use of ivabradine leads to a total cost saving of €4826 per patient over 5 years. The use of ivabradine also leads to a higher effectiveness, as it reduces the average number of revascularisation procedures from 1.100 to 0.143, including the initial revascularisation procedure for the standard care arm of the model. The number of revascularisations during the 5-year period is about similar, when excluding the initial revascularisation procedure (0.100 to 0.143). Sensitivity analyses show that ivabradine remains cost saving over the complete range of the input variables. CONCLUSIONS: Ivabradine is a cost-effective treatment and, in fact, a dominant treatment: Ivabradine yields to a higher effectiveness as standard treatment with respect to number of revascularisations, but leads to substantial overall cost savings.

PODIUM SESSION II: ECONOMIC EVALUATIONS II

EE5

COST-EFFECTIVENESS OF ATORVASTATIN IN TYPE 2 DIABETES PATIENTS: A PHARMACO-ECONOMIC ANALYSIS OF THE COLLABORATIVE ATORVASTATIN DIABETES STUDY (CARDS) IN THE BELGIAN POPULATION

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OBJECTIVES: To estimate the cost-effectiveness of atorvastatin 10 mg compared with no treatment for the primary prevention of cardiovascular (CV) events in Type 2 diabetes patients with no CV history. METHODS: A Markov model with 1-year cycles was developed to simulate the CV event and death risk according to the therapeutic approach initiated. The transition probabilities for CV event in the 'no statin treatment' group were derived from the risk-equations reported from the large UK Prospective Diabetes Study (UKPDS). The hazard ratio (HR) from the CARDS clinical trial (0.63; 95% confidence interval [CI], 0.48, 0.83; P = 0.001) was used to adjust these CV event probabilities in the atorvastatin 10 mg treatment group. Characteristics of Type 2 diabetes patients with no CV history were derived from the Belgian Optimize Cardiovascular Prevention in Diabetes (OCAPI) survey. The public health care payers’ perspective was taken into account for costing. The direct medical costs of CV events were based on the Public Health Authorities’ hospital database for acute care costs and on literature for follow up costs. Drug cost did consider the impact of generic entry on the reimbursement system. Costs and outcomes were respectively discounted at 3% per annum. Univariate and probabilistic sensitivity analysis was performed to evaluate uncertainty. RESULTS: The addition of atorvastatin to chemotherapy increased QALYs by 1.223, 1.034, 0.858 and 0.471 years for MCP, CVP, CHOP and CHVP, respectively, compared to chemotherapy alone. The incremental cost per QALY gained was £5620, £6455, £7970 and £8422, for MCP, CHOP, CVP and CHVP, respectively, all below commonly used thresholds in the UK. Sensitivity analyses indicated these results were robust, and most sensitive to the duration of treatment effect. CONCLUSIONS: For all chemotherapy regimens evaluated, the model demonstrated the addition of atorvastatin increased quality-adjusted life expectancy and is a highly cost-effective treatment option for patients with advanced FL.

ECONOMIC ANALYSIS OF PROPHYLACTIC CERVICAL CANCER VACCINATION IN ITALY: THE NATIONAL AND REGIONAL LEVEL

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OBJECTIVES: The impact of cervical cancer prevention, through 12-year-old female vaccination with Cervarix™ (GlaxoSmithKline), has been published for many countries at the national level. However, to our knowledge no attempt has been made to address the impact at a regional level. Since the Italian health reforms of the early 1990s, introducing “managerialism”, decentralization and quasi-market mechanisms; regional authorities have consequently been experimenting with different organizational and funding models to achieve an acceptable combination of equity, efficiency, freedom of choice and cost-containment. METHODS: A Markov model, previously described and successfully adapted to the national scenario (La Torre, 2007), has been used to explore the impact of prophylactic cervical cancer vaccination with Cervarix™ at a regional level in Italy. Resource use was based on a standard therapeutic path applied to all regions. However we quantified the impact of the so-called “decentralization progress” by collecting regional data on: Pap-test coverage, tariffs for treatments and cost of the vaccination course. The analyses were combined with regional budget impact analyses, considering the demography and the effective tender price for each region. RESULTS: Our analyses demonstrated the heterogeneity present at regional level in Italy (e.g. regular screening, ranges from 36% to 84%; cost of cervical...