

**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. The outcomes from this decision will have a number of consequences for the NHS and the pharmaceutical industry alike. The objective of this poster is to evaluate the impact of VBP implementation on the NHS and pharmaceutical industry specifically with regards to drug access, health care drug expenditure and promoting innovation. **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 interviews to compare and contrast the views of health care workers, NICE and the pharmaceutical industry about NHS reform and concept of value as it pertains to VBP. **RESULTS:** VBP as expected has been quite a contentious and controversial issue for the pharmaceutical industry with regards to the proposed NHS reform. NICE's position on value based pricing based on cost-effectiveness analyses is arguably not perfect, but it does define outcomes for the pharmaceutical industry in a more transparent manner. Clinician stakeholders, including the proposed GP commissioning groups will have difficulty in determining value without prescribed criteria and specified guidelines based around innovation and value. It is also questionable whether VBP would indeed spur innovation of drug development or in fact hamper research and development due to increased market access requirements and decreased profitability in the pharmaceutical sector. **CONCLUSIONS:** The 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.

#### PHP71

##### EFFECT OF SIADH ON PATIENT OUTCOMES AND HEALTH CARE RESOURCE UTILIZATION IN HOSPITALIZED PATIENTS

Amin A<sup>1</sup>, Deitelzweig S<sup>2</sup>, Lin J<sup>3</sup>, Christian R<sup>4</sup>, Baumer D<sup>5</sup>, Lowe T<sup>6</sup>  
<sup>1</sup>University of California-Irvine, Orange, CA, USA, <sup>2</sup>Oschner Medical Center, Jefferson, LA, USA, <sup>3</sup>Novosys Health, Flemington, NJ, USA, <sup>4</sup>Otsuka America Pharmaceutical, Inc., Rockville, MD, USA, <sup>5</sup>Premier Research Incorporated, Charlotte, NC, USA, <sup>6</sup>Premier Healthcare Alliance, Charlotte, NC, USA

**OBJECTIVES:** Syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) is a common cause of hyponatremia contributing to 30-50% of hyponatremia cases. 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. Hyponatremic/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 hyponatremia development, these patients were excluded from the analysis. The final analytic sample contained 65,973 SIADH patients and 407,874 non-hyponatremia/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 (55.53%, CI=52.53-58.60; p<.0001), ICU cost (38.07%, CI=33.18-43.15; p<.0001), total LOS (45.11%, CI=43.20-47.03; p<.0001), and ICU LOS (42.72%, CI=38.36-47.23; p<.0001). SIADH patients were significantly more likely to be admitted to the ICU (OR=2.131; p<.0001), and readmitted at 30- (OR=1.399; p<.0001), 90- (OR=1.495; p<.0001), and 180-days (OR=1.459; p<.0001) in comparison with non-SIADH patients. **CONCLUSIONS:** The presence of SIADH in hospitalized patients is significantly associated with increased total and ICU cost and LOS, likelihood of ICU admission, and likelihood of readmission.

#### PHP72

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

Patcharanarumol W, Bundhamcharoen K, Pongkantha W, Prakongsai P, 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 informants and meeting among stakeholders to answer four specific **OBJECTIVES:** a) burden of disease (BOD) priorities; b) health interventions currently implemented in Thailand against what recommended by DCP2; c) costs of top-ten BOD in terms of medical expenditure, productivity loss due to life loss and morbidity; and d) assessment of medium term economic framework in different scenario. **RESULTS:** Since 1999 there has been an increasing trend in BOD attributable from alcohol and tobacco consumption, consumption of high fat high calorie diet, lack of fibre food and physical activities, increasing incidence of diabetes mellitus, hypertension and 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. Total health expenditure in 2009 was 179 USD per capita, 4.3% of GDP, and mostly spent on curative services, only 4.5% of that was for disease prevention and health

promotion. **CONCLUSIONS:** Thailand can invest more on health of the population, in particular on disease prevention and health promotion to address 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 local administrations and communities, and should be managed by efficient and accountable agency with effective mechanisms.

#### PHP73

##### GOVERNMENT REDUCES PUBLIC PHARMACEUTICAL EXPENDITURE IN HUNGARY: RATIONAL DECISIONS IN CHALLENGING ECONOMIC TIMES?

Intotai A<sup>1</sup>, Merész G<sup>1</sup>, Kalo Z<sup>2</sup>

<sup>1</sup>Syreon Research Institute, Budapest, Hungary, <sup>2</sup>Eötvös Loránd University, Budapest, Hungary

