packets). The most widely kept medicines are medicines for the central nervous system (21%), the disorders in the digestive system and metabolism (16.7%) and medicines for the diseases of the respiratory system (14.5%). Nearly three-fourths of opened packets were not entirely consumed. A large number of medicines in home pharmacies (79%) were self initiated and many of them were beyond their expiry date (9.5%), a total of 25% of the financial means for those medicines was provided from health insurance funds. The total cost of medicines in home pharmacies per a family in Serbia was €25.13. A total of 72% of that amount was paid by the patients themselves. Pharmacoeconomic indicators in certain groups of medicines show that the largest percentage of the financial means for home pharmacies in Serbia is spent on the medicines for gastrointestinal problems and metabolism disorders (17%).

CONCLUSIONS: Based on the analyzed data, self-medication, that is, unacceptable use, sometimes requires additional treatment, which only increases the expenses for both the patients and health funds. Therefore, it is necessary to closely monitor the issuing of prescriptions as well as educate the population.

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13th Euro Abstracts

PHP74

PRIMARY HEALTH CARE AND POTENTIALLY AVOIDABLE ADMISSIONS: AN ASSESSMENT FROM THE PERSPECTIVE OF A HEALTH CARE PLAN

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OBJECTIVE: To determine the evolution of the rate of admissions for ambulatory care sensitive conditions in beneficiaries of a health care plan, monitoring of access to the health system and its performance and identifying strategies that will enable the improvement of the health situation of the population and the appropriate allocation of resources.

METHODS: Retrospective analysis of 212,360 hospital admissions occurring between 1999 and 2008, among beneficiaries of a health care plan, resident in Brazil. The outcome of the study was the proportion of admissions for primary care sensitive conditions, identified by ECD-10. The proportion of these admissions in relation to the total hospital admissions was established, as well as the quotient for the number of hospital admissions and the population, either total or by age group and specific causes, besides hospital direct costs. The significance was tested and estimates of the rates were defined based on their 95% confidence intervals. RESULTS: Admissions for primary care sensitive conditions accounted for $5.3% of 212,360 admissions reimbursed by the health plan (26.0%). The rate of admission for primary care sensitive conditions fell by 28.0% during the period (from 347.6 to 250.3 per 10 thousands). The most frequent cause was gastroenteritis (30.9%), followed by arterial hypertension (13.6%), cerebrovascular diseases (9.6%), heart failure (8.1%), kidney and urinary tract infections (6.8%), diabetes mellitus (5.8%) and angina pectoris (5.3%). The mean annual expenditure on admissions was $15,232,494 against $51,440,680 for other conditions (22.8%). CONCLUSIONS: The reduction observed in the rate of admissions for primary care sensitive conditions suggests possible improvements in primary health care. Further actions and strategies could reduce the number of avoidable admissions and contribute to the financial balance of the health care plan.

PHP75

EVALUATION OF THE IMPACT OF INPATIENT CLINICAL PHARMACY SERVICES ON THE QUALITY AND COST OF PHARMACOTHERAPY IN INTERNAL MEDICINE WARDS

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OBJECTIVES: The purpose of this longitudinal descriptive study was to evaluate the influence of interventions by clinical pharmacists on processes, outcomes of care and economical outcomes. METHODS: The patients who were hospitalized at internal medicine wards, Songkhla hospital during October 1, 2008-September 30, 2009 were recruited to this study. The core set of clinical pharmacy services were admission drug histories, drug protocol management, adverse drug reaction management, drug information, medical rounds and patient discharge counseling. The clinical pharmacists collected patients’ data, pharmacists’ interventions, direct drug cost-saving and activities on a specific designated form. The data was processed on a computerized database. Clinical pharmacist interventions were counted and classified and analyzed to determine the influence on the quality and cost of pharmacotherapy. Descriptive statistics were used in data analysis. RESULTS: At the end of the study period the following were found: a total of 3796 patients were recruited. Clinical pharmacy services on internal medicine wards contribute to maximizing the pharmacotherapeutic effect and rationalization of drug therapy in 609 patients (16.0%), increase medication safety in 338 patients (8.9%) and reducing drug expenditures in 575 patients (15.1%). Cost-saving from reconciling process was $12,682 and cost-saving from pharmacists’ interventions were $38,298. The frequent type of interventions was maximizing the pharmacotherapeutic effect (40.8%), rationalization of drug therapy (30.3%) and minimizing the risk for developing adverse drug effects (28.9%), respectively. The top two of drug related problems found in cardiovascular drugs (30.5%) and antibiotic drugs (24.8%), respectively. CONCLUSIONS: This conclusion of the study indicate that important clinical pharmacy services on internal medicine wards contribute to rationalization of drug therapy, increase medication safety and reduced the direct expenditures on medications. Therefore, future studies should include multiple sites such as in a general surgical department and clinical pharmacy services should be continued.

