OBJECTIVES: To estimate the incremental cost of implementing a care program for people with type 2 diabetes in Argentina. METHODS: ALAD guidelines were used to identify resources necessary to implement a diabetes care program in two Argentine provinces with opposite socioeconomic characteristics (Córdoba and Misiones). Probabilistic sensitivity analysis following Monte Carlo simulation was used to determine the number of visits and practices, probability of insulin treatment, combined drug therapy for hypertension, dyslipidemia, and diabetes. The lowest cost was associated with human resources (~5%). The annual individual incremental expenditure was 32% higher in Córdoba due to the pharmacological treatment (diabetes - ~90%). The pharmacological statistical comparison for incremental costs in Córdoba and Misiones indicated that: a) Misiones has a 32% average incremental expenditure was 32% higher in Córdoba due to the pharmacological treatment and whether these differences could lead to different conclusions and decision making. METHODS: Two previously published preventive models, developed in Excel and delivering outcomes in QALYs, were adapted to estimate DALYs: a) Human Papilloma Virus (HPV) – a Markov model comparing screening to vaccination in 12 year old girls - and a pneumococcal vaccination model (PNEUMO) – a deterministic model which considers the occurrence of pneumococcal diseases in a calendar year, across all age cohorts. We selected Argentina, Chile and the UK as country examples as models were used in these countries and EQ-SD social value weights were available to provide as model inputs for local QALYs' weights. A primary study with descriptive vignettes was done (n = 73) to obtain descriptive EQ-SD data for all health states included in both models. Several alternative scenario analyses were carried out. RESULTS: In HPV, QALYs' gains were generally larger than DALYs avoided, which leads to more favorable decisions using the former. Differences were larger in UK and smaller in Argentina. The incorporation of discounting and age weighting increased differences in all countries, where incremental DALYs avoided represented the 75%, 68% and 43% of the QALYs gained in Argentina, Chile and UK, respectively. Differences directly influenced decision making using usual thresholds. In PNEUMO differences using QALYs or DALYs were less consistent and sometimes in opposite directions. Chile showed the largest gains using both methods. The study objectives were achieved, and probabilistic sensitivity analysis (PSA) in the cost-effectiveness plane was conducted. Summary results are shown in Figure 1. CONCLUSIONS: These data: a) provide further evidence of the potential of the care program developed in Argentina, b) provide a basis for comparing the cost-effectiveness of different prevention strategies in the future, and c) support the need for more comprehensive quality of life measures for diabetes patients in Argentina. EX3 INCREMENTAL COST OF IMPLEMENTING A CARE PROGRAM FOR PEOPLE WITH TYPE 2 DIABETES IN ARGENTINA

CONCLUSIONS: This exploratory analysis shows that using different benefit metrics in these case studies could influence final results and decisions informed by cost-effectiveness thresholds.

EX4 EFECTIVIDAD DE LOS INDICADORES DE CALIDAD DE LA PRESCRIPCIÓN REGIONALES EN EL SNS ESPAÑOL

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OBJECTIVES: To estimate the incremental cost of implementing a diabetes care program in two Argentine provinces –50% of the annual incremental cost per patient followed by that of the treatment of hypertension, dyslipidemia and diabetes. The lowest cost was associated with human resources (~5%). The annual individual incremental expenditure was 32% higher in Córdoba due to the pharmacological treatment (diabetes - ~90%). The pharmacological statistical comparison for incremental costs in Córdoba and Misiones indicated that: a) Misiones has a 32% average incremental cost lower than Córdoba, and b) the dispersion around the adjusted mean is greater for Córdoba than for Misiones. The main determinants of incremental costs varied according to proposed treatment in Córdoba and Misiones were: a) probability of insulin treatment; b) unitary cost of SMBG strips; c) number of Hba1c determinations; and d) number of strips and lancets needed. The impact of each of these variables would be different in each province. CONCLUSIONS: These data: a) provide the first objective evaluation of the cost of a diabetes program in Argentina, from a public payer perspective, and b) identify critical issues to consider when planning the implementation of such a program in places with limited resources.

RESULTS: The SMBG treatment was the most frequently used resource (7.75 ± 7.02 [mean ± SD]) visits/patient-year and there were also 0.48 ± 1.35 spontaneous visits to this specialist. The number of visits to the psychologist was 0.99 ± 5.13 per patient-year. Hospitalization rates since the index and the study index date were 0.33 ± 0.54 and 0.18 ± 0.54 per patient-year, respectively. Visits to group therapy sessions, general practitioners and the emergency room since the index date were 0.13 ± 0.75 per patient-year, respectively. N = 166
corrected to 50% of the annual incremental cost per patient followed by that of the treatment of hypertension, dyslipidemia and diabetes.