Cost of Dengue Cases in Eight Countries in the Americas and Asia: A Prospective Study

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Abstract. Despite the growing worldwide burden of dengue fever, the global economic impact of dengue illness is poorly documented. Using a common protocol, we present the first multicountry estimates of the direct and indirect costs of dengue cases in eight American and Asian countries. We conducted prospective studies of the cost of dengue in five countries in the Americas (Brazil, El Salvador, Guatemala, Panama, and Venezuela) and three countries in Asia (Cambodia, Malaysia, and Thailand). All studies followed the same core protocol with interviews and medical record reviews. The study populations were patients treated in ambulatory and hospital settings with a clinical diagnosis of dengue. Most studies were performed in 2005. Costs are in 2005 international dollars (I$). We studied 1,695 patients (48% pediatric and 52% adult); none died. The average illness lasted 11.9 days for ambulatory patients and 11.0 days for hospitalized patients. Among hospitalized patients, students lost 5.6 days of school, whereas those working lost 9.9 work days per average dengue episode. Overall mean costs were I$514 and I$1,394 for an ambulatory and hospitalized case, respectively. With an annual average of 574,000 cases reported, the aggregate annual economic cost of dengue for the eight study countries is at least I$587 million. Preliminary adjustment for under-reporting could raise this total to I$1.8 billion, and incorporating costs of dengue surveillance and vector control would raise the amount further. Dengue imposes substantial costs on both the health sector and the overall economy.

INTRODUCTION

Dengue fever, a viral infection transmitted by the Aedes aegypti mosquito, is a rapidly growing public health problem in tropical and sub-tropical countries. A large share of the world population is at risk, as over 2.5 billion people live in affected areas, and an additional 120 million people travel to affected areas annually. The annual number of dengue infections is estimated at 50 to 100 million. Cases reported to the World Health Organization (WHO) over the past four decades show an upward trend, partly resulting from an increased spread of vector mosquitoes and increases in total human population, including specific increases in urban populations at risk of dengue infection. In preliminary studies, potential dengue vaccines and certain vector control strategies were highly cost effective, but more and better cost information are needed to evaluate preventive interventions in multiple settings.

Cost of illness studies quantify the economic value of resources lost because of disease or consumed in its prevention, treatment, and care. Endemic and epidemic dengue imposes economic and social stress on health care systems, affected households, and society at large. Previous cost studies have been limited to a single country and did not address all these associated economic losses.

The objectives of this study were to measure the cost of a dengue case (either ambulatory or hospitalized) comprehensively in several countries in Asia and the Americas, collecting data prospectively using a common protocol, which included data on lost productivity, school absenteeism, and unpaid time of caregivers. The countries participating in this collaborative study represent 64% of worldwide reported dengue cases. Therefore, this analysis provides some indication of the global costs imposed by dengue illnesses.

METHODS

Study design. We conducted prospective health care facility-based studies on disease burden and cost of dengue illnesses in eight endemic countries. Five of the countries were in the Americas (Brazil, El Salvador, Guatemala, Panama, and Venezuela) and three were in Asia (Cambodia, Malaysia, and Thailand) (Figure 1).

The study population consisted of patients with febrile illness that met the WHO clinical case definition for dengue. In Panama and Venezuela, only laboratory confirmed dengue cases were included. Investigators chose age groups and facilities based on dengue endemicity and access in consultation with national authorities (see Table 1). All sites included children (< 15 year of age) and five also included adults. All sites enrolled patients admitted to major provincial or national reference public hospitals. Six sites (those in urban areas) also enrolled ambulatory patients from outpatient facilities linked to the selected hospitals. In Brazil, patients attending private facilities were also recruited into the study. The studies used a core protocol under the supervision of a coordinating institution. This protocol sought to document, but not to change, patterns of visits and hospital days.

Patients were selected consecutively or systematically (where patient volume exceeded interviewer capacity). Selected patients or legal guardians (for children) were invited to participate, asked to sign an informed consent form, and then enrolled in the study. Although the number of individuals choosing not to participate in the study was minimal, no systematic effort was made to characterize these individuals. Recruitment periods varied by country, extending from
September 2004 through January 2007, with most patients enrolled during the 2005 dengue season.

