PP140 Burden of Illness And Health Care Costs In People with Alzheimer's Disease

Sophie Edwards (CRJP@novonordisk.com), Julie Hahn-Pedersen, Danielle Robinson, Mei Sum Chan, Benjamin Bray, Alice Clark, Milana Ivkovic, Wojciech Michalak, Christian Wichmann, Sasha Berry and Marc Evans

Introduction: Alzheimer's disease (AD), the most common cause of dementia, is becoming increasingly prevalent worldwide. Understanding the current burden of AD is important in health economic evaluations of new therapies. We aimed to estimate the burden of illness, and healthcare costs of people living with AD using a large, comprehensive real-world database in England.
Methods: A retrospective cohort study was undertaken in the Discover-NOW dataset, a real-world database containing the linked primary and secondary care electronic health records of ˜3 million people living in North West London, England. Patients diagnosed with AD were followed from the later of 1 January 2010 or AD diagnosis date, to the earlier of 31 December 2021 or end of follow up (maximum 10 years). Baseline prevalence of 33 comorbidities, incidence of 7 outcomes (survival, cardiovascular, care home admission, hepatic and renal outcomes), healthcare resource utilisation and total direct healthcare costs (using National Health Service tariffs and unit cost approaches) were calculated.
Results: Of 18,116 patients diagnosed with AD, at baseline the mean age was 81 years, 62 percent were female, 65 percent were White, 16.5 percent Asian and 8.9 percent Black. At baseline, hypertension prevalence was 60.2 percent, chronic kidney disease 35.5 percent and Type 2 diabetes 22.4 percent. The highest incidence rates across these outcomes were 13.4 (95% confidence interval [CI]:12.2,14.7) per 1,000 person years for stroke, 7.5 (95% CI: 6.6, 8.5) for myocardial infarction, and 83.6 (95% CI: 80.1, 87.0) for care home admission. Median survival was 4.9 years from diagnosis. Their annual total direct healthcare cost was GBP4,547 per patient, of which 58 percent were from hospital admissions. The majority (75%) of healthcare contacts were from primary care. AD patients had an average length of stay of 11.5 days per inpatient admission, and spent on average one week per year as inpatients.
Conclusions: AD is associated with high direct healthcare costs, with patients' annual costs ˜1.7 times that of the UK population. The majority of these costs are associated with inpatient hospital admissions.

PP145 The Impacts Of The Corona Virus Disease 2019 Pandemic On Bariatric Surgeries In The Private Healthcare In Brazil

Silvana Kelles (silvanakelles@gmail.com), Camila Pereira, Carina Martins, Daniel Reis, Ernesto Azevedo, Geraldo Ribeiro, Karina Zocrato, Lélia Carvalho, Marcela Freitas, Maria Horta, Mariana Barbosa, Mariza Talim and Marcus Borin

Introduction: The Corona Virus Disease 2019 (COVID-19) pandemic has impacted the functioning of health systems, imposing the need for adaptations. Elective surgeries also needed to adapt, and research has shown higher mortality in newly infected surgical patients after or during procedures. Thus, was recommended the suspension of elective surgeries during the pandemic. Early studies evaluating the effect of COVID-19 pandemic on bariatric surgery have reported a substantial reduction in procedures performed.
Methods: This retrospective study evaluated the impact of the suspension of bariatric surgeries for a Brazilian Health Maintenance Organization: UNIMED-BH, based on the analysis of data from before and during the pandemic of COVID-19.
Results: There were 2,641 bariatric procedures conducted in 2019 with a 14.1 percent reduction in volume to 2,314 procedures in 2020. In 2021, there were 2,813 bariatric procedures and 1,700 procedures were observed from January to August 2022. Therefore, it appears that in 2022 the demand for bariatric procedures will be similar to the year 2019, which was before the COVID-19 pandemic.
Conclusions: From the analysis of the data, a decrease in bariatric surgical volume was evidenced during the year 2020 when compared to 2019. Post-pandemic, monitoring is necessary to assess whether the system was able to meet the demand for bariatric surgical procedures.

PP146 Seeing Eye-To-Eye on Real-World Evidence: Are Guidance from Japan and China Consistent with Recommendations from REALISE in Asia?

