was little difference in compliance between daily and weekly bisphosphonate users. Between patients on daily and weekly therapy, the cost of anti-TNFs accounted for the direct cost. While there was only about 5% RA patients were treated with this drug in the Taiwan. The mean age of anti-TNF user was younger, but sex distribution seen no statistically difference in user and non-user group. In patients with anti-TNF use, the continued use of anti-TNF users was increased from 9.3% to 5.3%. The surrogate measure for compliance showed little difference in use of weekly therapy increased from 0.1% to 8.4%, while use of daily therapy dropped from 5.9% to 4.9% and risedronate at 2.9%. There was a times the rate of use among males (3.3%). In 2006–2007, alendronate had the highest surrogates for compliance with therapy.

**CONCLUSIONS:** The percentage of anti-TNF agent use in RA patients is relative low in Taiwan. Some proportion of anti-TNF user still need full dosage DMDAR treatment which suggest the possibility of inadequate response to anti-TNF agents in the population. The age–sex standardized rate of bisphosphonate use across all provinces increased from 8.9% in 2001–2002 to 12.9% in 2006–2007. The rate of use among females (20.4%) was more than twice the rate of use among males (13.2%). In 2006–2007, alendronate had the highest rate of use, at 5.9%, followed by etidronate at 4.9% and risedronate at 2.9%. There was a significant shift from the use of daily to the use of weekly therapy. The rate of use of weekly therapy increased from 0.1% to 8.4%, while use of daily therapy dropped from 9.3% to 5.3%. The surrogate measure for compliance showed little difference between patients on daily and weekly therapy. The cost of anti-TNF agents accounted for 25% of total health care costs. Currently, patients at very high CV risk seem to be less likely to receive celecoxib vs. tNSAIDs, while those with GI risk factors seem more likely to receive celecoxib.

**METHODS:** Using a nationally-representative inpatient care dataset, the HCUP National Inpatient Sample, from 1998 to 2007, we had an available sample of 809,750 Caucasians, 74,869 African-Americans, 48,010 Latinos, 8,976 Asians, and 2,554 Native Americans who were eligible for total knee replacement surgery based on their ICD 9 codes. Multivariable logistic regressions were used to estimate the racial and ethnic disparities in the rates of actual receiving knee replacement surgery among these eligible subjects. Blindier-Oaxaca decomposition techniques were employed to determine the extent to which racial and ethnic disparities reflect differences in observable population characteristics versus unobserved heterogeneity across racial and ethnic groups. RESULTS: Approximately 90% of Caucasians, 70% of African-Americans, 75% of Latinos and Asians, and 83% of Native Americans who were eligible to receive total knee replacement surgery actually did receive it. These disparities persisted in the multivariable analyses. Compared to Caucasians, the odds of having the total knee surgery was 0.46 for African Americans (p < 0.001), 0.49 for Latinos (p < 0.001), 0.45 for Asians (p < 0.001), and 0.67 for Native Americans (p < 0.001). The Blindier-Oaxaca decomposition showed that 39%–59% of the observed differences in the racial and ethnic disparities in receiving the total knee replacement surgery can be explained by observed population characteristics, most important of which are differences in age and health insurance coverage by race and ethnicity. CONCLUSIONS: Substantive racial and ethnic disparities exist in total knee replacement surgery among the eligible. Observable population characteristics account for most of the differences, with age and health insurance key factors driving racial and ethnic disparities in receiving this surgery. Unobserved heterogeneity, which may include physician-patient relationships, mistrust, and cultural factors, are also related to these disparities.