prerequisites in the regulatory and healthcare system to ensure and monitor the benefits of vaccination across the product life cycle. A focus group of medicine regulators and healthcare system experts was established to discuss the existence of these measurements within the Egyptian regulatory framework and healthcare system context. Finally a list of policy recommendations will be set for the safe introduction of the HPV vaccine, approved by "adaptive pathway" market.

RESULTS: Health system decision makers and the Egyptian Drug Authority should ensure that the following measurements will be in place before starting the introduction of "Adapting licensing" medicines: Vigilance regulation is fulfilled. Regulatory bodies closely monitor the promotion practice and prescribing practice to prevent off-label use, The Egyptian Drug Authority should revisit the definition of unmet medical need, Payers and health insurance organization should reconsider the reimbursement mechanisms and shift the payment for-performance scheme; The MOH should ensure the availability of unbiased clear information for patients; Patient Registry systems in MOH and University tertiary hospitals should be strengthened. Morocco should be a model for other countries for any resulted harms from the therapy.

CONCLUSIONS: Medicines approved by "adaptive pathway" should get a market authorization in Egypt only if there is an unmet medical need.

PHP188
DRIVING UHC IN EMERGING EMERGING: AN EGYPTIAN CASE
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OBJECTIVES: Health Insurance Organization (HIO) is the governmental health insurance of Egypt. It is the largest insurer, since it covers 8 million people in population segments in the community, as salaried public and private sector employees, pensioners, widows, school students, pre-school children, female headed households and farmers. The current population under the HIO coverage is 58% of the (approximately) 20 million people eligible for the scheme. To lead to the transition to universal health coverage (UHC), planned in 2020. However, HIO is facing many challenges that could hamper this leading role. Those challenges affect the medical, financial, administrative and legal departments, in HIO, was formed to identify the following aspects: LAC countries with HPV universal vaccination, year level reached by country. Inequalities in HPV introduction were assessed comparing the financial situation of HIO. Consequently, quality of service provision (both clinical and service aspects) is affected, and ultimately jeopardizing beneficiary satisfaction and financial protection. This paper discusses the process of driving a policy change, from the contract, to the implementation and to the health plans on the road to UHC, in Egypt, as a model for challenging emerging markets.

METHODS: A cross-functional task force representing the medical, financial, administrative and legal departments, in HIO, was formed to identify and analyze environmental factors, using DEPLSET model, and identify and analyze stakeholders. A multi-criteria decision analysis (MCDA) was conducted to develop evidence. Kotter’s model for change was used to develop a policy change plan to convince key stakeholders with the required changes.

RESULTS: Improving HIO financial viability will strengthen the purchasing power of the organization, which will help advance reimbursement of healthcare providers and pharmaceutical and medical suppliers, expand the contracting capacity of HIO, which in turn, will enhance patients’ choice through competition between healthcare providers. Nevertheless, the road to reaching a political consensus, even for the most right-equal decisions, requires thorough and scientific navigation process.

CONCLUSIONS: Getting such a politically critical decision to be implemented, especially in economically struggling economies, requires a systematic approach to driving change.

