attempt to identify barriers to access. This study aims to investigate the factors that act as determinants of HSU for the Greek population, as well as highlight their evolution since 2006. **METHODS:** The study was based on data collected by three cross-sectional health interview surveys conducted by the National School of Public Health, Athens, Greece, in 2006, 2011 and 2015 with representative national samples of 4003, 6569 and 2012 adults respectively. Respondents were asked to answer a series of questions on HSU and report their demographic characteristics. **RESULTS:** A significant decrease in the basic measures of HSU between 2006 and 2015 was detected. In 2006, 74.6% of respondents answered that they had used a health service in the last 12 months, whereas in 2015 the corresponding figure was only 46.5%. There was a statistically significant association between HSU and gender of respondents, with females utilizing the services at a considerably higher rate (52.9%) than men (38.6%). The degree of non utilization health services was not changed substantially in these surveys, however the reasons for not using the services were found to change and brought up statistically significant associations with age, income and occupation of respondents. It is noteworthy that the percentage of population unable to access healthcare due to inability to pay was 5.9%, 8.5% and 27.4% in 2006, 2011 and 2015 respectively. **CONCLUSIONS:** It is evident that demographic and socioeconomic determinants influence the HSU. The findings highlight the problem of social inequalities as a major issue of health policy.

PHP67

ASSESSING JAPAN'S THREE EARLY ACCESS PROGRAMS BASED ON RECENT DISCUSSIONS: SCOPE AND FINANCIAL AID

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OBJECTIVES: Access to medicines is usually given under the regulatory approvals and subsequent coverage decisions, after efficacy and safety have been proven by clinical trials. Recently, systems to enable exceptional early access have been explored to meet significant, unmet, and urgent medical needs for frontier medicines. In Japan, the Advanced Medical Care B system (AMCB) is already in operation. Two other systems, the Compassionate Use system (CU) and the Patient-Initiated Mixed-Care system (PIMC), are planned to start. The objective of this study is to understand the design and institutional positioning of these three systems, identifying opportunities for further improvements. **METHODS:** A documentary research was conducted by analyzing government documents and the Diet Record. **RESULTS:** For the AMCB system, the review board designates technologies that include the use of unapproved medicines or off-label indications, after requests from health care professionals. The CU system is to be fully introduced in 2015 and targets medicines at later stages of clinical development, opening up opportunities for patients who are not eligible for the trials. The PIMC system is to start in 2016 and focused on medicines or patients that are not covered by the other two systems. The three systems have no legal financial aid programs to cover the costs of experimental medicines, while the systems allow coverage of other treatment costs than those medicines. Details of the CU and PIMC systems are currently under discussion. **CONCLUSIONS:** The scopes of the three systems were found to be complementary to one another, covering both unapproved medicines and patients excluded from clinical studies. Legal financial aid would be worth considering for more equitable and extensive early access.

PHP68

DOES CHINA'S NEW MEDICAL REFORM IMPROVE HEALTH EQUITY OF RURAL RESIDENTS? EVIDENCE FROM HOUSEHOLD SURVEYS BEFORE AND AFTER THE IMPLEMENTATION OF NEW MEDICAL REFORM IN SHAANXI PROVINCE, CHINA

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OBJECTIVES: China's New Medical Reform (NMR), which started in 2009, aims at improving the equity of basic health service, especially in the less well-off areas. The purpose of this study is to know whether the popularity of NMR has alleviate the existing health inequity in rural West China by comparing indicators of health equity of rural residents covered by New Rural Cooperative Medical System (NRCMS) before and after China's NMR. **METHODS:** Related data have been collected respectively from 2860 and 2432 rural residents through random-sampling household questionnaire survey in Z County, Shaanxi, China, in November 2009 (before NMR) and October 2012 (after NMR). The sample residents are divided into 5 groups by per capita annual income in families, and equity of health need, utilization and benefit have been calculated through Concentration Index (CI) and ANOVA. **RESULTS:** On equity of health need, CIs for two-week morbidity and half-year prevalence rate of chronic diseases among rural residents of different income levels in 2009 and 2012 are -0.0524, -0.0536 and -0.0792, -0.0840 respectively. On equity of health service utilization, CIs for treatment of two-week morbidity in 2009 and 2012 are -0.0096 and -0.0992 respectively; CIs for hospitalization and non-hospitalization of residents are 0.0032, -0.1712 and -0.0396, -0.1548 respectively. On benefit equity, CIs for hospitalization rate of residents in 2009 and 2012 are -0.0208 and -0.0712 respectively; CIs for average compensation of hospitalization are -0.0212 and -0.1620 respectively. Difference in economic burden caused by diseases among residents of different income levels is non-significant after the implementation of NMR ($P>0.05$). **CONCLUSIONS:** NMR has improved the equity of health service need of rural residents to some extent while reduced the utilization equity little. Benefit equity is enhanced since low-income residents benefit more than high-income counterparts from in-patient health service. Rural residents' economic burden caused by diseases has reduced significantly after NMR.

