Health Care Use & POLICY STUDIES – Equity and Access

PHP12

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 explore the ratio of public reimbursement and patients' 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 (OEP), 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 patients' co-payment at county and regional level. Hunmgary is devided 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 (OEP). At regional level, the ratio of patients' co-payment varied between 22.7 % (in the Northern-Great Plane 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 %), Hajdú-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.

PHP13

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 analyze 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 (OEP), 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 visits. The geographical inequalities were calculated for county level. Both indicator was calculated to 10.000 population. **RESULTS:** 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 (65), Baranya (65), Jász-Nagykun-Szolnok (64), Vas (59), Csongrád (54), Borsod-Abaúj-Zemplén (54) and Győr-Moson-Sopron counties. The lowest utilization rate was measured in Komárom-Esztergom (43), Fejér (43), Nőgrád (38) and Szabolcs-Szatmár-Bereg (26) counties (all are for 10.000 population). The average number of home care visits was 1188 visits/10.000 population at national level. The number of home visits was the highest in Fejér (1342), Komárom-Esztergom (1333), Jász-Nagykun-Szolnok (1327), Nőgrád (1310), Győr-Moson-Sopron (1285) counties. The lowest home visit rate was measured in Budapest (1162), Somogy (1142) and Szabolcs-Szatmár-Bereg (614) counties (all are for 10.000 population). **CONCLUSIONS:** We found significant inequalities in the utilization of home care (nursing) in Hungary measured both by the number of patients and the number of visits per 10.000 population.

PHP15

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 following decision domains for pricing and reimbursement: international referencing; cost-plus analysis; economic evaluation and budget impact; innovation; unmet needs; therapeutic referencing; negotiated agreements; demand side controls; and societal benefit. In primary research 4 senior stakeholders in Brazil and Mexico were asked to rate the importance of these domains in access decisions, and provide a rationale. **RESULTS:** Decision criteria in Mexico and Brazil reflect the historical origins of their respective health systems, but recent developments reflect a centralising trend in decision-making in both countries. This suggests that economic evaluation will increasingly determine access in both countries but pricing criteria will remain different, notably due to the greater role of price negotiation in Mexico. **CONCLUSIONS:** The mix of empirical and context-based decision criteria in Brazil and Mexico represent valuable alternative models for other countries, such as the UK National Health Service (NHS), which is currently contemplating a move towards "value-based pricing" for pharmaceuticals. In particular, Mexican and Brazilian evaluation mechanisms may inform future considerations of therapeutic innovation in the UK.

PHP16

WAITING TIME AND ITS IMPLICATIONS ON THE UTILIZATION OF ANTENATAL SERVICES IN A FREE SERVICE PROVISION SETTING IN THE ASANTE AKIM NORTH MUNICIPAL, GHANA

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OBJECTIVES: The study sought to estimate the waiting time and assess its implications on the utilization of antenatal services in the Asante Akim North Municipal, Ghana. **METHODS:** The study was a cross sectional descriptive type using both qualitative and quantitative methods. In all 200 pregnant women presenting at the Konongo Odumasi Government Hospital and the Agogo Presbyterian Hospital were randomly selected for the study. Structured questionnaires were used to obtain data from respondents. Key informant and household heads interviews were also conducted and used to augment the information obtained. Descriptive and inferential statistics were used in the data analysis; statistical differences were set at 0.05 or less and at 95% confidence interval. **RESULTS:** Of the 200 respondents 35.5% (71) made four visits and 64.5% (129) made one or more visits. Pregnant mothers had to forego GH¢ 31(US$ 22.14) and GH¢ 15(US$10.17) as their incomes whenever they attended ANC. Significant differences existed between national health insurance policy holders and antennal clinic (ANC) visits ($p=0.022$), trimester of pregnancy and ANC visits ($p<0.001$), and place of residence (indicating distance to health facility and ANC visits ($p=0.017$). **CONCLUSIONS:** Long waiting is associated with high opportunity cost and are likely to reduce utilisation of ANC services in a free services provision setting. Further studies on feasibility of creating of separate pharmacy, laboratory and records units for antenatal clinic users and effects of waiting time on service utilization may be helpful to improve utilization of ANC services and reduction in pregnancy related maternal mortality.

Health Care Use & Policy Studies – Formulary Development

PHP17

MEXICO'S NATIONAL AND INSTITUTIONAL ESSENTIAL MEDICINE LISTS

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BACKGROUND: Essential medicines are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. To be selected, medicines must be available through health systems, in suitable amounts and dosage forms. The Essential Medicines List can help countries rationalize the purchasing and distribution of medicines, thereby reducing costs to the health system. Most countries have national lists and some have provincial, state or institutional lists as well. Mexican Health System has 2 main institutions who provide healthcare services to population: IMSS and ISSSTE; each of them have an institutional list and also there is a National essential medicine list. **OBJECTIVES:** To compare the National essential medicine list with the institutional lists of IMSS and ISSSTE. **METHODS:** The National essential medicine list (2009 version) and the latest web versions available for the essential list of each institution where analyzed to compare by product key and by generic name for each of the 23 therapeutic groups excluding the groups referring to vaccines, nutrimental components and electrolytic solutions. **RESULTS:** There were a wide difference between the national essential list and the institutional list especially in the group for treating endocrinology, oncology and infectius conditions. Also there were big differences for more than 50% of the therapeutic groups examined between the institutions. **CONCLUSIONS:** There remains, significant opportunity for improvement of the national and institutional essential medicines list because don't seem to be uniform criteria to selection.

Health Care Use & Policy Studies – Health Care Costs & Management

PHP18

IMPACTO DE LA PARTICIPACION DEL FARMACEUTICO COMO PARTE DEL EQUIPO DE SALUD EN EL PRIMER NIVEL DE ATENCION SOBRE LOS COSTOS

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OBJECTIVOS: Analizar el ahorro en costos por la intervención del farmacéutico sobre errores de prescripción, desde la perspectiva del proveedor de servicios de salud. **METODOLOGÍAS:** Análisis de costo-efectividad, tipo árbol de decisiones. Se estimaron costos y efectividades de incluir en las decisiones médicas un farmacéutico y corregir prescripciones de antihipertensivos e hipoglucemiantes combinados con analgésicos e hipolipemiantes. La medida de efectividad fue la probabilidad de otorgar prescripciones farmacológicas sin eventos adversos graves (EAG), con horizonte temporal de 30 días. La probabilidad de corrección por la intervención del farmacéutico se obtuvo a través de un ensayo clínico (EC) y la probabilidad de la ocurrencia de EAG (hemorragia gastrointestinal, rabdoimiolisis, enfermedad vascular cerebral y fractura de cadera) como consecuencia de la no corrección se obtuvo de la literatura publicada. Se estimaron los costos de la atención médica con y sin farmacéutico del EC y los costos esperados de los EAG de publicaciones de costos nacionales. Los costos son expresados en pesos mexicanos del 2010. **RESULTADOS:** Costo promedio por paciente esperado sin la intervención del farmacéutico durante el horizonte temporal fue de $12,481.60 y el costo promedio por paciente con la intervención fue de $9,127.97, lo que significó disminución en el costo por paciente de 27%. El número de prescripciones que evitaron interacciones riesgosas fue superior con la presencia del farmacéutico y la posibilidad de que un paciente no presentara alguno de los desenlaces evaluados por efecto de la inter-