must have at least 1 prior MDD diagnosis (ICD-9-CM: 296.2 or 296.3), but no prior diabetes (ICD-9-CM: 250.xx) or bipolar disorder (ICD-9-CM: 296.4-296.8x) diagnosis. The non-duloxetine patients were matched to the duloxetine patients via propensity scoring (1:1 ratio), controlling for differences in demographics, comorbid conditions, prior treatment, and pain levels in the 12 months pre-index periods. Propensity scores were used to compare health care utilization over the 12 months post-index period including outpatient visits, emergency department (ED) visits, hospital admissions and length of hospital stay. Chi-square tests were used to compare percentages of patients with hospitalization or ED visit. RESULTS: The study sample included 878 patients (duloxetine: n = 439; non-duloxetine: n = 439) with comparable baseline characteristics. Compared with duloxetine patients, non-duloxetine patients on average had 12.0 more outpatient visits (95% Confidence Interval [CI]: 1,477-1,515), 0.16 more hospital admissions (CI: 0.07-0.26, p = 0.001), and 0.79 more hospital days (CI: 0.17-1.41, p = 0.013). Additionally, a higher percentage of non-duloxetine patients was hospitalized (17.8% vs. 10.9%, p < 0.004). No group difference was found in ED visits. CONCLUSIONS: Controlling for cross-cohort differences, the 2 patient groups were matched to ensure comparability. Maintenance associated with lower health care utilization compared with those treated with antidepressants.

A DYNAMIC MARKOV APPROACH ASSESSING THE BURDEN OF ILLNESS OF GENERALIZED ANXIETY DISORDER (GAD) IN CANADA

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OBJECTIVES: GAD is a chronic disease with waxing and waning of symptoms; exerting substantial economic and humanistic impact. To date, economic evaluations have been limited, despite ongoing horizonsof <12 months in duration. The study aimed to: 1) model the course of GAD over a patient's lifetime and quantify COI. Absenteeism contributes substantially to the COI. This is the first known study to model the course of GAD over a lifetime. Pharmaco-economic models are useful for understanding disease burdens and cost of illness. OBJECTIVES: To develop a comprehensive pharmacoeconomic model that quantifies the lifetime cost-of-illness (COI) for GAD (direct and indirect costs). METHODS: TreeAge® software was used to develop an incidence-based Markov model with 9 health states (6-month cycles): Family physician assessment, treatment decision assessment for 2nd and 3rd line therapeutic options, maintenance therapies, Treatment discontinued and Death (absorbing). Patients seeking treatment entered the model between the ages of 18-80 and subject to age of onset. Pharmacotherapy was based on Canadian Psychiatric Association (CPA) guidelines; revised and validated by an expert panel. Meta-analysis of CPA-cited evidence population distribution and response rates. Published literature determined absenteeism, treatment discontinuation, onset of illness, and relapse rates. Physician, pharmacotherapy, hospitalization costs based on published public (Province of Ontario) rates. All cause mortality (2000-2002) and hourly wage rates (2008) were published by Statistics Canada. COI was reported in 2008 Canadian dollars, discounted at 5%. A total of 10,000 iterations were used for 1st order micro-simulation. RESULTS: Mean lifetime COI patient = $6671(SD = $4678), Mean age of onset = 48 years. Mean (SD) tracker values: Relapse patient = (1.02), Treatment resistant patients = 20% (40%); Discontinued treatment time = 1388 years. Absorbing state (Death) captures 99% of patients. The range of uncertainty for relapse (1-5%) and cost of absenteeism ($0-$6071) exerted the highest impact of all variables on mean COI $5,000-$8,000 and $1,000-$12,000 respectively. Breakdown cost analysis: 52% absenteeism, 8% pharmacotherapy, 7% physician, 2% hospitalization. 95% of all patients discontinued treatments. CONCLUSIONS: This is the first known study to model the course of GAD over a patient's lifetime and quantify COI. Absenteeism contributes substantially to the COI for GAD. Relatively low attribution of pharmacotherapy cost to COI possibly due to treatment discontinuation.

A SYSTEMATIC REVIEW TO IDENTIFY STUDIES PUBLISHED IN ENGLISH REGARDING THE COST OF SCHIZOPHRENIA IN FRANCE

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OBJECTIVES: Bipolar disorder (BD) is a long-term condition that has a high impact on patients, families, health care systems and society. One of the main challenges in mental health is to determine the burden associated with it. The purpose is to establish the different perspectives and measures used to assess the burden of BD. METHODS: A systematic review was performed to identify studies in PUBMED, MEDLINE, EMBASE and Cochran library. The search strategy used the MeSH terms: “bipolar disorder” & “cost of illness”, combined with “burden of disease”, “disability”, “burden of illness”. There weren’t constraints on date or language. Titles and abstracts were examined by reviewers, selecting for inclusion articles reporting an explicit aim to evaluate the burden of BD, measured by prevalence, morbidity associated with BD, quality of life, disabilities, impairments and/or costs. Articles were classified into 4 categories, depending on focus studied: 1) patients; 2) caregivers (family, partners); 3) health care-system; and 4) society. RESULTS: A total of 188 articles were identified, 32 met study criteria. Eleven studies were reviews, and 21 were manuscripts, classified as 53.1% caregivers (n = 12), 28.2% health care-system (n = 5), 32.1% patients (n = 5) and 3.1% society (n = 1). The main outcome measures were: distress and subjective burden in caregivers scope, costs in health care-system, morbidity in patients and a set of all (prevalence, patient-related issued, disabilities and costs) in society. CONCLUSIONS: Concept of burden of disease varies depending on the studies perspectives and researchers concern. Our study suggests that the main interest when evaluating the burden of BD is focused on assessing the impact of the disease on relatives. As BD causes a high level of impairments and disabilities, that affects specially to caregivers, costs associated with it are difficult to estimate. Additional research is needed in order to determine them properly.

COVARIATES ON THE INCIDENCE AND TERAPY NON-ADHERENCE IN SCHIZOPHRENIA PATIENTS

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OBJECTIVES: Data concerning costs of illness in patients with schizophrenia are scarce. Aim of this claims data analysis was to examine the costs of schizophrenia from the perspective of a major statutory health insurance fund. METHODS: A nation-wide database was used to evaluate the costs of schizophrenia in 2006. All patients with schizophrenia (ICD F20) were identified via a special algo-rithm based on claims data. All schizophrenia related costs for outpatient care, inpa-tient care, medications, rehabilitation, occupational therapy, and sick leave payments were evaluated. RESULTS: Data from 31,513 patients were available, with 47% being female (and 46 years of age). Mean costs of EUR 4,966 in the year 2006 were incurred from the health insurance perspective. A total of €2924 (59 %) were incurred by inpatient care, and €1333 (27 %) were due to medication. A total of €421 (8 %) resulted from schizophrenia related outpatient psychological specialists visits. Costs