patients. A typical PCU admits patients in the final phase of life. A high quality of care by a multi disciplinary team (including nurses, physicians, psychologists, music therapy, physiotherapists and others) results in substantial costs (recent survey in German PCUs: on average €400/day). The average length of stay is in the range of 11–15 days, the proportion of discharged patients varies between 40–70%, for the remaining patients the admission ends not unexpectedly with the death of the patients. The gain in utility close to death is difficult to estimate, but even high assumptions (e.g. 0.5) result in costs for QALYs, which are unexpectedly high. Scenario 1: 14, 0.5, 30, 0.5, 400, 192455; scenario 2: 14, 0.7, 30, 0.5, 400, 172455; scenario 3: 14, 0.5, 30, 0.3, 400, 320758; scenario 4: 10, 0.5, 30, 0.5, 400, 182000 for length of stay (d), proportion surviving, survival after discharge (d), gain in utility, cost/day, resulting cost / QALY. People experiencing the shear necessity of palliative care for a dear one might use these data as an argument against the QALY concept. Only by including longterm changes e.g. in the utility gained by relatives (small gains over a long period in several persons, e.g. by avoiding pathological grief) the model results in costs/QALY which seem acceptable.

CN4 METHODOLOGICAL ISSUES OF CONTROL ARM ADJUSTMENTS FOR COMPARATIVE EFFECTIVENESS ASSESSMENTS: AN EXAMPLE BASED ON THE COMPARISON OF FIRST-LINE BEVACIZUMAB + INTERFERON ALPHA-2A VS SUNITINIB IN RENAL CELL CARCINOMA

OBJECTIVES: To get insight in what criteria as presented in HTA studies are important for decision makers in health care priority setting.

METHODS: We performed a budget impact analysis reporting annual incremental costs. RESULTS: The ICERs of PegIFN + RBV compared to other established treatments in EUR 15,000 EUR/SVR avoided, EUR 42,000/decompensated cirrhosis avoided, and EUR 4,000/QALY. The ICERs are substantially lower than those of the last segments of the respective EFs i.e., ICER of IFN + RBV vs. IFN monotherapy indicating cost-effectiveness of PegIFN + RBV. The expected incremental annual budget range between 15 and 134 million EUR. The introduction of new genotype-specific treatment guidelines led to cost-savings when compared to IFN + RBV. CONCLUSIONS: PegIFN + RBV should be cost-effective compared to other established treatments in CHC. The EF approach should be feasible for HTAs in the CHC area. However, several issues remain to be solved and the conclusions derived from HTAs based on IQWIG’s framework may substantially differ from HTAs assuming uniform willingness-to-pay thresholds across the entire health care system.

PODIUM SESSION II: ECONOMIC EVALUATION AND REIMBURSEMENT DECISIONS I

EE1 USING IQWIG’S EFFICIENCY FRONTIER APPROACH FOR THE ECONOMIC EVALUATION OF HEAPTITIS C TREATMENT—A PILOT AND FEASIBILITY STUDY COMMISSIONED BY IQWIG

OBJECTIVES: The German HTA agency IQWIG published new guidelines on health-economic evaluations for the statutory health care system. The goals of this pilot study commissioned by IQWIG were: 1) to apply the efficiency frontier (EF) approach to evaluate the cost-effectiveness of combination therapy with peginterferon plus ribavirin (PegIFN + RBV) in patients with chronic hepatitis C (CHC); and 2) to assess the feasibility of the EF approach in this case example. METHODS: IQWIG’s EF approach assesses the cost-effectiveness of the new treatment compared to the best available therapies within the specific disease area (i.e., CHC) by comparing the new treatment’s incremental cost-effectiveness ratio (ICER) to ICERS of established treatments. We used a lifetime Markov model to determine health outcomes and costs of all treatment options. Health outcomes included sustained virological response (SVR), lifetime risk of decompensated cirrhosis and quality-adjusted life years (QALY). Model parameters were derived from the published literature and German databases. We adopted the perspective of citizens insured through the statutory health insurance. We performed a budget impact analysis reporting annual incremental costs. RESULTS: The ICERs of PegIFN + RBV compared to interferon plus ribavirin (IFN + RBV) were EUR 15,000 EUR/SVR avoided, EUR 42,000/decompensated cirrhosis avoided, and EUR 4,000/QALY. The ICERs are substantially lower than those of the last segments of the respective EFs (i.e., ICER of IFN + RBV vs. IFN monotherapy) indicating cost-effectiveness of PegIFN + RBV. The expected incremental annual budget range between 15 and 134 million EUR. The introduction of new genotype-specific treatment guidelines led to cost-savings when compared to IFN + RBV. CONCLUSIONS: PegIFN + RBV should be cost-effective compared to other established treatments in CHC. The EF approach should be feasible for HTAs in the CHC area. However, several issues remain to be solved and the conclusions derived from HTAs based on IQWIG’s framework may substantially differ from HTAs assuming uniform willingness-to-pay thresholds across the entire health care system.

DEAR POLICYMAKER: HAVE YOU MADE UP YOUR MIND?

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OBJECTIVES: To get insight in what criteria as presented in HTA studies are important for decision makers in health care priority setting.

METHODS: We performed a