products. The average prices per physical unit and price changes after the policy varied significantly by manufacturer type. 1.8 EGP (0.26€USD) for drugs produced by state-owned companies increased by 238%, 2.3 EGP for domestic-private company products increased by 10%, 13 EGP for multinationals products decreased by 6%, and 41 EGP for imported products increased by 13%. CONCLUSIONS: Switching to a more cost-effective price system for public hospitals is expected to reduce OOP health expenditure. Despite this ten-year program, OOP spending has decreased slightly (11%) when compared to South Africa where there is a threefold decrease. CONCLUSIONS: Turkey has still room to improve its private insurance system along with OOP spending to reduce the medical costs. Turkey with a private dominant health insurance system and lower OOP spending is trying to transfer its resources towards a national health insurance system. United States stands as a stabilized private dominant health insurance model which significantly differs from Turkey and South Africa.

PHP60 MEDICATION USE SURVEY OF INPATIENTS WITH BASIC HEALTH INSURANCE FROM 2010 TO 2011 IN CHINA
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OBJECTIVES: To understand hospitalization costs, costs covered by insurance and disease distribution among urban inpatients with basic health insurance (BHI) in China between 2010 and 2011, providing data evidence for the government to improve the regulation system in the further. METHODS: A nationwide, cross-sectional sampling of urban inpatients with BHI was conducted in mainland China. A retrospective analysis was adopted and all results were extrapolated to the whole country according to the population, economic and other factors in the inpatients’ cities. The statistics analysis software was SQL Server 2003. RESULTS: There were 38.2 million hospitalization cases after extrapolating (sample=37,9822) in 2011, with an increase of 21.42% than that of the previous year. The statistic of cost was received more hospitalization cases (45.56% of the total) in 2011 than the previous year (40.10% of the total). Average hospitalization cost per visit in 2011 was 8210 RMB, an increase of 1.30% from the previous year. Remarkably, medical expenses paid by voluntary insurance we calculated approximately equal to the previous year. The expenses covered by BHI accounted for 68.39% for each visit, and 74.21% of the total costs. CONCLUSIONS: The total hospitalization cost of cancer (7.8 bil-lion RMB) was the highest, followed by cerebrovascular disease (32.8 billion RMB) and ischemic heart disease (25.7 billion RMB). The most common chronic disease was hypertension (23%), followed by COPD/asthma (13%), dyslipidemia (10%) and diabetes (6.3%). Integration of different data flows to the evaluation of cost of illness which varies from 18.00E for cancer or 12.00E for diabetes to 1200E for Acute Coronary Syndrome. Most part of this cost is due to hospitalization (49% vs 40% for drugs and 12% for diagnostic examination and lab tests). Cost of illness is strictly correlated to age and presence of co-morbidities, actually a considerable number of patients has more than one disease (17%), in elderly this percentage rises up to 50%. CONCLUSIONS: A big data infrastructure is very important to integrate administrative and clinical data for real world analyses and it is a valid instrument to support clinical governance and clinical research decision making.

PHP61 THE PROMISE OF BIG DATA – DOES THE FINANCIAL INVESTMENT PROVIDE A RETURN ON INVESTMENT FOR SMALL TO MID-SIZE MANUFACTURERS?
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OBJECTIVES: Analysis of large datasets such as claims and health care utilization databases has become a routine way that drug, device and diagnostic manufacturers understand current treatment pathways and project market potential for development products. The time, resources, and costs associated with these data analyses can be small- to mid-size companies. OBJECTIVES: To understand current treatment pathways and project market potential for development products. The time, resources, and costs associated with these data analyses can be small- to mid-size companies. METHODS: A review of published literature on claims analyses in four therapeutic areas (cardiovascular, ophthalmology, oncology, and women’s health) to better understand the costs associated with engaging in this type of research. METHODS: A literature review of published articles from January 1, 2000 – December 31, 2013 was conducted to understand the analyses of large datasets being conducted in company size. The data were then abstracted to obtain the following data: therapeutic area, funding support for data analysis, company size, large dataset utilized, approximate cost of obtaining data, approximate cost of analyzing data, approximate US patient population for drug/device indications, and scientific under development. RESULTS: Analyses of large datasets were just as likely to be conducted by government and academic institutions as private sector organizations (research firms and manufacturers). Of the 35 articles that met inclusion criteria in cardiovascular disease, 19 conducted by private sector organizations. For the 19 analyses conducted by private sector organizations, 3 were conducted by manufacturers, of which two were large pharmaceutical companies and 1 was a nationwide pharmacy chain. CONCLUSIONS: None of the claims data conducted by manufacturers were small- to mid-size companies. It is unclear whether this is due to the cost of data and analysis or the desire to have a seem- ingly unbiased third-party author. Further research is needed to determine why small- to mid-size drug, device or diagnostic manufacturers are not engaging in this type of research.