Yan Ran Wee (yanran.wee@costellomedical.com), Natsumi Fujita and Jennifer S Evans

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Introduction: The REAL World Data (RWD) In Asia for Health Technology Assessment (HTA) guidance was developed by a regional working group to facilitate the increasing acceptance of real-world evidence (RWE) in Asia. We compared the consistency of REALISE against guidance from Japan and China.
Methods: Country-specific guidance for RWE/RWD use in pharmaceutical development were identified in May 2022 through governmental websites, with validation searches via Google. Sections from local guidance were mapped onto REALISE and categorized as "agree", "mixed", "disagree" or "missing" based on coverage and consistency.
Results: Five Japanese and three Chinese documents were mapped. Most sections in Chinese guidance (77%) and 36 percent of sections in Japanese guidance were tagged "agree" or "mixed", with general alignment on definitions and good practice considerations (study design, accountability); however, 63 percent of Japanese sections were tagged "missing" from REALISE. As local documents took the regulatory perspective, they lacked REALISE's discussion of translating RWD to RWE for HTA/economic evaluations specifically. Local guidance focused on practicalities of RWD collection in local contexts, including descriptions of specific actions (e.g., evaluating RWD sources, ensuring data security) rather than overarching principles described in REALISE; specifically, Japanese guidance described how to access and analyze databases/registries, reflecting Japan's landscape of robust sources of national healthcare data, but lacked discussion of other RWE study types, data sources and specialized analytical methods. While Chinese guidance had a broader view of RWD types (more similar to REALISE), they also contained discussions on pharmacovigilance and omics data, communication with regulatory bodies, and incorporation of RWE into the approval pathway for traditional Chinese medicines.
Conclusions: Despite differing purposes (with no RWE guidance from local HTA bodies), local and regional guidance align on general principles/good practice in generating/using RWE, providing common ground for increasing usage of RWE in HTA in Asia.

PP147 What Does Real World Evidence (RWE) Offer Health Technology Assessment (HTA) Procedures In Australia?

Gabrielle Challis (gabrielle.challis@medtronic.com), Michelle Hill, Liesl Strachan, Kate King, Shajedur Rahman Shawon, Oluwadamisola Sotade and Louisa Jorm

Introduction: Medical device health technology assessment (HTA) in Australia is largely coordinated by the Medical Services Advisory Committee (MSAC). Its remit to improve the public's health by deciding where to allocate public healthcare funding, can be enhanced by considering real world evidence (RWE). Existing data sources have limitations that can be addressed through RWE, including coverage of Australian patient populations who may not meet trial eligibility criteria, and long-term follow-up through data linkage and datasets. We partnered with a university to explore what information could be gained from an analysis of linked administrative patient data, with a view to addressing current evidence gaps and/or limitations. The findings can be used as a source of local data to define patient populations, estimate actual costs of care, and enable more comprehensive economic modeling to inform medical device HTA.
Methods: The University-developed New South Wales Cardiovascular Cohort dataset, comprising person-level longitudinal NSW administrative data for all patients admitted to hospital with a cardiovascular diagnosis from 2001 onwards, linked to national Medicare Benefits Schedule and Pharmaceutical Benefits Scheme claims data, was interrogated.
Results: Working with RWE is resource intensive in terms of time and costs. The potential of these data was revealed as the research progressed. It was possible to continually refine the data analyzed and reported,as well as expand the data requested. Varied expertise is required to accurately analyze the administrative datasets, particularly clinical classification skills and expertise in methods for causal inference using observational data. Findings from this study will enable the refinement of information for MSAC submissions, including identifying the most relevant patient population and reporting comprehensive costs, beyond an admitted hospital setting. The data will enhance engagement with clinicians and refine messaging, for example regarding patient risk factors.
Conclusions: RWE enhances Australian HTA applications. Local data, extended periods of time and insights not apparent from a focus on admitted hospital episodes can be revealed. Data can be refined during the process for specificity and applicability.

PP149 Reengineering Of Processes For The Elaboration Of Health Technology Assessment Reports In Catalonia

Maria-Dolors Estrada (destrada@gencat.cat), Jessica Ruiz-Baena, Roland Pastells-Peiró, Edurne Gallastegui-Calvache, Anna Godo, Laura Llinàs-Mallol, Pablo Martinez-Diaz, Berta Mestre-Lleixà, Carolina Moltó-Puigmartí, Daniel Pérez-Troncoso, Laia Ramos-Masdeu, Joan Segur-Ferrer, Gerard Solís-Díez and Rosa Maria Vivanco-Hidalgo

Introduction: In order to increase the value of its services and activities, the Agency for Health Quality and Assessment of Catalonia (AQuAS) has incorporated in its strategic plan the commitment to improve the processes, quality and people, while ensuring transparency, independence, rigor and efficiency following the guidelines of the European Foundation for Quality Management. We aim to present the standardization processes to improve the efficiency in elaborating health technology assessment (HTA) reports at AQuAS.

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