

failure, patients' dependence and risk of falls is high. Direct medical costs are substantial. Our study offers baseline data for further health economic analysis in Hungary.

#### PUK10

##### **DIRECT COST OF URINARY INCONTINENCE OF ICELANDIC WOMEN, 16 YEARS AND OLDER IN THE YEAR 2004**

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**OBJECTIVES:** To estimate annual direct cost due to urinary incontinence (UI) of women in Iceland in 2004 and to evaluate proportion of out-of-pocket cost for different age groups and treatments. **METHODS:** The prevalence calculations are based on published studies and a questionnaire of 10,000 women reporting prevalence, proportion seeking care and out-of-pocket expenditures. The direct cost estimate included cost for diagnosis, therapy and routine care. It did not include cost due to the consequences of the disease or the monetary loss as a result of seeking treatment. Cost of active treatment and routine care came from the National Insurance, University Hospital, smaller hospitals and 7 nursing homes. All cost was from the year 2004 except the cost from the questionnaire and that was adjusted to the year 2004. Three subgroups of women with UI were identified. **RESULTS:** For the largest subgroup 16–64 yrs. old the total annual direct cost was 4.4 million \$ or 132 \$ per woman, 35% was due to active treatment and 70% was out-of-pocket cost. For the next largest subgroup 65 yrs. and older the total annual direct cost was 1.9 million \$ or 284 \$ per woman, 37% was due to active treatment and 46% was out-of-pocket cost. For the smallest subgroup 65 years and older in nursing homes the total annual direct cost was 8.3 million \$ or 7538 \$ per woman. **CONCLUSION:** Seventy percent of the annual total direct cost of UI is due to women 65 yrs. and older. This cost will increase substantially with aging population. Women with UI in nursing homes generate 55% of the total cost. If the proportion of active treatment is increased in the younger age group, health care authorities cost will increase but it could be more cost effective.

#### PUK11

##### **THE COST OF END STAGE RENAL DISEASE IN GREECE**

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**OBJECTIVES:** End stage renal disease (ESRD) is associated with a substantial clinical and economic burden that impacts significantly on health-care systems. The objective of this study was to estimate the direct costs associated with ESRD in the Greek health care system. **METHODS:** A cost of illness analysis was performed using a Markov model to estimate the direct costs associated with the treatment of ESRD. Clinical inputs were derived from ERA-EDTA Registry 2004 Annual Report and published data of the renal replacement therapy (RRT) in Greece. The costs for hospital haemodialysis (HD), continuous ambulatory peritoneal dialysis (CAPD), automated peritoneal dialysis (APD) and kidney transplantation (TX) were calculated. All costs were calculated from the perspective of the Greek health care system, in 2006 Euros. **RESULTS:** At the end of 2006, it was estimated that more than 11,000 patients were receiving RRT. The total economic burden of the Greek health care system for the RRT of these patients was estimated at more than 392.746 million Euros during 2006, almost 30% more than 2003, and represents 0.16% of the gross national product. The average weighted cost of RRT per patient year was 38,413 Euros.

Although the cost of TX per patient year (after transplant surgery) was just 20,727 Euros, only 18.6% of the patients with ESRD received TX. **CONCLUSION:** The magnitude of the economic burden that the public insurance system pays for the treatment of ESRD in Greece is another reason for developing strategies to reduce the incidence of ESRD, as well as the cost of its treatment. Among the latter, an increase of kidney transplantations in national level seems to be a quite effective measure.

#### PUK12

##### **THE ECONOMIC BURDEN OF HAEMODIALYSIS IN GREECE DURING 2006**

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**OBJECTIVES:** At the end of the year 2006 in Greece, about 74% of patients with end-stage renal disease (ESRD) were treated with haemodialysis (HD). Although the percentage of HD is the highest among the countries of the European Union, the economic aspects have not been widely explored. Therefore, the aim of this study was to estimate the haemodialysis related costs in Greece from the perspective of the social security system. **METHODS:** A cost analysis was performed from the perspective of the Greek social security system that covers the HD-related expenses. A decision analysis model was developed with Microsoft Excel software to simulate clinical decisions and outcomes. Only direct costs covered by the social security system were considered in the analysis including drug therapy, clinical and laboratory monitoring, treating complications, hospitalizations, HD sessions and transportations. All costs were calculated in euros, with 2006 as reference year. **RESULTS:** The total cost per patient per year was 38,580 euros for the first year including surgical set-up and 37,378 euros thereafter. From the latter cost, more than 70% accounts for the costs of HD sessions and hospitalizations. The cost of drug treatment was 8245.07 euros per patient year, whereas the average annual cost of erythropoietin per patient was 4833.25 euros. The cost of treating vascular access infections was just 1711.62 euros per patient year. During 2006, the Greek social security system paid 322.529 million euros for the treatment of ESRD patients with HD. **CONCLUSION:** Haemodialysis is an expensive alternative renal replacement therapy which burdened the Greek social security system with more than 320 million euros during the year 2006. To afford dialysis for those in need, smarter, more efficient use of limited funds is mandatory. Strict control of the use of some expensive drugs like erythropoietin and decrease of the hospitalizations may reduce the cost of haemodialysis.

#### PUK13

##### **COST OF DIALYSIS IN A UK SETTING—A MULTICENTRE MICROCOSTING STUDY**

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**OBJECTIVES:** Payment by Results represents a complete change to NHS funding, the core of which will be a national tariff price based on health care resource groupings [HRG]. The renal tariff is expected to improve financial management so it is important that the tariff level is set to reflect actual costs of treatment. The objective of this study was to obtain detailed costings for automated PD (APD), continuous ambulatory PD (CAPD), hospital-based haemodialysis (HD) and satellite-centre-based HD (SHD) and to identify potential cost differences and cost drivers.