OBJECTIVES: The British government has decided to impose a system of value based pricing (VBP) in England as part of a wide-ranging national health care system (NHS) reform. A clearer understanding of VBP and implications for the NHS and the pharmaceutical industry alike. The objective of this paper is to evaluate the impact of VBP implementation on the NHS and pharmaceutical industry specifically with regards to drug access, health care drug expenditure in Thailand and research. METHODS: A literature review was conducted in order to understand health economists’ evaluations about VBP and stakeholders’ reaction to proposed reform. Ten stakeholders from academia, the pharmaceutical industry and representative members of the NHS, were involved in qualitative interview. RESULTS: Different meanings for different stakeholders. A clearer understanding of VBP and definitions of innovation and value in the pharmaceutical industry and the NHS have different meanings for different stakeholders. A clearer understanding of VBP and its expected outcomes would be helpful to bridge the gap between the pharmaceutical industry and the NHS.

RESULTS:

EFFECT OF SIADH ON PATIENT OUTCOMES AND HEALTH CARE RESOURCE UTILIZATION (SOFTWARE PATIENTS)

Amin A1, Deitelwitz S2, Lin J3, Christian B4, Baumer D5, Lowe T6
1University of California-Irvine, Orange, CA, USA, 2Dochser Medical Center, Jefferson, LA, USA, 3Novartis Healthcare, Filmmont, USA, 4Istratea America Pharmaceutical, Inc., Richmond, MD, USA, 5Premier Research Incorporated, Charlotte, NC, USA, 6Premier Healthcare Alliance, Charlotte, NC, USA

OBJECTIVES: Syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) is a common cause of hyponatraemia that complicates 30-50% of intensive care morbidities. Little is known of the influence of SIADH on health care resource utilization. This study assessed the effect of SIADH on inpatient total and intensive care unit (ICU) cost and length of stay (LOS), the likelihood of ICU admission, and 30-, 90-, and 180-day readmission.

METHODS: The Premier hospital database was utilized to identify US hospital inpatients discharged between January 1, 2007 and June 30, 2009. Hypoanhydratic/SIADH patients were identified using primary or secondary ICD-9 codes (n = 430,731) and were matched to a control group (n = 430,731) using exact matching on age, gender, provider region and 3M™ APR-DRG assignment. Matching was further refined using propensity scores based on additional patient and hospital covariates. Due to the contribution of congestive heart failure and cirrhosis on hyponatraemia development, these patients were excluded from the analysis. The final analytic sample consisted 65,973 SIADH patients and 407,874 non-hypoanhydratic/SIADH patients. Cost was analyzed using gamma regression, LOS with negative binomial regression. ICU admission and hospital readmission were analyzed using multivariate logistic regression. RESULTS: In contrast to non-SIADH patients, patients with SIADH had significantly higher total inpatient cost (55.3%, CI:52.5-58.0, p < 0.0001), ICU cost (33.1%, CI:31.3-34.9, p < 0.0001), total LOS (45.1%, CI:43.0-47.2, p < 0.0001), and ICU LOS (42.7%, CI:38.6-47.2, p < 0.0001). SIADH patients were significantly more likely to be admitted to the ICU (OR = 2.13, CI= 1.94-2.34, p < 0.0001), readmitted at 30-days (OR = 1.459, CI= 1.420-1.500, p < 0.0001), and 180-days (OR = 1.459, CI= 1.420-1.500, p < 0.0001) in comparison with non-SIADH patients. CONCLUSIONS: The presence of SIADH in hospitalized patients is significantly associated with increased total ICU cost and LOS, likelihood of ICU admission, and likelihood of readmission.

EVIDENCE-BASED PRIORITY SETTING FOR THE NATIONAL HEALTH DEVELOPMENT PLAN OF THAILAND

Patcharawanumol W, Bundhanchaoren K, Mungkantha W, Prakongpi S, Tangcharoensathien V

International Health Policy Program, Nonthaburi, Thailand

OBJECTIVES: To describe how Thailand use evidence on country’s burden of disease and cost-effectiveness of health interventions from the 2nd edition Disease Control Priority in Developing Countries (DCP2) to set priorities in health sector investment in the National Health Development Plan. METHODS: The study applies comprehensive literature reviews, secondary data analyses, interview of key informant and meeting among stakeholders to answer four specific objectives: a) burden of disease (BOD) priorities; b) health interventions currently implemented; c) what should recommended by health c) workers; d) costing BOD in terms of medical expenditure, productivity loss due to life loss and morbidity; and e) assessment of medium term economic framework in different scenario.