**Research procedures.** We developed, piloted, and translated (into Khmer, Malay, Portuguese, Spanish, and Thai) a patient questionnaire. This questionnaire documented demographic and socioeconomic data for patients and other household members, characteristics of the illness episode and its effects on health status, use of medical services, work and school absences, hours of patient care provided by household members, household spending, and household income lost. We abstracted medical records of hospitalized patients to obtain clinical data, including length of hospital stay. Additionally, we used a hospital cost form to collect each facility’s annual operating expenses, number of beds, occupancy rates, and number of emergency and outpatient visits for calculating unit costs.

### Table 1

**Dengue epidemiologic and economic indicators for study countries and sites***

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Americas</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Currency name</strong></td>
<td>Brazil: Real</td>
<td>Cambodia: Riel</td>
</tr>
<tr>
<td><strong>Exchange rate used</strong></td>
<td>Brazil: 2.53</td>
<td>Cambodia: 3.80</td>
</tr>
<tr>
<td><strong>GDP, US$/capita</strong></td>
<td>Brazil: 3,460</td>
<td>Cambodia: 4,960</td>
</tr>
<tr>
<td><strong>GDP, I$/capita</strong></td>
<td>Brazil: 8,230</td>
<td>Cambodia: 10,320</td>
</tr>
<tr>
<td><strong>Ratio: GDP I$/US$</strong></td>
<td>Brazil: 2.38</td>
<td>Cambodia: 2.08</td>
</tr>
<tr>
<td><strong>Minimum daily wage, I$ (US$)</strong></td>
<td>Brazil: 12.8 (5.4)</td>
<td>Cambodia: 11.4 (3.6)</td>
</tr>
<tr>
<td><strong>Cost per day of school, I$ (US$)</strong></td>
<td>Brazil: 4.4 (1.9)</td>
<td>Cambodia: 9.6 (4.6)</td>
</tr>
</tbody>
</table>

**Characteristics of study site**

<table>
<thead>
<tr>
<th>Location</th>
<th>City</th>
<th>Province</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population (millions)</strong></td>
<td>Brazil: 1.20</td>
<td>Cambodia: 5.60</td>
<td></td>
</tr>
<tr>
<td><strong>Main year of recruitment for study</strong></td>
<td>Brazil: 2005</td>
<td>Cambodia: 2005</td>
<td></td>
</tr>
<tr>
<td><strong>Reported dengue cases in site</strong></td>
<td>Brazil: 9,033</td>
<td>Cambodia: 39,686</td>
<td></td>
</tr>
<tr>
<td><strong>Children (0–14 years), %</strong></td>
<td>Brazil: 15%</td>
<td>Cambodia: 22%</td>
<td></td>
</tr>
<tr>
<td><strong>Adults (15 plus years), %</strong></td>
<td>Brazil: 85%</td>
<td>Cambodia: 78%</td>
<td></td>
</tr>
<tr>
<td><strong>Circulating dengue serotypes</strong></td>
<td>Brazil: Predominant 1,2,3</td>
<td>Cambodia: Predominant 1,2,3,4</td>
<td></td>
</tr>
</tbody>
</table>

**Unit costs in participating facilities†**

<table>
<thead>
<tr>
<th></th>
<th>Per inpatient bed day, I$ (US$)</th>
<th>Per ambulatory visit, I$ (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brazil</strong></td>
<td>193.7 (81.4)</td>
<td>29.1 (12.2)</td>
</tr>
<tr>
<td><strong>Cambodia</strong></td>
<td>160.0 (76.5)</td>
<td>24.0 (11.5)</td>
</tr>
<tr>
<td><strong>Malaysia</strong></td>
<td>823.4 (448.8)</td>
<td>12.3 (6.7)</td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td>173.8 (110.1)</td>
<td>26.1 (16.5)</td>
</tr>
<tr>
<td><strong>Panama</strong></td>
<td>91.1 (68.1)</td>
<td>13.7 (10.2)</td>
</tr>
</tbody>
</table>

