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**

Umbach I, Quaetaert M, Vannecke C, Dewitte M, Ravelingien I, Verpoorten G, Tomas M

NIHISB, Brussels, Belgium

**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 reimbursement proposal within 150 days, to be endorsed by the CRM. Guidelines have been developed to assist applicants in preparing their submissions. Dossiers have been submitted to the CRM. Seventy-one results were completed with alternative methods of data collection.

**RESULTS:** To assist applicants in preparing their submissions, a reimburserment proposal within 150 days, to be endorsed by the CRM. Guidelines have been developed to assist applicants in preparing their submissions. Seventy-one results were completed with alternative methods of data collection.

**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?**

Pirk O, Rosenfeld S, Hass B, Fricke FU

Fricke & Pirk GmbH, Nuremberg, Germany

**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 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”.

**PHP4**

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

Ooms D, Puttevils D, Wissels G, Koen P, Dirk C, Beeckmans J

Free University Brussels, Brussels, Belgium

**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 database (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”.

**Conclusions:**

The What-if-analysis gives proof that in the ratio of €114,93 to €56,18 “aut idem” is more expensive...