poorly appreciated the professional performance of pharmacists. Therefore, raising the awareness about the important role of pharmacist in providing public health is warranted.

**PHS119**

PROFILE OF PATIENTS USING IMMUNOLOGICAL IN A HEALTH PLAN OPERATING IN FORTALEZA, BRAZIL: ECONOMIC AND PHARMACOTHERAPEUTIC INDICATORS

**OBJECTIVES:** To profile the use of an operator in immunological supplemental health Fortaleza - Brazil, to identify the most prescribed therapeutic groups and costs. **METHODS:** Cross-sectional study in two hospitals accredited service provider, from March to November/2012. Data were recorded by medical expertise in computerized management system (Sabius®) performed after the medical consultation. Later, these were entered in Microsoft Excel 2007 and analyzed by pharmacists auditors. The cost was calculated from the value contained in Brasindice Unit 765, using the Consumer Price Max. The doses used for rheumatoid arthritis Etanercept 50 mg, 40 mg Adalimumab, abatacept 750 mg, 500 mg infliximab, 560 mg Tocilizumab, Rituximab 1g and Golimumab 50 mg based on a 70 kg adult. **RESULTS:** We analyzed 64 patients with a mean weight 67 kg, of which 70.31% (n = 45) were women aged 30-59 years whose most frequent indications were rheumatoid arthritis (n = 33, 51.56%) and ankylosing spondylitis (n = 19, 29.69%). The most immunologically commonly prescribed were infliximab (n = 36, 56.25%), Tocilizumab (n = 11, 17.19%), abatacept, and Rituximab (n = 8, 12, 50%) and golimumab (n = 1, 1.56%). It was observed that 89% of patients were classified by the operator's profile with the ICD-10-UM (20) disease and 21% initiated with anti-TNF, whereas 61.9% (n = 13) moved into one another with immunological mechanism of action and 38.1% (n = 8) continued with an anti-TNF, changing only the drug. The average cost of treatment/dose first line was R$ 1,091.96, resulting in 1.66 as a pharmacotherapeutic profile becomes important for planning strategies aimed at streamlining and optimization of these drugs on quality of care.

**PHS120**

MEDICAL RE-ADMISSIONS AT THE ROYAL LONDON HOSPITAL – PATIENT SPECIFIC AND DISEASE SPECIFIC FACTORS AT ONE WEEK AND ONE MONTH

**OBJECTIVES:** The Royal London Hospital is a teaching hospital in East London, UK. We hypothesised that medical patients with multiple co-morbidities and complex disease are likely to present with a new diagnosis when re-admitted within a month. Further, re-admission within a week is likely to be related to the initial diagnosis. **METHODS:** We conducted a retrospective audit of all non-elective adult acute medical admissions over a 6 week period during 2012. We collected information on patient demographics, ICD-10 diagnosis, length of hospital stay, along with readmissions within one week and one month. We reviewed the original and subsequent electronic discharge summaries. We highlight patient specific and disease specific factors. **RESULTS:** There were a total of 124 readmissions from the original audit (n=859). A large proportion (40%) of all admissions were within 30 days of discharge. Seventeen percent of readmissions were within a month, and 37% (30%) within a week. Fourteen patients (11%) were readmitted within a week, and again within a month. COPD (33%), PE (29%), and Diabetes (24%) had the highest re-admission rates. Our audit points to a 14.4% readmission rate in our cohort. We aim to address the precipitating factors in our new physician led ambulatory care clinic. We highlight patient specific factors through audit methodology. **CONCLUSION:** Our findings correspond to our hypothesis readmissions within a month were related to the original diagnosis, interestingly this was less so when re-admitted within a week. Our audit has helped highlight the need for better community management plans prior to discharge. This has led to closer links with the Community Rehabilitation and Support Team (CREST) in order to reduce readmission rates.

**PHS121**

DO PATIENTS NEED TO BE ACCOMPANIED IN ICU WARDS?

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**OBJECTIVES:** For treatment needs, accompaniment is limited for ICU patients. A 30-minute visit a day is allowed for their families. However, mental disturbance have been reported in ICUs. Actually, patients suffer from not only diseases but also loneliness in the units. The study was conducted to answer the question whether ICU patients need to be accompanied? **METHODS:** A questionnaire was designed around four questions about the attitudes to accompany to accompany was conducted in General Hospital of Shenyang Military Area in China. The 3 questions are: 1) Do you need an accompany when treated in ICU? (Yes/No); 2) If you need, who will be the candidate? (A relative or friend/Anyone/Available); 3) How long do you need to stay with your family members each day in ICU? (Half an hour/One hour/Half a day/All day). After repeatability test, the questionnaire was filled by patients randomly selected from cardiology and general wards from January 1 to August 31, 2011. Chi-square tests were used to compare the choices between patients from different wards, of different gender and age. **RESULTS:** Repeatability for the 3 questions were 0.742, 0.783, and 0.785. Totally, 142 patients were involved in, including 69 ICU patients and 73 general patients, 117 males and 25 females, 53 young & middle aged (≤60) and 89 old ones (>60). Fifty-seven percent of the patients needed accompandies in ICU, 86.6% of the patients chose family members as the candidates, 74.6% of the patients needed all-day accompany by family members (n=86) and all-day accompany by family members were higher in ICU and old patients than those in general and younger ones (p<0.05). **CONCLUSIONS:** Patients do need to be accompanied in ICU. An all-day accompany by family member is highly preferred.

