from interviews with practising Spanish GPs and psychiatrists. Costs from official price/salaries lists were applied. Model outcomes included total treatment costs, quality-adjusted life years (QALYs) and symptom-free days (SFD). The robustness of findings was assessed in sensitivity analyses. RESULTS: In primary care, incremental cost per QALY for duloxetine vs Venlafaxine XR was €29,457 and for duloxetine vs SSRIs was between €11,867–€21,957 (extreme values vs paroxetine and fluoxetine, respectively). Incremental cost per SFD was 13€ vs. Venlafaxine XR and ranged from 14€ to 26€ vs. paroxetine and fluoxetine respectively. In secondary care duloxetine was dominant vs. all the drugs except for the comparison with fluoxetine (cost per QALY gained was 650€ and cost per additional SFD was 1€). Results were sensitive to changes in the trial remission and response rates, and in the distribution of switch therapy options. CONCLUSION: Duloxetine showed a reasonable cost-effectiveness ratio vs. the comparator drugs and could therefore be considered a cost-effective treatment for MDD patients in primary and secondary care in Spain.

PMH28
A PHARMACOECONOMIC EVALUATION OF ESCITALOPRAM VS. PAROXETINE IN THE TREATMENT OF GENERALIZED ANXIETY DISORDER IN NORWAY
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OBJECTIVES: To assess the cost-effectiveness of escitalopram versus generic paroxetine in the treatment of generalized anxiety disorder (GAD) in Norway. METHODS: Cost-effectiveness analysis was based on a decision-tree model, reflecting the current guidance for the treatment of GAD. Escitalopram 10–20 mg/day was compared to paroxetine 20–50 mg/day, the only SSRIs licensed for the treatment of GAD in Norway. Initial treatment started in primary care; failure to respond to a second-line SSRI after switch from initial treatment resulted in referral to a psychiatrist. The evaluation was performed over a 9-month time horizon. Model data sources included published clinical trials and standard national data sources. The main effectiveness outcome was first-line treatment success, defined as a response after 12 weeks of treatment (≥50% reduction in HAM-A) and absence of relapse during the following 24 weeks. Other outcomes included quality-adjusted life years (QALYs), rate of maintained treatment response (response at week 12 maintained at week 36) and rate of referrals to secondary care. The analysis was performed from the societal perspective and evaluated direct treatment costs, including out-of-pocket payments and costs covered by health insurance. RESULTS: Patients treated with escitalopram had 11.3% higher first-line success and 5.4% higher maintained response rates compared with paroxetine-treated patients. Rates of referrals to secondary care were 5.5% lower with escitalopram compared with paroxetine. Per patient direct treatment costs associated with escitalopram and paroxetine treatment amounted to NOK 4424 and NOK 4172, respectively. Incremental cost-effectiveness ratio (ICER) was NOK 2,230 per first-line treatment response and NOK 37,612 per QALY. Sensitivity analyses demonstrated robustness of the model to changes in key input parameters. CONCLUSION: Escitalopram appears to be cost-effective compared with paroxetine in the treatment of GAD in Norway, based on direct treatment costs.

PMH29
SWITCHING FROM BRANDED TO GENERIC RISPERIDONE IN PATIENTS WITH SCHIZOPHRENIA: AN ESTIMATION OF POTENTIAL ECONOMIC CONSEQUENCES IN THE NETHERLANDS
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OBJECTIVES: The oral variant of the antipsychotic drug risperidone will lose patent protection at the end of 2007, which opens the market for generic variants. However, since many schizophrenic patients suffer from paranoia, some of them will be less willing to take a different drug. Switching might therefore cause non-compliance, which is in its turn the most important predictor of relapse and hospitalisation in schizophrenia. We therefore made an estimation of potential economic consequences regarding drug and hospitalisation costs when stable patients in The Netherlands currently using branded risperidone are switched to the generic version. METHODS: A simple health economic model was developed, based on published data regarding hospitalisation durations, rates of compliance, relapse, and additional relapse resulting from switching to generics. A one-year perspective was applied. RESULTS: Due to a somewhat higher relapse rate after switching to generics in the first year after the switch, total per-patient drug and hospitalisation costs were estimated to be higher for the generic product as compared to the branded product (€5110 and €4680, respectively). Sensitivity analyses showed the stability of the relative result. CONCLUSION: Switching patients who are stabilised on branded risperidone to the generic version might cause higher health care costs. The analysis is dependent on assumptions, but given their evidence-based character, there is sufficient reason to believe that the relative result will hold in countries where only a little difference will exist between the price of branded and generic risperidone after the patent expiry.

PMH30
DIRECT COSTS ASSOCIATED WITH MILD COGNITIVE IMPAIRMENT IN PRIMARY CARE
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OBJECTIVES: Little is known about the direct costs of individuals with mild cognitive impairment (MCI). This study investigates the direct costs associated with MCI according to recent diagnostic criteria from a societal perspective. METHODS: A total of 452 primary care patients aged 75+ from Leipzig, Germany, were investigated in face-to-face interviews regarding MCI according to the current diagnostic criteria of the International Working Group on MCI, resource utilisation and costs (cost diary), as well as chronic medical illness (Chronic Disease Score). Resource utilisation was monetarily valued using 2004/2005 prices. RESULTS: Mean annual direct costs were EUR 4443 for patients with MCI (N = 39) and EUR 3,814 for patients without MCI (N = 413) (p = 0.34). Looking at the cost components, patients with and without MCI only significantly differed regarding pharmaceutical costs (EUR 1210 vs. EUR 1062; p < 0.05) not caused by antidepriment drugs. CONCLUSION: Direct costs of individuals having MCI are not significantly increased in comparison to direct costs of individuals without cognitive deficits.