with relevant follow up for positive tests. Prior to the test, attenders were given a questionnaire about their doubt and arguments in relation to the participation decision, including a statement 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 argumenet was that they did not want to know about the test result. Among non-attenders, 46% would reconsider attendance after further information, the main argumenet for doubt being the same as for attenders. Further arguments were self-perceived risk low and the trouble and costs associated with attending. Attendees values of the programme were statistically 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 non-attenders who did not doubt, the WTP was the highest 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
Hulis T1, Koskinen H2, Valtonen H2
1National Institute for Health and Welfare, Helsinki, Finland, 2The Social Insurance Institution, Helsinki, Finland, University 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 referenced 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, rasmine, olanzapine, quetiapine) for the whole 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 was used to examine the factors associated with the choice of an originator drug. RESULTS: After the introduction of reference pricing the use of originator drugs declined but some of the consumers choose originator drugs even when priced higher than reference price. An important factor explaining the probability of choosing over referenced price originator drugs is habit, 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. CONCLUSIONS: In earlier studies it has been shown that some of the consumers have prejudices on generic products and they want to stick with doctor’s choice of medicine. The results of our study also indicate that doctor’s primary decision of the prescribed medicine probably has an influence on some consumers choices and that decision has an important role in promoting the use of cheaper, generic products.

PCV125
THE INCREASING BURDEN OF ATRIAL FIBRILLATION ON HEALTH CARE IN SCOTLAND
Choy AM1, Punekar YS2, Keech M3
1Nineelli Hospital and Medical School, Dundee, UK, 2Sanofi-Aventis, Guildford, UK, 3Pharmacies Ltd., St. Albans, UK

OBJECTIVES: Atrial fibrillation (AF) is the most common cardiac arrhythmia in clinical practice with increasing prevalence in the ageing 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 the respective years. Amongst those in doubt, the WTP was the same for attenders and non-attenders. In general and vascular surgeons, cardiologists, neurologists and rehabilitation therapists were conducted in opinion-based study. The total of 546 face-to-face interviews with physicians of different specializations (orthopedists, general surgeons, vascular surgeons, neurologists, general practitioners, interventional cardiologists, 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 hospitalized due to other reasons (17%). Vitamin K antagonists accounted for 65% of market in outpatient practice, while warfarin (LMWH) constituted 35% of total market.

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 ANTITHROMBOCYTIC AND STATIN THERAPY IN PATIENTS WITH NEWLY DIAGNOSED TYPE 2 DIABETES MELLITUS
Tunche K1, Sun P2, Seck T3, Ambeggakor B3, Lento K1, Davies M3, Zhang Q3, Radain L1
1Cancer Care Network Sharp & Dharma Corp., Whitehorse Station, N, USA, 2Rado Research Group, Fishers, IN, USA

OBJECTIVES: To assess the time to initiation of therapy with an oral antithrombytic agent (OAH/A) or statin in patients with newly diagnosed type 2 diabetes mellitus (T2DM). METHODS: retrospective US cohort study. The general Electric 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-thrombytic 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 OAH/A and statin was determined based on the first prescription record for each therapeutic class.

RESULTS: Of the 2525 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, 43% had dyslipidaemia, 97% were obese, and 11% were smokers. After 2 years of follow up, 48% and 53% of patients initiated an OAH/A and statin, respectively, with 18% initiating both agents on the same day. The median time from diabetes diagnosis to initiation of OAH/A was 119 days and 325 days for statin therapy. Median time from diagnosis of T2DM to the initiation of OAH/A was 69 days.

CONCLUSIONS: Treatment with OAH/A 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 OAH/A 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 ANTICOAGULATION SERVICE
Rose P1, Chapman K2, Marshall R2
1University Hospitals Coventry & Warwickshire, Warwick, UK, 2University Hospitals Coventry & Warwickshire, Coventry, 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 chart review was collected on patient characteristics (age, BMI, concomitant medications), number of INR (International Normalised Ratio, prothrombin 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 reviewed by the researcher (R) 2 weeks after initial visit and experts opinion-based study. The study was conducted in a general medical practice in the UK. RESULTS: Data were collected from 388 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