to be concentrated among the rich in both years. Decomposition indicated that "illegitimate" factors remained large contributors to income-related inequality in SRHS even after the equity-centered reform of 2005. **CONCLUSIONS:** Findings suggest that income-related inequality in SRHS 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

Carraro WH, Mengue SS, Haddad EW

Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil

OBJECTIVES: To characterize the users of access to medicines program developed in Brazil, known as *Aqui Tem Farmácia Popular* Program (PAFP), by identifying those users who migrated from other supply of basic 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 survey instrument used gathering the users of *Aqui Tem Farmácia Popular* program has been applied in 15 counties from 14 Brazilian states. 1073 interviews composed the sample, in 27 establishments of private pharmacies, during august 2012. The collection instrument was composed by three 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 users migration from other programs identified that, before the PAFP, 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 discount. **CONCLUSIONS:** The conducted survey 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.

PHP54

A NATIONWIDE SURVEY ON PATIENT SAFETY CULTURE IN JAPAN

Hirose M[1], Egami K[2], Tsuda Y[2], Honda J[2], Shima H[2]

[1]*Shimane University Hospital, Izumo, Japan,* [2]*St. Mary's Hospital, Kurume, Japan*

OBJECTIVES: To explore safety culture dimensions among health care professionals using Hospital Survey on Patient Safety Culture (HSOPSC) by developed by AHRQ (Agency for Healthcare Research and Quality). **METHODS:** 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 360 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 with social insurance hospitals, six medical corporation hospitals, and one other hospital. Number of all respondents was 5,118 persons (response rate: 88.9%), and included 295 physicians (90.8%), 2,909 nurses (95.5%), and 146 pharmacists (96.7%). In terms of 12 dimensions, the overall average positive response rate (RR) for the 12 patient safety dimensions of the HSOPS was 49.2%, extremely lower than the average positive RR for the AHRQ data (61%). In terms of health care professionals, the overall average positive RR for pharmacists (46.2%) was lower than that for physicians and nurses (49.6% and 49.4%).With regard to pharmacists, the average positive RRs for 8 dimensions of the 12 dimensions were the lowest among three professionals, and three average positive RRs were the highest; Frequency of event reporting (pharmacists: physicians: nurses=73.6%:53.3%:67.9%), Non-punitive response to error (48.8%:42.6%:40.4%), and Staffing (29.1%:27.0%:25.4%). **CONCLUSIONS:** The HSOPSC measurement provides the evidence for assessment of patient safety culture in Japan's hospitals. This result that patient safety culture has been in a state of development, compared with the US hospitals.

PHP55

COST AND QUALITY OF DYING IN HOSPITAL: RESULTS FROM THE ARGENTINE-HEALTH CARE COST AND UTILIZATION PROJECT (A-HCUP)

Insua JT[1], Villalon R[1], Giunta D[2], Ioli P[3]

[1]*Hospital Universitario Austral, Universidad Austral, Derqui, Argentina,* [2]*Hospital Italiando de Buenos Aires, Caba, Argentina,* [3]*Hospital Privado de la Comunidad, Fundacion Medica de Mar del Plata, Mar del Plata, Buenos Aires, Argentina*

OBJECTIVES: Little is known about dying in Argentina, we studied costs and readmissions (ReH) <30 days of hospital dying adults. **METHODS:** A cross sectional study of 1 year hospital discharges, with HCUPs methods, of patients ≥19 yrs old. We obtained deaths, first admission (1 adm) and ReH ≤365 days and ReH <30 days; total direct medical cost (TC I$), mean (I$) (SD), median I$ (Q1-Q3) discharge cost, (in I$ PPP, 2008), stratified by age/sex, admissions and ReH <30 days and <365 days. **RESULTS:** Total mortality for ≥19 yrs old patients was 4,70%. Among 2137 deaths, Total cost of those dead in hospital, TC I$: 40 540 842 ; mean cost per discharge (I$) was 19853 (SD 45 599); Median cost per discharge I$ 4182; (Q1: 1452-Q3: 17730 I$), comprising 8,31 % of TC I$. Among 43321 discharges, TC$ of those alive, TC: 447 300 754 I$; mean cost per discharge ($) was 10569 I$ (SD 21 217); Median cost per discharge 14 091 I$; (Q1: 2 496- Q3:10 054 I$). Relative dead /alive I$ was 1,88 times higher. Mean discharge cost of deceased stratified by age group (mortality 19-64 yrs. old: 1,52%, I$ 48332, age 19-64/≥19 yrs old ratio: 2,43; 65-74 yrs old: 4,72%,I$ 25968, age ratio: 1,31; 75-84 yrs old: 8,45%; I$ 15471, age ratio: 0,78; 85+ yrs old: 14,09%, I$ 7832, age ratio: 0,39), and sex, males (47,4%) had a I$: 22679 (M/F I$ ratio: 1,45). In 1 adm.(53% of deaths), mean cost was I$ 23 792; while ReH ≤365 days (47% of deaths), I$ 13 530, cost ratio ReH/1 adm= 0,57 ; and if ReH <30 days (29,5%), I$ 12354, cost ratio ReH<30/1 adm=0,52. **CONCLUSIONS:** Understanding the economic burden of dying helps promote better and cost-effective ways of promoting palliative care, old and readmitted deaths are less costly.

