PHS82 DETERMINANTS OF HEALTH SERVICE UTILIZATION IN URBAN PAKISTAN

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OBJECTIVES: To examine inequalities in health service utilisation in urban Pakistan. This analysis investigates how household economic status, duration of illness and distance to a provider influence health service utilisation in Pakistan. METHODS: The analysis uses data from the Pakistan Socioeconomic Survey (PSES) and analysis is based on 1,407 individuals who belong to 855 urban households. Health care providers are classified into public hospitals, other public providers, private doctors/clinics and other private providers. Household economic status is measured by a wealth index constructed using data from the survey on ownership of durable assets and housing conditions. Principal components analysis (PCA) is used to construct the index. Multinomial logistic regression is used to investigate the effects of various characteristics of individuals/households on health service utilisation in Pakistan. RESULTS: Overall, 78.6% of those reporting any health complaint sought health care. A large gap in health service utilisation exists between poorest patients (60.5%) and richest patients (89.4%). Almost three-fourth patients visited private providers, 57.3% visited private doctors/clinics and 15.7% visited other private providers; remaining one-fourth visited public hospitals (19.7% visited public hospitals and 7.2% other public providers). Multinomial logistic regression reveals that poorest patients are significantly more likely (p<0.01) to visit public hospitals whereas patients of poorest, poor, middle and rich households are significantly less likely to visit private doctors/clinics compared to members of richest households controlling for other factors such as education, occupation, duration of illness, distance to a provider and residence. An additional day of illness significantly (p<0.05) increases the likelihood of visiting public hospitals and private doctors/clinics. The distance travelled to visit a provider shows a significant positive (p<0.01) and negative association with visiting public hospitals and other private providers respectively. CONCLUSIONS: Large gaps exist in health service utilisation in urban Pakistan.

PHS83 POTENTIAL TIME SAVINGS WITH RITUXIMAB SUBCUTANEOUS (SC) INJECTION VERSUS RITUXIMAB INTRAVENOUS (IV) INFUSION: RESULTS FROM INTERVIEWS AT 13 EUROPEAN SITES AS PART OF A TIME AND MOTION STUDY (T&M)

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OBJECTIVES: Generate preliminary estimates of active health care professional (HCP) time required /potential time and cost savings between SC vs IV rituximab processes at the care unit and pharmacy in sites participating in T&M sub-study to MO25455 trial (ClinicalTrials.gov identifier NCT01461928). METHODS: As part of our ongoing multi-country, multi-centre, prospective, T&M study run as a sub-study to MO25455, one interview with a nurse and pharmacy member was conducted per site, using a structured questionnaire to elicit practice pattern flow and time estimates for rituximab-related tasks for both IV and SC processes. Estimates of SC injection time were obtained from the Spark-Thera Phase IIb trial (BP22333) (in the absence of staff-elicited time estimates). Estimated total time/cost was calculated as the sum of individual task times/costs. UK salary costs were assumed. Results were then compared to our previous BMS and Genentech products. RESULTS: Medication and IV administration/infusion time for IV vs. SC processes was estimated at 57 and 26 minutes, respectively, equivalent to approximately £79 and £37 (estimated 54% reduction with SC). For IV, process time is taken up by premedication (27%) and rituximab pharmacy reconstitution (18%), with the remaining 55% distributed across other care unit tasks. For SC, premedication (57%), injection (24%) and rituximab pharmacy dispensing (19%) constitute the whole process. Potential time savings are expected because of avoiding tasks related mainly to infusion line (disconnection, infusion initiation/dose escalations, and IV pharmacy reconstitution, which is only partially being replaced by SC injection. CONCLUSIONS: A switch from IV to SC rituximab potentially results in important care unit and pharmacy time savings to be reinvested in improving overall patient care. Patients could potentially be moved out of the chemotherapy area to SC administration in other settings and free up valuable chair time, thereby increasing the unit’s throughput and overall efficiency. Data of the T&M study is awaited.

