applied in a rural district in Mexico. Identify barriers to be considered in its implementation. METHODS: Cost Study: A pilot cross-sectional, multicenter case study was conducted in 2003 in Sanitary District No. III, State of Morelos, Mexico. A general hospital, an urban health centre and two rural health centres, all managed by the Ministry of Health, were selected. The Mother-Baby Package Costing Spreadsheet was used to estimate the total cost and cost by intervention under the current model and Mother-Baby Package model. Qualitative Study: Key informants from the hospital, the urban centre and eight rural health centres were interviewed. The “3 Delays Model” was used to identify barriers to be considered. RESULTS: The total cost of the Mother-Baby Package is twice the cost of the current child and maternal health care model in Morelos, Mexico. Of the 18 interventions evaluated, those consuming the highest proportion of total costs were antenatal-care and normal-delivery. Personnel costs represent more than half of total costs. Barriers identified were machismo, culture and the negative perception of health centres amongst users (causing delay in deciding to seek care), difficulty obtaining transportation in emergency situations (generating delay in reaching a first referral level facility); and shortage of drugs, adequate equipment and trained staff (causing delay in receiving care after arriving at the facility). CONCLUSIONS: Improving the delivery of child and maternal health care in a poor setting in accordance with the Mother-Baby Package standards would require a budget two times that which is currently assigned to these services. However, before implementing a scaled-up version of the package it would be essential to manage problems that appear to be barriers that exist in providing and accessing appropriate maternal and child health care.

MEN’S AND WOMEN’S HEALTH

MEN’S AND WOMEN’S HEALTH—Quality of Life/Utility/Preference Studies

VALIDATION OF THE SPANISH VERSION OF THE SELF-Esteem And Relationship (SEAR) QUESTIONNAIRE FOR MEN WITH ERECTILE DYSFUNCTION (ED)

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OBJECTIVES: To assess the clinimetric properties of the Spanish version of the Self-Esteem And Relationship (SEAR) questionnaire to be used in Spain with patients with ED. METHODS: The SEAR questionnaire comprises 14 items divided into two domains: Sexual Relationship (8 items) and Confidence (6 items), the latter comprising Self-Esteem (4 items) and Overall Relationship (2 items). The USA-English-version of SEAR questionnaire was adapted linguistically into Spanish by using forward and back translation methods and a conceptual equivalence approach. The SEAR questionnaire was administered to a group of patients with ED (IIEF < 26) seven days before starting treatment and at baseline and after three months of treatment (group A), and to a group of healthy control subjects (IIEF ≥ 26) (group B) in a single visit. SF-12 and HAD scales were also administered. RESULTS: Of 831 recruited subjects (n = 732, group A; n = 99, group B), 559 subjects were included as evaluable for validation analysis (n = 504, group A; n = 55, group B). The percentage of patients without response was < 5% for all domains. Cronbach’s Alpha coefficient was 0.92 and 0.86 in groups A and B. The SEAR questionnaire discriminated between patients and controls (area under curve = 0.999) and groups of patients by severity of ED (Kruskall-Wallis test; p < 0.0001). Correlation was high with Erectile Function scale of IIEF (r = 0.69) and moderate with HAD (r = −0.14) and SF-12 Mental Health (r = 0.38). The SEAR questionnaire also showed responsiveness with improvement in scores from start to end of treatment (Mann-Whitney-Wilcoxon test; p < 0.0001). CONCLUSIONS: The SEAR questionnaire showed adequate feasibility, reliability, validity and responsiveness for its use for measuring the emotional tension and relationship difficulties associated with erectile dysfunction.

INFERTILITY TREATMENT POLICIES IN GERMANY AND THE UNITED KINGDOM—WILLINGNESS TO PAY AMONG AFFECTED COUPLES

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OBJECTIVES: Assisted Reproduction is among the fastest growing areas of medicine, rising debates about financing in vitro fertilisation (IVF) or other assisted reproductive techniques by national third party payers. This study describes policies of infertility treatment as well as willingness to pay for treatment in affected couples in Germany (contribution-financed health care system) and the U.K. (tax-financed health care system). METHODS: Literature review with the key words: infertility, willingness to pay, epidemiology. For assessment of national reimbursement policies, websites of the respective health care institutions were reviewed. RESULTS: In 2001, over 25,000 IVF treatment cycles were carried out in Great Britain, 25% being funded by the National Health Service. New clinical guidelines accepted by the Department of Health, assure that from 2005, more assisted reproduction services are covered by the NHS, such as one full cycle of IVF. Over 2/3 of the patients currently paying privately are expected to demand for NHS services resulting in an enormous increase in IVF treatment. In Germany, about 75,000 treatments were performed in 2001. Since January 2004, German statutory sick funds restricted reimbursement to 50% of the costs for the first three IVF treatment cycles. Due to these regulations, changes in treatment patterns for IVF can be expected for the future. An ongoing online-questioning revealed that for only 60%, the decision for IVF treatment remained unchanged, whereas the rest either postponed the decision or cancelled IVF. Two studies (USA, Sweden) revealed the willingness to pay of infertile couples to be 14,500€ or more. CONCLUSIONS: Contradictory dynamics between willingness to pay and change of mind due to restrictive reimbursement policies show need for more research in the field of infertility treatment. Economic and social consequences of changing frame conditions for IVF should be closely assessed, to ensure high quality of life for affected couples.