HEALTH CARE USE & POLICY STUDIES – Risk Sharing/Performance-Based Agreements

PHP189
HPV VACCINATION POLICIES IN LATIN AMERICA: ACHIEVEMENTS AND PENDING MATTERS
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OBJECTIVES: To describe processes and policies behind the HPV vaccine introduction in LAC. To identify inequalities in the HPV vaccine introduction processes in LAC. METHODS: We reviewed national and regional sources of information to identify the following aspects: LAC countries with HPV universal vaccination, year of introduction of universal HPV vaccination by country, type of HPV vaccine and vaccination scheme used by country, age groups targeted by country, and coverage level reached by country. Inequalities in HPV introduction were assessed comparing the rates of cervical cancer between countries with and without vaccination. Information on cervical cancer incidence and mortality by country were extracted from GLOBCAN 2012. RESULTS: More than 20 countries in LAC have introduced universal HPV vaccination among women but they differ in the type of vaccine used and vaccination policies. Most countries, excepting Ecuador and Peru, use the quadrivalent vaccine, and all of them, but Mexico and Ecuador, use a three doses schedule in the recommended vaccination strategy. In the case of young ages, they target different age groups with Argentina, Uruguay and Panama vaccinating one-year wide cohorts (11, 12, and 9 years old respectively), while Brazil, Colombia, Ecuador and Panama vaccinated multiyear cohorts (9-13 years, 9-17 years, 9-11 years and 9-10 years respectively). Vaccination coverage with 2 doses at least ranged from 86% in Mexico to <30% in Peru. The average incidence rate of cervical cancer for LAC was 21.2 per 105 inhabitants in 2012. Ten out of twelve countries which, so far, has not introduced the vaccine have incidence rate above the LAC average. CONCLUSIONS: Inequalities in HPV vaccination persist in the Region because with the highest rate of cervical cancer have been unable to afford the vaccine. Monitoring impacts on HPV infections is needed to assess whether differences in vaccination policies lead to differences in clinical outcomes.

PHP190
THE MATURE OF HTA IN EVOLVING HEALTH CARE SYSTEMS: DEVELOPING HTA STRATEGY FOR THE UNITED ARAB EMIRATES
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OBJECTIVES: 1) What lessons can be applied from established HTA systems in various OECD countries to the UAE? 2) What form may a HTA strategy devised for the UAE take? 3) What impact could the system have on the UAE health system? METHODS: Literature review of national health systems and HTA systems among OECD nations, and interview of officials from the UAE Ministry of Health, the Health Authority of Abu Dhabi and the Dubai Health Authority. RESULTS: The UAE health system is uniquely characterised by central government (Ministry of Health) and local government (Health Authority Abu Dhabi and Dubai Health Authority) agencies, each with varying and often overlapping levels of jurisdiction and impact on reimbursement and pricing decisions. Private insurers also play a small, but significant role in coverage and pricing. In light of the above context, we regard it differs from the centrally governed national health systems with their own national HTA policy (UK, France, Netherlands, Japan, Israel etc.). To date there is no official HTA and Health Economic strategy at the national level in the UAE. CONCLUSIONS: The study identified the need for major health policy changes in the UAE. This includes the establishment of a multi-stakeholder HTA and reimbursement committee.

PHP191
COVERAGE OF PHARMACOGENOMIC TESTS AMONG MINNESOTA HEALTH INSURANCE PLANS
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OBJECTIVES: To determine the type and level of insurance coverage, and identify specific pharmacogenomic tests that are covered or excluded from coverage by Minnesota health plans. Pharmacogenomics is a growing area that identifies an individual’s drug response based on their genetic profile and can help in choosing the most appropriate treatment for an individual. METHODS: Major health plans in Minnesota were included in the study if they were listed under “Individual plans” as licensed by the State of Minnesota and were a member of the Minnesota Exchange. Health plans were selected for review and analysis to perform specific coverage policies were reviewed and analyzed as of July 2015. RESULTS: Five health plans were selected for review and analysis. As of July 2015 the five plans provided coverage for an average of 12 different pharmacogenomic tests. Across all plans pharmacogenomic tests were covered for eight different disease categories. Cancer had the highest number of covered pharmacogenomic and biomarker tests covered at a total of 20 different tests across the five plans. Four health plans provided coverage for non-cancer conditions with an overall coverage of eight different tests. CONCLUSIONS: Contrary to the common perception, some plans provided coverage for a vast range of pharmacogenomic tests, while others provided limited coverage. This review helps in identifying the growth and gaps in pharmacogenomic testing among major health plans in Minnesota. To address the limitations of this study of using only publicly available online information, the next step is to directly contact the health plans and confirm their coverage policies.

