

there was a cost-saving of INR46,986 (574USD) per death averted and INR5,169 (63USD) per patient treated over a seven-year time horizon. The analysis demonstrated that FFR inclusion in the current clinical practice saves INR2,651 (32USD) per patient in overall upfront cost and INR2,518 (31USD) per patient in overall follow-up cost over a seven year follow-up period owing to improved diagnosis and prognosis.

**Conclusions:** In conclusion, FFR prevents unnecessary stenting, reduces overall mortality, and proves to be a cost-saving intervention in the long-term when used as a decision-making criterion in CAD patients in the Indian context.

## PP65 An Economic Evaluation of Day Care Surgery For Non-Acute Hernia Repair In Government Hospitals Of Sri Lanka

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**Introduction:** Early discharge of publicly funded non-acute hernia repair patients may save healthcare costs by reducing inpatient stays. This study reports a cost analysis of establishing day-care surgeries for publicly funded patients undergoing non-acute hernia repair in Sri Lanka.

**Methods:** A decision tree model was developed to represent the pathway probabilities and costs. Cost data was taken from the Medical Supplies Division, relevant hospitals, and laboratories. Hospital costs per-day were calculated based on WHO-CHOICE model with inflation adjusted to 2022 value. The model assumed that 60 percent of the hernia patients presented to the outpatient department, 39 percent were referred from private clinics, and 1 percent of hernia repairs admitted as inward transfers or emergencies. Of the hernia repairs that were conducted, 95 percent were assumed to be uncomplicated hernias, and the most common post-operative complication encountered was urine retention accounting for 95 percent of the complicated cases.

**Results:** It was estimated that in the current situation for a cohort of 1,000 patients undergoing non-acute hernia repair, 2,055 overnight in-hospital days were utilized. If day surgery services can be performed with patients observed for less than 24 hours before being discharged the overnight stay can be reduced to 155 patients. In the current scenario the total cost for non-acute hernia repair at a state hospital was estimated LKR170.9M (≈USD529K) per 1000 patients while the same procedure done as a Day Care procedure cost estimate

was LKR155.7M (≈USD482K) per 1000 patients. The savings from implementing day-care surgeries for non-acute hernia repair will amount to approximately LKR15M (≈USD40K) when caring for 1,000 patients. The results were sensitive to length of stay and proportion of complicated cases.

**Conclusions:** Shifting uncomplicated non-acute hernia repair patients from an inward scenario to a day care scenario would lead to a considerable financial saving to the government. More evidence on the value of expanding day care services and observation services capacity should be explored as this would guide efficient and sustainable publicly funded healthcare system in Sri Lanka.

## PP67 What Patients Want – Optimizing Oncology Value Assessment To The Goals Of Patients

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**Introduction:** Cancer is now diagnosed and treated earlier, resulting in improved patient benefit and outcomes. While overall survival (OS) is crucial to patients, there are other value dimensions, such as quality of life (QoL) and reduction in severe side effects, that change patient lives while on treatment. Considering patient reported outcomes (PROs) in value assessments for decision-making can improve individual, population and societal outcomes.

**Methods:** A multidisciplinary, international group of experts working in the cancer field was brought together to reach consensus on key principles of defining and assessing cancer treatment value. A Delphi-based approach including surveys, virtual panels, interviews and structured online discussions was used to reach consensus. This work was funded by AstraZeneca.

**Results:** Use of PROs in oncology value assessment is important because it can lead to: improvements in caregiver/patient/physician communication; unmet problem and needs detection; disease and treatment tracking; and better cost effectiveness. While some health technology assessment (HTA) bodies are already accepting QoL data, such as the Institute for Quality and Efficiency in Health Care (IQWiG) in Germany and US Centers for Medicare and Medicaid (CMS), many others do not. It is important that there is consistency in use of QoL data and other PROs, ensuring inclusion and a standardized and simple way of capture. In trials, tolerability data collected via PROs and QoL should be routinely and consistently incorporated and emphasized in HTA value assessments together with safety, efficacy and effectiveness. Data from PROs should be considered in decision-making to help build a better picture of health-related QoL, morbidity and adverse events from the patient perspective.