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* GDP = gross domestic product; US$ = U.S. dollars; I$ = international dollars.
† Participating hospitals in the Americas:
- Brazil: Hospital de Doencas Tropicais (state and country’s public reference hospital for tropical infectious diseases); Hospital Santa Helena (state’s private reference hospital for infectious diseases); El Salvador: Children Hospital Benjamin Bloom (country’s pediatric reference public hospital); Guatemala: Roosevelt Hospital (country’s pediatric reference hospital); Zacapa Regional Hospital (regional reference public hospital); Panama: Santo Thomas Hospital (country’s reference public hospital); Venezuela: Coro Hospital (state’s reference public hospital).
- Participating hospitals in Asia:
  - Cambodia: Kandal Hospital (provincial’s reference public hospital); Malaysia: University of Malaya Medical Center (state and country’s reference hospital); Thailand: Khon Kaen Provincial Hospital (provincial’s reference public hospital).
Data collection and management. Patients were interviewed by a trained health interviewer using the patient questionnaire. Each study participant had a final interview around or after the time of his/her recovery. In six countries, an additional interview was administered during the acute stage of illness. All patients received at least one in-person interview (at the health facility or the patient’s home or workplace). The additional interviews, when performed, were conducted either in-person or by telephone. Data were entered into a Microsoft Access database (2003, Microsoft Corp, Redmond, WA). To standardize data accession, quality control, analytical procedures, and training of interviewers, site investigators participated in at least one of three international workshops, received site visits, accessed a list serve from the coordinating unit, and conferred regularly with the coordinating unit via e-mail and phone. Missing data were generally imputed from other items from the same household (e.g., missing transportation cost was imputed of other household members).

Analytic framework. The unit of analysis is a dengue case, defined as a documented acute febrile illness with a clinical diagnosis of dengue. This study examined all dengue illnesses, regardless of severity, using the WHO case definition. In countries located in the American hemisphere, the diagnosis of dengue syndromes complied with the Pan-American Health Organization (PAHO) case definition, whereas in Asian countries the WHO case definitions of dengue fever and dengue hemorrhagic fever were used. However, the case definitions between the two regions are very similar and the minor differences, which lie in the criteria for dengue shock syndrome, were not consequential for this study. Although dengue laboratory confirmation was a condition for enrollment only in Panama and Venezuela, the majority of the patients enrolled in all the other countries, except Thailand, had dengue laboratory testing. Dengue testing was based on IgM capture enzyme-linked immunosorbent assay (ELISA) performed in provincial or national reference laboratories, which followed WHO guidelines. In addition, four countries (Cambodia, Guatemala, Panama, and Malaysia) also performed virus isolation on appropriately timed samples. Among recruited and interviewed patients, we excluded from analysis in all countries except Panama patients discharged from the hospital with a non-dengue diagnosis or patients whose first interview was later than 30 days after the onset of symptoms. In Panama, where laboratory testing took unexpectedly longer, we extended this period to 60 days. We estimated the economic cost of a case by summing direct medical costs, direct non-medical costs, and indirect costs borne by government, households, and employers during the entire illness episode.

We estimated direct medical costs as a sum of the products of the quantity of services used (ambulatory or inpatient) by sector (public or private) times their respective average unit costs. We calculated unit costs of uninsured private medical care by dividing household payments by numbers of visits, as providers needed to recover their costs from users. In Malaysia, where panel doctors were paid directly by employers, we assumed the payment equaled 80% of average out-of-pocket payments for private consultations on the assumption that panel doctors agreed to a volume discount. In Brazil, where the major private insurer (Uniao Medios) (UNIMED) paid negotiated fees, we used these reimbursements as proxies for unit costs for both private and public facilities. In all other countries, unit costs were based on the cost of an average hospital day in the participating hospitals following a macro-costing approach, dividing the hospitals’ expenses by their weighted units. This macro-costing approach found that the average cost of a hospital outpatient visit ranged from 12–60% of the cost of inpatient day, with an average of 32%. As dengue visits require few medicines or procedures, we assumed that its cost would be 20% of the cost of an inpatient day (i.e., in the lower half of this range). Furthermore, as less sophisticated health facilities tend to have lower unit costs, we assumed that the average unit cost of all public-sector outpatient visits (which include health centers and dispensaries, as well as hospitals) would be 75% of the cost of the hospital outpatient visit. In Brazil, where the reimbursement prices paid by the public health insurance, Sistema Único de Saúde (SUS, Unified Health System) generally do not cover the full economic costs of care, we used private sector reimbursement rates. Table 1 summarizes the unit cost of health services provided by the studied public facilities by country as well as the country-specific economic indicators used for other cost calculations.

