vestment, recognising the NHS budget (providing free universal healthcare) was not unlimited. Local organisation of disinvestment policy was preferred, though some national co-ordination was felt necessary to retain equity across geographical jurisdictions. Technologies of unproven or negligible clinical benefit, or obsolete technologies were cited as disinvestment priorities. Respondents preferred disinvestment decisions be clinician-led. Other decision-making groups (e.g. patients) were viewed as being too distant or subject to influence from the pharmaceutical industry.

**PHP130 USING ECONOMIC EVIDENCE AND STAKEHOLDER’S PARTICIPATION IN DECISION MAKING ON BENEFIT PACKAGE OF PUBLIC HEALTH INSURANCE IN THAILAND**

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**OBJECTIVES:** With the increasing demand for health care from aging society and rapid technological advancement, the National Health Security Office (NHSO) of Thailand demands for the development of systematic, transparent, and participatory processes for selection of new health interventions to be included into the benefit package of universal health coverage scheme. This study aims to describe experiences in the development of guidelines for economic evaluation and participatory process of key stakeholders in submission and topic selection of new health interventions into the UC benefit package. Lessons learnt from this initiative are drawn in order to share experience with Thailand to other developing countries.

**METHODS:** Research methods comprise comprehensive literature review, focus group discussion, and brainstorming meeting among key stakeholders, working groups, and subcommittee members.

**RESULTS:** Research findings indicate that the draft guideline produced by several rounds of stakeholder consultations has been gradually adopted and adjusted by policy makers and key stakeholders. Key features of the guideline comprise a) transparency in topic selection for economic appraisal with full engagement of key stakeholders; b) economic evaluation on selected interventions using incremental cost-effectiveness ratio (ICER); c) budget impact analysis. The ICER threshold of 1 GDP per capita for hernia surgery in Germany. In an evaluation phase, all patients who were intended to treat with 3-dimensional meshes, were registered with consensus into a database through a web-based portal. CCS questionnaires were mailed to patients 4 and 12 weeks after surgery. Patients were requested to send pseudonymized responses to an independent proxy for inputting answers into the database. Clinical examinations were made 4 and 12 weeks postoperatively. Additional follow-up is planned 52 weeks after surgery. CCS consists of 23 questions in 7 activity-categories and 3 dimensions: sensation of mesh, movement limitations, pain. RESULTS: During the first year (Oct 2009 to Sept 2010) 1429 patients were registered (1271 male, 158 female, median age 53 years) and treated for primary (88%) or recurrent (11%) hernia. 1300 (90%)/1246 (87%) patients were clinically reviewed 4/12 weeks after surgery. 1072 (75%)/1002 (70%) questionnaires were retrieved 4/12 weeks after surgery. Patient satisfaction rate was 98%. CCS scores are shown to be decreased from 4 to 12 weeks in all dimensions (Sensation: 0.51 to 0.15; Movement: 0.40 to 0.20; pain: 0.45 to 0.26). CONCLUSIONS: CCS, a short, hernia-specific quality-of-life questionnaire, is easy to use and well accepted by patients. It is shown to be a feasible instrument to evaluate patient reported outcomes after day-case hernia surgery in a web-based multicentre quality assurance system.

**Health Care Use & Policy Studies – Population Health**

**PHP133 LEVEL OF POPULATION RISK STRATIFICATION BASED ON THE COST OF CARE IN PATIENTS WITH CHRONIC DISEASES**

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**OBJECTIVES:** To determine the population risk stratification based on the cost of care (health resource use) in patients with chronic diseases in primary health care (PC). **METHODS:** Multi-center observational design. We included all patients from 6 centers of PC that demanded assistance in 2010 managed by Badalona Serveis Assistencials SA (health organization). The risk population was defined being from the complexity (co-morbid chronic [CC]) and fragility (socio-demographic and clinical criteria). Main measures: services (medical, paediatric, chronic co-morbidity [CC] and direct cost model. From a group of experts identified the different conditions and population risk levels: Level 1 NO CC, Level 2 1-2 CC, Level 3 3-4 CC and Level 4 (≥ 5 CC). Fixed (operation) and variable costs were considered. Statistical analysis: linear regression model (coefficient of determination [R2], dependent variable: health care costs) and principal components, p < 0.05. RESULTS: We included 83,090 patients, mean age 40.9 years, women: 53%. The total cost was 56.1 million / EUR. Average / unit cost: 675.3 euros. The cost for drugs was 41%. Stratification levels: level 1 (N = 36,859, 44.4%, 2831.9, level 2 (N = 32,644, 39.3%, 6641.6, level 3 (N = 10019, 19.6%, 23,410.4), level 4 (N = 3132.1). Musculoskeletal diseases (38.1%), mental (31.6%) and cardiovascular (30.4%) were the most frequent, p < 0.001. Predictive model (R2): age = 23.4%, age-sex = 24.1%, age-sex-CC = 41.8% (medical: 47.9%; Paediatrics: 15.1%, p < 0.001). It details the costs for each age, age-sex and age-sex-CC. CONCLUSIONS: The CC is associated with increased healthcare costs. The number of co-morbidities explains much of the costs. Knowledge of the risk / complexity / fragility of the patients should allow preventive intervention strategies.

**Health Care Use & Policy Studies – Prescribing Behavior & Treatment Guidelines**

**PHP134 COMPARISON OF THE KNOWLEDGE IN STANDARD TREATMENT GUIDELINES AMONG MEDICAL PRACTITIONERS AND MEDICAL STUDENTS**

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**OBJECTIVES:** Introduction of module in rational use of medicine (RUM) to pharmacy curriculum needs analysis of existing knowledge among health care work- ers. The knowledge and attitudes of medical practitioners (MPs) and medical stu- dents (MSs) on Standard Treatment Guidelines (STG) were assessed. METHODS: Forty-two MPs and 120 MSs were given pretested structured questionnaire on STG and core policies of RUM. RESULTS: Results showed that only 78 % of MPs were confident that they knew all the STG and 7% of them had knowledge of MPs and MSs showed 78% and 84% on contents of STG while the knowledge in core policies was 73% and 34% respectively. More than 99% of MSs and 71% of MPs were attentive on the inclusion of clinical features of the illness in STG. Knowledge of STG was significant and MSs as guidance for prescribing. 88% of MPs and 84% respectively while 96% of MSs had acquainted in those two areas. Both groups had good knowledge on STG is not an accordance with person- nel experience (MPs-71%, MSs-74%). 80% of MSs and 75% MPs discerned that com- mon treatment practices is not an inclusion criteria for STG. CONCLUSIONS: We found that MSs had good knowledge about the contents of STG and skills in application in RUM are limited. MPs were detailed on core policies & application of STG for does not provide universal healthcare) was not unlimited. Local organisation of disinvestment policy was preferred, though some national co-ordination was felt necessary to retain equity across geographical jurisdictions. Technologies of unproven or negligible clinical benefit, or obsolete technologies were cited as disinvestment priorities. Respondents preferred disinvestment decisions be clinician-led. Other decision-making groups (e.g. patients) were viewed as being too distant or subject to influence from the pharmaceutical industry.