HEALTH CARE USE & POLICY STUDIES – Regulation of Health Care Sector

PHP56

FROM "GENERIC SCHEME" TO "BRAND-GENERIC SCHEME": THE EFFECT OF NEW POLICY (2003-2004) ON EFFICIENCY OF IRANIAN PHARMACEUTICAL INDUSTRY

Hashemi Meshkini A[1], Varmaghani M[1], Yousefi M[2], Yaghoubifard S[1], Zekri H[3], Kebriaeezadeh A[1]

[1]*Tehran University of Medical Sciences, Tehran, Iran,* [2]*Tarbiat-Modarres University of Medical Sciences, Mashhad, Iran,* [3]*Allameh-Tabatabaee University of Human Sciences, Tehran, Iran*

OBJECTIVES: Brand-Generic scheme was implemented in Iran to improve the competition in the market. In this study we aim to assess if this new policy has had any positive effect on efficiency of Iranian pharmaceutical companies. **METHODS:** We used Data Envelopment Analysis (DEA) to evaluate the relative efficiency of pharmaceutical companies for the years 1999-2008. The Wilcoxon matched-pairs signed-rank test and also sign test were used to assess the difference between mean relative efficiency of companies before and after policy. **RESULTS:** Although the Wilcoxon matched-pairs signed-rank test did not show any significant difference between before and after new policy in term of both technical and pure (managerial) efficiency of included 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 special attention to infrastructural requirements including non-discriminating and 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 ADEQUATE AND AN INTEGRAL ASSISTANCE IN BRAZILIAN PRIVATE HEALTH PLANS

Silva FHCV

Agência Nacional de Saúde Suplementar, Rio de Janeiro, Brazil

OBJECTIVES: To describe the main actions promoted by the The Federal Regulatory Agency for Private Health Insurance and Plans (ANS) to regulate 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 guidelines implementation is another important instrument identified in this study to the improvement of private health assistance. ANS established a collaboration term with the Brazilian Medical Association (AMB) to develop guidelines, to spread and to monitor their implementation. **CONCLUSIONS:** The actions presented 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 will be a guide to upgrade the health plans management and their efficiency. The patients will have safer end more effective treatments and ANS keeps the balance and promotion of health in private health with a new model.

PHP58

A MEDIAÇÃO DE CONFLITOS NA AÇÃO FISCALIZATORIA DO SETOR DE SAÚDE SUPLEMENTAR BRASILEIRO

Tanaka FHR, Franco S

ANS - Brazilian Private Health Regulatory Agency, Rio de Janeiro, Brazil

OBJETIVOS: Demonstrar a eficácia da utilização de meios consensuais de mediação de conflitos pela Administração Pública no controle e fiscalização do cumprimento das normas que regulam a assistência suplementar à saúde no Brasil. **MÉTODOS:** Desde 2010, a ANS – Agência Nacional de Saúde Suplementar implementou o procedimento NIP (Notificação de Investiação Preliminar), cujo objetivo é realizar a mediação de conflitos entre operadoras de planos de saúde e consumidores, no que tange a situações que envolvem negativa de cobertura assistencial. A NIP é um processo totalmente eletrônico, que confere maior celeridade e eficácia na resolução das reclamações dos consumidores, induzindo uma melhora na relação operadora/consumidor. Com a NIP, as operadoras têm prazo de 5 dias para solucionar o conflito junto ao beneficiário e responder à ANS sobre as medidas tomadas. Após processamento na NIP, a reclamação pode ser finalizada por inexistência de infração, reparação de conduta ou encaminhada para abertura de processo administrativo, nos casos em que o conflito não foi resolvido. **RESULTADOS:** Desde sua implementação, a resolutividade dos conflitos na NIP manteve-se acima de 70% do total de reclamações recebidas, o que em 2012 significou a conclusão de 42.672 das 54.412 denúncias de negativa de cobertura assistencial (78,4% de resolutividade). Antes de seu advento, as reclamações eram analisadas por meio de instituição de processo administrativo sancionador, que duravam, em média, 18-24 meses para sua conclusão, podendo levar ao arquivamento da denúncia ou lavratura de auto de infração contra a operadora. **CONCLUSÕES:** A NIP conferiu maior eficácia ao processo fiscalizatório da ANS, proporcionando maior

satisfação aos beneficiários de planos de saúde. Os dados obtidos na NIP são utilizados para monitoramento da garantia de atendimento e acesso às coberturas obrigatórias, que podem gerar a suspensão de comercialização dos planos identificados com falhas assistencias, bem como instauração de regimes especiais de recuperação pela ANS.

