Patients. Patients receiving midazolam had higher mortality rates (31.7%) compared to patients on lorazepam (29.2%). However, these results were not confirmed when controlling for disease severity and other factors. Multivariate regression analysis revealed that type of sedative/analgesic drug treatment and whether the hospital had a care plan were not associated with shorter ICU and total hospital stays when controlling for patient demographics and disease severity. In fact, patients admitted to hospitals with care plans had longer total hospital stays. More severe patients had shorter total hospital stays, probably due to higher mortality. Higher mortality was associated with older patients and higher disease severity.

CONCLUSION: There is much discussion about treatment guidelines and use of care plans to improve quality of care and reduce hospitalization costs. In this study, the type of sedation and analgesia treatment in mechanically ventilated ICU patients and whether the patient had a care plan did not influence days in ICU or mortality. Whether following treatment guidelines and care plans reduces total costs, needs further evaluation.

A MODEL FOR COMPARING COSTS ASSOCIATED WITH PRESCRIPTION WASTAGE WITH APPLICATION TO VA PRESCRIPTION DATA
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OBJECTIVE: The objective of this study was to determine the frequency and cost of prescription switches for 90-day vs. 30-day outpatient prescriptions dispensed by a VA pharmacy and to develop a model to determine the prescription fill policy with the lowest total costs. METHODS: VA outpatient prescription records for one year for simvastatin and lovastatin (30 or 90-days) were analyzed to determine the frequency, quantity and cost of medication wasted due to medication switches. The quantity wasted was defined as the difference between the quantity dispensed and the quantity of drug used before changing to a new drug or dosage. Differences in dispensing costs for a given time-period were also included. Sensitivity analyses were conducted for quantity wasted, drug costs, and dispensing costs. RESULTS: A total of 16,990 prescriptions were analyzed. The quantity and costs of medication wasted were higher for 90-day prescriptions than for 30-day prescriptions. However, average costs to the VA pharmacy were $2.45 higher per prescription for the 30-day supply because of additional dispensing costs for the 30-day fill. The model and sensitivity analyses show that a 90-day supply policy results in lower total pharmacy costs under several scenarios. Only in the case of high drug costs was the 30-day policy favorable to the 90-day policy in terms of total costs. CONCLUSION: Prescriptions given in a 90-day supply resulted in lower total costs. The projected cost savings of having a 90-day versus a 30-day policy would hold true for prescriptions with similar drug costs and similar rates of wastage that result from changes that physicians make to patients’ prescriptions. In addition, the model provides a flexible framework for pharmacy administrators to assess refill policies in terms of excess or unnecessary cost for different classes of drugs, given patient and/or physician behavior.

PHP 19 USING FINANCIAL RATIOS TO COMPARE PHARMACY SPENDING IN THE DEPARTMENT OF VETERANS AFFAIRS
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OBJECTIVE: To understand how pharmacy spending varies across the VA Medical Centers in the United States. Pharmacy costs continue to rise. From 1990 to 1994 pharmacy expenditures were reported to be 6% of the total Veteran’s Health Association (VHA) budget. In 1995 and 1996 it was 7%. In 1997 it was 8% and in 1998 it was 9%. Then in 1999 it went to 11%. Future projections are for a continued increase in budget spending. METHODS: Ratios of yearly Pharmacy to Medical Center expenditures were compared. These ratios were ranked and compared with geographical location. The years of 1997 and 1998 were studied. RESULTS: The majority of the highest ratios were located in the Midwest, South, and Southern regions of the United States. CONCLUSIONS: Financial ratios can demonstrate variations in expenditures and identify areas that may require further inquiry.

THE LAG BETWEEN EFFECTIVENESS AND COST-EFFECTIVENESS EVIDENCE OF NEW DRUGS AND DECISION-MAKING IN HEALTH CARE
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BACKGROUND: A new drug is approved for use if its effectiveness has been demonstrated. Recently decision-makers in a number of countries have begun to account for both the effectiveness and cost-effectiveness of new drugs. However, cost-effectiveness evidence lags behind the effectiveness data. OBJECTIVE: To explore the timeliness of delivering cost-effectiveness information about new drugs with established effectiveness and significant financial impact. METHODS: New drugs were identified, based on guidance documents and reports published by the National Institute for Clinical Excellence of England and Wales, and the following data were collected: dates of publication of first effectiveness and cost-effectiveness evidence, methodology of the cost-effectiveness analysis, funding of the research, etc. RESULTS: Guidance documents for the following new drugs/drug groups have been published by NICE by the end of 2000: tax-