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 ressentiment, 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 integrated treatment having an ICER of NOK 91,825/QALY gained and 98.9% probability of being cost-effective. A 60% lower DAA price led to negative ICER of NOK -20,607/QALY gained, with 100% probability of being cost-effective and 66.8% 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.