Priority setting: the need, the practice, the challenge

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HTAsiaLink

NEWSLETTER TO STRENGTHEN COLLABORATION AMONG HTA AGENCIES IN ASIA

"Price gouging like this in the specialty drug market is outrageous. Tomorrow I'll lay out a plan to take it on." Hillary Clinton tweeted in response to the outrageous price rise of Daraprim.
"NHS faces biggest financial crisis 'in a generation'" The Telegraph

In the past few months, world news headlines raised several health system concerns regarding the escalating healthcare costs in many countries. How can countries keep their health systems accessible in terms of cost, availability, and service sustainability? June 2012, Brazil, world leaders and thousands of participants from governments, private sector and NGOs came together to discuss sustainable development in a United Nations Conference, which accomplished setting 17 sustainable development goals (SDGs). The fourth goal of the SDGs is to ensure healthy lives and promote well-being for all at all ages. Under this SDG, the Universal Health Coverage has been recognized as one of the ways to achieve health sustainability. In order to achieve sustainable UHC priority setting with evidence-based support and Health Technology Assessment (HTA) should be taken into account at all levels of decision making. Starting from the micro level, evidence-based priority setting can help decide how many resources should be spent on particular drugs, technologies, interventions, and policies within a health problem to the macro-level in which evidence based priority setting can provide information on how much should be spent on infrastructure development and human resources.

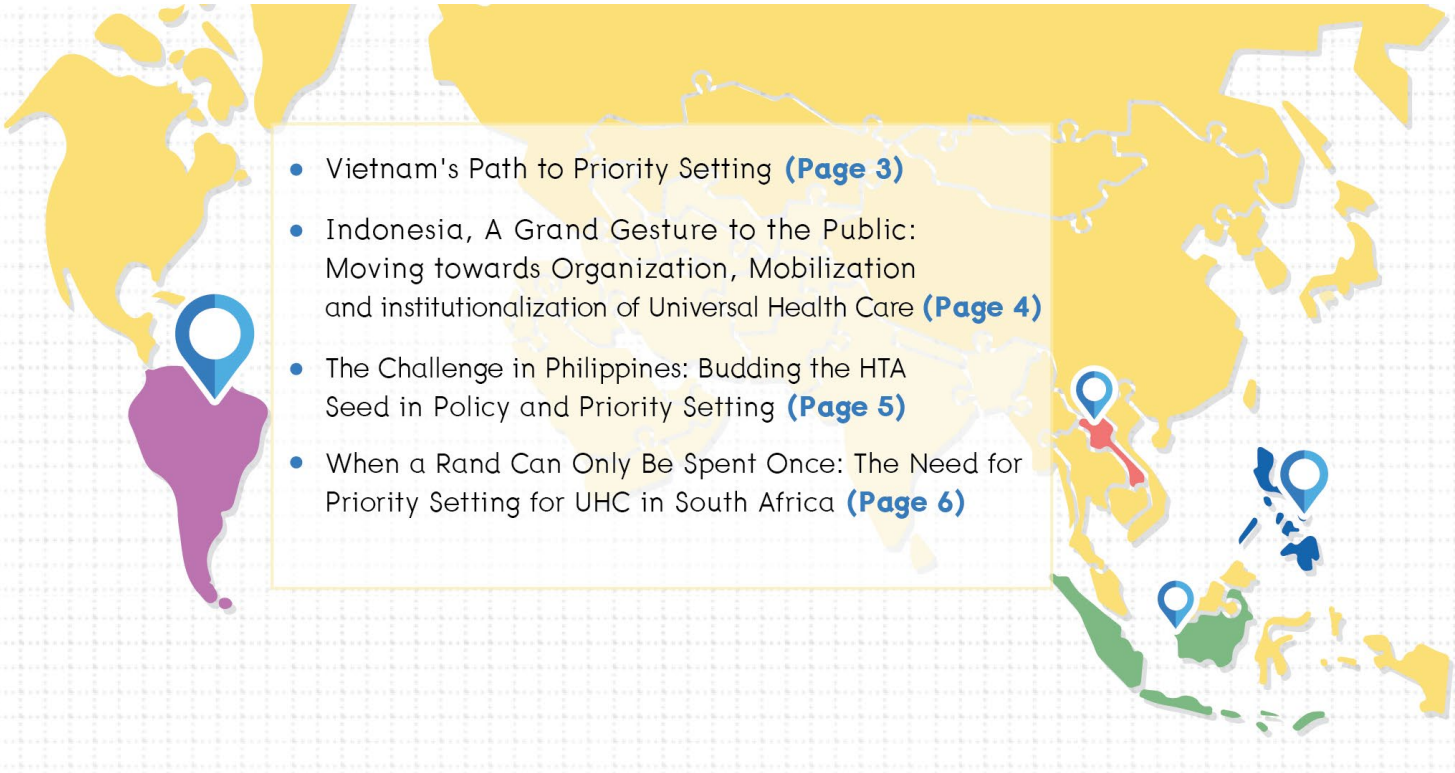
In January 2016, around 1,000 participants from around the world including policymakers, senior officers, Ministry of Finance, Ministry of Health and other relevant agencies, and related stakeholders will join together Prince Mahidol Award Conference 2016 in Bangkok to discuss priority setting for universal health coverage. The conference will focus on organizing priority setting, using priority setting in UHC decisions, and practical experiences of priority setting.

