per minute for basic surgical procedure, excluding physician costs) were used to estimate potential cost. A systematic review was undertaken to identify any studies reporting adverse event risk due to mOCS treatment. Seventy-two (72) studies were identified. The review focused on eight disease outcomes representing the bulk of the mOCS cost and QALY burden: type II diabetes, myocardial infarction, stroke, cancer, severe gum disease, arthritis, infection, and stroke. A risk estimate for each adverse event was calculated, based on the daily dose and mOCS exposure that best represented asthma-related mOCS use in Australian clinical practice. The excess risk for each comparator was estimated as the excess risk of complications in patients receiving mOCS, relative to those patients not receiving mOCS, was applied to the annual cost and QALY burden of each event in the Australian population. The cost and QALY burden attributable to mOCS was estimated on a per patient per year basis.

**RESULTS:** The expected annual cost of aseptic and related disease outcomes was estimated to be $9582 per patient per year. Each patient treated with mOCS also suffers a QALY loss of 0.0367 per year of treatment. These effects are considered reversible once patients stop taking mOCS. Cost and QALYs are associated with a disease-free survival benefit for patients with severe asthma which is likely underestimated by the approach adopted in this study. These results are likely to be useful for economic evaluations of new asthma interventions which replace or delay mOCS.

**PM32**

**CONSCIENTIOUS SEARCH IN SYSTEMATIC REVIEW LITERATURE REVIEWS IN NICE SUBMISSIONS**

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**OBJECTIVES:** The aim of this study was to establish the excess risk of complications associated with long-term mOCS use, and to quantify the cost and QALY burden. A systematic review was undertaken to identify any studies reporting adverse event risk due to mOCS treatment. Seventy-two (72) studies were identified. The review focused on eight disease outcomes representing the bulk of the mOCS cost and QALY burden: type II diabetes, myocardial infarction, stroke, cancer, severe gum disease, arthritis, infection, and stroke. A risk estimate for each adverse event was calculated, based on the daily dose and mOCS exposure that best represented asthma-related mOCS use in Australian clinical practice. The excess risk for each comparator was estimated as the excess risk of complications in patients receiving mOCS, relative to those patients not receiving mOCS, was applied to the annual cost and QALY burden of each event in the Australian population. The cost and QALY burden attributable to mOCS was estimated on a per patient per year basis.

**RESULTS:** The expected annual cost of aseptic and related disease outcomes was estimated to be $9582 per patient per year. Each patient treated with mOCS also suffers a QALY loss of 0.0367 per year of treatment. These effects are considered reversible once patients stop taking mOCS. Cost and QALYs are associated with a disease-free survival benefit for patients with severe asthma which is likely underestimated by the approach adopted in this study. These results are likely to be useful for economic evaluations of new asthma interventions which replace or delay mOCS.
The cost of the therapy ranges between 8.4 million HUF and 31 million HUF, if we primarily focus on the applied therapy. This endpoint is the SVR rate in the treatment of HCV infection. An inability to tolerate IFN to receive treatment. Introduction of these new HCV regimens has arrived. The availability of IFN-free regimens allows many patients who could not previously be treated due to lack of medical or psychological contraindications or an inability to tolerate IFN to receive treatment. Introduction of these new HCV drugs may potentially have a financial strain on the payer. The use of performance-based financing is a way to maintain the balance of the budget.

**PRM38**

**THE COST OF TREATMENT OF THE NEW ANTIVIRAL THERAPIES AGAINST THE HEPATITIS C VIRUS**

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OBJECTIVES: To analyze the costs of treatment of the new antiviral therapies against the Hepatitis C virus (HCV) submitted to the Department of Health Technology Assessment of the National Institute of Pharmacy and Nutrition.

METHODS: In our analysis, we examined the cost of treatment with the available interferon (IFN)-based and IFN-free therapies based on the current PUPHA database from the official website of National Health Insurance Fund of Hungary. The cost estimates have been made in two different ways both from the payer's view.

Results: The first calculation does not take into account the success of therapy as it’s based on the SPC with the assumption of a complete possible length of the treatment. The second calculation method is based on the reimbursement per responder (SVR) and includes the best indication of therapeutic success.

RESULTS: Performance-based risk-sharing arrangements should be focused on an endpoint which is meaningful both from the payer’s and provider’s perspective. The first calculation does not take into account the success of therapy as it’s based on the SPC with the assumption of a complete possible length of the treatment. The second calculation method is based on the reimbursement per responder (SVR) and includes the best indication of therapeutic success.

CONCLUSIONS: Performance-based risk-sharing arrangements should be focused on an endpoint which is meaningful both from the payer’s and provider’s perspective. The first calculation does not take into account the success of therapy as it’s based on the SPC with the assumption of a complete possible length of the treatment. The second calculation method is based on the reimbursement per responder (SVR) and includes the best indication of therapeutic success.

**PRM41**

**BUDGET IMPACT ANALYSIS IN THE UK SETTING – KNOW YOUR AUDIENCE**

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OBJECTIVES: When developing a budget impact model (BIM) the design stage is key. A particular element which should be carefully considered during the design phase is the perspective and in particular who the audience will be. The objective of this study was to identify who the potential users and healthcare decision-makers may be and what elements should be captured within the BIM to meet their requirements so that a BIM can be integrated into service planning. This study was conducted in a staged approach. The first stage involved identifying the different types of potential users of a BIM. After identifying these different users, the next stage of research sought to understand what cost criteria each user is expected to assess a BIM against, thus informing what should be captured in an analysis. The final stage then identified what cost categories are required in a BIM to satisfy these criteria.

