

of 12 months and cycle lengths of 1 month was designed to evaluate the cumulative costs over time of plastic and metal stent. A meta-analysis of all published randomised trials was performed to derive the transitional probabilities for first and second occlusion and for death. A national health care perspective was adopted. Unit cost data was obtained from available public sources in France, Sweden and England. Resource use was derived from expert opinions in each country. **RESULTS:** Initial procedural costs were higher with metal than with plastic stents: the cost difference was €953 for Sweden, €739 for France and €653 for England. However, due to fewer reinterventions for exchange, follow-up costs were substantially reduced with metal stents. In Sweden and England, the cost break-even point was after 4 months and for patients with longer survival, metal stents became cost-saving. In France, the break-even point was after 5 months. At 12 months, the difference per patient cost in favour of metal was €493 for France, €620 for England and €1002 for Sweden. **CONCLUSION:** This analysis demonstrates that initial metal stent placement can be a cost-saving strategy, especially if the patient survives more than 4 to 5 months. The higher procedural cost with a metal stent is offset by a reduction in re-treatment costs. Avoiding reinterventions will benefit patients in terms of quality of life and the health care system as a whole.

CS4

COST-BENEFIT ANALYSIS OF AN INTERNET-BASED PATIENT EDUCATION PROGRAMME FOR ASTHMATIC CHILDREN AND ADOLESCENTS

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OBJECTIVES: With a prevalence of 10% asthma is the most common chronic disease among children and adolescents in Germany. Approaches to reduce the burden of asthma comprise patient education as a well-recognised and effective component that helps to improve self-management skills. We determined whether a continuous internet-based education programme (IEP) as an add-on to traditional education improves health outcomes of asthma patients (8–16 years) at a favourable benefit-cost ratio. **METHODS:** We performed a prospective cost-benefit analysis alongside a non-randomised trial. A total of 438 patients in 34 study centres in Germany were enrolled in the investigation. Study participants were assigned to a control group and two intervention groups. Patients in both intervention groups received traditional patient education. In one group patients received additional self-management education through the IEP for the duration of 6 months. At the initial visit and at 6 and 12

months health service utilisation data were collected. **RESULTS:** Utilisation of various Health care services (e.g. number of consultations, urgent medical examinations) decreased significantly in both intervention groups. In the first year after intervention traditional education realised morbidity cost savings of 333 EUR per patient. Adding the IEP provided incremental savings of €143. From a payer perspective, the benefit-cost ratio of the traditional education programme was 0.45. Adding the IEP improved the ratio (0.69). For patients with moderate or severe asthma the benefit-cost ratio were 1.07 and 1.42 (with IEP). In individuals who had experienced an emergency visit due to asthma 6 months prior to the study entry, the ratios were 1.11 and 1.21, respectively. **CONCLUSIONS:** As a supplementary to traditional asthma education programmes, the IEP offers the potential to realise incremental morbidity savings. Subgroup analyses demonstrated that within 1-year morbidity cost savings surpass the intervention costs in patients who belong to risk groups.

CARDIOVASCULAR DISEASE PREVENTATIVE STUDIES

CV9

A HEALTH ECONOMIC EVALUATION OF N-3 POLYUNSATURATED FATTY ACIDS (PUFA) IN THE SECONDARY PREVENTION AFTER MI

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OBJECTIVES: Patients who survived an acute myocardial infarction (MI) have an increased risk for subsequent major cardiovascular events and cardiac (often sudden) death. The use of highly purified omega-3 polyunsaturated fatty acids (n-3 PUFAs) in addition to standard secondary prevention after MI was associated with a significant reduction in risk of sudden death. Our study assessed the cost-effectiveness (CE) of adding n-3 PUFAs treatment to the current secondary prevention treatment after acute MI in Belgium. **METHODS:** Based on the clinical outcomes of the GISSI-prevenzione study (MI, stroke, revascularisation rate and mortality) a decision model was built in DataTM Pro. Adding n-3 PUFAs to standard treatment was compared to standard treatment alone in patients with a recent history of MI (age = 59 years) from the health care payer's perspective. The time horizon of the model was 3.5 years (identical to the GISSI-prevenzione study). The cost of non-fatal events was based on Belgian literature data and the cost of cardiac death on a patient chart review (n = 60). The unit cost of n-3 PUFAs was €1.25. Life expectancy data for cardiac disease were obtained from published sources and adjusted to the Belgian population. Results are expressed as cost (€) per life year gained (LYG). **RESULTS:** Treatment with n-3 PUFAs results in 0.287 life years gained at