This newsletter presents a glimpse of current situations of several countries that are on the beginning phase of developing UHC as well as a HTA system such as Vietnam, Indonesia, the Philippines and South Africa (Page 2-10). Moreover, the newsletter covers a special article from High-level Decision Makers in Asia discussing the use of HTA for UHC (page 16-19), as well as voices from young staff from HTAsiaLink members toward the use of HTA in UHC. Last but not least, the newsletter features a game section for HTAsiaLink subscribers where our readers can participate and win a prize. For the first 10 winners who can complete our HTAsiaLink crossword puzzle, send us your answers to htasialink@hitap.net within January 2016. There will be a gift delivery at your door!

Best Wishes,
The Editorial Team

Priority for UHC in developing countries

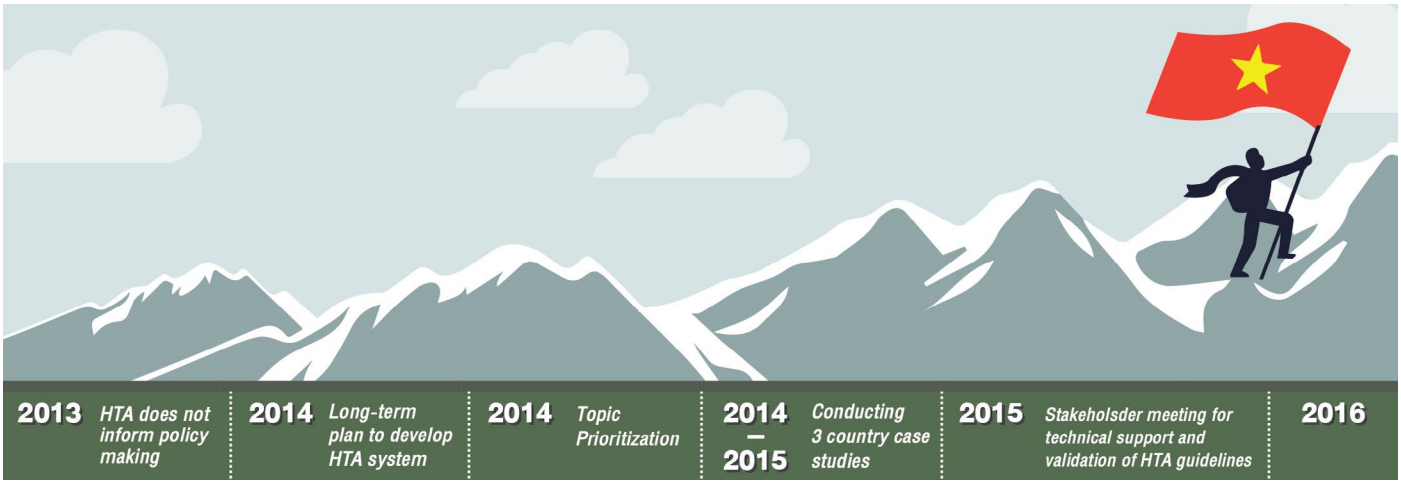
At present, more than a hundred low- and middle-income countries (LMICs) are taking steps toward universal health coverage (UHC) — to ensure that their citizens can access quality health services without financial hardship. **"Implementing 'health for all'** does not necessarily mean **'all for health.'** The reality of resource constraints is a significant barrier for a **'health for all'** scenario. Evidence-based priority setting is expected to play an essential role in healthcare resource allocation.



Vietnam's Path to Priority Setting

By Apinya Mattadet

Why **Vietnam** needed to prioritize topic selections?



In late 2013, a scoping visit to Vietnam by NICE International and HITAP was conducted. The state of HTA in Vietnam was nascent. The key findings showed that the principles and methodologies of HTA were at a rudimentary level and the HTA system lacked input from stakeholders in topic selection and there was not yet adequate trust in the HTA process. Furthermore, HTA did not inform policy decision-makers. Current policy decisions were influenced by physicians and industry, and were affected by political factors.

The challenges for Vietnam stood ahead: raising awareness and policy advocacy for HTA, developing national HTA methods and process guidelines; a participatory process for HTA topic selection; robust process of HTA funded by public sources; and learning from the use of HTA in decision making. In 2014, the Rockefeller Foundation took a step on the path as part of a project on building a global agenda and institutional capacity for priority setting. The project focuses on developing a strategic roadmap for introducing HTA as a tool for priority setting into policy in Vietnam with support from NICE International and working with local technical groups and authorities as well as other relevant stakeholders. The long-term plan comprises of three phases including 1) HTA topic selection, 2) assessment of selected HTA topics, and 3) HTA results dissemination.

