use programmes (CUP) or special access pathways (SAP). In theory, accelerated access is beneficial for patients with few therapeutic alternatives. In practice, it remains unclear if early access products actually deliver meaningful clinical benefit.

METHODS:

Seventy-five drug-indication pairs were identified that have proceeded through a CUP or SAP in one or more countries including Canada, Australia, France, Sweden, England, and Scotland. Data was collected from regulatory and HTA websites on length of CUP or SAP, time prior to MA, time prior to HTA decision, time between MA and HTA decision, French Transparency Commission added clinical benefit (ASMR), and HTA decision. Cohen kappa scores were calculated in order to assess inter-agency agreement.

RESULTS:

Across the 75 drug-indication pairs, average time between CUP and marketing authorization was 243 days, and average time between MA and HTA decision was 252 days. No products were deemed to be of major added clinical benefit (ASMR I), only 2.7 percent of products had important added clinical benefit (ASMR II), 26.7 percent of products had moderate added clinical benefit (ASMR III), 40.0 percent of products had minor added clinical benefit (ASMR IV), and 22.7 percent of products had no added clinical benefit (ASMR V). There is little inter-agency agreement in HTA recommendations for products that have proceeded through a CUP. The highest amount of agreement was seen between Canada and Scotland ($k = 0.24$).

CONCLUSIONS:

Preliminary results suggest that CUP and SAP products accelerate access, but often only provide only moderate or minor improvements in clinical benefit. Further, there is very little agreement across HTA agencies on the value of these products.

OP20 When Are Nationally Available Discounts Introduced In NICE Appraisals

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INTRODUCTION:

Offering a nationally available discount has become common to increase the chance of being recommended by the National Institute of Health and Care Excellence (NICE). This study reviewed all NICE technology appraisals (TAs) since October 2007 to determine whether a national available discount was submitted, and explore when these discounts were introduced.

METHODS:

All TAs between October 2007 and August 2017 were reviewed. The timing of the nationally available discount submission was allocated into one of four categories: initially submitted; initially submitted but changed; introduced after submission; or, other discount. An analysis was conducted to examine whether there was a temporal pattern in the introduction of nationally available discounts before or after January 2014, when the current Pharmaceutical Price Regulation Scheme (PPRS) came into effect.

RESULTS:

Before 1 January 2014, a nationally available discount was only used in the minority of cases across recommended (22 percent of cases) and not recommended (19 percent) technologies. In the period since 1 January 2014, use of a nationally available discount increased overall, but to a greater degree in technologies ultimately receiving a positive recommendation from NICE (not recommended: 19 percent to 39 percent; recommended: 22 percent to 59 percent). In the period since 1 January 2014, the proportion of technologies with a positive recommendation where implicit price flexibility during the appraisal was revealed increased (from 20/186) to 40/182.

CONCLUSIONS:

With the current PPRS, the majority of technologies have offered a nationally available discount, most commonly at the time of submission; however, there is increasing evidence of implicit price flexibility during the appraisal process to achieve a positive recommendation.

OP23 Setting The Value Of New Technologies - A Survey

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https://doi.org/10.1017/S0266462318000855 Published online by Cambridge University Press

INTRODUCTION:

Technology assessment in hospital traditionally involves parameters of safety, effectiveness and costs. The prosperity of medical innovations in an era of scarce resources requires more precisely refined methodologies to measure 'added value'. Our aim was to reveal the added values of technologies by asking professionals to prioritize their adoption into hospitals.

METHODS:

Twelve innovative technologies that were discussed for adoption over three years were controversial regarding their actual "added value". Fifty-two managerial health professionals ranked these technologies on two scales: hierarchic importance (league scale) and comparative score rating (CSR), reflecting willingness-to-pay (WTP). The distribution of ranking indicates the internal agreement (IA) among the participants.

RESULTS:

There was only partial correlation between the two scales. For example, glucose-monitoring was ranked 'highly important' on the hierarchic (league) scale with high CSR/WTP, but with low IA. This can be interpreted as "a valuable technology but with disagreement on comprehensive adoption in the entire hospital". The surgical robot was ranked 'highly important' on the hierarchic scale with low CSR/WTP, but with high IA, meaning "a valuable technology but with consensus to delay adoption in the hospital". Overall, the participants raised thirty-two "values" that can be assorted into five clusters of significance: clinical effect (6 values), social/public dimension (8 values), patient-physician interaction (9 values), technological aspect (5 values) and policy-regulatory perception (4 values).

CONCLUSIONS:

We identified different ';patterns' for defining the 'value' of various technologies. Revealing these aspects can create a "set of values" of relative weights that may explain the added value considerations in prioritization of decision making. Interestingly, there were technologies that were ranked low, but achieved a high rating. This can be explained by individual personal-oriented added value perspectives. Using this innovative tool to incorporate social value-based scores can assist in understanding the determinants, beyond the current traditional rationing mechanism, that guide professionals while prioritizing medical technologies.

OP24 Sensitizing Researchers And Developers For Patient Needs And Value

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INTRODUCTION:

Valuable health technologies must improve health and well-being of patients. For sensitizing healthcare industry stakeholders for the unique perspective and values of patients we developed a workshop format including both knowledge transfer and experiential modules.

METHODS:

The one-day pilot workshop was attended by two patient representatives and multidisciplinary participants from the healthcare industry (n=12) who wanted to learn about patient involvement in health technology assessment (HTA) and healthcare decision making and the implications for product development. Three content sessions covered key aspects of HTA and patient engagement and each was followed by an session which aimed at discovering the values of participants as healthy individuals or when the diagnosis of a disease and the subsequent therapy decisions (including potential clinical trial participation) impact quality and length of life. The workshop concluded with the participants prioritizing their expectations for innovation and HTA as patients or as citizens.

RESULTS:

Overall, participants rated the workshop as excellent or good for knowledge and experiential sessions. Integration of both learning modalities was described as innovative, useful, and enjoyable. Participation in the clinical trial session triggered cognitive responses among the industry participants due to a strong focus on advancement of science for innovation. Otherwise, the responses of the industry participants matched those of the patient representatives well. Overall, patient perspectives were considered useful to enrich the value perceptions beyond those of industry. Emotions describing the personal experiences included despair, shock, anger, guilt, hope, and the will to live. As citizens, they emphasized expectations such as finding solutions, remaining independent, enjoying life and "giving back".

https://doi.org/10.1017/S0266462318000855 Published online by Cambridge University Press