A PROSPECTIVE STUDY OF THE FINANCIAL COSTS OF MULTIPLE SCLEROSIS AT DIFFERENT STAGES OF THE ILLNESS IN IRAN

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The economic burden of Multiple Sclerosis (MS) on society and the individuals concerned is not known. Documenting such costs is essential for several reasons: costs of illness is a key factor of optimal disease management policies, knowledge of cost is useful for allocating research and development. The aim of our study was the first pharmaceutical treatment in Iran was to focus on patients of the local ethics committee. The mean total cost/patient for one year was estimated at the Division of Neurology at Ghaem Hospital and MS association in Mashhad in northeast of Iran and was approved by the local ethics committee. The mean total cost/patient for one year was estimated at $27,095, $27,997 and $31,662 for stage I, II and III, respectively. Both direct and indirect costs increased with MS progression. For indirect cost the main item was productivity loss. The mean extra medicine (treatments for MS symptoms and adverse events) cost was $5,352 ($9588), $814,058 ($34487) and $441,716 ($32511) at mild, moderate and severe stages respectively in France; $3,125 ($4319), $48,457 ($18374) and $5,069 ($17477) in Italy. Associated EQ-5D utilities are respectively 0.79 (±0.18), 0.39 (±0.37), 0.11 (±0.3) in France; 0.39 (±0.40), 0.39 (±0.42), 0.23 (±0.44) in Italy. The primary cost driver is productivity loss. In France, hospitalization and medication costs are the main components of direct costs. For more severely affected patients, medical resource utilization diminishes while caregiver involvement increases significantly (the shift is greater in Italy than France). Physical, mental and social HRQoL domains are all seriously affected. CONCLUSIONS: Economic impact of NAB-testing in persistent NAB; based on the fact that development in persistently NAB-positive patients equals that of placebo-treated patients. Economic impact of NAB-testing in patients, and therefore switching, and not tested patients values were used. Patients were selected for inclusion if they had a diagnosis of RLS (ICD-9-CM code 333.94). Study measures included patient demographics and charges associated with the ED visit. Study measures were reported separately for patients with a primary versus secondary RLS diagnosis. Among patients with a secondary RLS diagnosis, the most common primary diagnoses were reported. RESULTS: A total of 6133 patients with a primary RLS diagnosis and 149,931 patients with a secondary RLS diagnosis were identified. Common primary diagnoses among patients with a secondary RLS diagnosis included respiratory symptoms (7.0%), general symptoms (4.6%), and pneumonia (3.7%). Mean (Std. Err.) age was 54.5 (0.6) years among patients with a primary diagnosis and 64.0 (0.3) years among patients with a secondary diagnosis. In both cohorts, over two-thirds of patients were female; the most common geographic regions were the South and Midwest, and Medicare was the most common primary payer (41.0% of patients with a primary diagnosis and 59.3% of patients with a secondary diagnosis). Over 90% of patients with a primary diagnosis had at least one RLS diagnosis, and most patients with a secondary diagnosis were admitted to the facility as an inpatient. Mean (Std. Err.) charges were $816 ($48) for patients with a primary diagnosis and $2,043 ($62) for patients with a secondary diagnosis. CONCLUSIONS: This nationally representative study suggests that patients admitted to the ED with RLS accrue substantial indirect costs during their visit. Further research is needed to more fully assess the total economic burden of the disease.