DIRECT MEDICAL COSTS ASSOCIATED WITH STROKE IN NON-VALVULAR ATRIAL FIBRILLATION IN INDIA

OBJECTIVES: To estimate the stroke related disease burden in terms of health care resource utilization and average per-patient costs among patients with a prior diagnosis of non-valvular atrial fibrillation (NVAF) in India. METHODS: Data were collected retrospectively in three large multidisciplinary community hospitals in three cities in India. Medical charts of 400 patients diagnosed with stroke and NVAF from October 1, 2011 to December 31, 2011 were reviewed. Data abstracted were demographic characteristics, clinical diagnosis, risk factors, comorbid conditions, date of diagnosis/admission, date of discharge, and type of inpatient procedures. Regarding outpatient services such as physician visits, laboratory tests, INR monitoring, diagnostic tests, nursing services, and speech/physical therapy over a three month period post-discharge were obtained via patient follow-up surveys. Costs associated with inpatient services were obtained from hospital discharge bills and the pricing menu of the three hospitals. RESULTS: The mean age of patients in the study was 67 (SD 10) years, the majority of patients (62%) were male. Of the 400 patients, 61% had ischemic stroke and about 60% of the patients were moderate to moderate-severe disabled based on the modified Rankin Scale. The mean length of stay for patients with ischemic stroke was 16 days (SD 4). The direct medical costs for patients with moderate or severe ischemic stroke (inpatient and outpatient) over the 3 month follow-up period was Indian rupees, Rs 130,976 (SD 3,913) with inpatient hospital costs accounting for a major portion (Rs 114,202) of the overall costs (per patient). CONCLUSIONS: The findings of the study indicated that the acute medical stroke care post hospitalization phase poses considerable economic burden (US $7,138) among patients in India. As inpatient costs are major cost drivers, clinical efforts should focus on timely management of NVAF induced strokes and use of preventive treatments.

ECONOMIC BURDEN OF SEASONAL INFLUENZA B IN FRANCE DURING WINTER 2010-2011

Pharmacological treatment prescribed. We used as reference the 2011

CLOSE MEDICAL COSTS ASSOCIATED WITH STROKE IN NON-VALVULAR ATRIAL FIBRILLATION IN INDIA

OBJECTIVES: The incidence of hospitalized bacteremia/sepsis and meningitis in per 100,000 person years were: 2.07 and 1.34 (CR), 1.0 and 0.49 (SK), 0.46 and 0.32 (PL), and 1.36 and 1.01 (HU). The case fatality rate was: 31% and 25%, 12% and 25%, 40% and 63%, and 11% and 29%. An exponential increase in both measures was evident for patients with advancing age. The total economic burden of IPD in adults over 50 was: EUR 666,050; 159,528; 180,015 and 140,249. Adults >65, who represent 41% of the combined population, account for 54% of the costs. CONCLUSIONS: The IPD burden in adults increases with age, and is associated with a high risk of death. Higher burdens in HU obtained from inpatient records seem to more reliably reflect the reality and highlights systematic underreporting of national surveillance systems.

PHS23

DIRECT MEDICAL COSTS ASSOCIATED WITH STROKE IN NON-VALVULAR ATRIAL FIBRILLATION IN INDIA

METHODS: The incidence identified the hospitalization bacteremia/sepsis and meningitis in per 100,000 person years were: 2.07 and 1.34 (CR), 1.0 and 0.49 (SK), 0.46 and 0.32 (PL), and 1.36 and 1.01 (HU). The case fatality rate was: 31% and 25%, 12% and 25%, 40% and 63%, and 11% and 29%. An exponential increase in both measures was evident for patients with advancing age. The total economic burden of IPD in adults over 50 was: EUR 666,050; 159,528; 180,015 and 140,249. Adults >65, who represent 41% of the combined population, account for 54% of the costs. CONCLUSIONS: The IPD burden in adults increases with age, and is associated with a high risk of death. Higher burdens in HU obtained from inpatient records seem to more reliably reflect the reality and highlights systematic underreporting of national surveillance systems.

CONCLUSIONS: Gastrointestinal bleeding is a major cause of resource utilization and time from the clinical and demographic days of hospital stay which cause a high economic impact on accessibility to other hospital claims.
burden is important in informing health care planning and policy development. This study was conducted to describe the health care associated with AF management in routine UK clinical practice. METHODS: A retrospective observational study of 825 patients with AF was undertaken in 8 UK primary care practices in 2010. Data were collected from the clinical records of all eligible, consenting patients, for a period of up to 3 years. The first 12 weeks following diagnosis was defined as the "initiation phase", the period after week 12 was defined as the "maintenance phase". RESULTS: Mean aged 55.9 (±13.9) per patient in the initiation phase and £456/€571/$731 (597/€727/$930) per patient year in the maintenance phase. Inpatient admission and secondary care attendances accounted for 83% of total initiation phase and 64% of total maintenance phase costs. Significant variables contributing to high cost in the initiation phase were co-morbid hypertension and lower patient age, although only accounting for 5% of cost variability. Significant variables in the maintenance phase were cost variability were co-morbid cardiovascular disease and diabetes, and day-case attendances, ECCs and hospitalisations in the initiation phase. Mean maintenance phase costs were higher for patients managed by practices providing antiocoagulation services (£555/€676/$865) than patients receiving secondary care antiocoagulation (£421/€513/$656, p=0.002).

