BURDEN OF ILLNESS IN ALZHEIMER’S DISEASE IN THE UNITED KINGDOM
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A study by Kurz et al. (2003) proposed categorisation of burden of illness in Alzheimer’s Disease (AD) dividing activities of daily living into basic and instrumental categories. OBJECTIVE: To validate the approach used by Kurz et al. METHODS: We analysed patient data from the LASER (London and South East Region) UK Alzheimer Project of 224 AD patients using the above methodology. We transformed activity of daily living item scores from the ADCS-ADL scale into qualitative evaluations of level of dependency. Six items corresponding to basic activities were identified (eating, walking, bowel/ bladder function, bathing, grooming, dressing). The remaining 17 items were explored using principal component analysis. Backward selection on ANOVA models was used to determine the most relevant cost drivers. RESULTS: Two factors corresponding to domestic and communication activities had eigenvalues >1. Patients were then classified into three disability clusters by applying nearest centroid-sorting method to different standardized (mean = 0; SD = 1) ADL sub-scores. The first cluster had low scores on basic, domestic and communication ADL and was designated as “dependent”. The second had high scores on basic and relatively high scores on both domestic and communication ADL and was designated as “non-dependent”. The third had high scores on basic ADL but only moderate impairment in domestic and communication ADL (designated “Non-Dependent with Instrumental Functional Disability; ND-IFD”). Clinical scale scores differed significantly between disability levels. Estimated costs over 6 months also differed significantly (3013€ for non-dependent patients, 8788€ for ND-IFD and 21,649€ for dependent patients). Disability was a significant predictor of costs in the more advanced stages of the disease whereas severity of cognitive impairment was a stronger predictor in the earlier stages. CONCLUSION: This study validates the three AD categories and confirms the relevance of disability as a cost driver.

HEALTH POLICY EVALUATION

EVALUATION OF GENERIC DISPENSING INCENTIVE PROGRAM (GDIP)
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OBJECTIVES: An insurer has implemented the Generic Dispensing Incentive Program (GDIP) through a pharmacy benefit manager (PBM) in a local market beginning the second half of 2001 to encourage network pharmacy providers to dispense prescriptions with generic drugs. The GDIP increases reimbursement amount by $2.00 for any prescription dispensed with a generic drug when network pharmacies have recorded generic dispensing rate of 41% to 46%, and increases it by $4.00 when generic dispensing rate is 46% or higher. This study evaluates the impact the GDIP has on generic dispensing rate. METHODS: The PBM provided pharmacy data consisting of numbers of prescriptions filled with brand-name and generic drugs, and their respective drug ingredient costs for each network pharmacy for seven 6-month periods (1st half of 2000–1st half of 2003). The program saving was computed as the additional reimburse amount. The program saving was as “the increase in the number of generic dispensing” multiplied by ingredient cost difference between brands and generic drugs. An important assumption was that the increased generic dispensing was only attributed to the GDIP. RESULTS: The GDIP cost $2.4 million but saved around $5.4 million for the network pharmacies (668–676 pharmacies). The generic dispensing rate hovered around 38% before the GDIP but continually increased to 44.26% in the latest period. The number of pharmacies that had moved upward in generic dispensing rate increased while the number of pharmacies with downward transitions decreased. There were six times more upward transitions than downward ones in the latest period. CONCLUSIONS: The GDIP increased the generic dispensing rate by 6%. That increase in generic dispensing rate was translated into the net savings of $3 million into the first half of 2003.

EFFECT OF COPAY INCREASE ON FOUR MEASURES OF COMPLIANCE: A NATURAL EXPERIMENT
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OBJECTIVES: Compliance is a behavior that responds to incentives. Economic theory would suggest that as the price of a product increases, the quantity demanded decreases. Therefore compliance would be altered but the magnitude of the behavioral effect is not known. This descriptive study examines the effect of a prescription copayment change on four measures of compliance behavior, medication possession ratio (MPR), consistence, number of gaps, and maximum gap within one therapeutic category STATINs. METHODS: The data for this study is from a for profit network model managed care organization. On January 1, 1999, the co-payment for prescription drugs