higher than self. Using DBDC questions seems to have additional benefit of refining open ended questions. These results were higher especially in parametric estimation models using only DBDC questions. This observation raises concerns of using a specific analytic method may influence the results. CONCLUSIONS: This study is the first step forward toward resolution of controversies around economic evaluations of healthcare in Korea and hopes to encourage more local research on this issue.

**PHP70**

PREVENTABLE HOSPITALIZATIONS AND HEALTH INSURANCE COVERAGE IN HARRIS COUNTY, TEXAS

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OBJECTIVES: Preventable hospitalizations (PHs) are hospitalizations that can be avoided with appropriate and timely access to primary care. Lack of health insurance has been associated with frequent PHs in several communities in the U.S. in Harris County, public/private safety net clinics provide subsidized primary care to uninsured individuals. Therefore, being uninsured may not result in unnecessary hospitalizations. The objective of this study was to determine the prevalence of PHs and to examine the effect of health insurance on the risk of PHs in Harris County (Houston), Texas. METHODS: This study was restricted to non-elderly adult (age 18 to 64) residents of Harris County, Texas. The Agency of Healthcare Research and Quality (AHRQ) guidelines were used to identify a hospitalization as preventable or not from the Texas Health Care Information Collection inpatient discharge data - 2007. Prevalence was measured as the rate of PHs; i.e. the number of PHs per 100 hospitalizations. Health insurance status was classified as “uninsured”, “Medicaid-insured” or “privately-insured”. A Δ2-analysis following by a multivariable logistic regression controlling for demographic and socioeconomic characteristics was performed to determine the effect of health insurance on the prevalence of PHs. RESULTS: There were 17,810 PHs among non-elderly adults in Harris County in 2007 (PH rate = 7.83 PHs per 100 hospitalizations). Health insurance status was significantly associated with PHs (Δ2 = 78.13; p < 0.001). In the multivariable model, the uninsured had 60% higher odds of having a PH (OR = 1.628; p < 0.001) as compared to the privately insured. Medicaid-insurance was also associated with a marginally higher risk of PHs (OR = 1.065; p < 0.05). CONCLUSIONS: Lack of health insurance is an important factor in determining risk of PHs in Harris County, despite the presence of safety net clinics. If recent healthcare reforms are successful in increasing health insurance coverage, a large proportion of these unnecessary hospitalizations may be avoided.

**PHP71**

IMPACT OF THE MEDICARE PART D COVERAGE GAP ON PRESCRIPTION DRUG UTILIZATION AND MEDICATION ADHERENCE

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OBJECTIVES: To assess impact of the Medicare Part D coverage gap on prescription drug utilization and medication adherence using data from Medicare beneficiaries enrolled in a large health plan in New Mexico in 2007. METHODS: Quasi-experimental, retrospective, pre-post with control group study design was utilized. Pre- and post-coverage gap prescription drug utilization and medication adherence of beneficiaries enrolled in a health plan with no prescription drug coverage during the coverage gap (no coverage gap) was compared with generic drug coverage (generic coverage plan) and full prescription drug coverage (full coverage plan) plan beneficiaries. Prescription drug utilization was assessed using total number of prescriptions per member. Medication adherence was measured using Medication Possession Ratio and the Proportion of Days Covered (PDC). Difference-in-difference analysis (DiD) was used to compare pre- and post-coverage gap prescription drug utilization and medication adherence between the three plans. RESULTS: Of the 14,846 beneficiaries who met inclusion and exclusion criteria, 2,661 (17.92%) entered the coverage gap in 2007. DiD analyses indicated that beneficiaries in the no coverage plan filled significantly fewer prescriptions in the post-coverage gap period, than beneficiaries in the full coverage plan (14.67 fewer prescriptions; p < 0.001) and generic (12.52 fewer prescriptions; p < 0.001) coverage plans. Significant decrease in post-coverage gap medication adherence was observed between no coverage and full coverage plan beneficiaries with respect to statins (5.8%), ARBs (16%) and PFIs (18.1%). Significant decrease in post-coverage gap medication adherence was also observed between no coverage and full coverage plan beneficiaries utilizing statins (1.1%) and ARBs’ (12%). No significant differences were observed between full and generic coverage plan beneficiaries. Significant differences in adherence were found only when adherence was measured using the PDC. CONCLUSIONS: Lack of prescription drug coverage during the Medicare Part D coverage gap may lead to decreased utilization and adherence to certain classes of prescription drugs.