How to prioritize topics for **Vietnam** ?

Between May – June 2014, HITAP teamed up with researchers from Health Strategy and Policy Institute (HSPI), Vietnam Health Economic Association (VHEA), Hanoi School of Public Health (HSPH) and Hanoi Medical University (HMU) to discuss fine tuning the primary set of criteria for topic selection developed from literature reviews on how to select criteria and how to use and define the criteria and scoring system. Before the consultation workshop, 'Consultation Workshop on HTA Topic Selection in Vietnam', for topic nomination began, a set of eight criteria was agreed among them to be used for the first set of HTA topics. The criteria set could be further developed at a later stage for future use. Moreover, the HTA process manual for Vietnam was drafted to help guide the HTA studies to be conducted. During the workshop, relevant stakeholders such as policymakers, academics, and practitioners at the hospital level, but no involvement of patient groups and general public, submitted topic nominations verbally and through the nomination forms. Among the topic nominations, the following three topics were prioritized for assessments:

- Using Interferon and peg-interferon for treatment of chronic hepatitis C
- Using trastuzumab for treatment of HER 2+ breast cancer
- Using MRI for non-specific diagnosis

Workshop on Technology Assessment Methods
June 30 - July 4, 2014, HSPI, Hanoi

HTA research of the first **3** topics

In March 2015, three HTA studies on health interventions were selected as country case studies:

- Magnetic Resonance Imaging (MRI) in Vietnam: Diffusion and utilization
- Cost-effectiveness of pegylated-interferon (peg-IFN) in patients with hepatitis C virus infection
- Cost-effectiveness of trastuzumab in patients with HER-2 positive breast cancer

Latest follow-up

The topic prioritization movement is now under the umbrella of the International Decision Support Initiative (iDSI). Recently, a stakeholder meeting was conducted to review the results of two of the three studies (hepC and trastuzumab) and to collect stakeholders' comments on its scope, methods and results. With regards to the validation of the process manual, there were minor amendments in each phase of the process except for the topic selection phase. The major revisions included improvement on topic nomination process and transparency of stakeholder participation. In this phase it was agreed that the topic selection in Vietnam will be conducted annually in the 1st quarter of each year.

Indonesia, A Grand Gesture to the Public:

Moving towards Organization, Mobilization and institutionalization of Universal Health Care

By Karlena Luz

With a big move from the Republic of Indonesia, the head of the government and its health ministry flexes its political arms in a move towards institutionalizing UHC. In the year 2013, the President of the Republic of Indonesia issued Regulation No. 12/2013, a comprehensive health care benefits scheme designed to achieve complete population coverage by 2019. The ruling appoints Indonesia's Social Security Agency — Badan Penyelenggara Jaminan Sosial (BPJS) as the provider for the Healthcare Benefit Program which will be regulated in coordination with the Ministry of Health (MoH). Given its push for UHC, the need for conducting Health Technology Assessments (HTA) in Indonesia also became apparent. The ruling may seem ambitious, but given political will and policy opportunity, institutional efforts are poised to come to fruition.

Taking point from Korea and Thailand's HTA agencies, the MoH invited the National Evidence-based Healthcare Collaborating Agency (NECA) and the Health Intervention and Technology Assessment Program (HITAP) for a workshop on their experiences with HTA. These agencies are set to aid in constructing a roadmap and a work plan for Indonesia. Path International's Access and Delivery Project (ADP), a five-year project (2013-2017) aimed at establishing support for (LMICs) to build capacity on technologies for malaria, NTD's and TB, among others, is expected to have a synergistic partnership with Indonesia's efforts. On the other hand, iDSI also considers if Indonesia can be a pilot country for its capacity building efforts.

International support certainly contributes to enabling the right environment towards mobilizing and organizing UHC however in order to implement it at an institutional level entails creating further mechanisms that allow for establishing systematic evidence-based priority setting through the use of HTA.

International experience sharing 'Discussion on the Roadmap for HTA in Indonesia, and High Level meeting on HTA Development in Indonesia' September 22, 2015

Rather than starting from the bottom-up, the initiative for HTA in Indonesia is a top-down process. As such its management benefits from the appointment of senior ranking officials assigned by the Health Minister. These officers include Professor Agus Purwadianto, Acting Director General of Disease Control and Environmental Health, and Professor Sudigdo Sastroasmoro, Chair of the National HTA Commission. Despite a leadership that is strong politically, some disadvantages to the managing body include limitations in capacity and manpower as these officials also fill other roles in the Ministry. As such, creating an infrastructure for HTA systems, will pose a challenge. Capacity wise, supply gaps, in terms of organizations that can provide economic assessments of technology, and the capacity to advocate and inform decision makers and disseminate HTA results to stakeholders is also lacking. The move to UHC then demands not just a strong leadership, but also a full-time leadership that can implement HTA systematically.

