the validated, Canadian risk scoring model were sensitive to
the resulting variation in RSV-related hospitalization rates. In
instances where risk was low, palivizumab was not cost-effective.
However, for infants with at least moderate risk (2 or more risk
factors), palivizumab had incremental costs per QALY that indi-
cated moderate to strong evidence for adoption (range: $1,598 to
$30,819 per QALY). CONCLUSION: Palivizumab was cost-
effective and our model supports prophylaxis for infants born at
32 to 35 weeks GA, particularly those with moderate risk of
RSV.

WITHDRAWN PIH12

A CONCEPTUAL FRAMEWORK TOWARD A MODIFIED
REFERENCE CASE FOR DEVELOPING COUNTRIES:
INCORPORATING DONOR FUNDING FLOWS IN
COST-EFFECTIVENESS ANALYSIS
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To make appropriate use of the growing economic evidence
base in health care, developing countries need applications rele-
vant to their own national health objectives. One objective is
protection for individuals and governments against the financial
risks of ill health, more critical in low-resource settings. Yet,
advancements in cost-effectiveness analysis (CEA) have not
focused on the importance of efficiency in contributing to this
goal. The lowest income nations also rely heavily on external
funds from donor countries and organizations. While the recent
emergence of non-traditional donors has greatly increased
funding levels for global health, the large scale, narrow focus
and time limitations of some of the funding have also raised
questions of their effects on national health priorities as well as
on the opportunity costs of the interventions supported by this
funding. In attaining efficiency with a view towards minimizing
financial risk, CEA must address two issues in this case: that the
additional resources are efficiently allocated and that the
resources themselves are not a source of financial risk. This
doctoral project proposes a conceptual framework for a CEA
“reference case” in the broader context of health financing in
developing countries. Suggested modifications of the prevailing
reference cases are literature-based, iteratively guided by key
informants. Costing and sensitivity analysis with respect to
external funding are highlighted. An application to the intro-
duction of rotavirus immunization illustrates the framework.
The conceptual framework anticipates the imminent introduc-
tion of expensive new vaccines targeted at resource-poor, donor-
dependent health systems. It allows analysts and policy-makers
to harmonize efficiency and financial risk objectives. It also
helps donors in assessing aid effectiveness of assisted programs.
Ultimately, this framework improves the transferability and gen-
eralizability of existing CEA results by suggesting adjustments
relevant to developing countries.

ECONOMIC EVALUATION OF ATOSIBAN VERSUS
BETA-MIMETICS IN THE TREATMENT OF PRETERM LABOUR
IN GERMANY
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OBJECTIVE: Treatment of preterm labour constitutes in-vari-
able inpatient cost, and use of tocolytics is central in delaying
birth to allow neonatal lungs to mature. The study aimed to
compare cost implications of adverse events following tocolysis
with atosiban and beta-mimetics. METHODS: Major literature
databases were systematically searched to identify randomised
clinical trials comparing atosiban with beta-mimetics during the
initial 48 h of hospitalisation. Adverse events data from three
double blind trials were included in a meta-analysis. Clinical
resource use was determined based on routine practice in a
regional German hospital. Cost of drug treatment was calculated
based on trial protocols and German hospital drug purchase
costs; analysis was performed for fenoterol, the only beta-
imetic licensed in Germany for tocolysis. Costs per case were
calculated with G-DRG Grouper. Costs were expressed in €2007.
RESULTS: Use of atosiban was associated with significantly
lower frequency of adverse events compared to beta-mimetics.
From the payer’s perspective, cost-saving from using atosiban
versus fenoterol was €423 per patient starting treatment. From
the hospital’s perspective, savings from using atosiban versus
continuous fenoterol ranged from €259 for 18 hours of tocolysis
to €105 for 48 hours; the respective values for bolus fenoterol
were €244 and €55. From the combined perspective, using
atosiban versus continuous fenoterol saved from €226 for 18
hours of tocolysis to €71 for 48 hours; versus bolus fenoterol the
results were €211 and €21, respectively. In the probabilistic sen-
sitivity analysis atosiban was cost-saving versus both continuous
and bolus fenoterol in 100% of iterations at 18 hours and in at
least 87% of iterations at 48 hours. CONCLUSION: Atosiban
was cost-saving versus beta-mimetics in the treatment of preterm
labour in Germany from the payer’s, hospital’s and combined
perspectives. The results were robust in the probabilistic sensi-
tivity analysis.

STUDENT PHARMACIST INTERVENTIONS LEAD TO COST
MINIMIZATION OF MEDICARE PART D PRESCRIPTION DRUG
PLAN COSTS
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OBJECTIVE: Given the complexity of the Medicare Part D
(MPD) prescription drug benefit, many Medicare beneficiaries
lack the knowledge and experience to select optimal MPD pre-
scription drug plans. This challenge is exacerbated in low-income
and other vulnerable populations. A Cost-Minimization Analysis
(CMA) was performed to determine whether and to what extent
student pharmacists’ interventions reduce out-of-pocket
(OOP) prescription drug plan costs for Medicare beneficiaries.
METHODS: Trained student pharmacists throughout California
provided one-on-one MPD prescription drug plan consultations
during community outreach events. Cost information for the
participant’s current and lowest-cost plan for 2008 was obtained
by conducting a personalized plan search using the online MPD
Plan Finder tool. RESULTS: Twenty-two outreach events were
conducted statewide and data were collected from 250 Medicare
beneficiaries. The mean ± SD age of the participants was
74.3 ± 9.1 years, and 91 (36.4%) were male. The mean ± SD
(range) number of prescription drugs per participant was
5.6 ± 3.9 (0–26). Eighty-three participants (33.2%) had limited
or no English proficiency, 82 (32.8%) had less than a high school
education, and 102 (40.8%) were enrolled in both Medicare and
Medicaid. Data from 95 participants (72 of whom were not
enrolled in a MPD drug plan during 2007 and 23 of whom had
incomplete data) were necessarily excluded for purposes of the
CMA. For the other 155 participants, the median annual OOP
costs for continued enrollment in their current MPD prescription
drug plan in 2008 were $440.00, compared to $200.00 for the