to new medicines. Our goal was to determine the time period between the registration and reimbursement date in Hungary. **METHODS:** We selected all newly reimbursed pharmacy drugs between January 2004 and April 2010 and looked for the date of registration and reimbursement in public websites and Bulletins of EMEA/EMA, National Institute of Pharmacy and National Health Insurance Fund. We excluded hospital only medicines and drugs with special reimbursement budget from the analysis due to the lack of transparency of reimbursement dates in publicly available data sources. **RESULTS:** 106 newly reimbursed innovative medicines between January 2004–April 2010 were included into the analysis. The average time period between registration and reimbursement was 677 days. **CONCLUSIONS:** Hungary joined the European Union in May 2004 and implemented the EU Transparency Directive. Time to reimbursement of innovative medicines in Hungary is significantly longer than the recommended 90 + 90 days for pricing and reimbursement process set by Transparency Directive. The pricing and reimbursement process in Hungary takes more time than in 15 European countries included in the EFPIA Patients W.A.I.T. indicator database (from 101 to 403 days). Acceleration of patient access to innovative medicines is highly recommended in Hungary.

PHP35

THE IMPACT OF THE HOSPITAL FUNDING SYSTEM ON THE RANGE OF THE EXPENSIVE DRUGS AVAILABLE IN FRENCH AND ENGLISH HOSPITALS

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OBJECTIVES: In French and English hospitals, there are a lists of drugs financed out of scope of casemix-based payment system that are Payment by Result (PbR) and "Tarification à l'activité" (T2A). We examined a difference in the range of these drugs in both countries. **METHODS:** In the study were included the drugs registered on the list "en sus" in French system, the drugs from the high cost drugs list (HCD) and from the oncology regimens list in English system. The information is available in official sources. The number and overlap of entities excluded from the casemix-based payment system in two countries were determined, as well as similarity rate. **RESULTS:** 210 entities are financed out of scope of casemix-based payment system in England and 101 in France. 69% (145/210) of entities excluded from PbR are not on the list "en sus". Around 36% (36/101) of entities excluded from T2A are not on the English lists. There are 65 entities common for both lists; 51% (33/65) are from ATC class L (antineoplastic and immunomodulating agents). Four ATC classes have none common drugs. The aim of the list in two systems is fair reimbursement of the expensive drugs within the casemix-based payment system. In French system this list is used also to improve the access to the expensive and innovative drugs. So, 50% (73/145) of the entities excluded from PbR and not included on the list "en sus" are on another list in French system, the retrocession list. **CONCLUSIONS:** There is a difference in the range of drugs financed out of scope of casemix-based payment system in French and English hospitals. More drugs are excluded from the casemix-based payment system in England, but it does not facilitate access to new drugs.

PHP36

THE AVAILABILITY AND FUNDING OF ORPHAN DRUGS IN BOSNIA AND HERZEGOVINA IN COMPARISON WITH NEIGHBORING COUNTRIES

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OBJECTIVES: The aim was to examine the current availability and funding of orphan drugs in both entities of B&H and compare the obtained data with neighboring countries (Croatia, Serbia and Montenegro) and the EU. **METHODS:** We have analyzed the current published list of medicines in B&H and neighboring countries. We have compared the drugs that have the status of orphans according to the Orphanet report. **RESULTS:** In BiH there are no lists of orphan drugs while some of them are included in the list of chemotherapeutic agents and drugs for specific diseases (RS). Only Croatia has made a special list of expensive medicines containing drugs for treatment of hereditary enzyme deficiency. All countries have imatinib reimbursed. Only in the RS and Serbia thalidomide is reimbursed, and Serbia has listed sildenafil, zinc acetate and busulfan. Present practice in all countries is that patients apply individualy for orphan drugs reimbursement approval to HIFs. **CONCLUSIONS:** In order to improve access to orphan drugs it is necessary to adopt a national policy which will be harmonized with the EU. Decisions on the reimbursement must be based on real possibilities and it is necessary to implement appropriate registries for future resource allocation decissions.

