

there was a cost-saving of INR46,986 (574USD) per death averted and INR5,169 (63USD) per patient treated over a seven-year time horizon. The analysis demonstrated that FFR inclusion in the current clinical practice saves INR2,651 (32USD) per patient in overall upfront cost and INR2,518 (31USD) per patient in overall follow-up cost over a seven year follow-up period owing to improved diagnosis and prognosis.

Conclusions: In conclusion, FFR prevents unnecessary stenting, reduces overall mortality, and proves to be a cost-saving intervention in the long-term when used as a decision-making criterion in CAD patients in the Indian context.

PP65 An Economic Evaluation of Day Care Surgery For Non-Acute Hernia Repair In Government Hospitals Of Sri Lanka

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Introduction: Early discharge of publicly funded non-acute hernia repair patients may save healthcare costs by reducing inpatient stays. This study reports a cost analysis of establishing day-care surgeries for publicly funded patients undergoing non-acute hernia repair in Sri Lanka.

Methods: A decision tree model was developed to represent the pathway probabilities and costs. Cost data was taken from the Medical Supplies Division, relevant hospitals, and laboratories. Hospital costs per-day were calculated based on WHO-CHOICE model with inflation adjusted to 2022 value. The model assumed that 60 percent of the hernia patients presented to the outpatient department, 39 percent were referred from private clinics, and 1 percent of hernia repairs admitted as inward transfers or emergencies. Of the hernia repairs that were conducted, 95 percent were assumed to be uncomplicated hernias, and the most common post-operative complication encountered was urine retention accounting for 95 percent of the complicated cases.

Results: It was estimated that in the current situation for a cohort of 1,000 patients undergoing non-acute hernia repair, 2,055 overnight in-hospital days were utilized. If day surgery services can be performed with patients observed for less than 24 hours before being discharged the overnight stay can be reduced to 155 patients. In the current scenario the total cost for non-acute hernia repair at a state hospital was estimated LKR170.9M (≈USD529K) per 1000 patients while the same procedure done as a Day Care procedure cost estimate

was LKR155.7M (≈USD482K) per 1000 patients. The savings from implementing day-care surgeries for non-acute hernia repair will amount to approximately LKR15M (≈USD40K) when caring for 1,000 patients. The results were sensitive to length of stay and proportion of complicated cases.

Conclusions: Shifting uncomplicated non-acute hernia repair patients from an inward scenario to a day care scenario would lead to a considerable financial saving to the government. More evidence on the value of expanding day care services and observation services capacity should be explored as this would guide efficient and sustainable publicly funded healthcare system in Sri Lanka.

PP67 What Patients Want – Optimizing Oncology Value Assessment To The Goals Of Patients

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Introduction: Cancer is now diagnosed and treated earlier, resulting in improved patient benefit and outcomes. While overall survival (OS) is crucial to patients, there are other value dimensions, such as quality of life (QoL) and reduction in severe side effects, that change patient lives while on treatment. Considering patient reported outcomes (PROs) in value assessments for decision-making can improve individual, population and societal outcomes.

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 cancer treatment value. A Delphi-based approach including surveys, virtual panels, interviews and structured online discussions was used to reach consensus. This work was funded by AstraZeneca.

Results: Use of PROs in oncology value assessment is important because it can lead to: improvements in caregiver/patient/physician communication; unmet problem and needs detection; disease and treatment tracking; and better cost effectiveness. While some health technology assessment (HTA) bodies are already accepting QoL data, such as the Institute for Quality and Efficiency in Health Care (IQWiG) in Germany and US Centers for Medicare and Medicaid (CMS), many others do not. It is important that there is consistency in use of QoL data and other PROs, ensuring inclusion and a standardized and simple way of capture. In trials, tolerability data collected via PROs and QoL should be routinely and consistently incorporated and emphasized in HTA value assessments together with safety, efficacy and effectiveness. Data from PROs should be considered in decision-making to help build a better picture of health-related QoL, morbidity and adverse events from the patient perspective.

Conclusions: We are calling on the cancer community to: continue to encourage the use of a broad set of oncology-relevant endpoints