€9375/LY and €8714/QALY. CONCLUSIONS: The use of peginterferon alfa-2a (40KD) in CHB patients, as compared with current practice, has the potential of improving clinical outcomes with a cost per LY and QALY gained below that of universally accepted therapies.

COST-EFFECTIVENESS OF OSELTAMIVIR FOR THE TREATMENT OF INFLUENZA IN ADULTS AND CHILDREN IN FINLAND

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OBJECTIVE: To estimate the cost-effectiveness of oseltamivir in the treatment of influenza in three different population groups in Finland: Otherwise Healthy Adults aged 13-65 years (OHA); Children aged 1-12 years (C); At-Risk Patients including elderly ≥65 years (ARP).

METHODS: The cost-effectiveness of oseltamivir vs symptomatic relief was compared using a decision-analytic model. Analyses were made both from the healthcare payer and the societal perspective. Health Outcomes determined were days of normal activity and quality-adjusted life years (QALY) gained. A life-time horizon was used to take account of life-years lost due to mortality. Probabilities, utilities and resource use data in the model were derived from published Finnish population level trials and registers, from oseltamivir clinical trials and from other published literature. A discount rate of 5% was applied. Unit costs were obtained from the 2001 Finnish Guidelines for Health Care Unit Cost converted to a 2005 level. Probabilistic Sensitivity Analysis was used to explore the uncertainty around the base case means. RESULTS: The mean cost from a health care payer perspective per day of normal activity and per QALY gained respectively for the 3 different population groups were: OHA €27/E12,008; C €14/E15,469; ARP €7/E685. In OHA, oseltamivir is cost-saving when loss of productivity is taken into account. CONCLUSION: The analyses demonstrate that, in comparison with usual care, cost per QALY gained with oseltamivir is below internationally accepted thresholds. Oseltamivir is a cost-effective treatment for influenza in all population groups (particularly in the ARP group) and is cost-saving from a societal perspective in OHA.

COST MINIMALISATION ANALYSIS OF AVERAGE ACUTE HOSPITAL INFECTIONS TREATMENT WITH TARGOCID (TEICOPOLANIN) OR VANCOMYCIN FROM SERVICE-PROVIDER PERSPECTIVE IN POLAND

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OBJECTIVE: To assess the clinical effectiveness and costs of teicoplanin or vancomycin use in acute hospital infections treatment from service-provider perspective in Poland. METHODS: Results of a systematic review of published clinical trials selected in accordance with Cochrane Collaboration criteria were used to assess effectiveness and safety. Systematic review was conducted in April 2006; Medline (Pubmed) Cochrane and EMBASE were searched. Only RCTs with a credibility assessment of 2 or more points according to Jadad scale were included in the systematic review; relevant clinical data were pooled with RevMan 4.2. Overall costs of treatment were taken into account; pharmacotherapy and drug administration, drug monitoring, patient monitoring and adverse effects influenced the total cost of treatment. CMA was used to assess savings from service-provider perspective in case of cheaper drug use in clinical practice. Sensitivity analysis was made according to range of costs of vancomycin generics available in Poland and number of days of therapy. All calculations were performed for 2006 (1Euro = 3.8PLN). RESULTS: Nineteen relevant clinical trials with direct comparison of teicoplanin and vancomycin were found. Clinical effects of the drugs were similar and no significant differences in effectiveness were found in pooled data from RCTs. Teicoplanin treatment was associated with higher costs of drug acquisition compared to vancomycin (difference: 337PLN (€88.7) but Targocid occurred much cheaper referring to: drug level monitoring, patient monitoring and administration costs. So, overall treatment with teicoplanin occurred cheaper than vancomycin; savings from service-provider perspective were: 743.3PLN (€195.6) per therapy. CONCLUSIONS: Targocid treatment lead to significant savings for service-providers in average acute hospital infections treatment in Poland in comparison to vancomycin.

ECONOMIC EVALUATION OF EARLY MONOTHERAPY WITH INTERFERON AND RIBAVIRIN IN PATIENTS WITH ACUTE HEPATITIS C

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OBJECTIVES: Comparative evaluation of two options for the treatment of acute hepatitis C: immediate monotherapy of all patients with (pegylated) interferon versus delayed combination therapy of patients who do not experience spontaneous viral clearance within three months after diagnosis with interferon and ribavirin, and also a comparison between the applied monotherapies for the immediate treatment option. METHODS: Economic evaluation is based on three prospective nonrandomized outcome studies. In two monotherapy studies (n = 128) patients were treated with 5 million units of Interferon alpha-2b daily during the first 4 weeks and three times a week during the following 20 weeks or with 1.5 μg/kg pegylated Interferon alpha-2b weekly over a period of 24 weeks. In the combination therapy study different dosages of interferon and ribavirin were administered. The evaluation focused on direct medical costs and included physician’s fees, laboratory, as well as medication costs, taking a societal perspective. Partial indirect costs were raised ex post by enquiry of participants and physicians. Costs were valued at 2002 market-prices. RESULTS: Monotherapy and combination therapy of hepatitis C showed a similar high efficacy (sustained response rate: 87% vs. 90%). Patients in delayed combination therapy study showed a quite high rate of spontaneous viral clearance of almost 50%. Direct medical costs of immediate therapy (€7064/patient) were €321 lower than those of delayed therapy (p = 0.8). Pegylated compared with unpegylated interferon yielded €311 additional costs per patient (p = 0.01) in monotherapies. Considering the current genotype-dependent therapy standard and the observed rate of sustained responders, average costs per patient amounted to €10,848 and were about 30% higher than costs of the immediate monotherapy. Sensitivity analysis indicated a robust model. CONCLUSIONS: As there are no significant differences in treatment efficacy, monotherapy seems to be slightly more cost-effective. Medication is responsible for more than 90% of direct costs.