applied in a rural district in Mexico. Identify barriers to be considered in its implementation. METHODS: Cost Study: A pilot cross-sectional, multicenter case study was conducted in 2003 in Sanitary District No. III, State of Morelos, Mexico. A general hospital, an urban health center and two rural health centers, all managed by the Ministry of Health, were selected. The Mother-Baby Package Costing Spreadsheet was used to estimate the total cost and cost by intervention under the current model and Mother-Baby Package model. Qualitative Study: Key informants from the hospital, the urban center and eight rural health centers were interviewed. The “3 Delays Model” was used to identify barriers to be considered. RESULTS: The total cost of the Mother-Baby Package is twice the cost of the current child and maternal health care model in Morelos, Mexico. Of the 18 interventions evaluated, those consuming the highest proportion of total costs were antenatal-care and normal-delivery. Personnel costs represent more than half of total costs. Barriers identified were machismo, culture and the negative perception of health centres amongst users (causing delay in deciding to seek care), difficulty obtaining transportation in emergency situations (generating delay in reaching a first referral level facility); and shortage of drugs, adequate equipment and trained staff (causing delay in receiving care after arriving at the facility). CONCLUSIONS: Improving the delivery of child and maternal health care in a poor setting in accordance with the Mother-Baby Package standards would require a budget two times that which is currently assigned to these services. However, before implementing a scaled-up version of the package it would be essential to manage problems that appear to be barriers that exist in providing and accessing appropriate maternal and child health care.

MEN’S AND WOMEN’S HEALTH

MEN’S AND WOMEN’S HEALTH—Quality of Life/Utility/Preference Studies

VALIDATION OF THE SPANISH VERSION OF THE SELF-ESTEEM AND RELATIONSHIP (SEAR) QUESTIONNAIRE FOR MEN WITH ERECTILE DYSFUNCTION (ED)

Rejas J1, Cabello F2, Calle A3, Chantada V4, Forá F5, García-García M6, Rico-Villademoros F7, Martínez-Sánchez EM8

1Pfizer SA, Alcobendas, Madrid, Spain; 2Instituto Andaluz de Sexología, Málaga, Spain; 3Hospital Clínico San Carlos, Madrid, Spain; 4Hospital Juan Canalejo, La Coruña, Spain; 5Centro Médico Teknon, Barcelona, Spain; 6Biometría CRO, Barcelona, Spain; 7Biometría CRO, Madrid, Spain

OBJECTIVES: To assess the clinimetric properties of the Spanish version of the Self-Esteem And Relationship (SEAR) questionnaire to be used in Spain with patients with ED. METHODS: The SEAR questionnaire comprises 14 items divided into two domains: Sexual Relationship (8 items) and Confidence (6 items), the latter comprising Self-Esteem (4 items) and Overall Relationship (2 items). The USA-English-version of SEAR questionnaire was adapted linguistically into Spanish by using forward and back translation methods and a conceptual equivalence approach. The SEAR questionnaire was administered to a group of patients with ED (IIEF ≤ 26) seven days before starting treatment and at baseline and after three months of treatment (group A), and to a group of healthy control subjects (IIEF ≥ 26) (group B) in a single visit. SF-12 and HAD scales were also administered. RESULTS: Out of 831 recruited subjects (n = 732, group A; n = 99, group B), 559 subjects were included as evaluable for validation analysis (n = 504, group A; n = 55, group B). The percentage of patients without response was < 5% for all domains. Cronbach’s Alpha coefficient was 0.92 and 0.86 in groups A and B. The SEAR questionnaire discriminated between patients and controls (area under curve = 0.999) and groups of patients by severity of ED (Kruskall-Wallis test: p < 0.0001). Correlation was high with Erectile Function scale of IIEF (r = 0.69) and moderate with HAD (r = -0.41) and SF-12 Mental Health (r = 0.38). The SEAR questionnaire also showed responsiveness with improvement in scores from start to end of treatment (Mann-Whitney-Wilcoxon test: p < 0.0001). CONCLUSIONS: The SEAR questionnaire showed adequate feasibility, reliability, validity and responsiveness for its use for measuring the emotional tension and relationship difficulties associated with erectile dysfunction.

INFERTILITY TREATMENT POLICIES IN GERMANY AND THE UNITED KINGDOM—WILLINGNESS TO PAY AMONG AFFECTED COUPLES

Kilgert K, Smala A, Berger K

MMRG Medical Economics Research Group, München, Germany

OBJECTIVES: Assisted Reproduction is among the fastest growing areas of medicine, rising debates about financing in vitro fertilisation (IVF) or other assisted reproductive techniques by national third party payers. This study describes policies of infertility treatment as well as willingness to pay for treatment in affected couples in Germany (contribution-financed health care system) and the U.K. (tax-financed health care system). METHODS: Literature review with the key words: infertility, willingness to pay, epidemiology. For assessment of national reimbursement policies, websites of the respective health care institutions were reviewed. RESULTS: In 2001, over 25,000 IVF treatment cycles were carried out in Great Britain, 25% being funded by the National Health Service. New clinical guidelines accepted by the Department of Health, assure that from 2005, more assisted reproduction services are covered by the NHS, such as one full cycle of IVF. Over 2/3 of the patients currently paying privately are expected to demand for NHS services resulting in an enormous increase in IVF treatment. In Germany, about 75,000 treatments were performed in 2001. Since January 2004, German statutory sick funds restricted reimbursement to 50% of the costs for the first three IVF treatment cycles. Due to these regulations, changes in treatment patterns for IVF can be expected for the future. An ongoing online-questioning revealed that for only 60%, the decision for IVF treatment remained unchanged, whereas the rest either postponed the decision or cancelled IVF. Two studies (USA, Sweden) revealed the willingness to pay of infertile couples to be 14,500€ or more. CONCLUSIONS: Contradictory dynamics between willingness to pay and change of mind due to restrictive reimbursement policies show need for more research in the field of infertility treatment. Economic and social consequences of changing frame conditions for IVF should be closely assessed, to ensure high quality of life for affected couples.