length of stay (LOS) and costs. Results were projected to the national level. Generalized linear models were used for the analysis. Covariates included the baseline patient-level surgical risk factors and hospital characteristics. **RESULTS:** SSI incidence was highest among colon surgery [12.0%, 95%CI:11.78-12.2%0)] and CABG [6.1%; 95%CI:5.88-6.2%)] cases, and lowest among C-section [0.3%; 95%CI:0.28-0.31%)] and vaginal hysterectomy [0.16%; 95%CI:0.13-0.2%)] cases. The projected national rates captured by Premier database were similar to the rates reported by the National Health Safety Network reported rates. Among all surgical procedures, health resource use associated with CABG and colon surgery cases were most affected by SSI. SSI resulted on an average 10.58 [SD 2.78; (95%CI:10.56-10.60)] days and 9.72 [SD 3.43; (95%CI:9.70-9.74)] days of additional LOS and $38,796 [SD $8,555; (95%CI:$38,741-$38,850)] and $19,349 [SD $5,720; (95%CI:$19,315-$19,383)] of additional costs in CABG and colon procedures respectively. **CONCLUSIONS:** Despite rise in infection control practices postoperative SSIs continue to remain associated with significant increases in LOS and hospitalization costs.

PIN37

THE COST OF MANAGING CHRONIC HEPATITIS C IN SWEDEN - MEDICAL RESOURCE UTILISATION IN DIFFERENT STAGES OF THE DISEASE

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OBJECTIVES: Approximately 3% of the global population is infected with the hepatitis C virus. 20% of the patients will develop cirrhosis within 20 years of infection, and these patients have a 1% to 5% risk per year of developing hepatocellular carcinoma (HCC). Standard treatment for hepatitis C is pegylated interferon combined with ribavirin. The objective of this study was to obtain an understanding of the resource utilisation and costs associated with chronic hepatitis C in Sweden. **METHODS:** A literature review was conducted to identify resource utilisation and costs of chronic hepatitis C in Sweden. The MEDLINE, EMBASE, NHS EED and Cochrane CCTR databases were searched. To validate the results of the literature review and fill gaps in the evidence base, interviews were conducted with eight clinicians and one nurse specialised in the areas of infection, gastroenterology or transplantation medicine. The Skåne price list was primarily used to obtain the unit costs. **RESULTS:** Twelve publications were relevant for inclusion in the review. There was a lack of resource utilisation data for certain disease stages, primarily decompensated cirrhosis and HCC, and for updated unit costs, in these publications. Also, no studies reported indirect costs associated with chronic hepatitis C in Sweden. The pooled data from the literature review and the interviews indicated a direct cost per year of EUR 300 for mild disease, EUR 400 for moderate disease, EUR 900 for compensated cirrhosis, EUR 13,000 for decompensated cirrhosis, EUR 20,000 for HCC and EUR 120,000 for liver transplantation (including one-year follow up). **CONCLUSIONS:** Chronic hepatitis C is associated with high rates of health care utilisation. The driver of the direct medical costs is the management of long-term consequences including cirrhosis, HCC and liver transplantation. More efficient therapies with higher cure rates could potentially result in long-term cost savings by reducing severe complications.

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GUIDELINE EVALUATION OF COSTS RELATED TO CHRONIC HEPATITIS C AND ANTIVIRAL TREATMENT STRATEGIES

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OBJECTIVES: Treatment of chronic hepatitis C infection is well established and will be expanded to triple treatment with new drugs like hepatitis C virus (HCV) protease inhibitors in Germany in fall 2011. Costs related to the current HCV guidelines will be a basis for further health economic analyses needed for pricing strategies but are not available yet. The aim of this study is to analyse the costs associated with diagnosis, treatment and monitoring of HCV infected patients according to the 2010 German S3-consensus guideline considering HCV genotype and length of therapy. **METHODS:** Patients with chronic HCV infection were divided in patients with 1) normal transaminases; 2) elevated transaminases; 3) compensated cirrhosis; and 4) decompensated cirrhosis. Direct costs according to the actual 2010 HCV German guideline were analysed for basic diagnostic procedures, monitoring and treatment for patient groups 1-3. Costs were modelled according to treatment duration (16 to 72 weeks) depending on the sustained viral response and HCV genotype. Costs were calculated according to the German outpatient fee scale EBM-2010. **RESULTS:** Costs for basic diagnostics including determination of HCV genotype and diagnosis of potential hepatic comorbidities accounted for €401 per patient. Monitoring costs accounted for €596 – €1173 depending on length of therapy. Pharmaceutical costs accounted for the largest part of the costs (€7,709 – €34,692). The total costs of a 16-week treatment including basic diagnostics, monitoring and pharmaceutical costs accounted for €8,706, €12,734 for a 24-week treatment, €24,529 for a 48-week treatment and €36,266 for 72-week treatment. **CONCLUSIONS:** State of the art and guideline cost evaluation for treatment of HCV infection show high costs for optimal and viral response guided therapy. These data can be used for further investigation of real life costs and costs of new triple treatment strategies in HCV treatment.