Moving forward, Indonesia progresses on its efforts towards UHC by creating further policy as well as establishing HTA guidelines to support the presidential decree. Further pilot projects, proposals and topic prioritization are being reviewed. Additionally, the HTA commission is also considering expanding its structure. The future of UHC and HTA in Indonesia is promising. But its successes and accomplishments depend on an unwavering commitment towards achieving UHC and sufficient manpower to streamline evidence-based decision-making.

The move to UHC then demands not just a strong leadership, but also a full-time leadership that can implement HTA systematically.

When A Rand Can Only Be Spent Once:

The Need For Priority Setting For UHC In South Africa

By Chalarntorn Yothasmutra

South Africa (SA) is in the process of establishing a National Health Insurance (NHI) scheme to reach UHC by 2025. Dr. Aaron Motsoaledi — the South African health minister described the current SA healthcare system in the WHO bulletin as "very expensive, destructive, unaffordable and not sustainable". The health spending data shows that 8.6% of SA's GDP is spent on health, a figure higher than most middle-income countries. Yet despite its high investment on public health, SA's country life expectancy is still significantly lower than the world average.

Prioritizing health interventions for optimal resource allocation has been a constant policy discussion in SA. However, rather than focusing on priority setting in health systems and its entirety, discussions were centered on specific health issues such as HIV/AIDS. In a recent HTAsiaLink interview with Karen Hofman, the director of Priority Cost-Effective Lessons for System Strengthening, South Africa (PRICELESS SA), she explained that on the outset, policy makers did not have much interest on evidence-based information for priority setting since the notion of value for money was not the primary topic of discussion. In 2009, PRICELESS SA was established with a mission to support the development of evidence-based information and to generate tools to optimize the use of scarce resources for an efficient and effective health system. To bring the attention of decision makers to value for money, the PRICELSS team started to involve key policy makers and stakeholders in the selection of research topics.

Illustration Credit: http://www.pricelesssa.ac.za/

Karen Hofman,
Director of PRICELESS SA attending the 2014 HTAsiaLink Conference

The collaboration between PRICELESS, policymakers and stakeholders resulted in the selection of four research topics: increasing life expectancy, decreasing maternal and child mortality, combating HIV/AIDS, and strengthening health system effectiveness. In one of the studies, they investigated the reduction of sodium content in high salt foods and its relation to the incidence of cardiovascular disease in SA. The findings of the study indicate that reducing salt intake can prevent about 3,000 deaths from ischemic and hypertensive heart disease. The results of the study stimulated policy makers to act. In March 2013, a regulation was passed in the Government Gazette that required food manufacturers to reduce the sodium content in their products. PRICELESS faced some backlash from the food industry. Some companies tried to stop the legislation process claiming that the government is trying to control people's lives. However, according to Hofman, some food companies also took the lead in the campaign to reduce salt consumption. Hofman noted that for policymakers, the study substantiated the benefits of using evidence-based decision making. After the study was launched, PRICELESS was commissioned further for priority-setting, especially in maternal and child health. Considering that SA is now moving toward developing UHC, Hofman anticipates that policy-makers and stakeholders will turn to evidence-based priority setting in order to develop health benefit packages.

Early this year, a stakeholders meeting was convened to identify ways of scaling up practical support for evidence-informed priority setting. The outcomes of the meeting yielded promising signs. High level government officials showed support toward evidence-informed priority setting as well as agreement to a country-wide network in response to the growing demand for HTA. Hofman pointed out that capacity building is the toughest issue in developing mechanisms for priority setting. PRICELESS cannot answer to increasing demand due to its limited capacity. A lesson that can be drawn from the development of HTA in Asia is that international collaboration is one of the key supporting factors to the success of introducing evidence-informed priority setting. Hofman mentioned that applying the HTAsiaLink networking model can serve as a solution to aid the introduction of evidence-informed priority setting in the African region.

The Challenge in Philippines:

Budding the HTA Seed in Policy and Priority Setting

By Karlena Luz

The Philippine academic and research community crosses the threshold of HTA by launching a bang for the buck economic evaluation of the human papillomavirus (HPV) vaccine and the pneumococcal conjugate vaccine (PCV). In a move towards increasing healthcare coverage, the Government of the Philippines with support from the Rockefeller Foundation through the National Institute for Health and Care Excellence (NICE International) commissioned the Health Intervention and Technology Assessment Program (HITAP) to build local capacity for conducting HTA, starting with the PCV and the HPV vaccine. The project was designed to include three missions over a six-month period from March to September 2013. As per the fulfillment of the Philippine Congress Cheaper Medicines Act of 2008, the Philippine Government planned to provide the maximum essential interventions to all Filipinos. However with competing policy agendas and tightening purses, the need for priority setting in order to efficiently allocate the health budget became an imperative.

