hospital characteristics, patterns of medication used, and outcome measures. Multivariate analyses such as general linear model (GLM) and logistic regression were performed. **RESULTS:** Logistic regression results show that hospital size ($p < 0.0001$), hospital type ($p < 0.0472$), type of procedure ($p < 0.0001$), and hospitals having a careplan for surgical site infection ($p < 0.0032$) were significantly associated with the probability for patients to get the recommended prophylaxis. Based on the results from GLM regression analysis, older age is significantly associated with longer LOS ($p < 0.0001$) for all procedures. Scheduled operations ($p < 0.0001$) and receiving the recommended prophylaxis ($p < 0.0214$) were significantly related to a decrease in LOS. Also, a significant effect on LOS was observed, depending what kind of surgical procedure patients underwent and what hospital they were admitted. **CONCLUSIONS:** Compliance with practice guidelines may reduce LOS, which suggests improved patient outcomes and decreased health care costs.

**PHP28**

## COST-BENEFIT ANALYSIS OF A STATE POISON CENTER

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**OBJECTIVE:** A cost-benefit analysis was conducted to compare the costs associated with operating a poison center to the benefits derived from center availability. **METHODS:** Costs were measured as the direct cost of operating the center, including personnel, reference sources for clinical information, equipment, and administrative overhead expenses. Benefits were measured as the opportunity cost of alternative treatment strategies had a poison center not been available to callers. Data were collected through a concurrent telephone survey of poison center callers at the time of the initial poison exposure call. Callers were asked a series of three questions regarding actions they would have taken if the poison center were not available. Follow-up calls were used to assess actions callers actually took after calling the center. Inputs and benefits were valued using average local prices for medical services from a state paid claims database. A decision analysis model was constructed to calculate the expected cost of poison treatments under two scenarios (poison center available or not). Model probabilities were derived from the percentage of callers indicating that they would pursue a particular course of action. **RESULTS:** A total of 1695 poison exposure cases were included in the analysis. The average cost per poison exposure associated with not having a poison center available was $62.40. This figure represents the benefit of having a poison center. The average cost of managing a poison call was $8.52, yielding a benefit per call ratio of $7.32. This ratio reflects the amount of additional health care expenditures avoided per dollar expended in a poison center consultation. A sensitivity analysis was conducted to assess the impact of changes in emergency service use on the model. **CONCLUSION:** Based on our analysis, the immediate information and treatment advice available through a state-run poison center has as a positive societal value.

**PHP29**

## WHERE DOES THE GERMAN HEALTH CARE SYSTEM WANT TO GO TO?

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**OBJECTIVES:** The focus of present health political discussion in Germany is concentrated on financing as an instrument to meet the future needs of German population. Government wants to cut back benefits by offering alternative funding mechanism, which is tax financing and additional patient payments. The recent and significant changes to Health care funding in Germany is reviewed. **METHODS:** A literature review was conducted to analyze a number of strengths to the financing and funding arrangements in the German Health care system. The potential advantages for priorities, efficiency, and equity from this structure of financing are considered. The results will be compared to the design of the currently started plans for a further Health care reform in Germany with focus on financing. **RESULTS:** The current most important scheme of social health insurance (SHI) finance intended to mobilize resources for health care, to insure against risk, and to provide stable finance seems for the government not to be any longer the funding mechanism that helps to control costs and to secure access to broad priority services. Government intends to use finance mechanism to shift low priority services into SHI and put high priority services into finance mechanism of user charges. The level of priority services is—so far—not a result of discussions in the community. Financial fairness is best served by the cornerstone of more progressive prepayments as it is the case for SHI premiums instead of patient payments. Co-payments have the effect of rationing use health care services but does not effect in rationalizing its demand by insured. **CONCLUSIONS:** Currently risks are distributed according to ability to pay rather than to risk of disease. Financing fairness is best served by the cornerstone of progressive prepayments as it is the case for SHI premiums instead of patient payments.

