through legislative changes. Formal RSA should be mainly a non-outcome based approach. This would also help the already supported R&D activities to be maintained the existence of pharmaceutical industry and protect the patients’ access to medicines has become hindered. Although it is natural for Turkey to maintain the existence of pharmaceutical industry and protect the patients’ access to medicines, it would be more favorable in the development of the industry that the expectations of the stakeholders in the industry are taken into account in the policy making process. This would also help the already supported R&D activities to be sustainable as well. The positive and negative aspects of Turkey’s offering the least regulatory and a more efficient use of the resources already available. The estimation of needs, consensus building methodologies, political incidence and advocacy strategies used in DR are guarantees of the financial sustainability for the following years.

**PHP334**

**HEALTH CARE COVERAGE THROUGH PRIVATE HEALTH INSURANCE**

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**BACKGROUND:** Achieving universal health coverage (UHC) is a common goal worldwide. As off today only some rich countries have succeeded to provide publically funded UHC to all their citizens. However, many low- and middle-income countries with a weak tax base are still far from achieving similar coverage despite a continuous increase in public and private healthcare expenditure. Patients in these countries have to rely on direct payments to finance their health care needs and in some regions these out-of-pocket (OOP) payments can account for up to 80 percent of total health expenditure.

**DISCUSSION:** OOP represents a significant financial risk to households. Low-income families, in particular, are very vulnerable and run the risk of further impoverishment if they have to carry both health expenditures and indirect costs (loss of productivity) associated with their illness. Alongside public and out-of-pocket spending for covering patients private health insurance (PHI) represents an important third source of health care funding. PHI allows for risk-sharing and as such could play a critical role in securing low-income families’ access to treatment. So far, the contribution of PHI versus UHC remains limited but it is expected to grow significantly in the near future in emerging markets such as Brazil. PHI ensures an important protection against catastrophic health care and a treatments. The rapid economic growth, increased demand and gaps in healthcare coverage will pave the way for a greater uptake of PHI. In some African countries, despite PHI being urgently needed, extreme poverty may favor community based health insurance schemes (CHI).

**CONCLUSION:** Given the increasing need for PHI to help developing countries, PHI has problem to develop thus exposing the low/medium income households to high financial risk. Extending PHI in those countries allows for risk sharing and thus could have important equity implications.

**PHP335**

**COMPARISON OF PHARMACEUTICAL PRICING AND REIMBURSEMENT SYSTEMS IN TURKEY AND CERTAIN OTHER EU COUNTRIES**

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This is an expository, exploratory study in Turkey, pharmaceutical pricing methods, reimbursement methods and basic health indicators, within the scope of changing pharmaceutical policies, in Turkey, reference countries and the United Kingdom; the implementations of which are of utmost importance for other countries. In the wake of the recent economic crisis, pharmaceutical market in Turkey has been performed on the basis of reference pricing system that takes into account Portugal, Spain, Greece and France as reference. The regulations regarding the reimbursement process are determined by SSJ. The reimbursement system has been changed numerous times and the discount rates has incrementally risen. In pricing, the on other hand, drug companies face difficulties in economic terms because of the fact that price discount of high rates are implemented over the reference price and the price of the drug is fixed when the reference price is revised. Moreover, it has been said that in Turkey the most drugs has been recognized that certain drugs have been hard to find within the market and the patients’ access to medicines has become hindered. Although it is natural for Turkey to put restrictions on drugs budget to ensure sustainable drug financing, in order to maintain the existence of pharmaceutical industry and protect the patients’ access to medicines, it would be more favorable in the development of the industry that the expectations of the stakeholders in the industry are taken into account in the policy making process. This would also help the already supported R&D activities to be sustainable as well. The positive and negative aspects of Turkey’s offering the least regulatory and a more efficient use of the resources already available. The estimation of needs, consensus building methodologies, political incidence and advocacy strategies used in DR are guarantees of the financial sustainability for the following years.

**PHP336**

**CLOSING THE FINANCIAL GAP OF ANTIRETROVIRAL AND HIV SUPPLIES FOR SUSTAINABILITY OF HIV NATIONAL RESPONSE IN THE DOMINICAN REPUBLIC**

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Since the first availability of ARV in the Dominican Republic, fueled by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Until 2009 there was a gross correspondence between the increase in the number of treated patients and the growth of the GFATM. However, since 2009 to 2013, the GFATM’s funding decreased of the international financial assistance for ARV, particularly by the GFATM, can be covered by the commitment of national resources to bridge the financial gap and to an efficient use of the resources already available. The estimation of needs, consensus building methodologies, political incidence and advocacy strategies used in DR are guarantees of the financial sustainability for the following years.

