PP49 Assessing Values In National And Regional Governance Of E-health

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INTRODUCTION:

Globally, countries are investing substantially in e-health. Failures of programs to achieve valuable economic, clinical and societal outcome are increasingly reported. Unsuitable governance models may be one explanation. Research on governance models' usefulness for realization of valuable outcomes is incomplete and scattered. Our goal is to fill this gap by producing knowledge on e-governance in Norway. Our hypotheses are: i) Co-governance and Relational Coordination will positively impact the realization of valuable outcome; and, ii) Multilateral stakeholder dialogue and collaboration, including health service delivery perspective, have been proposed to innovate health technology assessment (HTA). This will improve the relevance of HTA e-governance research.

METHODS:

We undertook the following: i) Systematic Review of e-governance in healthcare ii) Participatory observations, in depth interviews/focus groups iii) Document retrieval and analyses iv) Creation and support of arenas for dialogue between stakeholders on values and governance v) Analyses of co-produced value adjustments vi) Analyses of the usefulness of the Scientific Dialogue Approach for changing HTA paradigms. The study populations were: i) Governmental bodies responsible for innovation of the electronic health record (EHR) in Norway; ii) Regional and municipal authorities and management responsible for implementation of her; and, iii) The leaders of different levels at a municipal "Health House" established as a hybrid between primary and specialist health services

RESULTS:

The project runs between January 2018–2022. Expected findings are: i) Diverging and common values; ii) Diverging governance models; iii) Diverging attitudes towards "best governance practices"; iv) Diverging levels of trust; v) Different world views, belief-systems and individual values; vi) Attitudes towards consensus building or conflict; and, vii) Experiences to feed into the discussion of stakeholder dialogue as an HTA approach.

CONCLUSIONS:

We expect: i) To present results from the systematic review and preliminary findings from the first phases of participatory observations; ii) That results from the overall project will have high impact on the Norwegian governance models of e-health; and, iii) Publications in high impact scientific journals.

PP50 Microcosting With Time-Driven Activity-Based Costing Applied On Brazilian HTA System: ECMO Case Study

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INTRODUCTION:

Extracorporeal circulatory membrane oxygenation (ECMO) is a technology that allows recovery of adults in cardiorespiratory failure with encouraging results, but is not available in the Brazilian universal public health system (SUS) due to high implementation costs. Time-driven activity based costing (TDABC) is applied to measure processes in an economic perspective by identifying opportunities to make processes more efficient through the reduction of resources used in each activity. The literature has explored the use of TDABC to measure costs related with clinical procedures and technologies in microcosting studies, identifying opportunities to improve the process by making it more efficient. This research measures the real costs to implement ECMO in Brazil to compare with the current public reimbursement system.

METHODS:

This study applied TDABC using data from 6 patients to measure costs of ECMO intervention considering the public perspective in Brazil. In sequence, standard price payed by SUS was used to estimate the current reimbursement amount received by the hospital for ECMO procedure. Cost variable analysis was conducted to understand when and how patients receiving ECMO are using hospital resources. Cost data were collected

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from an academic public hospital using an average of 18 months (2016–2017) for the department costs.

RESULTS:

The real average cost was USD 128,923. Most significant resource costs was medical staff, particularly for the three survivor patients, and the ECMO equipment presented the second highest cost. ECMO activities were separated into: before implantation of ECMO, period using ECMO, intensive care post-ECMO and rehabilitation, being the period where ECMO is the most expensive, particularly in nurse and physician costs. The SUS average was USD 31,437, which shows a difference of USD 97,485 between the real ECMO cost and the public reimbursement in Brazil.

CONCLUSIONS:

A critical element of the propagation of ECMO in Brazil and its reimbursement by public health system is the high cost and out-of-date standard payments by the Ministry of Health. Effort to implement a trustworthy method to guide decisions of SUS for the adoption and financing new technologies is essential to contribute to the optimization of public health policies in a country with a universal health system and limited resources dedicated to health sectors.

PP51 Updating Canadian Pharmaceutical Budget Impact Analysis Guidelines

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INTRODUCTION:

The Canadian BIA guideline was published by the Patented Medicine Prices Review Board (PMPRB) in 2007. Our initial systematic literature review of national and international BIA guidelines showed that a number of new recommendations relating to BIA model structure, input data and reporting format have been adopted in other jurisdictions such as UK, Australia, Poland, Ireland, Belgium, France and the International Society for Pharmacoeconomics and Outcomes Research (ISPOR). The main objective of the present study was to conduct a comparative review of national, international and Canadian Federal, provincial and territorial BIA guidelines and provide a list of new recommendations related to the BIA key elements which have not been discussed or included in the Canadian PMPRB BIA guidelines.

METHODS:

BIAs guidelines were searched in databases such as MEDLINE, EMBASE, Cochrane, and the gray literature including regulatory agency websites. An Excel-based data abstraction form was designed in order to highlight differences between recommendations related to the BIA key elements provided by PMPRB, provincial, and other national and international BIA guidelines.

RESULTS:

Twelve guidelines were reviewed in detail. Sixty percent of the recommendations were new or were different from recommendations in the Canadian PMPRB BIA guidelines. They related to BIA key elements such as perspective, target population, costing, presenting results, data sources and handling the uncertainty.

CONCLUSIONS:

The present literature review is the initial step towards updating the Canadian BIA guidelines. This study presents a comparative review of key elements in BIA among different guidelines and provides a list of relevant practical recommendations for the improvement of the Canadian BIA guidelines. The new methodologic advancements and recommendations that were identified are being presented to Canadian stakeholders for their opinion and feedback prior to the development of a proposed new set of Canadian guidelines.

PP53 New Medical Device Law: Germany's Experience With Refund Restrictions

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INTRODUCTION:

Since 2005, new hospital examination and treatment methods (NUB) were reimbursed by hospital individual supplementary fees as long as they were not sufficiently covered by a DRG. In 2016, the NUB procedure was decisively changed by legal norm §137 h SGB.V to

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