PHYSICIANS’ ATTITUDES TO AND EXPERIENCE WITH INCREASED USE OF INDIVIDUAL REIMBURSEMENT VERSUS GENERAL REIMBURSEMENT OF NEW IMPORTANT PHARMACEUTICALS

Levorsen A1, Kristiansen IS2, Aasland OG1
1Oslo University/ MSD Norway, Oslo, Norway, 2Oslo University, Oslo, Norway

OBJECTIVES: In 2003 a restrictive reimbursement scheme, advocating increased individual reimbursement versus general reimbursement of new important pharmaceuticals, was implemented in Norway. This study was conducted 18 months after implementation, and investigates physician self-reported attitudes to and experience with the scheme from a clinical and administrative perspective. METHODS: Practicing physicians (n = 1399) from the NMA Research Panel were surveyed (75 question self-administered questionnaire) by mail, December 2004. The response rate was 71% (n = 993). Only data from respondents involved with the scheme in 2004 (n = 605; 61%) were analysed in this sub-study of 24 questions. Physicians’ attitudes and experience were addressed through 17 claims about the scheme and evaluated on Likert scales, in addition to questions on resource use and number of applications, referrals and application approvals/rejections. RESULTS: Of the 605 respondents in this sub-study, 87% agreed that the individual reimbursement scheme was complicated and demanding. Only 37% reported approval of all applications. Rejected applications were appealed by 26% of the physicians, 31% re-submitted/referred to specialists, 22% requested written justification, 21% recommended patients to pay for the pharmaceutical themselves, whilst 14% did nothing. The majority of physicians (71%) were dissatisfied with the scheme and 54% were dissatisfied with the application-process. In contrast, only 11% were satisfied with the scheme and 14% with the application-process. Fifty-seven percent reported that the scheme restricted physicians from prescribing the pharmaceutical they consider clinically best for a patient and 52% of patients choose to pay for the pharmaceutical themselves. Self-reported use of time to administrate individual applications (n = 110,000), was estimated to 11 physician-labour years and a cost of 42 million NOK in 2004. CONCLUSIONS: The majority of physicians in Norway are dissatisfied with the governments increased use of individual reimbursement. The results indicate that the scheme generates high administrative costs and may have negative consequences for patients.

TELEMEDICINE IN THE U.S. MEDICARE PROGRAM: 2007 REIMBURSEMENT IMPLICATIONS

Pierce CA1, Baker J2, McClard C2
1The Resource Group, Richfield, OH, USA, 2The Resource Group, Pickton, TX, USA

OBJECTIVE: Reform legislation has expanded the U.S. Medicare program for eligible telemedicine services and has required establishment of a process to add or delete covered services on an annual basis. This study explores the current reimbursement status of Medicare telemedicine reimbursement and its potential implications for 2007. METHODS: The Medicare rationale and historic progress of telemedicine coverage and reimbursement was constructed within a worksheet format. Major changes and additions to the program were highlighted and examined. A timeline of legislative and regulatory decisions was prepared. Criteria for coverage and payment were identified and summarized. Current definitions of required equipment and exceptions to these requirements were identified and their evolution tracked. The potential for 2007 reimbursement changes was evaluated. RESULTS: A summary of findings follows. The Medicare telemedicine program contains four major covered types of service that can now be performed by eight categories of specified professionals. Two types of geographic areas are eligible, although certain demonstration programs may be eligible regardless of geographic location. Billing and payment requires the use of stipulated codes. The process to add or delete services annually has been implemented. Each transaction must contain two sites; “distant” and “originating”. There are five types of originating sites. Payment is funded differently for “distant” versus “originating”. The required equipment is primarily represented by interactive telecommunications systems, although asynchronous technology is allowed in restricted instances. An upcoming Medicare report to Congress may recommend further expansion of the telemedicine program in 2007. CONCLUSIONS: Medicare telemedicine coverage and payment has continued to expand but remains restricted to certain geographic areas and to certain service provider sites. Health care decision-makers, including managers and payers, must be made better aware of the multiple benefits and efficiencies that telemedicine offers to both service providers and to patients.

