with relevant follow up for positive tests. Prior to the test, attenders were given a questionnaire about their doubt and arguments in relation to their participation decision, including factors willingness-to-pay (WTP) questions. Non-attenders were mailed a similar questionnaire. RESULTS: 70% responded to the questionaire, which lead to a study sample of 1,053 attenders and 435 non-attenders. Among attenders, 5% had doubt about participation and the most frequent argument was that they did not want to know about the test result. Among non-attenders, 46% would reconsider attendance after further information, the main argument for doubt being the same as for attenders. Further arguments were self-perceived low risk and the trouble and costs associated with attending. Attendees valued the test significantly higher than non-attenders but this was sensitive to exclusion of bidders who did not pass a simple test for internal consistency of the reported WTP. Doubt about participation was associated with significantly lower WTP among attenders whereas the opposite was the case for non-attenders. Among attenders who had doubt, the WTP was the same for attenders and non-attenders. CONCLUSIONS: Up to half of the non-attenders appeared to have doubt about their decision, which presents a potential for increasing the participation rate. Non-attenders in doubt about their participation decision value the programme at a similar level as attenders in doubt, suggesting that non-attenders in doubt do not differ significantly in their base-line valuations from those of the individuals in doubt who choose to attend.

Cardiovascular Disorders – Health Care Use & Policy Studies

**PCV124**

**REFERENCE PRICING, ORIGINATOR DRUGS AND CONSUMERS’ CHOICE**

Häme T1, Koskinen H2, Valtonen H3

1National Institute for Health and Welfare, Helsinki, Finland, 2The Social Insurance Institution, Helsinki, Finland, 3University of Eastern Finland, Kuopio, Finland

OBJECTIVES: Generic reference pricing of medicines was introduced in Finland in April 2009. The system restricts the amount of reimbursement paid to a consumer, thus creating a financial incentive for the consumer to accept the switch to a reference priced product. The aim of this study was to assess the impact of reference pricing on consumer’s choice, and to analyse the factors associated with the choice of an originator drug priced higher than the reference price. METHODS: The data used in this study was collected from the Social Insurance Institute’s prescription register. Data covers the records of the purchases in five active ingredient groups (atorvastatin, simvastatin, rivastigmine, olanzapine, quetiapine) in the Finnish population from January 2008 to August 2010. Data includes information of the consumer’s socio-demographic characteristics and income, and of the prescribed and purchased product. Logistic regression analysis and logistic multilevel regression analysis were used to analyse the factors associated with the choice of the originator drug. RESULTS: After the introduction of reference pricing the use of originator drugs declined but some of the consumers chose originator drugs even when priced higher than reference price. An important factor explaining the probability of choosing over reference priced originator drugs is the choice history of the patient. In some active ingredient groups’ higher age, higher income and female sex increased the probability of originator drug choice. The right to special reimbursement mainly lowered the probability. Female sex increased the probability of originator drug choice. The right to special reimbursement mainly lowered the probability.

**PCV125**

**THE INCREASING BURDEN OF ATRIAL FIBRILLATION ON HEALTH CARE IN SCOTLAND**

Choy AM1, Punekar YG2, Keech M3

1Ninevilles Hospital and Medical School, Dunbe, UK, 2Sanofi-Aventis, Guildford, UK, 3Pharmacy Ltd., St. Albans, UK

OBJECTIVES: Atrial fibrillation (AF) is the most common cardiac arrhythmia in clinical practice with increasing prevalence in the aging population. The objective of our study was to evaluate the impact of AF on secondary care costs in Scotland. METHODS: Patient hospitalisation data collected by the Information and Statistics Division (ISD) of the Scottish National Health Service (NHS) from 2004 to 2008 were analysed to estimate the trends in hospital episodes in the 5.2 million population of Scotland. The associated costs were estimated using the tariff prices in Scotland for the respective years. RESULTS: Over the 5 year period, the number of patients hospitalised for AF increased by 21.0% to 26,510 patients in 2008 from 21,907 in 2004, with a total of 162,449 hospital admissions for AF over this period and accounting for 20.8% of total cardiovascular (CV) hospitalisations in 2008. The total inpatient bed days in 2008 were 394,128, a 14.5% increase during this time, with mean length of inpatient stay for AF higher than the mean for all cardiovascular conditions (10.9 vs 8.7). The total cost (inpatient and day cases) attributable to AF was £138.9 million in 2004 to £162.5 million in 2008, accounting for a quarter (or more) of all hospital costs in Scotland. Overall, the burden of AF is higher among women and increased progressively with age. CONCLUSIONS: AF presents a significant and increasing burden on hospital care in Scotland. As a proportion of total CV burden, AF accounts for nearly a quarter and is increasing at a relatively higher rate.

