the 6 agencies (9 publications) that evaluated DPP-4 inhibitors, 2 recommended the drug not be listed or funded (CADDTH, AHTAPol) and 4 recommended restricted use (PBAC, SMC, CVZ and NICE). The most common reason for agency’s disinclination for listing/funding was insufficient information on the effectiveness and cost-effectiveness of the evaluated treatment. The mean number of more than 100 HTAs across the endocrine nutritional and metabolic therapeutic area, approximately half of them (49 projects) concern diabetes, 21 of which evaluate pharmacological treatment of diabetes (8 countries, 11 agencies). CONCLUSIONS: Diabetes prevalence is on the rise, attracting attention from health care agencies. Despite health-related data sources variable outcomes suggest to us that agencies are applying different weightings in their assessment process. The apparent failure to demonstrate effectiveness in specified populations suggests late segmentation by manufacturers and insufficient resource allocation. This is often due to late payer requests for such analyses motivated by financial considerations. Early segmentation and engagement with payers is thus critical for HTA success.

**ETHICAL ANALYSES IN HEALTH TECHNOLOGY ASSESSMENTS OF DIABETES TREATMENTS**

**OBJECTIVES:** Health Technology Assessment (HTA) is mostly known for its health economic properties even though it is a multidisciplinary form of policy research examining long-term consequences of health technology. There is an increased focus on ethical analyses on HTA. A descriptive analysis was conducted on diabetes HTA reports describing ethical analyses. METHODS: The NHS Centre for Reviews and Dissemination HTA database (http://www.crd.york.ac.uk/criweb) was searched (1991-2009) using the keyword “diabetes”. HTA reports in English with long-term diabetes management were included as a basis for a type of ethical analyses. RESULTS: Of 263 HTA reports identified in the initial search, 60 met the inclusion criteria. 4 reports included a type of ethical analysis (2 from CADTH, Canada; 1 from AHTA, Australia and 1 from NZHTA, New Zealand). CADTH conducted ethical analyses on short- and long-acting insulin analogues respectively, concluding that both types of insulin analogues did not exacerbate—might even better—the psychosocial issues of diabetes, however more quality-of-life evidence were needed. In AHTA’s assessment of a continuous glucose monitoring device examining short- and long-term consequences of the application of a health technology. CONCLUSIONS: The assessment of continuous glucose monitoring devices raises some ethical considerations of HTA analyses. Ethical analyses are sparse in diabetes, despite stated objectives of best practice and HTA definitions. In the identified cases, ethical analyses were targeted to meet patients’ needs as well as a tool to restrict access for the purpose of fair distribution in government funded health care systems. Further research on the methods of ethical analyses is warranted as well as an elaboration of guidelines to fully estimate the value and ensure an optimal role for ethical analyses in HTA.

**BASELINE CHARACTERISTICS OF PATIENTS BEGINNING BASAL, BASAL PLUS SHORT-ACTING, SHORT-ACTING OR PREMIX INSULIN: DATA FROM THE CREDIT STUDY**

**OBJECTIVES:** The ongoing Cardiovascular (CV) Risk Evaluation in people with Type-2 diabetes mellitus (T2DM) on Insulin Therapy (CREDIT) study is assessing the effect of insulin on the risk of vascular events. METHODS: CREDIT is a 4-year, 314 centre, non-interventional trial in North America, Europe and Asia. It includes 3031 people with T2DM who had recently started basal and/or short-acting insulin, premix insulin or another insulin type. This analysis examines and compares the characteristics between groups starting basal (n = 1563), basal + short-acting (n = 444), short-acting (n = 221), premixed (n = 700) or another (n = 103) insulin. RESULTS: Demographic and diabetes characteristics were reasonably balanced between the insulin groups, although those receiving basal plus short-acting insulin or premix had a trend to higher baseline HbA1c levels vs other insulin types (basal, 9.2 ± 2.1%; basal + short-acting, 9.4 ± 2.0%; premix, 9.9 ± 2.0%; other, 9.1 ± 2.0%). While the majority had previously used oral glucose lowering drugs (OGLDs) (basal, 97%; basal + short-acting, 83%; short-acting, 83%; premix, 94%; other, 83%), differences in the numbers continuing OGLDs when beginning insulin were observed. 2.0% of patients had previously used oral glucose-lowering drugs before insulin initiation, most commonly ARBs. New QOF clinical indicators have been agreed for 2009/10: DM23 achievement of clinical indicators and QOF points with payers is thus critical for HTA success.

**DIFFERENCES IN THE CHARACTERISTICS OF PEOPLE WITH TYPE 2 DIABETES STARTING INSULIN IN THE NORTH, SOUTH AND EAST OF EUROPE: DATA FROM THE CREDIT STUDY**

**OBJECTIVES:** Maintaining long-term glycemic control with insulin therapy can reduce the risk of vascular events associated with Type-2 diabetes mellitus (T2DM). The Cardiovascular (CV) Risk Evaluation in people with T2DM on Insulin Therapy (CREDIT) study is an ongoing 4-year, non-interventional trial in 314 centres across North America, Europe and Asia. METHODS: People with T2DM who recently started insulin were included. Here we report variation in baseline characteristics of participants in eastern vs northern vs southern Europe. RESULTS: Marked differences in participant characteristics were found between eastern Europe (n = 735), northern (n = 460) and southern Europe (n = 647), including proportion of males (25 vs. 61%, 95% vs. 35% and 60 vs. 11%, respectively). Diabetes prevalence and rates of diabetes were higher in eastern Europe. Differences in baseline characteristics were also observed in northern Europe and in females was highest in eastern Europe. LDL cholesterol was highest in southern Europe. Total cholesterol levels were lowest, but triglyceride levels were highest in northern Europe. Smoking was less prevalent in eastern Europe. Most people began with a basal insulin regimen (60 vs 63 vs 69%, respectively). People used meal-time insulins in eastern Europe (19 vs 11 vs 17%, respectively) and pre-mixes in northern Europe (22 vs 28% vs 13%). CONCLUSIONS: Baseline characteristics of people starting insulin reveals some striking differences between European regions; how these translate into CV events as the study progresses will be of interest.