**OBJECTIVES:** Scarcity of public resources, especially in challenging economic times, draws attention to the expenditure on pharmaceuticals. Over the next 3 years the Hungarian government plans to reduce the public pharmaceutical spending by 35%. Our objective was to assess the current level of pharmaceutical expenditure in Hungary by taking into account the economic status of the country and benchmarks from other OECD countries with special focus on Visegrad countries (Czech Republic, Slovakia, Poland, Hungary). **METHODS:** We completed international cross sectional and cluster analysis based on OECD Health Data 2010 and longitudinal analysis of public pharmaceutical expenditure in Hungary. **RESULTS:** The cluster analysis indicates that pharmaceutical spending is relatively higher in middle-income countries compared to high income countries above 30'000 USD GDP/capita (1.89 vs. 1.41% of GDP%, p=0.04; 23.58% vs. 14.14% of total health expenditure, p<.0001), as prices of pharmaceuticals are not adjusted to local price levels as opposed to prices of other health care services. International trends of the global pharmaceutical market are also valid in Hungary. The public pharmaceutical spending is close to the average of Visegrad countries, but the private pharmaceutical spending is the highest. The annual real growth rate of public pharmaceutical spending was only 1.0% between 1994-2010, whilst increased private funding (mainly out of pocket payments) was the major growth driver of total pharmaceutical expenditure in Hungary. **CONCLUSIONS:** Cost-containment of public pharmaceutical spending was very successful in the last 15 years. The burden of pharmaceutical market growth has been shifted to private households. The proposed public budget cut translates to over 30% decrease in real public pharmaceutical spending from 1994 to 2014. As morbidity and mortality indicators of the Hungarian population are extremely unfavourable, current evidences and international benchmarks do not justify significant reduction of the public pharmaceutical budget.

#### PHP74

##### CONSIDERABLE POTENTIAL SAVINGS FROM CHANGE IN DISTRIBUTION CHANNEL FOR SERIOUS DISEASES PRODUCTS IN GREECE: THE CASE OF OGA SOCIAL SECURITY FUND (SSF)

Georgiadou G<sup>1</sup>, Tsikalaki E<sup>2</sup>, Makridaki D<sup>3</sup>, Argyri S<sup>4</sup>, Kousoulou F<sup>4</sup>, Geitona M<sup>5</sup>

<sup>1</sup>OGA Social Security Fund, Athens, Greece, <sup>2</sup>Syngros Hospital, Metamorfosis, Greece,

<sup>3</sup>Sismanoglio Hospital / PEFNI Organization, Vrillisia, Greece, <sup>4</sup>General Secretary of Social Security Funds, Athens, Greece, <sup>5</sup>University of Peloponnese, Athens, Greece

Greek law (3816/2010) sets a list for serious diseases products (89 in total) which can be dispensed either through public hospitals or retail pharmacies for non-hospitalized patients. Each distribution channel incurs different costs for the NHS (public hospitals/SSFs). **OBJECTIVES:** Estimate potential savings for GR NHS (Social Security Funds & Hospitals) through dispensing products of serious diseases through hospital pharmacies instead of retail pharmacies. **METHODS:** Data derived from drug reimbursement database of OGA (Agriculture SSF) covering 20% of the GR population. The data represent actual reimbursement amounts to private pharmacies, from January to April 2011, extrapolated for the whole 2011. The price calculations were based on the following formulas: 1) Public hospitals buy at hospital price (HP) + VAT from pharmaceutical companies; 2) Public hospitals charge wholesaler price + 3% premium to SSFs; and 3) Retail pharmacies charge SSFs retail price (calculated as hospital price + 2.5% wholesaler margin + 18% pharmacy margin + VAT). **RESULTS:** Based on the mean of 5950 prescriptions per month the average value paid by OGA to the retail pharmacies was €1042 per prescription. By changing dispensing channel, via hospital, the mean cost per prescription for OGA was estimated at €930.93. Since both SSFs & hospitals are part of NHS, the actual cost of NHS/prescription is the hospital cost estimated at €818.72 and the estimated hospital gain per prescription is €112.21. The actual gain for NHS per prescription is €223.28. The extrapolated gain for OGA for 2011 is estimated at €7,930.398 while for NHS is €15,942.192. **CONCLUSIONS:** Distribution of products for serious diseases via hospital pharmacies, leads to considerable savings for NHS and SSFs while ensuring considerable gains for hospitals, under specific conditions (hospital personnel, budget, immediate payment by SSF). The expansion of the list is of absolute priority for reducing the NHS spending. More savings can be achieved by dispensing L3816 products through the newly formed unified health care fund (EOPYY) covering 90% of total population.

#### PHP75

##### THE COST PER DAY OF INTENSIVE CARE UNITS (ICU) IN FRANCE: THE CRRÉA STUDY

Garrigues B<sup>1</sup>, Lefrant JY<sup>2</sup>, Bazin J<sup>3</sup>, Bardoulat I<sup>4</sup>, Tagdichti K<sup>5</sup>, Courtial F<sup>5</sup>, Maurel F<sup>6</sup>, Pribil C<sup>7</sup>

<sup>1</sup>CH du Pays d'Aix, Aix-en-Provence Cedex1, Aix-en-Provence, France, <sup>2</sup>CHU Nîmes, Nîmes, France, <sup>3</sup>CHRU de Clermont-Ferrand, Clermont-Ferrand, France, <sup>4</sup>IMS Health, Puteaux Cedex, France, <sup>5</sup>IMS Health, Puteaux, France, <sup>6</sup>IMS Health, 92807 Puteaux Cedex, France, <sup>7</sup>GSK France, Marly le roi, France, France