

pared to active controls. Meta-analyses did not find a difference between rofecoxib and celecoxib in broad safety measures.

**CONCLUSION:** Caveats to this analysis include the potential for selection and instrument bias. The two coxibs show comparable overall efficacy and safety. However, caution is advised in applying the results of aggregate analyses at the individual patient level. Since the safety profiles for the coxibs are somewhat different, arthritis treatment should be individualized based on patient co-morbidities.

**PA02****ECONOMIC BURDEN AND LOSS IN QUALITY OF LIFE IN PATIENTS WITH OSTEOARTHRITIS**

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**OBJECTIVES:** To measure quality of life and health-care utilization related to osteoarthritis and to understand the relationship among different parameters.

**METHODS:** 245 patients with osteoarthrosis (176 female) of mean age 64 years were recruited within a musculoskeletal study in both primary care and rheumatology outpatient settings in Hungary in 1999 and 2000. Patients filled in both the generic EQ-5D quality-of-life questionnaire and the disease-specific WOMAC questionnaire and reported resource utilization. Mean quality-of-life and health-care-utilization values were reported and correlation coefficients between different measurements were analyzed.

**RESULTS:** Average EQ-5D index, EQ-5Dvas, WOMAC (pain (A), stiffness (B), physical function (C)) scores were 0.42, 49.18, 9.28, 3.87, 36.32 respectively. Average annual number of physiotherapy and spa treatment sessions were 33.32 and 9.88, respectively. Average number of GP and specialist visits were 31.4 and 8.54 annually. Patients spent a mean of nine days in hospital and they spent 12.5 days in bed due to osteoarthritis. Active patients spent a mean of 6.7 days on sick leave. Statistically significant correlation was observed between the following: EQ-5D index and EQ-5Dvas; EQ-5D index and WOMAC C; EQ-5Dvas and WOMAC C; days in bed and EQ-5D index; days in bed and EQ-5Dvas; days in bed and WOMAC C. Corresponding correlation coefficients were: 0.35; -0.59; -0.33; -0.35; -0.17; 0.24; respectively ( $p < .01$ ).

**CONCLUSIONS:** Results showed that osteoarthritis leads to substantial loss in quality of life, important direct medical costs, and substantial productivity loss among active patients.

**PA03****COST OF CARE FOR MEMBERS WITH ARTHRITIS—A MANAGED CARE PERSPECTIVE**

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**OBJECTIVE:** In order to assess the impact of intervention programs to be implemented, a baseline assessment of the burden of illness for arthritis is needed. Nearly one third of Philadelphians receive their medical care through Medicaid. To be representative of the population we serve, we therefore set out to measure the incidence and impact of arthritis in an inner city, Medicaid managed-care population.

**METHODS:** We identified members continuously enrolled (per HEDIS definitions) during 1999 with paid claims reflecting diagnoses indicative of arthritis. Primary through quaternary diagnoses for arthritis (ICD-9CM codes 095.6, 095.7, 095.8, 099.3, 136.1, 274, 277.2, 287.0, 344.6, 353.0, 354.0, 355.5, 357.1, 390, 391, 437.4, 443.0, 446, 447.6, 696.0, 710-716, 719.0, 719.2-719.9, 720-721, 725-727, 728.0-728.3, 728.6-728.9, 729.0-729.1, and 729.4) were used to determine incidence. Total amounts paid per claim were tallied. Arthritis-related drugs were those defined as AHFS classes 12:20.00, 28:08.04, 28:08.08 and unclassified arthritis related agents. Members' demographic data was also obtained.

**RESULTS:** From a cohort of 73,948 members, we identified 8197 (11.1%) individuals with a medical claim for arthritis. Females comprised 77.0% (1744) of these members, greater than the norm for this population ( $p < .05$ ). The average age was 53.8 years. This population with arthritis was composed of 46.8% African-Americans, 23.2% Caucasians, 23.7% Latinos, and 3.0% Asian-Americans. Medical claims and arthritis-related drug costs for this population totaled \$5,328,406 (\$650 per identified member).

**CONCLUSION:** Effects of interventions cannot be measured until baseline information is assessed. It is hoped that along with the data gathered here, an intervention can be implemented citywide, the effects of which can be measured. The diversity of Philadelphia's population should allow for differences that might exist among ethnic groups to be demonstrated. Managed care payers are also responsible for drug expenditures. The costs for some of these products are presented herein.

**PA04****THE COST-EFFECTIVENESS OF CELECOXIB COMPARED TO DICLOFENAC IN PATIENTS WITH RHEUMATOID ARTHRITIS IN POLAND**

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**OBJECTIVES:** to estimate the cost-effectiveness of celecoxib 0,2 g bid vs. diclofenac 75 mg bid in rheumatoid arthritis (RA) patients in Poland and to identify whether and to what extent celecoxib represents good use of health-service resources.

**METHODS:** A decision analytic model in the Polish