seems plausible that the observed differences reflect, at least in part, differences in underlying value judgments.

OP95 An Update On The Economic Value Of A Statistical Life Year In Europe

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INTRODUCTION:

Evaluation of "value for money" is an important component of Health Technology Assessments (HTAs). It is often conceptualized as "cost effectiveness" or cost per (quality-adjusted) life year gained. Whether used in isolation or alongside further drivers of social value (such as priority for younger or more severely impaired patient groups, or for access to effective treatment, even if costly), for example within a multi-criteria decision analysis framework, any reference "value of a statistical life year" (VSLY) should be supported by empirical data capturing the preferences of the population(s) in question. Here we report results based on a systematic review of relevant European economic studies, which were published during the last two decades, that is, from 1995 to 2015.

METHODS:

Our literature search (using the EconBiz and EconLit databases, supplemented by an analysis of relevant reviews) identified fourty-one European studies providing original data, yielding a total of fourty-eight average estimates for the value of a statistical life (VSL, or fatality prevented). We classified studies by methodology, for example, revealed preference (RP) or stated preference (contingent valuation, CV; discrete choice experiment, DCE) approach. We transformed VSL estimates into VSLY expressed in year 2014 Euros, using the life expectancy of the populations studied, a real discount rate of 3 percent, the national Consumer Price Index (CPI) for inflating, and purchasing power parities for currency conversion. We calculated confidence intervals by means of nonparametric bootstrapping.

RESULTS:

The median VSLY was EUR158,000 (for RP studies, EUR218,000; DCE, EUR188,000; CV,EUR143,000); we did not identify studies using the human capital approach. Our VSLY estimates showed large heterogeneity, both by methodology and regional origin; thus the differences that we observed did not reach statistical significance.

CONCLUSIONS:

Our results suggest that the empirical willingness-to-pay for a statistical life year might be substantially higher than benchmarks currently used by the international HTA community.

OP97 Program Budgeting Marginal Analysis For The Real World

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INTRODUCTION:

Program budgeting marginal analysis (PBMA) accommodates economic analysis, multi-stakeholder inputs, values, needs and perspectives within one framework in order to determine optimal use of available resources to deliver the highest 'health value'. Two pilot PBMA projects in two different services were conceived and completed in a Welsh Health Board (HB) as 'proof of concept' methodology for robust prioritization decisons and for improving quality of patient care, outcomes and experience. The pilots were essential to enable development of a 'bespoke' PBMA process for the HB to implement.

METHODS:

The PBMA methods were based on methods and criteria for successful PBMAs reported in the literature. Project

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teams and stakeholder communities supported the PBMAs which were executed over a 12 -18 month period between 2013–15. Group decision support methods were used to facilitate meetings and decision making. Formal interviews with project team members and informal feedback informed development of the final PBMA framework.

RESULTS:

Identifying the costs and resources attributable to services and those that could be moved around services was challenging. Evidence of outcomes and 'health value' was more easily available. One PBMA pilot recommended that some modest service reorganization and quality improvement could be made within budget but no substantial improvement/decommissioning could be undertaken. The other pilot agreed a disinvestment decision on the basis of evidence and reallocated the resources to a higher value service. The HB commissioning team found the information from the PBMA 'journey' as useful as the recommendations. A PBMA framework for the HB was devised.

CONCLUSIONS:

A 'Prudent PBMA' framework trimmed back to the critical essentials enables success criteria to be met. PBMA is to be adopted as a 'way of working' to operationalize resource reallocation and disinvestment in the 'real world' of Welsh healthcare commissioning.

OP100 How Health Technology Assessment Is Adapting To Orphan Drugs In Canada – Not!

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INTRODUCTION:

Some countries have distinct pathways for drugs for rare diseases (DRDs) (1). In May 2014, the Canadian Agency for Technologies in Health (CADTH) rejected the option of a separate review pathway for DRDs, reiterating that "pharmacoeconomic analyses are critical for all types of drugs". While the gap between positive recommendations for common and rare drugs may have narrowed, the rejection for DRDs is still proportionally much higher (2). The default has been to provincially negotiate drug access, for patient populations, subgroups or individuals. Still not wishing to create a separate pathway, in March 2016, CADTH produced a revised evaluation framework for "uncertain clinical and pharmacoeconomic evidence" and other considerations representing "significant unmet need" including rarity and difficulty to study because of small patient population"(3). This study analyzes recommendations for DRDs following the two CADTH revisions.

METHODS:

Methods used were: synthesis of previously conducted analyses of CADTH recommendations for rare and non-rare drugs, primary comparative analysis of CADTH recommendations for DRDs from 2004 to 2016, and qualitative analysis of two drugs submitted for both rare and non-rare conditions: everolimus (breast cancer, pancreatic neuroendocrine tumours, and tuberous sclerosis complex) and ibrutinib (chronic lymphocytic leukemia, small lymphocytic lymphoma, and Waldenström's Macroglobulinemia).

RESULTS:

Previous analyses found that DRDs received more negative recommendations than did non-rare drugs; both clinical and economic evidence were differentiating factors. The primary analysis provided an additional understanding of reasons for negative recommendations. There is low consistency across assessments and across the two CADTH review committees. The case studies illustrated the challenges for DRDs to overcome barriers of cost-effectiveness and certainty of clinical evidence, even with the revised framework.

CONCLUSIONS:

This research challenges the premise that Health Technology Assessment for all drugs can result in fair and equitable recommendations for DRDs. Moreover,

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