mental cost-effectiveness ratio (ICER). The analysis covered 10 years, with a Markov cycle of one day. Costs included medication, consultations and treatment interventions and additional costs for attending special education. Quality-adjusted life years (QALY) were used as effectiveness measures. Outcome probabilities were taken from the medical literature and an expert panel of five child psychiatrists and pediatricians. Univariate sensitivity analyses were performed to assess the robustness of the base case estimate. Multivariate sensitivity analysis was used to estimate a worst and best case ICER. RESULTS: The incremental cost-effectiveness ratio of methylphenidate-OROS treatment compared to IR-methylphenidate in youths with ADHD for whom treatment with IR-methylphenidate is suboptimal, was 2004 euros per QALY. Total costs after 10 years were 15,739 euros for the IR-methylphenidate pathway and 16,015 euros for the methylphenidate-OROS pathway. In the univariate sensitivity analysis, the ICER was sensitive to changes in resource use and the probability of stopping stimulant treatment in favor of IR-methylphenidate. An ICER of 0 was reached with a 6.2% price reduction of methylphenidate-OROS. CONCLUSIONS: Methylphenidate-OROS is a cost-effective treatment for youths with ADHD for whom treatment with IR-methylphenidate is suboptimal. With regard to the cost items evaluated in this analysis, higher medication costs of methylphenidate-OROS were compensated by savings on resource use, yielding similar 10-year costs compared to treatment with IR-methylphenidate. Future cost-effectiveness analyses should retrieve estimations for model parameters from clinical trials or large databases and include direct non-medical costs associated with methylphenidate treatment.

PMH18

DIRECT COST OF DEPRESSION—ANALYSIS OF A GERMAN CLAIMS DATABASE

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OBJECTIVES: To retrospectively evaluate 1-year direct health care cost (antidepressants, hospital stays, rehabilitation) of patients with depression based on claims data. METHODS: Billing data of a German sickness fund with 4.7 million life years insured were used for the period from 2001 to 2003. Beneficiaries were included, if they were covered at least three months by the health insurance and had either an inpatient or sick leave diagnosis of depression (ICD 10: F32, F33) or at least two prescriptions of an antidepressant (ATC: N06A*) during this period. For each patient direct health care cost was derived from the database for the individual observation period and standardized subsequently to obtain 1-year cost. RESULTS: Out of 1.54 million beneficiaries n = 75,078 fulfilled the inclusion criteria (mean age: 48 ± 13 years; 57 % female). Total 1-year cost of illness amounted to €363 per patient (SD: €389) as actuarial data. The median reimbursed cost of treating depression accounted for €31, the maximum was €57,404 p.a. per patient, representing that the majority of the patients caused relatively low expenditures and only a small group generated high health care cost. Stratification of total cost shows that inpatient care due to depression caused higher average cost per patient and year (212 ± €1479) than antidepressant treatment administered by office-based physicians (93 ± €177) or rehabilitation (54 ± €389). CONCLUSION: The study confirms that hospitalization is the main cost driver of depression. This is in line with current literature. There is also evidence that adequate antidepressant treatment prevents from hospital stays. Though, the findings reveal a distinct imbalance between inpatient and outpatient care, especially for antidepressant pharmacotherapy. Keeping patients in an ambulatory care setting, supported by an optimized pharmacotherapy, might contribute to reduced overall health care spending per patient.

PMH19

IMPACT OF REMISSION IN MAJOR DEPRESSIVE DISORDER ON ECONOMIC BURDEN OF ILLNESS IN SWEDEN

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OBJECTIVES: It is suggested that full remission should be the primary goal of depression treatment. However, few previous studies have directly measured the impact of remission on economic disease burden. The aims of this study were to compare costs of patients in remission with patients not achieving remission after an episode of major depressive disorder (MDD) in a Swedish primary care setting, and to determine effect of remission on overall cost of illness. METHODS: The cost of illness in remitters and non-remitters was estimated based on of a naturalistic longitudinal survey (HEADIS—Health Economic Aspects of Depression in Sweden). Records from 447 patients with a mean follow-up of 6 months were collected from 56 primary care centres, and the resource use was analyzed for patients having at least one follow-up visit. Unit costs were derived from standard Sweden sources. Swedish prevalence estimates were applied to per patient cost estimates to assess overall burden of illness among remitters and non-remitters. RESULTS: Full remission was achieved by 52% of the patients at end of follow-up. For non-remitters and remitters, total annual per patient costs amounted to SEK 128,000 and SEK 78,000, respectively. With MDD prevalence of 5% and Swedish 2005 population exceeding 9 million, overall burden of illness was SEK 46 billion. Increasing the proportion of remitters by 10% would decrease an overall burden of illness by 5%, to SEK 44 billion. CONCLUSIONS: Remission substantially affects economic burden of depression, decreasing total per patient cost by almost 40%. With high prevalence of MDD in Sweden, any strategy that will increase the remission rate will also markedly reduce the overall burden of illness. This indicates importance of full remission as the primary goal of treatment of depression and strengthens evidence that antidepressant treatments leading to rapid remission may be most beneficial.

PMH20

TREATMENT PATHWAYS AND COST ASSESSMENT OF SCHIZOPHRENIA IN GREECE: A PRIMARY ANALYSIS

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