Costs were estimated by the UNU-Casemix Group (UNU-CBG) system, a top-down costing system developed by the United Nations University-International Institute for Global Health and National University of Malaysia. The above-mentioned health care system was used in the countries included in this study. An episode of inpatient care for any condition was defined as all treatments provided by the hospital from the time of admission until discharge. Length of stay and cost per acute episode of MI were estimated for patients who survived for at least 1 year. The two most commonly prescribed drugs for the treatment of arrhythmia, across 6 countries (EU top 5 and US) were compared with respect to the cost of treatment for amiodarone and propafenone, the two most commonly prescribed drugs for the treatment of arrhythmia, across 6 countries (EU top 5 and US).

OBJECTIVES: To estimate the 1-year direct and indirect costs of ischemic stroke in Chinese patients with atrial fibrillation (AF). METHODS: A cost-of-illness study was conducted through hospital chart review and a patient follow up survey. Costs were estimated from the societal perspective. Three hospitals selected from 12-tier-1 hospitals and 6-tier-2 hospitals in 6 cities across China were randomly selected and reviewed for cost of stroke during hospitalization from patients discharged from January, 2009 to December, 2010 (discharge diagnosis of both, ischemic stroke, and AF). Of those, 50 patients were followed up to collect the long-term direct and indirect costs related to ischemic stroke in the year following discharge. RESULTS: We report here results from two hospitals (N = 30): patients had a mean age of 75 years and mean length of stay of 16 days (95% CI = [14, 19], females accounted for 43%. The mean time interval between stroke onset and hospitalization was 24 hours (95% CI = [14, 33]). The cohort scored on average 3 points (95% CI = [2, 4]) on the CHADS2-VASc, indicating a high risk of stroke considering patient demographics and disease history. Average total 1-year costs of stroke management were estimated at 19,560.01 RMB (2010 costs; 9451.90 US$), almost all of which was attributable to direct costs. Costs of inpatient care dominated direct costs, representing 90.3% of the total direct costs. Average total costs during hospitalization were estimated at 17,659.91 RMB (95% CI = [13,538.39, 21,780.23], 62.5% of which was attributable to medication: CONCLUSIONS: The findings indicate that ischemic stroke among AF patients are associated with high direct costs, imposing a considerable burden on society. Hospital costs are the predominant contributor, consistent with the current pattern of care in China, where patient care is usually provided via hospitals.

PV38  VENOUS THROMBOEMBOLISM: A REFINED UNITED STATES COST MODEL WITH LONG TERM ATTACK RATES

Weisinger AD1, Borrego M2, Spyropoulos AC2, Mahan CE2

1University of New Mexico College of Pharmacy, Albuquerque, NM, USA, 2University of Rochester Medical Center, Rochester, NY, USA, 3New Mexico Heart Institute, Albuquerque, NM, USA

OBJECTIVES: To develop United States (US) cost model estimates for venous thromboembolism (VTE), combined with deep vein thrombosis (DVT) and pulmonary thromboembolism (PE). Total US costs were calculated as well as hospital-acquired, "preventable", and indirect VTE costs. METHODS: A literature review was performed to determine VTE incidences, morbidity probabilities, case-fatality rates, and direct medical and indirect costs. Indirect costs were derived from present value of lifetime earnings (PVLE) due to premature death. Two decision trees mapping PE and DVT outcomes were developed, and cost models were constructed in Microsoft Excel. The decision trees first contain primary VTE characteristics and outcomes: hospital- or community-acquired, fatal versus non-fatal, readmission/recurrence versus no recurrence, and instant versus non-instant death. Indirect survival patients are at risk for associated morbidities: minor bleed; major bleed, heparin induced thrombocytopenia; chronic thromboembolic pulmonary hypertension; post-thrombotic syndrome, and resolution or no resolution of symptoms or death. The average patient’s cost, the sum of each decision tree pathway’s probability-weighted cost, were multiplied by low and high annual PE and DVT incident events to determine total cost ranges. All costs were adjusted to 2011 US dollars. Two multi-way sensitivity analyses were conducted: one analysis has higher probabilities and lower strength of the second stage pathways; the other analysis has lower probabilities and stronger second stage pathways; the other analysis has lower probabilities and stronger second stage pathways. RESULTS: US Annual total base case (LTAR sensitivity analysis), hospital-acquired, preventable, and indirect VTE cost range from $13.4-27.0 ($15.3-34.3) billion, $8.9-18.0 ($10.2-25.3) billion, $4.5-16.0 ($5.1-12.7) billion, and $4.5-9.8 ($5.6-11.7) billion, respectively. PE comprises the majority of VTE costs. Indirect costs due to PVLE represent at least 33% of total VTE costs. CONCLUSIONS: The United States could avoid substantial costs, morbidity and mortality if effective VTE prophylactic strategies were implemented. This attainable goal would contribute to important health care reform.

PV39  DETERMINANTS OF PHARMACEUTICAL EXPENDITURES FOR PATIENTS WITH HYPERTENSION

Cai H1,2,3,4,5

1School of Pharmacy, University of Utah, Salt Lake City, UT, USA

OBJECTIVES: Using longitudinal data, this study examined the determinants of pharmaceutical expenditures for patients with hypertension, and the impact of lifestyle and marriage status changes on pharmaceutical expenditures. METHODS: The 1986 Utah national household perspective three waves described physician practice and prescription drug cost data of Medical Expenditure Panel Survey (MEPS) for year 2008 and 2009 were employed. Five rounds of the survey were conducted for Panel 13 households between years 2008 and 2009. Only round 3 and round 5 surveys were used for this work because BMI values were successively updated. I included individuals older than 18 years, not pregnant, with hypertension but no other comorbid conditions, and who had obtained a prescription for antihypertensive agents for essential hypertension (ICD-9 code 402). The final panel data contained 1814 observations, among which average age was 53.65 years (SD = 13.49), the average age at the time of hypertension diagnosis was 44.22 (SD = 13.43) years, 49.91% (SD = 0.50) were male. Ordinary Least Square and Mixed Fixed Effect Model were employed to investigate the determinants of