tiple logistic regression models. As result of the very high correlation amongst MLHFsQ score, physical and emotional subscales, and HRQoL; it can be used for further quality of life utilities studies. The translated Hindi version of MDQ showed an excellent fit between CD4 count and HRQoL. METHODS: A hospital-based prospective cross-sectional study was performed on 204 HIV patients. The relevant, CD4 count and sociodemographic details were assessed using WHOQOL-HIV BREF questionnaire. RESULTS: A total of 101 patients were male and 103 female. 66.3% of male patients and 88.3% of female patients were younger than 40 years of age. 84.2% of the male patients and 70.9% of the female patients were married. 34.6% of male patients were manual laborers and 58.3% of the female patients were housewives. Heterosexual contact was the major mode of transmission (Male: 90.1%, Female: 97.1%). Most of the patients had a CD4 count of between 301-500, and HRQoL scores showed that there was significant difference between genders in physical, psychological and environmental domains in both baseline and follow up. HRQoL scores in patients having higher CD4 count is better than patients having lower CD4 count. CONCLUSIONS: The most important factors that have association with the health related quality of life of the patients in this study were gender, marital status and Duration of ART in one or more domains and endorsed the importance of patient education. IPTNQ7

QUALITY OF LIFE WITH TYPE2 DIABETES: TRANSLATION AND VALIDATION OF INDIAN VERSION OF MDQ

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OBJECTIVES: To perform the cultural adaptation, translation and validation of Multi Dimensional Questionnaire (MDQ) instrument for use in Indian type 2 diabetic patients. METHODS: Validated English version of MDQ instrument was selected for the study. Instrument was subjected to forward and back translation to generate final version in the Hindi language. The instrument consists of three dimensions of MDQ: 1) General perceptions of diabetes and related social support measuring interference, severity and social support; 2) Social incentives related to self-care activities measuring positive reinforcement and positive incentives; 3) Self-efficacy and outcome expectancies measuring self-efficacy and outcome expectancies. RESULTS: Validation was done in two hundred fifty Indian diabetic type 2 patients after the pilot testing in 20 patients. Internal consistency was assessed using cronbach’s alpha and value of 0.869 was gained for the summary score, indicating high levels of internal reliability. Alpha values for total ranged from 0.84 (max) to 0.82 (min). Alpha values for all the three subscales, General perceptions of diabetes and related social support was 0.81, Social incentives related to self-care activities was 0.93 and for Self-efficacy and outcome expectancies was 0.87. CONCLUSIONS: The results of the study reveals the validation of the MDQ instrument in Hindi language. This translated Hindi version of MDQ can be used for further quality of life utility studies.

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WILLINGNESS OF THE HEALTH CARE CONSUMERS TO PAY FOR HEALTH CARE SERVICES – RESULTS FROM A CONTINGENT NET VALUATION STUDY

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OBJECTIVES: We use contingent valuation (CV) method to elicit the willingness of the Hungarian health care consumers to pay for health care services covered by the social health insurance. METHODS: For the analysis, we use data from a household survey, which was carried out in Hungary, 2010. Respondents were selected based on a random-size-stratified probability method. In total, 1037 respondents filled-in the questionnaire. In the CV task respondents were asked whether they would be willing to pay in a given scenario for 1) a consultation/examination by a medical specialist, 2) for a planned surgery, if these services are provided with certain quality and access attributes. Those respondents who indicated willingness to pay were asked to point out the amount which they would be willing and able to pay. A visualization card was presented to the respondents, which described the definition of good quality and quick access and contained payment intervals. The scenario was prepared based on focus-group discussions prior to the survey. Payment intervals were set based on the pre-test of the questionnaire. RESULTS: The response rate of the survey was 67%. About 66% of the respondents indicated that they would be willing to pay for a consultation and examination by a medical specialist in order to obtain services with good quality and access as described on the visualization card. Median value for differences between reimbursement and hospital costs was 14 Euro (sd = 21) per visit. About 56% of the respondents indicated that they would be willing to pay for a planned surgery, on average 101 Euro (sd = 65) per hospital admission. CONCLUSIONS: Hungarian health care consumers are not against paying fiscal fees for health care services covered by the social health insurance, however they expect value for their money.

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DOES DISEASE ADVOCACY IMPACT PRIORITY SETTING: EVIDENCE FROM THE NEEDS AND PRIORITIES FOR COMPREHENSIVE LIVER CANCER CONTROL IN 12 COUNTRIES IN EUROPE AND ASIA-PACIFIC

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OBJECTIVES: According to popular opinion in Poland many health care services are publicly financed much below level of costs incurred by providers. However, scientific data on that issue is hard to find available. The aim of this study was to critically analyze the actual state of financing of hospital treatment of patients with venous thromboembolism (VTE). METHODS: Data on costs were collected through retrospective review of medical records (all patients admitted due to VTE in years 2006-2008; 166 qualified out of 370 analysed) and financial reports (FY 2009) obtained from three hospitals. The National Health Fund tariffs applied in 2009 (DRG system) were also used. Two scenarios of cost valuation were used: real cases (including all concomitant diseases) and VTE-isolated. Significance of differences between costs and reimbursement and among various patient groups was assessed using Mann-Whitney Utest. RESULTS: Reimbursement of real cases wasn’t significantly different from VTE-isolated. Advantage of applying TISS (Therapeutic Intervention Scoring System) scale for reimbursement was significant in VTE-isolated group (A> 67% for maximum values, 44% for minimum values; 36% for averages; 0% for medians; p=0.004) and in real cases scenario (A> 68% for maximum values, 44% for minimum values; 36% for averages, 0% for medians; p=0.004). Reimbursement exceeded hospital costs (VTE-isolated cases; A> 31% for total values and averages; p=0.0052). Median value for differences between reimbursement and hospital costs was 21.33. The highest positive differences were found in short-term hospitalizations due to pulmonary embolism with stay at Intensive Care Unit. Negative differences were found in long-term hospitalizations due to deep vein thrombosis with stay at ICU and without possibility of using TISS scale. CONCLUSIONS: Reimbursement of VTE hospital treatment with TISS scale exceeded incurred costs. Usage of TISS scale enabled hospitals to obtain higher reimbursement from the public payer.

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AN INFLUENZA VACCINATION POLICY BASED ON A PREVIOUS YEAR’S ILLNESS

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OBJECTIVES: Vaccination is the most efficient and cost effective method to prevent...