-4,319,412 and E/P (Beta: -0.16) (p < 0.05 both). Final adjusted R2: E: 0.937; Pds: 0.918; E/P: 0.906. CONCLUSIONS: trend is the most significant variable in the three models and when an impact is statistically significant, it seems not to present long-term sustainability because these supply measures have a short-term impact.

**PHP24**

**THE COST OF ILLNESS: SPAIN 1980–2000**

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OBJECTIVE: To distribute the total health spending in Spain for the years 1980–2000 among the seventeen ICD-9-CM categories. The study aimed to gather data for 1980, 1985, 1990, 1993, 1996, and 2000 in order to obtain a baseline from which to analyse the evolution of spending over time. METHODS: The method used was the top-down approach, starting with overall spending figures and, by means of various procedures, breaking them down to the desired level. The method comprised two stages. First, health spending was distributed according to the different types of health care: hospital care, primary care, drugs, and others. Second, the spending for each type of care was distributed among the ICD-9-CM categories. The base unit varied according to each level: admissions for hospital care, appointments for primary care, and consumption per therapeutic subgroup for drug treatment. RESULTS: In the period 1980–2000 health spending was concentrated into three ICD-9 categories: VII, VIII and IX (37.4% of spending in 1980 and 40.1% of spending in 2000). In terms of their relative rankings, category VII was second in 1980 (10.1%) but had moved into first place by the year 2000 (17.6%), showing one of the highest growth rates for the period. Category VIII (diseases of the respiratory system) was ranked first in 1980 (17.6%) but had fallen to second place by 2000 (13.2%). As regards the third category (IX: diseases of the digestive system) its relative position hardly varied: 9.7% in 1980 and 9.3% in 2000. The results also show that although the internal composition of each category (percentage of each type of health care) may vary widely, few important variations were observed between 1980 and 2000. CONCLUSIONS: The information provided may be of use to health managers and planners and it also establishes reference baselines for cost-of-illness studies of specific pathologies.

**PHP25**

**EXPENDITURES ON DRUGS IN DEVELOPED EUROPEAN COUNTRIES**

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OBJECTIVES: The article is transversal comparison expenditure analysis for drugs of 23 economically developed European countries that are members of OECD. The data are related to year 2003, financial indicators are expressed in dollars. METHODS: Drug expenses are analysed in relation with those variables: GDP per 1 inhabitant, health care expenses per 1 inhabitant, number of physicians in praxis per 1000 inhabitants, proportion of inhabitants of the age 65 years or more. Among all the variables medium strong to strong relation was observed, determination index between drug expenditure per 1 inhabitant and actual number of active physicians and proportion of inhabitants of the age 65 years or more reached the value of 51%. RESULTS: Average drug expenditure per 1 inhabitant of the given year were 343 dollars, absolute average year growth in the years period 1995–2003, 19.4 dollars. Propotional expenditure average of health care from GDP reached in the year 2003 value of 8.32%, expenditure proportion on drugs from GDP was 1,37% from health care expenditure 16.9%. By cluster analysis significant relation between drug expenditure and number of general physicians and elderly inhabitants was determined. CONCLUSION: Lower drug expenditures have countries with lower economical efficiency, but also economically developed European countries where systemic regulations are applied, directed towards main activators affecting the drug’s consumption and price.

**PHP26**

**SUPPLY SIDE COST-CONTAINMENT IN GERMANY: WIN SOME, LOSE SOME**

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Until the late 1980s, the German health care system worked well. Since then, it has been challenged the restructuring of the health care system of the former East Germany, economic downturn and changing demographics. OBJECTIVES: To analyze the reforms in financing and reimbursement in the German health care system over the past 15 years to guide health reforms elsewhere. METHODS: A policy and evaluation analysis was applied to the literature on health financing reforms in Germany to understand the contexts of the measures and their effects. To understand the impact of the policies, a scale was developed to assess the trajectory of the health care system as a result of the reforms based on the principles of solidarity and subsidiarity on which the German health care system was built. RESULTS: Classification of 12 reimbursement and financing measures indicates a shift away from the status quo from the solidarity-subsidiarity dyad towards either the solidarity-governmental interference or Eigenverantwortung (personal responsibility)-subsidiarity dyad. Unfortunately, despite their collective potential of far-reaching impact and long-term success, deficit in operating mechanism(s) and inconsistencies have hindered the supply-side cost-containment measures of the past 15 years. CONCLUSION: Just as a change in the environment requires new tools to address challenges faced by the system, so does the approach to instiuting reforms call for rethinking. While in the politics of health policy evolutionary reforms may make more sense than radical reforms, beyond evolutionary reforms which have produced only modest results the sustainability of the financing of the system calls for radical reforms.

**PHP27**

**THE ANALYSIS OF TEMPORARY WORK DISABILITY FOR THE PERIOD OF OVER 30 DAYS IN THE REPUBLIC OF SERBIA**

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OBJECTIVES: Analysis of utilization of the right to sick leaves of the beneficiaries of the Republic Health Insurance Institute (RHII) in the period from January to September 2005, lasting more that 30 days, analysis of the reasons for sick leaves and suggested measures for more efficient control over the rights to benefits, upgrading of utilization and guaranteeing the rights, providing equal rights to all beneficiaries, and abuse reduction. METHODS: Statistical data processing by uniform statistic forms containing data on all medical commissions, classification of groups of diseases according to the ICD-10. RESULTS: The total number of beneficiaries with temporary work disability was 263,825, 50,316 were enabled, 213,509 were given extensions and others. Second, the spending for each type of care was distributed among the ICD-9-CM categories. The base unit varied according to each level: admissions for hospital care, appointments for primary care, and consumption per therapeutic subgroup for drug treatment. ACTIVATORS affecting the drug’s consumption and price. Where systemic regulations are applied, directed towards main activators affecting the drug’s consumption and price.