RESULTS: Since 1999 there has been an increasing trend in BOD attributable from alcohol, tobacco, iron deficiency anaemia, hypertension, high blood lipid, traffic injuries, overweight and obesity. Evidence from the share of DALY loss, productivity loss and absenteeism from morbidity indicates three national health priorities: HIV/AIDS, traffic injuries and diabetes mellitus through cost effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector. The most probable scenario for increasing investment in health promotion and disease prevention is to double the amount of investment for health promotion and disease prevention. Also, resources can be mobilized from this disease through effective interventions in and outside the health sector.
OBJECTIVES: To estimate the daily cost of intensive care unit (ICU) stay in France using a microcosting methodology. METHODS: A multicentre prospective cost analysis was conducted in 18 of the 23 French ICUs randomly selected from the French National Hospital database stratified by hospital category (regional, university and private non-profit). Each ICU enrolled 5 adult patients admitted from May to October, 2009, selected at random, with a simplified acute physiology score (SAPS2) ≤ 75, excepted with at least 1 reanimation medical act. All health care resources used by each patient over a 24-hour period were recorded, as well as the time spent by all hospital staff involved in the patient’s management. All resources identified were valued from a hospital perspective (reference year 2009) based on costs coded and provided by each hospital (i.e. medical and nursing staff, pharmacy, laboratory, radiology, etc.). RESULTS: A total of 104 patients were enrolled by 21 ICUs (14 polyvalent, 3 surgical and 4 medical) were included. The mean age of patients was 62.3 years (SD 14.9); 64% were male; 86% were mechanically ventilated. The SAPS2 scores have totally predicted the inhospital mortality (area under the ROC curve was 0.82, p < 0.001). The average daily cost of ICU per patient was €1,424 (SD 650). Staff time represented the largest component of this cost (43%) followed by overheads, capita, hotel, and nutrition assigned to the ICU (22%). Medications and consumables used accounted for 18.6% of the total cost. The majority of the cost (59%) was patient-dependant. The two main patient-dependant factors associated with significantly higher costs were: a high SOFA score and being on continuous mechanical ventilation. CONCLUSIONS: This first French microcosting study in ICU demonstrated that the cost per day of ICU stay is substantially depends on the patient’s medical profile and mainly driven by labour components.

OBJECTIVES: To assess the relative ability of several health-related quality of life measures in the MEPS dataset in predicting future health services use. METHODS: A multicentre prospective cost analysis was conducted in 18 of the 23 French ICUs randomly selected from the French National Hospital database stratified by hospital category (regional, university and private non-profit). Each ICU enrolled 5 adult patients admitted from May to October, 2009, selected at random, with a simplified acute physiology score (SAPS2) ≤ 75, excepted with at least 1 reanimation medical act. All health care resources used by each patient over a 24-hour period were recorded, as well as the time spent by all hospital staff involved in the patient’s management. All resources identified were valued from a hospital perspective (reference year 2009) based on costs coded and provided by each hospital (i.e. medical and nursing staff, pharmacy, laboratory, radiology, etc.). RESULTS: A total of 104 patients were enrolled by 21 ICUs (14 polyvalent, 3 surgical and 4 medical) were included. The mean age of patients was 62.3 years (SD 14.9); 64% were male; 86% were mechanically ventilated. The SAPS2 scores have totally predicted the inhospital mortality (area under the ROC curve was 0.82, p < 0.001). The average daily cost of ICU per patient was €1,424 (SD 650). Staff time represented the largest component of this cost (43%) followed by overheads, capita, hotel, and nutrition assigned to the ICU (22%). Medications and consumables used accounted for 18.6% of the total cost. The majority of the cost (59%) was patient-dependant. The two main patient-dependant factors associated with significantly higher costs were: a high SOFA score and being on continuous mechanical ventilation. CONCLUSIONS: This first French microcosting study in ICU demonstrated that the cost per day of ICU stay is substantially depends on the patient’s medical profile and mainly driven by labour components.

OBJECTIVES: To assess the relative ability of several health-related quality of life measures in the MEPS dataset in predicting future health services use. METHODS: A multicentre prospective cost analysis was conducted in 18 of the 23 French ICUs randomly selected from the French National Hospital database stratified by hospital category (regional, university and private non-profit). Each ICU enrolled 5 adult patients admitted from May to October, 2009, selected at random, with a simplified acute physiology score (SAPS2) ≤ 75, excepted with at least 1 reanimation medical act. All health care resources used by each patient over a 24-hour period were recorded, as well as the time spent by all hospital staff involved in the patient’s management. All resources identified were valued from a hospital perspective (reference year 2009) based on costs coded and provided by each hospital (i.e. medical and nursing staff, pharmacy, laboratory, radiology, etc.). RESULTS: A total of 104 patients were enrolled by 21 ICUs (14 polyvalent, 3 surgical and 4 medical) were included. The mean age of patients was 62.3 years (SD 14.9); 64% were male; 86% were mechanically ventilated. The SAPS2 scores have totally predicted the inhospital mortality (area under the ROC curve was 0.82, p < 0.001). The average daily cost of ICU per patient was €1,424 (SD 650). Staff time represented the largest component of this cost (43%) followed by overheads, capita, hotel, and nutrition assigned to the ICU (22%). Medications and consumables used accounted for 18.6% of the total cost. The majority of the cost (59%) was patient-dependant. The two main patient-dependant factors associated with significantly higher costs were: a high SOFA score and being on continuous mechanical ventilation. CONCLUSIONS: This first French microcosting study in ICU demonstrated that the cost per day of ICU stay is substantially depends on the patient’s medical profile and mainly driven by labour components.