charge a fee of R$3.00 for this service. CONCLUSIONS: PIT is an important service that pharmacists deliver where the need exists. It is recommended that pharmacists be encouraged to counsel patients thoroughly when delivering a PIT service.

AN ANALYSIS OF DRUG COST CONTAINMENT POLICY AT A HOSPITAL IN SOUTHERN THAILAND
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OBJECTIVES: To examine drug cost containment policy implemented at a hospital in southern Thailand. METHODS: This study was a retrospective, pre-post policy intervention descriptive design. During the fiscal years of 2005 and 2009, various drug cost containment strategies, including generic substitution for any drug group and a successful formulary for orthopedic drugs, were adopted at a hospital in southern Thailand. Drug expenditures across those fiscal years were examined. The expenditure proportions between drugs listed and unlisted in National Essential Drug List were calculated. Cost-saving analysis of all generic substitution was conducted. Since the treatment guideline for orthopedic drugs was available in the hospital, their expenditures were also examined. RESULTS: Total drug expenditures had increased with decreasing rate across the study years. It increased by 47.1% from year 2005 to 2006, 43.19% from year 2006 to 2007, 21.17% from year 2007 to 2008 and 2.17% from year 2008 to 2009. The expenditures of essential drugs in the National Drug List were accounted for 61.64%, 56.62%, 54.38%, 48.67% and 50.94% across those study periods, respectively. Results showed that generic drug substitution policy reduced overall drug expenditures by 34.33%, or 7.66 million baths from year 2008. In 2009, only 11 items of generic drug substitution for branded name drugs could reduce drug expenditures by 13.33%, or 4.73 million baths which reflected annual cost-saving about 25.95 million baths. In the same year, a result showed that the implementation of orthopedic drug guideline reduced drug expenditures by 5.35% or 2.10 million baths. CONCLUSIONS: The study indicated that treatment guideline and generic drug substitution policies could control relative amounts of drug expenditures at a hospital in southern Thailand. Hospital administrators should consider to continue these policies.

ANNUAL HEALTH INSURANCE REIMBURSEMENT OF DENTAL CARE IN HUNGARY
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OBJECTIVES: The aim of this study was to assess the annual health insurance reimbursement of dental health service in Hungary. METHODS: The assessment base of the study was the annual reports of National Health Insurance Fund Administration (OEI). Only the data collected from the services in conactual relationship with the OEP and delivered in 2008 were evaluated. Dental care services are organised in different levels: general dental service, specialist dental care, special dental care on university level and inpatient departments. Our study covers primary, outpatient and hospital dental care. RESULTS: Dental care was supplied by 3378 general and specialist dental care services until the end of 2008. For the Hospital treatment cases 17 inpatient department is available with 154 patient beds. Within the period of examination (2008) 7.6 million cases or rather 23.6 million interventions were carried out. The health insurance expenditures of the OEP for outpatient dental care was 11.39 billion HUF (US$31.18 million). The health insurance expenditures of dental care (including primary, outpatient and hospital care) was 24.92 billion Hungarian forints (US$88.82 million) in 2008. CONCLUSIONS: The health insurance reimbursement of dental care services in Hungary is approximately 2% of the total health insurance expenditure of OEP.

EVOLUTION OF PUBLIC EXPENDITURE WITH PHARMACEUTICAL CARE IN BRAZIL DURING THE PERIOD 2005–2008
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OBJECTIVES: There is a known concern of health researchers and public managers in Brazil with the population’s access to medicines. We quantified the public expenditure on medicines from a data warehouse of the Ministry of Planning, Budget and Revenue of Brazil with the population’s access to medicines. We also computed the amounts transferred to official laboratories and the Federal Government. We also revisited. Applying our typology framework should allow health care payers and the industry to design and implement MAAs rationally and with transparency. MAAs in UK are a direct repercussion of a not favorable primary HTA.

