IMPACT OF REDUCED COPAYMENTS ON MEDICATION ADHERENCE: DX-RX PAIRING™ PROGRAM OUTCOMES
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OBJECTIVES: A large retail employer implemented Mercer’s Dx-Rx Pairing™ program. This program offers reduced copayments on diabetes, coronary artery disease, heart failure, and asthma medications with concurrent enrollment in disease management. We measured adherence and assessed medical utilization in 771 program enrollees (intervention group) and in those eligible but not enrolled (control group), n = 997. METHODS: Adherence, defined by Proportion of Days Covered (PDC), was calculated for prescribed drug use. RESULTS: One year after implementation of Dx-Rx™, paired t-test analysis compared the change in adherence pre- vs. post-implementation in both intervention and control groups. We calculated propensity scores to adjust for selection bias and subsequently used regression analysis to compare the change in adherence between groups. RESULTS: The overall adherence in the intervention group increased by 7% (p < 0.001) after implementation of Dx-Rx™, whereas the overall adherence in the controls decreased by 9% (p < 0.001). Adherence improved especially for inhaled steroid use among Dx-Rx™ users (46%, p < 0.01). However, adherence among diabetics to angiotensin-converting enzyme inhibitors (ACEIs) and angiotensin receptor blockers (ARBs) did not improve in either the intervention or the control group (~2%, p = 0.509–<8%, p = 0.002, respectively). Regression analysis concurred that Dx-Rx™ enrollees had a greater improvement in PDC than the controls (β = 0.094, p < 0.001). Larger increases in DX-Rx™ enrollees were seen in medical per member per month (PMPM) for Dx-Rx™ enrollees. CONCLUSIONS: The Dx-Rx™ program improved adherence, but did not reduce medical costs in this timeframe. Subanalyses revealed areas of the program’s success and areas for improvement.

IMPORVERISHING MEDICINES: A COUNTRY-CROSS COMPARISON OF THE AFFORDABILITY OF MEDICINES
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OBJECTIVES: In low- and middle-income countries medicine costs account for a substantial part of total health care costs (WHO estimate: 25–70%). In these countries, many patients pay for medicines out-of-pocket. This study’s aim was to calculate the affordability of four essential medicines (salbutamol inhaler (100 mcg/dose), glibenclamide (5 mg), atenolol (50 mg) and amoxicillin (250 mg)) for 17 low- and middle-income countries. METHODS: Previous research expressed affordability of medicines in the number of days’ wages of the lowest paid unskilled government worker. Using medicine prices from a joint project between Health Action International & WHO, and expenditure data and income distributions from the World Bank, this study calculated affordability of four essential medicines. RESULTS: Calculated affordability for four essential medicines in the number of days’ wages of the lowest paid unskilled government worker. Using medicine prices from a joint project between Health Action International & WHO, and expenditure data and income distributions from the World Bank, this study calculated affordability of four essential medicines. CONCLUSIONS: Eighty-five percent of the population in low- and middle-income countries can afford acceptable medicine prices. Improving affordability of medicines is an important first step to improving healthcare services. The number of poor people in low- and middle-income countries is large. These results call for action by politicians, policymakers, and civil societies.

HEALTH CARE USE & POLICY STUDIES – Equity and Access

UN POUR TOUT, TOUT POUR UN! AN EMPIRICAL ANALYSIS OF PHARMACEUTICAL COVERAGE DECISIONS IN THREE COUNTRIES
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OBJECTIVES: National public insurance coverage of drugs is based on evidence of comparative effectiveness and cost-effectiveness. This study compares the importance of these issues across three jurisdictions (Australia, Canada, and England and Wales) that have been at the forefront of evidence-based coverage internationally. METHODS: A retrospective comparative analysis of data on factors that have been influential in pharmaceutical coverage decisions in three countries (Australia, Canada, and England and Wales) that have been at the forefront of evidence-based coverage internationally. RESULTS: Recommendations varied considerably across countries in part because of different processes including the willingness to negotiate on price and the associated attitude to market proliferation of drugs with similar characteristics. The data suggest that the three agencies make recommendations that are consistent with a cost effectiveness framework; although it is clear that these committees have other objectives in addition to efficiency. This is consistent with previous empirical studies that suggest the strength of evidence of the comparative effectiveness of the drug as well the budgetary cost to government is also significant predictors of listing in addition to cost-effectiveness. CONCLUSIONS: NICE, PBAC, and CDR continue to face common issues with respect to the quality and strength of the experimental evidence in support of a clinically meaningful effect. There are significant differences in recommendations across countries in part due to differences in interpretation of evidence differences in objectives and associated processes, particularly with respect to price negotiation.

PRIMARY CARE AND AVOIDABLE HOSPITALIZATIONS: A COMPARATIVE ANALYSIS BETWEEN FRANCE AND THE UK
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OBJECTIVES: 1) Compare the quality of primary care in France to that in the UK, through a comparison of the avoidable hospitalization rates in both countries, and 2) Shed light on the determinants of the quality of primary care through a comparison of practices between the two countries for three Avoidable Hospital Conditions (AHC). METHODS: We counted the total number of hospitalizations for 12 AHCs defined by Weisman et al. Patient hospitalization records were drawn from the PMSI database for France (2006) and the HES database for England (April 2006–May