RESULTS: In all hospitals the drug’s price and the quantity prescribed have an influence on formulary decision-making, especially for drugs used in the same indication with similar effectiveness and safety. The drug’s price and the quantity prescribed seem to have more impact on PH than on PC. Information about costs avoided by the inclusion of a drug in the formulary might have an influence on decision-making: (1) time spent by nurses (5 PC and 9 PH); (2) medical devices (2 PC and 5 PH); (3) shorter hospital stays (2 PC and 4 PH). This information has little (6 PC and 10 PH) or very little (3 PH) impact and seems to have even less impact on PH than on PC. Moreover, published economic evaluations have very little impact on decision-making in all hospitals.

CONCLUSION: In hospital formulary development, economic information is mostly used for cost-containment considerations, especially in PH financed on a global budget basis. The current use of information related to economic evaluations and to costs avoided by the inclusion of a drug is limited, compared to its potential use.

THE INFLUENCE OF UPDATING THE ISRAELI NATIONAL DRUG LIST ON AVERAGE NUMBER OF DRUGS PRESCRIBED TO A PATIENT
Klang S1, Hammerman A1; Bar-Yosef N1; Lieberman N1; Peterburg Y2
1Clalit Health Services, Tel Aviv, Israel; 2Clalit Health Services, Tel-Aviv, Israel

The Israeli National Health Law was enacted in January 1995, making health insurance both compulsory and universal. The law determined a basic list of health services to which all residents are entitled, and stated that the government is responsible for funding those health services. The National List of Health Services was defined as the 1994 formulary of Clalit Health Services, Israel’s largest Sick Fund (3.5 million clients). After the law was enacted and until December 2000, 152 new drugs were added to the national formulary and none were removed. Our hypothesis is that adding new drugs to a formulary increases the number of prescriptions that patients receive.

OBJECTIVE: To determine if there was a change in the average number of prescriptions given to patients of Clalit Health Services in different age groups, between the years 1996 and 2000.

METHODS: Clalit Health Services’ database was accessed to determine the number of prescriptions given to patients in different age groups, who received drug therapy in the years 1996 and 2000.

RESULTS: Children aged 0–18 years received 4.49 annual prescriptions in 1996 vs. 5.00 in 2000 (D = 11%). Patients between ages 19–45 received 5.93 prescriptions in 1996 vs. 6.34 in 2000 (D = 7%). The age group of 46–65 received 14.88 prescriptions in 1996 vs. 16.41 in 2000 (D = 10%), and the elderly age group (66+) received 21.63 annual prescriptions in 1996 vs. 33.18 in 2000 (D = 53%).

CONCLUSIONS: After adding 152 new drugs to the National Drug List, the most significant change in the number of annual prescriptions was seen in the elderly age group. These patients are now clearly using more medications than they used five years ago, although this monthly average of 2.8 prescriptions per patient is slightly lower than has been published in other epidemiological studies from Switzerland and Italy (3.2 to 4.0 on average).

THE ROAD TO JAPAN/KOREA 2002: PROSPECTS FOR JAPANESE PHARMACOECONOMICS
Pang F
Kyoto University, Kyoto, Japan

OBJECTIVES: The aim of this study is to conduct an environmental assessment of the Japanese health-care system as it enters the year 2002 with a focus on the prospects of the use and impact of pharmacoeconomics. The drivers, resistors and changes in stakeholder influence on the pricing and prescribing of pharmaceuticals are examined as well as Japanese economic evaluations to evaluate their state of the art and to highlight methodological considerations for future studies.

METHODS: A review of the published and internet literature in English and Japanese on the Japanese health-care system was conducted, supplemented by interviews with representatives from academia, hospitals, pharmacies, the medical press, industry and government. A systematic review of Japanese economic evaluations was also conducted using databases (MEDLINE, OHE-HEED, NHS-EED), and each study was assessed using a modified 36-point BMJ quality checklist.

RESULTS: Debate regarding pricing reform has been taking place since 1997 and submission of economic data to the MHLW has been optional since 1992 although the influence of these studies on pricing and reimbursement is uncertain. Main barriers to economic evaluation are the lack of Japanese-specific clinical/cost data, low numbers of trained pharmacoeconomists, lack of decision-making expertise/knowledge and organizational disincentives. Thirty-four Japanese economic evaluations were identified (32 CCA, 1 CEA, 1 CMA), predominantly addressing screening or diagnostic issues and cancer. 63% of studies used observational data; 37% contained disaggregated presentations, 23% applied discounting, 29% employed sensitivity analysis and 50% reported ICERs.

CONCLUSIONS: Although Japan is considered a late-adopter of pharmacoeconomics, there are several encouraging signs, e.g., rising numbers of Japanese economic evaluations and methodological research taking place in Japan on the Japanese EuroQol, generalizability, impact and willingness-to-pay. This study offers insights into the current status of Japanese pharmacoeconomics, particularly barriers that need to be overcome for cost-effectiveness to be influential on health-care decision-making in Japan.