HEALTH INSURANCE SUBSIDY OF SPA TREATMENT IN HUNGARY
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OBJECTIVES: To calculate the average health insurance reimbursement of spa treatment according to counties in Hungary. METHODS: Data were derived from the Hungarian National Health Insurance Fund Administration (OEI) and covers the fiscal year of 2007. These data was analyzed in the light of different value of its average HIS/STN value was 12.67%. The other regions performed similar outcomes ratio between 1.33% and 2.95%. CONCLUSIONS: The main cause of the two outlier regions is the inadequate structure of spa facilities. Less people visit to North Transdanubian Region, because the number of spa facilities isn’t significant, but these thermal baths is significant, which price is higher. The North Hungarian Plan attracts a lot of patients with lower price. The result if the price is lower, the subsidy will be lower because of the financing system is based on relative method.

MARKET ACCESS AGREEMENTS IN EUROPE: TYPOLOGY AND RATIONALE
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OBJECTIVES: Achieving Market Access for new products has become complex for pharmaceutical companies. Faced with growing expenditure, health care authorities accept or propose various Market Access Agreements (MAA) (risk-sharing/performance payment schemes). Our study aimed at achieving market access for new products. METHODS: We performed in-depth analysis of their design and we formulate recommendations to stakeholders. METHODS: MAA is a formalized compromise between payers and industry to achieve: Price and Reimbursement, HTA recommendation and Formulary listing. We reviewed published and grey literature from major health insurers in France, Italy, Germany and UK. We conceptualize MAA typology according to the nature of uncertainty perceived by stakeholders and their motivations. RESULTS: We identified above 30 MAAs and classified them as follows: 1) Value for money not questioned: a) Conditional Market Access Agreement: Evidence development agreement→Aim: address actual uncertainty; b) Health Outcomes Booster: Evidence development agreement→Aim: improve economical and clinical outcomes; 2) Value for money questioned: a) Cost Containment Agreement: Basic commercial agreement→Aim: reduce/control drug bill; b) Health Outcomes Agreement: Value based to performance; 3) Second line of payment: a) Conditional Market Access Agreement: Disease Management Initiative→Aim: improve competitive advantage; c) Conditional Market Access Agreement: Evidence development agreement→Aim: reduce/control drug bill; d) Health Outcomes Agreement: Value based to performance. MOTIVATION of the industry: Main: Buy health production; Other: Control expenditure; Improve ICER of expensive products; Prevent media coverage of negative decision; Provide patient access; Expand benefits basket. MOTIVATION of the industry: Main: Achieve Market Access for a product at high price in all markets; Other: Mitigate development failure; Reassure shareholders; Improve company publicity; Fulfill requirements of authorities. In UK the design of MAA was a direct consequence of formalized HTA, in Italy there was no apposite rational. CONCLUSIONS: Commonly used noncertificated needs to be revisited. Applying our typology framework should allow health care payers and the industry to design and implement MAAs rationally and with transparency. MAAs in UK are a direct repercussion of a not favorable primary HTA.

VALUE OF CONGRESS ABSTRACTS ON COST-EFFECTIVENESS STUDIES FOR DECISION MAKERS
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OBJECTIVES: ISPOR, RHEA, and HTAi regularly organize congresses in the field of health economics. Given the number of abstracts accepted each year it is crucial to assess their credibility and how results on cost-effectiveness analyses differ across meetings. METHODS: We collected all abstracts published 2007–2009 at ISPOR (International and Europe), HTAi and RHEA meetings. Abstracts on cost comparison, cost of treatment, cost benefit, cost consequences, cost-effectiveness, cost minimization and cost utility were in the period. Results were in depth according to a reading grid which allowed extraction of essential information that could enable evidence-based decision-making in health policy. This included e.g. availability of key methodological parameters, involvement of the industry in authorship and details of conclusions. RESULTS: We analyzed 5488 abstracts from ISPOR, 1410 from HTAi and 1969 from RHEA. Our preliminary