ING THE FIRST RECOMMENDATION IN FAVOUR OF THE INNOVATION, AND THEN SUBSEQUENT ENTRIES IN-PRICE REDUCTIONS THROUGH PROFESSIONAL COMPETITIVENESS AS WELL AS A LOWER LIKELY REQUIRED R&D INVESTMENT.

CONCLUSIONS: The study finds that HTA decisions on medical devices can have a material impact on the market dynamics (and so prices) following a recommendation, because of the manner in which medical devices are procured. The findings of HTA will therefore vary depending on the point in time that they are undertaken, as relative prices change substantially over time. Re-reviewing cost-effectiveness, without any new clinical evidence, relative to a technology that has had a ‘disinvestment recommendation’ would therefore appear perverse, as it sets up a feedback loop that causes a perpetual downward spiral in prices. The study raises a number of policy issues for consideration. These include the interplay between different drivers of value in HTA and procurement, and the implicit ‘generalisation’ of evidence through the procurement process.

PMD50

SHOULD PATIENTS BE ALLOWED TO CO-PAY FOR DEVICES AND TECHNOLOGIES IN THE FUTURE?

OBJECTIVES: The objective of this research was to examine how regulatory re-authorization of use of MRI or CT tests at emergency rooms, office-based medical providers, and outpatient departments. The imaging utilization rate was defined as the number of visits involving advanced diagnostic imaging were identified based on self-reported use of MRI/CT tests at emergency rooms, office-based medical providers, and outpatient departments. Additional stakeholder research is anticipated to answer the implications surrounding equity and coverage and provide insights into novel funding mechanisms for new technologies.

PMD51

NATIONAL TRENDS IN ADVANCED DIAGNOSTIC IMAGING USE IN OUTPATIENT Settings: an analysis of the Medical Expenditure Panel Survey, 2000-2009

OBJECTIVES: The current global economic climate is putting increasing pressure on governments and payers to cut health care cost but continue to fund and grant reimbursement to innovative medicines, Devices & biotechnologies that demonstrate benefit to patient’s quality of life. One funding model that is attracting interest is patient cost co-payment (co-pay). Patient co-pay models are being used globally to allow patient access to medicines and medical technologies. However in United Kingdom and Europe these types of funding models are still being evaluated and assessed. A survey was designed to uncover the attitudes of physicians and patients towards co-pay models as potential funding mechanism for gaining access to new and innovative technologies.

METHODS: The United Kingdom was selected to carry out research to gauge the opinions of physicians and patients towards co-pay. A total of 150 specialist physicians involved in making budget decisions were surveyed via an internet based questionnaire and in a second survey 558 patients were interviewed face to face to evaluate their attitudes towards co-pay for new and novel technologies. The results from these two surveys were statistically analysed to reveal the attitudes of these two key groups toward patient co-pay and draw some initial conclusions.

RESULTS: The analysis and results from the patient survey showed that 83% of patients would consider co-pay as way of gaining access to new technologies that were not fully reimbursed by the UK public healthcare system. The physician’s survey showed that 72% of the 150 of specialist supported the co-pay concept in principle.

CONCLUSIONS: This UK research concluded that both physicians and patients would consider co-pay as a funding option to access new technologies. Additional stakeholder research is anticipated to answer the implications surrounding equity and coverage and provide insights into novel funding mechanisms for new technologies.

PMD52

INPATIENT REIMBURSEMENT LANDSCAPE FOR MEDICAL DEVICE AND DIAGNOSTICS IN DEVELOPED MARKETS

OBJECTIVES: The objective of this research was to examine how regulatory requirements in the inpatient setting impact the uptake and subsequent market presence of MDDs (medical devices and diagnostics). The study was conducted through 48 in-depth interviews spanning from 30 to 60 minutes in length. Subjects selected represent key stakeholders from industry, impatience, government, and health services across 9 major markets (EU 5, United States, Japan, Canada, and Australia). Interview questionnaires were designed to understand the national opportunities, market access barriers, and cross-country market similarities driven by secondary data included literature reviews, government and other relevant agency websites, and IHS proprietary Healthcare and Pharmaceutical services.

