

from 4–23 with the greatest variety in the mid-range. A small number of profiles usually accounted for the majority that occurred at each score. Differences in functioning were observed across 2–5 ADLs at scores of 5–15 and 90–95, and across 7–9 ADLs at scores of 20–85. **CONCLUSIONS:** Only a fraction (5%) of possible BI profiles occur clinically in stroke. Patients with the same BI scores may vary in ADL functioning and require different levels of clinical management. Depending on how ADLs are valued, preferences for disability states within scores may vary. In clinical trials, scores alone may not capture treatment effects that are important to patients. Properly adapted, a preference-based BI may constitute a more sensitive measure of effect than scores.

HEALTH POLICY I

HPI

THE RELATIONSHIP BETWEEN HEALTH INSURANCE TYPE AND COSTS OF PRESCRIBED DRUGS

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OBJECTIVES: To examine the relationship between health insurance type and prescribed drug costs for orthopedic outpatients of a regional hospital in southern Thailand. **METHODS:** Electronic data for 3117 prescriptions for osteoarthritis (OA) and rheumatoid arthritis (RA) new patients, whose age was 40 years or older and obtained their outpatient prescriptions from October 1, 2001 to September 30, 2002, were analyzed. Descriptive and linear regression analyses were used to analyze overall and subgroup (OA and RA) data. **RESULTS:** Results showed 94.6% of the patients had osteoarthritis. They were divided into three groups of health insurance type, which were Civil Servant Medical Benefit Scheme (CSMBS), Universal Coverage Scheme (UC), and Social Security Scheme (SSS). While the SSS and UC schemes paid by capitation basis, the CSMBS did by fee-for-service basis. The CSMBS and SSS patients received higher average cost per prescription and average cost per day than did the UC patients. The RA patients obtained more expensive drugs than did the OA patients. For OA patients, the CSMBS patients had the lowest number of drugs per prescription. However, the average cost per prescription and average cost per day of the CSMBS and SSS patients were significantly higher than those of the UC patients. For RA patients, the average cost per prescription and average cost per day of the UC patients were less than those of the CSMBS and SSS patients, while their numbers of drugs per prescription were slightly different. The regression analysis for all patients and each subgroup showed significant relationship between the patients' health insurance type and average cost per prescription and average cost per day. **CONCLUSIONS:** A significant relationship between the health insurance type and prescription drug costs was found. The UC patients tended to receive less expensive drugs than did the others.

HP2

EVALUATION OF CONDITIONAL REIMBURSEMENT AS A POLICY-INSTRUMENT

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OBJECTIVES: To promote rational drug use, governments may apply various instruments to aid health care professionals in clinical decision-making. Guidelines are a common approach, but

their impact on clinical practice is often limited. Therefore the Dutch government sometimes applies a stronger instrument: conditional reimbursement enforced by law, applied to drug groups listed on the so-called "Annex 2". We assessed process and outcomes of this instrument. **METHODS:** We quantitatively explored the effects of conditional reimbursement on drug use and costs for 33 Annex 2-drugs using the national GIP-database that administers funding decisions for people in insurance schemes. The qualitative process evaluation used document analyses, interviews (N = 70), and case studies (N = 6) to map perceptions of patients, physicians, pharmacists, insurers, manufacturers, and policy makers to attain insights into the performance of Annex 2. In focus groups we triangulated findings and identified improvements. **RESULTS:** The quantitative analysis showed that effects of conditional reimbursement varied with type of conditions and clinical setting. People responsible for implementation complained about administrative burden and lack of means to monitor if conditions for reimbursement were met (e.g. statins). An additional problem is that Annex 2 conditions lag behind evolving clinical knowledge (e.g. clopidogrel). The way in which conditions were operationalised appeared crucial for their implementation. When stakeholders had been actively involved in their operationalisation (e.g. TNF- β -blockers) implementation was successful, lack of consensus on the conditions was detrimental to effectiveness of Annex 2 policy. **CONCLUSIONS:** Overall, Annex 2 is considered a necessary instrument, although there are conditions to be met for a more effective functioning in the near future. There is a demand for more dynamic and pro-active communication strategy by the different Annex 2-actors to increase awareness of the existing policy and to narrow the gap between the clinical practice and policy regarding registration and reimbursement of drugs.

HP3

PHARMACOECONOMIC EDUCATION AT NON-US COLLEGES OF PHARMACY

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There is a global need for education in the field of pharmacoeconomics (PE). One is provided by Colleges of Pharmacy (COP's). Several surveys were conducted during the 1990's to determine the extent of pharmacoeconomic education at US-based COP's. One survey found that by 1999, 90% of US COP's provided PE education. On the other hand, only one study, conducted in 1997, was found that surveyed Non-US COP's. A total of 112 Non-US COP's in 44 countries were surveyed via e-mail; 41 COP's from 25 countries responded. Seventeen COP's from 13 countries reported providing PE education. **OBJECTIVE:** The objective of this study was to perform a follow-up study for Non-US COP's. **METHODS:** During January–May, 2004, surveys were sent to 291 Non-US COP's in 42 countries via e-mail using information from the World List of Pharmacy Schools (WLPS). Follow-up e-mails were sent to non-respondents and to respondents when clarifications of their responses were needed. **RESULTS:** A total of 89 COP's from 42 countries provided usable responses. A total of 46 COP's from 28 countries indicated that they provided PE education. Of these 46 COP's, nine provided education at the professional level only, 15 at the graduate level only and 22 at both levels. The median number of students enrolled at the professional level was 100, and 15 at the graduate level. The median number of class contact hours for PE education was 12 for professional students and 15 for graduate students. **CONCLUSIONS:** Fifty-one percent (51%) of respondents provided PE education compared to 41% from the 1997 survey. The majority of Non-US COP's that offered PE educa-