PHS84 ANALYZING PHARMACEUTICAL EXPENDITURE IN GREECE: UNWINDING ARIADNE’S CLUE

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OBJECTIVES: To compile pharmaceutical expenditure in Greece by financing scheme and type of provider, in order to investigate areas that cost containment measures could be monitored effectively. METHODS: The used method for the estimation of pharmaceutical expenditure is based on the System of Health Accounts 2011 set by OECD, EUROSTAT, and WHO, taking into consideration the national needs for data reporting both in outpatient and inpatient settings. Data were reported by type of provider, including hospital pharmacies, Social Security Funds, public pharmacies, private pharmacies, retail pharmacies and community pharmacies as well as by financing schemes, including SSFs, private payments and NHS payments. Additionally, pharmaceutical data are analysed using the new international classification of Factors of Health Care Provision. Estimates were obtained for 2009 and 2010. RESULTS: Total pharmaceutical expenditure –TFE (outpatient & inpatient) in Greece, decreased by 9.3% between 2009 and 2010. Pharmaceutical outpatient expenditure covered by SSFs was estimated at €5.1 b for 2009 (2% of GDP) and €4.46 b for 2010 (2% of GDP). Less than 8% of outpatient pharmaceutical expenditure covered by SSF, concern pharmaceuticals dispensed by NHS & SSF pharmacies. These public pharmacies dispense expensive pharmaceuticals (for serious and chronic diseases) at significantly lower prices than private pharmacies. Inpatient pharmaceutical expenses decreased by 9.1% (€1.2 b in 2009 and €1.1 b in 2010) resulting 55.3% of hospital pharmaceutical expenses (outpatient & inpatient), a proportion similar to the mean of other EU countries estimated at about 17%. Measures to control the volume of consumption were recently introduced via e-prescribing and the set up of controlling mechanisms. CONCLUSIONS: Reductions in pharmaceutical expenditure are correlated mainly to price reductions and less to a decrease in volume of consumption. Measures concerning pharmaceutical cost containment have to be reorganised not only concerning price and volume but also concerning new –innovative ways of distributing pharmaceuticals.

PHS85 THE COST OF PUBLIC CANCER PREVENTION IN ALBERTA

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OBJECTIVES: We provide an estimate of public expenditures on cancer prevention in Alberta. Our estimate covers all three levels of government – federal, provincial, and municipal. METHODS: Public cancer prevention is a government activity whose purpose is to expressly reduce the future incidence of cancer. As part of a wider initiative, we conducted a survey of ministries, in search of all programs whose express purpose was to promote health and prevent illness. We searched web pages, ministry annual reports and federal and provincial budget papers. We collected data on program type, type of intervention, and program cost. We then verified the results with each ministry. We sorted the data by risk factors, and selected the risk factors that were related to cancer. RESULTS: Expenditures for those risk factors that are related to cancer are shown in Table 1. In total expenditures on these risk factors were €206M. Of this, about two-thirds were expenditures that were incurred by non-health, provincial ministries. The risk factor with the highest preventive expenditures was environmental health. CONCLUSIONS: In Alberta, all levels of government spent $206 per person on risk factors that can prevent cancer, mostly in the long run. Without a cost–effectiveness analysis, we cannot say that this amount is too much or too little. However with this data, and a cost effectiveness analysis, we can in fact say whether we are spending too much or too little.

PHS86 A POPULATION-BASED STUDY OF THE RESOURCE UTILIZATION AND COSTS OF TREATING RESECTABLE NON-SMALL CELL LUNG CANCER

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OBJECTIVES: To describe resource utilization and costs associated with treating surgically managed non-small-cell lung cancer (NSCLC) patients in Ontario, Canada, to compare characteristics and average costs of patients treated with adjuvant chemotherapy after surgery alone, and to compare resource utilization across different health care regions. METHODS: A population-based retrospective cohort study of surgically resected NSCLC patients, diagnosed from Ontario Cancer Registry between 2004 and 2006, was identified using administrative health care data. Patients were followed for four years from date of surgery (to represent the cohort immediately after surgery). CONCLUSIONS: Among all levels of government spent $206 per person on risk factors that can prevent cancer, mostly in the long run. Without a cost–effectiveness analysis, we cannot say that this amount is too much or too little. However with this data, and a cost effectiveness analysis, we can in fact say whether we are spending too much or too little.