

specialized health technology assessment (HTA) organizations aimed at better informing health care policies and clinical practice. Although the first technology assessment institution, although not exclusively health related, was the Office for Technology Assessment (OTA) in the U.S. in the 1970s, HTA is not yet current nationwide practice. Nevertheless, there are more than fifty agencies in operation in over thirty countries to assist systematic priority setting, especially in high income countries. The cases of Ukraine, Colombia and U.S. represent different features of the need for systematic priority setting. Ukraine is moving from National essential medicines lists (EML) to more dynamic HTA use to update its publicly funded benefits package; Colombia established a few years ago nationwide HTA, but is currently attempting to use HTA for Pricing and Reimbursement since healthcare coverage is so heavily contested by judicialization. Nevertheless, even in countries where formal HTA activities are ongoing, and in most low and middle income countries, rationing still occurs as an ad hoc, haphazard series of non-transparent choices that reflect the competing interests of governments, payers and other stakeholders. Henceforth, there is the opportunity to closely review why the state of development for HTA varies so much according to setting.

METHODS:

Retrospective policy analysis considering common motivators for the implementation of HTA; the agenda setting model of the three streams (problems, policy and politics) for policy action ; and qualitative approaches for the inception of HTA are being used in these three cases.

RESULTS:

Through a qualitative approach, ten “drivers” previously emerged with the ability to help or hinder HTA development in Colombia were used to assess the difference of HTA development in the USA and Ukraine (i.e. availability and quality of data, implementation strategy, cultural aspects, local capacity, financial support, policy/ political support, globalization, stakeholder pressure, health system context, and usefulness perception). Policy/ political and financial support, stakeholder pressure, cultural aspects and health system context were the most prominent drivers to induce or prevent institutional development of HTA in different countries.

CONCLUSIONS:

Common motivators, similar drivers and context specific characteristics are all influential for the implementation

of HTA at the national level. Policy/political and financial support, stakeholder pressure, cultural aspects and health system context preliminarily seemed the most prominent drivers to induce or prevent institutional development of HTA in different countries. Henceforth, methods and processes matter, as well as the political economy for HTA. Further research is needed to test these preliminary findings.

OP109 Comparison Of The Health System Establishment Periods In Eighty-Eight Countries

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INTRODUCTION:

Health system reform is considered a tough issue worldwide. Great efforts have been made toward health system building and strengthening. However, it is still unclear which health system is appropriate for different countries. This study aimed to systematically compare the characteristics of the establishment periods between eighty-eight counties of National Health Service (NHS) and Social Health Insurance (SHI).

METHODS:

Forty-eight NHS countries and forty SHI countries with data availability were selected. The establishment years of current health systems and other eighteen indicators in economics, society, population and health during establishment periods were collected. Comparison between NHS and SHI was conducted by descriptive analysis of every indicator.

RESULTS:

Most NHS countries were established during the cold war, while SHI had been set up since the cold war ended. The median of gross domestic product (GDP) per capita, urbanization rate and aging rate of SHI were USD 1535 in current dollars, 58.2 percent and 9.8 percent, respectively; compared with USD 1387, 41.2 percent and 4.7 percent, respectively of NHS. NHS countries had a smaller total population, lower mortality rate and

elderly dependency ratio, while the birth rate and children's dependency ratio were higher. SHI countries showed a higher life expectancy and lower mortality rate in infants and children. NHS countries spent less in total health expenditure and a lower proportion of GDP. The median health expenditure per capita of SHI and NHS were USD 188 and USD 131 in current dollars, respectively. There was little difference among maternal mortality rates, and public and private health expenditure proportions.

CONCLUSIONS:

NHS and SHI countries had different characteristics during the health system establishment periods. NHS was established earlier than SHI overall, so that SHI revealed higher levels in economic and social development. Health outcomes of NHS countries were slightly lower than SHI ones, while health expenditure was more in SHI countries. Specific social, economic, demographic and health conditions should be considered when countries are building their own health systems.

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OP112 Stakeholder Views As Evidence For NICE's Public Involvement Review

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INTRODUCTION:

The National Institute for Health and Care Excellence (NICE) strategic review of its public involvement offer included a survey with stakeholders to explore how NICE can continue to deliver high quality, meaningful public involvement in a rapidly-changing environment.

METHODS:

NICE staff, committee lay members, and an external academic ran the project and designed an online survey. The survey was open for two weeks. A purposive sample, recruited through various communication channels, was invited to participate. The sample comprised: (i) external individuals involved in NICE work, (ii) NICE committee and Board members, (iii) NICE staff. The survey included qualitative and quantitative

questions, covering the 'who', 'when', 'how' and 'what' of NICE's public involvement approaches.

RESULTS:

The survey yielded 684 responses, which were stratified by stakeholder type. Overall the responses indicated that: (i) the suggested stages for involvement are all important, but on a sliding scale: 'defining outcomes guidance should consider' is most important, and 'helping committee chair recruitment' is least important; (ii) different perspectives are needed such as individual treatment or care decisions should incorporate views of directly affected people, and population-based public health decisions need the views of citizens. Quality improvement suggestions included: (i) seeking feedback on people's experiences of care, using clear, structured approaches including focus groups, interviews, surveys, social media; (ii) increasing communications about NICE's work, specifically about involvement opportunities and use of patient evidence; (iii) using data on people's experiences equally with academic evidence; (iv) providing education and training on involvement to NICE staff and the general public; and, (v) partnership working with other organizations to enhance engagement. A focus group with key stakeholders used the survey findings to shape the subsequent public consultation document.

CONCLUSIONS:

There was consensus that public involvement is necessary throughout guidance development; however, the type of person involved and nature of participation should vary across the development stages. Project challenges included managing diametrically opposing views, and the associated implications for engagement.

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OP113 Iramuteq Analysis Of Trastuzumab's Public Consultation In Brazil

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INTRODUCTION:

In Brazil, the "Sistema Unico de Saude" (SUS) is a public health system that has universal coverage,