OBJECTIVES: An increase of financial risk in healthcare is associated with many issues such as the inactivity of hospital care, bureaucratic procedures used in the hospitals, low remuneration of health professionals, financing based on not real costs of services and almost absence of procurement activities in hospitals. The aim of the study was to estimate outpatient and inpatient care costs in provincial hospitals.

METHODS: We used top down cost estimation method. Total eight provincial hospitals participated in the study.

RESULTS: Generally, 51 percent of the total costs was spent for inpatient medical care, 11 percent was spent on outpatient care, 5 percent was spent on emergency care, 18 percent was spent for additional services and 18 percent were for management costs. In Umnugobi provincial general hospital there were 455 outpatients per employee, whereas 200 outpatients per employee were in Dormod provincial general hospital. There were 34 and 17 inpatients per employee at Khovd provincial general hospital and Tov provincial hospital respectively whereas the average was 27. Day surgery costs were the highest, 248.583 MNT, and the lowest costs were for eye outpatient, 7270 MNT. The highest costs were average emergency care, 25.286.966 MNT; and tuberculosis treatment costs, 1.895.340 MNT. Average cost of inpatient care was 574.236 MNT. CONCLUSIONS: In average only 11 percent of hospital budget was spent on emergency care, which was insufficient. Umnugobi provincial general hospital employees had by 44.3 percent higher workload than those in Tov and Treatment Regional Centre Hospital's inpatient workload per employee was 50 percent higher compare to Tov provincial general hospital.

PHS133 MEDICAL RESOURCE UTILIZATION OF ISCHEMIC STROKE PATIENTS WITH OBJECTIVES: To describe and compare the first hospitalization cost and the readmission cost of Ischemic Stroke (IS) patients at Beijing urban area.

METHODS: Retrospective data on hospitalization of IS was selected from Beijing urban employees and residents medical insurance database. We randomly selected 10% of patients first diagnosed as IS during January 2012-December 2012 and then followed those patients to September 2013. 4504 patients were identified in our study and then 2371 patients reoccurred during the observation period. All information of patient demographic characters, length of hospital stay, day surgery costs and others were collected. This study was conducted by a national Survey on Medical Service Utilization of the BMI participants in 2012. Altogether 10,597 inpatients (2.2% of total) treated by ERCP technology were extracted from the 375 thousands total sample inpatients of all over the country. All the actual claim data of medical expenses and medical care utilization were collected. Descriptive analysis was applied to the data and related BMI payment policies were reviewed. RESULTS: 1) About 948 thousands inpatients were treated by ERCP technology in 2011. 83% of them suffered from the digestive system diseases. 2) The average hospitalization medical expenses of ERCP inpatients was 11293 RMB (about 1820 USD), among which 45%, 40% and 15% were for drugs, medical services and medical supplies respectively. 3) The 32 ERCP-related costs operation more than 414 million RMB (about 67 million USD), and Top 5 high-cost operations cost 80.4%. 4) The 16 ERCP-related medical care costs 194 million RMB (about 31 million USD) and Top 5 cost 58%. The highest price of the 16 medical supplies was 7500 RMB (120 USD) and 2) the first hospitalization cost and the hospital stays of different admissions showed no significant difference.

PHS134 THE MARKET FOR HEPATITIS C SERVICES IN ALBERTA

OBJECTIVES: Hepatitis C (HCV) is a curable disease that affects roughly 242,000 Canadians and 24,000 Albertans. Without treatment, those infected may develop severe liver disease, cirrhosis and possibly hepatocellular cancer (HCC) and irreversible decompensated cirrhosis (DC). This study examines the current Alberta “market” for HCV-related services. Little is currently known about the segmentation of providers within this market or the degree to which these segments of providers are integrated into the overall HCV services market. The expenditure required to fund various HCV service segments was also unknown. METHODS: We conducted a cost analysis to estimate the expenditure required to fund the current HCV services market and its variants in Alberta. In order to conduct this analysis, it was necessary to describe the current market associated with different segments of care for HCV. Information was obtained from the literature and through consultation with health care professionals involved in providing HCV-related services. RESULTS: Six segments were identified within the overall HCV service market. These included prevention, screening, early treatment, late treatment for advanced liver disease (including liver transplant), and finally end stage liver disease (ESLD). The estimated cost for HCV-related services overall was $47 million (CAD) per year. Late and ESLD were associated with a cumulative cost of $17.8 million ($8.5 million for late stage and $9.3 million for ESLD). Treatment with antivirals (i.e., early stage) was associated with $15 million. These costs are based on a hypothetical population of 100,000 infected people because of the current lack of integration across HCV service provider segments such as screening and early treatment referral. System capacity limitations for early treatment and liver transplant will also contribute to future increases in cost.

PHS135 COSTS OF PRIMARY AND SECONDARY HEALTHCARE UTILIZATION FOR PATIENTS WITH IRITABLE BOWEL SYNDROME CALCULATED USING BURTON ET AL. COLLECTED ELECTRONIC RECORDS TO ACCESS THE IMPACT OF SECONDARY CARE REFERRAL

CONCLUSIONS: In cases of patients with IBS, it is important to conduct an early diagnosis and liver transplants will also contribute to future increases in cost. Complete primary and secondary healthcare utilization and costs can accurately be calculated at individual and cohort level using routinely collected data from large databases and tariff prices. These data could be used directly in economic modelling from the payer’s perspective and to inform policy.