

willing to lower the prices to the requested level, on condition that the price will not appear on any kind of official price list, to prevent “reverse referencing” to the prices in other bigger markets in the EU. Even though unsuccessful, these attempts may indicate that the pharmaceutical sector will continue to make their pricing as secretive as possible.

CASE4**ASSESSMENT AND APPRAISAL IN THE NETHERLANDS**

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ORGANIZATION: This joint presentation of the Netherlands Organization for Health Research and Development and the Netherlands Healthcare Insurance Board will introduce the support structures for HTA in the country and its use when deciding on the composition of the insurance package. **PROBLEM OR ISSUE ADDRESSED AND GOALS:** Design and results of the Health Care Efficiency Research Program including early evaluation, effects and costs, implementation and high costs /orphan drugs research will be presented. The role of the Board in safeguarding and developing public preconditions for the health care insurance system will be delineated. Focusing on insurance package management, selection and prioritization of the topics will be explained. Processes in place for collection of HTA information, including coordination between research and package agenda as well as use of national and international methodology and results are discussed. **OUTCOMES ITEMS USED IN THE DECISION:** Through presentation of selected diseases / conditions and their treatments the pathway from research to package decision will be highlighted. In addition, the role of the advisory committees of the Board, including pharmaceutical, package clarification and package advise are explained. And the relation between the Insurance Board, the Health Care Efficiency Research Program and the Ministry of Health will be clarified. Furthermore, the conditions needed to optimize the assessment—appraisal interplay are described and critically evaluated. HTA information is not considered relevant only for the package decisions and advise to the MOH. **IMPLEMENTATION STRATEGY:** Other parties in the health system, including providers, insurers and patients are also increasingly making use of it. Ways and means of making the information, from the two organizations, accessible and understandable for other users will be presented. **RESULTS AND LESSONS LEARNED:** Finally, internationalization of the research methodology and results will be reviewed, as well as use of this knowledge in the Netherlands.

PODIUM SESSION III: ECONOMIC EVALUATION AND REIMBURSEMENT DECISIONS II**EE5****THE SEESAW OF COST-EFFECTIVENESS THRESHOLDS: HOW RELAXED REQUIREMENTS FOR LATER LINES OF TREATMENT WILL INCREASE HURDLES FOR NEW THERAPIES**

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OBJECTIVES: This analysis investigates the implicit cost-effectiveness requirements for new therapies used earlier in a treatment sequence when cost-effectiveness thresholds have been relaxed for later lines of therapies. Two examples of this are: 1) The National Institute for Health and Clinical Excellence (NICE) decision to allow higher cost-effectiveness thresholds for later lines of therapy in certain oncology indications, and 2) The Swedish Dental and Pharmaceutical Benefits Board (TLV) implicit decisions to accept higher thresholds with later line restrictions. **METHODS:** A simple example is constructed where a new competing 1st line therapy (A) can replace the currently used therapy (B). It is assumed that if no further lines of therapy exist then therapy A would be considered cost-effective compared to B using a formal threshold level of T. A third therapy (C) is approved to be used only in 2nd line therapy and is accepted at a higher cost-effectiveness threshold than T. The problem is focused on the formal evaluation of the incremental cost-effectiveness ratio of the new therapy A vs. B in the presence of therapy C. **RESULTS:** The implication of relaxing the cost-effectiveness requirement for later lines of therapies is a further strengthening of the requirement of new therapies for earlier use in treatment sequences. In the most extreme scenario a new therapy, with less cost and higher effectiveness compared to standard therapy in a specific line, may not be considered cost-effective. **CONCLUSIONS:** This increased implicit cost-effectiveness threshold by the new regulations may risk crowding-out of new cost-effective therapies in earlier lines unless the explicit requirements/thresholds are modified using the highest accepted ratio between the costs and efficacy in the treatment sequence. Another solution is to evaluate and compare complete treatment sequences.

