tion with treatment in chronic health conditions. However, responsiveness (sensitivity to change) still remained unknown. Thus, the goal of this study was to prospectively assess the effects of a novel NeP treatment. METHODS: We used data from a 6-month cohort prospective study carried out in chronic pain clinics, which included patients with NeP referred to pain clinics to change treatment in those cases when because of its refractory nature to previous treatments (pain score in a 0-100 mm VAS above 40 mm after, at least, one course of an analgesic at baseline) we demonstrated to be sensitivity to patient treatment. Sensitivity to patient treatment was defined as a relevant change in pain intensity and/or global treatment satisfaction at end of trial (pain reduction > 50% [responder]). Also, correlations between baseline to end-of-trial change in pain intensity and satisfaction scores were computed. RESULTS: The sample was formed with 755 subjects with refractory NeP; mean age: 57.8 years, 60.6% women, mean pain score of 74.2 (15.3) mm; after changing their therapy, 47% of patients were considered responders, and pain intensity was reduced by an average 42.9% (32.4), p<0.001, which was significantly correlated (r=0.524, p<0.001) with overall treatment satisfaction improvement in SATMED-Q which varied from 50.3 (17.3) to 74.2 (14.4) pts, p<0.001. Pearson r-coefficients between pain variation and SATMED-Q subdomains changes were significant and ranged between 0.189 and 0.465 (p<0.01 in all cases). Overall score in SATMED-Q was significantly higher in responders than non-responders, 80.9 (79.6-82.3) versus 66.5 (65.0-68.0), p<0.001. RESULTS: 3.8 weeks (1.6-6.5) were necessary to implement a novel NeP treatment. Challenges were to implement feasible and robust methods to collect and confirm Events of interest for the study (EoI) in ‘real-life’ settings, fitting health care standards, regulatory and cultural requirements of countries involved. METHODS: Longitudinal, international, observational study. Enrolling physicians were primary patient’s Health Care Providers; consequently, patients had to be the main contact to capture the EoI. Patients had to complete and sign a Contact Order Form that allowed trained interviewers performing follow-up calls at regular time points during the follow up period. Baseline clinical and demographic data were collected by enrolling physicians. Then, the medical confirmation of EoI detected through telephone interviews was ensured by the involvement of the concerned EoI’s treating physician. RESULTS: On average 85% successful interviews were performed, 2% patients withdrawn their consent, 3% patients were lost to follow up. On average, 80% of the EoI’s treating physicians accepted the process for medical confirmation and data collection of the EoI, despite strong variations depending on the country. CONCLUSIONS: The results of this study are in accordance with our previous experiences and confirms the benefits of using DPC in international observational and longitudinal studies. This study summarised and centralised method to obtain real life data overview for all patients included, whatever their country, a high level of patient adherence and a low rate of patient withdrawal, despite the large number of involved countries.
An alternative weighting algorithm of the Charlson Comorbidity Index (CCI) for risk adjustment in previously hospitalized patients. Wu et al. (2007) developed guidelines or tools for developing and reporting budget impact models. The guidelines were reviewed for whether they give advice on market share determination, sources of costs, inclusion of treatment of adverse events and the presentation of resource use and cost-effectiveness. The definitions of the term ‘incremental BA’ were also used inconsistently. An ISPOR Task Force has produced international guidance for budget impact methodologies, which is designed to support national guidelines rather than supersede them and also to improve consistency across BIs developed for different settings. CONCLUSIONS: Several national and international bodies have developed guidelines or tools for developing and reporting budget impact models. However, different specifications exist and not all methodological aspects are made explicit in every case. Consensus guidelines such as those produced by the ISPOR task force are required to shape future national BA recommendations.

PRM10

TO GET THE RIGHT PRICE – A DECISION SUPPORT METHOD TO OPTIMIZE MANAGERIAL DECISIONS ON PUBLIC FUNDING PRICE TO APPLY FOR Waddock NM1, Kocik K2

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OBJECTIVES: Budget impact analysis (BIA) is formally required by many national HTA regulatory agencies including NICE and the PBAC, in the UK and Australia, respectively. However, current practice only involves the use of point estimates to serve as a ‘best guess’ for decision-makers. However, using probabilistic sensitivity analysis (PSA) can serve to reduce parameter uncertainty in order to generate discussion and ultimately improve decision-making. METHODS: Using the same techniques applied for cost-effectiveness analysis, a PSA was incorporated into a budget impact model used for a client’s medical device. This involved creating and running a Monte-Carlo simulation (MCS) over 10,000 iterations to generate a 95% confidence interval (CI) around the overall budget impact in addition to a probability curve. RESULTS: The estimated budget impact was found to be a saving of £4.7m, based on a number of pre-defined input parameters in the model. Running a MCS generated a 95% CI of a saving of £10.1m, but also an incremental cost of £10.2m, either side of the point estimate. In addition, a probability curve was generated with overall budget impact on the y-axis and probability on the y-axis. 25 data points were generated running from a maximum potential saving of approximately £20m (1% probability) to an incremental cost of approximately £5m (100% probability). CONCLUSIONS: Using PSA in this budget impact model demonstrates that there is a significant likelihood this medical device could actually generate an incremental cost rather than saving (which the point-estimate shows). This serves as an example of how using this technique could serve to generate discussion among decision-makers in order to make more informed and improved budget impact decisions in the future.

PRM11

LEARNING EFFECT IN ECONOMIC EVALUATIONS OF HEALTH CARE INTERVENTIONS

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OBJECTIVES: The presence of the learning effect has an impact on the effectiveness of health technologies and so, it is relevant to capture this in an economic analysis. The aim of this study is to explore the bibliographic of learning curves in health care economic evaluations. METHODS: In order to understand the bibliography of learning curves, a systematic review was conducted to identify economic analyses that include a formal description of a learning effect. The following databases were searched: Medline, Medline (R), Embase, EconLIT, HEED and NHS EED. For a study to be included in the review, it had to be an economic evaluation defined as a cost, utility or cost-effectiveness study. In addition, the study also had to formally analyse the learning effect by using statistical analysis, graphs or tables. All non-human and non-English studies were also excluded.