changes in MRL on payer’s and patient’s one year budget on the example of angiotensin II blockers. METHODS: The three models were build to assess the changes in payer’s and patient’s budget/per patient if therapy is conducted using: 1) the only original medications; 2) only generic medications; or 3) if therapy had been started with original medications and changed to the generic (after changes on the list). All costs in polish złoty (zł): 1 euro = 3.80 zł. RESULTS: In all models (from 1 to 3) the payer’s payment will decrease from 281 zł to 154 zł per patient. From the patient’s perspective the one year payment will rise from 767 zł to 1048 zł or from 449 zł to 577 zł—depends on medication (in model 1) and from 281 zł to 409 zł (in model 2), only in model 3 it will decrease from 767 zł to 409 zł. CONCLUSION: The changes in MRL may lead to reduction of payer’s expenditures and usually increase the patient’s expenditures. As a result it could leads to reduction in patient’s access to medications.

HEALTH INSURANCE COSTS OF STROKE HOSPITAL TREATMENTS IN HUNGARY; 2003–2005
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OBJECTIVES: Our aim was to assess the social insurance costs of hospital treatments for acute stroke in Hungary between 2003 and 2005. We studied how much burden stroke patients impose on the insurer (National Health Insurer Fund Administration) in acute and chronic hospital admissions. METHODS: We extracted the data of ‘new’ stroke patients (ICD-10: I60–64 diagnosis) hospitalized in May 2003 from the database of the financer. We analyzed active and chronic hospital treatment costs of these patients in the period of 12 months before the stroke and in the following first and second 12 months. Data were distributed by sex and age (age groups: 25–44, 45–64, over 65). We studied patients hospitalized in May 2003 with the ICD-10: I60–64 main diagnosis but not treated with the same diagnosis in the previous 24 months. RESULTS: In the first 12 months of the active care the burden of the disease was (male vs. female) 65+: 1018.4 vs. 823.2; 45–64: 1365.6 vs. 1122.0; 25–44: 1480.4 vs. 1224.4 Euro per patient. In the second 12 months the costs were 202.4 vs. 144.8; 96.4 vs. 130.4; 110.4 vs. 99.2 Euro respectively. CONCLUSION: Annual stroke costs of the Insurance Fund—based on our incidence data (3535 patients/month)—amounted to 37.6 million Euros in active and to 4.3 million Euros in chronic hospital care in the first 12 months, which is 1.68% of the total budget. Average costs of stroke are higher in the case of males as are in the case of females, 1459.2 vs. 1212.0 Euro in the first 24 months. The significant difference results from active hospital treatment costs (1326.0 vs. 1048.4 Euro), while the discrepancy is smaller in the chronic hospital care (133.2 vs. 163.6 Euro).

ECONOMIC BENEFIT OF IMPROVED PRESERVATION OF EXPLANTED ORGANS IN HEART TRANSPLANTATION
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OBJECTIVES: Surgical techniques and immunosuppressive drugs have been improved over the past decades, while the method of preserving and transporting organs has not. In the UK only 22.3% of hearts from all consented heart beating donors were recovered in June 2005, whilst cold ischaemic time (CIT) increased by an average of 34 minutes over 8 years. The Organ Care System (OCS) may alleviate the organ shortage and improve transplant outcomes by maintaining explanted hearts in the normal functioning state ex-vivo. A health economic evaluation analysis was undertaken to compute the economic benefit of improved transportability of explanted hearts from the UK societal point of view. METHODS: Improved preservation with OCS plus heart transplantation (IPTx) was compared to medical management on the transplantation waiting list (MM) and heart transplantation with conventional cold preservation method (CPTx). We assumed that IPTx increases heart transplantation rates by 40% and reduces CIT to <1 hr. UK cost vectors were derived from the published literature. Twenty year direct medical costs and QALYs were calculated for each arm. Reducing CIT to <1 hr may extend the graft half life by 2.2 years (Schnitzler 2006). Discount rates of 6% were used for costs and 1.5% for QALYs. WTP for a QALY gain was assumed to be 30,000 British