**PHS122**

FIT FALLS OF THE NATIONAL HEALTH SERVICE (NHS) “INTERNAL MARKET” HEALTH CARE MODEL; DOES REIMBURSEMENT OF SECONDARY CARE MATCH COSTS INCURRED

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**OBJECTIVES:** Many NHS hospitals have developed an Acute Medicine Unit to streamline all non-elective medical admissions. The cost of providing this secondary care service is funded by the local primary care team, who in turn receive funding from central government. However, teaching hospitals in the capital would also care for a considerable number of international and national patients. We sought to examine if health care costs were reimbursed for these patients. **METHODS:** We undertook a retrospective audit of all admissions over a 6 week period at a central London teaching hospital. We collected patient demographics, ICD-10 diagnosis and length of stay. We identified all “out of area” patients and calculated costs incurred based on bed days, diagnosis and re-admission within a month. The ICD-10 codes were converted to cost (HRG) codes through the finance office. **RESULTS:** A total of 864 admissions and 124 readmissions were analysed. In all 28% (n=243) of admissions were “out of area”. This cohort accounted for 25% of bed occupancy, and cost the hospital £390,300. Further, 1% (n=8) of patients were of no fixed abode (homeless) and cost £7,200 in bed occupancy. The international patients account for 1% (n=6) and cost £4,500 in bed occupancy. The top 10 diagnoses presenting complaints with disease management costs were, Sickle cell anaemia (n=27–£34,899) chest pain (n=24–£16,757) and lower respiratory tract infection (n=19–£9,308). We went on to compare the incorrect generated from these admissions on an individual basis. Initial analysis point to a deficit in income generated. This has significant implications for the financial viability of secondary/tertiary care hospitals in the NHS. **CONCLUSIONS:** Our analysis point to a considerable financial burden from “out of area” patients to the hospitals. Reducing this financial burden does raise clinical and ethical challenges to the receiving hospital.

**PHS123**

THE EFFECT OF COPAYMENTS ON PRESCRIPTIONS FOR ADHERENCE TO MEDICINES IN PUBLICLY INSURED POPULATIONS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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**OBJECTIVES:** To quantitatively estimate the effect of copayments for prescriptions on adherence to medicines in a publicly insured population. **METHODS:** Eight electronic databases and the grey literature were systematically searched by one reviewer for relevant articles, along with hand searches of references in review articles and the included studies. Studies were included if they measured the effect of a publicly-insured copayment regulation, an attribute that includes the introduction of, or an increase in copayment and if the outcome was objectively measured adherence (or non-adherence) to medicines. Measures of adherence included a proportion of DRs Covered and Medication Possession Ratio. Study exclusion, data extraction and quality appraisal were carried out by two independent reviewers. A random effects model was used to generate the meta-analysis. **RESULTS:** We included 34 studies in our meta-analysis. The I^2 test; p=>0.1 indicated a lack of heterogeneity. **CONCLUSIONS:** Seven out of 41 studies met the inclusion criteria. Five studies contributed more than 1 result to the meta-analysis. The meta-analysis included 199, 996 people overall; 74, 236 people in the copayment group and 125,760 people in the non-copayment group. Average age was 71.75 years. In the copayment group, (versus the non-copayment group), the odds ratio for non-adherence was 1.11 (95% CI 1.09-1.14; P<0.05). An acceptable level of heterogeneity at I^2=10%, (p=0.05) was observed. **CONCLUSIONS:** This meta-analysis showed an 11% increased odds of non-adherence to medicines in publicly insured populations involved in a system where copayments for medicines are necessary. Policy-makers should be wary of potential negative consequences associated with copayment. Unintended economic repercussions of copayments are possible.

**PHS124**

REIMBURSEMENT LANDSCAPE AND POLICY DEVELOPMENT FOR RARE DISEASES IN CHINA: A CASE STUDY OF HEMOPHILIA

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**OBJECTIVES:** Hemophilia, a costly yet treatable rare disease, receives 100% reimbursement coverage in most developed world and some developing countries. In China, a Priced & Controlled Medicine. **RESULTS:** Reimbursement coverage for hemophilia in China and to explore potential funding mechanisms that could be expanded across China to improve reimbursement coverage to meet this economic burden. This study aims to understand the current reimbursement landscape for hemophilia in China and to explore potential funding mechanisms that could be expanded across China to improve reimbursement coverage to meet this requirement. **METHODS:** Hemophilia reimbursement policies of 3 major social insurance schemes were collected in 36 cities (provincial capitals and municipalities). In-depth interviews were conducted with selected government stakeholders to understand the rationale of different policies in different cities.