cognitive literature review, with expert panel judgment, informed the selection of criteria (and their relative weighting) for the pharmacotherapeutic evaluation. The resultant scoring system was circulated (in questionnaire format) to prescribers and stakeholders for comment. Based on statistical analysis of the latter survey results, the final scoring system was developed. Drug entities which exceeded the evidence threshold score were entered into a tendering process with pharmaceutical suppliers. Product lines submitted as a result of the tendering process were sequentially entered into the second and third phases of the STEPS process (safety/risk assessment; budget impact analysis).

RESULTS: Three drug entities (from the 5 currently available in the UK) exceeded the evidence threshold and 29 from 39 submitted product lines, containing these drug entities, satisfied the safety evaluation/risk assessment criteria. Two product lines, each containing a different drug entity, were selected for formulary inclusion as a result of the budget impact analysis. The estimated annual cost savings for statins as a result of this selection process (based on estimated annual usage in Defined Daily Doses) in this health board, was 40%. CONCLUSION: The STEPS model has a significant contribution to make in containing statin costs while retaining the most therapeutically appropriate agents.

**PHP19**

**COST SAVINGS ASSOCIATED WITH TABLET SPLITTING PROGRAM IN A PHARMACY BENEFIT MANAGEMENT SETTING**

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OBJECTIVES: The purpose of the study was to perform the impact of a tablet splitting program in a large pharmacy benefit management organization on the costs and utilization of prescription drugs. METHODS: Using a retrospective cohort study design, prescription records from January 1, 2005 to June 30, 2005 were obtained from a pharmacy claims database. Three study cohorts—voluntary, mandatory, and control cohort were created based on the enrollment status in the tablet splitting program. The number of prescriptions dispensed, the total costs and savings per prescription were analyzed and compared for the study drugs Lexapro, Lipitor, and Zoloft. RESULTS: A total of 606,068 prescriptions, 594,825 in the control, 5226 in the mandatory and 6017 in the voluntary cohort were included. Total cost savings were obtained by subtracting the difference in cost/days supply between drugs in the control group and each active treatment group. Total cost savings are at $179,575.85 and $74,119.53 for the mandatory and the voluntary cohort respectively after adjusting for the operation costs and subtracting the costs from the treatment cohorts. An average per prescription cost saving of $34.36 for the mandatory and $12.31 for the voluntary program was realized for the three drugs studied. CONCLUSIONS: A tablet splitting program has been shown to produce significant savings, $34.36 and $12.31 per prescription for the health plan enrolled in the mandatory and voluntary programs respectively.

**PHP20**

**ISPOR CONTRIBUTED RESEARCH 1998–2005: EVALUATION OF TRENDS & QUALITY INDICATORS**

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OBJECTIVES: The purpose of this study was to perform a longitudinal content analysis to assess trends in contributed research papers presented at ISPOR Annual Meetings and European Congresses from 1998 through 2005 as available in the ISPOR Research Digest at www.ispor.org, as well as to assess research quality indicators. METHODS: The database of 5852 contributed presentations at the ISPOR meetings from 1998 through 2005 were analyzed for trends and quality indicators. Trends were evaluated for outcomes assessed (clinical, economic, patient-reported outcomes), and types of health policy and diseases studied. Quality indicators were defined as abstracts including “study perspective, “discounting”, or “ statistical considerations (“confidence interval”, “standard deviation”, “mean/median”, “sensitivity analysis”). RESULTS: ISPOR held 16 international meetings during 1998–2005. The annual number of contributed research presentations increased from 270 to 1248 for an eight-year total of 5852 with all topics and disease categories increasing over time. The major topic areas covered were cost (42%), patient-reported outcomes including methods (23%), health policy (23%), methods and concepts (10%), and clinical outcomes evaluations (6.4%). The top four diseases (4992 disease-specified papers) were neurologi cal/mental health (18.5%), cardiovascular (17%), cancer (9%), and infectious diseases (10%). With respect to quality indicators, of the abstracts analyzed, a study perspective was mentioned in 18% (37% cost studies, & all others ~4% each); discounting in 8% (16% cost studies & all others <2% each). For statistical considerations, the percent mentioning mean, median, standard-deviation, confidence intervals, or sensitivity analysis (12%), was 41%. Overall, the percent of abstracts with these quality indicators generally increased over the study period. CONCLUSION: The number of papers has increased over the study period for multiple topics and diseases. Although the general quality of papers, as considered in this analysis, was increasing, the percent of papers that include these quality indicators needs further evaluation & improvement.

