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/EFA, National Institute of Pharmacy and National Health Insurance Fund. We excluded hospital only medicines and drugs with special reimbursement budget from the analy-
sis due to the lack of transparency of reimbursement dates in publicly available data sources. RESULTS: 106 newly reimbursed innovative medicines between January 2004 and 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 Transpar-
ency Directive. The pricing and reimbursement process in Hungary takes more time than in 15 European countries included in the EPIFA Patients W.A.I.T indicator database (from 101 to 403 days). Acceleration of patient access to innovative medi-
cines is highly recommended in Hungary.

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

Grigoucha L, Aulos-Griot M, Maurain C, Bigaud B
Université Victor Segalen Bordeaux 2, Bordeaux, France

OBJECTIVES: In French and English hospitals, there are a lists financed out of scope of casemix-based payment system that are Payment by Result (PbR) and “Assurance maladie à l’actuariat” (TZA). We examined a difference in the range of these drugs in both countries. METHODS: In the study we included the drugs registered on the list “en sus” in French system, the drugs from the high cost drugs list (HCD) and from the oncolgy regimen list in English system. The information is available in official sources. In France, the overlap of the list of drugs is low and in English 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 103 in France. 69% (145/210) of entities excluded from PbR are not on the list “en sus”. Among them 36% (36/103) of entities excluded from TZA are not on the English list. 65 entities common for both lists; 51% (33/65) are from ATC class L (antineoplastic and immunomodulating agents). Four ATC classes have no common drugs. The aim of the list in two systems is fair reimbursement of the expensive drugs within the limited budget of the payment system. In French system this list is mainly to improve the access to the expensive and innovative drugs. 30, 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.

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

Cani T, Bajramovic A
Society for Pharmacoeconomics and Outcomes Research in Bosnia and Herzegovina, Sarajevo, Bosnia

OBJECTIVES: The aim was to examine the current availability and funding of orphan drugs in both entities of BiH and compare the obtained data with neighboring countries (Croatia, Serbia and Montenegro) and the EU. METHODS: We ana-
lyzed the current published list of medicines in BiH and neighboring countries. We have compared the drugs that have the status of orphan 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 chemotherapy 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 individually 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 decisions.

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

Prakongsai P
International Health Policy Program (IHPP), Nonthaburi Province, Thailand

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 ser-
vices. The Kalkwani 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 expenditure on health decreased from 24% in 2000 to 2.0% in 2006. The 1st (poorest) quintile experienced a 77.5% reduction in the proportion of households facing cata-
ostrophic health expenditure, while there was a 41% reduction in the share of house-
holds 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 health expenditure: comprehensive benefit package covering almost all health services which are free at point of use, and well-functioning primary care providers.