**PHP337**

**PROPOSAL FOR A REGULATORY FRAMEWORK FOR HEALTH APPS TO ENSURE A PATIENT CENTERED COMPETITION BETWEEN PROVIDERS**

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**BACKGROUND:** The number of newly developed and distributed health apps is legion and they are no longer a novelty. However, the standard framework defining the concepts and a sound business model is not always perceivable at first hand, it can be observed that in many cases patients and providers are either trying to bind patients with lock effects and proprietary protocols or want to gather sensitive personal data for further use. New health care programs and solutions are rather made for marketing purposes than to serve the individual need of the customer (e.g. patient). Our project discusses the urgent need for regulatory rules ensuring that competition between providers of these health care apps serves the patients needs and leads to an improvement of patient relevant outcomes. In the course of the young lions “Health Parliament” the issue at hand was brought up by the authors in the board of core topics: the challenges of chronic disease of diabetes. To highlight the importance of continuous support in behavioral change we asked patients about their individual incentives and their expectations in a regulatory framework of health care needs.

**DISCUSSION:** In order to develop a delphi-panel like process a regulatory framework was developed which could ensure that competitive forces act in a way that the patient’s needs are met for all kind of chronic diseases. To align the competitive forces onto patient centered outcomes the following aspects need to be considered: 1) Market access; 2) Quality assurance; 3) Protection of data privacy; 4) Open standards for interchangeability; 5) Pricing and reimbursement mechanisms. With our poster we would like to present our claims to an international audience to gain further insights on the topic and to foster the discussion into a more patient centered competition.

**PHP338**

**PATIENT BEHAVIOUR AS A COST DRIVER IN THE MANAGEMENT OF CHRONIC DISEASE PATIENTS**

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**BACKGROUND:** Maintaining chronic disease patients clinically stable after discharge is an important imperative for avoiding costly hospital readmissions. A great deal of the clinical risk of readmission and of the cost burden could be studied, it was not possible to identify the most important factor predictive of unfavorable patient outcomes. However, an often overlooked risk factor is patient behavior and patient decision drivers. Insights from the behavioral sciences can shed light on how individuals actually make decisions. Behavioral sciences have been used in marketing for years but are rarely used in the medical field. Recent studies from the UK have shown that up to 40% of the costs incurred for readmission or emergency room visits are incurred by patients that should have been taken care of at home or at home. The behavioral drivers for these patients vary: not a good image of GPs, patients that are overly worried and anxious, an opportunity to get access to health care without an appointment. **DISCUSSION:** Not applying insights from the behavioral sciences to the medical field carries an important and avoidable cost for the health system caring for chronic disease patients. Healthcare should invest resources allowing to segment chronic disease patients at discharge, according to their behavioral profile, and provide support and education for those patients that are likely to burden the emergency rooms and hospitals for non-eligible reasons.

**CONCLUSION:** Profiling chronic disease patients at risk of costly hospital readmissions based on insights from the behavioral sciences represents an opportunity to address an important cost driver that is currently overlooked in relation to the traditional clinical risk assessment.

**PHP339**

**SOFOSBUVIR: THE FAILURE OF PRICING POLICIES IN THE EUROPEAN UNION**

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**BACKGROUND:** Sofosbuvir, a breakthrough anti-HCV (hepatitis C virus) polymerase inhibitor, was first approved by the European Medicine Agency (EMA) in 2013. The drug was granted a marketing authorisation in the United-States (US) and in the European Union (EU), by the end of 2013 and beginning of 2014, respectively. Shortly after its approval, Sofosbuvir’s massive price tag (EUR 250,000) has led several national health authorities to consider an additional benefit and find it cost-effective for a price around USD 80,000 in US and USD 55,000 in EU for a 12-week course treatment. **DISCUSSION:** Sofosbuvir price may have led to health insurances (HI) bankruptcy in EU and to substantially decrease of the international financial assistance for ARV, particularly by the GFATM, can be covered by the commitment of national resources to bridge the financial gap and to an efficient use of the resources already available. The estimation of needs, consensus building methodologies, political incidence and advocacy strategies used in DR are guarantees of the financial sustainability for the following years.
on media to dispute sofosbuvir price considered as scandalous, while compliant with French regulations, French Health Minister was forced to control its price. Under tremendous media, political and administrative pressure, the manufacturer accepted significant price decrease, early entry agreement in France and later in most EU countries. Following this saga, to ensure drug budget will not undermine confidence in E.U. countries, French Drug Agency (AFSSAPS) budget expenditure for HCV. CONCLUSION: This case highlights limit of current pricing policies which are unable to match affordability and drug prices. Even if sofosbuvir generation of Pharmaceutics were efficient for reimbursement, sofosbuvir case confirms the inability of cost-effectiveness analysis to address affordability issue. Budget impact decision making will become more and more critical in the future.