Since its release to the Philippine market, the two vaccines have been the subject of policy debates. With both drugs already included in "the essential drugs list" or the Philippine National Formula (PNF), the question to implement both drugs into the expanded program on immunization (EPI) was raised. Focal persons from the National Center for Pharmaceutical Access and Management (NCPAM) were nominated to hold the responsibility for overall matters for each vaccine evaluation. The team of experts included researchers from the Institute of Clinical Epidemiology as well as economic advisors, NCPAM Deputy Program Manager, Melissa Guerrero, NCPAM Project Manager, Alexander Haasis and Dr. Hilton Lam of the University of the Philippines (UP), Manila.

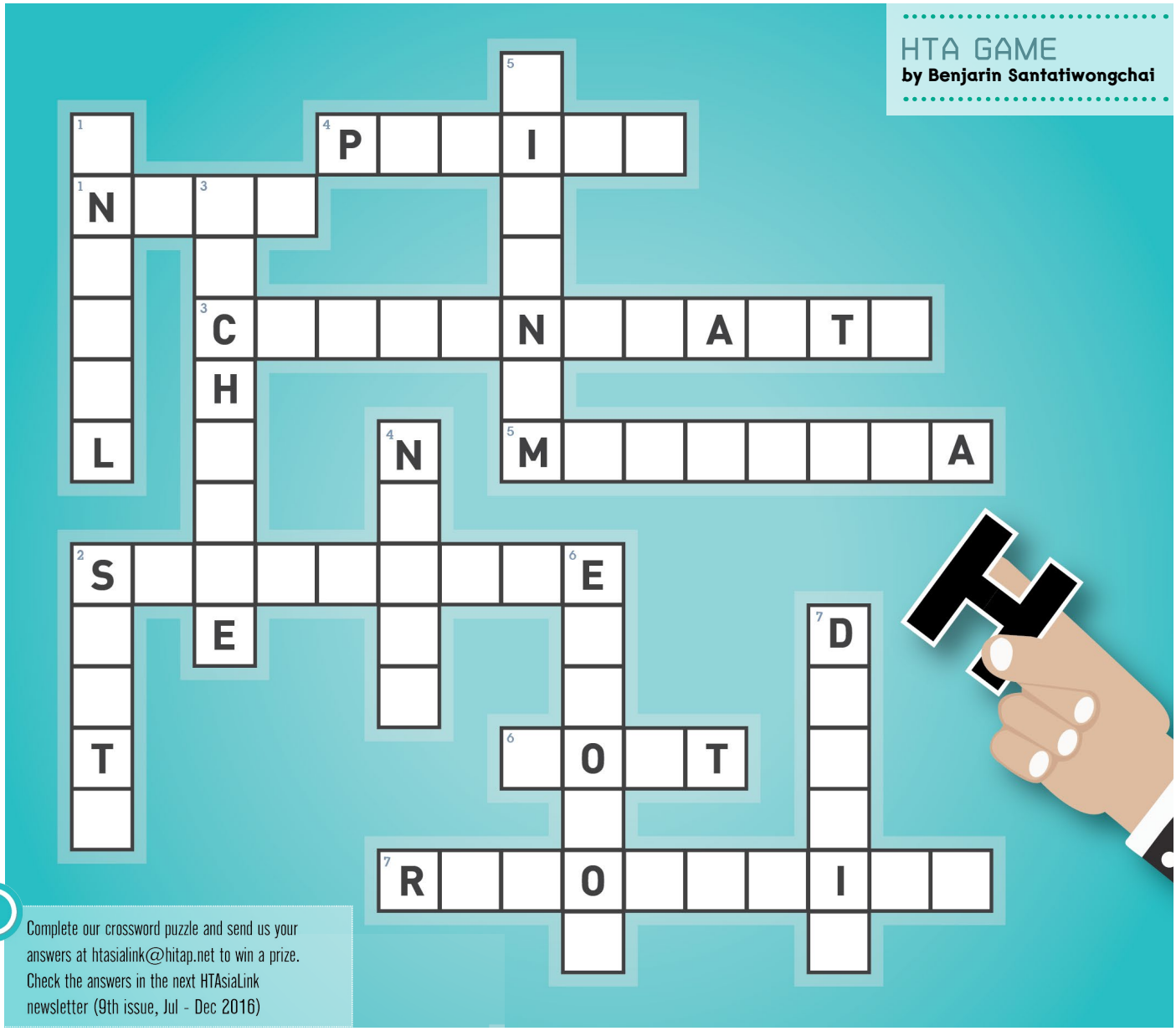
Writing a manuscript for the economic evaluation of HPV vaccine in Philippines 1-7 February 2015 HITAP, Thailand

The research resulted in the forecast of four scenarios. Namely, the first being universal health coverage in which the Philippine Health Insurance Corporation (PhilHealth) covers 100% of the cost for all Filipinos; the second being differential pricing with universal health coverage where PhilHealth covers the vaccine cost for the low-income bracket (25% of the population) and the rest (75% of the population) pays out of pocket resulting in 100% coverage; the third being differential pricing without universal coverage where PhilHealth covers for the low-income bracket (25% of the population) and 35% of the population can afford the vaccine as included in household expenses; and lastly being the status quo where PhilHealth covers the cost only for the 25% low-income bracket of the population, in which case only 25% of the total population will be covered.

