among the highly motivated German physicians.