**Conclusions:** We are calling on the cancer community to: continue to encourage the use of a broad set of oncology-relevant endpoints

in clinical trials to further validate their relevance as endpoints either as predictors of clinical outcomes or endpoints with intrinsic value; collect complementary PRO data in clinical trials and as real-world evidence to better tailor treatment options to the outcomes that individual patients value most; involve patients in HTA processes.

## PP68 When Evidence Takes A Backseat To Politics – The Rise Of Robot Surgery In Australia

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**Introduction:** A 2018 health technology assessment (HTA) on robot-assisted surgery (RAS) led to a national committee recommendation, which some state Health Ministers adopted as policy, which stated: (i) no further public investment in RAS until subsequent HTAs demonstrate improved evidence; and (ii) clinical and patient outcomes from existing platforms should inform future decisions. This work also identified the Royal Australasian College of Surgeons (RACS) does not accredit any RAS training program for Australian surgeons, nor is there any nationally agreed or consistent credentialing mechanism, which creates ambiguity for hospitals (can this surgeon safely deliver?). Some state governments are ignoring its own policy and investing in RAS. At the same time, some public hospitals are ignoring the policy and procuring RAS through affiliated private hospitals. While market competition is expected to reduce price, governments responding to 'squeaky wheels' sets a dangerous precedent for high-cost technology procurement, especially if it needs to be replaced, and cost of delivery may not offset revenue generated.

**Methods:** Australia's states and territories can collaborate to commission HTAs. Since 2015, they have, jointly or independently, commissioned HTAs to monitor RAS evidence, which led to the 2018 HTA and policy. However, this policy is being ignored by hospitals and governments.

**Results:** RACS is working with local agencies to develop accredited training programs for different RAS platforms, which should offer comfort to provider hospitals regarding surgeon credentialing. Surgeons and patients are increasingly vocal regarding RAS, resulting in some governments investing in RAS. Not consulting with all stakeholders has led to confusion and a questionable role for policy makers. Private hospitals operated by public hospitals are procuring RAS in contravention of the policy and with no consequences, creating further confusion.

**Conclusions:** While accredited surgeon training will improve skills and outcomes, governments ignoring their own policy is resulting in unplanned technology introduction, which led to the need for HTA in the first place. Do we need to rethink the role of HTA, or should we accept that politics trumps evidence?

## PP69 Health Technology Assessment And University Health Center Affiliation Agreement: Current Situation And Potential Developments In Quebec

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**Introduction:** According to the Quebec law on health and social services, health technology assessment (HTA) is part of university hospital centers' mission, together with training, research and care. However, unlike these other functions, HTA is not covered in current affiliation agreements that bind a university with academic health institutions. Université Laval and its affiliated health institutions set up a consultation committee whose mandate is to propose the terms of an agreement to specify collaboration regarding HTA between the university and its affiliated institutions. This study investigates perceptions and needs of stakeholders from Université Laval and its affiliated health institutions with respect to the HTA mission.

**Methods:** Semi-structured interviews were conducted with four types of participants, namely university faculty members, health professionals and managers from institutions with and without HTA units, as well as external partners. Interview guides were developed based on the integrated analysis framework of Greenhalgh et al., and adapted to each group of respondents. Most interviews were conducted in groups and were facilitated by a research associate and a senior investigator. Interviews were recorded and uploaded to NVivo 1.6.2 software for codification and analysis.

**Results:** A total of 57 people were interviewed (nine group interviews and 35 individual interviews). Three main themes emerged, namely knowledge of HTA, factors related to the relevance of the HTA function, and organizational factors. Results showed that half of the respondents have a vague knowledge of HTA or have never heard of it. Most of the respondents agreed that the HTA function fits well with the mission of a health institution. They would accept getting involved with HTA activities at different levels if all conditions are met. Nevertheless, almost half of respondents believed that others strategies than including HTA into contracts of affiliation should be explored to regulate this function. Finally, organizational obstacles such as the lack of funding, shortage of staff and the lack of well-structured collaborations were highlighted by respondents.

**Conclusions:** Despite recognition of the importance of the HTA function in university health centers, interventions will be required at different levels to support the development of local HTA capacity. In particular, popularization of the HTA function and collaboration networks through specific projects should be developed.