

subjects without a cap: HR = 0.75 for \$750 (95% CI: 0.70–0.80); HR = 0.80 for \$500 (95% CI: 0.75–0.85); HR = 0.81 for \$250 (95% CI: 0.77–0.85). **CONCLUSIONS:** These preliminary analyses indicate that patients with annual drug benefit caps appear to anticipate exceeding the benefit limit, and reduce their drug consumption prior to reaching the cap amount. Further research is needed to assess how patients reduce their drug consumption and the clinical and economic impact.

PHP20**GENERIC DRUG PRICES REMAIN HIGHER IN CANADA THAN IN THE UNITED STATES**

Palmer WN, Neale S, Morris C

Palmer D'Angelo Consulting, Ottawa, ON, Canada

OBJECTIVE: This paper compares the prices of top selling generic drugs in Canada with prices for comparable generics in the United States (updating a 2002 study). **METHODS:** We compared manufacturer prices of 21 top selling (in 2004) generic prescription medicines in Canada that were marketed in both Canada and the US. Sources of Canadian prices included government reimbursed prices for Quebec, British Columbia and Saskatchewan. US prices were sourced from the Federal Supply Schedule (FSS) and three state Medicaid program Maximum Allowable Cost (MAC) lists. The prices of a subset of 11 drugs that appeared in both studies were compared to investigate trends. **RESULTS:** Of the 21 leading generic drugs, 20 had higher prices in Canada. Canadian prices were higher than US prices on all measures: Mean: +238%; Weighted Mean: +259%, Median +128%. If Canadians could access FSS prices for the 21 sample drugs, annual savings would exceed C\$440 million. If the price differences observed are extrapolated to all generic drugs sold in Canada, annual savings could exceed C\$1 billion. Canadian prices were also higher than state Medicaid MAC prices: Mean: +44%; Median: +15%. When comparing the 11 drugs that were included on both studies, a clear trend emerges: US prices have decreased 31% since 2001, while Canadian prices have remained stable. **CONCLUSIONS:** US prices of top-selling generics are lower than those in Canada and the price gap is widening. US generic prices are now on average 238% lower than those in Canada compared to 155% in 2001. Provincial government policies that establish Canadian generic prices at a percentage of branded products are one of the factors that appear to discourage price competition. Unlike Canada, US generic prices typically fall over time as more manufacturers enter the market and compete for government contracts and formulary listings.

PHP21**PHARMACEUTICAL POLICY IN GREECE: RECENT DEVELOPMENTS AND THE ROLE OF PHARMACOECONOMICS**

Yandoros C, Geitona M, Kontozamanis V, Karokis A

Hellenic Association for Pharmacoeconomics, Athens, Greece

OBJECTIVE: To evaluate the role of pharmacoeconomics in the Greek pharmaceutical environment. **METHODS:** The existing pharmaceutical reimbursement system in Greece and the proposal for the new pharmaceutical policy, announced in November 2004 by the Greek Ministry of Health and Social Solidarity were examined. **RESULTS:** The current reimbursement system in Greece consists of a positive reimbursement list. The main criterion for a product to be accepted for reimbursement is its daily drug cost in comparison to the average drug cost of the therapeutic cluster to which it belongs. Nevertheless, other factors are also taken into account in order to approve reimbursement, such

as the non-mandatory submission of pharmacoeconomic studies, even though their role in a positive or negative reimbursement decision is not clarified. The new system announced by the Ministry states that it plans to abolish the reimbursement list. In the place of the current reimbursement system it proposes, among other measures that aim to contain costs and alleviate patient burden, the implementation of a rebate system where drugs are grouped into therapeutic clusters and a reference price is calculated for each cluster. Pharmaceutical companies will return the weighted difference between their products' price and the reference price to social insurance organizations. The proposal states that rebate levels can be adjusted based on pharmacoeconomic evidence in order to reward cost-effective therapies. Additionally, the proposal announces the establishment of a Health care Technology Evaluation Agency that will evaluate technologies and produce guidelines based on evidence based medicine and cost-effectiveness parameters. This Agency will also evaluate pharmacoeconomic evidence in cases where there is a need to adjust rebate levels for specific products. **CONCLUSIONS:** At present, pharmacoeconomics play a limited role in the reimbursement of pharmaceuticals in Greece. The new pharmaceutical policy proposal reinforces the role of pharmacoeconomics in Greece, which is a welcome development.

PHP22**EFFECTS OF DECENTRALIZED RESPONSIBILITY FOR COSTS OF OUTPATIENT PRESCRIPTION DRUGS ON THE PHARMACEUTICAL COST DEVELOPMENT IN SWEDEN**

Bergstrom G¹, Andersson K¹, Carlsten A¹, Karlberg I¹, Petzold M², Lönnroth K¹

¹Göteborg university, Göteborg, Sweden; ²Nordic School of Public Health, Göteborg, Sweden

OBJECTIVES: To cut the escalating costs for pharmaceuticals the responsibility for costs of outpatient prescription drugs was decentralized from the government in Sweden to the county councils in 2002. The study aims to investigate if the introduction of decentralized responsibility had an impact on the pharmaceutical cost development in Sweden. **METHODS:** Monthly sales data, on the pharmaceutical benefits scheme, PBS, to each county council was obtained for the period January 2000 to May 2005. Interrupted time series analysis was used to investigate the effects of the introduction of decentralized responsibility on pharmaceutical costs in both total sales and sales of prescription drugs within total and within the PBS. This was investigated both on country level and with comparisons between county councils with different budget models for the decentralized responsibility. The investigation is continuing. **RESULTS:** Analyses show that there was no significant change in the cost trend associated with the introduction of decentralized responsibility for costs of outpatient prescription drugs. The county councils' costs of prescribed drugs covered by the PBS were on three levels; €19.5/inhabitant in 2000 and €23.9/inhabitant in May 2005, the second €15.7/inhabitant in 2000 and €19.5/inhabitant in May 2005 and the third €3.6/inhabitant in 2000 and €6.0/inhabitant in May 2005. All county councils remained on the same level throughout the study period. The budget model for outpatient prescription drugs had no impact on the level of costs. When considering total drug expenditures including inpatient drug costs the three segments diminish and all county councils are gathered between €21.7–26.0/inhabitant in 2000 and €28.2–34.7/inhabitant in May 2005. **CONCLUSIONS:** Pharmaceutical costs increased despite the introduction of decentralized cost responsibility for drugs in outpatient care. The budget models had no clear impact on the cost trend.