OncoLogy Drug Financial Toxicity a Specific US Issue? Choudhury, C1, Renuzat, C2, Caban A3, Toumi M4
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BACKGROUND: Cancer imposes enormous financial burden to society. Direct medical costs associated at around $51 billion across European (EU) countries (2009) and $88.7 billion in the United–States (US) (2011). The concept of “financial toxicity” has been first reported by US academic oncologists, Zafar and Abernathy in 2013. It refers to financial distress linked to out-of-pocket payments of costly oncology drugs (OD). This critical concept led to the development of a patient-reported outcome questionnaire by de Souza et al. This conceptual research aimed to address aspects of oncoology drug financial toxicity (ODFT) and how the US and European Union policies might affect patient’s financial burdens toward high OD prices. Direct medical costs has been reported to affect patient’s quality of life and treatment adherence. In US, ODFT is related to the positioning in specialty care tier (fourth or fifth tier), leaving a high co-pay for the patients. Moreover, 13% of the US population is uninsured (2013). This issue is not new; in 2007, a study reported that 16% of oncologist did not propose expensive products to some patients based on their perception of patient affordability. In EU, the cost of treating cancer is different from country to country. The majority of patients from ODFT. Patients are either 100% covered for all reimbursed drugs (France, UK, Germany, Spain, Italy), or drugs are not recommended/reimbursed and then not proposed to the patients nor requested by the patients. The level of availability, affordability and the time required for procurement varies substantially among public and private sector. However, uptake has been poor and the number of submissions negligible. OBJECTIVES: This study aims to examine the pharmacoeconomic guidelines in the context of existing legislation, policy and incentives in the private sector in South Africa. To make explicit the reasons for the poor uptake and challenges in implementing the guidelines.

METHODS: A review of existing legislation regulating reimbursement of medicines in the public sector was undertaken in relation to the implementation of the guidelines, as well as interviews with key stakeholders in the pharmaceutical industry, ministry of health and health insurance industries to understand attitudes to and challenges to adopting the guidelines submission criteria and results. RESULTS: Existing legislation means that results of pharmacoeconomic submissions are not enforceable – funders are not required reimbursement for products should the ministry of health evaluations process deem them cost-effective. Pharmaceutical companies are thus at risk of a negative finding on reimbursement with no assurance that a positive finding will improve reimbursement for new products. As submission is currently not mandatory, this is something they will be unlikely to do. The level of strict application or flexibility within the requirements of the guidelines is also not clear. CONCLUSIONS: Uptake and engagement with the South African Pharmacoeconomics guidelines has been poor, with submissions formally evaluated since the guidelines were finalised. Several existing policy and legislative barriers exist which make the success of these guidelines in this current environment unlikely. Building capacity for submitting analyses as well as within the ministry of health to evaluate submissions will be critical.

Health Professionals’ Involvement in Politics A Means to Improve Healthcare Delivery and Healthcare Legislation for Healthcare Seekers in Africa Odenigbo AO, University of Nigeria Nsukka, Nsukka, Nigeria

OBJECTIVES: Health Professionals in Africa in an attempt to improve healthcare delivery have brought up well thought out ways to offer better health care service, but for their lack of involvement in Politics and Legislation in their countries, efforts to implement their proposals have been met with brick wall. The Objective of this conceptual paper is to emphasis the need for Healthcare providers to be involved in Politics in their countries, to champion health care policies that will improve health care delivery. METHODS: Using Nigeria as case study I sort the views of several health professionals through their articles on Improving Healthcare delivery in Nigeria published in popular Journals and magazines. I consulted magazines and Journals from more advanced countries to seek out ways through which they have improved their health care system. RESULTS: Of all the views presented by these health professionals (Pharmacist and Medical Doctors), most pointed towards the role of the government in improving the healthcare sector, others suggested a need for health professionals to be involved in Politics without emphasizing on it. While in my analysis of the systems in the developed countries, I discovered that healthcare providers were involved in the government not as executive but as legislators, this way they sponsor health related bills and policies and were able to improve the value of healthcare delivery. CONCLUSIONS: To improve healthcare delivery and patient care in Africa, Health care givers (pharmacist and doctors) should be part of the countries policy makers (legislatures) so as to drive the needed transformation in the health sector.

Health Care Policy and Cost after Earthquake in Nepal Subedi N1, Poudeal R2
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Nepal is a topographically vulnerable country for many life threatening disasters like earthquake, landslides, avalanche, floods etc. Health care policy should focus on the disaster management plan and quick relief programs following major disasters. According to National census in 2011, 1851 people have been killed and 17,865 left injured. Nepal’s earthquake economic toll is massive in the health sector too. Many hospitals...