ranged from approximately GBP 100,000 (USD 133,000) to GBP 400,000 (USD 532,000; listed prices). Of the six technologies, three resulted in at least ten incremental QALYs (eclizumab, elosulfase alfa and asfotase alfa). From the information in the public domain, it is unclear whether this would result in ICERs below GBP 100,000 (USD 133,000) per QALY.

CONCLUSIONS:

It may become more difficult for HSTs to get recommended by NICE under the new guidance, which requires cost-effectiveness analyses, whereas previously there was no official ICER threshold. The additional weighting of QALYs may be insufficient to meet an ICER threshold of GBP 100,000 (USD 133,000) per QALY.

PP14 Development Of The European Network For Health Technology Assessment Standards Tool For Registries In Health Technology Assessment

AUTHORS:

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INTRODUCTION:

Bridging gaps between registry-holders, Health Technology Assessment (HTA) producers and users is one of the aims of the European Network for HTA (EUnetHTA) Joint Action 3. In this context, a post-launch evidence generation tool is being developed, including a quality standards tool for registries in HTA. The standards tool for registries in HTA will enable, among others, registry owners to consistently collect high quality registry data, and HTA agencies to use proper registry data collected by others as evidence for their assessments. The objective is to present the first draft version of the tool structure, which is going to be piloted during the forthcoming months.

METHODS:

A review and description of the currently available first version (November 2017) sections, items and criteria for HTA studies.

RESULTS:

The tool is divided in three sections; "Methodological Information", "Essential Standards" and "Additional Requirements". The first section enables users to analyze not only the ability of the registry to answer to research questions but also to check the registry transparency. The second section encloses the essential elements of good practice and evidence quality (therefore all of them must be met before an HTA report can use the registry data). Finally, the third section includes elements of good practice and evidence quality useful to consider in planning and evaluating registries for specific purposes. Although suggestions are defined, the third section item requirements could depend on the individual HTA agency perspectives and needs.

CONCLUSIONS:

There is a clear growing availability and requirement for real world data for health technology assessment. A piloted and robust registry standards tool for HTA can provide a relevant basis to improve both the evidence generation but also to make more trustful and excellent evaluations.

PP15 Incorporating Participatory Design Approaches Into HTA

AUTHORS:

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INTRODUCTION:

To address local workability, cross-setting variation, and clinician and patient perspectives, health technology assessment (HTA) practitioners and health system decision-makers incorporate varying forms of qualitative evidence into evaluations of novel health technologies. Employing principles and methods from long-established sociotechnical fields such as participatory design (PD) may help HTA teams in the production of formal, rigorous 'practice-based evidence'.

METHODS:

We draw on a theoretical review of foundational PD literature and experiences using PD for a large-scale health information technology project to summarize

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principles and strategies for the effective introduction and evaluation of new technologies in healthcare.

RESULTS:

HTA may benefit from observing some of the core commitments of PD: (i) Ensuring that technologies enhance rather than detract from the quality of working life; (ii) Fostering democratic engagement in the implementation and evaluation of technologies; and (iii) Proceeding via direct partnership with technology users. These are practical commitments stemming from the recognition that technology implementation entails re-configuring existing practices and social arrangements. The experts of this existing milieu are the people on the ground, who may reject or underutilize technologies that they perceive as impractical, ill-adapted to their needs, or having negative consequences on their work. At the same time, PD recognizes that local activities occur within larger systems and that effective technology introduction also requires attention to macro-politics (e.g. governance challenges, competing priorities). PD employs a diversity of methods (e.g. participant observation, focus groups, workshops, interviews) to develop evidence that is holistically informed.

CONCLUSIONS:

Many of the challenges that HTA faces, both in terms of evidence production and translation, have been encountered before in PD. Given that decision-making around health technologies necessarily involves consideration of many forms of qualitative evidence, there is value in producing and evaluating such evidence in carefully designed manner – a challenge to which fields like PD can lend a wealth of experience.

PP16 Turning The Tide On Antibiotic Use With Consumers And Health Professionals

AUTHORS:

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INTRODUCTION:

Many countries have a national antimicrobial resistance strategy. In Australia, primary care is especially important because this setting encompasses a high proportion of antibiotic use. While antibiotic use decreased during the 1990s, it began to increase again in the mid-2000s. In response to this, in 2009 NPS MedicineWise implemented a series of nationwide educational interventions for consumers, family physicians (general practitioners), and community pharmacies that aimed to reduce excessive antibiotic use.

METHODS:

For consumers a social marketing approach was used, including strategies that leveraged collectivism, nudge theory, celebrity endorsement, and co-creation. Channels included social, print, radio, and other media as well as practice waiting rooms and pharmacies. For health professionals, interventions included face-to-face education, audits, comparative prescribing feedback, case studies, and point-of-care materials. Surveys of consumers and family physicians were conducted periodically to evaluate changes in knowledge and behavior. National Pharmaceutical Benefits Scheme claims data were analyzed using a Bayesian structural time-series model to estimate the cumulative effect of interventions by comparing the observed and expected monthly dispensing volumes if the interventions had not occurred.

RESULTS:

The consumer survey results indicated that more people were aware of antibiotic resistance (seventy-four percent in 2017 versus seventy percent in 2014), with the minority requesting or expecting antibiotics for upper respiratory tract infections (URTIs) (twenty-two percent in 2017). People underestimated the usual duration of symptoms for URTIs and were more inclined to expect antibiotics beyond that timeframe. Compared with non-participants, family physicians who participated in the program reported more frequent discussions about hand hygiene (ninety percent versus eighty-two percent) and proper use of antibiotics with patients (ninety-five percent versus eighty-eight percent). Between 2009 and 2015 there was an estimated fourteen percent reduction in prescriptions dispensed to concessional patients for antibiotics commonly prescribed for URTIs.

CONCLUSIONS:

Family physicians and consumers have responded positively to national programs. Sustaining and building on these improvements will require continued education and further innovation.

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