originals (any pharmaceutical released before 01/08/1987, per 2007 decree). The products were assumed to be affected by the regulations. The effect of amended regulations was estimated for all five product groups by applying the change discount rates to the reference price throughout the years 2004 to 2011.

**RESULTS:** The reference price in 2004 was considerably different than in 2012. The price of original products without generics decreased from 100 to 59. The price of generic and original products with generics decreased to 47.5. The 20-year-old original and generic products were affected the least, as the price of the 20-year-old original products decreased to 69.1 and of generics to 71.3. The different effects of regulations on each product group indicate that companies are heterogeneously affected depending on inventory. **CONCLUSIONS:** Drug groups were not uniformly affected by the regulations. With less overhead and expenses (e.g., clinical trials, marketing, promotions), generic drug manufacturers are more easily adaptable to new regulations and market conditions. This may cause a shift to extensive production of generic medicines in the Turkish pharmaceutical industry and decrease research and development investments.

**HP64**

**EVALUATION OF PUBLIC PERCEPTION TOWARDS MEDICINE QUALITY AND PRICES IN AFGHANISTAN**

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**OBJECTIVES:** To evaluate Public Perception towards Medicine Quality and Prices in Afghanistan. **METHODS:** A cross-sectional descriptive survey involving 1282 population in six zones of Afghanistan was undertaken. **RESULTS:** The study findings revealed that a total of (50.2%) of responders agreed that imported medicines and (41.4%) said that locally manufactured medicines have good quality. High proportions (61.4%) of Afghan doctors are prescribing quality medicines, and also medicines given by public hospitals in Afghanistan are of high quality (64.9%). (38.4%) agreed that the drug regulatory authority controls the medicines. Interestingly, (96.3%) responders were agreed, that Afghan government should adopt health policies to control the medicine prices and expenditure. (89.6%) respondents agree that higher medicine costs negatively impacts patient outcomes. Half of the respondents (44.5%) say that in Afghanistan doctors have poor understanding on medicine prices. (68.7%) of responders agreed that the price regulation system should be implemented from manufacturer to patients. When responders asked, (94%) agreed that all medicine need to be disclosed on the dispensers medicine label. A round, (19.9%) of responders agreed that all prices in Afghanistan are affordable to everyone. (93.1%) of the responders said, prescription drug prices need to be regulated by the government. When responders asked (68.2%) agreed that medicine prices are high in private hospitals. **CONCLUSIONS:** The full national survey on medicine quality and pricing, suggests that, the government should take firm steps to control the quality and disparate medicine prices, to ensure accessibility, availability and affordability of medicine to all. The drug regulatory authority has less control to regulate medicine quality and prices, due to critical factors, e.g., lack of qualified staff and quality control lab, insufficient salaries and corruption. No medicine pricing policy is in place and pro-poor medical pricing policy development is crucial.

**PHP65**

**QUALITY OF CARE: REFERENCE AND COUNTER REFERENCE FROM FAMILY PHYSICIANS AND RHEUMATOLOGISTS’ PERSPECTIVES—A PILOT STUDY**

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**OBJECTIVES:** To delineate family physicians’ and rheumatologists’ point of view when choosing generic medicines in cases of rheumatic diseases. To experimentally identify barriers in the reference and counter reference. **METHODS:** This is a pilot study, transversally designed, with family physicians and rheumatologists in a single city. Methodological steps: 1) Development and preparation of three clinical scenarios that simulate and address different levels of clinical severity, 2) application of these scenarios in the sample, 3) validation of the study scenarios. Final scenarios: a) Scenario one: patient with an autoimmune disease diagnosis presenting fever and fatigue; b) Scenario two: patient with fibromyalgia and with poor adherence to the health care plan, requiring a medication to relieve the symptoms; c) Scenario three: patient with septic arthritis, prostration, and in poor clinical conditions. Decisions to be chosen: Decision 1: To apply a health care plan (investigation and/or treatment) and refer to a rheumatologist; Decision 2: to prescribe medication and do not refer to a rheumatologist; Decision 3: refer to a rheumatologist without primary care intervention. Afterwards, a multiple-choice questionnaire addressing potential factors that lead to barriers in the reference and counter reference process was applied. Descriptive analysis was performed to map the results and bootstrapping was performed for correcting hypothesis testing. **RESULTS:** Twenty-two family physicians and rheumatologists were involved. For Scenario one, the majority of the interviewee chose Decision 1 [127 (1 - 3), SD 0.59]. For the Scenario two, respondents chose the decision 2 [2 (1 - 3), SD 0.76]. For the Scenario three, decision three was the preferred [147 (3 - 3), SD 0.83]. For the reference and counter-reference evaluation, interviewees considered that there is a poor communication between family physician and rheumatologist [4 (2 – 5), SD 1.01]. **CONCLUSIONS:** Proper communication seems to be a hurdle for the reference and counter reference system.

**PHP66**

**SOCIOECONOMIC INEQUALITIES IN HEALTH IN URBAN PAKISTAN**

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**OBJECTIVES:** The objective of this analysis is to examine socioeconomic inequalities in health. It investigates whether, and to what extent, household economic status and other socio-demographic characteristics are associated with health inequalities in all areas of Pakistan. **METHODS:** The study uses data from the Pakistan Socioeconomic Survey (PSES) and analysis is based on 11,069 individuals who belong to 1,435 urban households. Health status is based on self-reported morbidity during the two weeks preceding the interview. Household economic status is measured using the survey weight on ownership of durable assets and housing conditions. Principal components analysis (PCA) is used to construct the index and households are categorised into quintiles by PCA scores. The logistic regression is used to estimate the effects of various sociological, demographic, economic and regional characteristics of individuals/households on health status. **RESULTS:** Overall, 12.7% individuals reported any health complaint during the two weeks preceding the interview. Male household members have lower prevalence of morbidity (10.6%) compared to females (14.9%). A total of 33% members of the lowest quintile reported health complaint compared to 11% of the highest quintile. Furthermore, highest morbidity was reported by members of Muslim households (12.9%), widowed/divorced/separated members (26.2%), those with no education (16.8%), agriculture/fisheries workers (18.3%) and those residing in urban areas of Balochistan (14.2%). The logistic regression exhibits a strong significant (p<0.01) association between household economic status and health status. Members of poorest, poor, middle and rich households are significantly (p<0.01) more likely to report any health complaint compared to members of the richest households, controlling for gender and age, religion, marital status, education, occupation, and residence in an area. **CONCLUSIONS:** Socioeconomic inequalities in health are widespread in urban Pakistan. Public health policies aimed at reducing gaps between health status of poor and non-poor need to be initiated.