the 6 agencies (9 publications) that evaluated DPP-4 inhibitors, 2 recommended the drug not be listed or funded (CADTH, AHTApol) and 4 recommended restricted use (PBAC, SMC, CVZ and NICE). The most common reason for agency's disapproval for listing/funding was insufficient information on the effectiveness and cost-effectiveness of DPP-4 inhibitors versus the comparator populations. Of these more than 100 HTAs overall, about 66% are related to 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 care 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 processing to generate data. 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.

**PD87**

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

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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 technologies. 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/crdweb) was searched (1991–2009) using the keyword 'diabet*'. HTA reports in English with long- and short-acting insulin analogues included in their assessment of a health technology. 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—he psychosocial issues of diabetes, however more quality-of-life analyses motivated by financial considerations. Early segmentation and engagement with payers is thus critical for HTA success.

**PD88**

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

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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. 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—he psychosocial issues of diabetes, however more quality-of-life analyses motivated by financial considerations. Early segmentation and engagement with payers is thus critical for HTA success.

**PD89**

**DO PEOPLE BEGINNING BASAL INSULIN HAVE A DISTINCT CLINICAL PROFILE COMPARED WITH THE OVERALL POPULATION IN THE CREDIT STUDY?**

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OBJECTIVES: The Cardiovascular 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, which can be reduced via long-term glycaemic control. 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 or basal plus short-acting insulin, premix insulin or another insulin type. Baseline insulin type for 89% had been basal insulin (n = 1563), basal plus short-acting insulin (n = 444), short-acting insulin (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 ± 1.8%; basal plus 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 plus short-acting, 83%; short-acting, 83%; premix, 94%; other, 83%), differences in the numbers continuing OGLDs when beginning insulin were found. Continued use of OGLDs was highest with basal insulin (89%) versus the other insulins (basal plus short-acting, 86%; short-acting, 45%; premix, 62%; other, 34%). However, the distribution of types of OGLD used before insulin was similar between the groups. There are no clear patterns in CV risk profile by insulin type. Previous diagnosis of hypertension (basal, 71%; basal plus short-acting, 65%; short-acting, 57%; premix, 76%; other, 82%), family history of CV disease (basal, 29%; basal plus short-acting, 25%; short-acting, 21%; premix, 23%; other, 14%) and body mass index tended to be lower in the short-acting insulin group. However, triglyceride levels were lower in the short-acting and ‘other’ insulin groups vs premix, basal and basal plus short-acting groups. CONCLUSIONS: People starting different insulins have somewhat different clinical characteristics, which may confound attempts to compare future vascular outcomes between regimes.

**PD90**

**MEASURING GYCOLOSSYLATED HAEMOGLOBIN LEVELS IN PATIENTS WITH DIABETES: IMPACT OF LOWER QOF TARGETS ON ACHIEVEMENT OF CLINICAL INDICATORS AND QOF POINTS**

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OBJECTIVES: The 2008/09 Quality and Outcomes Framework (QOF) indicators for measuring glycated haemoglobin (HbA1c) levels are DM20 and DM07, which measure percentage of diabetic patients with HbA1c of either 7.5 or less or 10 or less respectively. New QOF clinical indicators have been agreed for 2009/10: DM23