the French Sickness Fund. METHODS: Medical consumption was based on clinical trial data. Cost data (medical fees, hospitalization, surgery) were extracted from the National Health Insurance website (www.ameli.fr) and from PMSI database. Cost-efficacy ratios were calculated to compare therapies when significant differences were demonstrated on study outcomes. RESULTS: Costs per clinical progression prevented were respectively €7404 for finasteride, €7314 for doxazosin, and €8206 for the combination of both as compared with placebo. Cost-efficacy ratio (additional drug costs per invasive therapy avoided) was €16,153 for finasteride versus placebo, and €3153 versus doxazosin. It was €16,400 for combination therapy versus doxazosin, and €28,779 versus placebo. CONCLUSION: Cost-efficacy ratios of finasteride and doxazosin for the prevention of clinical progression were in the same range. The cost-efficacy ratio of the combination was slightly higher, but with a further significant clinical benefit. Only finasteride alone or in combination with doxazosin reduced the risk of invasive therapy. Its cost-efficacy ratio for preventing invasive therapy remains in an acceptable range in the French setting.


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OBJECTIVES: This study’s objective was to estimate the burden of illness (BOI) of overactive bladder (OAB) and urinary urge incontinence (UUI) in the over 40 population using recent findings from a prevalence survey (EPIC) and recent published literature. METHODS: New prevalence data was incorporated into a previously published BOI model. A literature search obtained data pertaining to consequence probabilities for OAB, UUI and related co-morbidities. The model was then used to produce estimates of the total burden of OAB in 6 countries. RESULTS: It is estimated, for these 6 countries, that over 20 million people have OAB symptoms of which 2 million have UUI. The annual total direct cost of OAB was calculated to be 12 billion euros (2005 prices). 80% of this cost is associated with UUI. The total costs per country are: €2,577,402,489 Canada, €5,301,967,560 Germany, €4,536,571,901 Italy, €5,509,697,531 Spain, €3,227,640,146 Sweden and €1,026,091,457 UK. The cost of OAB management (medical visits, diagnostic testing, incontinence pads and drugs) and co-morbidities (UTIs, skin conditions, falls/fractures, depression and increased likelihood of nursing home admission) ranged from €2600 in Spain to €35,000 in Italy per person. The largest cost driver was the increased likelihood of nursing home admission followed by the cost of incontinence pads. CONCLUSIONS: These estimates of the total direct cost burden of OAB are higher than previous published estimates. This is due to current prevalence rates and probabilities of developing consequences of uncontrolled OAB. The OAB symptom UUI is associated with the most co-morbidity costs. These COI results may under-estimate the true costs, as OAB also affects people under 40 years old. Indirect and intangible costs have also been excluded. Cost-effective treatments for OAB and UUI in particular have the potential to significantly improve the allocation of health care resources in a growing proportion of the population.

COST UTILITY ANALYSIS OF ERYTHROPOIETIN THERAPY IN THE MINISTRY OF HEALTH DIALYSIS PROGRAMME

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OBJECTIVES: End-stage renal failure patients are normally anaemic due to failure of renal to produce endogenous erythropoietin (EPO). Erythropoietin is used to treat anaemia in these patients but the drug is expensive. The objectives of this study were to determine the life expectancy, the improvement in quality of life associated with haemoglobin, the utility of the dialysis patients, and the cost utility as cost per quality-adjusted life year (QALY) saved. METHODS: The perspective was for the health provider and the treatments compared were haemodialysis and CAPD. The National Renal Registry database for the period of 1997–2004 formed the basis of patient selection. There were 406 haemodialysis and 333 continuous ambulatory peritoneal dialysis (CAPD) patients to evaluate the utility of quality of life. The health-related quality of life questionnaires and the time trade-off were used to acquire the quality of life index and the utility.