**PHP21**

**CALCULATION OF LORENZ CONCENTRATION CURVES AND GINI COEFFICIENT OF HEALTH EXPENDITURES IN HUNGARY**

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OBJECTIVE: The aim of the study to calculate the Lorenz concentration curves and Gini coefficient of health expenditures in Hungary. METHODS: Data derived from the financial database of the Hungarian National Health Insurance Fund Administration, covering the period 2000–2004. The Hungarian health care financing system based on a regular patient level data reporting system which allows us to calculate the cumulative frequency distributions of health expenditures. In each type of care we put the patients into 100 percentile group ranked by the health expenditure. The visualization curves are presented for each type of care mentioned earlier and for the five years between 2000–2004. There was not any significant time trend within the same type of care. We found the following Gini coefficients (2004): out-patient care: 0.6352, in-patient care: 0.5278, chronic care: 0.5624, CT/MRI examinations: 0.4459, home care: 0.4319, renal dialysis: 0.4251, drug reimbursement: 0.7444, medical devices reimbursement: 0.7480. We found significant
changes between 2000–2004 in inpatient care, home care, CT/MRI examinations. CONCLUSIONS: The budgets of drug and medical devices reimbursement are highly concentrated while the distribution of renal dialysis expenditures was the most linear. Gini coefficient of inpatient care, home care and CT/MRI examinations showed significant time trend.

PHP22
PRESCRIPTION DRUG PRICE COMPARISONS BETWEEN CANADIAN AND US ON-LINE PHARMACIES OVER A SIX-MONTH PERIOD
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OBJECTIVES: Prescription drug prices between Canadian and US on-line pharmacies were studied over a 6-month period. METHODS: Prices for 28 popular brand name medications were collected from eight Canadian and five US on-line pharmacies weekly for six months. Prices were compared between Canadian and US on-line pharmacies, and price changes were monitored each week. RESULTS: During the study period, purchasing from Canadian on-line pharmacies would save consumers >$1.00 per unit for 12 drugs (42.9%). Savings were demonstrated in two drugs if purchased from US on-line pharmacies: sildenafil 25 mg ($2.06/unit) and amiodipine 10 mg ($0.02/unit). Average price increases from the first to the last week of the 6-month period were greater from Canadian on-line pharmacies ($0.10/unit) compared to the US ($0.07/unit). From Canadian on-line pharmacies, prices from all the medications increased during the study period except one, which stayed the same. The two drugs with the greatest price increases were alendronate 70 mg ($1.04/unit) and sildenafil 25 mg ($0.45/unit). From US on-line pharmacies, nine drug prices decreased during the study period, four remained the same, and 15 increased. The greatest price increases were for alendronate 70 mg ($0.62/unit) and olanzapine 10 mg ($0.41/unit). Consumer savings from purchasing Canadian on-line drugs decreased from the first to the last week of the 6-month period for 17 medications (60.7%), with the greatest decrease in savings being for 100 units of gabapentin 300 mg (19.4% decrease) and sertraline 100 mg (35.1% decrease). CONCLUSIONS: When 100% of prescription drug payments are out-of-pocket, consumers usually save money when buying from Canadian on-line pharmacies. Although prices were lower using these pharmacies, price increases over the study period were greater. In order to get the best price for medications purchased on-line, one would need to compare prices from multiple pharmacies in Canada and the US for each prescription drug over a period of time.

PHP24
ELECTRONIC INTERFACES FOR SHARING PATIENT DATA: ESTIMATING RETURN ON INVESTMENT IN HOSPICE
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OBJECTIVES: To estimate the return on investment (ROI) associated with database integration technology enabling automated bidirectional sharing of patient data between a hospice and hospice pharmacy provider. METHODS: ROI was calculated as total direct savings (TDS) and payback period in years (PPY). Formula inputs were costs of implementing a bidirectional interface between the pharmacy and hospice, and costs of telephone/fax transmission of demographic and medication data. The net present value (NPV) adjusted for inflation was used to forecast future cash inflows across three years. RESULTS: Estimated annual savings for unidirectional interface were $7500 and bidirectional savings were $22,500 for a hospice admitting 300 patients/month, assuming $50,000 nurse salary. Hospice nurses were assumed to use wireless phones for transmission of patient admission data. Replacement of voice with interface resulted in estimated savings of $1800 annually. Telephone savings for medication profile data transmission yielded $1620 annually. After summing the immediate gains of recovered time inefficiencies and reduced telephone usage, implementation of a pharmacy/hospice interface resulted in TDS of $33,420 annually. The discounted or investment yield rate utilized was 10%. Therefore, while projected total net savings generated by a pharmacy/hospice interface across 3 years equaled $100,260, the total NPV, reflecting the time value of money, was $84,596. The annual ROI represented by the NPV of the pharmacy/hospice interface was 1127.94%. The PPY (break-even analysis) in which the financial benefits exceed the initial investment would be reached in 0.27 years. CONCLUSIONS: “Low-tech” bias and lack of capital for investment in technology have contributed to a lag in adoption of technological innovations in hospice. Projected ROI for automated data sharing via interface suggested considerable decrease in administrative costs. Hospice administrators could apply the formulas used in this study with their unique data to forecast ROI in their settings.