HP12 THE RATIO OF PUBLIC REIMBURSEMENT AND PATIENTS’ CO-PAYMENT IN THE FINANCING OF SPA SERVICES IN HUNGARY

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OBJECTIVES: Hungary has long and strong traditions in providing spa services. The reimbursement of spa services includes both public health insurance scheme and patient co-payment. The aim of our study is to analyse the ratio of public reimbursement and co-payment in financing of spa services in Hungary.

METHODS: Data were derived from the nationwide administrative dataset of the National Health Insurance Fund Administration (OEI), the only health care financing agency in Hungary covering the year 2007. We calculated within the total spa spending the annual health insurance reimbursement and the patient co-payment at county and regional level. Hungary is divided into 7 regions and 20 counties.

RESULTS: On nationwide level, the average ratio of patients’ co-payment was 28.0 %, while the remaining 72.0 % was reimbursed by the National Health Insurance Fund Administration (OEI). At regional level, the ratio of patients’ co-payment varied between 22.7 % (in the Northern-Transdanubian region) and 35.4 % (in the Western-Transdanubian region). At county level, we found the lowest ratio of patients’ co-payment in county Csongrád (19.8 %), Hajdu-Bihar (21.3 %) and Békés (23.1 %), while the highest ratio of patients’ co-payment was observed in county Zala (53.4 %), Veszprém (46.6 %) and Somogy (33.3 %). CONCLUSIONS: in financing of spa services in Hungary, patient co-payment has a significant role: 28.0 % of total expenditures. There are important inequalities in the ratio of patient co-payment at both regional and county level.

HP13 GEOGRAPHICAL INEQUALITIES OF HOME CARE (NURSING) IN HUNGARY

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OBJECTIVES: Home care (nursing) was introduced into the Hungarian basic health insurance package in 1996. The aim of our study is to analyse the geographical inequalities in home care (nursing) in Hungary.

METHODS: Data were derived from the nationwide administrative dataset of the National Health Insurance Fund Administration (OEI), the only health care financing agency in Hungary. The utilization of home care (nursing) services was measured by the number of patients and the number of home care visits per 10,000 population. Both indicator was calculated to 10,000 population.

RESULTS: We found the highest utilization in the following counties: Zala (65), Baranya (65), Jász-Nagykun-Szolnok (64), Vas (59), Somogy (54), Borsod-Abaúj-Zemplén (54) and Győr-Moson-Sopron counties. The lowest utilization rate was measured in Komárom-Észtergom (43), Fejér (43), Nógrád (38) and Szabolcs-Szatmár-Bereg counties (all are for 10,000 population). The average number of patients in the Hungarian home care system was 50 / 10,000 population. We found the highest utilization in the following counties: Zala (53.4 %), Veszprém (46.6 %) and Somogy (33.3 %).

CONCLUSIONS: in financing of spa services in Hungary, patient co-payment has a significant role: 28.0 % of total expenditures. There are important inequalities in the ratio of patient co-payment at both regional and county level.

HP15 IMPLICATIONS OF LATIN AMERICAN PHARMACEUTICAL PRICING REFORM FOR THE UK NHS

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OBJECTIVES: Mexico and Brazil have well-developed pharmaceutical pricing systems, with an increasing trend towards use of Health Technology Assessment in access decisions. However, there are significant differences in the prices of innovative medicines in the two countries. The object of the study is to clarify to what extent local decision making criteria can account for these discrepancies and therefore which evaluation mechanisms may have international relevance.

METHODS: Secondary research was carried out to identify prices in Brazil and Mexico for 5 patented oncology medicines. A rating scale was then devised with the number of patients and the number of visits per 10,000 population.

RESULTS: We found significant inequalities in the utilization of home care (nursing) in Hungary measured both by number of patients and the number of visits per 10,000 population.
TECHNOLOGY INTRODUCTION

efficient and contribute to the sustainability of the health system. However, the rational public health policy. They could improve health care expenditure efficiency, and reduce costs for healthcare providers and patients. In the Hungarian health care system, there was a clearly supporting health policy regarding the increasing role of private health care providers. The aim of the study is to analyze the market share of for-profit private sector from the public health insurance expenditures on medical services. METHODS: Data were derived from the nationwide administrative data-set of the National Health Insurance Fund Administration (OEP), the only health care financing agency in Hungary, covering the period 2006-2009. The analysis includes the medical provisions (primary care, hospital care, dental care, and inpatient care, home care, kidney dialysis, CT-MRI). We calculated the health care insurance reimbursement according to the following categories of health care providers’ ownership status: local authorities, central government, for-profit companies, and non-profit providers. RESULTS: In 2006 only 15.8% ($12.8 billion Hungarian Forint, HUF) of total expenditure for medical services went to for-profit private providers. After 2006, the market share of private for-profit health care providers increased to 30.9% (222.3 billion HUF), the local authorities had 43.8%, the central government 22.7% and the non-profit sector 2.5% market share. We found the largest increase of private for-profit health care providers in acute (from 0.8% in 2006 to 14.3 in 2009) and chronic care (from 1.1% in 2006 to 20.6% in 2009). CONCLUSIONS: In line with the health policy objectives between 2006-2009, we found a significant increase of private for-profit companies from health insurance financing; they doubled their market share from 15.8% (2006) to 30.9% (2009). This increase was attributed to the functional privatization of acute and chronic care hospitals.

