from an academic public hospital using an average of 18 months (2016–2017) for the department costs.

RESULTS:

The real average cost was USD 128,923. Most significant resource costs was medical staff, particularly for the three survivor patients, and the ECMO equipment presented the second highest cost. ECMO activities were separated into: before implantation of ECMO, period using ECMO, intensive care post-ECMO and rehabilitation, being the period where ECMO is the most expensive, particularly in nurse and physician costs. The SUS average was USD 31,437, which shows a difference of USD 97,485 between the real ECMO cost and the public reimbursement in Brazil.

CONCLUSIONS:

A critical element of the propagation of ECMO in Brazil and its reimbursement by public health system is the high cost and out-of-date standard payments by the Ministry of Health. Effort to implement a trustworthy method to guide decisions of SUS for the adoption and financing new technologies is essential to contribute to the optimization of public health policies in a country with a universal health system and limited resources dedicated to health sectors.

PP51 Updating Canadian Pharmaceutical Budget Impact Analysis Guidelines

AUTHORS:

Naghmeh Foroutan (foroutn@mcmaster.ca), Mitchell Levine, Jean-Eric Tarride, Feng Xie

INTRODUCTION:

The Canadian BIA guideline was published by the Patented Medicine Prices Review Board (PMPRB) in 2007. Our initial systematic literature review of national and international BIA guidelines showed that a number of new recommendations relating to BIA model structure, input data and reporting format have been adopted in other jurisdictions such as UK, Australia, Poland, Ireland, Belgium, France and the International Society for Pharmacoeconomics and Outcomes Research (ISPOR). The main objective of the present study was to conduct a comparative review of national, international and Canadian Federal, provincial and territorial BIA guidelines and provide a list of new recommendations related to the BIA key elements which have not been discussed or included in the Canadian PMPRB BIA guidelines.

METHODS:

BIAs guidelines were searched in databases such as MEDLINE, EMBASE, Cochrane, and the gray literature including regulatory agency websites. An Excel-based data abstraction form was designed in order to highlight differences between recommendations related to the BIA key elements provided by PMPRB, provincial, and other national and international BIA guidelines.

RESULTS:

Twelve guidelines were reviewed in detail. Sixty percent of the recommendations were new or were different from recommendations in the Canadian PMPRB BIA guidelines. They related to BIA key elements such as perspective, target population, costing, presenting results, data sources and handling the uncertainty.

CONCLUSIONS:

The present literature review is the initial step towards updating the Canadian BIA guidelines. This study presents a comparative review of key elements in BIA among different guidelines and provides a list of relevant practical recommendations for the improvement of the Canadian BIA guidelines. The new methodologic advancements and recommendations that were identified are being presented to Canadian stakeholders for their opinion and feedback prior to the development of a proposed new set of Canadian guidelines.

PP53 New Medical Device Law: Germany's Experience With Refund Restrictions

AUTHORS:

Elvira Müller (e.mueller@analytica-laser.com), Kurt Neeser, Ilse-Barbara Oelze

INTRODUCTION:

Since 2005, new hospital examination and treatment methods (NUB) were reimbursed by hospital individual supplementary fees as long as they were not sufficiently covered by a DRG. In 2016, the NUB procedure was decisively changed by legal norm §137 h SGB.V to

https://doi.org/10.1017/S0266462318002131 Published online by Cambridge University Press