PHIP45
PHYSICAL PRESCRIPTION MEDICATION USE NOT CAPTURED BY PRESCRIPTION CLAIMS DATABASES
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OBJECTIVES: Despite advances in claims databases commonly used for identifying patients for disease management programs, studying health outcomes and reporting on quality measures. A shortcoming of claims databases for these purposes is that they include only prescriptions that are adjudicated through insurance plans. Growth in the use of cash discount generic programs and the frequent use of drug samples suggests that an increasing number of prescriptions dispensed to insured consumers may not be captured on claims databases. We examined the extent to which prescription claims databases do not provide complete prescription history. The insurance claims database included patients’ prescription drug use. METHODS: We used the 2009 Medical Expenditure Panel Survey (MEPS) dataset. We included participants who purchased at least one prescription drug in 2008 and who had prescription drug coverage in the use of the MEPS. We quantified the extent to which insured patients used drug samples, drugs paid for by cash only, and/or discount generics. We measured the numbers of prescriptions in each of these categories and the numbers of consumers who had at least one prescription in each category. We reported descriptive statistics.

RESULTS: A total of 75.1% of the U.S. non-institutionalized civilian population was insured for prescription drugs. Of the total number of prescriptions dispensed to insured consumers, at least 0.8% were drug samples and 23.3% were paid for by cash, of which 11.3% were potentially discount generics. Additionally, 11.6% of insured consumers received at least one sample medication, 68.0% paid for at least one of their prescribed medications by cash, of which 42.5% used at least one potential discount generic prescription. Our results indicate that drug samples and cash/insurance do not contribute substantially to the problem of missing prescription data on claims databases. On the other hand, substantial number of prescriptions, paid for by cash and discount generics, may be missing from these databases.

PHIP46
IMPACT OF DRUG REIMBURSEMENT MODALITIES ON TREATMENT ADHERENCE IN PATIENTS COVERED BY PRIVATE DRUG INSURANCE
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OBJECTIVES: To compare adherence to prescribed medications between patients with and those with immediate reimbursement at the point of service among Quebecers (Canada) with private drug insurance. METHODS: A retrospective cohort was constructed by selecting patients aged 18-64 recorded with private drug insurance from the reMed database between March 2008 and December 2012. An algorithm was developed to assess the patient’s reimbursement modality, i.e. the drug cost covered by the insurance company is reimbursed immediately at the point of service (Cash reimbursement) or at the point of purchase (at the pharmacy). Adherence was measured with the proportion of days covered (PDC) over one month for statins. Corresponding figures were 48.3% and 45.1% for new users of proton pump inhibitors, thyroid hormones, antidepressants, and antihypertensive medications. Linear regression models were used to estimate the adjusted mean difference of the PDC between the two groups for each drug class. RESULTS: The cohort included 6,494 patients with immediate and 1,950 patients with delayed drug reimbursement. More than 40% of patients were 35-49 years, 26% were men, 38.1% had a annual income less than INR 63) in 2014) A1-A295

PHIP47
RAJASTHAN’S UNIVERSAL HEALTH CARE PLAN WITH FREE DISTRIBUTION OF QUALITY MEDICINES THROUGH COST MINIMIZATION
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OBJECTIVES: To compare adherence to prescribed medications between patients with and a Poisson model for modelling the number of hospitalizations. RESULTS: 4.88% of the population used ambulatory services during the last two weeks and 3.89% required hospitalization at least once during the last year. Significant statistical differences were observed between gender, income and age with the ambulatory and hospital care use. The results from the Probit model showed that men were less likely to use ambulatory services compared to women, as well as individuals at younger ages (0-9 years) (Z = 7.95). Additionally, at higher income deciles, a positive significant impact was found for this service. It is believed that education, employment and medical insurance are statistically significant variables with positive impact on the times people are hospitalized. Finally, other variables with a negative impact on the outcome were included in the model.

PHIP48
PUBLIC EXPENDITURE ON health on India is around 1% of GDP and 79% expenditure in health of people is through out-of-pocket. Almost 30 % of the households slide into poverty due to high treatment costs and medicines. Though, India is considered as pharmacy for developing countries, yet due to poor regulatory control there is huge price variation in off-patent branded generics, even 50 times or more and leaving affordability at the mercy of prescribers/dispensers. It is said that “The Government (a federal state with population about 70 million) has launched a scheme called Chief Minister’s Free Drug Distribution Service (CMFDDS) for providing free essential medicines to all irrespective of their income status, with high establishing an autonomous Rajasthan Medical Services Corporation (RMSC). By well-defined transparent prequalification measures for products and suppliers, RMSC procures quality medicines through cost minimization. Educational, managerial and regulatory strategies have been used to promote compliance by stakeholders RESULTS: Quality essential medicines are procured at unbelievable low cost compared to market retail prices, e.g. procurement cost / market retail prices for strip of 10 tablets of DICLOFENAC 50 mg. ATORVASTATIN 10 mg. GLIMEPIRIDE 2 mg. and CLOPIDOGREL 75 mg are INR 1.24/31.73, 2.98/103.74, 1.95/125.00 and 8.54/147.44 respectively (1 USD =INR 63) resulting an increase in access and equity with monthly patient inflow increased from 44,000 to 66,000,000 and decreasing retention of our pocket expenditure, as amount spent on medicines in 2 years is around INR 5,070,00,000 whereas market price of these medicines would be. INR 30,000,00,000. CONCLUSIONS: Essential medicines are not costly but are being made expensive. By utilizing the pricing information of quality medicines along with transparent pooled procurement and proper distribution system can make free access to medicines, especially under-served population with a strong political commitment coupled with the proper strategies in low resource settings.