PHP192
Pricing and Reimbursement of Innovative Technology in MENA and the Development of Managed Entry Agreement
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OBJECTIVES: The main objective of this descriptive study was to assess the access regulations applied in the MENA countries and examine how Managed Entry Agreement projects are implemented in the MENA these recent years. METHODS: To provide a comprehensive description of Pricing and Reimbursement regulation used in MENA region: We focused on the pharmaceutical policy in six countries: Algeria, Lebanon, UAE, KSA, Jordan, and Egypt. The analysis involved reviewing the literature in each country. First we reviewed the pricing and reimbursement procedures for the innovative drugs Secondly, we focused the review on the use in the regulatory process of MEA. Third we examined the agreements achieved in these region. RESULTS: We noticed that there are a lot of similarities and differences in principles of pricing and reimbursement of pharmaceuticals in the six countries studied are similar. The Pricing decision is taken at national level by a reimburse- ment committee within an institutional context (Ministry); most countries take into account the price levels prevailing in other countries, external price referencing e.g. KSA, UAE, Algeria, or for alternative therapies (internal reference pricing) e.g. Egypt, Lebanon, Algeria. The Reimbursement is an administrative negotiation between the relevant committee and the manufacturer. In the regulatory process we didn’t find explicit coverage for the drugs tested on the case studies. Conclusions- in some countries practice the MEA especially in KSA, Egypt, and Lebanon. CONCLUSIONS: In the MENA region, there are still important legal and structural obstacles for the implementation of risk sharing schemes and only few agreements have been implemented. Mainly financial-based, and the scientific literature on such schemes in the MENA countries is still sparse. However, as a response to uncertainty associated with new high cost of innovative drugs, we believe that the Managed Entry Agreement will increase in the MENA regions.

PHP193
DATA GOVERNANCE FOR REAL-WORLD EVIDENCE: CROSS-COUNTRY DIFFERENCES AND RECOMMENDATIONS FOR A GOVERNANCE FRAMEWORK
PHP194 MANAGED ENTRY AGREEMENTS FOR PHARMACEUTICAL PRODUCTS IN MENA COUNTRIES: PERSPECTIVE OF MANUFACTURER EXPERIENCE AND OUTLOOK

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OBJECTIVES: The aim of this study is to explore Managed Entry Agreements MEA activity, incentives, and issues involved in the actual design, implementation, and evaluation of pharmaceutical and medical device decision makers’ perceptions, future outlook, and key drivers for the development of MEA in MENA region. METHODS: We took Algeria, Lebanon, UAE, KSA, Jordan and Egypt as a representative sample of the MENA region. To capture perspective from policy makers and pharmaceutical industry officials, we conducted interviews which were followed by a survey targeted at key stakeholders from the MENA countries. For each country, we developed a semi-structured interview questionnaire and Subsequent survey were formulated around the below objective. OBJECTIVE: To list the types of MEA used in MENA countries. To identify the pharmaceutical class (Orphan drug or not) and the disease area that benefit from MEA. To have an in-depth understanding about the main incentives from both sides to enter such agreements. Main challenges encountered during the implementation and evaluation of the MEA. RESULTS: The current Managed Entry Agreements are mainly classified as non-outcome, patient and population level based schemes. Especially the price volume agreements; The vast majority of those agreements are implemented in oncology area. The incentives for such agreement are limiting total expenditure, improving access to public side and address some promising therapies from pharmaceutical side. CONCLUSIONS: The main barriers are related to the lack of organizational infrastructure and capabilities from both pharma and public health perspective, implement, and evaluate such schemes. According to professionals in both sectors, the lack of information technology in healthcare, local data collection challenges. However, there are some differences related to healthcare systems and country economy across MENA studies countries that impacted the future outlook of MEA.

