

systematic nutritional screening was undertaken on admission. This study demonstrates which patients receive enteral tube feeding and estimates the hospital burden of such patients. **METHODS:** The CHKS hospital dataset contains aggregated, anonymised information on diagnosis, hospital experience, and patient demographics for over 80 million episodes in the UK, representing 55% of hospital admissions. It was used to identify patients who received enteral nutrition (using OPCS-4 codes) and compared their hospital stays with a control group who had the same primary diagnoses but were not tube fed. Both groups were analysed for comorbidities, procedures, and length of stay (LOS). **RESULTS:** We identified 14,328 patients who were tube fed in 2001/2002 out of 947,897 patients who were hospitalised for various diseases/conditions: dysphagia, cancer; stroke; neurological, respiratory and GI disorders, cystic fibrosis, feeding difficulties/anorexia, renal disease, and others. Tube fed patients had 28,768 separate episodes compared to 2,502,937 episodes for patients having the same disease/condition who did not receive any tube feeds. Overall, tube fed patients had one additional procedure, i.e. the tube feeding procedure, during their hospital stay compared to controls (average of 2.3 procedures across disease groups for tube fed patients). Daily tube feeding costs vary between £10.20 and £13.18. This represents only 2.8–3.6% of the daily inpatient cost of, for example, £359 in a surgical ward. **CONCLUSIONS:** Over 26,000 patients who are tube fed are admitted yearly in England. However the number of patients receiving tube feeding is very restricted, even though the cost is a small fraction of hospital costs. Does every patient who could benefit from tube feeding receive it? If not, should tube feeding remain severely restricted when it is known that its use could improve patients' recovery?

HEALTH CARE POLICY—New Health Technology Studies

PHP3 I

PAYMENTS FOR HIGH COST NEW TECHNOLOGY DRUGS AND BIOLOGICALS IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM: POLICY IMPLICATIONS

Baker JJ

University of Rochester, Pickton, TX, USA

OBJECTIVE: The Centers for Medicare and Medicaid Services (CMS) computes payment for high cost new technology drugs and biologicals in the hospital outpatient prospective payment system (OPPS) under two methods. This study examines the results of CMS computations over the initial thirty months of the hospital outpatient prospective payment system. **METHODS:** Phase I: CMS methods used first for payment of high cost new technology drugs and biologicals eligible for initial pass-through payment status and second for subsequent

expired pass-through payment status were identified. Underlying assumptions were examined and formal methodology evaluations were collected. Phase II: A thirty-month time line was constructed. The assumptions utilized for CMS changes in payment status at month one, month nineteen and month twenty-eight were examined and analyzed. Analyses employing descriptive statistics identified components of payment assumptions and variations between the assumptions utilized at each of the three time line milestones. Findings were compared to a sample of actual CMS payments received by hospitals. **RESULTS:** A database of methodology explanations, visuals, and evaluations was created. An evolutionary time line of CMS methodologies and underlying assumptions was created. Study analyses revealed a statistically significant differential between aggregated mean payment amounts for the same high cost new technology drugs and biologicals at the first and the third milestones of the time line. Over one-half of the affected drugs and biologicals sustained payment rate reductions exceeding forty percent. **CONCLUSIONS:** CMS payment methods and underlying assumptions for expired pass-through drugs and biologicals is flawed. In addition, the basic hospital drug acquisition cost assumptions made by CMS are not consistent with actual hospital data. These findings will be of use to economists, cost accountants, and policy makers interested in arriving at equitable payments for high cost new technology drugs that are essential to modern health care in U.S. hospitals.

PHP32

MANAGING TECHNOLOGICAL INNOVATION IN THE HEALTH CARE SECTOR

Haycox AR

University of Liverpool, Liverpool, United Kingdom.

OBJECTIVES: This outlines the lessons learned by the author who is Director of one of the six units in the UK that undertake independent academic evaluations of Technology Assessment Reviews for NICE. The author provides an insiders' view of the major issues that arise in managing the evaluation process. **METHODS:** The Liverpool TAR group assists NICE to provide guidance on appropriate treatment for specific conditions in specific sub-groups of patients. The aim is to standardise clinical practice around the most clinically and cost-effective interventions. The aim is to spread cost-effective new treatments more quickly across the health service to promote successful innovation on the part of the pharmaceutical industry. The importance of this UK initiative goes beyond its national borders as other governments are guided by NICE judgements in their reimbursement decisions and many are developing similar systems of appraisal. **RESULTS:** The paper analyses the impact of the 6-stage structure of NICE evaluation and assesses how generalisable the process may be to other countries. Issues underlying the targeting of NICE appraisals will also be examined together with the challenges presented

to the pharmaceutical industry by the NICE initiative. Although it remains a fairly recent innovation, it would appear to be timely to undertake an initial assessment of its implications, both for the pharmaceutical industry and for national health systems. **CONCLUSIONS:** The nature and extent of the learning process through which NICE has progressed will be explored, together with the current state of the art with regard to NICE evaluation. In addition, the potential benefits that arise to health services from a NICE-style appraisal process will be presented. Methods by which the clinical and economic evaluations can be integrated will be presented.

