not reflect the actual level of utilization and need to be completed with alternative methods of data collection.

**PHP3**

**IMPROVING PATIENT ACCESS TO INNOVATION—THE NEW BELGIAN REIMBURSEMENT PROCEDURE**

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**OBJECTIVES:** Belgium has implemented since January 2002 a new reimbursement structure—the Commission for the Reimbursement of Medicines (CRM). One of the objectives is to improve time taken between the granting of a marketing authorisation and pricing/reimbursement decisions in full consistency with the European Community legislation. **METHODS:** The CRM is responsible for both clinical and economic evaluation of the submissions. The decision relating to the admission of a specialty to the list of reimbursed products is taken after evaluation of several criteria: therapeutic value, price and basis for reimbursement, therapeutic and social needs, budget impact and cost-effectiveness. With regard to the therapeutic value, three classes have been defined: class 1) demonstrated added value; class 2) no added value; and class 3) generic drugs. For an independent evaluation of the dossiers the NIHISB has appointed a team of internal experts. They provide evaluation reports within 60 days and a reimburserment proposal within 150 days, to be endorsed by the CRM. Guidelines have been developed to assist applicants in preparing their submissions. After five months of CRM functioning, the timelines are respected and a large majority of the evaluation reports were endorsed. The decision relating to the admission of a specialty to the list of reimbursed products is taken after evaluation of several criteria: therapeutic value, price and basis for reimbursement, therapeutic and social needs, budget impact and cost-effectiveness. With regard to the therapeutic value, three classes have been defined: class 1) demonstrated added value; class 2) no added value; and class 3) generic drugs. For an independent evaluation of the dossiers the NIHISB has appointed a team of internal experts. They provide evaluation reports within 60 days and a reimburserment proposal within 150 days, to be endorsed by the CRM. Guidelines have been developed to assist applicants in preparing their submissions. **RESULTS:** From January 1st to June 1st, 2002, 219 dossiers have been submitted to the CRM. Seventy-one evaluation reports were issued during the same period and timeline compliance was >90%. **CONCLUSIONS:** After five months of CRM functioning, the timelines are respected and a large majority of the evaluation reports produced by the internal experts were endorsed. The main challenges for the future will be to keep transparency and consistency in the decisions taken, to respect the short deadlines, to maintain the independence of mind of the experts, and to continue to evaluate sequentially the scientific and financial aspects in the decision making process.

**PHP4**

**OUT-OF-POCKET PAYMENT IN BELGIUM: AN ANALYSIS IN RELATION TO PATHOLOGY**

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**OBJECTIVES:** Although mainly financed by public resources, Belgian patients are in most cases bound to pay a contribution for medical acts and services described in a very precise nomenclature. In order to lower the burden of health care costs, the minister of social affairs recently restricted this patients’ contribution to a maximum (regarding the nomenclature and lump sum fees), according to the financial resources of the beneficiary. The goal of this study is to detect elements that force the level out-of-pocket payment up so that government actions can take these results into account. **METHODS:** A representative sample of 30 acute hospitals (277,521 inpatient stays) related to data on utilisation of resources and data concerning the pathology, was withdrawn from national databank (1996). Using descriptive statistics the patients’ contributions were mapped. Patients with high personal contributions were selected and analysed. **RESULTS:** On average 17% of the total invoice for a hospital stay is paid by the patients’ own resources (€198,79). This amount consists of lump sum fees (60,1%), either paid per admission (medical imaging, technical procedures, etc.) or depending on the length of stay, not reimbursed drugs (14,4%), medical acts and services as described in the nomenclature (11,3%), supplements for medical devices (7,4%), various costs (6,7%) and clinical biology (0,1%). Certain patients groups, depending on the pathology, bear a significant larger personal contribution. **CONCLUSIONS:** The “maximum invoice” does not fully cover all out-of-pocket payments. These findings may lead to further discussion considering criteria for the “maximum invoice”.