PHARMACOEPIDEMIOLOGICAL ANALYSIS OF THE USEING DRUGS FROM REIMBESMENT LIST IN RUSSIA

Yagudina R1, Kulikov A1, Saffiulin R2, Yarkaeva F2
1Moscow Medical Academy, Moscow, Russia, 2Kazan Medical University, Kazan, Russia

OBJECTIVES: To estimate volumes and structure of consumption of the drugs received by separate categories of citizens which have the right to free-of-charge reception under reimbursement program (DLO) in 2005 in Tatarstan (on example Tatarstan region). To allocate diseases having the greatest prevalence and/or the greatest financial loading for budget. METHODS: In 2004 there was not the federal reimbursement system. In 2005 DLO was launched. A total of 216,722 persons have the right to receive drugs by DLO. We received the information on each of 2,543,599 purposes of drugs. Ischemic illness of heart, hypertonic illness, diabetes, cancer of a mammary gland were leaders on volume. Expenses Ischemic illness of heart, hypertonic illness, diabetes, cancer of a mammary gland were leaders on volume. Expenses Ischemic illness of heart, hypertonic illness, diabetes, cancer of a mammary gland were leaders on volume. One thousand patients with these diagnosis were randomized. We compared their therapy in 2004 vs. 2005. RESULTS: Total cost of DLO in Tatarstan in 2005 was €26,368,244. Average cost of one recipe in 2005 in DLO was €10.5. Average expenses for one patient in 2005 a year in DLO was €124. The maximal expenses for one patient was €23,534. On ischemic illness of heart 7% of charges are necessary, arterial hypertension 9%, diabetes 16%, oncology 19%. CONCLUSION: Introduction of system of reimbursement has rendered beneficial effect on quality of treatment of patients 2005 vs. 2004 percentage of patients on a regular basis received drug therapy in occasion of cardiovascular diseases (with the miss no more than three months for a year) has grown from 15,8% up to 32,8%.

GENERIC COMPETITION: EFFECT ON PRICES AND SUBSTITUTION EFFECTS

Engstrom A, Lundin D, Jacob J
LFN Pharmaceutical Benefits Board, Solna, Sweden

OBJECTIVES: To calculate a price index for pharmaceuticals in Sweden and to examine the effects of generic competition on patented pharmaceuticals. METHODS: Price and volume data...
Abstracts

for the period 2002–2005, for the 180 most selling substances were used to calculate a chain price index. A regression model was used to estimate the effects of analog substitution, i.e. switches from one substance to another of the same class, for 5 major products whose patent expired during the period.

RESULTS: The general price level of pharmaceuticals has fallen 15% during the period and off-patent drugs have experienced a 40% fall in price level. In addition to the direct effect on prices of a substance due to generic competition, there has also been analog substitution effect from patented drugs to off-patent drugs. For two groups of pharmaceuticals, statins and PPIs, there were significant substitution effects between substances due to the changes in relative prices. CONCLUSIONS: Generic substitution in Sweden has been effective in reducing prices of off-patent pharmaceuticals. Generic substitution has also had more farreaching effects than what has been previously believed. There has been a move from patented to off-patent products within the same therapeutic area.

HEALTH TECHNOLOGY ASSESSMENT IN HUNGARY
Nádudvari N
National Institute for Strategic Health Research, Budapest, Hungary

OBJECTIVE: Hungary’s accession to the European Union in May 2004 compelled reconsideration of the social insurance inclusion of pharmaceutical products. The Office of Health Technology Assessment (HTA) of the National Institute for Strategic Health Research was formed in 2004 with the aim of establishing an independent institution to support decision-makers in their rational use of health care resources. METHODS: The Office provides an organisational framework for the technology assessment that forms the basis for the medicine subsidy approval policy of the National Health Insurance Fund, and performs the related medical and economic assessment duties. The National Health Insurance Fund makes decisions regarding the granting of subsidies for medicines, based on the findings presented by the Office of HTA, which X determines the professional guidelines for analysing health technology, coordinates the assessment of new and existing technologies, and issues instructions for the use of individual technologies X provides reliable and undistorted information for the appraisal of individual procedures, comparing them with alternative opportunities for the use of resources based on a combination of clinical evidence, efficacy and cost-effectiveness factors, X facilitates the appropriate use of cost-effective health care technologies, and provides support for decision-makers. RESULTS: The majority of applications were related to anti-tumour drugs and products designed to treat diseases of the cardiovascular or central nervous system. The Office also performs problem-oriented comparative examinations, such as the comprehensive policy study of Positron Emission Tomography (PET) and Gamma-knife surgery, Drug-eluting Coronary Stents, etc. CONCLUSION: In the initial period, staff at the Office of Health Technology Assessment focused primarily on assessments of medicines to determine their eligibility for social insurance funding, but as the new institutional structure becomes more firmly established, it is increasingly able to perform thorough, comprehensive assessments of other health technologies.

