however, as the NICE and SMC examples show, although strong downward price pressure is exerted (high frequency of PASs), this may come at the cost of many therapies (~33 percent) being denied access. By contrast, the flexibility enabled by a distinct price negotiation phase may enable more therapies access, as shown by the G-BA/GKV example (<10% medicines withdrawn). Nevertheless, the relative effectiveness of the downward price pressures, a key determinant of HTA process effectiveness, cannot be compared due to the confidential nature of UK PAS discounts.

PP149 Features Of Accountable And Reasonable Processes For Coverage Decision-Making

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INTRODUCTION:

The Accountability for Reasonableness (A4R) framework addresses the legitimacy of coverage decision processes by defining four conditions for accountable and reasonable processes: Relevance, Publicity, Appeals, Implementation. Cost-per-quality-adjusted life year (QALY) and multicriteria-centered processes may have distinct implications for meeting A4R conditions. The aim of this study was to reflect on how the diverse features of decision-making processes can be aligned with A4R conditions to guide legitimized decision-making. Rare disease and regenerative therapies (RDRTs) pose special decision-making challenges and offer a useful case study.

METHODS:

To support reflection on how different approaches address the A4R conditions, thirty-four features operationalizing each condition were defined and organized into a matrix. Seven experts from six countries explored and discussed these features during a panel (Chatham House Rule) and provided general and RDRT-specific recommendations for each feature. Responses were analyzed to identify converging and diverging recommendations.

RESULTS:

Regarding Relevance, panelists highlighted the importance of supporting deliberation, stakeholder participation and grounding coverage decision criteria in the legal framework, goals of sustainable healthcare and population values. Among seventeen criteria, thirteen were recommended by more than half of panelists. Although the cost-effectiveness ratio was deemed sometimes useful, the validity of universal thresholds to inform allocative efficiency was challenged. Regarding Publicity, panelists recommended communicating the values underlying a decision in reference to broader societal objectives, and being transparent about value judgements in selecting evidence. For Appeals, recommendations included clear definition of new evidence and revision rules. For Implementation, one recommendation was to perform external quality reviews of decisions. While RDRTs raise issues that may warrant special consideration, rarity should be considered in interaction with other aspects (e.g. disease severity, age, budget impact).

CONCLUSIONS:

Improving coverage decision-making towards accountability and reasonableness involves supporting participation and deliberation, enhancing transparency, and more explicit consideration of multiple decision criteria that reflect normative and societal objectives.

PP151 Comparison Of Patients Undergoing New Technology For Prostate Cancer

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INTRODUCTION:

Prostate neoplasia affects more than one million people worldwide. Surgical treatments have evolved from open or video prostatectomy, up to the High Intensity Focused Ultrasound (HIFU) technique. HIFU studies cite less costs and better quality of life during the first year of follow-up. The objective of this study is to describe a consecutive series of eligible patients, with Gleason score 6 and 7, and compare resources used along those three treatment techniques.

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METHODS:

A comparative and retrospective study was conducted during the first 2017 semester, at Hospital de Transplantes de São Paulo, São Paulo city, Brazil. Consecutive eligible patients were matched by age, disease stage and profile and Gleason score 6 or 7. Resources used were assessed through medical records review and in- and out-patient visit interviews.

RESULTS:

A total of 152 patients were followed: 50 underwent open surgery prostatectomy, 50 underwent video prostatectomy and 52 underwent HIFU. Mean age did not differ between groups (66.6, 64.1 and 65.6 years, respectively). All patients were followed for at least three months. The average operating room time was 4.7, 4.1 and 2.3 hours, and the average anesthetic recovery time was 2.0, 1.9 and 2.0 hours, respectively. Average inpatient length of stay was 2.5, 2.7 and 1.5 days, respectively. Postoperatively, nine (18 percent) open surgery patients, and 14 (28 percent) video-prostatectomy patients required an average of one full day of intensive care, compared to only one (2 percent) HIFU patient. During follow-up, the same effectiveness was observed between the groups, none required re-intervention. Thus, considering the 50 percent economy in hours of operating room and of days of hospital stay, as well as 10 times less use of intensive care unit days when the HIFU technique was compared to conventional surgeries, it is estimated the HIFU program allowed 30 percent cost savings.

CONCLUSIONS:

The HIFU program presented effectiveness and savings. The hospital can increase access to care for prostate neoplasia patients.

PP152 Options To Approach Health Litigation In Brazil: A Policy Brief

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INTRODUCTION:

In Brazil, health is a constitutional right and the government is responsible for its guarantee. The Brazilian health system is characterized by universality, equality, and integrality, but citizens still strive to guarantee their rights through litigation. This work aimed to develop an evidence brief to support the decision-making process of judges with respect to health technologies, based on scientific evidence.

METHODS:

Support tools from the Evidence-Informed Policy Network (EVIPNet) were used to develop the evidence brief. After defining and describing the problem, a comprehensive search was conducted in PubMed, Health Systems Evidence, The Campbell Library, The Cochrane Library, Rx for Change, and PDQ-Evidence for systematic reviews published from 2010 to 2016. Nine systematic reviews were found. Review selection and quality appraisal were conducted independently by two reviewers. Three strategies for addressing the health litigation were defined. Evidence was summarized on benefits, harms, resource use, cost-effectiveness, uncertainties, and implementation. Implementation barriers and facilitators were also described.

RESULTS:

Three strategies were found: (i) Rapid response services to support evidence-informed decision making in health technology decisions—educational activities and materials were described as an effective way to involve different stakeholders and inform decision making, even when financial reallocation is needed; (ii) Continuing education programs focused on developing health technology assessment knowledge among law workers—continued education and educational outreach may be effective in knowledge and ability acquisition and retention, changing professional practices. Eventual lack of interest from or availability of the professionals can be addressed by involving leaders and opinion makers, as well as offering multimedia educational materials and activities adapted for the public; and (iii) Restorative justice conferencing (RJC) focused on the litigation of health technologies—the use of RJC through face-to-face meetings or social councils involves citizens in the decision-making process, including resource management. There are multiple barriers to this option (e.g. a lack of understanding among the public, conflicts of interest, a lack of professionals capable of conducting RJCs, and the need for legal reformulation) because of its unprecedented use in the healthcare setting. Opinion leaders should be invited to facilitate communication and the decision-making process among citizens, government, and the law.

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