CONCLUSIONS: There did not appear to be differences in HbA1c and lipid levels across the quartiles, higher compared to those in the lowest quartile ($3,200 versus $19,700). Although the range of costs among these patients is quite large. Studies have also illustrated that patients with complication is 1.4 times that without any complication. The cost of patients with complication is 1.4 times that without any complication. The mean direct cost of those diabetics who had no complication (only 28% of the sample) was Rs. 1,226 ($US20) compared to those who have one or more diabetes complication that is 1,779 ($US30) and this difference was statistically significant (P < 0.005). About 40% of those who have one or more co-morbidity are not taking any medication for their health condition, which may further compound this cost in the future. CONCLUSIONS: It has been recognized that health care expenditures related to the complications of diabetes account for a substantial proportion of the public health care budget. Reducing the risks of developing complications can improve the quality of life, increase life expectancy and reduce the overall cost of medical care. In this era of scarce resources and rising costs, it is critical to have an understanding of the economics of diabetes and its complications in order to develop and implement sound public health and prevention policies.

AN ANALYSIS OF DIFFERENCES IN COST QUARTILES FOR PATIENTS WITH TYPE 2 DIABETES IN A LARGE CLAIMS DATABASE WITH LINKED LABORATORY RESULTS

OBJECTIVES: A number of studies have reported that patients with type 2 diabetes have higher annual health expenditures than those without this condition. Additionally, the range of costs among these patients is quite large. Studies have also illustrated that certain acute events and co-morbidities drive excess mean costs. Whether these events and conditions affect cost in the same way across the distribution has not been studied. In this study, we assessed potential drivers of mean costs across quartiles of the cost distribution. METHODS: Data for this study come from a US health plan affiliated with 13 Inovus. We included members aged 18 or older that had evidence of type 2 diabetes over the period January 1, 2004 to December 31, 2006. An index date was defined as the date of the earliest qualifying medical or pharmacy claim. Patients were required to have continuous enrollment two years prior to (baseline period) and 2 years following (follow-up period) the index date. Variables were created for the following categories: demographics characteristics, diagnoses, medications, procedures and clinical markers (e.g., lab values for HbA1C, Lipids). Differences in potential cost drivers across the quartiles of the cost distribution were assessed. RESULTS: Mean annual cost for those in the highest quartile was 6X higher compared to those in the lowest quartile ($3,200 versus $19,700). Although there did not appear to be differences in HbA1C and lipid levels across the quartiles, meaningful differences were seen in many of the other variables analyzed. For example, “diabetes of the heart” ranged from 17% in the lowest quartile to 42% in the highest quartile. CONCLUSIONS: The study illustrates that a quantile-based analytical approach may allow for a deeper understanding of the drivers of health care costs.

MEDICAL COST AND SETTLEMENT PATTERN STUDY ON DIABETES MELLITUS INSURANTS IN CHINA

Objective: To quantify and compare annual resource use and costs over time in insulin-naive type 2 diabetes patients with type 2 diabetes treated with oral antidiabetic (OAD) alone and who subsequently initiated insulin treatment. METHODS: The study was based on data from the Real-Life Effectiveness and Care Patterns in Diabetes Management (RECAP-DM) study, a retrospective, population-based study on patients with type 2 diabetes identified in electronic patient records from 26 primary care centers in Uppsala county. Patients treated with OAD alone the year prior to insulin initiation in 2001-2003 were identified. Resource consumption was available from the patient records and the resource items included were visits to General practitioners (GP) or nurses at Primary care settings, visits to acute physician and visits at outpatient clinics and inpatient days. The annual costs were calculated by multiplying quantities of resource use by unit costs from a previous study and from the price list of Uppsala University Hospital. RESULTS: A total of 397 patients with type 2 diabetes were identified that initiated insulin treatment 2001-2003 after only receiving OAD. The annual resource cost for diabetes patients treated with OAD alone was significantly more annual resources. Annual mean costs also increased significantly, driven by the increased costs of inpatient days and diabetes nurse visits.