PHLP18

REIMBURSING OFFICE-BASED DRUG MANAGEMENT COSTS: POLICY OPTIONS

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OBJECTIVE: The Centers for Medicare and Medicaid Services (CMS) computes clinical staff incident-to services in physician offices under a zero work hour alternative method. This study compares the results of CMS alternative method payment computations for indirect overhead costs with the actual resource-based level of effort for office-based drug management costs as incurred in U.S. physicians' offices. METHODS: Phase I: CMS methods used for zero work hour practice expense rate-setting were identified. Underlying assumptions were examined and formal methodology evaluations were collected. Phase II: On-site activity analyses were performed in over 70 physicians' offices located in 27 states. An activity database was created from study data obtained through direct observation and on-site interviews. Analysis employing descriptive statistics identified activities, tasks, and staff type involved in specific tasks, including drug management. The activity analysis findings were compared to the CMS reimbursement assumptions about these activities. RESULTS: A database of CMS methodology explanations, visuals, and evaluations was created. Activity analysis identified costs of labor and space to order, track, receive, store and pay for the drug; drug inventory carrying costs; net receivables carrying costs and average bad debt cost. Study analyses illustrate that current CMS practice expense payments do not adequately recognize drug management costs in physicians' offices. Study results revealed a statistically significant differential between actual and assumed use of administrative labor for indirect overhead zero work pool tasks, including those of drug management. CONCLUSIONS: CMS zero work hour methodology to compute payments for office-based practice expense is deficient as to drug management costs. Payment for this component does not align with actual practice occurring within the physicians' offices. These findings will be of use to economists, cost accountants, and policy makers interested in arriving at an equitable resource-based payment for drug management.

PHLP19

CONSUMER VALUATION OF PRESCRIPTION DRUG BENEFIT PLANS

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OBJECTIVE: To examine consumers' perspective of the quality of prescription drug benefit plans (Rx plan) using a prescription-drug quality index. Additionally, consumers' satisfaction and perception of importance of Rx plans were evaluated. METHODS: Consumers with prescription drug benefits were recruited from community pharmacies and random-digit dialing (RDD) to participate in a telephone survey. The questionnaire was constructed from published literature and in-depth interviews with six pharmacists, four consumers, and two employee benefit managers. RESULTS: Two hundred and one consumers participated in a 20-minute telephone interview. When asked to select optional health services over and above hospital and medical services, 62.6% selected prescription drugs services as most important. Using a 10-point scale, with 10 as the highest score, the average perceived quality rating of prescription drug benefit plans was 7.91 (2.0); the average rating for satisfaction with the plan was 7.22 (2.3); and the average rating for importance of the plan was 9.15 (1.3). Few consumers (20%) reported having plan-related problems when obtaining prescription medications. The majority (87%) reported having a copayment/coinsurance. The average prescription drugs out-of-pocket payment was $560 (ranging from $0–$7200) and the median was $200. Of the six prescription-drug quality indicators, only two were found
MARKET SHARE AND CHARACTERISTICS OF GENERIC DRUGS IN GREECE

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OBJECTIVE: To investigate the market share of generics, their production and promotion process by the Greek pharmaceutical industry. METHODS: Analyses are based on questionnaire mailed to companies members of the Greek Federation of Pharmaceutical Companies, in 2002 with a response rate of 52%. Questionnaire was divided in three sections, first requested information on the companies’ involvement in the production of generics, second on companies’ opinion regarding generics characteristics and government interventions, third on policies affected generics demand. Data was analyzed in two stages, first concerning detailed description of outcomes and second percentage comparisons through binomial tests. RESULTS: A total of 46.4% of the companies are involved in the production and distribution of generics while 53.6% are not, their difference is not statistically significant (equality of percentages test p = 0.59). The mean period of companies involvement is 12 years while 80.8% of the respondents expressed positively for their companies involvement in generics. A total of 30.8% of the companies consider that the most important characteristic of generics is that they are safe and cheap substitutes of the brand drugs. Of the companies, 88.5% consider government does not promote the prescription of generics, whereas 11.5% had different opinion, binomial test for the equality of percentages resulted in p < 0.001, meaning that the difference is statistically significant. The majority of companies (70.4%) consider that cost-effectiveness analyses should be the criteria for inclusion in the prescribed drug list vs. 18.5% the cost of treatment, 3.7% for reference pricing and 3.7% for the daily dose cost of treatment. Finally, majority of companies consider the positive list as the most important factor for the promotion of generics from health professionals. CONCLUSION: The self-report documentation tool in this constitute confirms the potential to minimize the risks, cost saving and to improve hospital prescribing associated with drug therapy.

IMPACT OF PHARMACY INTERVENTIONS ON QUALITY OF HOSPITAL PRESCRIBING: INTERVENTIONS AND COST SAVINGS ASSESSMENT
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OBJECTIVES: To demonstrate the impact of staff pharmacists of interventions at a large (2389 beds), tertiary care teaching hospital in Southern Taiwan. METHODS: Based on the self-reported documentation made by pharmacists during the conduct of routine dispensing activities in ambulatory and inpatient setting. Those intervened suggestions were accepted by prescribing physicians. A peer-review team decided the potential clinical significance of the self-reported documentation, and assessed their cost savings results. Data collection period was from January 1 to December 31, 2001. RESULTS: A total of 4424 interventions (94.8% of reported documentations) by 25 pharmacists were analyzed. Of which, 59.4% of these interventions were found to affect inappropriate prescribing, 35.4% of these interventions were associated with inappropriate drug utilization and the remaining 5.2% of interventions were drug interactions and miscellaneous. Six percent of reported documents were evaluated in terms of direct cost savings (the difference in actual acquisition costs between prescriptions). Cost savings were over $7400 and average $27 per intervention for those sampled data. The most cost-saving interventions were related to incorrect quantity with the indication, no indication, and improper concomitants/duplication. CONCLUSIONS: The self-report documentation tool in this constitute confirms the potential to minimize the risks, cost saving and to improve hospital prescribing associated with drug therapy.

AN INVESTIGATION OF GENERIC DRUG UTILISATION AND POTENTIAL SAVINGS FROM GENERIC SUBSTITUTION IN THE IRISH HEALTH CARE SETTING
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OBJECTIVES: Expenditure on medicines continues to increase significantly in Ireland. Total payments to pharmacies by the state for the year 2001 was €674.8 million, a 27% increase as compared with the year 2000. Prescribing less expensive generic preparations is one method of reducing costs while maintaining therapeutic efficacy. While generic prescribing is encouraged, generic substitution by pharmacists is not permitted. In this study the