the assumptions about the length of the treatment benefit.

CONCLUSIONS: Anastrozole is a cost-effective alternative to tamoxifen for the adjuvant treatment of postmenopausal women with HR+ early breast cancer from the UK NHS perspective, with the cost per QALY gained with anastrozole falling well within the range considered acceptable for reimbursement in the UK.

PCN35
A COST UTILITY ANALYSIS OF FULVESTRANT VERSUS EXEMESTANE IN THE SECOND LINE TREATMENT OF POSTMENOPAUSAL WOMEN WITH ADVANCED BREAST CANCER IN GREECE (PRELIMINARY RESULTS)
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OBJECTIVE: To estimate the cost and effects (measured in QALYs) of fulvestrant as replacement of exemestane in the second line treatment of postmenopausal women with advanced breast cancer (ABC) in Greece. The preliminary results are presented in this analysis.

METHODS: A Markov model was used in order to compare cost effectiveness of two patient cohorts receiving: fulvestrant (cohort A) or exemestane (cohort B) as 2nd line treatment, megestrol acetate (A) as 3rd line treatment and a palliative care package (A, B). The perspective of the study was that of the National Health care System. Clinical evidence was derived from published clinical trials. Treatment effects were estimated in QALYs. Direct costs included drug therapy, oncologist visits, monitoring tests and adverse events treatment. Information on resource use was obtained from a panel of 3 oncology key opinion leaders. As patients can use either public or private sector, charges of both sectors for year 2005 will be used. Public sector prices are used in this analysis. The time horizon of the study was 11 years and the discount rate used for both costs and QALYs was 3.5%

RESULTS: Cohort A had a higher proportion of responders with a longer duration on 2nd line treatment. In a cohort of 100 patients, fulvestrant produces 8.1 extra QALYs at a 18% extra cost compared to exemestane resulting in an incremental cost effectiveness ratio (ICER) of €35,633 per QALY. However, as public sector charges highly underestimate cost of treatment, further scenario analysis will be carried out in order to capture true cost of treatment in Greece.

CONCLUSIONS: Fulvestrant proves to be more beneficial than exemestane at an extra cost of €35,633 per QALY. Fulvestrant produces extra benefit with a reasonable extra cost for ABC patients in Greece.

PCN36
A COST UTILITY ANALYSIS OF FIRST-LINE CHEMOTHERAPY REGIMENS IN THE TREATMENT OF METASTATIC BREAST CANCER AFTER ANTHRACYCLINE FAILURE
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OBJECTIVES: Four chemotherapy regimens: gemcitabine-paclitaxel (Gem/Pac), paclitaxel in monotherapy (Pac), docetaxel in monotherapy (Doc) and docetaxel-capcitabine in association (Doc/Cap), are commonly used in the first-line treatment of metastatic breast cancer after anthracyclines failure. The purpose of the study is to rank these strategies according to their incremental cost-utility ratios.

METHODS: A Markov model was constructed in order to evaluate all 4 protocols, based on efficacy and tolerance data from recently published phase III studies. Ravdin showed superiority for Doc compared to Pac in monotherapy. O’Shaughnessy for the Doc/Cap regimen and the phase III registration study for the Gem/Pac showed superiority for Doc/Cap and Gem/Pac compared to Doc and Pac respectively. An indirect comparison of these 4 regimens was conducted, all possible scenario with averages and extreme data were tested. The costs were calculated by adding DRG costs, onerous drug costs reimbursed over DRGs and transportation expenses. Costs of severe toxicities, diagnosis and palliative care, were taken into account. RESULTS: The Gem/Pac strategy appears to be the most effective compared to Doc, Pac and Doc/Cap. In terms of survival, Gem/Pac has an additional efficacy of 16.5 weeks and an incremental cost-effectiveness (ICER) of €5570 compared to Doc/Cap, with an ICER of €18,000 per year of life gained. In terms of survival adjusted to quality of life, the efficacy gain is 12.1 weeks and the ICER is €22,000 per year of life gained. When the D8 gemcitabine is administered at home, the Gem/Pac ICER is €12,000 year of life gained. CONCLUSION: The incremental cost-effectiveness ratios of Gem/Pac regimen are between €10,000 and €22,000 per year of life gained, still below the limits recognized as reasonable at the international level. Another advantage of the Gem/Pac combination therapy is to allow home care on day 8 of the cycle.

PCN37
IMPACT OF HEALTH CARE REFORMS AND CHANGING PAYMENT MECHANISMS ON HEALTH ECONOMIC EVALUATIONS IN GERMANY
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OBJECTIVES: Since January 1, 2004 several changes concerning payment mechanisms became effective. These changes include changes in drug costs (new definition for pharmacy add-ups (affecting primarily very low and high priced drugs, and mandatory manufacturer discounts), the introduction of a DRG-system for hospital care and a new tariff system for private practices. The impact of these changes on health economic evaluations using the third party payer perspective was evaluated.

METHODS: Resource utilization data for two different intravenous therapies for oncologic indication was collected from 89 quarterly fee listings of office based specialists in 2000. Findings were projected to the hospital care setting and an oral treatment option. The resource utilization data for each therapy and treatment setting were analyzed 3 times: 1) drug costs, physician services and hospital per diem rates (2002); 2) drug costs, physician services and hospital per diem rates (2004); and 3) drug costs, physician services and hospital DRG rates (2005).

RESULTS: Compared to the 2002 analyses treatment cost in 2005 in private practices decreased by 3–18%, mainly due to lower drug costs. Cost for hospital treatment changed in different directions depending on the type of hospital. Treatment cost in municipal hospitals increased by 52%–229%, whereas cost in university hospitals decreased by 1%–65%. CONCLUSION: Recent changes due to health care reforms and resulting changes in payment mechanisms had a major impact on calculating treatment costs from a third party payer perspective in Germany. Although these results refer to an oncologic indication, it is very likely that similar differences will be observed in other therapeutic areas as well. Results of health economic evaluations from the third party payer perspective performed prior to 2005, particularly those involving hospital care and not using DRGs may be misleading today and re-analysis should be seriously considered.