The result of the study was presented to the Formulary Executive Council (FEC) and used as information by the Philippine Department of Health (DOH) and PhilHealth in considering inclusion of the vaccines in the National Vaccination Program. On April 2014, NCPAM in collaboration with UP, NICE International and HITAP held an after-action review of the study chaired by former Department of Education Undersecretary Francisco Valera. Despite the support received by the research in its first release, the after-action review was met with some hesitation. A conducive political landscape may be HTA's biggest challenge in taking off in the Philippines. And invariably, the use of proper HTA as an evidentiary basis for decision-making may be the prime solution to curbing controversy in government health schemes.

HTA GAME

by Benjarin Santatiwongchai



Complete our crossword puzzle and send us your answers at htasialink@hitap.net to win a prize. Check the answers in the next HTAsiaLink newsletter (9th issue, Jul - Dec 2016)

Across

1. Which member organization is working to maintain HTAsiaLink website?
2. Where will the HTAsiaLink 2016 be held?
3. Incidentally, member organizations that are not located in Asia are all from the countries which are part of the _____ of Nations.
4. The purchasing power _____ estimates the amount of adjustment needed in the exchange rate between countries in order to make the exchange equivalent to the currency purchasing power.
5. Which country has the highest number of organizations joining HTAsiaLink?
6. ICER is the acronym for 'Incremental _____-Effectiveness Ratio'
7. During 67th World Health Assembly, HTA is adopted as a part of World Health Assembly _____.

Down

1. How often is HTAsiaLink conference held?
2. In conducting regression analysis, different programs can be adopted as a tool, e.g. SPSS, R, _____, etc.
3. Which collaboration is well-known for its database for systematic review?
4. What is the name of the member organization located in the country of which the flag both the sun and stars?
5. Which country is the new member of HTAsiaLink whose name's anagram is 'ship' from?
6. What is the name of the association that designed the tool for measuring of quality of life with 5 dimensions?
7. Where did the pioneers of HTAsiaLink first meet?

HTAsiaLink

Australia & New Zealand

- Health PACT
- The Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S),
- National Health Committee
- University of Sydney, Australia

Bhutan

- Essential Medicines and Technology Division (EMTD), Department of Medical Services, Ministry of Health (MOH)

China

- Division of Health Policy Evaluation and Technology Assessment, China National Health Development Research Center (CNHDRC)