PHP76

ALLOCATION OF A SINGLE BUDGET FOR HEALTH CARE, PROFESSIONAL EDUCATION, AND RESEARCH

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OBJECTIVES: Funding for health care programs competes with funding for professional education (ie, implementation of health care programs) and funding for research to reduce uncertainty around program cost-effectiveness. No study has yet shown how to allocate the combined budget for health care, education, and research. Previous work did not consider the fundamental idea that interventions with an acceptable incremental cost-effectiveness ratio (ICER) for an adoption decision may not be acceptably more or less effective than those available from other sources simultaneously. Furthermore, previous work did not consider that cost-effectiveness of research is conditional upon the programs chosen for adoption and implementation. The purpose of this work is to present a sequential process to allocate a combined budget with the goal to maximize health. METHODS: Development of a 3-step allocation process to maximize health based on a single budget for health care, professional education, and research. RESULTS: As a first step, a league table approach determines which programs would be funded if the combined budget were spent just on adoption. The second step analytically determines a new (lower) threshold ICER which maximizes health by discontinuing programs above the new threshold and investing in implementing programs below the threshold. The third step considers cost-effectiveness of research funded conditional program cost-effectiveness. In order to fund this research, the threshold ICER for adoption plus implementation has to be reduced further. In order to maximize health, ICERs of research studies need to equal the newly defined threshold ICER for adoption plus implementation. CONCLUSIONS: A 3-step allocation process is able to maximize health based on a single budget for health care, professional education, and research. Compared to a programmed approach the proposed approach yields a closed-form analytical solution and is able to consider that research decisions are conditional upon adoption and implementation choices.

PHP77

DIRECT CONTRACTS ON PATIENT-PROTECTED PHARMACEUTICALS IN GERMANY: MOTIVES OF SICK FUNDS AND PHARMACEUTICAL COMPANIES

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OBJECTIVES: To investigate the motives of both contracting parties, sick funds and pharmaceutical companies, to enter into direct contracts on patient-protected pharmaceuti- cals in the outpatient sector in Germany. METHODS: A systematic literature search was performed in March 2010 to identify contracts on patient-protected pharmaceuti- cals in Germany. Standard literature databases such as PubMed and EMBASE, different market research databases and the ‘Lauer-Taxe’, the official German price registry for pharmaceuticals were utilised. We included only officially reported contracts. A detailed market analysis was conducted to identify the motives of the identified con- tracts. RESULTS: The number of direct contracts has been recently increasing. A total of 116 contracts were found. Formally, they are all rebate contracts due to German law. However, they include risk-sharing (n = 6), cost-sharing (2), added value (5) and simple rebate contracts (103). For sick funds, major motives were cost cutting, positioning within the market, attracting the ‘right’ members, improving the medical treatment and right coding. Pharmaceutical companies show several motives that can be clustered into proactive and reactive motives. Proactive motives were: gaining access to reimburse- ment beyond standard coverage, funding of managed care concepts, bridging a time gap until market entry of a successor, maintaining the attractiveness after patent expiration and shaping the market access environment. Reactive motives were: rebate con- tracts of competitors, limitations and exclusions from reimbursement by the federal joint committee as well as reacting to attempts by sick funds and Associations of Statutory Health Insurance Physicians to control drug expenditures. CONCLUSIONS: Direct contracting on patient-protected pharmaceuticals seem to play a increasing role in the strategic considerations of pharmaceutical companies and sick funds.

PHP78

A TALE OF FOUR COUNTRIES: COMPARING REIMBURSEMENT SUBMISSION REQUIREMENTS IN IRELAND, ENGLAND, WALES AND SCOTLAND

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OBJECTIVES: Requirements for a Health Technology Assessment (HTA) submission vary within the UK (England and Wales [National Institute for Health and Clinical Excellence (NICE)], Scotland [Scottish Medicines Consortium (SMC)], and Wales [All Wales Medicines Strategy Group (AWMSG)]) and the Republic of Ireland (National Centre for Pharmacoeconomics (NCPE)). The objective of this study is to determine the likelihood of reimbursement in these markets is linked to HTA submission requirements. METHODS: Dossier requirements issued by NCPE, NICE, SMC and AWMSG were compared, and a checklist of requirements compiled. We investigated 20 interventions most recently reviewed by the NCPE, and recorded the recommendations for these com- pared to those issued by NICE, SMC and AWMSG. RESULTS: Economic analysis is key for an NCPE submission, although there are no specific requirements or template for the clinical data. Requirements for NICE are the most stringent; SMC and AWMSG have similar requirements. Of 20 interventions reviewed by NCPE, 11 (55%) were reimbursed