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PNS118
HOW TO REALIZE THE BENEFITS OF POINT-OF-CARE TESTING AT THE GENERAL PRACTICE: A COMPARISON OF FOUR HIGH-INCOME COUNTRIES
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Objectives: The successful implementation of point-of-care tests (POCTs) proven to be cost-effective, demands transformation and integration of services across healthcare organizations. However, in some countries, such as the Netherlands and Norway, POCT is more widely implemented compared to other countries, such as England and Australia. The aim of this paper is to identify the current value networks in place applying to POCT implementation at general practices (GPs) in England, Australia, Norway and the Netherlands and to compare these networks in terms of seven measures. We published facts that support the successful implementation, sustainability and scale-up of innovations.
Methods: The value networks were described based on formal guidelines and standards published by the respective governments, organizational bodies and affiliates. This involved identifying key actors involved in the operations of the GP, as well as those who can have a direct influence on POCT integration and services. The value network of each country was validated by at least two relevant stakeholders from the respective country.
Results: The analysis revealed that the biggest challenge for countries with low POCT uptake was the lack of effective communication between the several organizations involved with POCT as well as the high workload for GPs’ aim to implement POCT. It is observed that countries with a single national authority responsible for POCT have a better uptake as they can govern the task of POCT roll-out and management and reduce the workload for GPs by assisting with set-up, quality control, training and support.
Conclusions: Although it is possible for day-to-day operations to fall under the responsibility of the GP, this is only feasible if support is readily available to ensure that the workload associated with POCT is as low as possible. Bringing about the necessary changes and integration can be complex and time-consuming, but it is nonetheless feasible, given the example of Norway.

PNS119
QUALITATIVE AND QUANTITATIVE COMPARISON BETWEEN LESS THAN FOURTH DRUG LIST OF RUSSIAN FEDERATION AND ANALOGOUS DRUG LIST OF ENGLAND AND ITALY
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Objectives: Vital and Essential Drug List (VEDL) of Russia contains drugs, which are reimbursed and whose prices are limited by government. Most of developed countries have analogous drug lists. The aim of our study was to compare Russian VEDL and analogous English and Italian lists quantitatively and qualitatively.
Methods: English and Italian drug lists used in this study were identified through search in open sources. The qualitative and quantitative analysis was performed to explore: a) whether drugs from English and Italian lists are registered in Russia; b) complementarity of VEDL and English and Italian lists; c) ATC (Anatomical Therapeutic Chemical) code based consistency d) ICD-10 (International Classification of Diseases) based indication coverage within ATC group L ‘Antineoplastic and immunomodulating agents’. Results: Four English and one Italian lists were analysed. English and Italian lists 41% and 23% of drugs respectively are not registered in Russia, while 67% and 53% of drugs respectively are not included in the VEDL. Ratio of drugs by ATC groups generally is also leaning towards England and Italy in comparison with Russia (206 medications in English list vs 161 in VEDL, in ATC group L), while ratio of drugs indications from ATC group L by all ICD-10 codes favorable towards VEDL in compare with English list (1143 vs 519 indications).
Conclusions: Results of this study show that absolute amount of medications and ATC groups distribution in Russian VEDL are inferior to English and Italian lists. However, indication coverage of ATC group L in VEDL is superior to English lists. This situation could be related with Russian regulation processes specialty, particularly, reimbursement by all indications. Results of such type of studies could be helpful as a source of information on coverage of different therapeutic groups in a variety of healthcare setting and may help to define areas that require optimization.