PHP62 A COMPARATIVE ANALYSIS OF PRIVATE HEALTH INSURANCE SYSTEMS IN UNITED STATES, SOUTH AFRICA AND TURKEY
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OBJECTIVES: This poster presents a comparative analysis of the private health care insurance systems (PHI) in Turkey, United States and South Africa. METHODS: OECD published health data, Turkish State Health Insurance Association, World Health Reports, Publications of Turkish Social Security Institution (SIS) and official web pages of US and South Africa Departments of Health are examined for 2001-2011. RESULTS: In comparison to Turkey, United States and South Africa have similar characteristics in terms of total medical expenditures prevailing with a higher coverage. Due to lower levels in Turkey, Out of Pocket (OOP) payments constitute a significantly higher amount. In Turkey, PHI coverage has almost tripled over the last 30 years, but still accounts only for 34.0% of the total population. The trend towards strengthening the PHI is basically due to the promotion of PHI solutions such as supplementary coverage that has been implemented in Turkey since December 2012. Total volume of PHI in Turkey is expected to expand as the scope of the coverage and the level of insurance implementation increases. There exists a diminishing trend of OOP expenses across all three countries however this is again relatively much lower for Turkey. Since 2003, Turkey has been implementing a Health Transformation Program where PHI was introduced to try to reduce OOP health expenditure. Despite this ten-year program, OOP spending has decreased slightly (11%) when compared to South Africa where there is a threefold decrease. CONCLUSIONS: Turkey has still room to improve its private insurance system along with OOP spending to reduce the medical costs. Turkey with a private dominant health insurance system and lower OOP spending is trying to transfer its resources towards a national health insurance system. United States stands as a stabilized private dominant health insurance model which significantly differs from Turkey and South Africa.

PHP63 THE ROLE OF BIG DATA IN HEALTH CARE DECISION MAKING: AN ITALIAN EXPERIENCE
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OBJECTIVES: The need to use real-world data to support Health Care decision was the main driver for the Italian Inter-University Consortium (CINEA) to set-up a population-based patient centric database (ARNO Observatory) which integrates big administrative data from National/ Regional Information Systems to monitor health economic, patient’s outcomes and measure health performance in the real world. METHODS: On a population of almost 12 million, since 1987, ARNO Observatory routinely collects and integrates NHS administrative data for each single patient over time and complete information. ARNO provides comprehensive data referred to patient: demographics, outpatient drug prescrip-tions, inpatient hospital discharges, imaging and lab tests prescriptions. From ARNO database we explored data on population subgroups to evaluate prevalence of chronic disease, co-morbidities and cost of total burden of illness. RESULTS: From a cohort of 2.5 million of ARNO population, one third subject (624 thousands during 2013) and this proportion rose with ages (84% in elderly over 80 years). The most common chronic disease is hyper-tension (23%), followed by COPD/asthma (13%), dyslipidemia (10%) and diabetes (6.3%). Integration of different data flows led to the evaluation of cost of illness which varies from 18.00E for cancer or 12.00E for diabetes to 1200E for Acute Coronary Syndrome. Most part of this cost is due to hospitalization (49% vs 40% for drugs and 12% for diagnostic examination and lab tests). Cost of illness is strictly correlated to age and presence of co-morbidities, actually a considerable number of patients has more than one disease (17%), in elderly this percentage rises up to 50%. CONCLUSIONS: A big data infrastructure is very important to integrate administrative and clinical data for real world analyses and it is a valid instrument to support clinical governance and clinical research decision making.
life insurances, ranking #1 worldwide in 2012. For individuals who purchase private insurances to add protections it is natural to ask which insurance policy provides the most favorable return. The objective of this study is to establish a valuation system for private life and annuity insurance plans using a robust, flexible, distributed cloud computing architecture. METHODS: Using the fixed income model and by constructing a valuation system based on the biochemical properties of corporate bonds, we can approximate the internal rate of returns of each insurance policy and compare their performance versus the time value of money of the full implementation of the reform legislation led to 5.8% more discharges, 5.0% more inpatient stays: The primary objective of this study is to examine the hospitals’ risk-adjusted costs, and Medicare Advantage (MA) enrollees and Fee-for-service (FFS) beneficiaries’ use of high-cost hospitals. The second objective of this study is to document the variation in racial and ethnic disparity in visitng high-cost hospitals between and within MA enrollees and FFS beneficiaries as policymakers mostly have focused on the location of care as an explanation for important disparities in many health outcomes. METHODS: We used 2006-2010 Healthcare Cost and Utilization Project State Inpatient Databases from California, Florida, Massachusetts, New York, Tennessee and Wisconsin, American Hospital Association Annual Survey Database, and Area Resource Files. We calculated the hospital cost index by dividing the actual costs to base costs for each state, which takes value 1 if the hospital cost index is less than 0.95; value 2 if it is within 0.95 - 1.05; and, value 3 if it is greater than 1.05. We used ordered logistic regression models. We also estimated the same model using a different specification of high-cost hospital definitions to ascertain any effects resulting from sample sizes. RESULTS: We found lower prevalence of high-cost hospitals among MA enrollees than among FFS beneficiaries. Our risk adjusted results show that the odds ratios for non-Hispanic white patients registered to Spanish speaking physicians is 3.8 compared to non-Hispanic white patients registered to non-Spanish speaking physicians. The results of our baseline results, we conducted several empirical estimations and tested their significance. RESULTS: Our risk adjusted estimates show that the odds ratios for Hispanic patients registered to Spanish speaking physicians is 3.8 compared to non-Hispanic white patients registered to non-Spanish speaking physicians. The results show that hospital inpatient costs associated with Hispanic patients registered to Spanish speaking physicians is about $650 less relative to Hispanic patients registered to non-Spanish speaking physicians. Our risk-adjusted results also show that hospital inpatient costs associated with non-Hispanic white patients registered to non-Spanish speaking physicians relative to the non-Hispanic white patients registered to Spanish speaking physicians lower by about $700 per visit. CONCLUSIONS: We found a strong correlation between the Hispanic patients and the non-Hispanic patients. Better communications between patients and providers can provide patients with better care.