PHP69

ALL QALYS ARE EQUAL, BUT SOME QALYS ARE MORE EQUAL THAN OTHERS; A COMPARISON OF THE NICE END OF LIFE CRITERIA AND SMC PACE PROCESS

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OBJECTIVES: Within the National Institute for Health and Care Excellence (NICE) Appraisal process, quality adjusted life years (QALYs) are regarded as having equal weighting. However, in January 2009, NICE introduced the end-of-life (EOL) criteria, giving more weight to QALYs for life-extending, and EOL interventions. In May 2014, the Scottish Medicines Consortium (SMC) introduced the Patient and Clinician Engagement (PACE) process for evaluating EOL medicines and medicines used to treat very rare conditions, to allow a more flexible approach to considering such medicines. These two initiatives allow a greater cost per QALY gained willingness-to-pay threshold than usual in the United Kingdom (UK), however there are differences in their requirements and outcomes. The aim of this study was to compare the process and conclusions drawn by NICE and the SMC for health technology appraisal submissions either meeting NICE EOL criteria after May 2014, or being accepted into the PACE process based on EOL. **METHODS:** All technologies reviewed under the PACE process, NICE EOL criteria or both were identified. Information collected included whether EOL criteria were met, incremental cost effectiveness ratio (ICER) and SMC and NICE decisions. **RESULTS:** In total, 15 technologies were reviewed. Of the 15, 14 were reviewed under PACE; 8 were given positive SMC Advice, 3 were given restricted positive SMC Advice and 3 were given negative SMC Advice. Of the 14 technologies reviewed under the PACE process, 7 were reviewed by NICE, 4 met EOL criteria, 2 of which were given positive NICE Guidance. **CONCLUSIONS:** Of those technologies considered by both NICE and SMC since May 2014, fewer met the NICE EOL criteria than the PACE EOL criteria, and fewer still received positive NICE Guidance. There are differences in access to interventions for diseases with short life expectancies within the UK, although further research into the changing Cancer Drugs Fund is needed.

PHP70

CAUSES AND COST IMPACT OF VARIABILITIES ON THE A&E WARD UTILIZATION ACROSS HOSPITALS IN SPAIN

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OBJECTIVES: To analyse the causes and financial implications of the variability of use of A&E resources (visits, admissions) across Spanish Hospitals and Regions **METHODS:** Review of the Configuration Management DataBase Set (CMDB) and Hospital Discharge Statistics during the period 2010-2012, using a multivariate analyses controlling for factors like: region, sex, age, income, etc. to explain the relative rate to average and variations within and between regions. **RESULTS:** There is a significant variation between and within regions and hospitals, which is mostly explained by personal income, distance to hospitals, availability of alternatives in Primary Care, and, quite interestingly ($p<0.05$ within Hospitals of same regions), size of hospital measured in terms of available beds. This impacts on the resource allocation, new hospitals to be erected -new investments- and cost per patient. **CONCLUSIONS:** Variability of A&E resource utilisation (frequency of visits, hospitalizations) is greatly explained using a multidimensional approach within and betwen regions, having more than 80% explanative variables laying into Personal Income, Distance to Hospital, Available Beds, and Primary Care Ambulatory alternatives. Other variables were not deemed to be significant.

PHP71

DIFFERENTIAL PRICING FOR PHARMACEUTICALS: OVERVIEW OF A WIDELY DEBATED PRICING CONCEPT AND KEY CHALLENGES

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OBJECTIVES: Differential pricing (DPR) is based on the economic concept of price discrimination. DPR is reported as a potential effective way to: (1) Improve access to medicines in lower income countries whilst maintaining welfare in higher income countries; (2) Preserve incentives for R&D through higher prices in high income countries. This study aimed to assess the current situation of DPR for pharmaceuticals in the European Union (EU). **METHODS:** A literature review was conducted in MEDLINE®, WHO, OECD, and EU Commission websites, complemented by a grey literature search. Key DPR principles were identified and current implementation challenges in the EU were assessed. **RESULTS:** Ramsey (1927) developed a well-known DPR theory stating that prices should differ across markets according to inverse relation to demand elasticity, with more price-sensitive users, (i.e. lower income countries) charged at a lower price than less-price sensitive users. Another approach to DPR proposed by Danzon et al. (2013), called "value-based differential pricing", would be to have prices reflecting utilization in each country. DPR is highly discussed among national/EU institutions and industry given the differences in GDP per capita and price levels of EU countries. However, several challenges were reported to limit DPR implementation: (1) DPR scheme is based on average per capita income; (2) Manufacturers attempt to apply higher price in low income markets and lower price in high income markets; (3) Differential distribution margins; (5) Risk of parallel trade; (6) Use of external reference pricing (ERP) where prices and undisclosed rebates in high income countries drive high prices in lower income countries. **CONCLUSIONS:** DPR is widely debated to enhance access to innovative expensive medicines in the low income market. However, DPR optimization requires wide coordination and interaction, between the countries and the industry to minimize various counteracting policies and initiatives.

PHP72

INVESTIGATING THE ACCESSIBILITY OF UNINSURED POPULATION TO HEALTH SERVICES IN GREECE

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OBJECTIVES: One of the most significant effects of economic crisis in Greece is the rising number of unemployed and uninsured citizens. A large percentage of the