million square kilometers and 146.5 million people; therefore the organizing of a stable and effective system is a challenge for decision makers. In this paper we make an effort to clarify main principles and aspects.

METHODS:

To systemize all the information concerning Russian medicines provision system, we review legislation, literature and made interview of experts.

RESULTS:

By 2015 more than 3,230 International Non-proprietary Names and 26,239 Trade names were registered in the Russian Federation. The pharmaceutical market consists of the commercial drug sector, drug reimbursement and hospital sector: 8 percent, 22 percent and 70 percent in monetary values and 1 percent, 19 percent and 80 percent in volume terms, respectively. Medicines provision through compulsory health insurance is divided into in-patient health services (first health and sanitary treatment, special health treatment and palliative treatment) and emergency services. Three drug lists form the reimbursement system: "list of vital and essential medicines", "7 disease areas" and "Medicines provision population". The "List of vital and essential medicines" is a basis for all other drug lists and fixes the maximum sale price for drugs. The "7 disease areas" detach high-priced drugs that are used in treatment of particular diseases and optimize the financing of treatment of people with high-cost diseases. The "Medicines provision for population" states the list of drugs that are reimbursed by the federal budget. Federal and regional budgets divides medicines into fully and partly reimbursed medicines.

CONCLUSIONS:

At the present time, the Russian system of medicines provision is rather complicated. Nevertheless, the system still develops: in 2016 Russian Ministry of Health began the development of the concept of medicines insurance system.

VP76 European Collaboration In Health Technology Assessment – Experiences And Possible Benefits

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INTRODUCTION:

Consistently high-quality health care is expected throughout Europe while concurrently, financial resources of member states are decreasing. National Health Technology Assessment (HTA) institutes are informing evidence-based reimbursement decisions in the national context, leading to redundancies in HTA production and tying up limited resources. Since 2006, the European Union project, the European Network for HTA (EUnetHTA) is aiming at enhancing the efficient use of HTA resources and facilitating transnational collaboration. Our aim is to present previous experience in joint assessment of medical devices. Furthermore, possible benefits of European collaboration for stakeholders will be discussed.

METHODS:

Processes and challenges of the completed EUnetHTA Joint Action (JA) 2 are summarized and discussed. Benefits, aims and opportunities of the ongoing EUnetHTA JA 3 are described.

RESULTS:

Six rapid assessments of medical devices, focusing on the assessment of effectiveness and safety, were published during EUnetHTA JA 2. Challenges in European medical device assessment encompass the choice of topics, the time point of assessments and the lack of European standards for systematic patient involvement. Characteristics of medical devices, like learning curves, call for monitoring them throughout their lifecycle.

The benefit of European collaboration for stakeholders is manifold: uncertainty with regard to actual added

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value of a technology is minimized through Early Dialogues; harmonized and transparent assessment processes increase the quality of reports; work division among HTA organizations allows a resource-efficient assessment of a bigger amount of technologies; patient involvement ensures consideration of patient relevant endpoints.

The importance of cross-border collaboration in HTA is shown in the continuation of the EUnetHTA project, which aims to sustainably strengthen international collaboration even after expiration of EU-funding.

CONCLUSIONS:

European collaboration in medical device assessment can ensure cross-border health care and efficient cooperation of national health systems. The focus should be set on a wide implementation of jointly established methods and quality standards. The European collaboration can lead to a concrete benefit for various stakeholders.

VP78 Cross-Country Variation In Health Technology Assessment Preferences: An International Survey

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INTRODUCTION:

Several studies have explored how Health Technology Assessment (HTA) processes, HTA submission requirements, perception and handling of uncertainties vary across different jurisdictions (1-3). However, no study has elicited HTA stakeholders' preferences/priorities on criteria that shape coverage decisions across countries. We aimed to identify the extent to which preferences on criteria, uncertainties and other factors that shape HTA recommendations differ across countries.

METHODS:

HTA stakeholders in Brazil, England, France, Italy, Netherlands, Spain and Sweden were invited via email to complete a web-survey. A number of clinical, economic and other criteria (that is, rarity/orphan status and stakeholder input, among others) considered in HTAs, along with additional factors related to clinical evidence uncertainties, unmet need and innovative nature of treatment were ranked in terms of their importance on a 7-point Likert-scale. Responses were anonymised and analyzed using descriptive statistics.

RESULTS:

Responses were received from Brazil (n = 9), England (n = 7), France (n = 10), Italy (n = 6), Netherlands (n = 3), Spain (n = 3) and Sweden (n = 3). "Achievement of/Concerns around clinical benefit" was the only clinical criterion/uncertainty scoring equally important across countries (100 percent of respondents in each country). The requirement for/uncertainty around "Appropriate comparators" scored high in importance overall but was not consistent across countries, nor was the "Acceptability of surrogate rather than clinical endpoints". Variation was seen in all economic criteria, apart from "Budget impact analysis" (equally important for more than 80 percent of respondents in each country). Greater differences were observed in the level of priority that innovation, disease severity and stakeholder input have towards HTA coverage decisions across countries.

CONCLUSIONS:

Although agreement was seen in preferences mostly for some of the clinical criteria and/or evidentiary requirements ranked, there were notable differences on countries' priorities for economic evidence criteria/uncertainties and the extent to which unmet need, disease burden and innovation are considered important towards HTA decision-making, possibly explaining differences in HTA recommendations.

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