**PCV126**

**MULTIDIMENSIONAL NON-INTERVENTIONAL STUDY TO ASSESS CURRENT PRACTICE, UTILIZATION OF RESOURCES AND COSTS RELATED TO ANTIICOAGULATION TREATMENT IN POLAND – “ECONOMEDICA”**

Wilczynska J1, Haldas M2, Bolisage DP, Rutkowski J1, Smaga A1, Wladysiuk M2

1Sequence Partners, Warszawa, Poland, 2PharmaCenta, Krakow, Poland

OBJECTIVES: To evaluate current practice, characteristics of treated population, utilisation of resources and direct medical costs related to anticoagulation treatment in 6 indications in Poland. METHODS: The study consisted of 3 parts: cross-sectional survey (performed in hospitals and open care), retrospective chart review and experts opinion-based study. The study was carried out between December 20, 2010 and March 15, 2011. Patients data on anticoagulation therapy or with atrial fibrillation or immobilized were included in cross-sectional part (2011 hospitalization dataset and 4517 patients treated in 2010). Consecutive patients were treated for stroke, myocardial infarction, coronary artery disease, deep vein thrombosis, pulmonary embolism or atrial fibrillation or undergoing surgery (e.g. hip or knee replacement) was included in retrospective chart review. A total of 546 face-to-face interviews with physicians of different specializations (orthopedists, general practitioners, cardiologists, neurologists, vascular surgeons, hematologists and rehabilitation therapists) were conducted in opinion-based study. Projection of treated population was made in order to generalize the results to the whole country. RESULTS: About 150,000 prescriptions for anticoagulants were made within 2 weeks of study. Approximately 36,000 patients daily were treated with anticoagulants in hospitals. The main reason for administering anticoagulants in outpatient treatment was primary stroke prevention in patients with atrial fibrillation (28%), secondary prevention of venous thromboembolism (18%) and secondary stroke prevention in atrial fibrillation (14%). During hospitalization anticoagulants were administered mainly as a prevention of venous thromboembolism in patients who underwent a surgery (33%), or were immobilized due to other reasons (17%). Vitamin K antagonists accounted for 65% of market in outpatient practice, while LMWHs and other low-molecular-weight heparins (LMWHs) for 35%. The most common anticoagulant treatment CONCLUSIONS: Administration of anticoagulants in inpatient treatment is usually surgery-related, while in outpatient treatment the most common reason is stroke prevention. Oral anticoagulants are usually administered in outpatient treatment, while LMWHs are most commonly used in hospitals.

**PCV127**

**TIME TO INITIATION OF ORAL ANTHTHYPERGLYCAEMIC AND STATIN THERAPY IN PATIENTS WITH NEWLY DIAGNOSED TYPE 2 DIABETES MELLITUS**

Tuncel K1, Sun P2, Seek T1, Ambekogar R1, Lento K1, Davies M1, Zhang Q1, Radacin L1

1Astellas Pharma Ltd., St. Albans, UK, 2Ninewells Hospital and Medical School, Dundee, UK

OBJECTIVES: To assess the time to initiation of therapy with an oral antihyperglycaemic agent (OAHAA) or statin in patients with newly diagnosed type 2 diabetes mellitus (T2DM). METHODS: In a retrospective analysis of a general Electric medical electronic medical record database, patients ≥18 years were included if they were newly diagnosed with T2DM between January 1, 2004 and December 31, 2005 (index period), with last pre-index A1C ≥7%, and had not received any anti-hyperglycaemic agents within the 2 years prior to diagnosis (index date). In addition, patients were required to be eligible for statin therapy per 2008 American Diabetes Association recommendations but not on a statin within 1 year prior to index date. Patients had to have medical records 1 year prior to (baseline) and at least 2 years after (follow up) the index date. Initiation of OAHAA and statin was determined based on the first prescription record for each therapeutic class. RESULTS: Of the 2545 patients with newly diagnosed T2DM (58% male), mean age at index date was 58 years. The most recent mean HbA1c before diagnosis was 8.5% and mean LDL-cholesterol was 106 mg/dL. Further, 21% of patients had pre-existing hypertension, 40% had dyslipidaemia, 37% were obese, and 11% were smokers. After 2 years of follow up, 48% and 53% of patients initiated an OAHAA and statin, respectively, with 18% initiating both agents on the same day. The median time from diabetes diagnosis to initiation of OAHAA was 119 days and 325 days for statin. Median time to initiation of both agents was 69 days. CONCLUSIONS: Treatment with OAHAA and/or statin was suboptimal after years in patients with newly diagnosed T2DM who were also eligible for statin therapy. Of those treated, patients initiated treatment earlier with OAHAA than with statin.

**PCV128**

**A REAL WORLD EVALUATION TO DESCRIBE THE CHARACTERISTICS, OUTCOMES AND RESOURCE USE ASSOCIATED WITH PATIENTS BEING MANAGED BY A SECONDARY CARE BASED ANTIICOAGULATION SERVICE**

Rose P1, James K2, Chapman O3, Marshall S4

1University Hospitals Coventry & Warwickshire, Coventry, UK, 2University Hospitals Coventry & Warwickshire, Coventry, UK, 3University Hospitals Coventry & Warwickshire, Coventry, UK, 4Myth Associates, Marlow, UK

OBJECTIVES: To describe the resource use and level of anticoagulation control associated with different patient characteristics within a secondary care anticoagulation service. METHODS: An observational research study was conducted in one secondary-care anticoagulation service between March and June 2010. Retrospective data were collected on patient characteristics (age, sex, concomitant medications), number of INR (International Normalised Ratio, pro-thrombin time) visits and time in target range (TTR) from all patients registered with the service after January 1, 2008 and >3 months before data collection. Data were collected by initiation (6 weeks after initiation of treatment ≈ week 12) and maintenance (≈ week 12) phases and correlations run to explore relationships. RESULTS: Data were collected from 288 patients; mean age 67 years, 54% male. 45% had atrial fibrillation (AF), 37% were receiving warfarin for venous thromboembolism treatment and/or prevention (VTE), 18% other reasons (e.g. cardiac valves). Mean number of INR visits was 8.4 during initiation and 1.6 per month during maintenance for patients with AF and 10.2 and 1.9 respectively for VTE. Mean TTR was 45% during