RESULTS: Two main user groups were identified: (1) primary care and commissioners. The criteria that a provider is expected to consider is: what is the incremental cost and resource use implications of providing the intervention in question? What is the incremental income that will be received for providing this intervention? Whereas, the criteria that a commissioner is expected to consider is: what is the incremental cost and resource use implications of commissioning the provision of the intervention? Is there any added value in terms of quality, capacity or outcomes? An example of appropriate costs which are aligned with the perspectives of a provider and commissioner would be NHS reference costs and national tariffs, respectively.

CONCLUSIONS: Determining the audience of a BIM is crucial in designing a model fit for purpose. Key requirements of a BIM will be dependent on the audience, in particular capturing costs appropriately. Research should be conducted for other countries.

**PRM42**

**STRUCTURE OF HEALTH-RELATED DIRECT COSTS IN UKRAINE - THE FIRST STEP OF ANALYSIS**

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OBJECTIVES: Research was conducted in a staged methods approach. The first stage involved identifying the different types of potential users of a BIM. After identifying these different users, the next stage of research sought to understand what cost criteria each user is expected to assess a BIM against, thus informing what should be captured in an analysis. The final stage then identified what cost categories are required in a BIM to satisfy these criteria.

METHODS: The methods: were informed by a review of level-of-agreement studies concerned with resource use in older persons suffering from cancer, every day of hospital care, resource use data collected on care home residents were obtained as part of the CAREMED cluster randomised controlled trial. Descriptive statistics were explored before assessing level-of-agreement through the BIM. 95% limits of agreement, and Lin’s concordance correlation coefficient (CCC). Sensitivity analyses excluded non-users and tested timeframe. Factors affecting the magnitude of difference were explored using multiple-level modelling. Results: Several resource items (number of GP, out of hours GP and podiatrist contacts) were found to have substantial agreement (0.61 to 0.80) between the GP records and care home records according to the CCC. The number of total visits, dietician, paramedic and SLT contacts showed moderate agreement (0.41 to 0.65). Most resources showed a poor (less than 0.00) or slight (0.00 to 0.22) level of agreement either due to care home records (for chiroprist, music therapy, and social worker contacts) or GP records (for phlebotomist and practice nurse) recording a greater number of visits.

CONCLUSIONS: This research suggests that both sources of data are reliable for some resources but not others, indicating dial sources may be necessary where a wider perspective is important and feasible in terms of costs of data collection.

**PRM40**

**ARE QALYS AN APPROPRIATE MEASURE TO USE WHEN EVALUATING PUBLIC HEALTH INTERVENTIONS IN THE UK?**

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OBJECTIVES: Quality-adjusted life years (QALY's) are commonly used in health technology appraisals, including those by NICE in the UK. However, QALY's only include 'health-related' aspects of life (QOL) which may not apply to interventions that have benefits and costs that fall outside of the NHS. NICE recommends that public health economic evaluations take a cost consequence or cost benefit approach and present a public sector or societal perspective. However, it is not clear how or if the costs and benefits that fall outside the NHS should be incorporated into this threshold for cost-effectiveness. The objective of this research was to investigate the measurement and modelling, presenting how this has on predicted cost-effectiveness and to make recommendations about the most appropriate methods to use.

METHODS: We reviewed past NICE public health guidance and the associated economic evaluations to assess if methods tended to be used consistently. We also identified examples of the cost-effectiveness acceptability curve (CEAC) to determine those instances where non-health benefits are included, we evaluated how this was done and if it was done consistently.

RESULTS: Results showed that a range of methodology was used to evaluate public health interventions in the UK and that the methods used were inconsistent. ICERs were often calculated despite not always being the most appropriate measure. There tended to be considerable uncertainty around data inputs in the majority of economic evaluations.

CONCLUSIONS: The methodologies to be used for public health interventions in the UK vary, mostly by the type of economic evaluation and the perspective taken. ICERs were not always the most appropriate outcome. Variations in the methods could result in inconsistent recommendations across Public Health Guidance.

**PRM43**

**CONSTRUCTION OF SIMULATION TECHNIQUES FOR DEVELOPMENT OF OPTIMAL CERVICAL CANCER SCREENING STRATEGIES: EXPERIENCE OF UKRAINE**

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OBJECTIVES: Modern economic tools used in health technology assessment (HTA) are quality adjustment life years (QALYs). These tools are increasingly used in public health interventions. However, if some benefits fall outside of the National Health Service (NHS), one can face the same disadvantage as in the health sector. These benefits may be related to changes in the social and economic characteristics of the population.

**METHODS:** We present the results of the construction of simulation techniques for the development of optimal cervical cancer screening strategies. The methods used in the construction of the simulation techniques were the following: simulation, Markov modeling, demographic cohort modeling, multi-criteria decision analysis, cost-effectiveness analysis, cost-utility analysis, and societal perspective. The methods used in the construction of the simulation techniques were the following: simulation, Markov modeling, demographic cohort modeling, multi-criteria decision analysis, cost-effectiveness analysis, cost-utility analysis, and societal perspective.