PHS114
AGE AND GENDER DISTRIBUTION OF OUTPATIENT CARE PHYSIOTHERAPY SERVICES FOR SHOULDER AND UPPER ARM INJURIES IN HUNGARY
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OBJECTIVES: The aim of our study is to assess the utilization of out-patient care physiotherapy services related to the shoulder and upper arm injuries according to age and gender. **METHODS:** Data were derived from the countrywide database of Hungarian Health Insurance Administration (HHIA), based on official reports of outpatient care institutes in 2009. The activity list was provided by the rulebook on the application of the activity code list in out-patient care. The shoulder and upper arm injuries were reported in diagnosis code S40-S49. The number of cases in physiotherapy activities related to for shoulder and upper arm injuries were determined per 10,000 persons by age and gender in outpatient care. Population distribution was taken into account on the basis of the data of the Central Statistical Office from January 1st 2009. **RESULTS:** The total number of the 151 different physiotherapy services was 697.896 cases at the shoulder and upper arm injuries in the year of 2009. The average number of cases of physiotherapy activities per 10,000 persons accounted for 695,54 cases. The average number of cases per 10,000 persons for males and females were 675,69 cases for males and 712,95 cases for females. The number of cases of the shoulder and upper arm injuries were higher than the average in the 40-84. age groups in males and in the 50-84. age groups in females. The number of cases were the highest in the 55-59 age group in males (1.298,54), and in 65-69. age group (1.897,72) in female. **CONCLUSIONS:** In case of the shoulder and upper arm injuries, the highest demand of the outpatient care physiotherapy services occurred older injured patients. The differences in young males vary with the physical activity and the type of recreation activities, and with the condition of osteoporosis in elderly females.

PHS115
HEALTHCARE COVERAGE, EXPENDITURES AND POPULATION HABITS IN ARGENTINA
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OBJECTIVES: To describe the proportion and type of health coverage, family monthly budget designated to health care and population habits regarding health care resources utilization in Argentina. **METHODS:** 1022 face to face surveys were done by TNS – Gallup during November 2014 across the country in an adult population of Argentina representative of the whole country (SD +/- 4, 2%, IC 95%). A probabilistic, polietapic and stratified by home quotations sample design was used. Only one interview per home was done. **RESULTS:** Sample Demographics: Gender: Female 53% / Male 47%. Age: 18 – 24: 19% / 25 – 34: 21% / 35 – 49: 28% / 50 – 64: 20% / 65 - >: 12% Social Stratification: ABC1 5% / C2C3 38% / DE 57% Country Distribution: Capital City 9% / Buenos Aires 25% / Other States 66% Proportion and type of health care coverage: Without health coverage (public sector): 42% HMO: 38% Private Insurance: 10% PAMI (Retirees): 10% 10 months is the time that in averages every Argentinean goes to the physician. Visits vary from 12.58 Months (Without Insurance) to 4.99 Months (PAMI – Retirees Insurance); private sector average is 8.31. 50% of all the visits are done for a general medical examination (just 22% due illness or symptoms). 16% is the monthly familiar budget designated to health care resources. 8% of the population have expressed borrowed due medical expenditures. **CONCLUSIONS:** As is seen in other studies, population covered with a private insurance and those in the older ages uses health resources more frequently than the uncovered and younger population (Hazard Risk?). How the population uses health care is influenced somehow due variables like age, socioeconomic status and type of coverage. **Full references, additional variables explored and additional conclusions will be presented in the full paper.**

PHS116
THE IMPACT OF NCMS POLICIES ON INPATIENT HEALTH EXPENDITURE AND ITS EQUALITY IN RURAL CHINA
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OBJECTIVES: Our study intends to explore the impact of The Chinese New Rural Cooperative Medical System (NCMS) on inpatient expenditure, the inequality of the reimbursement and the influence factors and the longitudinal change of the inequality. **METHODS:** The study used individual level data in 2006, 2008, and 2011. The Generalized Linear Model was adopted to analyze the impact of NCMS policies on inpatient out of pocket expenditure and reimbursement. The Concentration Index (CI) and its decomposition were used to measure whether or not the poor households received more reimbursement than the non-poor and the contribution of variables to the inequality. The Oaxaca-type decomposition was used to explore the differenced in inequality across cross-sectional units. **RESULTS:** Nominal and actual reimbursement rate was both inversely proportional to out of pocket expense and was proportional to reimbursement. Setting deductible can significantly improve the patients' out of pocket payment. In the year 2006, 2008 and 2011, Concentration index of reimbursement was 0.035, 0.020 and 0.033 respectively. The contribution of real inpatient reimbursement rate to CI was negative in 2006 and 2008, while positive in 2011.The change of concentration index between 2006 and 2008, 2008 and 2011 was -0.015 and 0.013 respectively. The contribution of reimbursement rate, deductible and ceiling prompted CI of NCMS beneficial degree favoring low income group during 2006 and 2008, accounting for 11.33% of total change. The improvement of reimbursement rate and ceiling prompted CI of NCMS beneficial degree favoring high income group during 2008 and 2011, accounting for 32% and 17% of the change of concentration index in the two years. **CONCLUSIONS:** There exist inequality in reimbursement, favoring rich. In 2006 and 2008, reimbursement rate improved the beneficial degree in low-income group, while reimbursement rate and ceiling contribute to high income group getting more reimbursement in 2011.

