Results. Our analysis suggests that despite several changes made over the years in the process for updating the benefits package, for example, increase in transparency, introducing a structured appeal process, it only partially fulfills the four A4R conditions. In order to accomplish these goals more fully, several widely used considerations such as cost-effectiveness analysis and incorporating views from patients should be included. Additionally, this decision-making process should become even more transparent than it currently is.

Conclusions. The annual process of updating the benefits package in Israel where hundreds of technologies are "competing" with each other for coverage under a pre-defined budget is unique and not without merit. This process has been operating in the same pattern with only minor changes made since 1999. The main barriers for fulfilling all A4R conditions may relate in part to the large number of technologies assessed each year within a short time frame. Several changes in the process including the assessment of societal values, involvement of diverse stakeholders including patient advocate groups should be made to improve its legitimacy.

OP270 Why The Haute Autorité de Santé Rejects the Widespread Use Of "Mini-Bypass"/One Anastomosis Gastric Bypass For Obesity In France

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Introduction. One anastomosis gastric bypass (OAGB) has become a widespread technique over the last few years in France, without any prior assessment and despite existing controversies among bariatric surgeons. An older bypass technique for treating obesity, the Roux-en-Y gastric bypass (RYGB), is available and reimbursed, having been assessed and approved for use in 2005. In 2019, the French Haute Autorité de Santé (HAS) assessed OAGB for the treatment of severe and massive obesity. This assessment, the first in the world, was undertaken for OAGBs carried out with a 200- or 150-centimeter biliopancreatic-limb (BP-limb) length.

Methods. A systematic review (SR) of the literature and consultation of a working group consisting of both healthcare professionals (clinician and surgeons) and patients were carried out. The primary aim of our assessment was to determine whether the OAGB technique can replace RYGB. The efficacy and safety profile of OAGB was compared with RYGB in adult patients with massive, severe obesity. Complications and postoperative follow up specific to OAGB were identified.

Results. The three selected randomized controlled trials (RCTs) could not confirm the superiority or the non-inferiority of OAGB, compared with RYGB, on the selected efficacy endpoints of weight loss, resolution of comorbidities, and quality of life. Adverse events reported for OAGB included severe nutritional complications and bile reflux that could potentially lead to lower esophageal cancer. In one RCT, the frequency of serious adverse events in the OAGB group was almost two times higher than in the RYGB group.

Conclusions. HAS considered that OAGB carried out with a longer (200 centimeter) BP-limb is not a validated technique for the surgical treatment of massive, severe obesity. Thus, it cannot be considered an alternative to RYGB. There were insufficient data available on OAGB performed with a 150-centimeter BP-limb. Thus, HAS recommended undertaking a multicenter RCT to assess the efficacy and safety of OAGB. Patients who have already undergone OAGB should receive the same follow up as patients who have received RYGB, including close monitoring for nutritional complications and lower esophageal cancer and an endoscopic examination five years after surgery.

OP272 Two-Year Within-Trial And Estimated Lifetime Cost Effectiveness Of The Weight Management Program In The Diabetes REmission Clinical Trial (DiRECT)

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Introduction. Type 2 diabetes results mainly from weight gain in adult life and affects one in twelve people worldwide. In the Diabetes REmission Clinical Trial (DiRECT), the primary care-led Counterweight-Plus weight management program achieved remission of type 2 diabetes (for up to six years) for forty-six percent of patients after one year and thirty-six percent after two years. The objective of this study was to estimate the implementation costs of the program, as well as its two-year within-trial cost effectiveness and lifetime cost effectiveness.

Methods. Within-trial cost effectiveness included the Counterweight-Plus costs (including training, practitioner appointments, and low-energy diet), medications, and all routine healthcare contacts, combined with achieved remission rates. Lifetime cost per quality-adjusted life-year (QALY) was estimated according to projected durations of remissions, assuming continued relapse rates as seen in year two of DiRECT and the consequent life expectancy, quality of life and healthcare costs.

Results. The two-year intervention cost was EUR 1,580 per participant, with over eighty percent of the costs incurred in year one. Compared with the control group, medication savings were EUR 259 (95% confidence interval [CI]: 166–352) for anti-diabetes drugs and EUR 29 (95% CI: 12–47) for anti-hypertensive medications. The intervention was modeled with a lifetime horizon to achieve a mean 0.06 (95% CI: 0.04–0.09) gain in QALYs for the DiRECT population and a mean total lifetime cost saving per participant of EUR 1,497 (95% CI: 755–2,331), with the intervention becoming cost-saving within six years.

Conclusions. The intensive weight loss and maintenance program reduced the cost of anti-diabetes drugs through improved metabolic control, achieved diabetes remission in over one-third of participants, and reduced total healthcare contacts and costs over two years. A substantial lifetime healthcare cost saving is anticipated from periods of diabetes remission and delaying complications. Healthcare resources could be shifted cost effectively to establish diabetes remission services, using the existing DiRECT intervention, even if remissions are only maintained for limited durations. However, more research investment is needed to further improve weight-loss maintenance and extend remissions.

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