All of the recommendations consider the international classification of diseases (CID) as a common language that allows health professionals and managers to understand standardized information, to identify trends and benefits of recommendations in each therapeutic area.
Methods: This exploratory, descriptive and retrospective study aims to provide qualitative and quantitative data from the technologies evaluated by the Conitec in the period June 2012 to November 2022. Data were extracted in Conitec's website.
Results: The searches resulted in 763 recommendations in total. Among them, the most evaluated therapeutic area was Infectology with 126 technologies (16.5%). In this field the highlighted diseases and conditions were Hepatitis 42 (33.3%); HIV 23 (18.3%) and COVID-19 11 (8.7%). In Oncology, 113 recommended technologies (14.8%) were identified, in order of prominence for the diseases: Breast Cancer 21 (18.6%); Colorectal Cancer 11 (9.7%); Leukemias 17 (15.0%). In the Respiratory Diseases area, 89 technologies (11.7%) were recommended, among them: Chronic obstructive pulmonary disease (COPD) 17 (19.1%); Asthma 15 (16.9%) and COVID-19 11 (12.4%). These results clarify which diseases are most needing new technologies to be treated.
Conclusions: The results show what conditions and fields in health needs to be prioritized for public policies and prevention measures. This study demonstrates how important is to make accessible the public health information, improving public knowledge and social actions in SUS.

PP44 Time Is Now: Advancing Value Assessment Of Cancer Therapies To Help Eliminate Cancer As The Cause Of Death

James Ryan (james.ryan@astrazeneca.com)

Introduction: Earlier cancer diagnosis and advances in science are resulting in improved patient and societal outcomes. However, payer frameworks and methods can find it difficult to keep pace with scientific progress, evolution of endpoints, and assess the wider value of these advances.
Methods: A multidisciplinary, international group of experts working in the cancer field was brought together to reach consensus on key principles of defining and assessing of cancer treatment value. A Delphi-based approach including surveys, virtual panels, interviews and structured online discussions was used to reach consensus. This work was initiated and funded by AstraZeneca.
Results: Twenty-four experts from across the world (including patient advocates, oncologists, health economists, regulators, members of payer and health technology assessment (HTA) bodies) reached consensus on seven key principles across two themes, oncology relevant endpoints and dimensions of value. Three of the seven principles were found to be of particular relevance to HTA bodies and payers: assessing broad economic impact of new medicines (including socio-economic and caregiver impact), where early-stage cancer treatments can enhance patients' ability to lead productive lives and contribute to economic activity; consider other value aspects of relevance to patients and society; use of Managed Entry Agreements (MEAs) supported by ongoing evidence collection to help address decision-maker evidence needs and address clinical uncertainty.
Conclusions: Incentivizing access to early-stage treatments can promote cancer control, improved outcomes and generate long-term societal benefit. Furthermore, early diagnosis and treatment at earlier stages of cancer can be cost-effective, and sometimes cost-saving, as well as provide opportunities for cure. Expanding value components in therapy assessments to include, for example, insurance value, the value of choice, scientific spillovers, and wider societal perspectives, along with structured MEAs to manage clinical uncertainty and balance budgets will help realize the potential to eliminate cancer as the cause of death.

PP47 Experience And Its Implication For Reassessment Of The Transcatheter Aortic Valve Implantation Using Real World Data

Jung Mi Park (jamiepark@hira.or.kr), Seung Jin Han and Kyoung Hoon Kim

Introduction: South Korea has introduced conditionality to coverage decisions for certain difficult or high-risk procedures. The transcatheter aortic valve implantation (TAVI) was included in the coverage with evidence development (CED) in 2014. This study reviewed the results of reassessment for the TAVI using real world data (RWD) and suggested its implications.
Methods: Healthcare providers authorized to use the promising technologies are required to collect the RWD for suitability evaluation, safety monitoring, and cost-effectiveness, differing from the general reassessment process. In 2021, 45 healthcare providers collected clinical information for TAVI patients. Their registries were linked with the national health insurance claims, which provided data on 19 items to assess safety and effectiveness such as overall mortality, reoperation rates, hospital readmission rates, and degree of functional improvement.
Results: According to the Society of Thoracic Surgeons' predicted risk of mortality (STS), 988 TAVI patients were classified into three groups; high (STS >8 percent, n=347), intermediate (STS 4-8 percent, n=272), and low (STS <4 percent, n=369); We compared main outcomes and estimated survival probabilities between subgroups. Within 30 days, the overall mortality rates were 4.9 percent (high), 2.6 percent (intermediate), and 1.4 percent (low); major bleeding rates were 7.6 percent (high), 6.2 percent (intermediate),and 1.4 percent (low); incidence of new atrial fibrillation were 6.8 percent (high), 4.2 percent (intermediate), and 3.2 percent (low). Based on the quantitative results using RWD and systematic review for the safety and effectiveness, TAVI is reported to have essential benefits for high-risk group and elderly patients (>80 years). Whereas, intermediate and low-risk groups

https://doi.org/10.1017/S0266462323001927 Published online by Cambridge University Press

have out-of-pocket payment rates of 50 percent and 80 percent, respectively.
Conclusions: The reassessment system through RWD accumulation enabled the evidence-based evaluation for the TAVI. Based on the transition to CED for essential benefits, a systematic framework such as RWD collection from treatment commencement should be introduced to broaden RWD use for benefit management of medical technologies with uncertain levels of evidence. Therefore, this ensures overall quality of care and effective coverage in health.

