Whether to legalise direct-to-consumer advertising (DTCA), the authorised advertising of prescription drugs direct to the consumer, within the European Union (EU) is often discussed. But how would allowing DTCA help EU governments looking for solutions to rising costs, rising patient expectations, loss of public confidence and ageing populations? This poster summarises the main arguments for and against the EU legalising DTCA. OBJECTIVES: To explore the arguments for and against allowing the use of DTCA in EU states; to determine the validity of the propounded arguments, by evaluating actual data which highlights the effects of introducing DTCA in the US and New Zealand. METHODS: Using PubMed and a within-literature search, a literature review of published information on the arguments for and against DTCA, and DTCA's associated costs was undertaken. RESULTS: Advocates believe DTCA will enable the pharmaceutical industry to significantly improve the effectiveness of its marketing campaigns. DTCA's opponents argue that health care providers' ability to ration health care based on clinical need will be destroyed. US data indicates that DTCA rose 38.5% in 1999 to $US1.8bn, whilst in New Zealand expenditure rose 47.1% in 2000 to $US21.5m. DTCA has caused US retail spending on prescriptions to soar. Yet in New Zealand DTCA is credited with improving awareness, choice and treatment of previously neglected conditions. CONCLUSIONS: DTCA's ability to allow the pharmaceutical industry to connect with its ultimate consumers (patients) would lead to increased strains on European health systems. But, the increased awareness that DTCA will bring to currently neglected conditions (such as osteoarthritis in men) could lead to huge benefits to patients quality-of-lives and help refocus changing health systems towards patients needs. As such, DTCA could be part of the solution to Europe's health care crisis, but its introduction will bring to EU states as many headaches as it solves.

PHP11

USE OF THE ANDERSEN HEALTH CARE SERVICES UTILIZATION BEHAVIORAL MODEL TO UNDERSTAND THE RELATIONSHIP BETWEEN HEALTH INSURANCE COVERAGE AND HEALTH CARE SERVICES UTILIZATION AMONG THE ELDERLY
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OBJECTIVES: The purpose of this study was to determine the relationship between health insurance coverage (Medicare, Medicaid, other public, employer-sponsored, and other private) and health care services utilization (i.e., physician visits, hospitalizations, and the ability to get needed prescription medications) among the elderly.

METHODS: The 1996 National Health Interview Survey and its supplements were utilized as the data sources. Elderly persons (>65 years) who had Medicare coverage (N = 27,727,536) were included in the study. The Andersen Health Care Services Utilization Behavioral Model provided the study framework and was used to understand the effect of health insurance coverage on health care services utilization while controlling for other variables. The framework models the relationship between predisposing (age, gender, living status, race, and education), enabling (income, health insurance coverage, usual source of care, geographic location, and out-of-pocket spending), and need for care (health status, activity limitation, restricted bed days, and comorbidities) factors and health care services utilization. RESULTS: Elderly persons with additional public health insurance coverage (Medicare plus Medicaid or Medicare plus other public health insurance) had significantly more physician visits than those with Medicare only (p = 0.0159 and 0.0258, respectively). Elderly persons who had Medicare plus other public health insurance and Medicare plus other private health insurance were significantly more likely to be hospitalized than those who had Medicare only (p = 0.0341 and 0.0327, respectively). Elderly persons with Medicare plus employer-sponsored insurance were more likely to get needed prescription medication(s) (p = 0.0076) than those with Medicare only. CONCLUSIONS: Elderly persons who had additional health insurance coverage (i.e., in addition to Medicare) were more likely to have more physician visits, hospitalizations, and they were more likely to obtain needed prescription medications. Additional health insurance coverage may be beneficial in increasing access to health care services among the elderly.

PHP12

ACUTE CARE ELDERLY UNITS: THEIR PREVALENCE, CHARACTERISTICS AND DETERMINANTS
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BACKGROUND: The acutely ill hospitalized elderly patients face the risk of functional decline and poor quality care. To improve the outcomes of hospitalization, various intervention models have been used. However, the contributors to the functional loss and quality of care are interrelated and warrant a multidimensional intervention. The Acute Care for Elders (ACE) unit is a one such promising model of care for elderly to minimize adverse outcomes of hospitalization. OBJECTIVE: To analyze the determinants, prevalence and characteristics of ACE units. METHODS: We surveyed all established Geriatric Medicine Divisions (n = 100) across US to determine presence of ACE unit. Data on demographics, resource, structure, administration, and patient care was obtained via a questionnaire. Hospital data regarding number of beds, revenue, number of medicare inpatients, and average length of stay was obtained from Annual Survey data of the American Hospital Association. Descriptive analysis and step-wise logistic regression were used to analyze the characteristics and determinants of ACE units. RE-
SULTS: Of the 82 responding geriatric divisions, 15 had an active ACE unit. Average daily census on ACE units ranged from 5 to 25, average length of stay was 5.2 days and the average nurse to patient ratio was 1:6. Community dwelling was the most common pre-admission living setting. Two most common admitting diagnoses were congestive heart failure and pneumonia. T-test showed significant difference (<.05) between hospitals with ACE unit and hospitals without, with respect to number of beds and total revenue. The step-wise logistic regression indicated that total hospital revenue was the only significant factor in determining the presence of an ACE unit.

CONCLUSIONS: Thus, application of the ACE unit model remains modest given the paucity of information regarding its long and short-term benefits and cost-effectiveness. Further research in this direction can facilitate informed policy decisions.

INDICES FOR EVALUATION OF DRUG COST/UTILIZATION: EVERY SILVER LINING HAS A GRAY CLOUD

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OBJECTIVE: Given the high cost of pharmaceuticals, particularly “blockbuster” drugs such as the COX-II inhibitors, the issue of value-for-dollar is an increasingly important one for managed care decision-makers. Due to the complexity of conducting full economic evaluations, it is often tempting to try to reduce such analyses to the most simplistic methods possible—either by assuming equal effectiveness of two drugs and performing a cost-minimization analysis, or by using an index of drug cost/utilization such as DDD (number of defined daily doses of a drug used in a population), PMPM (per member per month cost/utilization), PPPM (per patient per month cost/utilization), ADC (average daily cost of drug therapy), or DACON (daily average consumption of a drug in a population). If a partial economic evaluation based on drug cost/utilization is necessary or preferred, decision-makers should bear in mind the relative strengths and limitations of these approaches prior to making policy decisions. The objectives of this paper are: (1) to describe several indices of drug cost/utilization, (2) to discuss their strengths and limitations, (3) to provide illustrations of their use, and (4) to offer suggestions for appropriate interpretation. METHODS: Using numerical examples focusing on COX-II inhibitors, several indices of drug cost/utilization are described and compared, including DDD, PMPM, PPPM, ADC, and DACON. General limitations and assumptions of “partial” economic evaluations based solely upon cost/utilization data are discussed, including assumptions of equal effectiveness, compliance, continuation and safety; as well as confounding by indication, severity of illness and time on market. RESULTS: Depending upon the index used, results (data) on drug cost/utilization for COX-II inhibitors vary. CONCLUSION: Numerous indices are used to describe and evaluate drug cost/utilization. Each has its own strengths and limitations, and must be interpreted in the appropriate context to best inform pharmaceutical policy decision-making.