Direct non-medical costs included patients’ out-of-pocket payments for transportation, food, lodging, and miscellaneous expenses associated with seeking and obtaining medical care and/or household members visiting patients at the hospital. Indirect costs were the monetary values of 1) days of school lost, 2) lost days of work for pay, and 3) other days lost by either the patient or any other household member who provided care to the patient during an illness episode. The personal and societal cost of school absence is difficult to value. Because all countries fund primary education publicly, the economic value of a day of school must be at least equal to the cost of providing a day of public primary school. Being conservative, we assumed that this economic value was equal to the cost of schooling, as shown in Table 1. We then calculated the economic loss attributed to school days lost as the product of the daily cost times the number of school days lost. We valued a day of work lost to the worker or to the employer as the higher of the reported daily loss or the country-specific minimum daily wage (Table 1), and then calculated the total economic costs of work days lost as the product of this average daily loss times the number of work days lost. To value “other” days (caregiver and patient days lost other than for school or work) we used a country’s daily minimum wage for patients or household members 15 years of age or above. Household total days affected are the sum of school, work, and other days lost. As there were no deaths in our cohorts, the economic costs of premature deaths were not incorporated into the facility-based estimates of cost per case, but are included subsequently under aggregate national and multi-country estimates.

Standardization of costs across countries. To standardize measurements of economic impact across countries and facilitate comparisons and interpretations, we expressed all direct and indirect costs in 2005 international dollars (IS), which adjust for purchasing power parity (PPP), using the ratio of the gross domestic product (GDP) per capita in IS to the GDP per capita in US dollars (US$) at the market exchange rate (see Table 1). Specifically, WHO describes IS as “the costs in local currency units converted to international dollars using PPP exchange rates. The PPP exchange rate is the number of units of a country’s currency required to buy the same amount...
of goods and services in the domestic market as the US$ would buy in the United States.\(^{31}\)

In addition, we expressed total cost in US$ to facilitate within-country interpretation. To compare dengue costs with economic costs calculated for previous studies of dengue and other acute infectious diseases in low- and middle-income countries, we also expressed costs in days of GDP per capita (per capita GDP divided by 365).

**Statistical analysis for cost per dengue case.** We conducted separate analyses for each country by type of care—ambulatory (participants without any hospitalization) and hospitalized (participants with a hospital stay of at least one day). Using SPSS,\(^{32}\) we calculated unweighted means and standard deviations for continuous variables and cross tabulated categoric variables, which provide a natural weighting for all the participants. We could also have used the true number of treated dengue cases by setting in a country as the weight—percentage of cases by setting (ambulatory and hospitalized), cost for 2001–2005 of Brazil (38.6 ± 1.1) as the proxy for other American countries, following expert opinion, we used Brazilian rates. On the basis of epidemiologic similarities, we used the annual average age at death (mean ± standard error) for 2001–2005 (11.7% ± 2.4%), Malaysia (which includes primarily hospitalized patients) for 2005–2006 (95% ± 1.9%), and Thailand (which also includes primarily hospitalized patients) for 2002–2005 (83.0% ± 1.7%). The share for Cambodia (98% ± 2.0%) resulted from the structure of its reporting system, which is almost exclusively based on hospitalizations. For the remaining American countries, following expert opinion, we used Brazilian rates. On the basis of epidemiologic similarities, we used the annual average age at death (mean ± standard error) for 2001–2005 of Brazil (38.6 ± 1.1) as the proxy for other American countries and Malaysia, and of Thailand (7.6 ± 2.0) for Cambodia.

The model’s country–specific inputs were dengue cases, percentage of cases by setting (ambulatory and hospitalized), cost of a dengue case by setting, number of deaths by age, and GDP per capita.