**PHP5**

**“AUT IDEM”—250 MILLION € SAVINGS P.A. FOR STATUARY HEALTH INSURANCE IN GERMANY?**

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**OBJECTIVE:** According to a law recently enacted in Germany “aut idem” is an imprint on the prescription obliging the pharmacist to give the patient a drug out of a group of its cheapest generic versions, unless the physician excludes this by marking “nec aut idem” on the prescription. In view of the Statuary Health Insurance spendings on pharmaceuticals the Ministry of Health thus intends to achieve savings of €250 million p. a. but doubts are manifold. To analyse the efficiency of “aut idem” a model calculation was made for epilepsy treatment. **METHOD:** In a decision tree model the costs of “aut idem” versus “nec aut idem” prescription of Carbamazepin were calculated. “Nec aut idem” brings no change for the patient whereas “aut idem” effects a drug switch with multiple risks for the patients. On the basis of up-to-date literature and official data sources assumptions were made on the reduction of drug efficacy due to modified bioavailability, a risk for 15% of the patients, with additional fits leading to an increase in treatment expenses of which only the costs for the patients’ social health insurance were taken into consideration. **RESULTS:** The What-if-analysis gives proof that in the ratio of €114,93 to €56,18 “aut idem” is more expensive
than “nec aut idem” per patient and quarter year. The sensitivity analysis shows that “aut idem” will only lead to cost savings if more than 92% of the pharmacists inform the practitioners about the substitution and they consequently check the medication. CONCLUSION: With a conservative estimate of 150,000 patients in Germany suffering from epilepsy and treated with Carbamazepin “aut idem” could lead to an increase in expenses of €36 million p. a. Taking into account that there are another 16 indications such as diabetes and cardiac diseases which “aut idem” could also bring additional expenses about the cost saving effect of “aut idem” is truly to be doubted.

**HEALTH POLICY—Healthcare Management/Practice Guidelines/Prescribing Studies**

**PHP7**

**MODELLING, ECONOMIC EVALUATIONS, AND THE DEVELOPMENT OF CLINICAL PRACTICE GUIDELINES: A SURVEY OF 38 GUIDELINES IN THE NETHERLANDS**

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**OBJECTIVES:** To examine the types and roles of models for economic evaluations in support of clinical practice guidelines development in the Netherlands. **METHODS:** The guideline development process for 38 recent treatment guidelines was surveyed to study the economic evaluations performed during their development, starting in 1998. To this end, a standardised questionnaire was completed by those participants who performed the economic evaluation. Since one goal of this study was to examine how models were used in the economic evaluation process, each respondent was asked a series of questions relating to the use of modelling as part of the economic evaluation activities. **RESULTS:** The most common type of patient management issue involved treatment (19 of 38, 50%), followed by prevention (8, 21%), diagnosis (6, 16%), screening (4, 11%) and care (1, 3%). Despite this variation, a limited selection of model types was used: Markov model (11, 29%), decision analysis (9, 24%), micro-simulation (8, 21%), other types (5, 13%), and no model (5, 13%). The purpose of most Markov models (10/11) was to extrapolate research results, while the purpose of decision models often varied. Existing models such as the Eastman diabetes model were often used (18/38, 47%) although new models were frequently created (15/38, 40%). **CONCLUSIONS:** During the development of clinical practice guidelines, models are often used to assist in economic evaluation. While the purpose of a model is associated with model type, the choice of model also depends on the experience in the field and the specific question at hand. As well, the frequent uniqueness of the issues faced for a given guideline means that new models are often developed. A taxonomy based on function is advised. Acceptance of the model results among clinicians was almost 100%, however this is partly explained by the iterative nature of guidelines development.

**PHP6**

**DRUG COSTS REGULATION SYSTEM IN THE SLOVAK REPUBLIC**

Tomčík D

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**OBJECTIVES:** During last decade Slovakia has been undergoing a transformation of its economy and the health care has also been completely changed. A system of health insurance had to be created and regulation tools to restrain growing expenditures, especially drug costs, had to be introduced. Nowadays one of the most developed tools is reimbursement scheme based on ATC (anatomic, therapeutic and chemical classification of WHO) & DDD (defined-daily dose) classification. The substance of this system and financial impact of reimbursement reviews are to be presented herein. **METHODS:** Mathematical modeling of current costs and expected costs were applied. Impact of non-quantitative reimbursement changes aimed at rationalizing of prescription were also analyzed. All calculations were made on the basis of health insurance data regarding drug consumption compulsorily reported to the Ministry of Health. **RESULTS:** Due to reimbursement review, difference between the drug costs trends (assuming constant reimbursement levels) and actual costs (reimbursement changes are included) for the period of 1996 through 2002 stands for approximately SKK 3.9 billion. This figure represents the savings of health insurance funds, which can be used for other purposes. **CONCLUSIONS:** Drug costs monitoring system, through obligatory reports of health insurance companies to the Ministry of Health, together with reimbursement level set per one DDD of drug enable us to influence drug costs through reimbursement reviews. Nowadays some steps to equalize the reimbursement levels of different active substances are being taken and large database analysis are in progress. It should also be emphasized that all countries are confronted with health costs increase regardless of their level of economic development. They are creating their own system of dealing with drug containment. In order to facilitate the development of most effective regulation tools the information exchange should start.