C1

IMPACT EVALUATION OF PROVIDER PAYMENT REFORM UNDER THE NEW COOPERATIVE MEDICAL SCHEME IN GAN SU PROVINCE, CHINA

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OBJECTIVES: The New Cooperative Medical Scheme (NCMS) which aims to reduce cost of catastrophic health spending for rural residents has substantially improved health care access and utilization in China. However, cost containment and provider incentive remains a huge challenge, which has been particularly acute in poorer rural areas, such as the North-West. Over the past years, several counties in Gansu province have introduced a variety of provider payment reforms, shifting from the traditional Fee-for-Service to case-based, global budget and/or per diem methods. This study provides the first impact evaluation of these reforms.

METHODS: Using the experimental design and a collected NCMS claims data from 2008 to 2013 in three counties. A difference-in-difference analysis is performed to take advantage of the variation in provider payment methods implemented at different years across the counties. We also control for patients age, gender and diagnosis as well as demographic factor of each county in estimating the effects of payment reform on cost (measured by inpatient health care expenditure) and utilization (measured by inpatient and outpatient visits). In this study, we conduct key informant interviews with policymakers, hospital administrators, and medical professionals to better understand the design and implementation issues involved in the reform process.

RESULTS: Preliminary data analysis indicates that in one county, the provider payment reform is associated with 9.8% drop in total health care expenditure per admission. Length of stay fell by 4.9% as a result too. However, other factors such as changes in the demand-side reimbursement rate may also influence the outcomes. Differences in local infrastructure and technical capacity have led to the same payment method implemented differently at the county level.

CONCLUSIONS: Provider payment reform in rural China can be an effective way to control health expenditure. However, more technical guidance on designing the right payment is needed for future reforms.

C2

HEALTH CARE UTILIZATION AND COST COMPARISON BETWEEN ADHERENT HYPERTENSION PATIENTS TREATED BY SINGLE EXFUGE HCT AND AMLODIPINE/VALSARTAN/HYDROCHLORTHIAZIDE FREE COMBINATION

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OBJECTIVES: Single pill combinations (SPC) are associated with improved adherence and persistence in hypertensive (HTN) populations. High adherence and persistence can provide medical benefit for patients and reduce the total health care utilization and costs. This study investigated if Exforge HCT is associated with reduced health care utilization and costs compared to amlopidpine, valsartan and hydrochlorothiazide (FC) cohort, and at least 80% Medication Possession Ratio (MPR) were required. Chi-square tests and independent sample t-tests were used after propensity score matching (PSM) (absolute standardized differences (ASD) < 0.1) using demographics, comorbidities, pre-index IBD, pre-index costs and valsartan initial dose. RESULTS: Adherent Exforge HCT patients (N=6,004) had better outcomes compared to adherent FC patients (N=1,084) in the 12 months follow up period: less all cause hospitalization (8% vs 16.6%, p<0.05; Mean 0.1 vs 0.2 per 100 person years), less all cause ER visits (19% vs. 29.9%, p<0.05; Mean 0.3 vs 0.6, p<0.001), less HTN specific ER visits (7.0% vs 12.0%, p<0.05; Mean 0.1 vs 0.2, p<0.001), less total medical service cost(7247 vs $10370, p<0.0001), less total prescription drug cost ($9356 vs $3550, p<0.0001) and less total health care costs ($1173 vs $15720, p<0.0001). After applied PSM, adherent Exforge HCT patients still had lower proportion of all cause hospitalization, all cause ER visit and less number of all prescriptions, p<0.05. CONCLUSIONS: Real-world data indicate that Exforge HCT is associated with less health care utilization and costs compared to amlopidipine/valsartan/hydrochlorothiazide FC among patients with adherent treatment of HTN.

C3

ANTICIPATED PRICE DISCLOSURE IMPACT ON FUNDING DECISIONS IN AUSTRALIA

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OBJECTIVES: Generic entry of pharmaceuticals in Australia triggers a price reduction of the brand, followed by further reductions via a process called ‘Price Disclosure’ (PD). Significant price reductions for standard of care (SOC) derived through PD significantly lower all-cause mortality rate (14.4% vs 51.7%, p<0.001) and fewer hospitalizations due to cardiovascular problems (p<0.001) were observed in patients discharged with statins. LDL-C goal attainment of < 100 mg/dL (2.6 mmol/L) resulted in a significant reduction in mortality (10.8% vs 24.2%, p<0.001), but not for goal attainment of < 70 mg/dL (1.8 mmol/L). Significant differences in overall survival existed between LDL-C < 100 mg/dL (2.4 mmol/L).

CONCLUSIONS: This study revealed a J-curve phenomenon in ACS patients of Hong Kong. Further research should be conducted to assess the necessity of aggressive LDL-C reduction to < 70 mg/dL (1.8 mmol/L).

C4

DOES THE CURRENT RECOMMENDED TARGET LDL GOAL IMPROVE SURVIVAL FOR ACUTE CORONARY SYNDROME PATIENTS IN HONG KONG?

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OBJECTIVES: This study primarily aimed to assess the current prescribing pattern of lipid-lowering agents and the percentage of LDL-C goal attainment in myocardial infarction (MI) patients in local practice, and to evaluate clinical outcomes of patients defined by prescription of statins and by LDL-C level after discharge. METHODS: We retrospectively reviewed 696 hospitalized patients in the local ACS registry of Prince of Wales Hospital during 1 January 2008 to 31 December 2009 with data retrieved using computerized clinical records of all patients. RESULTS: Of the 403 MI patients included, 104 (25.9%) were prescribed with statins at discharge. Percutaneous coronary intervention (PCI) performed or planned during hospitalization (OR: 0.324, p=0.001) and latest LDL-C level before discharge (OR: 0.321 for an increment of 1 mmol/L, p=0.001) were significant independent predictors of the absence of statin prescriptions at discharge. A signifi-