only a few were deemed relevant, acceptable, and feasible for use in the child health context. In addition, there were diverging views on whether it is possible to compare and integrate adult and child value sets with different properties.
Conclusions. Several questions remain to be answered before the public and other stakeholders can have confidence in child health state valuation protocols. We propose a research agenda, including both empirical and conceptual work, to inform future methodological development and to help HTA agencies make recommendations about how child utility values should be generated.

PD58 Implementation And Assessment Of A Lung Cancer Screening Pilot Project In Québec Through Multi-Stakeholder Collaboration

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Introduction. In 2019, the Québec provincial health technology assessment body (INESSS) recommended that lung cancer screening with low-dose computed tomography (LDCT) be accessible in Québec only within the context of an evaluation in the 'real-world' care setting. Based on this recommendation, the ministry of health (MSSS) decided, in 2020, to implement a screening pilot project and to conduct a formal evaluation, partnering with a clinical leader (principal investigator), participating hospitals, the provincial public health agency (INSPQ) and INESSS. The goal of this evaluation is to facilitate decision-making regarding the implementation of a province-wide screening program.
Methods. To support the implementation of the pilot project, algorithms and recommendations were developed to guide management of screening program participants. This material, based on Lung-RADS (Lung Computed Tomography Screening Reporting and Data System of the American College of Radiology), was developed by reviewing the literature and by consulting clinical experts. The evaluation plan proposes various indicators, focusing on six main topics: (i) costs, (ii) screening and investigation processes, (iii) clinical effectiveness and other effects on health, (iv) effects on smoking cessation, (v) organizational impact and (vi) implementation issues.
Results. INESSS has developed 12 algorithms and close to 50 recommendations for lung cancer screening and investigation, a tool for assessing lung cancer risk and a benefits/risks table. For the evaluation of the pilot project, MSSS, INSPQ and INESSS developed more than 100 indicators; short-term indicators are currently being measured and others will follow in the longer term. Since starting in June 2021, the pilot project is progressing well (as of November 28, 2021): 2,365 people have been referred, 1,272 were eligible for screening, 678 have had their first LDCT and 19 were Lung-RADS 4B or 4X. Results on indicators will help the ministry decide on the feasibility of scaling up screening to the provincial level and will highlight aspects to be improved.
Conclusions. This project shows how health technology assessment products can elicit changes in the health system, and how multi-stakeholder collaboration can actively support practice implementation and inform decision-making.

PD60 What Are The Opportunities And Challenges To Implementing Value Based Healthcare Pilots In The Brazilian Private Healthcare System?

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Introduction. The Brazilian National Agency for private healthcare system (ANS) regulates the private healthcare system in Brazil. ANS, since 2019, has been running the pilot value-based new payment models project. In total, 13 projects were selected by ANS. This investigation aims to identify opportunities and challenges to implement value based healthcare (VBHC) in Brazil.
Methods. We interviewed managers participating in the ANS' Value-Based Payment Models. Data were collected through semi-structured interviews during 2021. Twelve managers were invited to participate in the interview and eight accepted the invitation. The key questions were: "what are the main factors that facilitate – or limit - the transition from the fee for service model to a value-based model in the private healthcare system? And "will the payment models be scalable?" For data analysis, Bardin's content analysis was chosen. Data validation was performed using the debriefings technique.
Results. The interviews identified two key facilitating factors: people (identified by 50% of respondents) and processes (identified by 50% of respondents). Reponses relating to people nominated the need for professionals with VBHC knowledge (33%), support of senior management (25%), support from the provider (25%) and care team (17%). Reponses relating to processes nominated the need for partnership (58%), health-driven management (25%) and results (17%). We also identified that limiting factors (49%) were: providers (39%), in details: non-support from the provider, (56%), fear of financial loss (22%) and provider only wanting profit (22%); information system (30%), with data management; culture (17%), current versus innovative models; and peoples (13%), knowledge. More than 90 percent found it to be scalable, particularly, in vertical health plans (38%), large operators (38%); and provide diagnostic services (13%). We found that non-scalable situations are those where fee for service is hegemonic in terms of payments.