PNS120
ASSESSMENT OF THE READINESS OF VBHC IN THE SWISS HEALTHCARE SYSTEM - A LANDSCAPING PROJECT
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Objectives: There are still knowledge gaps regarding the landscaping of value-based healthcare (VBHC). The aim was to review the Swiss VBHC market and assess knowledge and concerns around VBHC in the healthcare system. Methods: First, a secondary desk research (SDR) was performed to review the VBHC market, to map key stakeholders guiding VBHC in Switzerland and to develop key interview questions for the interviews. The SDR was performed on Google, Yahoo, Google Scholar and PUBMED. Second, eight in-depth interviews were conducted among persons in decision-making positions representing the academic, digital health, payer, industry and consultant sector. They were interviewed according to a structured questionnaire, which was pre-tested in three pilot interviews. Results: The SDR revealed that in Switzerland the collection of standardized outcome measurements are limited to few institutions. Few initiatives are targeting hospitals to improve value for patients or assessing costs. As yet, no recognized outcome-based mechanism is available. According to the interviewees, the healthcare system is well funded and efficient, but VBHC could help to improve the system and reduce waste. In spite of this, VBHC is being explored in some areas in Switzerland but it is in its early stages. Main hurdles include the lack of commitment and inability to use AI in demonstrating value. In contrast, drivers for VBHC include a highly effective health system, willingness of authorities to new concepts and trained professionals. Conclusions: The present work indicated that implementation of VBHC in Switzerland is possible. The Swiss health care system is developing. In order to progress, behavioural change (quantity to quality) is key for the transition to VBHC. Additionally, evidence from real-world studies, pilot programs around VBHC components (such as patient related-outcome measures and costs) at hospitals and the usage of new technology to manage data are needed.

PNS122
SPATIAL DISTRIBUTION OF PUBLIC HEALTH CARE FACILITIES: IDENTIFYING UNDER-SERVED POPULATION IN KANO STATE, NIGERIA
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Objectives: The aim of this paper is to analyze the categories of health facilities in Kano according to Local government areas (LGA), show the spatial distribution of health facilities in Kano state and determine the proportion of underserved areas in Kano state.
Methods: Location quotients (LQ), Average Nearest Neighbor Analysis (ANN) and Health facility density was used to ascertain areas that were underserved within Kano state. Results: This research showed that there are three categories of health facilities: primary, secondary and tertiary in the study area. The total one thousand four hundred and seventy eight (1478) health facilities studied, 94.2 % are primary health care facilities which in turn mean that preventative medicine is what is most provided in the state as this is the mandate of primary health care facilities. Also, analysis from nearest neighbor shows that health facility within Kano state were randomly distribution since observed mean distance is 1878.072±score 1.069657 and p-value is 0.284774. It was observed that LQs like Kumbotso (0.3151Q) and Gwale (0.312 LQ) are lagging, while other LGAs such as Tofa (3.184 Q), Rimin Gado (2.51), Kabo (2.438 Q) and Bagwai (1.877 Q) has these facilities more than expected. A comparison between LQ and health facility density was used to identify underserved LGAs. Analysis shows that Kumboto, Gwale, Dala, Kano municipal, Ungogo, Dawakin Kudu,Gaezaa and Nassarawa LGA since they all have a less LQ ratio( less than 0.30 and not greater than 0.80 LQ) and low health facility density( less than 0.30 and not greater than 1 Conclusions: This paper concluded that looking at the population to facilities, these LGAs are the ones which allocate or are equiped the exiting health center to accommodate the present pandemic and health challenges in Kano. A need assessment for these lagging LGA should also be conducted.

PNS123
MEASURES TO REDUCE THE BACKLOG OF HOSPITAL SERVICES AFTER THE COVID-19 PANDEMIC
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Objectives: In Portugal, due to the COVID-19 pandemic, almost 1.4 million hospital consultations were not conducted at public hospitals and the number of surgeries was reduced by 40% in comparison with 2019. Local safety measures applied by hospitals reduced hospital capacity by 1/3; SimPLI - Simulating Capacity Performance Leading to Impact, a capacity simulator to test the effectiveness of measures to reduce the hospital backlog within capacity constraints, is hereby introduced. A proof of concept was presented for a hospital ophthalmology service. Methods: A spreadsheet-based simulator was developed for testing measures to accelerate the realization of delayed external consultations and outpatient surgeries. Inputs include the number of rooms and operation times, waiting room capacity, and allocation of healthcare professionals (HCP) to multiple roles. The impact of several measures was assessed systematically by the reorganization of HCP schedules and hiring, patient prioritization criteria, the specific allocation of rooms, and increasing teleconsultations. The baseline backlog is represented by the number of delayed procedures. The time to eliminate this backlog was calculated and compared with the output for scenarios when only one or more measures were implemented. Results: The implementation of telemedicine for subsequent ophthalmology consultations and the reduction in 10 minutes in the time of face to face consultations would allow eliminating the consultations backlog in 9.3 months vs 16.7 months without any measures. Pertaining to surgeries, creating an additional outpatient program in the ASC and hiring a medical doctor were predicted to reduce the time to perform all backlog
No Specific Disease - Health Technology Assessment

