2002 were obtained from Minnesota’s Department of Human Services. Cost estimates include nursing and ancillary staff care, as well as room and board. Costs are reported in 2002 US$. RESULTS: Of the 3548 ischemic stroke cases identified in 1995, 618 qualified for analysis. Of those, 74% were female and the mean age was 84 years (range: 37–102). The proportion of residents in the low and medium dependency levels decreased from 37% to 22% over 6 years; whereas, the high dependency group rose from 63% to 78%. In 2000, significantly (p = 0.001) more of the cohort was noted as physically and/or mentally incapable of self-preservation than in 1995. On average, this increase in care needs resulted in an additional annual cost of $3650 per resident by the end of the 6-year period and roughly $2.25 million for the cohort. CONCLUSIONS: Stroke patients residing in nursing homes continue to deteriorate both physically and mentally over time, resulting in increased care needs and costs.

CV4

EVALUATION OF SURVIVAL AND ISCHAEMIC AND THROMBOEMBOLIC EVENT RATES IN PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION IN THE GENERAL POPULATION WHEN TREATED AND UNTREATED WITH WARFARIN

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OBJECTIVES: A large proportion of patients with nonvalvular atrial fibrillation (NVAF) remain untreated with warfarin. We aimed to compare survival and adverse outcome in patients with NVAF treated with or without warfarin. METHODS: A number of data sources were linked from a large population in the UK from 1995 to 2000. Adverse events were characterised from inpatient and death records. Survival was estimated using Kaplan-Meier and Cox proportional hazards models, and comparisons between event rates using logistic or Poisson regression and the Sign test. Patients were assumed to be receiving warfarin if they had more than four INR measurements. RESULTS: We identified 6108 patients with NVAF, of whom 36.4% received warfarin. Mean survival in warfarin and non-warfarin groups was 32.0 months and 38.2 months, respectively (p < 0.001), and 14.4 months (p < 0.001) after adjustment for confounding factors. Warfarin patients in the upper quartile of INR control had significantly longer survival (57.5 months) compared with those in the lowest quartile of control (38.1 months; p < 0.001). The risk of stroke in the warfarin group when on treatment was lower than that in the non-warfarin group (Relative Rate = 0.74, p < 0.001). The risk of death from ischemic stroke was lower (RR = 0.43; p < 0.001) and there was a lower risk of all ischemic and embolic events (RR = 0.74; p < 0.001) in the warfarin group when on treatment compared to the non-warfarin group. Risk of bleeding in the warfarin group on treatment was greater compared to the non-warfarin group (RR = 1.78; p = 0.001). CONCLUSIONS: These data suggest that failure to treat according to guidelines in routine clinical practice, both in terms of patients selected for anticoagulation and difficulty maintaining those selected patients within the recommended target INR range of 2.0–3.0, is associated with additional mortality and morbidity in patients with NVAF.

IN2

IS PROVISION OF ANTI-VIRAL INFLUENZA TREATMENT A SOUND INVESTMENT FOR PRIVATE AND PUBLIC EMPLOYERS IN THE UK?

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OBJECTIVES: To investigate the net return to employers in the UK of providing antiviral influenza treatment for their employees to reduce the impact of influenza epidemics on work participation and productivity. METHODS: A probabilistic decision-analytic model was developed to investigate the cost-effectiveness of providing influenza treatment compared to symptomatic treatment for a healthy adult working population (18–64 years) from the employer’s perspective. Data from clinical trials, the literature and published UK sources were used. The human capital approach, based on average income, was used to value an employee’s work absenteeism due to illness. Characteristics of firms and markets that determine how the gross benefits of reduced work absenteeism are distributed between employer and employees are taken into account in one-way sensitivity analyses. RESULTS: The expected gross benefit of reducing work absenteeism of £85.00 per treated employee outweighs the costs of providing influenza treatment (£18.18), resulting in a net benefit of £67.00. Sensitivity analysis shows a net benefit of £25.00 and a net cost of £10.00 if the value of 1 day work loss is 50% and 10% of the average salary respectively. If the actual work loss is only 30% of the days to return to normal activity the intervention results in a net benefit of £13.00. However, if work loss is 30% of the days to return to normal activity and the value of work loss is

OBJECTIVES: Recent re-pricing of the ritonovir (RTV) has been criticized as making the antiretroviral drug unaffordable. These criticisms generally considered only cost and not cost-effectiveness. Our study re-evaluates a previous cost-effectiveness analysis of RTV while considering re-pricing. METHODS: A previous cost-effectiveness analysis of HIV salvage regimens suggested that therapy including RTV is cost-effective ($37,889 per responding patient), although slightly less cost-effective than a similar regimen using nelfinavir (NFV) ($31,476) (Becker R, Shakur I, “Cost-effectiveness of salvage therapy with delavirdine in NNRTI-naive patients failing indinavir,” (abs) Int. Conf. On AIDS, Barcelona, Spain 2002.). Our present study applied 2003 drug prices for the two regimens (RTV + saquinivir [SQV] + adenosine [ADV] and NFV + SQV + ADV) with and without delavirdine (DLV) to determine the total drug cost with each regimen. The cost of RTV reflected recent re-pricing from $8.25 to $34.28 per dose. As with the previous study, results from the ACTG 359 trial were used to calculate the cost-effectiveness of the three-drug regimens versus the four-drug regimens over a 48-week timeframe. The results were compared to the earlier results and sensitivity analyses were run. RESULTS: At 48 weeks, the 2003 cost-effectiveness of treating with a 4-drug combination including RTV was $60,963 per responding patient. This reflects a 60.1% increase from the regimen’s incremental cost effectiveness ratio (ICER) in the earlier study. In contrast, the four-drug combination with NFV had an ICER of $34,310, or a 9.0% increase over the combination’s ratio in the previous study. CONCLUSIONS: The re-pricing of RTV has a significant impact on cost-effectiveness analysis involving the drug. This analysis illustrates that studies once showing RTV to be cost-effective may now show less cost-effective compared to other regimens given current prices. Other prior cost-effectiveness studies that included RTV should be re-analyzed in light of the new pricing.

IN4

IMPACT OF RECENT RITONOVIR RE-PRICING ON COST-EFFECTIVENESS ANALYSIS

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OBJECTIVES: Recent re-pricing of the ritonovir (RTV) has been criticized as making the antiretroviral drug unaffordable. These criticisms generally considered only cost and not cost-effectiveness. Our study re-evaluates a previous cost-effectiveness analysis of RTV while considering re-pricing. METHODS: A previous cost-effectiveness analysis of HIV salvage regimens suggested that therapy including RTV is cost-effective ($37,889 per responding patient), although slightly less cost-effective than a similar regimen using nelfinavir (NFV) ($31,476) (Becker R, Shakur I, “Cost-effectiveness of salvage therapy with delavirdine in NNRTI-naive patients failing indinavir,” (abs) Int. Conf. On AIDS, Barcelona, Spain 2002.). Our present study applied 2003 drug prices for the two regimens (RTV + saquinivir [SQV] + ade-