**3610**                                                                 POSTER

**Implementation of Insurance Coverage for Cancer Patients a Study**

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**Background:** Although there is substantial evidence that Insurance status is important factor to access and utilization of health resources. Also economic issue influence choice of treatment and poorer survival. To adddress such a need in India this study was undertaken to estimate the burden of cancer patients taking treatment each year, percentage of patients insured, different types of Insurance coverage, estimate increase in Insurance coverage in last 3 years and trends in insurance coverage and utilization of health care resouces.

**Methods and Material:** The data were gathered through a computer assisted database for all adults above the age of 18 years diagnosed with cancer and taking treatment in Sri Ramachandra Medical College and Research Institute. Software Oracle was used with Acess SQL to analyse the data of patients who reported during 2008, 2009 and 2010.

A total of 4453 cases were available. The total number of cases registered for treatment in 2008 was 1250 and increased to 1437 in 2009 and further increased to 2166 by 2010. Increased in number of patients covered by insurance almost from 35% in 2008, to 47% in 2009 and 62% by 2010. The different types of Insurance coverage in these patients showed number of patients treated with private insurance in 2008, 2009 and 2010 were 128, 296 and 362. These are mainly Star Health Insurance, ICICI Lombard, Mediassist, New India insurance, etc. The governmental and non governmental insurance include Ex serviceman Insurance, Central government employees, etc were 309 in 2008, 377 in 2009 and 483 in 2010. The state governemt of Tamil Nadu introduced the Insurance scheme for Life saving treatment in 2010 under Star Health and Allied Insurance Company Limited and there were 500 new cases of cancer patients treated in last year. There is also a steady rise in private and individual insurance.

**Conclusion:** There is a overall increase in insurance coverage for treatment of cancer and gradual increase noted last 3 years. Also there is increase in health care utilization in all cancer subtypes. Further study on effect of this with survival, stage, gender, race, age will give us a more through knowledge and subsequently help in resource allocation, screening and prevention. This is one of the few studies of its kind from India.

**3611**                                                                 POSTER

**Capacity Building in Palliative and Supportive Care in Georgia −
Follow-up of Palliative Care National Plan for 2011−2015 − Approved
by Parliament of Georgia**

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**Background:** Currently the National Healthcare Policy is still under development in Georgia. The conception of primary care setting-oriented model, considered as priority for the end of 20th century, is gradually substituted by complex development model conception by now.

During the last years in Georgia − through the permanent collaboration of devotees with Governmental Institutions and NGOs (including International Organizations) was created the basis for the development of Palliative Care as an integral part of National Healthcare System.

We have to note that, launching of palliative care national program has led to brilliant results on the way of palliative care establishment in national healthcare systems, not only in developed countries, but also in post soviet countries of Eastern Europe and in developing countries.

The aim of the research is to identify the current status of palliative care follow-up the implementation and practical legalization of National Plan in Palliative Care and outline the challenges and the ways of its further development.

**Material and Methods:** All legal, clinical, education and research issues in 2010−2011 underwent to analysis.

**Results:** According the PC National Plan for 2011–2015, which approved by Health Care Committee of Parliament of Georgia from February 2010 in two different districts and since 2011 in one more districts of the country, was implemented Palliative Care Services. During this period 1578 patients received home and inpatient palliative and supportive care. In 29.9% (473) of cases was found challenging terminal symptoms which was fixed and solved by home based PC teams and in 43.2% (682) cases challenging problems (uncontrolled pain, dyspnea, fatigue, delirium and others) ware managed in inpatient units. More than 2300 family members received the supporting and bereavement services.

**Conclusions:** PC becomes non-separate part of Health Care System in Georgia. The main challenges on the way of PC development are lack of: adequate information among the society as well as potential stakeholders and decision-makers; knowledge among healthcare professionals and finances.

**Prospective:** Increase in the educational activities and informational campanies in cooperation of international organizations and experts; To involve more donors and sponsors and stakeholders seem to be the real ways of further development of PC in Georgia.

**3612**                                                                 POSTER

**Cost Utility Analysis of Modified FLOX as First Line Chemotherapy
for Metastatic Colorectal Cancer**

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**Background:** Incorporation of new drugs for colorectal cancer has led to a clear improvement in patients overall survival (OS) but the added cost of treatment is a major concern worldwide. As previously described in a retrospective analysis of 82 consecutive patients (pts) in our center, modified FLOX (mFLOX) regimen is an active and feasible first line regimen in metastatic colorectal cancer (MCRC) pts, with a median OS of 19 months and clinical benefit (PR + SD) of 75.7%.

**Material and Methods:** In order to access cost-effectiveness of mFLOX (leucovorin-20 $mg/m^2$, in combination with weekly bolus 5-FU 500 $mg/m^2$ for 6 consecutive weeks, and oxaliplatin 85 $mg/m^2$ weeks 1, 3 and 5, in 8-week cycles) in comparison to mFOLFOX6, a Markov model with a 2-year time horizon and 2-week cycles was developed. Probabilities of toxicities (neutropenia, diarrhea, and neuropathy), progressive disease, overall survival and likelihood of second line therapy, were based on published literature and data obtained in our retrospective analysis. Utilities were based on the available literature data. Costs for physician, hospital services and drugs were derived from DATASUS, ANVISA and local resources. The analysis took a Brazilian government perspective. Health outcomes were measured in quality-adjusted life years (QALYs). To address uncertainty in model parameters, one-way sensitivity analyses were performed. Costs and utilities were discounted at 5%. Even producing similar Kaplan–Meier curves, it was assumed that mFLOX was 20% inferior to mFOLFOX6 in terms of efficacy and that the median time on first line therapy was 20 weeks.

**Results:** The mFLOX regimen had a cost of BRL 9,000 (1 BRL = 2.29 EUR) and mFOLFOX6 BRL 22,000 leading to an incremental cost of BRL 13,000, considering a 20-week duration of first line therapy. The incremental effect of mFOLFOX was of 0,117 QALY. The incremental cost-effectiveness ratio of mFOLFOX6 was of BRL 110,344/QALY. In 10,000 probabilistic Monte Carlo simulations mFLOX was cost effective in 60% of trials using a threshold of BRL 100,000/QALY. No differences in outcome measures were detected with sensitivity analysis.

**Conclusions:** The mFLOX regimen is not only active, but also cost-effective as first line chemotherapy in MCRC, especially in scarce resources scenarios. This regimen must be explored in larger prospective studies.

**3613**                                                                 POSTER

**Health Resource Utilization (HRU) Associated With Skeletal-
related Events (SREs) by Tumour Type in Patients With Bone
Metastases/lesions: European Analysis of a Prospective Multinational
Observational Study**

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**Background:** Bone metastases/lesions are commonly associated with SREs and are likely to result in increased patient morbidity. Future resource requirements and estimation of the value of new treatments to prevent/delay SREs require data on the patient and economic burden. However, there is paucity of prospective data in this regard in the literature.

**Material and Methods:** Eligible patients had bone metastases secondary to breast (BC), lung (LC) or prostate cancer (PC) or multiple myeloma (MM) and were required to have had at least one SRE within 90 days prior