models as obstacles to equity of access to HCDs. They were concerned that there were inequities in decisions for individual patients depending on public or private sector hospital status. Tertiary public hospitals were perceived to be at the 'cutting edge' and therefore were required to fund new, expensive drugs. A major concern for respondents was that, as a consequence, this meant prioritizing between patient groups and individual cases. "Why is one patient group more important than another patient group and how do we decide which drugs should be available to each patient?" The majority of respondents identified equity problems in access to HCDs, however they had difficulty in identifying solutions. Respondents described that, besides safety, effectiveness, efficacy and cost, ethical principles should be borne in mind when deciding whether a HCD should be available in a public hospital. Most wanted a transparent, accountable, evidence-based decision-making process. **CONCLUSION:** The preliminary results of this study suggest that decision-makers were concerned about the equity of access to HCDs in public hospitals. They were concerned regarding the process for decision-making and the outcomes of these decisions. Further research will explore the views of the public regarding funded access to HCDs.

COMPARISON OF REIMBURSEMENT SYSTEMS OF VARIOUS COUNTRIES IN CENTRAL AND EASTERN EUROPE, AFRICA, AND MIDDLE EAST

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AIM: To perform a comparative examination of the drug reimbursement systems in 16 secondary markets in Central and Eastern Europe, Africa, and Middle East. **METHODS:** The results of this study are derived from published literature and through interviews with key opinion leaders and reimbursement officials in each of the 16 countries. The reimbursement system in each country is assessed by using a set of predefined criteria. Specifically, the criteria aim to investigate whether there is public reimbursement of pharmaceuticals in the country, to identify whether a formalised review process for reimbursement application exists, whether or not a pharmacoeconomic evaluation is required in the reimbursement application, and to determine if a reference pricing system is implemented in price determination for new pharmaceuticals. These criteria will allow an understanding of the types of reimbursement systems in these countries and identifies trends in drug reimbursement policy. **RESULTS:** A majority of the countries considered in this study had some form of public reimbursement system for pharmaceuticals. Notable exceptions include middle-eastern countries where reimbursement is restricted to inpatients, while private health insurance is more prevalent in countries like South Africa and Russia. Very few countries, however, have an established formal reviewing system for reimbursement applications. Reference pricing was common in these markets. Several countries are in the process of introducing formal pharmacoeconomic requirements. **CONCLUSION:** The main concern of reimbursement authorities in these countries is containment of increasing drug costs. Several countries are increasingly formalizing this process.

IMPACT OF MEMBER COST-SHARING LEVELS ON POPULATION-BASED STATIN USE RATES

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OBJECTIVE: Numerous studies have found that substantial increases in drug co-payments result in reductions in utilization and spending. A recent study found that significantly more members faced with substantially increased costs stopped statin therapy than a control group. High co-payments can influence the decision to start needed drug therapy as well as to discontinue it. This study analyzes population-based statin use rates as one way to look at the impact of high cost sharing on the decision to start therapy as well as to continue statin therapy. **METHODS:** The study included 15,937 statin users in 16 employer groups with average member cost share greater than 30% (HIGH) and 86,605 statin users in 48 employer groups with member share less than 15%. Employer groups with DAW penalties were excluded. LOW and HIGH share groups both had retail and mail coverage. Drug utilization and group eligibility data for 2003 came from Caremark Rx claims data system. HIGH and LOW groups were compared on age and gender. Age-specific population use rates were computed for 12 five-year age bands between 30 and 89. **RESULTS:** Age-specific population-based use rates for the HIGH share group averaged only 79% of the level of the LOW share group. For example, the statin use rate for 60–64 years of age was 279.1 per 1000 for the HIGH share group and 359.8 per 1000 for the LOW share group. **CONCLUSIONS:** High levels of member cost sharing impact population-based statin use rates. Additional educational efforts may be necessary to encourage use of preventive health care as members assume greater responsibility for the costs of medication.

HEALTH CARE COST EVALUATION

A FRAMEWORK FOR COSTING RECOMMENDATIONS IN PHARMACOECONOMIC GUIDELINES

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OBJECTIVE: Since 1992, pharmacoeconomic guidelines, which contain specific costing recommendations, have been available yet reviews of recent economic evaluations indicate that investigators are still using a wide range of methods. This discourages uniformity of results. Two possible reasons for this are 1) insufficient detail in the recommended guidelines and 2) a lack of standardization. We conducted a comparative review of national costing guidelines to determine the degree of detail provided in the guidelines and the degree of correspondence. The main purpose was to develop a more comprehensive framework. **METHODS:** Guidelines were identified and reviewed. A framework with categories were developed, and all guidelines were reviewed in light of these categories. **RESULTS:** Our framework contained the following headings: General items, Resource identification and classification, Resource measurement, Resource Valuation, and reporting cost per patient. Our review of guidelines indicated that major differences arose because of different study purposes (studies conducted for formal formulary submissions versus general purpose studies). Other differences between the stated guidelines resulted from analytical differences in costing analysis, in areas such as lifetime unrelated costs and lost productivity costs. We also found an absence of detail in the costing recommendations. **CONCLUSIONS:** Both with regard to resource measurement and resource valuation categories, very little conceptual guidance relating to the basic cost measure was provided, and no systematic recommendations emerged with regard to inter-temporal and geographical adjustments to the basic cost measure. A more detailed set of recommendations is proposed.