PHS117
REDUCING MATERNAL AND CHILD MORTALITY IN GHANA: IS NATIONAL HEALTH INSURANCE SCHEME'S FREE MATERNAL CARE PROGRAMME HELPING?
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OBJECTIVES: To evaluate the impact of the National Health Insurance Scheme's Free Maternal Care Program (FMCP) on maternal health care utilization and mortality rates. **METHODS:** Review and participant observation methods were employed to review maternal care utilization data from the NHIS and Ghana Health Service over the 2005- 2012 period. Maternal and child mortality data from UN Inter-agency Group for Child Mortality Estimation (WHO, UNICEF, UN DESA, UNPD, World Bank) were also reviewed. **RESULTS:** The amount of money paid for maternal health services increased from GHS21.9 million (USD6.88m) in July 2008 to GHS52.4 million (USD16.39m) in December, 2009. As of June 2010, an amount of GHS26.3 million (USD8.24m) had been paid. Antennal care coverage (at least four visits) increased from 61% to 72% between 2008 and 2012; postnatal care coverage increased from 54% to 58% between 2006 and 2008 and went up to 65% in 2011; skilled delivery saw no improvement between 2006 and 2008 (44%) but went up to 59% in 2012. The institutional maternal mortality ratio (IMMR) recorded a reduction of 7% over the 2005-2008 period and went down considerably by 23% to 155 deaths per 1000 live births over the post 2008 period. Under-five mortality rate declined from 88.4 to 83 deaths per 1000 live births (5.4%) between 2005 and 2008; it went down to 72 deaths per 1000 live births (11%) over the post 2008 period. **CONCLUSIONS:** There have been substantial improvement in maternal care utilization and reduction in mortality rates five years after full implementation of the FMCP. However, big gaps exist between the current mortality rates and MDG 4 and 5 targets, with barely a year to the 2015 deadline. Therefore, much effort is needed from government, development partners, and maternal care advocates to accelerate progress towards achieving MDG 4 and 5.

PHS118
DEFINITION OF END-OF-LIFE PERIOD AND QUALITY BENCHMARKS IN TERMINAL CANCER CARE: A LITERATURE REVIEW
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OBJECTIVES: There is no consensus on definition of end-of-life period in cancer care. Nevertheless, a disproportionate part of overall costs in cancer therapy emerge within last weeks or days of life. The aim of this study was to synthesize the information about how the end-of-life period in cancer care is defined, as well as to describe quality benchmarks used in health economic studies within the cancer setting. **METHODS:** A literature review was performed in order to identify publications describing or assessing the end-of-life care across all cancer settings. Medline (through PubMed) was searched for economic studies describing the end-of-life period and utilizing quality benchmarks in cancer care. Reviewed studies served as a source for evidence synthesis regarding the defintion of end-of-life period in economic evaluations. **RESULTS:** In the literature, special emphasis is given to the last 6, 3 and 1 months as well as the last 14 days of life. The most utilized benchmarks indicating poor quality of cancer care were: 1) increase in chemotherapy utilization in the end-of-life period; 2) possible misuse of chemotherapy resulting in high rates of ER visits, hospital and ICU stays; and 3) underuse of hospice services due to late or lack of referral. While several researchers identified an increase in hospice utilization 1 week before death, evidence suggests that only two-thirds of patients with advanced cancers utilized outpatient hospice services in the U.S. between 2002 and 2008. **CONCLUSIONS:** Definition of end-of-life period in cancer care is not consistent among identified studies. However, quality benchmarks remain similar across different cancer settings. Future research should focus on cost differences between various cancer sites, as well as differences in resource utilization between hospice and non-hospice patients.

PHS119
THE IMPACT OF PATIENT CENTERED MEDICAL HOME IN A MANAGED MEDICAID POPULATION
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OBJECTIVES: This study sought to evaluate the impact of the PCMH practice transformation on healthcare utilization in a Managed Medicaid population with a Hispanic majority and served specifically by safety-net clinics. **METHODS:** The PCMH group included eleven safety-net clinics (23,662 members) that were recognized as patient centered medical homes in late 2011 in the greater Los Angeles area, and the non-PCMH group consisted of 176 other safety-net clinics (138,152 members) in the same area . The study timeline ranged from January 2011 to December 2013 which required accounting for a concurrent federal waiver, effective June 1, 2011, under which California began transitioning senior and people with disabilities (SPDs) with fee-for-service (FFS) Medicaid into managed care systems. To avoid the potential confounding effect from the sudden influx of SPDs, the study cohort was further divided into clinic types, one with less than 10% SPD membership and the other with greater than 10%. **RESULTS:** Our findings show that in clinics less impacted by the SPD transition, PCMH could reduce ED visits by an average 70 visits per thousand members per year (PTMPY), avoidable ED visits by 20 visits PTMPY, and increase office visits by 1000 visits PTMPY. No significant improvements were found in clinics with SPD membership greater than 10%. **CONCLUSIONS:** This study further supports the effectiveness of the PCMH model in a previously untested