Indonesia

- Subdivision of Allied Pharmaceutical & Medicine Technology

Japan

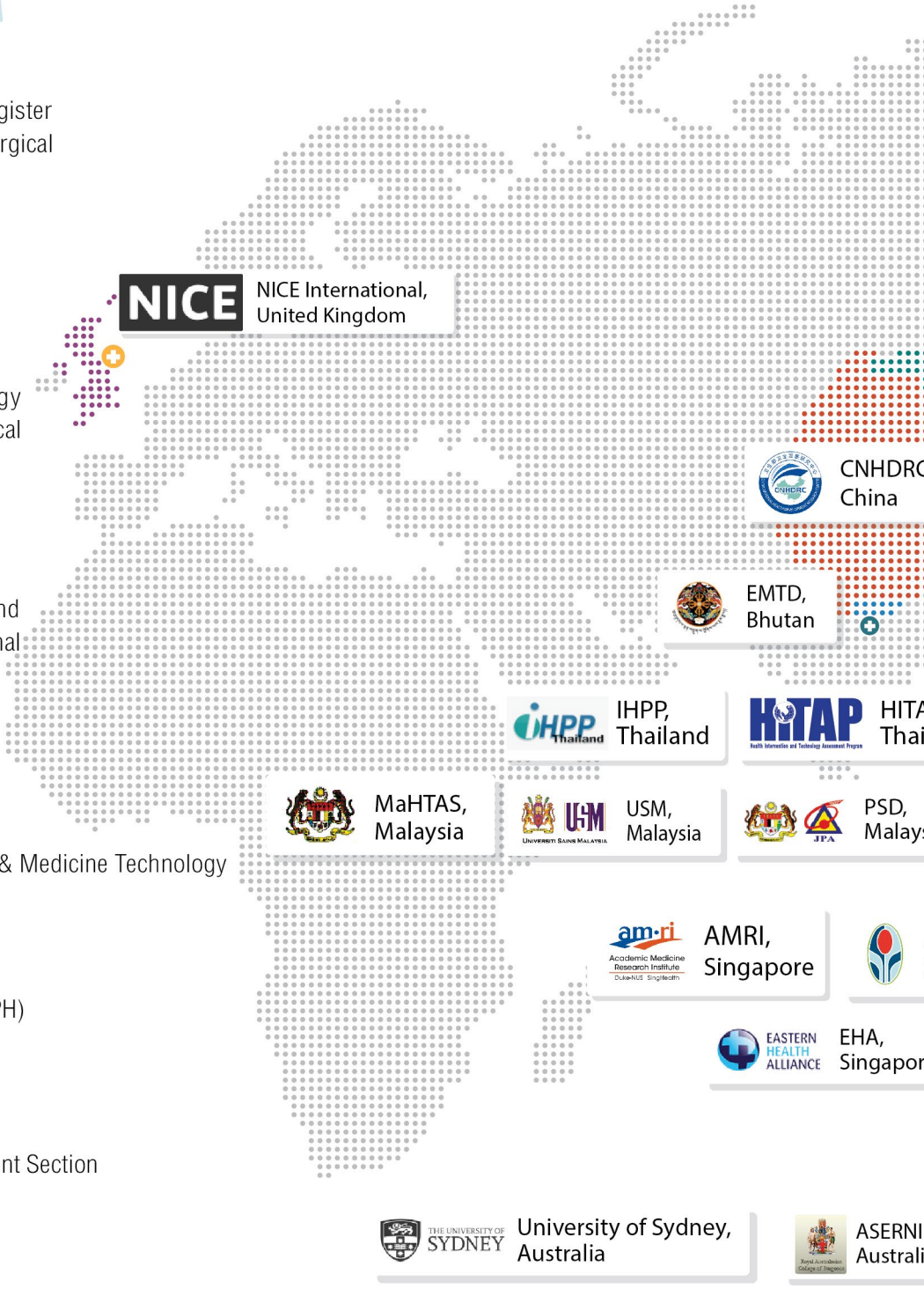
- National Institute of Public Health (NIPH)

Malaysia

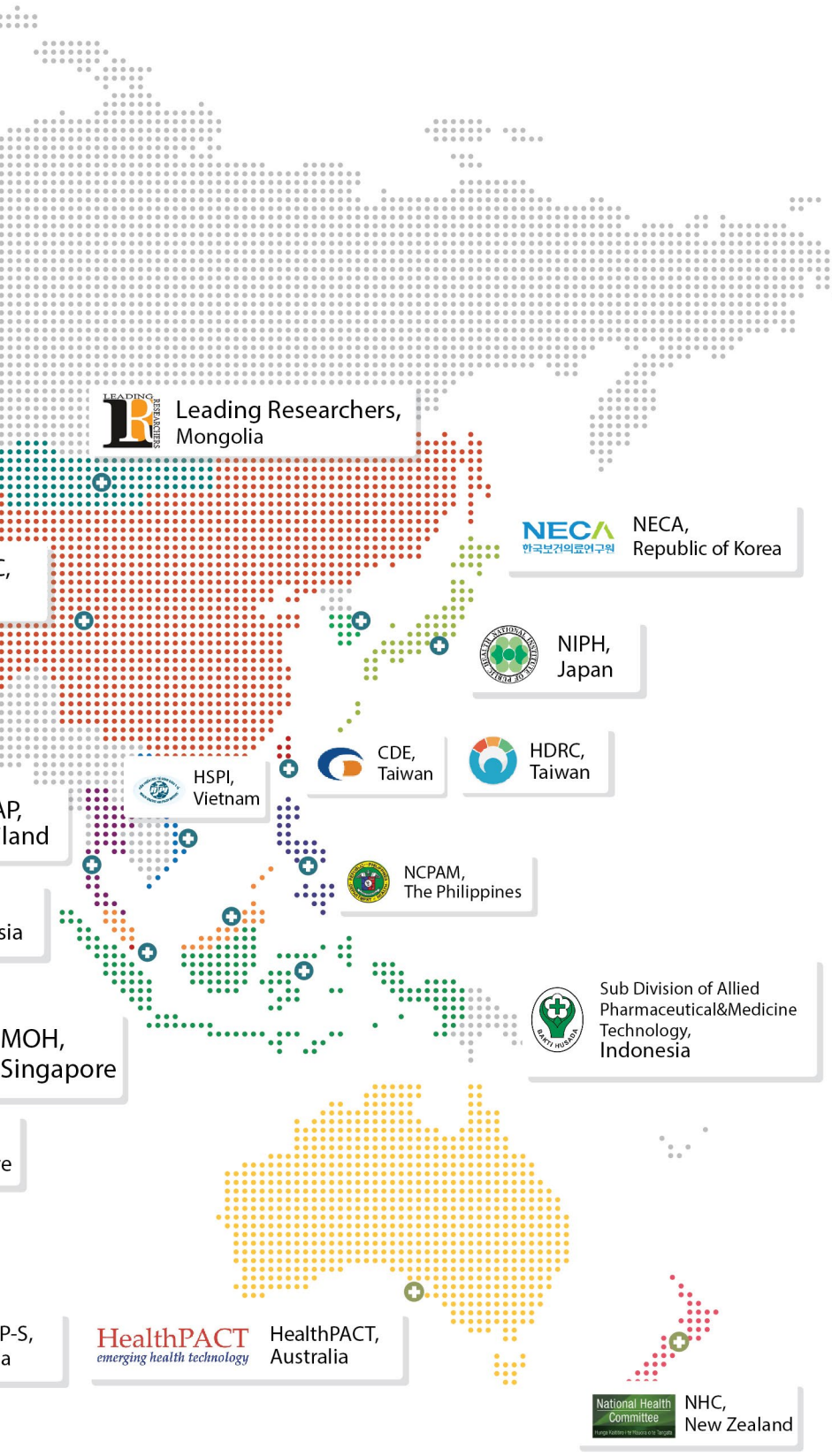
- Malaysia Health Technology Assessment Section (MaHTAS), Ministry of Health (MOH)
- School of Pharmaceutical Sciences, Universiti Sains Malaysia (USM)
- Pharmaceutical Services Division (PSD), Ministry of Health (MOH)

