this study was to analyze how the KA model could be institutionalized within the HTA framework. This is conducted by a systematic search on “KA” theoretical approaches and empirical evidence. Based on a comparative analysis of relevant articles, and over a series of discussion meetings with different stakeholders, we generated an adjusted KA model fitting the purposes of HTA. Then, we identified the key elements of the model, and in particular, the elements that would be critical for the institutionalization of the adjusted KA model in the context of HTA.

**RESULTS:** The evidence on the KA model focuses on solving real problems, the use of evidence from different sources, and the need for innovative tools and methods. The KA model is designed to empower patients and providers, and to provide a structured approach to HTA.

In the adjusted version, the institutionalization of KA within the HTA framework is challenged by, at least, the following questions: (i) the KA model requires new types of KA, including references of evidence; (ii) how to monitor the application of guidelines to local contexts; (iii) how to ensure the relevance of the model; (iv) and which are the implied outcomes that are expected from the KA model.

**CONCLUSIONS:** The KA model is a promising element to HTA, which can be useful for the institutionalization processes in many countries of the world. This piece of research identified the main components/questions that need to be addressed to undertake this institutional process.

**PHP23**

**EXTENSION OF INDICATION WITH MATURE PRODUCTS: TOWARD MORE INCENTIVES REWARDING INNOVATION?**

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**BACKGROUND:** Mature products (MPs - marketed for 10 years or more) are widely used off label (from 15 to 35% according to studies) despite little evidence on benefit risk ratio. It can expose patients to risks of low efficacy and healthcare providers to liability. However manufacturers are rarely investing in R&D development for MPs. Indeed MPs face price cuts in Europe, whether due to generic competition, price negotiations or in reference price groups. Moreover new indications, even if demonstrating a higher value of the drug, often lead to price reductions in Europe due to a combination of price/value agreements and external reference pricing. Products are included in reference price groups even for a new indication. While reference prices are typically included off-patent drugs, they may include patented drugs in Spain (if older than 10 years) and Germany. There are significant disincentives for manufacturers to invest in R&D for MPs, preferring instead to develop new molecules rather than unlocking the full therapeutic potential of MPs. This is especially the case for small populations (rare and ultra-rare diseases) where there is high unmet medical need and MPs could offer cost-effective solutions with known safety profiles.**DISCUSSION:** The development of new indications for MPs on a case by case basis will not be enough for new therapies to be implemented in the healthcare system, as patients will not be able to access new products. Therefore, a structured Pricing and Patient Access (PPA) framework that empowers countries to tailor their policies to the particular hospital’s needs, establishing a HTA unit seems the most practical in the case of big university hospitals.

**METHODS:** The models must be tailored for the hospital environment as HTA is a high level decision that must be considered in the context of the particular hospital’s needs.

**RESULTS:** Based on management needs survey, assessment requirements are divided into four categories according to the hospital environment. Urgent, important, relevant and not relevant. These categories are determined in the context of the particular hospital’s needs.

**CONCLUSIONS:** Technology requires to be substituted due to impracticality of its recovery. 2. Technology requires to be expanded due to existing demand. Incorporation of new innovative technology or planned replacement of obsolete technology. For each category of technologies a list was charted describing the assessment process and priority setting.

**PHP25**

**THE IRISH COST-EFFECTIVENESS THRESHOLD: DOES IT SUPPORT RATIONAL RATIONING OR MIGHT IT LEAD TO UNINTENDED HARM OF IRELAND’S HEALTH SYSTEM?**

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**BACKGROUND:** Ireland is one of few countries worldwide to have an explicit cost-effectiveness threshold. It was agreed in a 2012 agreement between government and the pharmaceutical industry in conjunction with substantial cost-savings on existing medicines, based on a threshold of €60,000/QALY. Prior to this, there had been an unofficial threshold of €40,000/QALY. The agreement only applies to pharmaceuticals, so there remains no official threshold for non-drug interventions.

**METHODS:** This study explores the impact of this threshold through a systematic review of evidence from 32–100% across UK healthcare providers. Another UK study looked at the uptake of NICE guidelines for several procedures, including laparoscopic repair of inguinal hernia, and reported that although Hospital Episode Statistics suggested 96% compliance, a detailed audit of healthcare trusts showed only 65% compli-