OUT OF POCKET EXPENSES FOR BREAST CANCER SURVIVORS: DIFFERENCES BY TIME SINCE DIAGNOSIS IN A RURAL POPULATION

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OBJECTIVES: The out-of-pocket (OOP) expenses for care related to breast cancer can be burdensome for survivors. We know little about the kind and amount of OOP for survivors’ care, health maintenance and management of side effects. The objective is to report on expenses in 150 participants in the Rural Breast Cancer Survivor Intervention (RBCSI), a clinical trial evaluating a psychoeducational quality of life intervention. METHODS: Breast cancer survivors recruited for the trial were 1-3 years post diagnosis, at least 21 years old and residing in rural Florida. OOP data collected from bar charts included expenditures for: Biologic Therapy, Home Care (medical supplies, medicines, cook, clean, clothing, additional maintenance or child care). We report mean monthly costs for the period from diagnosis to baseline. RESULTS: Of 150 mostly white women, 91.3% were insured, 30.0% had incomes > $50,000, and 60.7% were >24 months post diagnosis. A total of 94.7% reported OOP spending (mean 119.6, median 53.16). Medical Care costs and Home Maintenance costs were highest, 129.3 and 87.6, respectively, for women 25-36 months post diagnosis. Medical Care costs were lowest for women >49 months post diagnosis, 33.7, and Home Maintenance costs were lowest, 15, for women 10-24 months post diagnosis. CONCLUSIONS: Rural breast cancer survivors continue to have OOP costs related to their disease years after diagnosis. Understanding how and how much they spend is important information to be considered in cost-effectiveness analyses of interventions to improve their quality of life.

MORTALITY COSTS FROM GENITAL CANCERS IN MEN—UNITED STATES, 2004

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OBJECTIVE: To estimate mortality costs measured as years of potential life lost (YPLL) and productivity loss in 2004 due to deaths from all cancers and from genital cancers specifically among men in the US. METHODS: To estimate YPLL, we used 2004 national mortality data and life tables by multiplying the number of deaths and average remaining life years for specific age groups. To estimate lifetime productivity loss, we applied the human capital approach by multiplying the number of deaths by the expected value of decedents’ future earnings estimated using the American Time Use Survey, accounting for both the market value and the imputed value of housekeeping services. We calculated results for age and racial/ethnic groups and for four categories of male genital cancer (prostate, bladder, testicular and all others). Results: In 2004, 4.5 million YPLL attributable to deaths from all cancers among US men. Prostate cancer accounted for 94.2% of the YPLL, and testicular cancer accounted for the highest average number of YPLL per death (37.9). Non-Hispanic whites accounted for 75.9% of the YPLL from male genital cancer deaths, and non-Hispanic blacks had the highest YPLL rate (297,010,000 men). Overall, genital cancers had the highest relative contribution to YPLL among men aged ≥50 years compared to other age groups. In 2004, the estimated lifetime productivity loss due to deaths from male genital cancers was $5.4 billion, 5.7% of the estimated $97.9 billion loss due to deaths from all cancers among US men. CONCLUSIONS: Male genital cancers impose a considerable health and economic burden in terms of premature deaths and productivity loss in the United States.

RETROSPECTIVE COST AND OUTCOME ANALYSIS OF BREAST CANCER PATIENTS TREATED IN A BRAZILIAN OUTPATIENT CANCER CENTER (OCC)

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OBJECTIVES: To determine the cost and outcome related to breast cancer patients treated in a Brazilian OCC in Rio de Janeiro, Brazil. METHODS: This is a retrospective study of women with breast cancer treated at a private practice OCC in Rio de Janeiro, Brazil. All patients were covered by Aami, a Brazilian HMO. Direct costs (DC) of 199 patients diagnosed since 2002 and followed to the end of 2009 were analyzed and correlated to clinical stage. We used Kaplan-Meier method to analyze patients’ outcome. RESULTS: Forty-eight percent of women were diagnosed in stage I, 34% patients in stage II, and only 2.5% were diagnosed in stage IV, similar numbers to those seen in developed countries. The average DC of their medical care per patient was 21,658.94 USD for stage I compared to 48,295.29 USD for stage II, and were 63,662.06 USD for stage III and 63,697.33 USD for stage IV. We also observed that the average DC per patient-year increased according to clinical stage. In the first year, average cost was 15,183.85 USD for stage I, while it was 44,160.74 USD for stage IV. Those DC decreased along the years in all stages. For example, in the seventh year of follow-up, the average DC was only USD 467.27 for stage I (2005 purchasing power index 1 USD = 1.4 BRL). The 5-year overall survival and progression free survival were 100% and 100% for stage I, 92.2% and 91.9% for stage II, 87.5% and 82.1% for stage III, and 60% and 60% for stage IV, respectively. CONCLUSIONS: Breast cancer accounts for a significant part of the health insurance budget. Later stage at diagnosis is associated with higher DC per patient-year of treatment, and lower probability of disease-free survival.