Conclusions: Given that an efficient uniform price is dependent on the uptake in each indication, there are additional challenges to implement the optimal price in a market, compared to indication-specific pricing. The difference in the drug acquisition incurred for the payer under different strategies will lead to the profits for the manufacturer varying under the different pricing strategies. For an estimated efficient uniform price there may be reduced patient access and inefficient pricing if the indications reaching final approval are different to those used to set this price.

PNS57

BUDGET IMPACT ANALYSIS OF A WEARABLE REMOTE CONTINUOUS MONITORING DEVICE TO FACILITATE EARLY DISCHARGE OF BARIATRIC SURGERY PATIENTS IMMEDIATELY AFTER POSTOPERATIVE OBSERVATION IN THE RECOVERY WARD

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Objectives: A large regional hospital in the Netherlands, providing secondary care to approximately 450,000 persons, has started an initiative that strives to drastically reduce length of stay by providing part of treatment at home. This is currently organized on a per diagnosis basis, while it is being investigated what level of scale is most appropriate. This study was intended to provide insight into this, by estimating budget impact of implementing discharge immediately after postoperative observation in the recovery ward in bariatric surgery patients facilitated by a wearable remote continuous monitoring device. ***Methods:*** A budget impact model was developed to estimate the expected change in healthcare costs over five years, from the perspective of the hospital, resulting from reduced length of stay. Eligibility of patients was based on expert judgement, as the early discharge pathway is currently hypothetical. Resource consumption and costs were acquired from the hospital's financial department. Complication rate is assumed to be unaffected in the base case scenario. The model was enriched with a capacity estimation model, as the primary expected source of cost savings is reducing nurse shifts. ***Results:*** Additional cost of the intervention over five years is estimated to be €1,095,000; €509,400 of which is incurred in the first year, and €146,400 every year thereafter, not accounting for inflation. The majority of costs in the first year are due to investments in infrastructure and project management. In subsequent years costs originate mainly from functional management and support. Given that reducing day shifts by one during the entire week could result in savings of €100,000; reducing day shifts by two could approach cost neutrality. However, nurse shifts could not be reduced under the base case scenario. ***Conclusions:*** Implementing early discharge for one specific patient group is likely to result in additional costs. Larger numbers of eligible patients could result in savings.

PNS58

ANALYSIS OF FINANCIAL STATUS AND DETERMINANTS WITH ALTMAN'S Z-SCORE MODEL: A PANEL DATA INVESTIGATION FROM TRADITIONAL CHINESE MEDICINE LISTED COMPANIES IN CHINA

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Objectives: The financial status of traditional Chinese medicine (TCM) listed companies directly affects the development of the Chinese national pharmaceutical industry. This study aimed to evaluate current status of financial risks of TCM listed companies and analyse their determinants. ***Methods:*** This study used the data of A-share TCM listed companies in both Shanghai and Shenzhen Stock Exchange in China from 2007 to 2018. A total of 38 companies were included. We used the Altman Z-Score model to analyse the financial status of TCM listed companies. Then we used Z-Score as a financial performance indicator, firm's age, cash holdings ratio, firm's size, debt-to-assets ratio, tangibility ratio, debt to income ratio, book to market ratio, return on assets, operating income-sales ratio and liquidity as explanatory variable indicators to analyse the relationship between them by panel data regression method. Last we used the system-GMM to test the robustness of the model. ***Results:*** From 2007 to 2018, the Z-Score of mostly TCM listed companies were at a healthy level ($Z>2.99$). But in 2008, their financial conditions were not good with 10 companies were in the financial gray stage (10/38), and 4 companies had a Z-Score below 1.81, which was in financial risk. From the result of panel regression, we saw that the firm's age (β=0.249 $p<0.05$), return on assets (β=10.34 $p<0.01$), and liquidity (β=1.073 $p<0.01$) had positive effects on the listed company's financial position, while the firm's size (β=-1.680 $p<0.05$), book to market ratio (β=-1.728 $p<0.05$), and debt-to-assets ratio (β=-13.14 $p<0.001$) had negative impacts on financial conditions. ***Conclusions:*** The overall financial situation of TCM listed companies were relatively good. Increasing the proportion of liquidity, market value of companies, reducing current liabilities and the accumulation of debt, and rationally using the company's assets are conducive to maintaining the companies in good financial situation.