PP48 Cardiac Implantable Electronic Device (CIED) Infections In New South Wales, Australia: A Non-Interventional Study Utilizing Linked Secondary data

Shajedur Rahman Shawon, Oluwadamisola Sotade, Michelle Hill (michelle.d.hill@medtronic.com), Liesl Strachan, Gabrielle Challis, Kate King and Louisa Jorm

Introduction: Cardiac Implantable Electronic Device (CIED) infection is a serious complication associated with morbidity, mortality and high healthcare costs. Internationally, the published rate of CIED infection ranges from 1.0 percent to 1.6 percent. There is a lack of data on CIED infection rates in Australia; the reported range is from less than 1 percent at 30 days to 7 percent over 5 years. Due to the variability within the limited number of studies there is a need for further analyses of CIED infection rates in Australia.
Methods: This was a retrospective cohort study using secondary linked hospital (the NSW Admitted Patient Data Collection) and mortality data for patients who underwent CIED procedures between July 2017 and June 2020 in NSW. Overall and procedure-and patient-specific incidence of infection was calculated.
Results: A total of 23,786 CIED procedures were performed among 22,404 patients and 422 CIED infections were identified, giving an overall infection rate of 1.77 percent. When infections were limited to those following a CIED procedure in the period July 2017-June 2020 (n=309), the procedure-specific CIED infection rate was 1.30 percent, ranging from 1.01 percent for permanent pacemaker (PPM) to 2.71 percent for cardiac resynchronization therapy-defibrillator (CRT-D). The proportion of patients undergoing CIED procedures in this period who had a subsequent CIED infection was 1.29 percent, ranging from 0.97 percent for permanent pacemaker (PPM) to 3.05 percent for cardiac resynchronization therapy defibrillator (CRT-D). Procedure-based infection rate in high-risk patients (generator replacement; system upgrade; revision; or CRT-D procedure) was 1.47 percent and patient-based infection rate was 1.68 percent. Infection rate was highest within the first month following the CIED procedure that dropped significantly over time.
Conclusions: Rates of infection were highest among patients with cardiac resynchronization therapy (CRT) devices, and those who underwent revision or upgrade procedures. Ongoing monitoring of CIED infection rates and preventative measures are necessary, especially for high-risk patients. This study highlights the important role linked secondary data has in reducing uncertainty and removing the reliance on international estimates by providing targeted, local data for health technology assessment.

PP49 Cost Of Cardiac Implantable Electronic Device (CIED) Infections In Australia: A Private And Public Sector Payer Perspective

Michelle Hill (michelle.d.hill@medtronic.com) and Adam Gordois

Introduction: In Australia, approximately 200,000 patients have a cardiac implantable electronic device (CIED), and in an aging population that number is rising. CIED-related infections are also increasing, causing considerable morbidity and mortality, and substantial healthcare costs. Internationally, the rate of CIED infection ranges from 1.0 percent to 1.6 percent, while in Australia, the reported range is from less than 1 percent to 7.0 percent. The average hospital cost to treat an infection in the US ranges between USD48,000–USD83,000. To date, few publications have estimated the cost of CIED infections in Australia. Critical appraisal of these studies has highlighted issues in their methodology, making them unreliable sources for use in economic evaluations. The purpose of this study was to utilize Australian routinely collected health data to robustly model costs of CIED infections to reduce uncertainty for future health technology assessment (HTA).
Methods: The cost of treating a CIED infection was modeled for the public and private sector including cost of system removal and re-implantation procedures, hospital and intensive care unit (ICU) stay, and outpatient follow-up. Cost inputs were obtained from the Australian Prostheses List, Medicare Benefits Schedule, Australian Institute of Health and Welfare, and Private Hospital Data Bureau. Other inputs were obtained by surveying Australian clinicians, which were validated with published data. Phone interviews and online surveys were conducted with clinicians to elicit specific Australian practice pathways for patients with a CIED infection.
Results: The majority of patients with a CIED have their device system removed (95-100%) and re-implanted (83%) once the infection has cleared. In the private sector, cost of infection ranged from AUD80,869 (USD54,384) for a single chamber pacemaker (PM), to AUD140,103 (USD94,248) for a dual chamber Implantable Cardioverter-defibrillator (ICD). Modeled costs of CIED infection were slightly lower in the public sector (AUD73,643-AUD88,446 (USD49,555 – USD59,516) for the same devices).
Conclusions: The cost of a CIED infections to the healthcare system is high and differs by device type. Utilizing local real-world data to

https://doi.org/10.1017/S0266462323001927 Published online by Cambridge University Press