decided to apply a time limit. Products with a G-BA conditional approval achieved additional benefit in 78% of cases. As of June 2018, 20 assessments with G-BA conditional approval had expired and already been converted into regular assessments, whereas in 11 cases the additional benefit improved. The impact on price still needs to be analysed by comparing negotiated rebates (using LauerTaxe PpU data) after the initial, conditional assessment versus the negotiated rebates after the final assessment with the full dataset available **CONCLUSIONS:** More often than not, the G-BA defines conditional approval by itself and does not follow conditional EMA approval. This implies that manufacturers, specifically of orphan drugs, need to be prepared to deliver subsequent analysis and data to the G-BA, even without conditional EMA approval. It seems only in some cases helped additional data (e.g. RWE Data) after expiry of the time limit to improve HTA outcomes and reimbursement price.

PHP140

CURRENT CHALLENGES AND POTENTIAL SOLUTION FOR PRICING REGULATORY AND REIMBURSEMENT FRAMEWORK OF INNOVATIVE DRUGS IN EGYPT

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OBJECTIVES: Achieving fair pricing and ensuring long-term sustainability of health care systems and access for patients is one of the biggest challenges for health &pharmaceutical systems in Egypt. To describe the current pricing regulatory and reimbursement framework and position of innovative drugs in main disease areas. **METHODS:** A variety of sources informed the evidence, including a broad-ranging literature review of local data of Pricing department &PE unit in Ministry of Health. The primary research and data component is based on direct input from decision makers (governmental, Private sectors, and pharma). A detailed questionnaire was developed and issued to all participants. which addressed a number of key questions, including:Does a country-specific definition of high-cost or innovative medicines exist? What are the key challenges to the funding these medicines? What the need actions to improve the pricing and reimbursement process? Are there specific pricing policies for innovative medicines compared to ordinary medicines? and Which requirements needed for the assessment? **RESULTS:** The key disease areas are:1-diabetes, 2-cancer, 3- rheumatoid arthritis, 4- hepatitis C, 5-orphan conditions respectively. These treatments represent examples of innovative medicines which carry considerable implications for the country' health budgets because they can be considered either "high volume" for treating many patients or "high cost" because of the price of a single course of treatment. The Current regulations require comparability for quality, efficacy, and safety assessments. No specific innovation regulations are adopted for pricing. There is a gap in introduction and/or management of these medicines by careful handling to ensure that access and equity are maintained, along with sustainable financing. till now, the main instrument influencing the market entry prices in Egypt is ERP. **CONCLUSIONS:** The conceded recommendations were: adoption a further initiatives/policies to better manage the entry of new medicines. MCDA should be designed to study the criteria critical to uptake of innovative drugs.

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THE PRIVATE HEALTHCARE MARKET IN BRAZIL: A REVIEW OF 18 YEARS OF PROGRESS

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OBJECTIVES: The aim of this study is to review official data on the number of people covered by healthcare insurance plans in Brazil. **METHODS:** We conducted a search in the public electronic database available Agencia Nacional de Saude Suplementar (ANS) website. ANS is the Federal Agency in charge of regulating the relation between HMOs and private healthcare consumers. The search took the longest data range available in ANS database, starting in 2000. In addition, we combined IBGE (National Brazilian Institute of Statistics) data on total population to further extract information for our analysis. Furthermore, to better understand the trends we included economic growth and employment data from the Brazilian Central Bank (BACEN). **RESULTS:** The Brazilian population grew 19% (+33 million people) in 18 years (2000: 175 million people; 2018: 208 million people). Meanwhile, the population covered by private healthcare plans grew 66% or +18.9 million people (2000: 28.6 million people; 2018: 47.4 million people). From 2004 to 2014 the number of people covered by a private insurance plans increased 4.7% yearly (CAGR 2004-2014). 2014 was the apex in the number of people in the private market: 50.3 million. From 2015 to 2017 a total of 3 million people left the market, a 6% reduction. The slowdown of the Brazilian economy during that period (2015-2017) impacted the jobs market which had an effect on the private healthcare market. Circa 80% of the people in this market have healthcare plans via their employers. Preliminary data for 2018 (January-March) show a slight increase in the number of people covered by private healthcare plans (+ 122 thousand people) vs. December/2017. **CONCLUSIONS:** Despite the contraction in previous years, the Brazilian private healthcare market still encompasses a significant portion of the population (22.7% as of March 2018). Recent data show the private market is recovering.