SHORT-TERM AND LONG-TERM PSYCHOSOCIAL CONSEQUENCES OF FALSE POSITIVE SCREENING MAMMOGRAPHY—DEVELOPMENT OF TWO NEW QUESTIONNAIRE BASED ON THE PSYCHOLOGICAL CONSEQUENCES QUESTIONNAIRE (THE PCQ)

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OBJECTIVES: Adaptation and validation of measures of short-term and long-term consequences of false positive screening-mammography. METHODS: After translation (including quality
control) of the PCQ it was presented in six focus groups (5–7 women) and in 15 telephone interviews. All interviewees had previously experienced false positive screening-mammography. Validation-I: Six hundred women completed the short-term questionnaire together with the Danish version of the Nottingham Health Profile (NHP). One-third had had abnormal and two-thirds had had normal screening-mammography. Validation-II: One hundred twenty-seventy women who had had false positive screening mammography up to 6 months ago, and 197 women with normal mammography completed the long-term questionnaire. Data were analysed using traditional psychometric theories and Item Response Theories. RESULTS: None of the PCQ items were found irrelevant. The interviewees, however, found that not all consequences of false positive screening-mammography were covered by the PCQ. Twenty-eight items were generated (including splitting of double-barrelled item) and it was decided to divide the questionnaire into 2, 1 measuring short-term and another long-term consequences. Both questionnaires were found to be reliable with Cronbach’s Alpha 0.95 and 0.90. Validation-I: 4 strongly correlated dimensions (24 items in total) were found to be in order and additive, 4 single items were kept because of high face validity and five “bad” items (including one of the original PCQ items) were deleted. Results on Know Group Validity and Concurrent Validity (i.e. correlation with the 6 NHP sections) confirming the a priori hypothesis will be presented at the conference. Validation-II: No bad items were identified. Three strongly correlated dimensions (13 items in total) were found to be in order and additive. CONCLUSIONS: Two reliable and valid instruments, one on short-term and one on long-term psychosocial consequence of false positive screening-mammography have been developed and are currently under adaptation into Norwegian and English.

NEUROLOGICAL DISORDERS (Migraine, Alzheimer’s, Dementia)

NEUROLOGICAL DISORDERS (Migraine, Alzheimer’s, Dementia)–Clinical Outcomes Studies

PREVALENCE, HEALTH RESOURCES USAGE AND COST OF VASCULAR DEMENTIA IN COMPARISON WITH ALZHEIMER DISEASE IN A POPULATION SETTING IN SPAIN

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OBJECTIVES: To assess the prevalence, health resources usage (HRU) and cost of Vascular Dementia (VD) in comparison with that of the Alzheimer Disease (AD) in a population setting in Spain. There few data available on HRU and cost of VD, and no information is available in Spain. It is estimated that economic impact of VD may be even higher than AD. METHODS: A cross-sectional & retrospective, observational study with two phases was designed. In 1st phase, patients with diagnosis of dementia were selected from a database claim. During 2nd phase, a clinic evaluation, including administration of Mini-Mental State Examination, was performed along with data collection on HRU. Direct costs were estimated by sum of HRU during last 6 months. Also, caregiver burden was determined by counting the time dedicated to patient care. Descriptive statistics, regression models and bootstrap techniques were used.

RESULTS: A total of 6004 claims were reviewed, of whom 224 out of 258 with dementia fulfilled criteria of VD or AD diagnostic. Subjects with mixed dementia were excluded from the analysis. Total prevalence was 4.3% in population above 64 years old and increased with ageing; 64.3% was of AD type, and 28.1% of VD. The total cost of dementia per patient per a 6-month-period was significantly higher for VD than for AD; 10.316€ versus 8.209€, p < 0.05. The proportion of cost attributable to caregivers was the main component of burden in both types; 85.5% in AD versus 84.4% in VD. CONCLUSIONS: Prevalence of dementia increases with ageing, although no sociodemographics differences could be identified. Health care costs are substantial for this disorder, particularly for VD in comparison with AD. Cardiovascular risks prevention in VD should be associated to a positive impact in health care resources utilization for this dementia.