**PHP72**

ASSESSING THE QUALITY OF PHARMACOECONOMIC STUDIES IN INDIA: A SYSTEMATIC REVIEW

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OBJECTIVES: The aim of the study was to evaluate the quality of pharmacoeconomic studies based in India. METHODS: A literature search was conducted using PubMed, Medline, EconLit, PsychInfo and Google Scholar to identify published work on pharmacoeconomics studies based in India. Original research studies that evaluated pharmaceuticals, and were conducted between 1990 and 2010 in India were included. Two reviewers independently reviewed the articles using a subjective 10-point scale (10 being the highest) and the 100-point Quality of Health Economic Studies (QHES) questionnaire (100 being the highest). RESULTS: The included articles (n = 29) were published in 23 different journals. Only 9 articles were published in journals based in India. The first article was published in 1998. Each article was written by an average of five authors. The majority of authors resided in India (62%) at the time of publication and had a medical background (90%). Cost-effectiveness analysis was the most frequently used method of analysis (79%). The source of funding and study perspective was not listed in 45% and 41% of the studies respectively. The study design was a randomized controlled trial for 41% of the studies. The mean subjective quality score of the all the articles (n = 29) was 7.8 (SD = 1.3) and the mean QHES scores for the studies evaluating costs and outcomes (n = 26) was 86.92 (SD = 13.7). The quality score was significantly higher in studies related to country of residence of primary author (non-India = higher) and the study design (randomized controlled trials = higher). CONCLUSIONS: The need for economic evaluation of pharmaceuticals is imperative, especially in developing countries like India, because it can help decision makers allocate scarce resources in a justifiable manner. Standardization of guidelines, and improved pharmacoeconomic education - starting from the undergraduate level to specialization - are two suggestions to help improve the quality of the pharmacoeconomic research in India.

**PHP73**

SYSTEMATIC LITERATURE REVIEW ON HETEROGENEITY OF RELATIVE EFFECTIVENESS AND RELATIVE EFFICACY OF MEDICINES IN EUROPE

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OBJECTIVES: To understand the extent of likely variation if any in underlying factors which may lead to differences in effectiveness of drugs used in one or more of the 27 Member States (MS). METHODS: A systematic literature review of four databases was conducted for the period January 2000 - May 2010. Medline, Embase, EconLit and Health Management Information Consortium (HMIC). Logical combinations of keywords related to effectiveness, generalisability, external validity, transferability. Europe and review were searched. RESULTS: A total of 326 articles were initially identified and ten formed the bases of the review. Nine were reviews or original cost-effectiveness studies and relevant data on the effectiveness results was extracted. First, we found that there is a common assumption in the literature that relative efficacy is constant across countries and therefore generalisable. Less is known about whether relative effectiveness is indeed similar or different. Second, we grouped the factors that could potentially introduce variation in relative effectiveness: (i) patients and disease characteristics; (ii) comparators used; (iii) different measures of health outcomes; (iv) variations in clinical practice. Third, no observational studies were identified. Evidence from studies using efficacy data, mainly from RCTs, was mixed; three studies found no differences in clinical outcomes across countries, one study found differences due to patients’ characteristics and severity and another study using multilevel analysis found country and patients characteristics explaining partly the heterogeneity of treatment effects. One review report differences in clinical practice as one major causes of variations in clinical outcomes between countries. CONCLUSIONS: The literature was scarce and therefore more evidence is needed before any statement can be claimed on the existence of variations in relative effectiveness or efficacy in different countries. Future collaboration among the MS harmonising methodology, generating data and sharing patients’ registry data will be crucial to produce this evidence.

**PHP74**

CLINICAL TRIAL LEARNING CURVES AFFECT OUTCOMES MEASUREMENT, PATIENT SAFETY AND TRIAL SUCCESS: CONTRIBUTING FACTORS AND A POTENTIAL SOLUTION IN CLINICAL TRIAL SIMULATION

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OBJECTIVE: Evidence has recently emerged regarding the presence of investigator learning curves in the context of clinical trials (i.e., the association between clinical protocol departures and patient enrollment sequence). We reviewed the literature to identify factors contributing to clinical trial learning curves and potential impacts of learning curves on outcomes accuracy, patient safety and overall trial success. METHODS: The search was conducted using clinical trial learning curve effects and potential solutions to these effects, using search term combinations including “clinical trial”, “clinical protocol”, “learning curve”, and “enrollment sequence”. RESULTS: Learning curve effects were identified in trials including those for treatment of sepsis (PROWESS and ADDRESS) and high-risk cardiovascular disease (VALIANT). Outcomes of these trials potentially resulting from learning curves included ambiguous treatment benefit, increased adverse events and mortality, and overall trial failure. Potential contributing factors include those related to study site (e.g., large multicenter trials; sites with poor enrollment or poor trial experience), inexperienced staff and high staff turnover/rotation study protocols (e.g., imprecise or complex protocols), and disease severity. Preventing such learning curve effects would likely have required extensive trial site and staff screening and training, as well as improved trial protocol design prior to first patient enrollment. Clinical trial simulation, a methodology identified in several reviews or original cost-effectiveness studies and relevant data on the effective-