values and mortality rates were obtained from published literature. Costs in each state were obtained from local observational studies and official, local unit costs or from published literature. A lifetime horizon was taken. Discount rates varied according to local guidelines. RESULTS: The base-case incremental cost-utility was €18213 (£13111)/QALY, €17605 (SEK 70379)/QALY, €17592/QALY and €7990/QALY in the UK, Sweden, Italy and Belgium, respectively. Assuming a threshold of €30,000/QALY, DRV/r remained cost-effective over most parameter ranges tested in extensive one-way sensitivity analyses. Probabilistic sensitivity analysis revealed a probability of = 67% of an ICER below this threshold in all countries. CONCLUSIONS: From the British, Swedish, Italian and Belgian payer perspective, DRV/r 600/100 mg bid is predicted to be cost-effective versus LPV/r in the management of LPV/r-naïve, PI-resistant, HIV-infected adults with a broad range of prior PI use/failure.

PIN24

ECONOMIC AND CLINICAL IMPACT OF IMPLEMENTATION OF AN ACELLULAR PERTUSSIS VACCINE IN CANADA

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OBJECTIVES: To determine the cost-effectiveness of 7-valent PCV in a national immunisation programme in Turkey.

METHODS: A model was developed in MS-Excel™ to estimate the incidence of four diseases: pneumococcal meningitis, pneumococcal septicaemia/bacteraemia, all-cause pneumonia and all-cause acute otitis media in a cohort of children zero to ten years of age. The efficacy of the vaccine against these conditions was assumed to be 97.4%, 97.4%, 7% and 6% respectively. In addition, corresponding adult disease burden was incorporated into the model by assuming reductions of 32%, 8% and 18% in the age groups 20–39 yrs, 40 to 64 yrs and 65 + yrs respectively, due to indirect (herd) effects. Turkish data used were from reports of the Ministry of Health, the Turkish Statistics Organisation, data from 11 major hospitals in Istanbul (serving about 80% of the 12 million city population), the National Burden of Disease Survey and the Verbal Autopsy Study. When Turkish data were not available, estimates were developed through expert opinion and/or extrapolated data. When paediatric costs were not known they were assumed to be one-tenth of UK costs; when adult costs were not known they were assumed to be one-fifth of UK costs. It was estimated that 1972 annual adult deaths occurred due to pneumococcal infection in Turkey. The estimated serotype coverage for invasive pneumococcal diseases was 63% for those <2 yrs of age and 35% for those 2 to 10 yrs of age. It was assumed that only 80% of the primary birth cohort would be vaccinated and the schedule would be 4 doses. RESULTS: The addition of indirect (herd) effects to the model reduced the cost-effectiveness by 12.5%. If one-tenth of the recognised cost-effectiveness threshold (US$60,000 cost per life-year gained) is taken as the cost-effectiveness threshold for Turkey ie US$6000, then 7-valent PCV would be cost effective at a cost-per-dose of US$45. The costs per QALY in Turkey for the treatment of lung cancer is US$6141 and for hepatitis C treatment US$6638. CONCLUSIONS: The inclusion of 7-valent PCV in a fully-funded Turkish national immunisation programme would be highly cost-effective.