processes and decisions. The health economics and health policy literature was reviewed for commentaries and case studies of particular decisions. Where decisions had been made by different bodies on the same technology those were reviewed for consistency. Parallels were drawn with methods of regulating market access in other European countries. RESULTS: NICE procedures were the most thorough but could not be applied early or to all technologies because of their resource-intensive nature. Methodological expectations for company submissions were similar between organisations, but the degree of independent review varied with the annual number of technologies assessed. In most cases, NICE and SMC decisions on the same drug were consistent. SMC most resembled equivalent systems in other European countries by evaluating drugs at launch. AWMSG was most concerned with budget impact. CONCLUSIONS: Most differences between the organisations could be explained by their differing objectives, scope of activities and timing of their intervention. The SMC was more concerned with timely and comprehensive coverage of all drugs, reflecting its closer links to NHS. NICE was only beginning to address implementation. Properly co-coordinated, the sequence of evaluations could follow a logical development of evidence quality over time, with minimal redundant work on company submissions. Without such co-ordination a waste of valuable time and resources is likely.

**PHP14**

**OPPS PHARMACY HANDLING COSTS: POLICY IMPLICATIONS**

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**OBJECTIVE:** The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 directed the Medicare Payment Advisory Commission (MedPAC) to conduct a study of hospital pharmacy handling costs. The June 2005 MedPAC report recommended payment for handling costs of Part B specified outpatient drugs based on submitted charges, reduced to costs. This study explores policy implications of MedPAC recommendations concerning potential OPPS pharmacy handling cost payment methodology. **METHODS:** Various methods of recording charges for pharmacy services were collected from a hospital survey of systems (n = 399) and categorized. Past CMS and MedPAC discussions of pharmacy costs and charges were identified and accumulated in an indexed database. Findings from the hospital sources and the governmental sources were compared and underlying assumptions examined with a view toward predicting 2006 CMS approaches to determining hospital pharmacy handling cost payment. **RESULTS:** The hospital survey revealed significant variation in whether hospital pharmacy department drug charges recognize overhead such as handling costs. Forty-three percent of survey respondents did include such a charge. Types of charges reported were for dispensing (35%), compounding (25%), a combination of dispensing and compounding (23%) and all other (17%). When entries in the indexed database of CMS and MedPAC discussions of pharmacy costs and charges were compared to the hospital responses about actual departmental cost and charge methods currently in use, analyses revealed a significant differential between methods reported by hospital respondents (including charge compression) and methods discussed in published CMS and MedPAC sources. **CONCLUSIONS:** Future payment rates for hospital pharmacy handling costs will likely be derived from hospital submitted charges, per the MedPAC recommendation. If the payment methodology does not take existing variations of recording pharmacy costs and charges into account, the resulting method will be significantly flawed and hospital providers may find they are underpaid for pharmacy handling costs in 2006.

**PHP15**

**THE CONSUMPTION OF DRUGS FINANCED BY THE SPANISH NATIONAL HEALTH SYSTEM AND THE IMPACT OF PHARMACOVIGILANT ACTIONS**

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**OBJECTIVES:** The Spanish Agency of Medicines and Health care Products (SAMHP) makes regulatory decisions concerning pharmacovigilance. Here, we analyse the impact of actions related to safety adopted by the SAMHP on drug consumption financed by the Spanish National Health System (NHS), over the period 1990–2004. **METHODS:** A retrospective analysis of the consumption was made, selecting drugs which were eventually withdrawn from the market. Consumption data was provided by the Ministry of Health and Consumne (MHC) database and expressed as number of prescriptions. Drugs selected were classified according to type of Adverse Drug Reaction (ADR), Anatomic Therapeutic–Chemical Classification (ATC) and degree of therapeutic innovation at the moment of authorisation, according to the MHC. **RESULTS:** Fourteen drugs were selected for the purpose of this study, and none of these were categorised as “an exceptional therapeutic novelty”. The most common ADRs concerned severe liver (7/14) or heart (5/7) toxicity. At least 8 of the 14 drugs were associated with one safety action before being withdrawn. This was either a product labeling modification (astemizole, droxicam, nimesulide, nefazodone, cerivastatine, trovafloxacine, and rofecoxib) or classification as hospital diagnostic (cisapride). Rofecoxib was the only one with two actions. A high level of consumption and in a very short time from authorisation until the first safety action (between one to three years) was found in nimesulide, cerivastatine and rofecoxib. In the rest of the drugs, the only action was the withdrawn. This happened after one year post-authorisation (tolcapone, sertindol, and grepafloxacine) or in the case of ebrocoxib. The effect on medicine prices. The quantities of 76 medicine groups were used as the dependent variable with real GDP per capita, EML dummy, hospital dummy, time, and percent of insured population, as independent variables. Another set of regressions were defined with real medicine price per defined daily dose as dependent variable and real GDP per capita, EML, dummy, hospital dummy, time, and percent of insured population, as independent variables. Another set of regressions was also analyzed to measure the indices of rational medicine use. The indicators of rational use of medicines were assumed to be a function of EML, and 16 health center dummy