Both hospital and outpatient products, as well as orphan drugs have been included in this analysis. All medicinal products have been assessed on the INN level, without differentiating original, innovative products from generics. In addition to general statistical analysis, the GDP adjusted comparison has also been performed. Subsequently we have used more detailed analyses, which are to be major healthcare cost drivers: C (cardiovascular), J (anti-infective), L (oncology), M (musculo-skeletal) and N (neurology, psychiatry). RESULTS: As expected, linear correlation between national GDP and number of reimbursed INNs have been observed. However, major differences in mentioned ATC groups have revealed the inconsistency of the current HTA activities across countries leading to sometimes unfair treatment possibilities for patients with different diseases which could have not been justified by unequal socio-economic characteristics of investigated countries. CONCLUSIONS: There is a strong need for the continuous education of the decision makers on the principles and processes of the HTA. New innovative ideas of financing the health care in developing countries are urgently needed in order to ensure ethical standards in health care and subsequent patient access to cost effective treatment, but at the same time to engage patients in investing in their personal health and wellbeing.

HEALTH CARE USE & POLICY STUDIES – Formulary Development

PHP16

HEALTH ECONOMICS DATA: USE AND PERCEIVED VALUE IN U.S. PAYER UTILIZATION STUDIES

Multim CD1, Ratner J1, Ball D2
1University of Maryland, Baltimore, MD, USA, 2Westat, Rockville, MD, USA

OBJECTIVES: Recent studies have documented problems with US payers’ utilization of pharmacoeconomic studies for decision-making. By replicating an in-depth survey methodology, this study aimed to determine the extent to which US practices had changed over the past decade. METHODS: Semi-structured exploratory interviews were conducted in 2007 to develop a survey instrument—fielded in 2007–08 with key formulary decision-makers at US insurers and US public payers in 9 pre-identified categories. The structured set of questions examined US health care payers’ 1) use of, and attitudes and perceptions regarding, pharmacoeconomic information, and 2) opinions about how pharmaceutical manufacturers present pharmacoeconomic information. RESULTS: Compared to 10 years ago, U.S. payers regard pharmacoeconomic information much more favorably, despite variation in their use of and attitudes toward pharmacoeconomics. Payers cluster in three groups: a minority who use pharmacoeconomic information frequently and rigorously; a broader group who examine pharmacoeconomic information informally and do rigorous analysis occasionally; and a group who only review pharmacoeconomic information in broad terms along with other drug-related information. Across all categories, payers acknowledge that the quality of pharmacoeconomic studies has improved. Payers suggest that pharmacoeconomic studies often “answer the wrong questions”—e.g., by failing to identify the subset(s) of patients where the drug is most effective. Payers remain skeptical towards pharmacoeconomic information and studies provided/sponsored by industry—e.g., when they perceive companies present only favorable studies. Increasingly, payers are more comfortable and consider clinical reviews from pharmacoeconomic evaluations; the latter may be integrated with reediting discussions. CONCLUSIONS: US payer attitudes about and use of pharmacoeconomic information have improved; however, formal, rigorous use of cost-effectiveness analysis is not the norm. Most payers forming their own evaluation using pharmacoeconomic evaluation data would welcome a neutral entity that produced pharmacoeconomic evidence—although some question whether even government funding could insulate it from industry and political influence.

PHP38

HOSPITALIZATION COST OF PATIENTS ADMITTED TO THE TEACHING UNIVERSITY HOSPITAL OF LARISSA (TUHL) IN THE REGION OF TESSALY

Andriotou L1, Theodoratou D2, Gaitouna M2
1University of Thessaly, Athens, Greece, 2University of Thessaly, Volos, Greece

OBJECTIVES: To estimate the hospitalisation cost of ICU patients admitted to the TUHL in the region of Thessaly, in Greece. METHODS: The ICU chosen is the only tertiary university ICU in the whole region of Thessaly accounting 27% of the total ICU beds. The study sample consisted of all patients (elective and emergency admissions) admitted to the respective TUHL in 2006. Clinical data were derived from patients’ medical records on a retrospective basis whereas economic data were derived from the Hospital’s Financial Department. The analysis included direct costs, using an up-to-date approach under NHS perspective. The annual hospital cost per ICU patient were based on the resource utilisation and the annual hospital balance sheets on NHS prices in Euros. RESULTS: 312 have been admitted to the ICU with a total direct cost of €4,799 million suffering from stroke, COPD, cancer, trauma, pneumonia with a mean length of stay 8.87 days. The mean cost per patient is estimated at €15,382 whereas social insurance funds reimburse only €1,666. Personnel costs are the major cost component accounting for 31% of the total cost, while the pharmaceuticals account for 23%, laboratory 11%, supply and on-call 17%. CONCLUSIONS: This research results in some meaningful conclusions for effects changing in hospital policies for better utilization of ICU resources, for optimizing patient care and incorporating economic assessment in decision-making.

