CONCEPTS: A total of about 40 publications from different countries were included in the study. To assess the change in PPI prescriptions dispensed after the introduction of a new reimbursement policy from February 1, 2007. The intention of the new policy was to reduce costs by shifting patients from esomeprazole to lanoseprazole, omeprazole or pantoprazole. New patients should not start on esomeprazole and ongoing patients should shift to a different PPI. Esomeprazole could be used upfront in severe cases or after having tried a different PPI first.

METHODS: The Norwegian Prescription Database (NorPD) contains data on all prescriptions dispensed making it possible to follow each individual over time. All PPI prescriptions dispensed from January 1, 2004 to January 31, 2006 were analysed. RESULTS: For patients using esomeprazole before February 1, 2007 and having a new PPI prescription dispensed the year after (n = 79781), 64% continued on esomeprazole and 36% changed to a different PPI. In the latter group 57%, 20% and 23% shifted to pantoprazole, lanoseprazole or omeprazole, respectively.

OBJECTIVES: To assess the changes in PPI prescriptions dispensed after the introduction of new reimbursement policy from February 1, 2007. The overall figure was 25%. For patients starting on PPI treatment during the year after February 1, 2007 (n = 32479), 42% started with pantoprazole, 36% with omeprazole, 19% with lanoseprazole and 23% with esomeprazole. Seven percent in the group of new PPI users shifted to a second PPI. There was a profound drop in new prescriptions dispensed for esomeprazole from 57% during the last quarter before the introduction, to 26%, 24% and 22% in the four quarters after introduction. CONCLUSION: The new reimbursement policy for PPIs had a significant impact in the pattern of prescription dispensed. The policy was easier to implement for new patients starting on PPI treatment compared to a compulsory shift for patients on ongoing esomeprazole treatment.

CONCLUSIONS: A systematic literature review of the 2 trials, unmatched and matched comparisons were made. Matching excluded two independent reviewers in order to create a refined list for analysis. The inclusion criterion for analysis was studies related to medications; publications related to vaccination or prevention programs were not included in the analysis. Data from 2006 to 2008 was used. CONCLUSIONS: Utilizing international cost-effectiveness analyses could facilitate the comparison among results generated by these studies. The use of international cost-effectiveness analyses could also allow information to be obtained about additional products and international experience; however these analyses should not serve as a gold standard in health economics.

GASTROINTESTINAL DISORDERS – Cost Studies

OBJECTIVES: To evaluate cost-effectiveness of infliximab and adalimumab for patients with refractory moderate-to-severe active ulcerative colitis (UC) in Canada. METHODS: A four-health state Markov model was constructed to compare cost-effectiveness of three management strategies: A) usual care without anti-tumor necrosis factor α (anti-TNF-α); B) 5 mg/kg infliximab for responders and adalimumab for non-responders; and C) 5 mg/kg infliximab for responders, 10 mg/kg infliximab for those lost their response in the maintenance stage, and adalimumab for non-responders to the initial therapy. ACTI and ACT2 randomized clinical trials were main sources of clinical parameters. The primary outcome measure was the incremental cost-effectiveness ratio (ICER) between the strategies. Both deterministic and probabilistic sensitivity analyses were performed. RESULTS: In the base case analysis, the ICER was $381,133/QALY for the strategy B versus the strategy A and $699,200/QALY for the strategy C versus the strategy A. The strategy B was dominated by the strategy B. The ICERs were sensitive to the remission rates, early surgery rate, and utility values. When the willingness to pay (WTP) was less than $150,000/QALY, the probability of the strategy A being the optimal strategy was 1.0. The probability of strategy B being optimal was 0.5 when the WTP increased to $400,000/QALY. The probability of the strategy C being the optimal strategy was very low despite the wide range of WTP values. CONCLUSIONS: Although infliximab and adalimumab demonstrated clinical benefits over standard treatment in patients with refractory UC, the cost-effectiveness of these treatments are not attractive due to significantly higher costs in Canada.