EVALUATION OF SCIENTIFIC QUALITY OF POSTMARKETING SURVEILLANCE STUDIES IN GERMANY
Dietrich ES, Zierold F
National association of statutory health insurance physicians, Berlin, Germany

OBJECTIVES: Anwendungsbeobachtungen (AWBs) are a common type of postmarketing surveillance studies in Germany. They provide information about medical benefit, safety, and effectiveness of drugs in daily practice and can support reimbursement decisions. As practice based research gains in importance the scientific quality of AWBs was evaluated. METHODS: The German drug law demands the reporting of AWBs to NASHIP. In the examined six-month period (July to December 2005), 453 AWBs were announced to NASHIP. Onehundredeighteen were announced for the first time, the others were supplementary information to ongoing AWBs. AWB-conducting companies were asked for more detailed information and AWBs designs were analysed by a validated data entry form that was based on recommendations of the Federal Institute for Drugs and Medical Devices for the conduct of AWBs. RESULTS: One hundred-eight AWBs included statements about goals: 46% listed drug utilisation, 87% safety, 68% effectiveness and 24% QoL. Only a third of AWBs chose a suitable design, basically those that examined safety and drug-utilisation. Only 10% were comparative. Most evaluated drugs were high-priced up to costs of Euro 4500 per prescription. Almost 50% of all drugs had obtained marketing authorisation during the last five years. Median observation time per patient was 140 days. Only 19% of all AWBs mentioned a planned publication of results explicitly. CONCLUSIONS: This study showed the very heterogeneous quality of AWBs in Germany. In most AWBs the marketing aspect dominated obviously and they were not suitable for reimbursement decisions on the basis of the price-benefit ratio.

COST-EFFECTIVENESS STUDY OF ADJUSTED CLINICAL GROUPS TO ASSESS THE ABILITY OF SPANISH PRIMARY CARE TEAMS TO BRING ISSUES TO RESOLUTION
Serrat J1, Sicras A2, Navarro R1, Ruano I2, Velasco S2
1Badalona Serveis Assistencials, Barcelona, Spain, 2Badalona Serveis Asistencials, Barcelona, Spain

OBJECTIVES: The aim of the study was to determine the cost-effectiveness ratio of professionals in five Spanish primary care teams (Spanish “EAPs”) on the basis of Adjusted Clinical Groups (ACGs). METHODS: Retrospective descriptive study. We included all patients attended by five EAPs in 2004. Principal measurements: age, sex, consultation episodes/reasons, total cost/expense (semi-fixed: personnel, procurement; variable: pharmaceutical expense, referrals, tests), department, centre, physician in charge (Spanish “UBA”—basic care unit) and a qualitative synthetic index (Spanish “ISC”) drawn from 36 process and outcome indicators relating to health care practice. Every patient was assigned to an exclusive ACG/category. We produced the adjusted efficiency index (Spanish “IE”) indicating relative efficiency with reference to a standard (observed/expected; grouper-6.0; Johns Hopkins University) and the ISC for each centre and UBA. We analysed the correlation of IE and ISC (Spearman’s rank correlation) and a range of indirect standardisations to adjust the results. Statistical significance p < 0.05. RESULTS: We studied 81,085 patients (use intensity 76%, with a mean of 5.0 ± 3.6 and 8.0 ± 8.2 visits per patient per year. The total cost per attended patient per year was 340 euros (reference average relative weight). Pharmaceutical prescription costs accounted for more than 60%. The efficiency indices (IE) of the centres were: 0.92, 0.94, 0.95, 1.06, and 1.06 (p = 0.000). The qualitative synthetic indices (ISC) were: 68.9%, 66.1%, 45.8%, 43.4%, and 31.6% (p = 0.000). An inverse correlation was found between IE and ISC (p < 0.001; R² = 36%). The explanatory power of the classification was 53%. CON-