**PNS128**
**IMPLEMENTATION OF HEALTH TECHNOLOGY ASSESSMENT IN EGYPT: COMPARISON BETWEEN THE CURRENT AND PREFERRED STATUS**

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**Objectives:** Implementation of Health Technology Assessment (HTA) has the potential to improve the allocative efficiency of scarce health care resources. This study aims to assess the current status of HTA implementation in Egypt and map the preferred directions based on feedback from multiple stakeholders.

**Methods:** A survey was conducted in July 2018 during a workshop held for Egyptian health care decision-makers about options for HTA implementation. The survey relied on an international scorecard that was designed to support the formation of HTA board functions in developing, including capacity building, HTA financing, process and organizational structure, the scope of HTA, decision criteria, standardization of methodology, use of local data and international collaboration.

**Results:** 31 local stakeholders filled in the HTA scorecard. Project-based HTA workshops or short courses are the most common form of HTA education in Egypt (55%), which may not be sufficient to induce hands-on training experience. Therefore, 77% of the participants supported the establishment of postgraduate HTA training programs in the future. Participants reported limited availability of funding for HTA research and critical appraisal.

They indicated the need for increased public budget and additional private funding through submission fees to improve the sustainability of critical appraisals. All respondents highlighted the need for local HTA evidence in the future. They recommended the use of decision thresholds, 20% preferred an implicit threshold, while 67% preferred explicit soft thresholds. Increased use of quality assurance tools can improve the reliability of HTA reports in the future.

**Conclusions:** Our results indicate the continuous need to strengthen the educational and methodological basis of current HTA activities in Egypt, leading to a more efficient health system. Findings also point out that the locally collected evidence should receive higher priority in policy decisions. Our roadmap sets up long-term objectives based on a multi-stakeholder dialogue.

**PNS129**
**INFLUENCERS ON ICER AND THE EVOLVING IMPACT OF ICER ON US FORMULARY DECISION BODIES**

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**Objectives:** This research aimed to analyze ICER assessments in the US to determine the quantity of pharmaceutical therapies assessed at the various QALY thresholds, as well as suggested discounting to reach QALY thresholds.

**Methods:** Publicly available ICER final evidence reports were used to analyze determination of cost-effectiveness at QALY thresholds at $100,000 and $150,000. Thresholds were analyzed across 111 treatments from 27 ICER assessments conducted between 2015 and 2020. Reports were also reviewed to analyze ICER determined price discounts required from the US list price to achieve the cost per QALY threshold price at $100,000 and $150,000. **Results:** Most of the drugs ICER assessed exceeded the commonly accepted $100K-$150K per QALY gained threshold. Three-quarters did not demonstrate cost-effectiveness at a $100K and/or $150K QALY threshold (76.6% (n=85) and 73.0% (n=81), respectively). Conversely, around a quarter of pharmaceuticals assessed were found to be cost-effective at a $100K and/or $150K QALY threshold (23.4% (n=26) and 27.0% (n=30), respectively). Of those cost-effective therapies, a very small percentage would remain cost-effective with a price increase of $100K and 8 at $150K QALY threshold. The analysis also found that most of the drugs reviewed would need to be discounted to meet the commonly accepted thresholds for cost-effectiveness. To meet the $100K threshold, drugs would need to be discounted anywhere from 4% to 94%, drug dependent, with an average discount of 48%, while achieving the $150K threshold would require a discount anywhere from 10% to 98%, with an average discount of 65%.

**Conclusions:** As predicted, ICER determined that most therapies assessed were not cost-effective at their US list price and would need substantial price reductions to achieve cost-effectiveness at thresholds of $100K, $150K. While most US payers have not historically assessed products based on cost-effectiveness thresholds, ICER and cost-effectiveness is becoming increasingly important in the US.