PNS59

INCORPORATING THE PATIENT'S PERSPECTIVE IN ECONOMIC EVALUATIONS OF HEALTHCARE

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Objectives: Patient-centricity has become increasingly important in healthcare. This requires the patient's perspective (PP) to be considered at all levels of decision making, ranging from coverage/reimbursement to clinical guideline development and shared healthcare decisions. In economic evaluations, different perspectives are reflected in the types of outcomes and costs considered. The objectives of this study are to understand whether and how PP has been incorporated in economic evaluations, to assess the need for more patient-centric economic models, and to propose a framework for better incorporating PP in economic evaluations. ***Methods:*** A targeted literature review of economic evaluations incorporating PP was performed. The key information on health outcomes and costs, the methods used to measure and value such parameters, and the decisions that the economic evaluations were intended to inform was extracted. Limitations of existing ways of incorporating PP and commentaries on how to fully reflect these were critically reviewed. A framework for better incorporating PP in economic evaluations was proposed. ***Results:*** Few economic evaluations included PP, and these were often grouped within a 'societal' perspective. Direct health benefits to patients, measured as life-years and quality-adjusted life-years are the most common outcomes estimated; other attributes were not considered, such as convenience, ease of use, or hope for patients and families. Direct medical costs were commonly included as relevant to patients, followed by direct non-medical and indirect costs. Intangible costs were rarely included. Average population or patient preferences were often used, with limited flexibility to account for patient heterogeneity. More patient-centric economic models are needed to reflect PP. An assessment framework using flexible model structures for better incorporating PP was developed. ***Conclusions:*** PP can be and should be better incorporated in economic evaluations of health care. This will ensure better informed decision making at all levels of the health care system.

PNS60

CAN WE APPLY NICE COST-EFFECTIVENESS TO FRENCH EFFICIENCY OPTIONS: A COMPARISON OF SEVEN NICE AND HAS BASECASE COST-EFFECTIVENESS SCENARIOS

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Objectives: To describe the impact of hypotheses and parameters in national institute for health and care excellence (NICE) and the health economic and public health commission (CEESP) of the french health autority (HAS) appraisals, on the incremental cost-effectiveness ratios (ICER) of six pharmaceutical products with a total of seven treatment indications with published cost-effectiveness analyses from both NICE and CEESP. ***Methods:*** In order to measure the impact of choices made by NICE and the CEESP on ICERs, we compared first final NICE and CEESP's appraisals for seven indications with a focus on: methodology of analysis, time horizon, discount rates, extrapolation of clinical efficacy, sources of utility, adverse events. ***Results:*** The analysis of the models revealed differences in the seven evaluations submitted to NICE and the CEESP. Some of these differences have an impact easy to interpret: longer time horizons and a slightly lower discount rate (3.5% vs 4.0%) were adopted in NICE submissions which individually tend to lower ICERs. Other differences regarding methodological choices are more difficult to handle when it comes to compare the ICERs, especially in the choice of comparators in five evaluations, survival extrapolation in four evaluations, model structure (semi-Markov vs partitioned survival) in two evaluations, population in two evaluations and method of estimation of adverse event in two evaluations. ***Conclusions:*** In order to evaluate the feasibility of comparing methodological choices used in NICE and CEESP appraisals, it is important to adapt the models to quantify the impact on ICERs. Finally, the differences regarding parameters and methodological choices used in the seven evaluations by NICE and CEESP submission showed that NICE's choices were more favorable regarding the ICER 6 times out of 7.

PNS61

DOES A STANDARD WILLINGNESS-TO-PAY THRESHOLD EXIST IN GREECE?

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Objectives: To systematically review the Willingness-to-Pay (WTP) threshold used in Greek cost-effectiveness (CE) studies over the last 10 years and investigate the methodology behind it. ***Methods:*** A systematic search of PubMed and ScienceDirect was conducted up to May 2019. The identified studies were independently reviewed by two investigators against pre-determined inclusion and exclusion criteria. The data of selected studies were extracted using a relevant form and consequently were synthesized. Qualitative variables were presented with relative frequencies (%) and quantitative variables with median and interquartile range (IQR). Mann-Whitney and Kruskal Wallis tests were performed where needed. ***Results:*** From the 221 identified studies, 102 satisfied the inclusion criteria. Studies were categorized to oncology (26.5%) and a non-oncology related (73.5%) based on drug treatment. The WTP threshold was reported to 71.6% of the studies (oncology: 59.3%; non-oncology: 76%), whereas the most frequently reported outcome associated with threshold was the "per quality-adjusted life year (QALY) gained" (oncology: 87.5%; non-oncology: 91.2%). A total of 34.3% of the studies with a reported threshold did not specified (NS) the origin of the threshold (oncology: 18.8%; non-oncology: 38.6%). From the rest of studies, the vast majority (91.7%) adopted thresholds equal to one-to-three times the gross domestic product (GDP) per capita [oncology: 100%; non-oncology: 88.6%],