Assuming that the distribution of cost per case by setting in our study was representative of the country’s dengue cases, we estimated each country’s aggregate cost by multiplying its average annual reported cases by its cost per case. To estimate the economic cost associated with reported dengue deaths, we used official 2001–2005 reports on the number of dengue deaths by age, and calculated the years of premature life lost as the remaining life expectancies at the ages of death based on the country–specific life tables.\(^{34}\) To adjust for standard time preferences, we discounted years lost at an annual rate of 3%. On the basis of the conservative “livelihood” approach,\(^{35}\) we then multiplied the discounted years lost by the country’s 2005 GDP per capita. The livelihood approach is considered the lower bound for the economic value of a discounted year of life lost.\(^{33,36}\)

Countries exhibited variations by year in the number of reported cases, setting of care, number of deaths, and ages at death. Therefore, we used Monte Carlo simulation methods to analyze the effect of variations in these inputs on aggregate costs.\(^{37}\) Because each input could be skewed to the right and had to be non-negative, we fitted lognormal distributions, commonly used in economic models, to each input. We used the means and standard errors of historic data of reported cases and deaths (from national data) and costs per case from our study. Combining Crystal Ball version 7.3\(^{38}\) and Excel 2003 software,\(^{39}\) we then ran a simulation with 200,000 iterations to generate precise estimates of standard deviations. Each iteration randomly drew values from the distribution of each input. From the resulting empirical distributions, we obtained means and standard deviations of the average annual aggregate cost of dengue in the study countries and the weighted (combining hospitalized and ambulatory cases and deaths) mean cost per reported case.

**Ethical considerations.** The study protocol was approved by Institutional Review Boards at Brandeis University, participating sites, and the sponsor.

**Role of the funding source.** One author (SBH) directs a different program sponsored by the funding source. In addition, other officers at the funding source read an early draft of this manuscript and suggested clarifications.

**RESULTS**

**Demographic and illness characteristics.** Of the 1,796 patients recruited and interviewed, 1,695 dengue cases in eight countries met the inclusion criteria for analysis. Table 2 summarizes demographic and illness attributes of study cases. Overall, 55% were treated in ambulatory settings, 45% were hospitalized for at least one day; 86% were treated in the public sector; 54% were females, 48% were < 15 years of age, and 83% were from urban areas. Study participants spanned the full range of socio-economic strata based on the household maximum level of education. No participants died during the study.

On average, ambulatory patients reported 11.9 days of illness, including 5.0 days with fever, and 78% had dengue documented by laboratory testing. On average, hospitalized patients reported 11.0 days of illness, including 5.9 days with fever. The majority of this cohort had evidence of bleeding (73%), leakage (vasculopathy, 62%), and laboratory documentation of dengue (75%).

**Use of medical services.** Table 3 shows the burden placed by an ambulatory or hospitalized dengue case on the health system and patients’ households. The proportion of patients who were studying or working at the time of the illness varies considerably by site, reflecting their target populations. Ambulatory and hospitalized patients averaged 4.2 and 4.6 ambulatory care visits, respectively, with country means ranging from 2.8 (Guatemala) to 6.3 (El Salvador) among ambulatory patients, and from 2.0 (El Salvador) to 7.1 (Malaysia) among hospitalized patients. The average hospitalized patient spent 3.8 days in the hospital, with country means ranging from 2.8 days (Malaysia) to 6.4 (Guatemala). Although no patients outside of Brazil were enrolled from private facilities, interview data found that visits to private facilities during the course of illness were not uncommon; they accounted for 30%
of all visits in the ambulatory cohort in Guatemala and 42% in the hospitalized cohort in Cambodia.

Dengue illness episodes affected school attendance and other productive activities of patients and household members. Patients in school at the time of the illness comprised 40% of the ambulatory cases, lost an average of 6.6 and 9.9 days of work, respectively. Similarly, patients who were working for pay at the time of the illness, constituting 43% of ambulatory and 18% of hospitalized cases, lost an average of 4.2 and 5.6 days of school, respectively. The burden on household members in addition to the patient was substantial. This impact represented 30% and 73% of paid work days lost in the ambulatory and hospitalized cohorts, respectively.

