to be concentrated among the rich in both years. Decomposition indicated that "illegitimate" factors remained large contributors to income-related inequality in SHIS even after the equity-centered reform of 2005. **CONCLUSIONS:** Findings suggest that income-related inequality in SHIS might have decreased in Chile after the health care reform. Beyond this observed difference over time, the remaining inequality is still largely due to illegitimate factors that should be tackled through broader policies in the country.

**HEALTH CARE USE & POLICY STUDIES – Quality of Care**

**PHP53**

**PERCEPTION OF USERS OF DRUG DISTRIBUTION PROGRAM IN BRAZIL**

**Hospital Universitario Austral, Universidad Austral, Derqui, Argentina, 2Hospital Italiando de Salud,** **ReH**

**OBJECTIVES:** To characterize the users of access to medicines program developed in Brazil by the ANS. A survey on 704 users of the PAFP (by phone), of users who migrated from other supply of medicines programs by means of a survey explicitly developed for this purpose. This work also seeks to evaluate the meeting customers’ needs by the Program and its satisfaction level. **METHODS:** The collection instrument was composed by two blocks: questions concerning the use of the PAFP and other programs of medicines supply; user’s profile information, and identification of the medicine supplied. **RESULTS:** The evaluation of the user migration from other programs identified that, before the P AFP, 52% of interviewed users was buying the medicines in the private pharmacy and more than 30% was using the Public Service in a Health Center of SUS, a piece of 11% began the treatment after the PAFP. More than 58% of users would use the service of the SUS if there was no PAFP. However, 36% of users reported that they would not use the SUS system for withdrawal of medicines. It was observed that 61% of users gave out to be economizing while withdrawing the medicines with gratuity or at a lower price. Most users made possible to characterize the users of PAFP showing aspects concerning the participation and the range of the program. Generally, it was found that the persons are satisfied and they reported to have saved with the program. They also pointed out the convenience they have with the possibility of the access to the medicine in any pharmacy with the PAFP.

**PHP64**

**NATIONWIDE SURVEY ON PATIENT SAFETY CULTURE IN JAPAN**

**Hirose M,1 Egami K,1 Tsuda Y,1 Honda J,2 Shimizu H**

1**Kyoto University Hospital, Iwata, Japan, 2St Mary’s Hospital, Kurume, Japan**

**OBJECTIVES:** We surveyed nationwide the situation of patient safety culture in 13 hospitals (5,760 persons) allowed for additional costs on patient safety countermeasures under the social insurance medical fee schedule. The questionnaire consists of seven unit-level aspects of safety culture including 24 items, three hospital-level including 11 items, and four outcome variables including nine items. **RESULTS:** An average number of beds was 560 beds (63 - 1,354 beds). With regard to ownership, 13 hospitals included three municipality and local incorporated agency hospitals, one public hospital, two juridical person companies (Pvalue: 0.079 and 0.07, respectively) but the one-sided sign test indicated that only relative pure (managerial) efficiency has improved after this policy (Pvalue: 0.031). **CONCLUSIONS:** The "Brand-Generic scheme" does not seem to be enough policy to improve efficiency of pharmaceutical companies in Iran. To achieve this aim, paying particular attention to implementing a new model of transparent laws and regulations for supporting competition, the competitive pricing policies, the presence of international companies in the market and full privatization of companies had to be also considered by policy makers.

**PHP57**

**REGULATING THE ACCESS TO AN ADAPTIVE AND AN INTEGRAL ASSISTANCE IN BRAZILIAN PRIVATE HEALTH PLANS**

**Brazil Rio de Janeiro, Brazil**

**OBJECTIVES:** To describe the main actions promoted by the The Federal Regulatory Agency for Private Health, Insurance and Plans (ANS) in the access of private health plans beneficiaries to an adequate and an integral assistance. **METHODS:** A retrospective analysis of data about coverage in health plans since ANS creation (1999) was done to identify the main actions promoted by the agency in this area. It included the set of rules published and ANS periodic publications. **RESULTS:** A very important identified mechanism that ANS employs for regulating the users access to a full assistance is the elaboration of a list of medical procedures. This list constitutes the minimum obligatory coverage for all plans. It is periodically reviewed and incorporations and/or exclusions are made according to some precepts like: clinical evidence, epidemiological relevance, among others. The ANS strives implementing and updating a system based in the Brazilian Medical Association (AMB) guidelines and policies. **CONCLUSIONS:** The guide lines created by ANS are the main one promoted by ANS to regulate the access to an adequate and an integral assistance. They can also improve the sector efficiency along with the rational use of techniques and medical technologies. The instruments discussed can be a guide to implement the health policies that improve their efficiency. The patients will have safer and more effective treatment and ANS keeps the balance and promotion of health in private health with a new model.
satisfacción a los beneficiarios de planes de salud. Los datos obtenidos no NFIP se utilizan para establecer una garantía de atención y acceso a cobertura de salud, que pueden generar una suspensión de comercialización de los planes identificados con fallas asistenciales, bien como instauración de regímenes especiales de recuperación por ANS.