PHP142

SEVERITY ADJUSTED PROBABILITY OF BEING COST-EFFECTIVE: A NOVEL APPROACH TO INTEGRATE SEVERITY AND COST-EFFECTIVENESS WITH APPLICATIONS TO NORWAY AND THE NETHERLANDS

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OBJECTIVES: Several countries have a higher willingness to pay for severe health conditions. Severity is heterogeneous and uncertain in patient populations. This study standardizes the assessment of severity, integrates it with cost-effectiveness results and provides decision-makers with a new estimate: the severity adjusted probability of being cost-effective. **METHODS:** Severity is expressed in proportional and absolute shortfall and estimated using life tables and country specific EQ-5D based quality of life values. We use an economic evaluation of an oncological treatment that shows that the current approaches to measuring severity result in a very high chance that the technology is incorrectly rejected or accepted for reimbursement. We use the severity based cost-effectiveness thresholds of Norway and The Netherlands to exemplify the case for those countries in specific, since these countries have explicit severity weighted thresholds. **RESULTS:** For the oncological treatment, both the highest and the second highest willingness to pay category fall within the confidence interval of the severity class. In the highest willingness to pay category the cost-effectiveness acceptability curves indicate a 85% probability of adopting the technology, which is only 3% for the equally likely second highest category. Applying our new methods, taking into account the uncertainty in the cost-effectiveness results and in the estimation of severity, results in a severity adjusted probability of being cost-effective of 66% for The Netherlands and between 0 and 25% in Norway. **CONCLUSIONS:** Higher willingness to pay thresholds for severe diseases reflect societal concerns for an equitable distribution of resources. The estimates of severity are uncertain and patient populations are heterogeneous and this should be accounted for. Our new method, the severity adjusted probability of being cost-effective is able to do this. The applications to The Netherlands and Norway suggest that not adopting the new method could result in incorrect decisions in the reimbursement of new health technologies.

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ECONOMIC EVALUATIONS AND BUDGET IMPACT ANALYSES OF INNOVATIVE MEDICINES ACCORDING TO THE CATALAN HEALTH SERVICE STANDARDS: A QUALITATIVE ASSESSMENT

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OBJECTIVES: To assess the quality of economic evaluations (EE) and budget impact analyses (BIA) submitted by pharmaceutical companies to the Catalan Health Service (CatSalut) within the Medicines Harmonization framework. **METHODS:** A revision of the EE and BIA received between December 2017 and May 2018 was performed based on the methodology guideline for economic evaluations and analyses (GAEIP) previously developed by CatSalut. The analysis was done through an adaptation of the validated checklist published in the guideline, which measures the inclusion or exclusion of 42 items for EE and 32 items for BIA. All the responses were aggregated in an anonymized dataset in order to calculate the average inclusion rate in each evaluation and the mean of compliance of each criterion. **RESULTS:** CatSalut received 6 EE and 18 BIA during the studied period, mainly concerning oncology, rheumatology and respiratory medicines. EE included 70.6% of the checklist items on average albeit BIA had a 55.3% average inclusion rate. The use of a "crosswalk index value of EQ-5D adapted to Spain" was incorporated in 33.3% of the EE, whereas "health outcomes and cost data from relevant sources" was identified in 66.7% of them. Regarding BIA, the items "proper identification of the target population" and "choice of adequate comparators" were included in 66.7% and 44.4% of the reviewed submissions, respectively. **CONCLUSIONS:** Study results suggest that the methodological quality of BIA is not entirely consistent with the GAEIP standards, while EE usually show a higher item inclusion rate. The difference could be associated with the requirement to develop more complex methods from the latest, which might also explain the fewer amount of EE submitted. The rates of inclusion of certain items appear to indicate that the implementation of GAEIP is still in process and there is a need to improve the quality of economic evaluations.

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IMPACT OF A CREATIVE QUALITY IMPROVEMENT STRATEGY TO REDUCE PATIENT WAIT TIMES BETWEEN PRIMARY AND SPECIALITY CARE IN A TERTIARY, UNIVERSITY PUBLIC HOSPITAL IN PORTUGAL

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OBJECTIVES: Increasing demand as a result of a 'freedom of choice' policy poses additional challenges to Portuguese hospitals and may paradoxically limit access to speciality care. This study describes the results of a quality improvement project aiming to increase access to speciality care in a tertiary hospital in Portugal. **METHODS:** The intervention started in October 2017 at Centro Hospitalar Sao João. Based on clinical information provided on referral from primary care, senior orthopaedics and rheumatology specialists identify a subset of patients on the waiting list likely to need fewer, ideally one, hospital appointments until a treatment plan can be safely transferred back to the responsibility of primary care. These patients are scheduled for a fifteen-minute speciality first appointment (compared to the usual 30 minutes). Pre- (March to September 2017) and post-intervention (October 2017 to May 2018) median waiting times (MWT - from referral until the first appointment) were compared, taking into account the variation of