THE CHALLENGE OF A LEGITIMATE BUDGET IMPACT RATIONING CRITERION IN DRUG REIMBURSEMENT DECISIONS

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OBJECTIVES: Health-policy observers increasingly view budget impact as an important factor in drug reimbursement decisions. In a number of instances budget impact seems to have been a more decisive factor than cost-effectiveness in determining a drug’s formulary placement. Nevertheless, budget impact usually is an implicit factor in the decision-making process, while cost-effectiveness is an explicitly defined criterion. The objective of our research is to summarize possible arguments supporting the use of budget impact as a criterion in drug reimbursement decisions, and to inform the debate on whether budget impact can be legitimately (and explicitly) used in reimbursement decision-making. METHODS: Based on a literature review spanning 1990 to 2006, we traced a variety of definitions of budget impact as well as rationales supporting its use. Furthermore, we conducted supplementing interviews with 15 key stakeholders involved in drug reimbursement decisions in The Netherlands.

RESULTS: We found that policymakers employ several definitions of budget impact that differ mainly in terms of their scope. However, policymakers did not reveal rationales that would support the use of budget impact in drug reimbursement decisions. Nonetheless, in health economics and policy literature, we identified five types of supporting rationales: “losing out” (opportunity cost), uncertainty regarding return on investment, equal access, equal opportunity and “loss outweighing gain.”

CONCLUSION: Budget impact is a legitimate rationing criterion, though its precise use, explicit or implicit, in policy practice remains unclear. We recommend that policymakers not confute budget impact and cost-effectiveness arguments. Further, we recommend that health economists and policymakers be aware that incremental cost-effectiveness ratios (ICERs) are of limited value in resolving the problem of maximizing subject to health gain, as ICERs fail to account for opportunity cost and ignore the important question of how many resources need to be set aside to fund adoption of newly approved cost-effective biopharmaceuticals.

COMPLEMENT OR SUBSTITUTE? COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) USE AND PRESCRIPTION DRUG USE AMONG AFRICAN AMERICANS

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OBJECTIVES: To examine the bivariate relationships between CAM use for treatment of a specific illness and prescription drug use among African American adults and to describe the extent of complementary and substitutive CAM use. METHODS: Using the 2002 National Health Interview Survey, the data included 4,256 AA adults representing 23,828,268 African American adults nationwide. Respondents were asked if they used certain CAM modalities in the past 12 months to treat a specific condition. Our study focused on those who used CAM for treatment and whether or not they also used prescription medication in the last 12 months. RESULTS: A total of 99.4 percent of African Americans who used CAM in the past 12 months used at least one CAM modality to treat a specific illness. Of these, 77.7% also used prescription medication during the past 12 months (complementary CAM users) while 22.3 percent did not (possible substitutive CAM users). For 13 of the 14 CAM modalities examined, a majority of CAM for treatment users (60.4 to 100.0%) also used prescription medication. The exception was folk medicine where 65% did not use prescription medication. A total of 13.6% of users of mind-body therapies (e.g., relaxation) were potentially substitutive users compared to 23.0 percent of manipulative therapy (e.g., massage) users, 25.2% of alternative medical system (e.g., acupuncture) users, and 25.7% of biologically-based therapy (e.g., folk medicine, herbs) users. Complementary CAM users had more medical conditions (p < 0.0001) and were more likely female (p < 0.0001) and publicly insured (p < 0.0001) compared to possible substitutive CAM users, who were more likely younger (p < 0.0001) and better educated (p < 0.01). CONCLUSION: While the majority of African Americans who use CAM for treatment for a specific condition also use prescription medication (complementary users), more than 20% may substitute CAM for conventional treatment.

INFLUENCE OF POLYPHARMACY BY APPLYING THE ADJUSTED CLINICAL GROUPS CLASSIFICATION IN A SPANISH POPULATION SETTING: A CROSS-SECTIONAL STUDY

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OBJECTIVES: To determine the prevalence of polypharmacy and the explanation power of Adjusted Clinical Groups (ACG) classification as a measure of morbidity burden in a Spanish population setting. METHODS: Cross-sectional study based on the clinical records from all the attended patients in five primary care centres along the year 2006. Main variables: age, sex, case-mix/episodes, pharmacy costs, therapeutic group, polypharmacy (regular utilization of more than 5 drugs at least 240 days/year), explained variance (predictive analysis and multiple linear regression). The ACG (Johns-Hopkins Case-mix System) classify individuals with similar needs for health care resources based on overall expenditures. For analysis purposes, the ACG are collapsed to one of eight mutually exclusive morbidity classes, known as resource utilization bands (RUB) (collapsed: Low-Comorbidity, Medium-Comorbidity and High-Comorbidity). Logistic regression and ANCOVA (Bonferroni adjustment) analysis were made to adjust the models. The statistical package SPSS was used (p < 0.05). RESULTS: Included patients: 80,775. Average number of episodes: 4.8±5.5; mean age: 40.7±22.9 years, males: 46.9%, intensity of use: 72.4%, pharmacy costs: €22.7 millions (55.6% of total costs) and mean cost: €281.05±627.85. Polypharmacy prevalence was 12.2% (CI: 12.0–12.4%), increasing with age (50%; in >85 years), female sex and morbidity burden (Low-Comorbidity [16.5%]: 1.1%, Medium-Comorbidity [78.3%]: 11.8% and High-Comorbidity [5.2%]: 40.3%), p < 0.0001. A strong association was observed with alcoholism, asthma, depression, and digestive and cardiovascular therapeutic groups (OR > 4.3, p < 0.0001). Predictive and regression analysis: ROC curve (pharmacy costs): 0.968; sensibility: 96.1%, specificity: 61.7%, R2 (Nagelkerke): 62.2%; explained variance: R2 = 26.8%; age, sex, comorbidity model: R2 = 42.2 (p < 0.001). Individual cost for patients with High-Comorbidity was €1436.53 and after adjustment was €1047.59 (CI: 1002.87–1092.31). CONCLUSION: The observed polypharmacy profile was similar to others described in the literature. ACG classification provides a fair good explanation of the pharmacy costs variability after adjustment by age, sex and comorbidity (42.2%), including a significative share of polypharmacy.