PHP59
CONSTRUCCIÓN DE UN MODELO DE PRIORIZACIÓN APLICABLE A LATINOAMÉRICA – EL CASO DE COLOMBIA
Avila A[1], Verbel A[1], Castro H[1], Mejia A[1], Sarria A[2]
[1]*Instituto de Evaluación Tecnológica en Salud - IETS, BOGOTÁ, Colombia,* [2]*Agencia Española de Evaluación de Tecnologías Sanitarias (AETS) del Instituto de Salud Carlos III, MADRID, Spain*
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 éste desafío. El Ministerio de Salud ha entendido la importancia de articular un sistema de salud que incorpore un sistema de priorización del gasto sistemático, transparente y legítimo. En el marco de lo anterior, fue creado el "Instituto de Evaluación Tecnológica en Salud (IETS)", que tiene como objetivo proporcionar recomendaciones sobre tecnologías en salud y mejores prácticas, basadas en evidencia, para el gobierno nacional y demás actores, como insumo para la toma de decisiones. En este proceso, uno de los primeros pasos es diseñar un proceso para la priorización y selección de 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 discusión, construcción colectiva y experiencia del piloto, se seleccionaron, definieron y ponderaron los criterios de priorización, y se diseñaron las diferentes etapas e instrumentos para llevar a cabo el proceso. **RESULTADOS:** Los criterios seleccionados fueron la gravedad de la enfermedad, la población afectada, el costo de adquisición de la tecnología, la atención a grupos vulnerables, el interés de salud pública y la solicitud de la ciudadanía. **CONCLUSIONES:** Emplear criterios explícitos facilita que la priorización sea un proceso legítimo y transparente. La propuesta permitirá al Ministerio de Salud, como líder del proceso con el concurso de otros actores, contar con herramientas para priorizar y seleccionar tecnologías para evaluación. La experiencia colombiana dará herramientas metodológicas a otros países interesados en la construcción de este tipo de procesos.

PHP60
THE NOTIFICATION OF PRELIMINARY INVESTIGATION (NIP) OF THE FEDERAL REGULATORY AGENCY OF PRIVATE HEALTH AND INSURANCE AND PLANS (ANS): A TOOL TO FACILITATE THE ACCESS TO THE MANDATORY COVERAGE
Silva FHCV
Agência Nacional de Saúde Suplementar, Rio de Janeiro, Brazil
OBJECTIVES: To describe the instrument NIP (Notification of Preliminary Investigation) and it's role on solving conflicts related to the obligatory coverage access, between health plans and patients. **METHODS:** A critical analysis of the rule that created NIP (Regulatory Resolution nº 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 (NIP) consists of a communication time to mediate the relationship between consumers and providers of health plans in cases of unauthorized procedures by the provider. NIP 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. This way, the health plan provider has the opportunity to solve the question without punishment and the beneficiaries can have a faster access to the procedure prescribed by the doctors. If the procedure doesn't have coverage according to the supplementary health rules (it is not listed on ANS Medical List of Procedures), the demand is filed. If the provider's answer is not enough to conclude the question, it's sent to the Inspection Department to a more detailed analysis before being finished. **CONCLUSIONS:** The NIP is a mediation instrument that can help ANS to solve the problems 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 mediation by NIP 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 FHCV
Agência Nacional de Saúde Suplementar, Rio de Janeiro, Brazil
OBJECTIVES: To define the qualitative profile of the coverage 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 (NIP) registers in 2011 and in the first half of 2012 was performed. The data were extracted from 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 regulation) and the type of the plan (individual/ family or collective). **RESULTS:** The study shows 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" (36,2% of he coverage complains)." It was possible to verify that, in both years considered, there was a prevalence of ANS regulated contracts of individual/familiar type (44.8% 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 increased number of complaints about "Time for coverage access" in 2012 may indicate that the services offered are not being enough to attend the users. The higher percentage of NIPs of individual/family plans, compared to collective ones, may be a reflection of a greater weakness in consumer-provider relationship in this type of contract.

