analysis. Average and incremental cost-effectiveness ratios (ICE) were calculated. One-way sensitivity analyses were performed varying pharmacist salary, medication costs, and levels of reimbursement. RESULTS: Net cost-per-patient in Group 1 (n = 40) was $1,204; in Group 2 (n = 32) was $1,432. Mean LDL-C reduction was 12.67mg/dl (Group 1) and 42.03mg/dl (Group 2). Mean percent LDL-C reduction was 8.95% (Group 1) and 50.70% (Group 2). Average CE ratios were $95.01 (unit LDL-C) and $134.50 (percent LDL-C reduction) for Group 2. ICE ratios for Group 2 versus Group 1 was $7.77 (unit LDL-C reduction) and $11.82 (percent LDL-C reduction). The obtained CE ratios were robust to sensitivity analysis parameters. CONCLUSIONS: The CVCRRP showed positive lipid management results for enrolled patients. Group 2 (those including pharmacotherapy) interventions were associated with higher costs and better LDL-C outcomes. Group 2 interventions also resulted in more favorable average CE ratios compared to Group 1. Study results could be used to develop similar cardiovascular risk reduction programs, expanding the clinical role of the pharmacist and improving patient outcomes.

SOCIOECONOMIC RELEVANCE OF TREATMENT OF CHRONIC HEART FAILURE STAGE NYHA II WITH CRATAEGUS EXTRACT WS 1442—ONE-YEAR-RESULTS OF A PROSPECTIVE PHARMACOECONOMIC STUDY

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OBJECTIVES: To evaluate the pharmacoeconomic properties of crataegus treatment compared to any other treatment option of CHF at stage NYHA II, a prospective 3-year observational study has been conducted since summer 1999. A cost-utility-analysis will be performed to investigate, if crataegus treatment avoids rapid deterioration with higher costs and lower HRQL. The results of the first year are presented. METHODS: Open, non-randomized observational cohort study. The first cohort (Crataegus-Cohort, CC) comprises patients receiving crataegus extract therapy of CHF. In the second cohort (Standard-Cohort, SC) patients without crataegus but any other treatment were observed. In 217 study centres 952 patients were included (CC: 588; SC: 364). For measuring HRQL the EuroQoL-5D was used. The perspective of the German statutory health insurance funds and the matched-pairs technique were applied. RESULTS: No significant differences in physical condition and demographic variables were detected between the matched groups. HRQL (143 pairs) shows significant improvement in both cohorts. The mean EuroQoL-VAS value for the CC is 55.50 before and 67.13 after half-a-year (SC: 58.06 before and 66.78 after). Improvement of HRQL in the CC is significantly higher (p = 0.023). After one year, an improvement of clinical symptoms were diagnosed in both cohorts (79 pairs) but slightly higher in the CC with no significance. Mean direct costs for CC patients amounted to DM 1,373 in the first year whereas SC patients amounted to DM 1,551 with no significant difference (p = 0.998, 98 pairs). Cost driving factors were drug acquisition and physicians fees. CONCLUSIONS: Even if the first analysis of the three-year-study indicates comparable direct costs in both cohorts and suggests improved HRQL in the CC further investigation in the second and third period is mandatory.

PATIENTS’ WILLINGNESS TO PAY FOR PHARMACIST MANAGED WARFARIN THERAPY AT COMMUNITY PHARMACIES

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OBJECTIVES: This study determined the benefits of pharmacist managed warfarin therapy (PMWT) at community pharmacies by the contingent valuation (CV) method. Benefits of PMWT in clinic have been documented. These are reduction in hospitalizations, emergency room visits and thromboembolic events due to side effects of inappropriate dosing and monitoring. However, these benefits were never measured from patient’s perspective using CV method. This study elicited willingness-to-pay (WTP) values for PMWT from community pharmacy patients. METHOD: A self-administered 24 question CV survey was mailed to 2800 patients’ homes. These patients were selected from files in community pharmacies or a rural health plan. They were divided into warfarin clinic (ex post) and non-warfarin clinic (ex ante) groups. A payment card method with visual aid charts elicited WTP values in form of out-of-pocket (OOP) expense and additional insurance premium (INS) for PMWT with six probabilities for success (3 probabilities for reduction in hospitalizations & 3 probabilities for reduction in blood clot events). RESULTS: Five hundred and thirty patients (393 usable) responded. Overall mean WTP values for PMWT in the form of OOP or INS were significantly greater than zero. The monthly mean OOP WTP amounts for 28% blood clot event reduction and 26% hospitalization reduction were $17.19 ± 15.57 and $19.26 ± 17.56 respectively. The monthly mean INS WTP for the same probabilities were $11.97 ± 13.66 and $12.66 ± 14.63 respectively. Regression analysis identified that annual household income, selection of health plan with PMWT and attitude towards the health plan’s inclusion of PMWT were significant predictors for OOP scheme and only annual household income and selection of health plan with PMWT for INS scheme. CONCLUSION: Patients were able to assign WTP values to different sizes of health gains. Range bias and inconsistency of choice were detected from this sampled population.