however, as the NICE and SMC examples show, although strong downward price pressure is exerted (high frequency of PASs), this may come at the cost of many therapies (~33 percent) being denied access. By contrast, the flexibility enabled by a distinct price negotiation phase may enable more therapies access, as shown by the G-BA/GKV example (<10% medicines withdrawn). Nevertheless, the relative effectiveness of the downward price pressures, a key determinant of HTA process effectiveness, cannot be compared due to the confidential nature of UK PAS discounts.

PP149 Features Of Accountable And Reasonable Processes For Coverage Decision-Making

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INTRODUCTION:

The Accountability for Reasonableness (A4R) framework addresses the legitimacy of coverage decision processes by defining four conditions for accountable and reasonable processes: Relevance, Publicity, Appeals, Implementation. Cost-per-quality-adjusted life year (QALY) and multicriteria-centered processes may have distinct implications for meeting A4R conditions. The aim of this study was to reflect on how the diverse features of decision-making processes can be aligned with A4R conditions to guide legitimized decision-making. Rare disease and regenerative therapies (RDRTs) pose special decision-making challenges and offer a useful case study.

METHODS:

To support reflection on how different approaches address the A4R conditions, thirty-four features operationalizing each condition were defined and organized into a matrix. Seven experts from six countries explored and discussed these features during a panel (Chatham House Rule) and provided general and RDRT-specific recommendations for each feature. Responses were analyzed to identify converging and diverging recommendations.

RESULTS:

Regarding Relevance, panelists highlighted the importance of supporting deliberation, stakeholder participation and grounding coverage decision criteria in the legal framework, goals of sustainable healthcare and population values. Among seventeen criteria, thirteen were recommended by more than half of panelists. Although the cost-effectiveness ratio was deemed sometimes useful, the validity of universal thresholds to inform allocative efficiency was challenged. Regarding Publicity, panelists recommended communicating the values underlying a decision in reference to broader societal objectives, and being transparent about value judgements in selecting evidence. For Appeals, recommendations included clear definition of new evidence and revision rules. For Implementation, one recommendation was to perform external quality reviews of decisions. While RDRTs raise issues that may warrant special consideration, rarity should be considered in interaction with other aspects (e.g. disease severity, age, budget impact).

CONCLUSIONS:

Improving coverage decision-making towards accountability and reasonableness involves supporting participation and deliberation, enhancing transparency, and more explicit consideration of multiple decision criteria that reflect normative and societal objectives.

PP151 Comparison Of Patients Undergoing New Technology For Prostate Cancer

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INTRODUCTION:

Prostate neoplasia affects more than one million people worldwide. Surgical treatments have evolved from open or video prostatectomy, up to the High Intensity Focused Ultrasound (HIFU) technique. HIFU studies cite less costs and better quality of life during the first year of follow-up. The objective of this study is to describe a consecutive series of eligible patients, with Gleason score 6 and 7, and compare resources used along those three treatment techniques.

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