SULTS: Of the 82 responding geriatric divisions, 15 had an active ACE unit. Average daily census on ACE units ranged from 5 to 25, average length of stay was 5.2 days and the average nurse to patient ratio was 1:6. Community dwelling was the most common pre-admission living setting. Two most common admitting diagnoses were congestive heart failure and pneumonia. T-test showed significant difference (<.05) between hospitals with ACE unit and hospitals without, with respect to number of beds and total revenue. The step-wise logistic regression indicated that total hospital revenue was the only significant factor in determining the presence of an ACE unit. CONCLUSIONS: Thus, application of the ACE unit model remains modest given the paucity of information regarding its long and short-term benefits and cost-effectiveness. Further research in this direction can facilitate informed policy decisions.

**INDICES FOR EVALUATION OF DRUG COST/UTILIZATION: EVERY SILVER LINING HAS A GRAY CLOUD**

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OBJECTIVE: Given the high cost of pharmaceuticals, particularly “blockbuster” drugs such as the COX-II inhibitors, the issue of value-for-dollar is an increasingly important one for managed care decision-makers. Due to the complexity of conducting full economic evaluations, it is often tempting to try to reduce such analyses to the most simplistic methods possible—either by assuming equal effectiveness of two drugs and performing a cost-minimization analysis, or by using an index of drug cost/utilization such as DDD (number of defined daily doses of a drug used in a population), PMPM (per member per month cost/utilization), PPPM (per patient per month cost/utilization), ADC (average daily cost of drug therapy), or DACON (daily average consumption of a drug in a population). If a partial economic evaluation based on drug cost/utilization is necessary or preferred, decision-makers should bear in mind the relative strengths and limitations of these approaches prior to making policy decisions. The objectives of this paper are: (1) to describe several indices of drug cost/utilization, (2) to discuss their strengths and limitations, (3) to provide illustrations of their use, and (4) to offer suggestions for appropriate interpretation. METHODS: Using numerical examples focusing on COX-II inhibitors, several indices of drug cost/utilization are described and compared, including DDD, PMPM, PPPM, ADC, and DACON. General limitations and assumptions of “partial” economic evaluations based solely upon cost/utilization data are discussed, including assumptions of equal effectiveness, compliance, continuation and safety; as well as confounding by indication, severity of illness and time on market. RESULTS: Depending upon the index used, results (data) on drug cost/utilization for COX-II inhibitors vary. CONCLUSION: Numerous indices are used to describe and evaluate drug cost/utilization. Each has its own strengths and limitations, and must be interpreted in the appropriate context to best inform pharmaceutical policy decision-making.

**COST ANALYSIS OF PHARMACEUTICAL SERVICES IN A TEACHING INSTITUTION**

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OBJECTIVES: The study purpose was to describe and quantify annual costs of pharmaceutical services per category (5) and clienteles (5) in a 452 bed mother and child teaching institution. METHODS: Based on a daily diary completed by each pharmacist, we calculated costs of pharmaceutical services in five categories in 1999–2000: distribution, management, clinical, teaching and research. Pharmacists were requested to provide a description of their activities, including the number of new patients/follow-up, verbal and written requests and number/type of interventions. Costs ratios were calculated. RESULTS: 1999–2000 fiscal year showed 21,330 admissions, 115,961 patient-days and 275,000 outpatient visits. Pharmacists represented 47% of total worked hours. Pharmacists’ total hours reported represented 89.6% of accounting data. Hours were dedicated to distribution (53%), clinical (29%), management (12%), teaching (5%) and research (1%) services. Pharmacists answered 26,491 questions while providing 26,065 interventions among 5 clienteles (intensive care, pediatrics, multi-specialties, mother and child and haematology/oncology). We calculated a ratio of interventions/worked hours with an average of 0.61 (min 0.015–max 1.35). An analysis of these differences will be provided. Pharmacists’ total annual costs represented $1,453,000.00 CDN including social benefits. Assuming our pharmacy model optimizes the number of potential interventions in our setting and that 100% of pharmacist’s paid time is required to materialize them, we calculated an average cost of $54.92 CDN/intervention (min $24.80 CDN–max $2,233.00 CDN). Differences were calculated between 1998–1999 and 1999–2000 showing an average of 104% difference (min 68%–max 197%). Differences can be explained by pharmacist expertise evolution, management decisions and changes in activity volumes. CONCLUSION: There are little data available to allow benchmarking in the costs of pharmaceutical services. Further studies are required to identify the most useful ratios to monitor such costs as well as relevant outcomes.