exact more stringent price controls. The purpose of this study is to provide empir-ical evidence on how price regulations in the OECD affected the adoption of new patent-protected pharmaceutical technologies during 1999-2008. METHODS: We use discrete time duration modelling with parametric and semi-parametric duration dependence to examine how price expectations shape the probability of launch, controlling for competition, market size expectations, firm and molecule heterogeneity across the major OECD markets during 1999-2008. A sub-sample analysis including only EU countries also investigates the impact of price inter-de-pendencies and potential firm strategies in launch and pricing decisions. RESULTS: The empirical analysis suggests there is a statistically significant and robust price and market size effect in the adoption of new pharmaceutical technologies. A unit increase in the log expected launch price and the log of expected market size increases the probability of launch by 0.003 and 0.002 respectively. Concentrated therapeutic subgroups, reflecting market crowding constitutes a significant barrier to entry. CONCLUSIONS: The results suggest that there is a large strategic firm influence with firms delaying launch in low-priced markets and attempts to maintain price differentials across interdependent markets to a minimum due to price comple-mentarities. Firm economies of scale and the therapeutic importance of innova-tions are other important drivers of early adoption. CONCLUSIONS: A significant and robust price and market size effect is observed in the likelihood of new phar-maceutical adoption. Price regulations slow down pharmaceutical adoption on a global scale and may impose welfare losses, particularly when the innovations that are delayed are cost-effective from a societal perspective. Due to scale advantages observed in the industry, price regulations may improve incentives for mergers and acquisitions, further increasing concentration levels and barriers to entry.

PHP22 ARE HOSPITAL MEDICINES PRICES INFLUENCED BY DISCOUNTS AND REBATES? Vogler S1, Zimmermann I2, Leopold C1, Habi C1, Mazag F1
1Gesundheit Österreich GmbH / Austrian Health Institute, Vienna, Austria; 2State Institute for Drug Control (RZK), Bratislava, Slovak Republic
OBJECTIVES: To understand the role of discounts/rebates impacting medicines prices in the hospital sector. METHODS: Qualitative interviews with pharmaceuticals and hospital pharmacists about purchasing strategies for hospital medicines with all EU Member States and two further European countries (Norway, Turkey) were conducted. Competing prices for the same medicines and preferences of purchasing practices were surveyed. Results: From participating countries, 25 countries reported about the practice of discounts and/or rebates (ex-post price reductions). The range of the discounts varied among the countries and with regard to the products. Apart from Italy with mandatory discounts to the NHS, discounts were always commercial and as such usually kept confidential. Free-cost medicines (i.e. medicines provided without payment) were reported to be a prac-tice in six countries, whereas it is legally forbidden in another six countries. In Austria, The Netherlands, Norway, Portugal, and Slovakia discounts were granted in individual negotiations between suppliers and hospitals for some of the surveyed products (e.g., for cardiovascular medicines where generics were available, how-ever no discounts for all oncology medicines of the sample). In Norway, discounts played no role since medicines were tendered centrally. In Austria and Slovakia medicines were provided cost-free to some/all hospitals (only in the indication of cardiovascular treatment). In Portugal, unit prices of nearly cardiovascular treatment). In Portugal, unit prices of nearly 0.00 were surveyed for a few cardiovascular medicines attributable to rebates. CONCLUSIONS: In the in-patient sector, confidential discounts, and, to a lesser extent, rebates and cost-free medicines are common in some countries. Discounts are more likely to be provided when there are no alternative therapeutic options available. Large dis-counts and cost-free provision appear to be a practice for “strategic products” which account for high volume and expenditure in the out-patient sector.

PHP23 ORPHAN DRUG ACCESS IN MEDICARE PLANS IN THE UNITED STATES Sepuhveda B, Doyle J
Columbia University, New York, NY, USA
OBJECTIVES: The increase in premium-priced orphan drugs coupled with health care budget constraints will pressure managed care plans to consider restricting market access. Coverage and reimbursement of ten FDA-designated orphan drugs (ceramide, alglucerase, isoflunamide, lamotrigine, laronidase, nitisinone, alpha-glucosidase, galafusufase, idursulfase, bosentan) were analyzed for ten popular Medicare plans. RESULTS: Of a total of 27 European countries, 25 countries reported about the practice of discounts and/or rebates (ex-post price reductions). The range of the discounts varied among the countries and with regard to the products. Apart from Italy with mandatory discounts to the NHS, discounts were always commercial and as such usually kept confidential. Free-cost medicines (i.e. medicines provided without payment) were reported to be a prac-tice in six countries, whereas it is legally forbidden in another six countries. In Austria, The Netherlands, Norway, Portugal, and Slovakia discounts were reported to be a prac-tice in six countries, whereas it is legally forbidden in another six countries. In Austria, The Netherlands, Norway, Portugal, and Slovakia discounts were granted in individual negotiations between suppliers and hospitals in some of the surveyed products (e.g., for cardiovascular medicines where generics were available, how-ever no discounts for all oncology medicines of the sample). In Norway, discounts played no role since medicines were tendered centrally. In Austria and Slovakia medicines were provided cost-free to some/all hospitals (only in the indication of cardiovascular treatment). In Portugal, unit prices of nearly 0.00 were surveyed for a few cardiovascular medicines attributable to rebates. CONCLUSIONS: In the in-patient sector, confidential discounts, and, to a lesser extent, rebates and cost-free medicines are common in some countries. Discounts are more likely to be provided when there are no alternative therapeutic options available. Large dis-counts and cost-free provision appear to be a practice for “strategic products” which account for high volume and expenditure in the out-patient sector.

