

Methods. Literature was searched by three different methods. First, a search strategy was used in six different databases. Second, the Database of Instruments for Resource Use Measurement (DIRUM) was hand-searched. Third, experts from six different European Union countries within the field of health economics were asked to provide relevant studies. Data was analyzed according to the Resource Use Measurement Issues (RUMI-) framework, which was developed for this study.

Results. Of the 3,478 articles provided in the initial search, 77 were fully analyzed. An overview with evidence is provided for every resource use measurement issue. Most research focused around the issue ‘how to measure’, in particular the effect of self-reported data versus administrative data. In contrast, little to no research has been done on issues ‘what to measure’ and ‘for which purpose to measure’.

Conclusions. Results of this study provide insight in the effect of a chosen measurement method. The results stress the importance of measuring the true quantities of resources utilized for generating valid costing estimates. Furthermore, this article highlights the lack of evidence in appropriate resource use measurement methods.

OP123 A Cost-Effectiveness Registry For Prioritization In Emerging Markets

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Introduction. Decision-makers in low- and middle-income countries (LMICs) often must prioritize health spending without quantitative benchmarks for the value of their purchases. The Tufts Global Health Cost-Effectiveness Analysis (GH CEA) Registry (healtheconomicvaluation.org/GHCEARegistry/) is a freely-available, curated and standardized dataset designed to address this need.

Methods. All indexed English-language articles published between 1995 and 2017 are currently included in the GH CEA Registry. Studies are limited to those reporting cost-effectiveness in terms of cost per disability-adjusted life years (DALYs) averted, a commonly-employed metric in global health. Abstracted data include intervention type, comparator(s), country, funding source, study characteristics (e.g., perspective, time horizon), primary study findings, sensitivity analyses, and disaggregated data on costs and DALYs. Study quality is assessed using a numerical scoring system (from 1-7, higher scores indicating better quality) based on accuracy of findings and comprehensive reporting of methods and results.

Results. To date, 620 articles have been included in the GH CEA Registry. Among LMICs, studies have been conducted primarily in Sub-Saharan Africa (41 percent) or South Asia (34 percent), have focused on communicable diseases (67 percent), and have involved immunization, educational, or pharmaceutical interventions (67 percent). As a priority-setting example, seven percent of interventions from higher-quality studies (ratings of 5 or higher) were reported to be cost-saving (i.e., lower costs and greater DALYs than standard care), two-thirds of which involved primary disease prevention (e.g., immunization, educational or behavioral interventions).

Conclusions. The GH CEA Registry is a new tool for decision-makers in LMICs, particularly those without a formal health technology assessment infrastructure but with a remit for providing access to essential, cost-effective health interventions. New functions are under development, including league tables for priority ranking, a repository for shared models, and tools for enhancing transferability between settings.

OP124 Disinvestment – A Global Challenge Requiring Collaboration?

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Introduction. Australia has had some success at utilizing Health Technology Assessment (HTA) to disinvest and reassess medical services. This has been achieved through a range of methods including identifying services through initiatives such as ‘Choosing Wisely’, examining real world service data and seeking expert clinical opinion. This presentation will discuss how better international collaboration in disinvestment and reassessment methods using HTA could lead to more efficient health care systems.

Methods. Both the Australian and South Korean governments have a particular interest in disinvestment and reassessment in their health care systems. These countries have been sharing information over the past two years with a common goal of improving their health systems through a rigorous reassessment process. The Australian Government is in the process of reviewing all publicly funded services utilizing expert clinical committee advice, often referring the reassessment of services to a HTA process. A similar process is also being undertaken in South Korea.

Results. Australia has disinvested in a wide range of services using HTA, including hip arthroscopy, lipectomy and hyperbaric oxygen therapy. It is also undertaking an extensive reassessment of 5,700 services. Reassessment may not lead to HTA, but it often includes an examination of whether a service should be subjected to HTA to remain publicly funded. Australia and South Korea have similar approaches in undertaking disinvestment and reassessment. HTA disinvestment and reassessment strategies have generated good outcomes for consumers, health care providers and funders in both countries.

Conclusions. Disinvestment and reassessment of medical services require funders that support the continual improvement of health care systems. Disinvestment and reassessment HTA can be difficult, mainly due to external interests - an issue experienced by many countries. Further international collaboration in this area may provide a more supportive environment to undertake HTA for disinvestment.

OP127 Sugar And Spice And All Things NICE - Managed Access Agreements

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