Background
Gatekeeper is one approach to efficiently allocating healthcare resources in primary care. In Japan, there has been an ongoing argument that the absence of gatekeeping might have contributed to excess demand in specialist or hospital care. By contrast, general practitioners (GPs) in England have played the role of gatekeeper since the establishment of the National Health Service (NHS). This study investigated how primary care doctors in both countries manage patients’ demands during the consultation while acting as a patients’ advocate.

Method
We conducted in-depth interviews with primary care doctors in England and Japan via an online videoconferencing platform or face-to-face between July and December 2021. We elicited participants’ experiences and views about rationing and managing patients’ demands in practice; hypothetical consultation scenarios were also used. Interview transcriptions were thematically coded and analysed in the original language. Emerging codes and themes were constantly compared to develop understanding and build analytic frameworks.

Results
In total, 8 GPs in England and 15 primary care doctors in Japan participated in the interviews. Most UK GPs expressed their frustrations over the growing pressure to handle rationing by the NHS. They had to manage patients’ expectations and offer alternative options when expecting a long wait or difficulty in accessing services within the NHS. Some of them shared the local guidance on referral during discussions with patients. By contrast, primary care doctors in Japan rarely mentioned their need to commit to priority setting. However, several physicians reported struggling to decline patients’ requests for unnecessary care and tended to use implicit judgement criteria in the absence of an explicit gatekeeping system.

Discussion
Although clinicians in both contexts struggled to manage patient demands, the presence of explicit gatekeeping seemed to increase the prominence of priority setting in practitioners’ minds and give them an additional mandate for action.

Conclusion
Large part of the public would likely support exempting orphan drugs from standard cost-effectiveness criteria. However, our results indicate considerable preference heterogeneity and the preferences of many depend on patients’ disease, and drug characteristics. The results provide insight into the circumstances in which offering a waiver to orphan drugs may receive public support and inform reimbursement decisions in healthcare.
analysis shows both reform decisions are in line with global lessons and evidence on UHC reforms. They were also based on advanced procedural regulations with considerable transparency throughout the process. However, the changes were perceived as unfair by major and influential stakeholders, leading to resentment, and creating risks for reform sustainability. The study sheds light on how this outcome could have been pre-empted with a fairer process. The reform process was focused on technical accuracy, transparency and reasons-giving but underinvested in meaningful public participation. It makes a case for using the new procedural fairness criteria as an ex-ante diagnostic tool to support sustainable changes in health financing, especially if stakeholders are not well organized and lack coordination platforms.

208:poster COST-EFFECTIVENESS OF INTEGRATED TREATMENT FOR HEPATITIS C VIRUS (HCV) AMONG PEOPLE WHO INJECT DRUGS IN NORWAY: AN ECONOMIC EVALUATION OF THE INTRO-HCV TRIAL

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Introduction People who inject drugs (PWID) have the highest burden of hepatitis C virus (HCV) globally, but are often undertreated due to stigma and lack of access to services. The INTRO-HCV randomised control trial conducted in Norway over 2017-2019 found that integrating HCV treatment, using direct-acting antivirals (DAAs), among PWID in community settings improved treatment outcomes, but did not compare longer-term health economic benefits. This study analyses the cost-effectiveness of integrated treatment compared to standard referral pathway.

Methods A health state transition Markov model of HCV disease progression and treatment was developed based on the INTRO-HCV trial. Treatment unit costs and health-related quality of life outcome data were derived from the trial and used to parameterise the model. The incremental cost-effectiveness ratio (ICER) was calculated in terms of cost per quality-adjusted life year (QALY) gained from the health provider’s perspective over a lifetime horizon and compared against a conventional (NOK 500,000) willingness-to-pay (WTP) threshold for Norway. Probabilistic and univariate sensitivity analyses were undertaken, focussing on DAA price reductions.

Results Compared to standard treatment, integrated treatment resulted in an ICER of NOK 213,498/QALY gained, with 90.8% probability of being cost-effective against the conventional WTP threshold. Sensitivity analyses suggest that cost of DAA medications strongly affected the ICER, with 30% lower DAA price resulting in an ICER of NOK 91,825/QALY gained and 98.9% probability of being cost-effective. A 60% lower DAA price led to a negative ICER of NOK -20,607/QALY gained, with 100% probability of being cost-saving. A 90% lower DAA price had negative ICER of NOK -140,205/QALY gained and 100% probability of cost-saving.

Discussion Integrating HCV treatment for PWID in community settings is likely to be highly cost-effective and may become cost-saving even with moderate reductions in DAA price.