PHP195 HOW VALUABLE IS A CANCER THERAPY? IT DEPENDS ON WHOM YOU ASK

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OBJECTIVES: In this study we look at two value assessment tools for cancer therapies, the Economic and Pharmacoeconomic Benefit Score (EMCS-avo) and the Society of Clinical Oncology (ASCO) Value Framework in Cancer, and evaluate how the two approaches differ in evaluating a cancer therapy as well as highlight important implications for practitioners. METHODS: We conducted a comparative evaluation across 74 non-curative oncology therapies in order to obtain value assessment ratings. RESULTS: Among the 74 treatments tested, the highest ASCO score produced was 64 out of 130. In contrast, many of the same treatments when evaluated by the EMCS-avo received no economic benefit grade (n=49) while their pharmacoeconomic rating was also more likely under the ASCO schema. CONCLUSIONS: The main barriers are related to the lack of organizational infrastructure and capabilities from both pharma and public health perspective, implement, and evaluate such schemes. According to professionals in both sectors, the lack of information technology in healthcare, local data collection challenges. However, there are some differences related to healthcare systems and country economy across MENA studies countries that impacted the future outlook of MEA.

PHP196 THE EVOLUTION OF PRIVATE HEALTH INSURANCE IN EGYPT WITHIN THE IMPLEMENTATION OF UNIVERSAL HEALTH COVERAGE

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INTRODUCTION: In 2015, only 58% of Egyptians had coverage by the public health insurer, the Health Insurance Organization (HIO), with an aim to achieve Universal Health Coverage (UHC) by 2030. Simultaneously, less than 10% of the population have coverage through private health insurance (PHI), with less clarity on characteristics of policyholders, and how many have dual insurance. Nonetheless, in 2015 the total value of Total Health Expenditures (TIE) was 22% of GDP with PHI share of 8%. With implementation of UHC, the role of PHI, within the Egyptian healthcare system, is expected to evolve. The aim of this study is to examine the characteristics of policyholders of PHI, in Egypt, and examine the role and evolution of PHI in the development of UHC policies and strategies.

PHP197 SINGLE-ENTRY MODELS FOR SCHEDULED SERVICES: TOWARDS A ROADMAP FOR THE IMPLEMENTATION OF BEST PRACTICES

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1University of Calgary, Calgary, AB, Canada, 2University of Manitoba, Winnipeg, MB, Canada, 3Kingston General Hospital Hospital Diau Hospital, Kingston, ON, Canada, 4Director, Health Technology Assessment, Alberta Health, Canada; the Health Insurance Organization included for the evaluation of Egyptian data. OBJECTIVE: Long waiting times for initial assessment continue to be a challenging issue in Canada. Single-Entry Models (SEMs) are one approach aiming to improve patient flow through the healthcare system. This paper provides a roadmap for healthcare decision-makers, physicians, and researchers to guide implementation and management of successful and sustainable SEMs. METHODS: The roadmap was informed by synthesizing the findings from multiple method research studies: 1) a systematic literature review and research on SEMs for adult elective surgical procedures; 2) a qualitative study to identify the barriers and facilitators to SEMs implementation of UHC. In depth semi-structured interviews with industry experts and policy makers, SEMs for adult elective surgical procedures; 3) a systematic literature review on SEMs for adult elective surgical procedures. RESULTS: PHI market is underdeveloped in the Egyptian, with trends commonly observed in employment-based insurance. However, it is expected to markedly progress, after the implementation of UHC. A process that requires innovation to develop appropriate policies and decision making. Active health insurance providers lacks, to be able to serve their expected and much needed role. CONCLUSION: Private Health Insurance is expected to play a different and significant role in Egypt after the implementation of UHC. Despite the current small size of market share of healthcare market in Egypt. This indicates the importance of involving PHI in the development of UHC policies and strategies.

PHP198 DEFINING END-OF-LIFE: IS THE SHORT LIFE EXPECTANCY CRITERION BIASED AGAINST YOUNG PEOPLE AND CHILDREN?

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OBJECTIVES: This study considered the criteria that currently define end-of-life (EdLo) and examine their potential implications on the young and children. METHODS: We conducted a comprehensive literature review to determine the current definitions of EdLo. RESULTS: The criteria for defining EdLo for children is based on the medical condition and lifespan rather than the age of the patient. Summary of the findings: EdLo criteria are not appropriate for the age of the patient and do not consider the medical condition and lifespan. CONCLUSIONS: The criteria for defining EdLo should be revised to include the age of the patient and the medical condition and lifespan.