The EMIs are collected and compared from 31 provinces; the indentors of EDs are evaluated before and after implementation. RESULTS: Although national EDI only contains 307 essential medicines, the number of added EDs in provincial EDIs are various from 64 through 455. The zero-markup policy of EDs conducted in public grass-root health facilities (urban community health centers and rural township hospitals) have reached to 98.8%. More than 95% EDs can be reimbursed by medical insurance schemes. The average percentage of price cutting was 25%-50% after tender bidding and purchasing. Quality assurance and sufficient provision of ED became a problem. The number of essential medicines is still not meet the needs of outpatients so that patients flow back to the secondary and tertiary hospitals. Financial subsidies from government usually are not supported timely. Along with the expansion of ED in village health posts and hospitals, how to incentive and maintain the income level of health professionals have to be considered. CONCLUSIONS: To promote the EMP, the adjustment of EDI is required in 2012. In addition, the implementation of essential medicines on provincial levels should be updated. The implementation of EMP will not be successful in village and urban hospital until solving the problem of reimbursement and payment system in health settings.

PHP15 COMPARISON OF HEALTH EXPENDITURES AND DRUG EXPENDITURES IN TWO WESTERN BALKAN COUNTRIES

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OBJECTIVES: To compare health expenditure as total % of GDP, per capita PPP and in US dollars as well as total drug expenditure with top ten ATC groups with highest expenditure in 2009 and 2010 in Bosnia & Herzegovina (B&H) and Croatia (CRO).

METHODS: Research was based on data published in latest official annual reports from two national Drug Agencies, from B&H and CRO, and official reports from The World Bank. Analysis was performed for all drugs and top ten ATC groups and compared in both countries for two years — 2009 and 2010.

RESULTS: The Health expenditure, total (% of GDP) in B&H was 10.94 in 2009 (10.31 in 2008), CRO - 7.83 in 2009 (7.83 in 2008). In 2009, total drug expenditure in B&H was 238.8 mil EUR compared to 269 in 2010 (increase of 11.23%), while in CRO in 2009 it was 626.5 mil EUR compared to 664.5 in 2010 (increase of 6.85%). Top 10 ATC 1st level drug groups with highest expenditure in both countries in 2009 and 2010 were rather similar but on ATC 2nd level we observed significant differences in the share of relevant ATC groups with leading C09, J01 and L01 for 2009 and C09, J01 and A10 for 2010.

CONCLUSIONS: CRO has a stable total health expenditure and universal health care system with twelve smaller increase in total drug expenditure compared to B&H. B&H is a country with decentralized health care system including drug politics and positive reimbursement drug lists which need to be equalized.

PHP16 REMOVING THE BARRIER OF COST TO SMOKELESS SMOKE CESSATION MEDICATIONS

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OBJECTIVES: As part of the Affordable Care Act of 2010 (ACA), smoking cessation medications (bupropion, varenicline, nicotine replacement drugs, will be provided at no cost to people with health insurance. However, the scope of the potential impact of this policy was unclear. This study explored which populations would benefit from this mandate. METHODS: A retrospective cross-sectional study of nationally representative Medical Expenditure Panel Survey data from 2009 was conducted. Adults who currently smoke, advised or recommended by doctors to quit smoking, or diagnosed tobacco-use disorders were extracted for analysis (weighted N=40,095,913). Chi-square tests and one-way ANOVAs were conducted to examine the heterogeneity in SCM use and related out-of-pocket expenses with respect to socio-demographic factors. A logistic regression was performed to examine the associations between socio-demographic factors and SCM use. All analyses were weighted based on complex survey design. RESULTS: Of the 40,095,913 smokers, only 3.1% of them used SCMs in 2009, whereas 52.1% were advised by doctors to quit smoking. Chi-square analyses revealed significant differences in SCM use based on race/ethnicity, relationship status, health insurance status, HMO status, perceived mental health status, and comorbid depressive/bipolar disorders (all p<0.01). Uses in bupropion and varenicline also varied with health insurance status (both p<0.01). There were significant differences in out-of-pocket expense for SCMs between smokers with different insurance status, with the uninsured paying the highest out-of-pocket price (p<0.01). The logistic regression revealed that non-Hispanic blacks were less likely to take SCMs compared with Hispanics (OR=0.87, 95% CI: 0.83-0.92). CONCLUSIONS: Cost is a substantial barrier to SCM use among smokers. Once this barrier is lifted with the ACA, many smokers who do not currently use SCMs are likely to use SCMs unless they have unfavorable attitudes towards SCM use and smokers who currently use SCMs might switch to more effective but expensive SCMs. Of the 40,095,913 smokers who currently use SCMs might switch to more effective but expensive SCMs. Smokers who currently use SCMs are likely to use SCMs unless they have unfavorable attitudes towards SCM use and smokers who currently use SCMs might switch to more effective but expensive SCMs. Unless they have unfavorable attitudes towards SCM use and smokers who currently use SCMs might switch to more effective but expensive SCMs. Once this barrier is lifted with the ACA, many smokers who do not currently use SCMs are likely to use SCMs unless they have unfavorable attitudes towards SCM use and smokers who currently use SCMs might switch to more effective but expensive SCMs.