PHP33

EVALUATION AND SELECTION OF MEDICAL HEALTH TECHNOLOGIES: A GROUP DECISION SUPPORT SYSTEM (GDSS)

Cantor E, Shtub A

Israel Medical Association, Ramat-Gan, Israel

OBJECTIVES: To select medical technologies that should be provided to the general public under the National Health Law. The rapid development of new technologies and the limited budget of the health care system make the selection process difficult. The research focused on the Israeli National Health Care System that faces budgetary constraint. Once a year a fixed budget has to be allocated among a set of candidate technologies. The constraint imposed by the fixed budget must be taken into account in the decision-making process. **METHODS:** We developed a Group Decision Support System based on a three-dimensional model: 1) Benefit (measured by the effectiveness of each technology); 2) Risk (measured by EBM); and 3) Cost: Based on the Analytical Hierarchy Process (AHP) methodology, a set of criteria was developed by a group of medical experts, economists, patient representatives, sociologists, law experts and ethical experts. EBM was used to assess the Risk (knowledge gap) associated with each alternative. While Cost was estimated by explicit market price of the technology in consideration. **RESULTS:** A set of candidate medical technologies evaluated by the proposed methodology revealed a clear Pareto distribution. The proposed methodology helped the decision-makers focus on the most promising technologies out of a total 193 technologies proposed. **CONCLUSIONS:** The proposed methodology helped decision makers by focusing their attention on the most promising medical technologies based on pre-defined objective set of criteria. The decision process is more effective and it achieves higher efficiency by using the Group Decision Support System (GDSS).

PHP34

THE EFFECTS OF GENETIC TESTING ON THE DEMAND FOR LIFE INSURANCE

Witt JC

University of Guelph, Guelph, ON, Canada

The accuracy and reliability of genetic tests has been rapidly improving, while the cost of such tests is becoming more affordable. The implications of this are potentially drastic: individuals will have access to information about their genetic predispositions, allowing them to alter their decisions accordingly. One consideration in this is the demand for life insurance: an individual at genetic risk may be inclined to purchase more life insurance in order to protect her family's future; however, insurance companies may also try to exclude "bad genetic risks", assuming they have access to that information. Both actions lead to adverse selection and inefficiency problems in the insurance market. This paper focuses on the implications of genetic testing for breast cancer genes (BRCA1 and BRCA2) on life insurance markets. Mutations on BRCA1/2 genes are not a definite predictor of breast cancer: there is roughly an 85% lifetime probability that a carrier will develop the disease, moreover, individuals can use prophylaxis and thereby considerably lower their risk of developing breast cancer. Hence, the interpretation of a positive test result is complicated, both for the individual and for the insurance company. **OBJECTIVE:** This paper looks at several scenarios (including different age and risk groups and income levels) to determine the impact on the demand for life insurance by women at genetic risk for breast cancer. **METHOD:** The methodology used is a microeconomic framework where individuals maximise their expected utility as a function of insurance purchases, and the insurance company may or may not know the results of the genetic test. **RESULTS:** The results show that women with higher incomes and higher levels of risk aversion are more likely to purchase life insurance. **CONCLUSIONS:** However, women that are less risk averse and have lower incomes tend to under-insure themselves, underscoring the need to ensure an adequate perception of own-risk.

PHP35

SMOKING CESSATION: RELEVANCE IN THE UNDER 25 GROUP

Taïeb C¹, Piergiovanni J², Randhaxe G³, Myon E¹

¹Pharmaco Economics & Quality of Life Department, Boulogne Billancourt, France; ²Centre de formation Ste Cecile, Albi, France; ³Pierre Fabre Santé, Boulogne Billancourt, France

OBJECTIVE: As part of an "outcomes program" on smoking cessation, we thought it relevant to evaluate in smokers under 25 years of age the obstacles to cessation, the level of dependency, the knowledge of tobacco dependency and the propensity to pay for cessation treatment. **METHOD:** For this pilot phase, an anonymous questionnaire was distributed in the "Etudiant" supplement of a French regional weekly newspaper. **RESULTS:** Obstacle to cessation: lack of willpower (51%), enjoyment of smoking (32%), force of habit (46%) The level of dependency on tobacco was evaluated using the Fagerström test: 48% had low dependency, 48% moderate