**PHP30**

## THE IMPLICATIONS OF THE USE OF TUBE FEEDING IN THE UK SECONDARY HEALTH CARE SYSTEM

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**OBJECTIVE:** Although tube feeding is commonly used in hospitals in the UK, clinician interviews showed that no

systematic nutritional screening was undertaken on admission. This study demonstrates which patients receive enteral tube feeding and estimates the hospital burden of such patients. **METHODS:** The CHKS hospital dataset contains aggregated, anonymised information on diagnosis, hospital experience, and patient demographics for over 80 million episodes in the UK, representing 55% of hospital admissions. It was used to identify patients who received enteral nutrition (using OPCS-4 codes) and compared their hospital stays with a control group who had the same primary diagnoses but were not tube fed. Both groups were analysed for comorbidities, procedures, and length of stay (LOS). **RESULTS:** We identified 14,328 patients who were tube fed in 2001/2002 out of 947,897 patients who were hospitalised for various diseases/conditions: dysphagia, cancer; stroke; neurological, respiratory and GI disorders, cystic fibrosis, feeding difficulties/anorexia, renal disease, and others. Tube fed patients had 28,768 separate episodes compared to 2,502,937 episodes for patients having the same disease/condition who did not receive any tube feeds. Overall, tube fed patients had one additional procedure, i.e. the tube feeding procedure, during their hospital stay compared to controls (average of 2.3 procedures across disease groups for tube fed patients). Daily tube feeding costs vary between £10.20 and £13.18. This represents only 2.8–3.6% of the daily inpatient cost of, for example, £359 in a surgical ward. **CONCLUSIONS:** Over 26,000 patients who are tube fed are admitted yearly in England. However the number of patients receiving tube feeding is very restricted, even though the cost is a small fraction of hospital costs. Does every patient who could benefit from tube feeding receive it? If not, should tube feeding remain severely restricted when it is known that its use could improve patients' recovery?

## HEALTH CARE POLICY—New Health Technology Studies

**PHP31**

### PAYMENTS FOR HIGH COST NEW TECHNOLOGY DRUGS AND BIOLOGICALS IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM: POLICY IMPLICATIONS

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**OBJECTIVE:** The Centers for Medicare and Medicaid Services (CMS) computes payment for high cost new technology drugs and biologicals in the hospital outpatient prospective payment system (OPPS) under two methods. This study examines the results of CMS computations over the initial thirty months of the hospital outpatient prospective payment system. **METHODS:** Phase I: CMS methods used first for payment of high cost new technology drugs and biologicals eligible for initial pass-through payment status and second for subsequent expired pass-through payment status were identified. Underlying assumptions were examined and formal methodology evaluations were collected. Phase II: A thirty-month time line was constructed. The assumptions utilized for CMS changes in payment status at month one, month nineteen and month twenty-eight were examined and analyzed. Analyses employing descriptive statistics identified components of payment assumptions and variations between the assumptions utilized at each of the three time line milestones. Findings were compared to a sample of actual CMS payments received by hospitals. **RESULTS:** A database of methodology explanations, visuals, and evaluations was created. An evolutionary time line of CMS methodologies and underlying assumptions was created. Study analyses revealed a statistically significant differential between aggregated mean payment amounts for the same high cost new technology drugs and biologicals at the first and the third milestones of the time line. Over one-half of the affected drugs and biologicals sustained payment rate reductions exceeding forty percent. **CONCLUSIONS:** CMS payment methods and underlying assumptions for expired pass-through drugs and biologicals is flawed. In addition, the basic hospital drug acquisition cost assumptions made by CMS are not consistent with actual hospital data. These findings will be of use to economists, cost accountants, and policy makers interested in arriving at equitable payments for high cost new technology drugs that are essential to modern health care in U.S. hospitals.

**PHP32**

### MANAGING TECHNOLOGICAL INNOVATION IN THE HEALTH CARE SECTOR

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**OBJECTIVES:** This outlines the lessons learned by the author who is Director of one of the six units in the UK that undertake independent academic evaluations of Technology Assessment Reviews for NICE. The author provides an insiders' view of the major issues that arise in managing the evaluation process. **METHODS:** The Liverpool TAR group assists NICE to provide guidance on appropriate treatment for specific conditions in specific sub-groups of patients. The aim is to standardise clinical practice around the most clinically and cost-effective interventions. The aim is to spread cost-effective new treatments more quickly across the health service to promote successful innovation on the part of the pharmaceutical industry. The importance of this UK initiative goes beyond its national borders as other governments are guided by NICE judgements in their reimbursement decisions and many are developing similar systems of appraisal. **RESULTS:** The paper analyses the impact of the 6-stage structure of NICE evaluation and assesses how generalisable the process may be to other countries. Issues underlying the targeting of NICE appraisals will also be examined together with the challenges presented