PIN39

COST ANALYSIS OF ANTIBIOTIC THERAPY OF ACUTE PERITONITIS IN UKRAINE

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OBJECTIVES: The cost analysis of ten schemes antibiotic therapy (AT) in patients with acute peritonitis was conducted. These schemes are recommended by the Clinical Protocol of acute peritonitis treatment (MHO of Ukraine, order 1297, 02.04.2010) for use in practice. **METHODS:** The schemes of antibacterial therapy are: I – ertapenem (1,0 gr intravenously (iv.) 1 time/day); II – cefotaxim (1,0 gr im. 3 times/day and metronidazol 100 ml (sol. 0,5%) iv. 2 times/day); III – amoxicillin clavulanate (1,2 gr 3 times/day); IV – moxifloxacin (400 mg 1 time/day); V – levofloxacin (500 mg iv. 1 time/day and metronidazol 100 ml (sol.0,5%) iv. 2 times/day); VI – cefepim (2,0 gr iv. 2 times/day and metronidazol 100 ml (sol.0,5%) iv. 2 times/day; VII – cefoperazone + sulbactam (2,0 gr 3 times/day); VIII – meropenem (500 mg iv. 4 times/day); IX – imipenem + cilastatin (500 mg/500 mg iv. 4 times/day); X – ciprofloxacin 400 mg iv. and metronidazol 100 ml (sol.0,5%) iv. 2 times/day. Three variants for each scheme were calculated: the schemes with original drugs, the schemes with generics and the schemes with ukrainian generics. Doses and duration of AT were calculated in accordance with the Clinical Protocol of acute peritonitis treatment. **RESULTS:** The costs range of treating one patient with acute peritonitis with original drugs is 3891 UAN (scheme I) - 7994 UAN (scheme VI). The costs range with generics of ukrainian production is 1924 UAN (scheme V) - 5413 UAN (scheme VIII) (1 EUR = 11,65 UAN). **CONCLUSIONS:** The costs of treatment schemes for patients with acute peritonitis with use of less expensive generic drugs are not always cheaper than the costs of original drugs using. The optimal schemes for treatment of patients with acute peritonitis were selected.

PIN40

LINEZOLID VERSUS VANCOMYCIN FOR SKIN AND SOFT TISSUE INFECTIONS BY METHICILIN-RESISTANT STAPHYLOCOCCUS AUREUS: A COST COMPARISON ANALYSIS UNDER THE PUBLIC HOSPITAL PERSPECTIVE IN BRAZIL

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OBJECTIVES: Seventy-nine percent of the skin and soft tissue infections (SSTI) are caused by staphylococcus aureus, from which 1/3 is methicilin-resistant staphylococcus aureus (MRSA). This study aims to compare SSTI-MRSA treatment costs with linezolid versus branded and generic vancomycin under the Brazilian public payer perspective. **METHODS:** A cost comparison study was performed to compare linezolid versus generic and branded vancomycin. As supported by clinical studies, overall treatment duration of 15 days with linezolid and 14 days with vancomycin was considered, using PO linezolid after a minimum 4-days cycle of IV infusion while vancomycin (1g bid) was entirely IV. A decision-tree model simulated SSTI-MRSA treatment assuming linezolid (600mg bid) IV can be switched to PO after 4-days and patients can be discharged if PO is implemented at physician discretion. Length of stay (LOS) and IV linezolid duration were ranged in one-way sensitivity analysis. Only direct medical costs were included in the analysis (hospital charges, medical visits, medical supplies and drug acquisition costs) and unit costs were obtained from Brazilian official price lists (2010 USD values). **RESULTS:** The linezolid scheme with 4-days IV (LOS=4 days) and 11-days PO resulted in overall costs per patient of 2,540 USD, while branded and generic vancomycin exhibited 3466 USD and 3663 USD, respectively. The incremental cost of vancomycin-treated patients was driven by hospital daily charges, responsible for over 60% of the overall vancomycin costs. One-way sensitivity analysis revealed cost-savings for linezolid up to LOS≥9 days, with overall costs per patient ranging from 2540-4548 USD even if IV therapy was maintained throughout the inpatient period (LOS=15 days). **CONCLUSIONS:** Linezolid exhibited a cost-saving profile over branded or generic vancomycin for the treatment of SSTI-MRSA under the Brazilian public payer perspective. This economic benefit was a direct result of potential early discharge of patients receiving PO linezolid.

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COST-BENEFIT ANALYSIS OF REGIONAL PROCURED ESSENTIAL MEDICINES IN THE SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADC) WITH A FOCUS ON ACCESS TO ANTIRETROVIRAL DRUGS

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OBJECTIVES: SARPAM is a programme, designed to ensure the improvement of access to quality essential medicines in SADC. An economic appraisal was undertaken from a societal perspective to assess the economic feasibility of SARPAM's implementation. The evaluative framework considered elements linked to improved access to quality medicines which included regional procurement of ARVs. The objective was to report the positive impact of this initiative on access to health care. **METHODS:** Direct health care costs were estimated as the incremental investment needed to effectively implement regional cooperation processes over a 4 year period. Direct healthcare benefits were defined as the *"negative costs"* incurred due to monetary savings and rational drug use. These savings were based on the well-established advantages of regional procurement cooperation. Indirect health care benefits were estimated using the Human Capital Approach. **RESULTS:** In total, an investment of US$14 million in SARPAM (discounted at a rate of 4.5%) over a four-year period will result in overall benefits of between US$20 million to US$38 million. The resultant benefit-cost ratio ranges from 1.40: 1 to 2.72: 1. In terms of HIV/AIDS in South Africa in particular, the analysis estimated a *potential* maximum incremental benefit of US$147 million which could treat an additional 757,000 patients with first line treatment. These results confirm that major benefits might be derived from the SARPAM programme, including a regional procurement cooperation intervention of ARVs. **CONCLUSIONS:** There is compelling evidence that the