Canada, Buenos Aires, Caba, Argentina, key design parameters that drive robustness as well as process elements that are with a process in order to measure task durations to estimate total process time. As international dollars PPP, (1Arg$)

OBJECTIVES: To study the economic impact of implementing a CET on the expenditure of innovative drugs in HMC. METHODS: This is a retrospective study, in which we analyzed the HMC drug utilization data for the period 2008-2010. From the Qatari perspective, a CET was calculated and used to screen innovative drugs for formulary inclusion. This was based on cost-per-quality adjusted life years (QALYs) values of innovative drugs, as analyzed from literature. Drugs that had estimated negative costs (savings) and equal or more QALYs compared with standard treatment were not taken into the analyses. Threshold and scenario one-way sensitivity analyses, and an uncertainty (Monte Carlo simulation) analysis were performed to assess the robustness of the study conclusions. RESULTS: Thirty-four innovative drugs were identified. In 2008, 2009, and 2010, there was no CET in the analysis. Based on an underestimation of the CET effect, a potential 22.2-68.0% reduction in innovative drug expenditure was demonstrated. Based on the uncertainty analysis, there is a 70% chance that a CET will result in the 68.0% innovative drug expenditure reduction. This was equivalent to QAR16,429,260 and to a 2% reduction in the overall HMC drug expenditure. Drugs were ranked as per their influence on the CET effect, where the drug ‘Siltalip’ had the highest influence. According to sensitivity analyses, study results were robust against uncertainties with inputs. CONCLUSIONS: Reduction in HMC innovative drug expenditure application was achieved through the implementation of a CET. For formulary drug selection, HMC decision makers should consider the cost-effectiveness of drugs, in addition to their effectiveness and safety.

OBJECTIVES: The burden of illness of chronic conditions (CC) among hospitalized patients: the Argentine health care cost and utilization project (A-HPUP)

METHODS: In a 1 year out of 3 hospitals, a CC (CMCR, 2006, 6: 327-546) table was used. A Pareto rank of first 10 CCs with CC (+) in primary diagnosis (Dx1) and secondary diagnosis (Dx2) among > 19 yrs old, costs, Clinical Classification Software-CCS single level-SL groupers (2009) (CCSs descriptive term), average length of stay (ALOS), total costs (CT) mean and median per discharge cost ($), (25%-75%-percentiles), in international dollar PPP, (3Arg$), 1-1.68 Arg$ PPP, 2009 were obtained. CTs of all CC burden is reported. RESULTS: Among > 19 yrs, 17,169 Dx1 with CC (+) (37.7%), had CTs: $24 393 494 (39.36% of total hospital cost) and $24 473,04, 15 102 discharges had 1 more CC (+) in Dx2 (32.97%), with a CT in PPP 216 158 768, (1.86% of discharge). In top 10 CCs with CC where 7489 discharges, a 16.39% of total discharges > 19 yrs old. CTs: $9 222,983 916. The first 10 CCs of the pareto ranking, mean age 42 yrs (SD 30.45 yrs), an ALOS was 3.54 (SD 5.07 days), with a ($) $7 150 560, (SD t 181,703), a median cost of $4 075,56 (25-75% percentiles) $1 022,97 (5-95%), and 92% of discharges. At top 10 CCs, 80% of ALOS increased, and CC (+) was ranked #1, followed by CCS #149 (Biliary tract disease), of which 19.34% was CC (+). In hospital mortality of CC (+) in Dx1 was 817 deaths (4.75%). CONCLUSIONS: CC table obtained the burden of CC in discharges at 38% of total costs. Behavior of CC in CCs are compatible with each condition. Future studies should address generalizability of results, accuracy of Dx2 coding and co-morbidity.

OBJECTIVES: To study the economic impact of implementing a CET on the expenditure of innovative drugs in Qatar. This study sought to estimate the economic impact of implementing a CET on the expenditure of innovative drugs in HMC. METHODS: This is a retrospective study, in which we analyzed the HMC drug utilization data for the period 2008-2010. From the Qatari perspective, a CET was calculated and used to screen innovative drugs for formulary inclusion. This was based on cost-per-quality adjusted life years (QALYs) values of innovative drugs, as described from literature. Drugs that had estimated negative costs (savings) and equal to more QALYs compared with standard treatment were not taken into the analyses. Threshold and scenario one-way sensitivity analyses, and an uncertainty (Monte Carlo simulation) analysis were performed to assess the robustness of the study conclusions. RESULTS: Thirty-four innovative drugs were identified. In 2008, 2009, and 2010, there was no CET in the analysis. Based on an underestimation of the CET effect, a potential 22.2-68.0% reduction in innovative drug expenditure was demonstrated. Based on the uncertainty analysis, there is a 70% chance that a CET will result in the 68.0% innovative drug expenditure reduction. This was equivalent to QAR16,429,260 and to a 2% reduction in the overall HMC drug expenditure. Drugs were ranked as per their influence on the CET effect, where the drug ‘Siltalip’ had the highest influence. According to sensitivity analyses, study results were robust against uncertainties with inputs. CONCLUSIONS: Reduction in HMC innovative drug expenditure application was achieved through the implementation of a CET. For formulary drug selection, HMC decision makers should consider the cost-effectiveness of drugs, in addition to their effectiveness and safety.

OBJECTIVES: Even though the lowest of the prices amongst reference countries were taken into account during price referencing, these prices are still relatively high according to our country’s purchasing power. The price of a certain medication is considered normal in a developed country whereas price for the same product presents itself higher than the purchasing power of developing country. Development of a new reference pricing system estimated in accordance with Turkey’s GDPc is proposed. METHODS: The most essential requirement for reference pricing, considering it will be applied on the molecules presented to the Ministry of Health (MCH) – was obtained through an assessment and GDPC no higher than the lowest reference country price. A committee of 5 academicians convened from different universities has evaluated bevacizumab, erlotinib and rituximab, using the assessment form prepared on grounds of 5 questions for the calculation of the coefficient. New public prices of the products were calculated by the use of the MCH. The pharmaceutical product pricing calculation is suggested as below: Product Price = Σ (Country GDPC/Ref. Country/GDPC + Ref. Country Price) × Molecule Significance Coefficient; Mol. Sig. Coeff. = Average Score/Total Score = 3. RESULTS: The MSC values for bevacizumab, erlotinib and rituximab were 1.09, 1.21 and 1.29, respectively. The probable the new calculated public prices depending the formulas were decreased from the public price, 37%, 40% and 21%, respectively. CONCLUSIONS: GDPc-based reference pricing sample may provide a new perspective in pharmaceutical pricing control in countries like Turkey. On the other hand, it also can provide an opinion for countries with insufficient facilities for approaching MSC and HTA, during reimbursement decision making. For instance, an MSC value under 1 is not included in reimbursement whereas one falling in between 2 and 3 is suggested for reimbursement. It is similarly used for determining the MSC reimbursement levels independent from reference pricing.