PHP37

THE IMPACT OF UNIVERSAL COVERAGE ON EQUITY IN HEALTH CARE FINANCE AND FINANCIAL RISK PROTECTION IN THAILAND

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OBJECTIVES: To assess the impact of achieving universal coverage (UC) on equity in health care finance and on financial risk protection from expensive medical care costs for Thai households. **METHODS:** Secondary data analyses using nationally representative household surveys conducted by National Statistical Office, the Socio-economic Survey 2000 (prior to UC) and 2002–2006 (after UC) to analyze changes in progressivity of overall health care finance and different health financing sources. The share of households facing catastrophic health expenditure in the poorest and richest income quintiles prior to and after achieving UC was also assessed. **RESULTS:** The financing of the Thai health care system became more equitable after the UC policy was implemented. Improved financial risk protection after achieving UC was observed due to the comprehensive benefit package and literally free at point of services. The Kakwani index value for overall health care finance changed from –0.0038 (regressive) in 2000 to positive (progressive) values of 0.0014, 0.0342 and 0.0406 in 2002, 2004 and 2006, respectively. The share of households facing catastrophic spending on health decreased from 5.4% in 2000 to 2.0% in 2006. The 1st (poorest) quintile experienced a 77.5% reduction in the proportion of households facing catastrophic health expenditure, while there was a 41% reduction in the share of households in the 5th (richest) quintile. **CONCLUSIONS:** Factors contributing to equitable health finance are: the increasing share of progressive financing sources in particular direct tax; the decreasing share of the regressive out-of-pocket payments for health. Using general taxation to finance the poor and the informal sector not only helps reach universal coverage, it is also the most progressive financing source. Various factors contribute to the low incidence of catastrophic heath expenditure: comprehensive benefit package covering almost all health services which are free at point of use, and well-functioning primary care providers.

PHP38

HOW EQUITABLE OF HEALTH SERVICE USE AND GOVERNMENT SUBSIDIES IN THAILAND AFTER ACHIEVING UNIVERSAL COVERAGE?

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OBJECTIVES: To assess trends of equity in health service use and distribution of government subsidies to ambulatory services and hospitalization across income gradients of the Thai population prior to and after implementation of the universal coverage (UC) policy in 2002 and explained how such equity has been achieved. **METHODS:** Secondary data analyses using nationally representative household surveys conducted by National Statistical Office, the Health and Welfare Survey (HWS) 2001 (prior to UC) and 2003–2007 (after UC) to analyze equity in health service use at different health care levels and the distribution of government subsidies for health. The analytical approach employed a standard method for health equity analysis of the large scale household surveys proposed by O'Donnell et al. **RESULTS:** Outpatient and inpatient service use of the Thai health systems were both pro-poor before achieving UC in 2002 due to various government interventions in extending health insurance coverage and countrywide distribution of health service infrastructure, and the significant increase in human resource production. After the UC policy implementation, the pro-poor service utilization was further progressed. Overall, public subsidies for health were found to be pro-poor for both outpatient and inpatient services with the concentration indexes of –0.226, –0.186 and –0.180, in 2003, 2006 and 2007, respectively. District health provider networks, in particular health centres, district and provincial hospitals are the major determinants of the pro-poor distribution of service utilization and public subsidies, due to their geographical proximity and better access by the poor. A comprehensive benefit package and the provision of services that are free at the point of use resulted in the pro-poor benefit incidence. **CONCLUSIONS:** The pro-poor outcome is the result of an availability of functional primary care at the district level, and implementation of the UC policy which focuses on contracting primary care networks at the district level.

PHP39

A COMPARISON OF GENERIC AND ORIGINATOR BRAND DRUG PRICES BETWEEN JORDAN AND THE UNITED KINGDOM

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OBJECTIVES: The study aimed to compare the retail prices of generics and originator brand for five drugs between Jordan and United Kingdom and to investigate the relation between number of generics available, retail price of originator and generic (s) and the effect of time in the market on these prices. **METHODS:** Prices of originators and generics and the number of generics available in each market were obtained from the Jordanian Food and Drug Administration, Royal Pharmaceutical Society of Great Britain, British National Formulary and Chemist & Druggist generics list. The prices were converted to British Pounds expressed per one dose unit. All data was tabulated in spreadsheets; prices were compared between the two countries at different preset times. **RESULTS:** The generics of all drugs investigated appeared in the Jordanian market before patent expiry of their originator worldwide due to lack of patency regulations in Jordan at the launch time of drugs under investigation (before 2004). Unlike the UK, the prices of originator drugs in Jordan did not change when the first generic was introduced to the market. The price of generic drugs have dropped dramatically in the UK at time of first generic launch approximately by 90% compared to 15% in Jordan. There was no apparent correlation between the numbers of generics available or the number of years of first generic being in the market and the prices of the drugs investigated in both countries. The current prices of all investigated drugs in Jordan are higher than the UK particularly for the generics. **CONCLUSIONS:** Although much lower income per capita in Jordan, generic drugs are more expensive than the equivalent prices of same drugs in the UK