EE6**INCORPORATING EQUITY IN COST-EFFECTIVENESS ANALYSIS: A SYSTEMATIC REVIEW**

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OBJECTIVES: Limited use of economic evaluation in decision-making may in part reflect neglect of equity concerns. We reviewed published studies describing formal methods to integrate equity into cost-effectiveness and cost-utility analyses (CEA). **METHODS:** Candidate articles were identified via a search of Pub Med and EMBASE databases without language or date restrictions, and hand-searching of article bibli-

ographies. All original research articles, reviews, commentaries or editorials describing formal methods to integrate equity into CEA were candidates for inclusion. To select studies, candidate titles, abstracts and full text articles were reviewed independently by each author. Review was not blinded. Authors jointly determined study inclusion on the basis of individual assessments and discussion. Disagreements of opinion were resolved by consensus. Articles were excluded if they met one or more of the following criteria: not about CEA, not about equity, not a formal proposal, not an original proposal, proposal lacking in specificity. To facilitate narrative synthesis, articles were classified into families of approaches based on consensus groupings established jointly by the authors. **RESULTS:** The search identified 679 potentially relevant studies, of which 93 were retrieved for detailed (full text) evaluation following a review of titles and abstracts. After full-text screening an additional 47 studies were excluded, yielding 46 studies for review. Studies were classified into the following approaches to equity: equity weighting by age ($n = 8$), gender ($n = 1$) or disease severity ($n = 7$); social welfare function approaches ($n = 10$); mathematical programming ($n = 8$); dispersion and concentration of health benefits ($n = 3$); proportionalism ($n = 4$); and multicriteria proposals ($n = 5$). Most ($n = 40$) described theoretical proposals. **CONCLUSIONS:** There exists a wide variety of formal methods to incorporate equity into CEA; however, their potential has not been fully exploited. To enhance viability and uptake, specific recommendations are made for further methodological development and increased links with normative theory.

EE7**A DISCRETE CHOICE EXPERIMENT COMPARING PUBLIC AND DECISION-MAKER STATED PREFERENCES FOR PHARMACEUTICAL SUBSIDY DECISIONS**

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OBJECTIVES: We report the findings of a discrete choice experiment (DCE) undertaken to evaluate the consistency of public and decision-maker preferences for the public subsidy of pharmaceuticals. **METHODS:** The DCE compares the relative importance of gains in survival, quality of life (QoL), chance of response success and government costs in pharmaceutical funding decisions, and the impact that the initial severity of illness has on preferences. The DCE was administered to a sample of the Australian public and members of the Australian Pharmaceutical Benefits Advisory Committee (PBAC) and its Economic subcommittee. A mixed logit model was employed for data analysis. **RESULTS:** For both samples, an increased survival, QoL or chance of response success, or a reduction in cost or uncertainty (decision-makers only), increased the likelihood that a pharmaceutical would be chosen for funding. Further, both samples were more likely to fund a pharmaceutical which was used for the treatment of severe illness. Considerable preference heterogeneity was observed for both samples. **CONCLUSIONS:** While there is consistency between attributes the public are willing for the government to pay more when compared with the decision makers who understand the budget restrictions on decisions. Overall, this novel study suggests a high level of agreement between public and decision-makers in the trade-offs they are willing to make when new pharmaceuticals are considered for public subsidy.

EE8**BRIDGING HEALTH TECHNOLOGY ASSESSMENT WITH MULTICRITERIA DECISION ANALYSIS (MCDA) AND AN ETHICAL FRAMEWORK FOR COMPLEX DECISIONS: CASE STUDY OF GROWTH HORMONE FOR TURNER SYNDROME**

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OBJECTIVES: To test and further develop a decision support framework (EVIDEM) using growth hormone (GH) for Turner syndrome (TS) as a complex case study. **METHODS:** The MCDA matrix included 15 quantifiable components of decision clustered in four domains (quality of evidence, disease, intervention and economics). Six non-quantifiable components of decision were identified and organized into a tool using an ethical framework. A synthesized health technology assessment (HTA) report on GH for TS tailored to each component of decision was prepared and validated by experts. A panel of representative stakeholders estimated the MCDA value of GH for TS in Canada by assigning weights and scores. Impact of non-quantifiable components of decision was also considered. Validity of approach was explored. **RESULTS:** The HTA report revealed data needs for decisionmaking in particular regarding patient reported outcomes. Panelists estimated the value of GH for TS at 41% (min: 26%, max: 54%) of maximum value on the MCDA scale. Retest value estimate was 40% with high intra-rater agreement. Main contributors to value estimate were quality of evidence, disease severity, improvement of clinical and patient reported outcomes compared to no treatment. Significant expenditures associated with GH contributed little to value. Ethical considerations had mixed effects on value of GH. On average, 71% of panelists indicated that the same 13 quantifiable and 4 non-quantifiable components should always be considered. **CONCLUSIONS:** The framework allows transparent consideration of all components of decision and underlying evidence. Further testing and validation is needed to further develop MCDA approaches in health care decisionmaking.