ever, many governments are forsaking such tactics to focus on shorter-term quick fixes. Whilst recognising that risks-sharing agreements represent an important market access strategy, the objective of this research was to examine if the market expansion in number of risk-sharing agreements through 2007-2010 is still continuing, or if there is a gradual levelling off across the world. METHODS: Secondary research was conducted examining reimbursement decisions around the world, with data collected from Australia, Belgium, Brazil, Canada, China, France, Germany, Hungary, Italy, The Netherlands, New Zealand, Poland, Russia, Spain, Turkey, UK and United States. This was supplemented by primary research with payers and organisations through interviews in native languages to identify potential risk-sharing agreements. The public debate was used as general opinion. RESULTS: Thirty-two new risk-sharing agreements were found in the period of review (May 2011 - May 2012), which is roughly in-line with the rate found in previous years. The number of new drugs with risk-sharing agreements attached to them actually declined, and most new agreements are being negotiated for drugs which already have a prior risk-sharing agreement. The results suggest that new agreements tend to be financially based, although new performance-based agreements continue to emerge, in- cluding in emerging markets. The majority continue to focus on the oncology area. CONCLUSIONS: Although risk-sharing continues to be a routine part of market access strategies, there appears to be a notable “levelling off” of the rapid expansion of this strategy in previous years. This is relatively unsurprising as it reaches a natural plateau, but still notable against the background of ongoing global austerity.

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IMPACT OF A FINANCIAL RISK-SHARING SCHEME ON BUDGET-IMPACT ESTIMATIONS: A GAME-THEORETIC APPROACH
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OBJECTIVES: As part of the process of updating the National List of Health Services (NLHS) in Israel, both health plans (“payers”) and manufacturers provide estimates on the expected number of patients that will utilize the drug. Currently, payers face major financial consequences when actual drug utilization is significantly higher than the allocated budget. We suggest a risk-sharing model that imposes a potential penalty on the two stakeholders: if the actual number of patients exceeds the manufacturer’s prediction, the manufacturer will reimburse the payers by a rebate of α from the deficit. In case of under-utilization, payers will refund the government at a rate of γ from the surplus budget. Our study objective was to identify the optimal early estimates of both ‘players’ prior to and after implementation of the risk-sharing scheme.
METHODS: Using a Game-Theoretic approach, we examined whether both players’ statements are considered simultaneously, we examined the impact of risk-sharing within a given range of rebate proportions (α, γ), on players’ early budget estimations.
RESULTS: With no risk-sharing, manufacturers and health-plans will choose to announce the smallest and highest number of patients, from the cumulative distributions of function of patients, respectively. When increasing “α” to be over 50%, manufacturers will announce a larger number and health-plans will announce a lower number of patients than they would without risk-sharing, thus, substantially decreasing the gap between their estimates. On the other hand, in- creasing “γ” changes players’ estimates only slightly. CONCLUSIONS: In reaction to applying a substantial risk-sharing rebate “α” on the manufacturer, both players are expected to adjust their budget estimates towards an optimal equilibrium. Since manufacturers do not benefit directly from the health-plans’ rebate to the government, increasing “α” is a better vehicle for reaching the desired equilibrium rather than increasing “γ”, as both players are substantially influenced by the manufacturer’s rebate “α”.

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RECENT GLOBAL INSIGHTS INTO RISK SHARING AGREEMENTS: A COMPARATIVE ANALYSIS
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OBJECTIVES: To evaluate whether risk sharing agreements (RSA) are utilised by health technology assessment (HTA) agencies over the world. Similarities and differences between appraisals where an RSA is applied will be assessed across the different agencies. METHODS: Nine select HTA agencies across the globe (MOHTLC, NICE, FRAC, SMTC, TML, INNESS, CADTH, NCPE, and AVMSG) were scanned to determine what type of RSAs were adopted for drug appraisals. Only single technology appraisals published between 2010 and April 2012 were included in the search. Comparisons were made between the agencies to determine whether any common trends were present, particularly for appraisals on the same drug.
RESULTS: In total 100 HTAs (74 treatments) were identified that included an RSA across the 9 agencies. The number of RSAs identified per agency was as follows: MOHTLC (24 HTAs), NICE (23), FRAC (15), SMTC (14), TML (10), INNESS, CADTH (6), NCPE (6), and AVMSG (2). Overall there was very little consistency between agencies as to which treatments included an RSA. For the very few treat- ments with an RSA with more than one agency, the type of agreement applied between these agencies varied. RSAs identified in NICE submissions were often elaborated whilst the remaining agencies usually applied simple price reductions or cost agreements. Interestingly, all recently submitted oncology therapies to INESSS were required to have a shared financial risk agreement for recommendation. CONCLUSIONS: RSAs are applied by several HTA agencies from around the world. There does not seem to be consistency in RSAs amongst the different agencies. If an RSA is made for a particular treatment for one agency, this does not mean an RSA will be applied by another agency for the same treatment.