were extracted. The numbers of the same International Classification of Diseases, Ninth Revision (ICD-9), codes before and after surgery were compared. If a number increased after surgery, this diagnosis was initially identified as a complication. All diagnoses with neoplasms were excluded. The incidence rates of complications for the three surgery groups were calculated. Chi-squared tests were conducted for the following nephrectomy comparisons: laparoscopic versus open; robot-assisted versus open; and robot-assisted versus laparoscopic.

RESULTS:

A total of 1,890 kidney cancer patients had partial nephrectomies. Among them, 1,080, 411, and 399 had open, laparoscopic, and robot-assisted nephrectomies, respectively. One patient who had two different nephrectomies on the same day was excluded from analysis. The robot-assisted group had lower rates of digestive complications (ICD-9: 537–578, 787, 789, 998.6) and infections (ICD-9: 004–041, 998.5) than the open group, and higher rates of genitourinary complications (ICD-9: 584–599, 788, 997.5) than the laparoscopy group. The robot-assisted group had lower rates than the open group for most of the complication categories, but the differences were not statistically significant.

CONCLUSIONS:

Robot-assisted surgery appears to be superior to open surgery, but no better than laparoscopic surgery, in terms of minimizing the risk of complications following partial nephrectomy.

PP165 The Resurrection Of The Cost-Minimization Approach In England

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INTRODUCTION:

For almost 20 years (1999–2017), the National Institute for Health and Care Excellence (NICE) focused primarily on cost utility analyses (CUA) for its health technology appraisals. This changed on the 01 April 2017, when a new fast track appraisal process was introduced for technologies that offer exceptional value for money. Under this process, a cost-comparison analysis can be included for technologies that are likely to provide similar or greater health benefits at a similar or lower cost to comparator technologies already recommended by NICE. This is in contrast to other jurisdictions (e.g. Scotland and Australia) that have long accepted cost-comparison analyses such as cost-minimization analyses (CMA) when a technology has comparable efficacy to relevant comparators. This research aimed to investigate if this new approach will have an impact on future appraisals

METHODS:

Publically available technology appraisal documents from NICE, Scottish Medicines Consortium (SMC), and Pharmaceutical Benefits Advisory Committee (PBAC) were screened (01/01/2016-01/12/2016), and the supportive economic analyses were identified and extracted.

RESULTS:

In 2016, the proportion of CMA submissions that formed the basis of technology appraisals were 0/53 (0 percent), 17/55 (31 percent) and 25/82 (30 percent) for NICE, SMC and PBAC, respectively. The likelihood that a technology was recommended (with or without restrictions) for those technologies that were assessed using a CUA was 60 percent, 66 percent and 33 percent for NICE, SMC and PBAC, respectively, while technologies that were assessed using a CMA were associated with higher positive recommendation rates: 76 percent and 76 percent for SMC and PBAC, respectively.

CONCLUSIONS:

Incorporating a cost-minimization approach may result in more technologies being recommended by NICE through the fast track appraisal process, whereby the likelihood of a technology having a positive recommendation is much greater than the standard appraisal process.

PP166 RedETS: 10 Years Of Economic HTA (Medical Devices) In Spain, 2006–2016

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https://doi.org/10.1017/S0266462318002908 Published online by Cambridge University Press

INTRODUCTION:

RedETS, created in 2006, is the Spanish network of health technology assessment agencies. The objective of this work is to describe and assess the quality of the full economic evaluation reports on medical devices (FEEMD) carried out by RedETS.

METHODS:

The FEEMD were identified through the RedETS website publications database. Assessments about screening technologies were not included. The characteristics of FEEMD were analyzed using a formal RedETS HTA quality checklist. The characteristics extracted were analyzed through a descriptive univariate analysis.

Results : Twenty-six FEEMD were found. The publication years were distributed quite uniformly over time (approximately 2/year), although 7 were published in 2008 and 7 in 2013. Thirteen studies analyzed cost-utility, ten cost-effectiveness but not utility, and three both. The most frequent medical devices (MD) class analyzed were "In vitro diagnosis MD" (n = 8) and Class III products (8). The most frequent sources to analyze effectiveness were literature (22) and data collected through ad hoc studies (6). The main sources of unit costs were official public tariffs (14), manufacturers direct values (10) analytical accounting of one/more centers or regions (11) and DRGs (7). In relation to the modelling used, 14 evaluations performed Markov models and 7 decision trees. The perspective of 23 studies was that of the National Health System (NHS), and the rest corresponded to the perspective of a specific region (2) or social perspective (1). All studies analyzing time horizons greater than 1.5 years, except for 1, applied discount rates in the modelling. All studies included a sensitivity analysis.

CONCLUSIONS:

The economic evaluations of MD published by the RedETS accomplish most of the quality checklist aspects and are therefore exhaustive. These FEEMD have been used in the framework of decision making for an efficient management of the NHS basic portfolio.

https://doi.org/10.1017/S0266462318002908 Published online by Cambridge University Press