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Conclusions. Our study found that knowledge and culture management positively impacts the projects. Service providers can be limiting when they are exclusively focused on economic perspectives. The new payment model is considered scalable.

PD61 What Are The Drivers Of Transitioning From Fee-For-Service To Value-Based Payment Models In The Brazilian Private Healthcare System?

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Introduction. The Brazilian National Agency for private healthcare system (ANS) makes the regulation for private healthcare system in Brazil. ANS, since 2019, is running the pilot value-based new payment models project. In total, 13 projects were selected by ANS. This research aims to identify the key drivers for moving from fee for service (FFS) to value-based payment models in the Brazilian healthcare private system.
Methods. We interviewed managers of private healthcare plans (13 in total) participating in the Value-Based Payment Models run by ANS. Data were collected through semi-structured interviews during 2021. Twelve managers were invited to the interview and eight accepted the invitation. The key questions were: "Why are healthcare providers transitioning from the fee for service model to value-based models?" and "What are your motivations to participate in the ANS project?" For data analysis, Bardin's content analysis was chosen. Data validation was performed using the debriefing technique.
Results. The main reasons for transitioning from FFS to value-based models were related to weaknesses of FFS (58%), strengths of the value-based payment model (14%) and sector needs (14%). Fee-for-service weaknesses are related to financial impacts – including waste and unsustainability (55%), and lack of transparency – including lack of trust and conflict of interest (28%). Strengths of the value-based payment model were related to financial benefits (100%), in other words, greater return on investment. The key unmet needs of the sector are related to improvement of the financial status - including lower costs and less waste (71%), and improvement of care delivery quality (29%). Continuity was reported as a benefit of FFS, according to 43 percent of respondents.
Conclusions. Our results suggest that financial motivations are the main reason to transition from fee-for-service to value-based models.

PD63 Impact Of Parallel Submission On The Rollout Time and Health-Technology-Assessment Recommendation Of New-Active-Substances

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Introduction. Australia and Canada have parallel submission processes that allow companies to submit their dossier to the respective Health-Technology-Assessment (HTA) body before the market authorization is issued, aiming to provide timelier access to drugs. The objective of this study is to investigate the associations of parallel submissions with the rollout times and HTA recommendations of new active substances (NASs).
Methods. Public data from 208 HTA appraisals were collected from the Pharmaceutical Benefits Advisory Committee (PBAC) from Australia and the Canadian Agency for Drugs and Technology in Health (CADTH) for NASs obtaining regulatory approval between 2012 and 2020. We implemented multivariable logistic and linear regression models allowing for type of submission (parallel or sequential) and jurisdiction (Australia and Canada) to examine associations with first HTA recommendation (positive and positive with restrictions vs negative) and rollout time (regulatory submission to HTA recommendation), respectively.
Results. A total of 121 appraisals followed a parallel submission. The therapeutic products that most used a parallel submission were antineoplastic agents (Anatomical Therapeutic Chemical Code=L;47.11%). A similar proportion of chemical and biotechnological products followed parallel submissions.

Multivariable linear regression showed that parallel submission presented 14-months decrease in rollout time when compared to sequential ($p<0.001$). Regarding jurisdictions, longer rollout times were seen for Canada when compared to Australia (β:4.0, p-value=0.024).

Parallel submission showed no association with HTA recommendation. Canada had higher odds of receiving a positive recommendation (Odds Ratio:4.84, 95% confidence interval:2.63-9.18) when compared with Australia ($p<0.001$).
Conclusions. Antineoplastic agents were the main products using parallel submissions. Appraisals following a parallel submission showed a considerably faster rollout time than those following the traditional sequential submission, illustrating the advantage of this approach for dossier submission. The submission type did not have an impact on the HTA recommendation, indicating that although quicker, the HTA decision was not affected. Canada has a more restrictive criteria regarding the timing of dossier submission compared to Australia, which may lead to disparities in their rollout time.

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