benchmarks led to a reduction of 29.36 percent in pre-procedural deaths, as well as 26.38 percent in pre-procedural hospitalizations and 30.31 percent in nonelective TAVIs.
Conclusions. Increases in TAVI capacity in Ontario must be accelerated to meet wait-time benchmarks in five years. Expansion of TAVI care in Ontario would be associated with considerable reductions in mortality and hospitalizations. Without intervention, both wait-times and adverse outcomes on the waitlist are expected to continue increasing. Prioritization strategies to mitigate the adverse effects of long wait-times must be used until wait-time targets are achieved.

OP11 Differences And Similarities In Past Health Technology Assessments In Beneluxa Initiative Countries

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Introduction. Conducting joint health technology assessments (HTA) is one of the main goals of the Beneluxa Initiative. To strengthen this collaboration, this study aimed to assess similarities and differences between past assessments of Beneluxa Initiative member countries (Austria, Belgium, Ireland and the Netherlands).
Methods. A retrospective comparative analysis was performed that investigated the similarities and differences in drug assessments in the period 2016 to 2020 in (i) the number and type of assessed indications; (ii) the conclusions within assessments performed by at least two member countries; and (iii) the main arguments leading to the conclusions through a qualitative analysis of selected cases, looking into the patient population, the intervention, comparator, outcome, timing, and included evidence.
Results. The scope of HTA differs between the countries, with Belgium and Ireland assessing most, the Netherlands focusing on drugs above a budget impact threshold and Austria on outpatient drugs. Furthermore, indications might slightly differ between countries. Therefore, only 44 (10%) of the 444 included drug-indication combinations were assessed through a full HTA by all four countries. Between any pair of countries, the overlap was higher, from 63 (Austria-the Netherlands) to 188 (Belgium-Ireland). Added benefit conclusions matched exactly in 62 to 76 percent of the indications, depending on the compared countries. In the remaining cases, often a difference of one added benefit level was observed (e.g., higher versus equal relative effect). Contradictory outcomes were very rare. Differences were observed with regards to whether a cost-effectiveness analysis was performed. When assessing the underlying arguments within the reports for nine cases with different outcomes, it became clear that organizations agree on almost all aspects, and that differences are mostly attributable to slight differences in weighing of some aspects and uncertainties.
Conclusions. Overall, which indications are assessed differs, but for those indications that are assessed by multiple member countries, considerations and assessment outcomes are similar.

OP12 Post-Launch Evidence Generation Among Health Technology Assessment Bodies In Europe

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Introduction. The need for timely access to innovative technologies has placed a special focus on the development of policies and practices that can guarantee the availability whilst ensuring the safety of these technologies after launch or licensure. The aim of this paper is to present and discuss Post-Launch Evidence Generation (PLEG) practices among health technology assessment (HTA) bodies at the European level to explore cross-border collaboration opportunities.
Methods. In December 2019, a survey composed of nine closed-ended questions with multiple choice answers about the PLEG practices in each country was sent to 25 partners of the European Network of Health Technology Assessment (EUnetHTA) Joint Action 3. In addition to the survey, the national practices were discussed during a face-to-face meeting with all partners of the dedicated work package. A quantitative analysis and a qualitative synthesis of the results was carried out.
Results. Twelve HTA bodies completed the survey. Of these, 11 reported procedures in place for official PLEG requests. In nine of the agencies, the requests are made at the time of the assessment/appraisal. Data collection and analysis mainly lies with companies for pharmaceuticals (60%) while it is more the responsibility of the HTA body for medical devices (75%). Only one agency reported owning the data and being able to exchange the data without asking permission. During the face-to face discussions, it was acknowledged that PLEG practices differ between countries depending on the topic concerned, but most rely on the usage of registries (mainly disease registries) for data collection. Most agencies estimated that a European collaboration could take place.
Conclusions. PLEG practices are in the remit of many European HTA bodies. Data sharing should be anticipated as only some own the data and can exchange them without asking permission. European collaboration on PLEG could commence once the evidence gaps have been defined or during the production of the HTA reports in the case of joint assessments.

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