cially influenced by the occurrence of motor complications.

CONCLUSIONS: Similar to earlier studies (Dodel et al., 1995), an increase in costs was calculated depending on HY stage and the occurrence of motor complications. Compared to the medical costs, the non-medical services contribute only in a small proportion to the overall direct costs. The major cost factor is the drug treatment of Parkinson's disease. The greatest proportion of these costs is for drugs introduced in the last five years.

PND7

ESTIMATION OF THE COSTS OF MULTIPLE SCLEROSIS BASED ON 157 FRENCH PATIENTS

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OBJECTIVES: To assess the costs of multiple sclerosis (MS) from a sample of 157 French patients followed during 2 years (1 year retrospectively, 1 year prospectively) and consecutively included from June 1995 to December 1996. Costs included health-care consumption, lost earnings and payment of short-term disability benefits by Social Security. METHODS: At the time of inclusion, the costs of MS were assessed by retrospective interviews covering a one-year period (health-care costs and sick leaves) or since the last consequence of MS on work (loss of earnings). The retrospective data concerning both the health-care consumption and sick leaves were completed with prospective data collected by means of a questionnaire during the three-months following inclusion. Loss of earnings was discounted at 5%. Cost estimates were crossed with medical data at inclusion, and econometric analyses were performed to assess explanatory variables of the health-care costs. RESULTS: Baseline statistics were: mean age, 42.9; women, 66%; secondary progression, 37%; primary progression, 11%; median EDSS score, 5.25. Average one-year retrospective health-care costs (N = 157) amounted to US$7,790.38 (+/− US$9,713.88), with 75.4% going towards hospital costs and 24.6% to ambulatory costs. Main cost items were hospital stay in the neurological ward (29.4% of the total cost) and physiotherapy (15.4%). Three-month prospective healthcare costs (N=101) amounted to US$1,813 (+/− US$2,056), with 56.5% spent on hospital costs. Physiotherapy and drugs were the main ambulatory cost items, accounting for 40.0% and 24.6% respectively of the total prospective ambulatory costs. CONCLUSION: The econometric analysis showed that the health-care costs were positively correlated with the number of years of schooling, the number of relapses, the EDSS score and the Kurtzke sphincter subscore at inclusion, negatively correlated with the Kurtzke sight subscore at inclusion, and were not affected by the form of MS.

PND8

IMPLICATIONS OF PRESCRIBING FOR PATIENTS WITH RELAPSING-REMITTING MULTIPLE SCLEROSIS (RRMS): INTRODUCING A TREATMENT ALGORITHM FOR GLATIRAMER ACETATE (COPAXONE)

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MS affects approximately 85,000 people in the UK, of which 25% to 40% will be RRMS patients. Treatment costs fall largely on the NHS, but savings on social and personal care will accrue if dependency is deferred. Simplistic treatment algorithms based on crude prevalence data may overestimate the number of patients and cost of treatment. OBJECTIVE: Present a treatment algorithm providing a more realistic estimate of the number of RRMS patients eligible for therapy, and thereby, an improved estimate of budget implications of prescribing. METHODS: Published prevalence data indicate the number of patients for whom treatment is theoretically eligible is 25 to 71 per 100,000 population (mid-point 48). However, using published literature and feedback from expert clinicians, we show that these numbers can be reduced to reflect those patients who will refuse injectable therapy, are too young (below 18), have not relapsed in the previous two years or are non-ambulatory. RESULTS: We present an algorithm based on glatiramer acetate, given the published evidence of long-term efficacy and the significantly lower price (almost 30% cheaper than the beta interferons in the UK). Using published data to quantify the proportions of ineligible patients, the original target population of 48 is reduced to 23. Depending on the proportion of these patients that receives glatiramer acetate, e.g., 20%, 40%, or 60%, the budget provision per 100,000 population would be £33,250, £59,850, or £93,100 respectively, based on direct acquisition cost of therapy alone versus best supportive care alone. CONCLUSION: The algorithm provides a tool for determining a more realistic estimate of the RRMS population eligible for treatment, and the direct costs to the NHS. Given that NHS and Social Care budgets will increasingly be managed jointly, budgetary impact is mitigated if wider benefits such as deferred dependency and ability to continue employment are taken into account.

PND9

IMPACT OF RIVASTIGMINE ON ANTIPSYCHOTIC UTILIZATION AND COST IN ALZHEIMER'S DISEASE

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