OBJECTIVES:

ECONOMIC EVALUATION OF POISON CONTROL CENTERS: A SYSTEMATIC REVIEW

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OBJECTIVES: To classify the existing economic evaluations of poison control centers (PCCs). METHODS: A literature search was performed to identify complete economic evaluations regardless of language or publication status by searching the following databases: Medline (via Pubmed), Embase, Centre for Reviews and Dissemination Databases, Cochrane Database, Cochrane Central, metaRegister of Clinical Trials, LIARCS, Scielo, ProQuest, Capes (Brazilian theses register) databases and abstracts at toxicology congresses. Two reviewers assessed abstracts for inclusion and extracted the data. Two experts assessed studies’ quality with a standardized tool (Drummond 2005). RESULTS: A total of 363 non-duplicated reports were identified, but only nine met eligibility criteria. Five studies were published in the 1990s, and four were published in the following decade. PCCs were compared to a scenario in which they did not exist. Benefits were measured as potentially avoided healthcare costs. Eight studies used cost-benefit analyses, and the other one used a cost-effective-ness approach. Only two studies did not meet at least seven of 10 quality criteria. Cost-benefit ratios ranged from 0.76 to 7.67, what means that each dollar spent on poison centers saves almost US$ 8 in other medical spending. Incremental cost-effectiveness ratios were US$ -12,000 for morbidity and -56,000 for mortality. These results indicate that a significant cost savings is realized with each successful outcome achieved by a poison center: US$ 12,000 in case of morbidity and US$ 56,000 in case of mortality. CONCLUSIONS: Investment in PCCs appears to be a rational public health policy. They could improve health care expenditure efficiency and contribute to the sustainability of the health system. However, the number of PCCs is decreasing in many countries.

MEDICAL SERVICES COST INFLUENCE ON THE RATIONALITY OF THE MEDICAL TECHNOLOGY INTRODUCTION

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OBJECTIVES: To define the value medical services cost while conducting pharmacoeconomic analyses. METHODS: A review of pharmacoeconomic researches of S-5 alpha reductase inhibitors (S-AR) application for treatment benign prostatic hyperplasia (BPH) has been conducted. The average costs for medical services for care and treatment of BPH patients have been defined. The prices analysis of the medical services Belarusian market in a “urology” specialty has been made. The average prices comparison (in US dollars) of the actual medical services and prices taken from medical literature has been done. RESULTS: The foreign medical literature review of using the S-AR for BPH patients shows the considerable economic expenses because of an acute urinary retention hospitalization and surgical treatment of BPH. The medical services cost is considerably cheaper to compare with the costs given by foreign researchers. We have identified three procedures providing the significant contribution to the above-stated discrepancies: the urologist examination cost in the USA 9 times exceeds the similar procedure in Europe (47.9 versus 5.1 euros). Transurethral resection (TURP) procedure costs is 5 times (794$ versus 155$) and 1 day hospitalization cost without operative interventions and anesthesia is 364 times (4089 versus 13,28) more. CONCLUSIONS: Hospital services and the medical staff work high cost in western countries allows proving economically out-patient treatment methods. The end-points choice of the events demanding hospitalizations is not optimum at making pharmacoeconomic researches in Belarus because of the low contribution in hospital expenses versus the drug therapy cost. A complex approach with integration of several economic analyses is required to introduce new expensive innovative drugs on the Belarusian pharmaceutical market.

USE OF DECISION MODELING TO ESTIMATE THE NEGATIVE IMPACT OF TOBACCO USE ON HEALTH CARE COSTS AND HEALTH DISPARITIES IN PEOPLE LIVING WITH HIV


OBJECTIVES: after people living with HIV (PLWH) start on highly active antiretroviral therapy (HAART), rates of hospitalization for PLWH’s declined, but continued to exceed non-HAART study group levels. This increase prevalence of tobacco use among PLWH and paucity of current data provide the rationale to study if tobacco use might affect cost and clinical benefits of HAART among PLWH. METHODS: A decision-tree model guided our assessment of the impact of tobacco on costs and effectiveness of HAART by race/ethnicity. Using a payer perspective, the probabilities related smoking status and outcomes were informed by survey (African-Americans, Caribbean, Hispanics, Caucasian) were obtained from our prior tobacco study (n=560) along with the number of hospitalizations. This information along with hospital bed/day costs, provided by Jackson Memorial Hospital’s patient accounting system, was used to estimate the impact of the tobacco with a 1-year time frame. Results were express as cost per hospitalizations related to smoking diseases (HRSD): Among patients receiving antiretroviral therapy, our data indicated that smoking contributed a $480,029 additional cost/year, with an average of $6,234/HRSD and an incremental cost of $4,750 compared to non-smokers in the same treatment group. In the Non-HAART Group, the incremental cost for smokers was $2,064,469, with an average of $8,054/HRSD and an incremental cost of $7,486. When racial group were evaluated for smoking habit, the average costs for Hispanics receiving HAART was $10,975/HRSD. African Americans despite the high cost reported for the total group had an average cost of $8011/HRSD. CONCLUSIONS: In PLWH receiving HAART, our analysis indicated that the benefits of HAART were negatively impacted by tobacco use and costs are increased in the smokers both in the HAART and Non-HAART groups. The data also indicated that focusing tobacco prevention efforts on minorities may maximize effectiveness in terms of disease prevention and cost reduction.