

**CONCLUSIONS:**

The POEM procedure should be carried out at an experimental or trial level only, with strict auditing of results. POEM procedures should ideally be performed at institutions where an adequate level of surgical and critical care backup is available to provide expert care should complications arise. Monitoring of patient outcomes, including symptom improvement, is recommended for clinical assessment and reporting to determine future adoption in the South Australian public health sector.

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## VP34 Incorporation Of Medical Equipment In Northeastern Brazil

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**INTRODUCTION:**

Improving universal health coverage is a big challenge in many nations. Nevertheless, in countries like Brazil, the Constitution provides for universal access to meet population needs. Medical equipment is indispensable for the diagnosis and treatment of diseases in public and private health services. This study aims to analyze medical diagnostic equipment incorporation in a Brazilian state.

**METHODS:**

This evaluative research was carried out using data from Brazil’s Unified Health System (SUS) and Private Health Services. The research took place in Ceará, Northeastern Brazil. It is the eighth most populous Brazilian state, with 8.8 million inhabitants. Data on the types and quantity of medical devices in the public and private services were collected from August 2005 to August 2017. The results were analyzed by comparing population and normative parameters with technology incorporation in Brazil.

**RESULTS:**

A mean of 17.6 +/- 10.6 (SD) devices were incorporated each year in SUS versus 31.7 +/- 15.7 (SD) in the private services. Over a twelve year period, the

incorporation of equipment increased 59.7 percent in the public system and 152.6 percent in the private services. The production from these technologies increased to 18.1 percent. Considering both public and private services, tomography equipment coverage exceeds (147.4 percent) the parameter established by the Ministry of Health while magnetic resonance imaging equipment coverage is 90.5 percent.

**CONCLUSIONS:**

An expressive number of medical devices were incorporated in public and private health services, with higher rates in the latter. Both services presented a downward trend, suggesting that the incorporation of equipment is no longer needed. Such an extra coverage reveals an uncritical incorporation of these devices, that was not based on real needs; therefore, it is necessary to develop an action plan aimed at a better distribution of these devices to allow effective universal coverage.

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## VP36 Benefit Cost Analysis Of Electronic Claims Processing System In Ghana

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**INTRODUCTION:**

Since the inception of the Ghana National Health Insurance Scheme (NHIS), it has been pursuing a number of provider payment mechanisms that could not only control the continuous escalating costs of claims payout, but also facilitate the claims processing time. In lieu of this, electronic processing of claims (E-claims) was introduced in 2013 as part of the World Bank supported Health Insurance project that sought to facilitate the financial and operational management of the NHIS. It was piloted in 29 health facilities up to March 2014. They reported cost savings made by the NHIS using E-claims, creating interest in scaling it up. However, the comparative effectiveness and cost effectiveness of E-claims to the health system compared to manual claims processing is unknown. Therefore, to provide decision makers with the appropriate information to choose between manual and E-claims processing, this study sought to evaluate the cost-benefit of E-claims.

**METHODS:**

A benefit-cost analysis was used to evaluate the efficiency of E-claims from the perspective of the health system. Health providers and the purchaser (NHIS claims processing center) were the study population. Resource use and costs were obtained from the study population. The volumes and values of claims reimbursed and the claims rejection rate were used as the benefits of claims processing. The incremental benefit-cost ratio (IBCR) was estimated for the provider, purchaser and the entire health system. Analysis was conducted in Microsoft Excel.

**RESULTS:**

The total cost per claim for providers were USD 1,177.04 and USD 1,240.65 for E-claims and paper claims respectively. The total cost per E-claims and paper claims for the purchaser were 592.17 and 502.19 respectively. Total benefit per E-claim and paper claim processing for the providers were USD 8,562.90 and USD 8,888.37 respectively while that for the purchaser was USD 11,037.62 and USD 8,737.60 respectively. Processing claims electronically led to incremental gains by both providers and purchasers. Providers gained additional USD 2008.51 while the purchaser gained USD 2,300.02. The IBCR was estimated at -19.75, 25.56 and 5.10 for all providers, purchaser and both providers and purchaser of the health system respectively. Thus the IBCR was less than 1 for the providers and more than 1 for purchaser and both purchaser and providers.

**CONCLUSIONS:**

The electronic processing of claims is more efficient compared to manual processing in the Ghana NHIS. This provides decision makers with evidence for scaling it up to all the facilities in Ghana.

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## VP40 Robotic Surgery: From Health Technology Assessment To State Health Policy

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**INTRODUCTION:**

The aging population means more men are diagnosed with prostate cancer, resulting in greater demand for

treatment. Robot-assisted radical prostatectomy (RARP) claims to offer additional benefits to patients and providers. The independent Victorian Health Technology Program Advisory Committee assessed safety, clinical effectiveness and cost effectiveness evidence and financial impact to inform policy, access and reimbursement decision-making by state government policy makers and public hospital providers.

**METHODS:**

Public and private hospital activity and costs for 2008–09 to 2012–13 from the Victorian Admitted Episodes Database (VAED) and the Victorian Cost Data Collection (V CDC) were identified. Data were extracted and reviewed based on (i) DRGs M01A and B, (ii) primary diagnostic code C61 (ICD-10-AM), and (iii) Australian Classification of Health Interventions procedure codes for open (ORP), laparoscopic (LRP) and RARP, supplemented by Victorian Prostate Cancer Clinical Registry data. English language Health Technology Assessments (HTAs)/systematic reviews published January 2009 to January 2015 were identified and analysed with comparative clinical outcomes data for RARP vs. ORP and RARP vs. LRP analysed. Not all reported the same data and most outcomes data presented were odds ratios and risk ratios.

**RESULTS:**

RARP offers patients a shorter length of stay (LOS) compared with ORP or LRP, but the procedure takes longer to perform. While RARP has similar safety and clinical effectiveness profiles compared with ORP and LRP, published data do not unequivocally demonstrate that RARP is superior to ORP or LRP in terms of clinical outcomes. RARP is more expensive than ORP and LRP. The cost differential increases when capital costs are taken into account. Cost offsets from a reduced LOS are insufficient to justify the higher cost.

**CONCLUSIONS:**

Since RARP produces similar clinical outcomes to ORP and LRP but at a higher cost, the Victorian Health Technology Program Advisory Committee considered the case for public sector support of RARP is weak and provided two recommendations: (i) State Government resources are not used to procure RARP capital equipment; (ii) public hospitals can refer patients to a RARP provider, provided costs are negotiated prior to patient transfer and fully covered by the referring hospital.

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