PHP62
PODER POPULAR Y REGULACIÓN DEL PRECIO DE LOS MEDICAMENTOS EN VENEZUELA
Adesso G
Universidad Central de Venezuela, Caracas, Venezuela
OBJECTIVOS: Explorar el rol del Poder Popular en el proceso de regulación del precio de los medicamentos en Venezuela, articulado por la Superintendencia Nacional de Costos y Precios (SUNDECOP) en conformidad con lo establecido en la Ley de Costos y Precios Justos y las Providencias Administrativas relacionadas. **METODOLOGÍAS:** Estudio exploratorio documental basado en la búsqueda y revisión de los artículos de prensa disponibles y publicados en la página Web oficial de la SUNDECOP. La búsqueda y recuperación de la información fue realizada el 10 de marzo de 2012. Se tomaron en cuenta para la revisión los artículos que incluían en su contenido las palabras: participación o poder popular y regulación del precio de medicamentos. **RESULTADOS:** Se identificaron 172 artículos noticiosos publicados desde 13 julio 2011 hasta 27 de febrero de 2013. Se revisaron 12 artículos de prensa que cumplían con el criterio de inclusión. El 50% de los artículos revisados resaltan la participación del Poder Popular en la definición de las políticas de precios y los criterios a tomar en cuenta por el Sistema Nacional Integrado de Costos y Precios para la fijación del precio de medicamentos, mientras que en 10 de los artículos se desprende el papel del Poder Popular como controlador social para vigilar el cumplimiento de la regulación una vez sea decretada por la SUNDECOP. **CONCLUSIONES:** Además de las eventuales acciones de inspección y fiscalización, el Poder Popular en Venezuela está aportando insumos a la SUNDECOP que serán incorporadas en el proceso de tomas de decisiones para fijar el precio a los medicamentos durante el año 2013. Se sugiere profundizar en un posterior estudio para conocer y analizar cómo y en qué medida esos aportes del Poder Popular están siendo incluidos en el análisis metodológico para establecer la definitiva regulación del precio de los medicamentos.

HEALTH CARE USE & POLICY STUDIES – Conceptual Papers

PHP63
NOVEL PRICING STRATEGIES TO SUPPORT SUSTAINABLE ACCESS TO MEDICINE IN LATIN AMERICA
Shankar R, Lindon L, Hooper J, Rowbottom RC
IMS Consulting Group, Cambridge, UK
With lower returns from price pressures in developed markets, it is imperative for pharma companies to seek growth in emerging markets such as Latin America. Simultaneously, with rising incomes, a growing middle class in emerging markets is increasing demand for access to innovative medicine, especially in diseases such as oncology, CV and diabetes. Achieving commercial expansion as well as increasing access to innovative medicine in Latin America needs new pricing strategies and funding models. We discuss and evaluate alternative pricing strategies and funding models to support commercial expansion and increase access to innovative medicines in Latin American markets such as Brazil, Argentina, Mexico and Colombia. These include current industry strategies, equitable pricing strategies and strategies focused on local market conditions. We model the impact of these strategies on both specialty and primary care medicines. The modelling is based on insights and assumptions drawn from analogue analysis in pharmaceuticals and other industries. It is supplemented by interviews with industry experts in Latin American market strategies. For the modelling we assume current market and public and private insurance coverage structures. We find that in primary care medicines there is considerable opportunity for commercial and access gain through more differentiated pricing strategies. These strategies are more commercially (revenue and profit) optimal than current industry strategy. At the same time, they are also access optimal in terms of the eligible patients they provide access to. In the case of specialty medicines, differential pricing strategies can increase commercial potential, but there is a gap between commercially optimal and access optimal strategies. This gap can be bridged through increased financing for these medicines. Based on this analysis, we suggest a path forward in which pharmaceutical companies can collaborate with governments and other stakeholders to achieve increased access to innovative medicines in a commercially sustainable manner.

PHP64
ACCESS TO MEDICINES INDEX: MEASURING HOW WELL COUNTRIES PROVIDE ACCESS TO MEDICINES
Shankar R[1], Hickson S[1], Gorokhovich L[2]
[1]*IMS Consulting Group, Cambridge, UK,* [2]*IMS Consulting Group, London, UK*
Developing countries are now following the steps of developed countries in implementing universal health coverage. Health care systems and policies differ across countries resulting in various levels of medicine access. To evaluate which systems and policies lead to better access, we need a measure to compare how well countries provide access to medicine for their populations. Using IMS proprietary data as well as public sources, our analysis proposes a Country Access to Medicines Index that compares and ranks countries on access to medicine outcomes across four pillars: medicine reimbursement coverage, time to reimbursement, medicine affordability and support for innovation. Medicine reimbursement coverage measures private or public insurance cover for a representative basket of medicines across major communicable and non-communicable diseases. It has three components: share of population covered, share of medicines covered and share of costs covered. The time to reimbursement pillar measures average time to reimbursement for the selected basket. The affordability pillar measures relative cost of medicine basket compared to the international average both in absolute terms and as a share of per capita GNI in each country. The innovation pillar measures local patents and investment in R&D. We used this index to compare and rank more than 30 developed and developing countries. We then look at the policies in these countries to identify features that lead to better index scores. We find that five broad factors can help explain