PHP59
CONSTRUCCIÓN DE UN MODELO DE PRIORIZACIÓN APLICABLE A LATINOAMÉRICA – EL CASO DE COLOMBIA
Ángela A. Velbel1, Castrillo H2, Mejía A3, Sarria A4
1Instituto de Evaluación Tecnológica en Salud – IETS, Bogotá, Colombia, 2Agencia Española de Evaluación de Tecnologías Sanitarias (AETS) del Instituto de Salud Carlos III, Madrid, España

OBJECTIVOS: Los sistemas de salud deben enfrentar el desafío de hacer uso eficiente de recursos limitados ante necesidades crecientes de salud. Colombia no ha sido ajena a este desafío. El Ministerio de Salud ha entendido la importancia de articular un sistema de salud que incorpore un sistema de priorización del gasto sanitario, transparante y legítimo. En el marco de lo anterior, se propone un método para priorizar y seleccionar tecnologías a evaluar. METODOLOGÍAS: A partir de una revisión de diferentes metodologías de priorización, se propuso un mecanismo de análisis de decisión de múltiples criterios, que fue discutido en panel de expertos del gobierno y otros actores. Se realizó un piloto de priorización que permitió detectar los principales riesgos y desafíos en cada etapa del proceso. A partir de la revisión, un consenso colectivo y experiencia del piloto, se seleccionaron, definieron y ponderaron los criterios de priorización. Se diseñaron las diferentes etapas e instrumentos para llevar a cabo el proceso. RESULTADOS: Los criterios seleccionados fueron la gravedad de la enfermedad, el impacto de la adquisición de la tecnología, la accesibilidad, la eficiencia, la eficacia y la sostenibilidad de la tecnología. Empieza a hacer un proceso de definición de las diferentes etapas e instrumentos para llevar a cabo el proceso de priorización y selección de tecnologías a evaluar. La propuesta permitirá al Ministerio de Salud, como líder del proceso con el ANS, coordinar las diferentes etapas e instrumentos para llevar a cabo el proceso, para poder facilitar la toma de decisiones. La propuesta permitirá al Ministerio de Salud, como líder del proceso con el ANS, coordinar las diferentes etapas e instrumentos para llevar a cabo el proceso, para poder facilitar la toma de decisiones.

PHP60
THE NOTIFICATION OF PRELIMINARY INVESTIGATION (NFIP) OF THE FEDERAL REGULATORY AGENCY OF PRIVATE HEALTH AND INSURANCE AND PLANS (ANS) TO FACILITATE THE ACCESS TO THE MANDATORY COVERAGE
Silva PFCV
Agencia Nacional de Saúde Suplementar, Rio de Janeiro, Brazil

OBJECTIVES: To describe the instrument NFIP (Notification of Preliminary Investigation) for solving conflicts, and its relationship to the obligatory coverage access, between health plans and patients. METHODS: A critical analysis of the rule that created NFIP (Regulatory Resolution n° 226/2010), established by The Federal Regulatory Agency for Private Health Insurance and Plans (ANS), was done to characterize the tool. RESULTS: The Notification of Preliminary Investigation (NFIP) consists of a communication time to mediate the relationship between consumers and providers of health plans in cases of unauthorized procedures by the provider. NFIP is an electronic process to solve the conflicts before a process that can lead to the punishment of the health plan provider. A contact is previously made to notify the health plan provider about the problem and it has five business days to answer it. If the health plan provider has not responded within the time allowed, the case is sent to the Inspection Department to a more detailed analysis before being finished. CONCLUSIONS: The NFIP is a mediation instrument that can help ANS to solve the problems that appear between beneficiaries and health plan providers giving a fast answer to both interested actors of the process. It can be positive because sometimes the questions are solved without the provider punishment and the beneficiaries' injury. The conflict mediated by NFIP can contribute to the change in the entities attitude and culture and can also promotes the interaction and the active participation of the actors involved.

PHP61
THE QUALITATIVE PROFILE OF THE COVERAGE COMPLAINTS MADE BY HEALTH PLAN USERS TO THE FEDERAL REGULATORY AGENCY FOR PRIVATE HEALTH INSURANCE AND PLANS (ANS)
Silva PFCV
Agencia Nacional de Saúde Suplementar, Rio de Janeiro, Brazil

OBJECTIVES: To define a qualitative profile of the NFIP complaints made by health plan users, to The Federal Regulatory Agency for Private Health Insurance and Plans (ANS). METHODS: A retrospective analysis of the Notification of Preliminary Investigation (NFIP) registers in 2011 and in the first half of 2012 were performed. The data were collected from the Inspection System (SIF). The variables considered were: the subject of the coverage complaints (Medical List of Procedures, Time for Coverage Access, Managed Care, etc.), the date of the contract (before or after ANS registration) and distribution of the complaints among the different NFIP cases. The study showed a change on predominant coverage subject: in 2011 43.5% of the complaints were about “Medical List of Procedures”. In 2012, the main subject was “Time for coverage access” (56.2% of the coverage complaints). It was possible to verify that, in both years considered, the prevalence of ANS registration is more than half in every type (48.5% in 2011 and 47.7% in 2012). CONCLUSIONS: This study helped to know the qualitative profile of the coverage complaints in Brazilian supplementary health. The increase in the number of complaints about “Time for coverage access” in 2012 indicates that the services offered are not being enough to attend the users. The higher percent-