CONCLUSIONS: ORUs on orphan drugs were prevalent in Medicare plans, with pa-tients bearing 40-60% of the OPC. The extent of restrictions was not proportional to the drug’s price, suggesting that further research is warranted to investigate the factors related to orphan drug access.

PHP24 HOW DOES THE COMMITTEE TO EVALUATE DRUGS (CED) MAKE DECISIONS ABOUT AMBULATORY PHARMACEUTICAL FUNDING IN ONTARIO? Furey T1, Evans G2, Mahaffy C1, Johnson A1
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OBJECTIVES: Pharmaceutical drug costs represent a large portion of government health care spending. A national standard to regulate the process of public financial reimbursement for drugs does not exist in Canada and variations in practices are evident across the country. The purpose of this study was to provide a compre-hensive overview of how drug funding decisions are made in Ontario. METHODS: Access to Ontario’s Committee to Evaluate Drugs (CED) meeting minutes (July 2009-July 2010) were granted. A data abstraction form was based on the method- framework established by Johnson et al. (2009). For each criterion, importance to the final decision, strength of evidence and quality of evidence were recorded. Two reviewers independently extracted the information and consensus was achieved. RESULTS: Forty-four submissions were included. Five main observations: 1) the CED considered certain criteria more frequently than others (e.g., clinical benefit was considered for all decisions, while societal values were discussed less fre-quently); 2) the relative impact of each criterion on the CED’s recommendation varied (e.g., overall clinical benefit, efficacy, value for money, and need had the largest influence); 3) the CED was more likely to discuss the strength of evidence when its recommendation did not support public funding (e.g., the strength of cost evidence was discussed 3 times more often for those drugs not recommended for funding); 4) the frequency with which the CED considered criteria varied according to whether or not the CED believed there was an established need; and 5) the majority of the comments made by the CED about the strength of evidence indi-cated that the quality of the data was low. CONCLUSIONS: This review identified trends in the influence of different criteria involved in the CED’s drug assessment process. Further development and application of a comprehensive, persistent, and transparent framework for reimbursement decision-making.

PHP25 DESIGNING FEASIBLE MODELS FOR AN OPTIMAL PHARMACEUTICAL CONSULTATION PROGRAM USING A SYSTEMATIC REVIEW Medina-Artom T1, Branski S2, Shavit O3
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BACKGROUND: Pharmaceutical consultation (PC) aims to maximize the successful outcome of a drug treatment. Although its benefits are well documented, several different PC models are implemented in various healthcare settings (HCS) and no optimal model has been identified. OBJECTIVES: To analyze the characteristics of PC models most relevant to key clinical, monetary, and social objectives, and to design models that optimize PC and could be implemented in HCS and in primary care in Israel. METHODS: We systematically reviewed studies of PC programs published from 2000–2010. We analyzed the programs by their organiza-tional characteristics and defined a scale for measuring their success that incor-porates the clinical, monetary, and social objectives. Their results were then scored accordingly. We calculated the association between each of the key organizational characteristics and the success score to identify the characteristics that maximize the program’s success. RESULTS: The analysis revealed three core patterns: consultation to patient and physician, consultation to patient and physician alone, and physician alone. For each pattern, three feasible models for optimal PC were found. The organizational charac-teristics of each model included the subject and location of the consultation, target population, consultant’s profession, communication method, incentives, duration, financing, and the PC process steps. CONCLUSIONS: This method for optimizing a model for PC program could be implemented in a variety of HCS to maximize successful drug treated reflected in the prevention and control of illnesses, improved clinical outcomes, enhanced well-being of the population and maximum economic benefits. Interviews with a sample of key players in HCS could reveal preferences and benefits, which then will be combined with the results of the previous analysis to optimize a PC program for primary care in Israel and for other HCS.

PHP26 HEALTH OUTCOMES AND ECONOMICS RESEARCH FOR REGenerative MEDICINE: CHALLENGES TO TIMELINESS, ACCURACY, AND COMPARABILITY IN PHARMACEUTICAL TECHNOLOGY ASSESSMENT AND REIMBURSEMENT REVIEW Faulkner EC1, Fernandez M2, Spinner DS1
1RTI Health Solutions, Research Triangle Park, NC, USA; 2RTI Health Solutions, RTP, NC, USA
OBJECTIVES: To systematically review studies of PC programs published from 2000–2010. We analyzed the programs by their organiza-tional characteristics and defined a scale for measuring their success that incor-porates the clinical, monetary, and social objectives. Their results were then scored accordingly. We calculated the association between each of the key organizational characteristics and the success score to identify the characteristics that maximize the program’s success. RESULTS: The analysis revealed three core patterns: consultation to patient and physician, consultation to patient and physician alone, and physician alone. For each pattern, three feasible models for optimal PC were found. The organizational charac-teristics of each model included the subject and location of the consultation, target population, consultant’s profession, communication method, incentives, duration, financing, and the PC process steps. CONCLUSIONS: This method for optimizing a model for PC program could be implemented in a variety of HCS to maximize successful drug treated reflected in the prevention and control of illnesses, improved clinical outcomes, enhanced well-being of the population and maximum economic benefits. Interviews with a sample of key players in HCS could reveal preferences and benefits, which then will be combined with the results of the previous analysis to optimize a PC program for primary care in Israel and for other HCS.

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