PHP39

COST MEASURE IN PRIMARY CARE: RETROSPECTIVE BEHAVIOUR OF A CASE-MIX SYSTEM AT A SPANISH INTERREGIONAL LEVEL

Sanz-Manjar A1, Navarro-Artesa R2, Velasco-Velasco S3, Escrivan-Herranz E4, Prados S5, Estellach F6
1Badalona Serveis Assistencials SA, Barcelona, Spain, 2Hospital Germans Trias y Pujol, Badalona, Barcelona, Spain, 3Badalona Serveis Assistencials SA, Badalona, Barcelona, Spain, 4Instituto aragonés de ciencias de la Salud, Barcena, Spain, 5Badalona Serveis Assistencials, Barcelona, Spain

OBJECTIVES: The objective of this study is to obtain behaviour of the cost’s relative attribution with the assistance with the retrospective application of the Adjusted Clinical Groups (ACG)’s in 16 teams of Primary Care with an attended population in the clinical practice use. METHODS: Multicentre, retrospective study based on electronic records of patients seeking care during 2008 in the regions of Aragon, Balears and Catalonia. Main measurements: universal variables (age, sex, health service family practice/paediatrics) and dependent variables: episodic cost (visits, diagnostic test, referrals, drugs). The ACG case-mix System software (version 7.1, N = 106) classified subjects into a single category for a given annual resource consumption. The model of cost per each patient was established differentiating the fix cost and the variable. Outlier patients were considered those surpassing T = Q3+1.5(Q3-Q1) = €1,778.6 for total cost consumption. Log transformation of the dependent variable was carried out to reduce skewness of the distribution and make it close to normal. Explanatory power was calculated by coefficients of determination (R2). Statistical software SPSS, p < 0.05. RESULTS: The total number of the studied patients was 227,235 (intensity of use: 75.6%), with an average 4.5 ± 3.2 episodes. The age average was of 44.1 ± 23.7 years, 56.6% women (13.5% paediatrics). The distribution of costs was €148,657,137. The total unitary cost per patient/year €54,2 ± 851.7€ (relative weights of reference). Patient’s case-max 57.2% of the study population was grouped into 10 ACG. The explanatory power of the ACG classification system was 36.3% (Ln: 41.2%), p < 0.001. 62.2% of patients were considered Outliers (N = 14,066). It details the form skewness and the average relative weights per each category of ACG’s classification. CONCLUSIONS: The ACG are an acceptable system of classification of patients in situation of clinical practice use. Some ACG classification categories should be separated due to the high outliers number.

PHP40

THE CONCENTRATION OF PHARMACEUTICAL MARKET IN SOME MEDICINE GROUPS IN FINLAND

Hietanen TT1, Jussila N2
1University of Turku, Turku, Finland, 2Pharma Industry Finland, Helsinki, Uusimaa, Finland

OBJECTIVES: To study how concentrated the Finnish pharmaceutical market is in certain medicine groups. During the last decade the Finnish authorities have implemented different acts to increase the competition in the pharmaceutical market.
The yearly expenses for pharmaceuticals for hospitalized patients grew with financial data. Using registered financial data from NIHDI the evolution of the Health system was introduced for standard medication (excluding new expensive drugs, 2006, a partial (approximately 75% of the expenses) lump sum reimbursement. It is clear that the current trend of increasing drug expenditure will continue and producing reference pricing whilst continuing to reward innovation.

23.9%, Nervous System 20.5%, Alimentary Tract and Metabolism 15.4%. Cost major therapeutic classifications by cost under the GMS are Cardiovascular System Scheme 22%, High Technology Drugs and others account for the remaining 1%. The index dropped from 0.48 to 0.23. In triptans the index dropped from 0.40 to 0.17. The smallest index was seen in antillicitics. In 2002 the index in this group was 0.14 and in 2008 it was 0.12. In 2008 the most concentrated group according to the index was the protoje pump inhibitors. The index in this group was 0.38. CONCLUSIONS: From 2002 to 2008 the concentration in medicine groups has clearly diminished. The difference between these groups is partly due to patents. The two self-care medicine groups used in the study are clearly less concentrated than the prescription medicine groups. The average for all 12 groups is 0.22 and exceeds the index point of 0.18. This indicates that among the medicine groups used in calculations the market is still concentrated.

METHODS: We examined the concentration of the pharmaceutical market by using the Herfindahl-Hirschmann Index. We calculated the index for 12 different medicine groups in 2002-2008. Ten of these groups were prescription medicines and two were self-care medicines. The index is calculated by summing up the squares of the market share for all the firms operating in the medicine group. It is important that all medicine groups in each group can be substituted to each other. The index value varies between 1/n – 1, n = firms. Greater value of the HHI indicates greater concentration. If HHI is below 0.18 there is no concentration at all. RESULTS: In 2002 the total HHI average for the 12 groups was 0.30 as in 2008 it was 0.22. In anti-dementia drugs the index dropped from 0.48 to 0.23. In triptans the index dropped from 0.40 to 0.17. The smallest index was seen in antillicitics. In 2002 the index in this group was 0.14 and in 2008 it was 0.12. In 2008 the most concentrated group according to the index was the protoje pump inhibitors. The index in this group was 0.38. CONCLUSIONS: From 2002 to 2008 the concentration in medicine groups has clearly diminished. The difference between these groups is partly due to patents. The two self-care medicine groups used in the study are clearly less concentrated than the prescription medicine groups. The average for all 12 groups is 0.22 and exceeds the index point of 0.18. This indicates that among the medicine groups used in calculations the market is still concentrated.

IN BELGIUM: ASSESSING THE ADVERSE EFFECTS OF 1/N

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The rapid adoption of health technology assessment in middle-income countries: what influence does it have on pharmaceutical reimbursement? Results from a survey of health care decision-makers in 11 countries

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