### Economic costs of a dengue case

Table 4 summarizes the costs of ambulatory and hospitalized dengue cases by country and overall. Cost varied greatly within each country, as reflected by the relatively large standard deviations (about 60% of the respective means). In the ambulatory group, indirect costs represented the largest share (overall 72%) of case costs in all countries except Malaysia. For hospitalized cases, direct costs represented the largest share of total costs. Expressed in terms of days of GDP per capita, the total cost of an ambulatory case ranged from 12 days in Venezuela to 31 days in Brazil and from 45 days in Venezuela to 110 days in Cambodia for a hospitalized case. The mean unweighted cost per case was I$514 for ambulatory patients and I$1,394 for hospitalized patients in our cohorts.

### Aggregate national, regional, and global cost of officially reported cases in eight countries

The yearly reported dengue cases by these eight countries for 2001–2005 averaged 574,000, but ranged from 253,000 to 1,020,000, reflecting variations in outbreaks by year. On average, during the same years there were 399 reported deaths (range 260 to 596) leading to 10,283 discounted years of life lost. Based only on these officially reported cases and deaths, the estimated annual total cost associated with dengue illness was I$587 million (range: I$448 to I$768 million). About 89% and 11% of this cost was imposed by dengue morbidity and dengue mortality, respectively. Dengue in Brazil and Thailand was responsible for 94% and 60% of the aggregate cost in the American and Asian study countries, respectively. The mean cost of a dengue reported case, weighted by the official numbers of deaths and cases by setting, was I$1,031 in the eight countries, but 2.7 times larger (I$2,005 versus I$759) in Asia than in the Americas.

### DISCUSSION

This was a prospective study in which dengue patients were identified using WHO case definition guidelines. A high rate of serologic confirmation of recent dengue infection was achieved. Reflective of the real world, a marked heterogeneity of demographic and socio-economic characteristics in these studies demonstrates the diversity in treatment sites, disease expression, or in disease descriptions in different country settings. Although some deaths might have been expected in this cohort of 1,695 patients, none were observed. Using the overall case fatality rates implicit in Table 5 in the Americas (0.014%) and Asia (0.27%), we would have expected two deaths. This absence of deaths may reflect chance or slight
under enrollment of severely ill patients. As all facilities, which range from ambulatory clinics and small provincial hospitals to major university hospitals, were predominant providers in their catchment areas, they were collectively representative of treatment locations for dengue across these countries. Although in three countries (Cambodia, El Salvador, and Thailand) patients were enrolled only from pediatric locations, the majority of reported cases from those countries were in children. Furthermore, the study did not appear to influence care, as the majority of medical providers were involved in the research.

This study incorporated empirical values for most of the components of health services used, and most of their unit costs. Furthermore, it examined actual medical practice, rather than the more expensive setting of a formal prospective clinical study of laboratory confirmed dengue infections.40

Not surprisingly, hospitalized patients had more severe illness than ambulatory patients, as evidenced by their higher incidence of bleeding phenomena, longer duration of fever, and more days affected. Within the six countries in which ambulatory and hospitalized cohorts were included, the total cost of a hospitalized case averaged 3.7 times that of an ambulatory case. This relationship could help estimate the cost of ambulatory cases, where direct costs are not available.

The variations in costs among countries might reflect many factors, such as the case-mix of the study participants, the type of facility at which they were enrolled, the cost of health services, patterns of treatment, the country’s wage rates, and cost of living. Nevertheless, as the cost per case in days of GDP per capita varied less than threefold across countries within ambulatory and hospitalized cohorts, the economic burden of dengue per case was fairly similar across the sites.

