RESULTS:

The calculated maximum support value of the package in 2015 was 267 percent. The median annual patient OOP expenditure was PHP 4,700 (USD 91). Maximum expenditure reached as high as PHP 392,000 (USD 7,551) per year mostly due to treatment for opportunistic infections (OIs), which are currently not included in the package. High OOP expenditure was also due to non-uniform coverage of services across different hubs; there was no consensus among providers on what specifically should be included in the package. This reflected a variety of package support values, with some hubs falling below patient expenditure.

CONCLUSIONS:

The current OHAT package, if properly implemented, is sufficient to cover the basic yearly healthcare needs of patients. However, non-uniform implementation and variation in prices of services per treatment hub means that coverage is not always sufficient in all areas, which can cause continued high OOP expenses for patients even with insurance coverage. Furthermore, coverage of OI's as the main driver of increased OOP expenses should be explored.

OP151 Weathering The Development To Adoption Storm: NICE Safe Harbors

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INTRODUCTION:

Getting technologies adopted in the UK healthcare system can be time-consuming and complex. The National Institute for Health and Care Excellence Office for Market Access (NICE OMA) has developed a novel approach to enable greater and more coordinated dialogue between life sciences companies and healthcare system stakeholders on market access issues.

METHODS:

When establishing NICE OMA, interactions were carried out with life sciences trade associations and key healthcare system stakeholders to explore challenges in market access landscape. Feedback highlighted that dialogue with NICE and other stakeholders is often limited and occurs in high-risk situations; indicating a need for greater and more coordinated dialogue between industry and multiple healthcare system stakeholders outside of formal processes.

RESULTS:

The approach developed is a safe harbor engagement framework which enables NICE OMA to facilitate interaction between life sciences companies and key healthcare system stakeholders; this collaborative approach promotes shared understanding of aspects that will allow innovative technologies to reach patients faster. It brings together multiple organizations in a safe environment where ideas can be exchanged between participants, allowing organizations to think beyond their own area of interest and to work collaboratively. Companies have used the engagement framework flexibly to engage at different stages along the development to adoption journey. Feedback indicates that companies have benefitted from channeling discussions through NICE to bring together key leaders from different organizations, as well as the neutral facilitation of discussions. Healthcare system partners have gained insights/knowledge that hadn't been apparent beforehand. Patient and clinical representatives have appreciated the opportunity to provide views to a broad range of stakeholders often early in the development of the technology.

CONCLUSIONS:

The NICE OMA safe harbor engagement framework has been well-received to date. Further feedback will be sought to understand the impact in helping to optimize the market access journey.

OP152 Level Of Agreement In EUnetHTA Joint Action 3 Early Dialogues

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INTRODUCTION:

A recent article reported a high level of commonality across European Health Technology Assessment bodies' (HTABs) positions in former parallel scientific advice procedure. Since 2017, the EUnetHTA joint action 3

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(JA3) offers a new early dialogue process involving a higher number of European HTABs. The present analysis aims to describe if the JA3 process modified the level of agreement across HTABs.

METHODS:

A descriptive analysis of the written recommendations provided during every JA3 early dialogues coordinated by the French National Authority for Health (HAS) until November 2017 was conducted. The level of commonality for each HTAB position identified was assessed globally and by domain (population, comparator, outcomes, study design and health economics) and classified as follows: "full agreement" if all HTABs had the same position, "partial agreement" if more than half HTABs had the same position and "disagreement" in all other cases.

RESULTS:

Four JA3 early dialogues were performed until November 2017: two in oncology, one in neurology and one in metabolic disorders. Between five and nine HTABs from eleven European countries participated. A total of forty-six positions were identified in these four early dialogues: ten on population, five on comparator, fifteen on outcomes, four on study design and twelve on health economics. Of the forty-six positions, full agreement was reached for twenty-eight positions, partial agreement for seventeen positions and only one disagreement was observed. The level of full agreements was highest for questions on comparators (five out of five) and population (nine out of ten) and lower for questions on health economics (six out of 12).

CONCLUSIONS:

Although the JA3 process substantially increased the number of HTABs participating in the early dialogues, this descriptive analysis suggests that the level of agreement remains very high. This may be facilitated by the high level of dialogue and coordination between HTAB ensured by the EUnetHTA process.

OP154 Industry And Clinician Views Of Medtech Innovation Briefings

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INTRODUCTION:

The National Institute for Health and Care Excellence Medtech Innovation Briefings (MIBs) are commissioned by the National Health Service (NHS) England and designed to support NHS and social care commissioners and staff who are considering using new medical devices and other medical, digital or diagnostic technologies. MIBs are fast flexible summaries of single technologies that are intended to be responsive to commissioners needs for information about innovative technologies. MIBs include a description of the technology, how it is used and its potential role in the treatment pathway. They also include a review of relevant published evidence and likely costs. As a relatively new product, the format of MIBs continues to evolve and in 2016 a more streamlined evaluation template was introduced. To ensure MIBs continue to meet users' needs, a study was conducted to understand the opinions and requirements of core stakeholders and to identify key areas for future development.

METHODS:

An initial cross-sectional online survey with NHS staff who were potential users of MIBs was carried out in December 2015. A second round of online and mail-out surveys were circulated between November 2016 and May 2017 to medical technology manufactures and an additional group of NHS staff. Descriptive analysis was used for all quantitative data and qualitative data was summarized using thematic analysis.

RESULTS:

Thirty-nine medical professionals and fourty-two manufacturer representatives participated in the surveys. More than half of clinicians were aware of MIBs and thought that raising awareness and visibility should be a future priority. Manufactures regarded MIBs as having a positive or mixed impact on innovation, access, or uptake by the healthcare system.

CONCLUSIONS:

Stakeholders are using MIBs in a variety of ways and there was and a range of suggestions for their future development particularly regarding moving from single technology evaluation to simultaneous assessment of similar technologies.

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