and in general such differences were not systematic (e.g., the result for Germany was not always more favourable than that for the UK). However, if a cost-effectiveness threshold (i.e. willingness-to-pay) for a life-year or QALY of $50,000 were assumed, the implications for decision-making would be similar across countries. CONCLUSIONS: It is concluded that, where the analyst allows factors to vary, cost-effectiveness results differ by country. However, the implications of such variation for decision-making depend critically on the cost-effectiveness thresholds applying in Europe.

**Abstracts**

**PHP5**

**HOW PHARMACOECONOMICS INDICATORS FOR THERAPEUTIC INNOVATIONS IN ACUTE AND CHRONIC DISEASE CAN ASSIST PAYORS IN THE DECISION MAKING PROCESS**

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**METHODS:** A literature review was carried out. A series of therapeutic innovations addressing life-threatening conditions were identified between 1988 and 2003. They were selected according to their cost/advantages profile. **OBJECTIVE:** This work seeks to analyse propensity and capacity of health systems to finance therapeutic innovations according to their cost/advantages profile. **METHODS:** A literature review was carried out. A series of therapeutic innovations addressing life-threatening conditions were identified between 1988 and 2003. They were selected according to: whether they were considered as innovations at time of their introduction into the market and their cost high. Forty-four publications in peer-reviewed journals were selected. Innovations were classified according to severity of the condition and the treatment impact on vital prognosis and survival. Reported costs were actualised to 2002 values. Common indicators across studies were identified. **RESULTS:** The cost per year of life saved (YLS) for breast cancer treated for combinations including paclitaxel in Europe varies between €7800 and €14000; at 5 years, the cost for trastuzumab/paclitaxel association is €23000 in UK. This is between €7000 and €14000 for ovarian cancer. Cost per YLS for myocardial infarctus treated by alteplase in France is €12000. It varies between €45000 and €79000 for implantable cardiac defibrillators. This cost varies between €10000 to €12000 in Europe and around €12000 in France for drotrecogin alfa (activated) (recombinant human activated protein C) for treatment of severe sepsis with multiple organ failure, recently launched in France. **CONCLUSIONS:** Pharmacoeconomic indicators such as cost per YLS can assist payors in decision-making process when confronted with costly innovations in chronic and acute disease. A further step is to consider the budget impact, taking into account criteria such as incidence, prevalence, severity, and mortality.

**HEALTH CARE POLICY—Cost Studies**

**PHP6**

**RESEARCH 5539: COMPARISON OF ACTUAL COSTS AND DRG-BASED REIMBURSEMENT OF INTENSIVE CARE IN GERMAN ICUS**

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**OBJECTIVES:** Financing of hospital services in Germany is presently transformed to a DRG-based system destined to derive 100% of the hospital revenue. The aim of this study is to determine whether the German DRG based reimbursement provides adequate coverage of actual costs of intensive care unit (ICU) patients. **METHODS:** Retrospective analysis of ICU length of stay (LOS) and direct cost data extracted from patients’ electronic records from the surgical ICU of the University Hospital Göttingen, Germany. Cost calculations performed for 1187 patients with LOS > 24 hours over a 24-month period (January 1, 2000–December 31, 2001). ICU reimbursement calculations based on the specific G-DRG according to the individual diagnosis and the fixed ICU proportion of the G-DRG reimbursement. Direct variable cost (consumables) were assessed bottom-up by means of a patient data management system. Personnel cost were calculated per day of treatment. Actual total costs were compared with the hypothetical DRG reimbursement. **RESULTS:** Total actual cost for ICU services was €5.58 million (mean per patient: €4697), while the corresponding DRG-based total reimbursement was €2.98 million (mean per patient: €513). The cost deficit is statistically significant (\(P < 0.001\)). Underfunding of the costs was evident in most DRG classifications, some with reimbursement deficits of over 80%. These differences showed a significant and negative linear correlation with ICU LOS (\(R = -0.593, p < 0.001\)). **CONCLUSIONS:** The computed G-DRG based reimbursement for ICU services differed significantly from the actual costs incurred. These findings highlight the importance of a more realistic and fair DRG-based reimbursement of hospital ICU services in Germany, particularly with respect to patients with extended LOS.

**PHP7**

**PHARMACOECONOMICS IN HEALTH CARE—DECISION MAKING: A SURVEY ON CHINA HEALTH CARE SYSTEM**

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