involvement of health technology assessment institutions, the adjustment of the reimbursement system in a time frame allowing the survival of the company, and the dissemination of the technology. RESULTS: Involvement of objective institutions like the Federal Committee (GemBA) or the Institute for Reimbursement in the hospital sector (INEK) is necessary to prevent implementation of new technologies without adequate medical efficacy and economic effectiveness. For positive recommendations a critical mass of clinical and health economic studies is prerequisite. But in time adjustment of the reimbursement catalogue, e.g. as new DRG or additional payment to existing DRGs, seem to be crucial for implementation of a new costly technology. CONCLUSION: Slow decisions processes can delay if not prevent the use of useful new therapeutic technologies. Although according to the German law cost effectiveness should be considered in reimbursement decisions, so far it did not play a relevant role in reimbursement decisions in the hospital sector.

PHP30
PRESCRIBING PATTERNS AND ASSOCIATED COSTS OF PSYCHOTROPIC DRUGS IN A MAJOR HEALTH CARE SYSTEM IN SAUDI ARABIA
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OBJECTIVE: Recognizing the prescribing pattern and associated costs of psychotropic medications and the factors associated with such prescribing is crucial and may play an important role in improving the health care services provided to patients on such medications. The objective of this study was to assess current trends and factors influencing the prescribing of psychotropic medications. The study also estimated the direct cost associated with these medications. METHODS: This is a retrospective study of (N = 71,136) prescription events of psychotropic medications identified from outpatient pharmacy records of a major health care system in Riyadh, Saudi Arabia for years 2002, 2003, and 2004. Patient characteristics, psychotropic medications use and the associated costs over the three years period were determined. Logistic regression was used to evaluate the influence of physician specialty and other relevant factors on prescribing of different psychotropic medications. RESULTS: Over the three years period the use of high cost agents have sharply increased to account for around 8% of the total outpatient spending on pharmaceuticals in 2004. Prescriptions by General Practitioners (GPs) accounted for 35% of the total psychotropic medications prescribed. However, patients on these medications were more likely to receive a high cost drug from a psychiatrist than from any other specialty. CONCLUSIONS: The results of the study indicate that psychotropic medications are mainly prescribed by GPs and that the likelihood of being prescribed a psychotropic medication, which may be of high cost, is greater when patients see a psychiatrist. In Saudi Arabia, health care systems should closely monitor prescribing patterns for psychotropic medications to avoid unnecessary cost and consequently, the potential for inappropriate use of such agents.

PHP31
CHARGES FOR HOSPITAL ADMISSIONS ATTRIBUTABLE TO HEALTH DISPARITIES FOR AFRICAN AMERICAN PATIENTS IN SOUTH CAROLINA DURING 1998–2002
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OBJECTIVE: To estimate the financial effect of racial disparities as reflected in differences in hospital admission rates each of the 25 Major Diagnostic Categories (MDCs) in the state of South Carolina. METHODS: Estimates were calculated for total submitted charges within each MDC that were attributed to higher admission rates for African Americans than for Caucasians in South Carolina, based on age-adjusted annual admission rates. Each of the 25 MDCs was evaluated to reveal which component Diagnostic Related Groups (DRGs) were the largest admission “drivers” or contributors to the observed differences in admission rates. South Carolina hospital discharge data for 1998–2002 was used for the analysis. The database includes all-payer billing data for inpatient hospital admissions as received on the UB-92 billing file for the covered episode. Charges were inflation-adjusted to 2002 constant dollars. RESULTS: Between 1998 and 2002, there were an estimated $1.6 billion in total charges for hospital admissions in South Carolina that were attributed to higher age-adjusted admission rates for African American patients. In addition, African Americans had consistently higher hospital admission rates for disease categories that are often associated with a failure to obtain ambulatory and preventive care. CONCLUSION: Our analysis reveals that age-adjusted hospital admission rates for African Americans in South Carolina are higher than for Caucasians, and that the gap appears to be widening over time. Given the magnitude of the financial implication, interventions with even a small impact on the conditions underlying the racial disparities in hospital admissions are likely to be cost-effective.

PHP32
COMBINING PHARMACY AND HOSPITAL DATA IN A RISK ADJUSTMENT MODEL
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OBJECTIVE: Health districts have been established as part of the decentralization of responsibility within the Italian National Health Service. A major challenge is to assure that appropriate financing is provided to meet the needs of the population. Risk adjustment models are being developed that can be used for districts’ resource allocation, planning and evaluation activities. METHODS: Pharmaceutical, hospital, and demographic data from 2000 and 2001 have been assembled for the entire population of Emilia Romagna, a large northern Italian region (4 million). Pharmaceutical and hospital tariffs were a proxy for costs. Morbidity indicators based upon pharmacy and hospital data were developed for risk adjustment. Prospective risk adjustment models were fit. We tested several models of increasing complexity, taking advantage of the predictive power of pharmacy- and hospital-based diagnostic groups. Our final adjuster was based upon a combination of the pharmacy and hospital groupings. We considered fairness across administrative units, as equity was a key policy goal. RESULTS: The pharmacy cost model predicts 25.8% of the variation in pharmacy costs. Our hospital cost model predicts 10.1% of variation in prospective hospital costs. Predictive accuracy for pharmacy cost models were improved by information from the hospital data; and were more stable for those who used health services in year 1, and better for those who used hospital and pharmacy services compared to those who did not have any service use. For the pharmacy model predictive accuracy by district ranged from 0.91 to 1.10; for the hospital cost model, predictive accuracy by district ranged from 0.93 to 1.13. CONCLUSIONS: We demonstrate that risk adjustment models using pharmacy data to identify individual morbidity are good predictors of future year costs. Regional and district health managers can use these models for...