in the case of UC. CONCLUSIONS: These preliminary results show that this innovative cost estimation obtained, with this carefully controlled use of population wide databases, is a valuable alternative to traditional analyses obtained with hoc designed and less representative protocols.

**DIRECT COSTS OF OBESITY IN POLAND**

*PSY22*

**Medical University of Warsaw, Warsaw, Poland**

**OBJECTIVES:** Measuring obesity is becoming to be treated like a worldwide epidemic. In Poland about 10.6% employees are obese. The objective of the studies was to estimate the indirect costs of obesity among Polish society. METHODS: Human Capital Approach method was used in costs quantifying. Data were collected from obese Polish employees. Direct and Activity Impairment General Health Questionnaire were used to estimate absenteeism and presenteeism in obese population. Indirect cost for general population was calculated on the basis of gross value added per employee in 2008. Central Statistical Office (GUS) data were used to identify obese epidemiology.

**RESULTS:** Data from 96 people were analyzed (mean age = 41.7 years, 34.4% men, average BMI = 34.2 kg/m²). Overall work impairment due to health problems in questioned population was estimated at 36.3%, with 11.8% of work time missed due to health problems. Taking into consideration that based on GUS data near 1.5 million employees are obese total indirect costs of obesity in Poland in the year 2008 were estimated at €1,013 million representing 0.9% of gross domestic product. Absenteeism costs accounted for less than 1/3 of this amount (€3.4 billion) while presenteeism costs accounted for the remaining amount of €7.0 billion. We didn’t find any correlation between BMI score and work impairment due to health problems (Pearson r = 0.15).

**CONCLUSIONS:** Previously estimated direct medical costs of obesity (without obesity related diseases) covered by public payer were quantified at 4 million EUR in the year 2008. We’ve found that indirect costs of lost productivity due to obesity are substantial to public economy. However we conclude that not obesity itself but obesity related diseases generate most of indirect costs.

**COST OF POMPE DISEASE IN POLAND IN 2008 AND 2009**

*PSY23*

**Baran A, Czech M, Hermanowski T**

**Medical University of Warsaw, Warsaw, Poland**

**OBJECTIVES:** The objective of this review is to estimate the direct and indirect costs of Pompe disease. METHODS: Direct and indirect costs were estimated based on a questionnaire (consisting of 108 questions) measuring costs specific for Pompe disease and a survey concerning the enzyme replacement therapy created for the research. The direct costs of Pompe disease were estimated from the patient’s perspective and the public health care system payer (National Health Fund) perspectives. While estimating indirect costs human capital approach methodology was used taking into consideration absence from work due to the illness, lost time and salaries of the members of the family taking care of the patients. The analysis was done in a 2-year time span.

**RESULTS:** In the research 80% of Pompe disease population were studied (N = 16). Indirect costs were estimated based on 3% of patient’s cost (€17,959.67 per patient in the year of 2008). The highest component of the amount was the cost of the illness lost by the members of the families taking care of the patients; 96% of the total direct costs were the direct medical costs (€50,975.03 per patient in the period of 2 years). The main medical cost determinant is the enzyme replacement therapy (€543,350.47)-constituting 99% of the total direct medical costs. CONCLUSIONS: Providing patients with the prompt access to the enzyme replacement therapy result in lowering future indirect and direct costs: smaller number of patients taking disability pension, lower cost of medical equipment used by patients and higher productivity of patients able to work. Additionally there is a need to introduce an unusual and untypical approach in Health Technology Assessment.

**COST OF CARE FOR CHRONIC MYELOID LEUKEMIA (CML) IN PATIENTS EXPERIENCING RESISTANCE AND/OR INTOLERANCE TO IMATINIB FROM THE PUBLIC HEALTH SYSTEM PERSPECTIVE IN MEXICO**

*PSY24*


**OBJECTIVES:** To assess treatment costs per overall patient rate with romiplostim+concurrent treatment vs. placebo+concurrent treatment in chronic adult iTP, from a national payer perspective in Spain. METHODS: Platelet response rate was defined as a platelet count of 500×10^9/L. Overall platelet response rates to romiplostim and placebo were compared for the analysis and derived from two parallel clinical trials in splenectomized and non-splenectomized iTP patients [1]. All patients were allowed to enter on concurrent iTP medication (danazol, corticosteroids, azathioprine) and receive rescue medication (e.g., intravenous immunoglobulins). Treatment costs were calculated over the 24-week clinical trial period and included intervention, rescue medication and management of bleeding-related events. Costs were based on the 2009 national reimbursement list. Mean treatment cost per response was calculated for overall population, and for splenectomized and non-splenectomized patients. RESULTS: Cost per response was substantially lower for romiplostim-treated patients (€3,407.4) as compared to placebo (€109/L. Overall platelet response rates to romiplostim and placebo were 42,557, respectively). The main cost-offsets were mean treatment costs were €15,781 for romiplostim and €8,111 for placebo (splenectomized patients €15,436 vs. €10,263, non-splenectomized patients €16,123 vs. €5,958, respectively). Cost per response with romiplostim was €39,013 compared to €15,871 with placebo (splenectomized patients €19,539 vs. infinite cost/response, non-splenectomized patients €8,324 vs. €42,557, respectively). The main cost-offsets were due to reduced immunoglobulin rescue use. CONCLUSIONS: Romiplostim represents an efficient use of health care resources in both splenectomized and non-splenectomized iTP patients for the Spanish health care system, leading to a significant improvement in managing a disease with a limited number of existing effective therapies. [1] Katter et al. Lancet 2008;371:393-403.