The absence of universal laboratory testing on all cases of suspected dengue reflected the standard practices at the participating institutions. A clinical diagnosis of dengue without laboratory confirmation is usual in ambulatory settings and in some hospitals, such as those in Thailand, where clinicians have extensive experience with dengue.41 In a few instances, laboratory diagnosis was not possible because properly spaced sera were not obtained for laboratory testing. Although 22%
Table 5

<table>
<thead>
<tr>
<th>Item</th>
<th>Brazil</th>
<th>El Salvador</th>
<th>Guatemala</th>
<th>Panama</th>
<th>Venezuela</th>
<th>Cambodia</th>
<th>Malaysia</th>
<th>Thailand</th>
<th>All participants</th>
<th>Cost share %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Official dengue reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cases (thousand)</td>
<td>387 ± 114</td>
<td>11 ± 3</td>
<td>8 ± 0.5</td>
<td>2 ± 1</td>
<td>44 ± 10</td>
<td>11 ± 1</td>
<td>31 ± 4</td>
<td>81 ± 20</td>
<td>452 ± 117</td>
<td>122 ± 17</td>
</tr>
<tr>
<td>Deaths</td>
<td>54 ± 25</td>
<td>5 ± 2</td>
<td>3 ± 1</td>
<td>1 ± 1</td>
<td>6 ± 2</td>
<td>151 ± 19</td>
<td>86 ± 11</td>
<td>93 ± 25</td>
<td>70 ± 25</td>
<td>330 ± 34</td>
</tr>
<tr>
<td>Aggregate cost, mean ± SD (million)</td>
<td>322.1 ± 93.4</td>
<td>3.6 ± 0.8</td>
<td>2.2 ± 0.2</td>
<td>1.4 ± 0.7</td>
<td>13.7 ± 3.0</td>
<td>18.2 ± 1.2</td>
<td>79.4 ± 8.2</td>
<td>146.9 ± 32.0</td>
<td>343.0 ± 93.5</td>
<td>244.5 ± 33.0</td>
</tr>
<tr>
<td>Mean cost per reported case (including fatal cases), mean ± SD (million)</td>
<td>322.1 ± 93.4</td>
<td>3.6 ± 0.8</td>
<td>2.2 ± 0.2</td>
<td>1.4 ± 0.7</td>
<td>13.7 ± 3.0</td>
<td>18.2 ± 1.2</td>
<td>79.4 ± 8.2</td>
<td>146.9 ± 32.0</td>
<td>343.0 ± 93.5</td>
<td>244.5 ± 33.0</td>
</tr>
</tbody>
</table>

*IS = international dollars; US$ = U.S. dollars.

Previous research on the economic impact of dengue has been limited to single-country studies and using less comprehensive costing methods.\(^{10-17}\) Cost per case in these studies, translated to days of GDP per capita, varied from 8 days\(^{14}\) to 56 days.\(^{15}\) Earlier estimates of the cost of dengue illnesses were below those estimated in our study. For example, previous studies found costs per case of $44 in Kampaeng Phet, Thailand in 2001,\(^{14}\) $120 and $140 for Suphan Buri and Bangkok regions of Thailand, respectively, in 1994,\(^{10}\) and $121 for Venezuela from 1997 to 2003.\(^{15}\) Less comprehensive analysis of government subsidies for public services and valuation of indirect costs, inflation, and use of US$ instead of IS$ were major reasons for the lower estimates.

We compared the total cost of inpatient dengue cases with those for other acute infectious diseases, such as influenza,
COST OF DENGUE IN THE AMERICAS AND ASIA

bronchitis, pneumonia, rotavirus, or typhoid fever, requiring inpatient care in low- or middle-income countries in The Americas and Asia. Of the examples found, only a few studies examined both direct and indirect costs.57-59 The wide range in total costs measured in terms of days of GDP per capita, from 4 days7 to 112 days,50 mainly reflects variations in methodologies and study scope (e.g., household versus societal perspective) rather than differences in impact among the diseases. Nevertheless, the range for these diseases overlaps substantially with the range for dengue, indicating that the economic cost of a dengue case is comparable to that of other infectious diseases.