RESULTS: The study found that the uptake of innovative devices is affected by the reimbursement environment in hospital. In-hospital use as a primary screening test was an increasingly common topic; comparing 2000-2006 to 2006-2011, this topic’s inclusion increased 6.4% (from 43% (B77) - 70% (D10)).

CONCLUSIONS: The current global economic climate is putting increasing pressure on governments and payers to cut health care cost but continue to fund and grant reimbursement to innovative medicines, Devices & biotechnologies that demonstrate benefit to patient’s quality of life. One funding model that is attracting interest is patient cost co-payment (co-pay). Patient co-pay models are being used globally to allow patient access to medicines and medical technologies. However in United Kingdom and Europe these types of funding models are still being evaluated and assessed. A survey was designed to uncover the attitudes of physicians and patients towards co-pay models as potential funding mechanism for gaining access to new and innovative technologies.

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PMD53

A REVIEW OF HEALTH TECHNOLOGY ASSESSMENTS (HTAS) FOR CERVICAL CANCER SCREENING TECHNOLOGIES

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OBJECTIVES: To conduct a review of cervical cancer screening HTAs to understand how new technologies are evaluated. The INAHTA website, CRD (University of York) and Avalere CER Intelligence databases, Google, and country-specific websites were searched. All cervical cancer screening HTAs published 2000–2011 were included. Reports unrelated to a screening intervention or not fully available in English were excluded. Topics, technologies, clinical results, primary or literature-based economic analysis, and incremental cost-effectiveness ratios (ICERs) were abstracted and analyzed.

RESULTS: Twenty-five cervical cancer HTAs were identified and 17 HTAs from 9 countries met inclusion criteria. Five technology types were evaluated: 2 cytology tests (conventional cytology (CC), liquid-based cytology (LBC)), 2 Human papillomavirus (HPV) molecular tests, and 1 computer-guided screening system. All 17 HTAs evaluated test sensitivity and specificity, as the measures of clinical effectiveness. An ICER result was included in 11 HTAs with 73% (8/11) of recommendations derived from primary economic analysis. All eight HTAs reporting primary economic analysis incorporated sensitivity analyses to test various screening intervals. Six reports addressed cost-effective-ness of LBC compared to CC. Of these, 66% (4/6) concluded that LBC can be a cost-effective strategy compared to CC at specified intervals. HPV versus cytology as a primary screening test was an increasingly common topic; comparing 2000-2006 to 2006-2011, this topic’s inclusion increased 6.4% (from 43% (B77) - 70% (D10)).

CONCLUSIONS: Over the last 12 years, seventeen HTAs on cervical cancer screening evaluated the role of cytology and molecular testing as a primary screening intervention. Incremental cost-effectiveness (9/17), test sensitivity and specificity (17/17) and screening intervals (8/16) were the most common measures used in HTA to evaluate new screening technologies.

PMD54

URINE DRUG MONITORING IN THE CLINIC – WHO ARE WE TESTING, WHAT ARE WE TESTING FOR, AND HOW OFTEN ARE WE TESTING?

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OBJECTIVES: The purpose of this study is to better quantify how urine drug monitoring (UDM) is used in clinical practice. While several published studies have reported utilization of UDM in clinical practice, little is known about how often patients are monitored, which patients are monitored, which substances are important to detect, and under what circumstances clinicians modify the frequency of monitoring. METHODS: An online survey was developed based on qualitative phone interviews with eight clinicians who use UDM as a routine component of clinical practice. One thousand fourteen randomly selected clinicians known to order urine toxicity screenings were invited by mail to respond to the online survey assessing their clinical needs and preferences with regards to UDM. Ninety-three responses were received before the online survey was closed. RESULTS: Of the 93 respondents, 43% (n=40) identified as primary care practitioners and another 42% (n=39) as family/internal medicine practitioners. Seventy-six percent of respondents (n=72) require all new patients to have UDM performed when they enter their clinic. The majority administer UDM to chronic opioid therapy patients four times a year. Overall, the respondents show that UDM is commonly used for the most common illicit drugs, the majority of opioids, and a handful of prescription medications associated with abuse. Ninety-one percent of respondents stated that all of their patients are tested for the same substances, regardless of abuse history. The most common reasons cited by clinicians for a change in the frequency of monitoring are patient history of substance abuse and aberrant behaviors. CONCLUSIONS: Despite a lack of agreement between guide-