CONCLUSIONS: The study confirms that inpatient admissions and secondary care attendances contribute most to total AF management costs. None of the variables analysed accounted for much variability in the total cost of AF management, suggesting that it is often not possible to predict which patients will be high resource users and what care work should focus on to safely reduce avoidable hospital admissions.

PHS29 COST OF TREATING PATIENTS WITH OBSTRUCTIVE SLEEP APNEA/HYPOPEANIA SYNDROME IN THE SOTIRIA CHEST HOSPITAL IN GREECE

Prapa P1, Giatra M1, Gourgoulis E1
1Sotiria Chest Hospital, Athens, Greece; 2University of Peloponessos, Korinth, Greece, Greece

OBJECTIVES: Studies estimating the cost of treating patients suffering from the Obstructive Sleep Apnea (OSAHS) or Hypopnea Syndromes (HPS) have not been conducted in Greece. The aim of this study was to investigate the annual cost of patients with OSAHS and identify the potential economic burden to the patients treated.

METHODS: A retrospective study was conducted in the sleep laboratory of Sotiria Chest Hospital in Athens from January 1, 2008 to December 31, 2008. A sample of 340 subjects was screened for OSAHS. Diagnosis was confirmed after polysomnography. Health resources' consumption was derived from patients' analytical records, the annual visits in the sleep laboratory and the purchase of the ventilation devices (CPAP, BiPAP). Outpatient visits' costs included labor costs, overheads, consumables related to the OSAHS patients. The bottom-up approach and the patients' perspective have been used.

RESULTS: A total of 262 males and 78 females, mean aged 55.9 (±SD12.4) years participated in this study. Overall mean annual cost reaches approximately €1,685/30 per patient out of which 15% is paid by NHS, 64% by social funds and 21% by patients' out of pocket payments. The major cost driver is devices' purchase (66.55%). Patients' out of pocket spending for the purchase of the BiPAP ranges from 5% to 48% of the CPAP from 0% to 33.5% depending on the social fund in which the patient belongs.

CONCLUSIONS: Variations found among patients' social insurance coverage related to the purchase of both devices as well as severe inequalities in patients' cost sharing among the various funds. Further research is needed in similar sleep laboratories in Greece.

PHS30 HEALTH CARE COSTS IN PSORIATRIC ARTHRITIS (PSA) PATIENTS NEWLY INITIATED ON A BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUG (DMARD) OR METHOTREXATE (MTX)

Zhao J1, Heacock R2, Curtis R3
1Celgene Corporation, Summit, NJ, USA; 2Analysis Group, Inc., Montreal, QC, Canada; 3University of Alabama at Birmingham, Birmingham, AL, USA

OBJECTIVES: To describe health care costs associated with the management of PSA in patients newly initiated on a biologic DMARD or MTX. METHODS: Adult patients with ≥2 PSA diagnosis (from office visits), continuously enrolled ≥6-month pre- and ≥12-month post-index date (i.e., first biologic DMARD/MTX prescription date), and no diagnosis for ankylosing spondylitis were selected from the MarketScan Commercial Claims database (2005-2009). MTX initiators were required to be both biologic and non-biologic DMARD naive prior to index date. Biologic initiators were required to be biologic-naive only prior to index date. All-cause and PSA-related total health care costs were estimated during the 12-month study period from a payer perspective (2011 USD). PSA-related medical cost was defined as costs associated with a claim with a PSA diagnosis or with DMARD administration by health care professionals. Office care and monitoring costs were defined as the sum of PSA-related outpatient and other medical services costs (excluding costs for drugs administration). Urgent care costs were defined as the sum of inpatient and emergency room costs. PSA-related pharmacy costs were defined as the sum of biologic and non-biologic DMARD costs.

RESULTS: A total of 1,217 MTX initiators and 3,263 biologic initiators met the eligibility criteria. MTX initiators had an average annual total health care cost of $14,529 where $6,065 were PSA-related. Pharmacy costs accounted for 92.7% of PSA-related total costs, office care and monitoring cost for 5.1%, urgent care cost for 2.3%.

CONCLUSIONS: PsA patients initiating a DMARD incurred substantial health care costs. Although pharmacy costs accounted for most of the PSA-related costs, office care and monitoring costs represented a significant part of the PSA-related costs.