A limitation of our research is that in the three Asian study countries, dengue cases were included from only a single institution. Nevertheless, this is the most comprehensive study of dengue costs published to date and the first to develop comparable data across two hemispheres, and comprises an important step to documenting the global burden of dengue. Earlier comparative economic evaluations across countries for other diseases, such as for rotavirus, encountered challenges in data interpretation because of methodologic differences among studies.52

Although it may be premature to extrapolate these preliminary data, we appreciated the interest in generating preliminary estimates of dengue costs using currently available case reporting data. The $587 million estimate for the average annual cost of dengue in the eight study countries was based on the officially reported dengue cases for the 2001–2005 periods. The validity of our estimate relies on our assumption that the distributions of cost per case in our study are representative for the country. On the basis of other studies,54 our estimate may be too high for countries where our site was a national referral hospital (such as in El Salvador and Malaysia), and too low where it was a small provincial hospital (such as Cambodia and Venezuela). These effects may tend to offset one another for the eight-country aggregate. The American countries bore only 17% of the reported dengue deaths, but 79% of the reported cases and 58% of the estimated total cost of dengue. These contrasts are a result of regional differences in both epidemiology53 and reporting of dengue.54 In the Americas, where dengue usually occurs as dengue fever (DF), patients generally receive care in ambulatory settings, which are included in dengue surveillance and reporting systems. In Asia, by contrast, more dengue cases are believed to develop dengue hemorrhagic fever (DHF), dengue shock syndrome (DSS), and death,52 and surveillance and reporting systems are mainly limited to hospitalizations.52 For example, because Cambodia had the highest average annual death rate (151 deaths out of 11,000 reported cases, or 1.4%) it had one of the highest resulting average costs per case ($1,733).

Our estimate of the eight-country cost of dengue illness is conservative. Official reports substantially underestimate the true number of cases and highlight the need for expansion factors to adjust for this underreporting.5 Previous research indicates expansion factors from 1.6 to 3.2 for hospitalized dengue,54,55 from 10 to 27 for ambulatory dengue,52 and 6 for all dengue cases.59 As a preliminary illustration, an overall expansion factor of 3 would suggest a cost of dengue illness in these eight countries averaging $1.8 billion per year, but ranging from $1.3 to $2.3 billion. With expansion factors of 2 or 6, the eight-country costs would range from $1.2 to $3.6 billion. Further analysis of the performance of each country's treatment reporting system would be needed to refine unit costs and expansion factors and project trends.

Furthermore, these estimates also exclude the substantial costs associated with dengue surveillance and vector control programs. For example, Brazil's budget for vector control in 1997 was US$0.6 billion, equivalent to IS$1.2 billion in 2005 prices.57 Panama, with a population of only 3.2 million people, spent US$5.0 million, equivalent to IS$7.9 million in 2005.56 Mass larviciding efforts against the dengue vector A. aegypti in two urban areas of Cambodia with a population of 2.9 million people between 2001 through 2005 had an annual average gross cost of US$568,000 in 2005 US$, or US$ 0.20 (IS 1.31) per person covered.

In summary, this study shows that dengue poses a heavy economic cost to the health system and society; that the cost varies by setting (ambulatory and hospitalized), that improved surveillance and reporting efforts are necessary to include ambulatory patients from at least sentinel sites (mainly in Asia), to officially report cases by setting, and to reduce underreporting. The study also suggests the potential economic benefits associated with promising dengue prevention interventions, such as dengue vaccines and vector control innovations.

Received September 22, 2008. Accepted for publication January 13, 2009.

Acknowledgments: We thank all the site research groups for careful study implementation and Martha Bazze, Elizabeth HaileSellassie, Clare L. Hurley, Aung Lwin, Ali MacLean, Chrisann Newransky, and William B. Stason from Brandeis University, Moh Seng Chang from WHO Cambodia, and PDVI officials for thoughtful comments.

Financial Support: This research was supported by research agreements from the Pediatric Dengue Vaccine Initiative (PDVI) (a program of the International Vaccine Institute) to the authors' institutions and by the endowment of the Schneider Institutes for Health Policy at Brandeis University.

Disclosure: The views expressed in this article are those of the authors and do not necessarily reflect the views of the authors' institutions or the sponsor. This analysis was completed while J. Suaya was a full-time employee at Brandeis University; he is currently working at GlaxoSmithKline on activities unrelated to dengue. D. Shepard is the principal investigator of a grant to Brandeis University from Sanofi Pasteur for a dengue study in a country not included in this manuscript. This grant began after all analyses reported in this manuscript were completed. This statement is made in the interest of full disclosure and not because the authors consider this a conflict of interest.

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