OBJECTIVES: To describe the key financial resources allocation supporting the HIV/AIDS prevention, treatment, and social support programs in Thailand and to identify facilitators and barriers in financial management and monitoring system.

RESULTS: A comprehensive review of financial reports and resources such as UNGASS, NASA and NAMC reports, we explored the key financial resources that support the HIV/AIDS prevention, treatment, and social support programs in Thailand. In addition, we conducted in-depth interviews with different knowledgeable people from the national policy on HIV/AIDS in provincial and district levels including domestic and international donors to assess the financial management, coordination and monitoring system.

RESULTS: The total expenditure on HIV/AIDS in fiscal years 2007, 2008 and 2009 were 204, 210, and 218 million USD, respectively. The national HIV/AIDS spending was roughly 20% to 25% of total health spending (38, 39 and 11% of health spending 2007, 2008 and 2009, respectively). Of those spending, emphasized on care and treatment while prevention budgeted for 14.1%, 21.7%, and 13.7%. The majority of treatment financing came from public health insurance schemes, but most preventive programs were from GFA/T and other international sources. Effective system development in program management, monitoring and evaluation are still lacking among practitioners. CONCLUSIONS: Thailand has shown its potential to be self-reliant in combating HIV/AIDS. Nevertheless, care and treatment expenditure overshadow prevention; and most of the preventive programs are from international sources. Thus, the dominance of entitlement programs in funding for HIV/AIDS treatment challenges policy makers to monitor the extent and quality of HIV/AIDS care and treatment. Opportunities in the cost of treatment and care, integral prevention is essential, especially due to the declining support from international funds.

CONCLUSIONS: More than half of the users hadn't had a previous HIV antibody test in the following three months after the exposure to the risk factor, when the test is not still accurate. One in four HIV infected patients is unaware of his condition, and 34.0% had HIV test outcome were positive (0.85%; 95%CI: 0.34 to 1.90; range: 16-82; 71% men). The test in the following three months after the exposure to the risk factor, when the test is not still accurate. Most of these patients likely due to the slow-evolving character of Hepatitis C.

CONCLUSIONS: Current models for cost-effectiveness analysis for end-stage liver disease used for hepatitis C or HCV patients, and the consequences of policy decisions could be performed. Conclusions: When focussing on statistical methods current data allows for a very limited validation of SRV as a relevant endpoint for the endpoint of Hepatitis C, only. There is a lack of long-term data (going beyond 5 years of follow up), especially for individual data of treated and untreated patients, likely due to the slow-evolving character of Hepatitis C.

CONCLUSIONS: Of the 36 studies reviewed, 32 were assessed. The vast majority of models are decision trees, considering one influenza season; however, if unit of outcome was life years or QALYs, impact of influenza mortality was incorporated as average life expectancy - foregone life. Most models considered both healthy and at-risk pediatric populations, six were UK models of which three papers considered treatment only and the remaining considered treatment and prevention. Ten models reviewed healthy adult populations only, two were UK models, one considering prevention, the other treatment. Another two other models reviewed adult populations (healthy and/or at-risk adults, excluding healthy working adults), nine were UK models. Eleven papers considered treatment only, two considered prevention only and the remaining considered treatment and prevention. Twenty-one models evaluated the elderly, including residential populations. Nine were UK papers; five considered treatment only and four considered treatment and prevention. Conclusions: No study assessed the cost-effectiveness in the entire population, only sub-group analyses have been performed. None of the studies considered the impact of policy options over multiple consecutive flu seasons during a lifelong time horizon, and – as a consequence – were not able to incorporate accumulated (Quality Adjusted) Life Years gained for various age groups. Our suggested approach is a one-year cycle length, life-time, multi-cohort, Markov model from the perspective of the NHS, with cohorts starting in different age groups and accounting for at-risk populations.

CONCLUSIONS: Development of a unique database using data from studies conducted during the clinical development and post-marketing of a virosomal aluminium-free hepatitis A vaccine. GlaxoSmithKline Biologicals, Wavre, Belgium

OBJECTIVES: Sustained virological response as patient-relevant endpoint in Hepatitis C?}

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OBJECTIVES: Chronic infection with Hepatitis C virus is causing advanced liver disease in a large proportion of patients. Standard treatment is antiviral therapy which is not curing patients but leads to a sustained virological response (SVR). The objective of the study was to validate SVR in the chronic infection Hepatitis C as patient relevant endpoint as defined by German code of social law. METHODS: Systematic literature searches were conducted in order to find relevant methods for the validation of surrogate endpoints in general and to find studies with appropriate data to perform the validation of SVR as a surrogate parameter in Hepatitis C. The validation will be realised with the best method according to the data available from the selected studies. RESULTS: Five studies were identified as basis for validation (out of 694 papers retrieved and 36 studies selected for further analysis). Due to the lack of long-term studies fulfilling the defined inclusion criteria, no differentiation between antiviral treatment schemes and different stages of the disease were possible. Methods of Prentice were identified as applicable for validation. With the four Prentice criteria, SVR could be validated as a surrogate endpoint for the endpoints liver stages and mortality. However, this was not possible with data from all five studies and only partly with analysis methods (combination) of data. For regression models or meta-analysis, data is not sufficient since individual patient data was not available. For one study further analysis (proportion of treatment effectiveness) could be performed. CONCLUSIONS: When focusing on statistical methods current data allows for a very limited validation of SRV as a relevant endpoint for the endpoint of Hepatitis C, only. There is a lack of long-term data (going beyond 5 years of follow up), especially for individual data of treated and untreated patients, likely due to the slow-evolving character of Hepatitis C.

CM09

MOCKING THE POLICY OF MANAGING SEASONAL INFLUENZA IN THE UK

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OBJECTIVES: Seasonal influenza policy in the UK is directed to the elderly and selected high-risk groups. The Department of Health Policy suggests that these individuals should be vaccinated every year to avoid possible costly or life-threatening complications. To define a cost-effectiveness modelling approach and structure that reflects the season-to-season impact of influenza on the entire UK population, and the consequences of policy decisions. A structured, iterative, literature review and analysis of seasonal influenza models. RESULTS: Fifty-four references were reviewed, 32 were assessed. The vast majority of models are decision trees, considering one influenza season; however, if unit of outcome was life years or QALYs, impact of influenza mortality was incorporated as average life expectancy - foregone life. Most models considered both healthy and at-risk pediatric populations, six were UK models of which three papers considered treatment only and the remaining considered treatment and prevention. Ten models reviewed healthy adult populations only, two were UK models, one considering prevention, the other treatment. Another two other models reviewed adult populations (healthy and/or at-risk adults, excluding healthy working adults), nine were UK models. Eleven papers considered treatment only, two considered prevention only and the remaining considered treatment and prevention. Twenty-one models evaluated the elderly, including residential populations. Nine were UK papers; five considered treatment only and four considered treatment and prevention. Conclusions: No study assessed the cost-effectiveness in the entire population, only sub-group analyses have been performed. None of the studies considered the impact of policy options over multiple consecutive flu seasons during a lifelong time horizon, and – as a consequence – were not able to incorporate accumulated (Quality Adjusted) Life Years gained for various age groups. Our suggested approach is a one-year cycle length, life-time, multi-cohort, Markov model from the perspective of the NHS, with cohorts starting in different age groups and accounting for at-risk populations.