Mongolia

- Leading Researchers, Department of Health



Member organizations



Philippines

- National Center for Pharmaceutical Access and Management Department of Health (NCPAM)

Republic of Korea

- National Evidence-based Healthcare Collaborating Agency (NECA)

Singapore

- Ministry of Health (MOH)
- Eastern Health Alliance Health Services Research Unit (EHA)
- Academic Medicine Research Institute (AMRI)

Taiwan

- Division of HTA, Center for Drug Evaluation (CDE)
- Health Data Research Center National Taiwan University (HDRC)

Thailand

- Health Intervention and Technology Assessment Program (HITAP)
- International Health Policy Program (IHPP)

United Kingdom

- NICE International

Vietnam

- Health Strategy and Policy Institute (HSPI)

Voices From
HTAsiaLink's new generation

By Apinya Mattadet

During the 4th HTAsiaLink Annual Conference held in Taiwan, May 2015, emerging waves of HTA researchers surfaced. This event gave young HTA researchers the opportunity to present their HTA research at an international forum. Let's get to know what they are expecting from HTA.

Malaysia
Tan Bee Ying

Position: Researcher and PhD candidate, University Sains Malaysia. She is now working on the 'Association among Calendar Packaging and Medication Adherence: Findings from a Focus Group Discussion among Hypertensive Patients in Penang, Malaysia'

Why work for HTA: As a statistics lover, while working in the field of public health, she believes HTA "helps policymakers make decisions accurately."

If HTA is a system: "Like a car catalogue which provides useful measuring points for your best buy for a car."

She wants to solve this problem for Malaysia: Diabetes. "The prevalence of diabetes in Malaysia is higher than that of hypertension and getting more serious. Each year, the Malaysian government spends too much money on medication and injection. It should include HTA procedures to help justify their payment."

Vietnam
Tuan Quang Kieu

Position: Researcher at Vietnam Health Economic Association (VHEA) for 5-6 years. He has expertise in healthcare financing mechanism and HTA. He conducted a research on economic evaluation and has been involved for 3-4 months in a joint project with Health Strategy and Policy Institute (HSPI) in establishing HTA system in Vietnam.

Why work for HTA: The escalating cost of running a hospital is very import to the health system, especially to patients who have to pay not just for the treatment but also other fees. So we look at the HTA as a way to control the cost and create efficiency to the system.

If HTA is a system: Human body. "HSPI, assigned by the Ministry of Health to be the focal point of HTA in Vietnam, is the head. Other parts of the body are other organizations working to support HSPI. I'm working like the left hand doing technical."

Biggest achievement so far: Healthcare financing reform pilot project in Vietnam: "We found that the cost and the length of stay is reduced after we tried out the new system in the pilot project, while the quality of health outcomes and services were maintained. I'm still at the early stage of developing HTA system so I'm proud of me for being a brick in the fundamental parts of constructing HTA system in Vietnam. I will do my best and learn from others in achieving this."

He wants to solve this problem for Vietnam: "Expand the coverage of UHC to 100% as soon as possible. Right now it's 70%."

Position: Researcher at National Evidence-based healthcare Collaborating Agency (NECA), division for healthcare technology assessment research. Sol-ji started working with NECA last year and already finished a research on policy decision making support.

Why work for HTA: Her first job is making evidence-based clinical guidelines for national cancer center. "In Korea, the evidence based research is quite strong and NECA is recognized in this field. So I moved to NECA last year. And now I also work on clinical guidelines."

HTA system to her: "Like a strong impact quality mark in the clinical field. This is because in Korea, any health technology can be used in clinical practice only when it has passed HTA and is listed for reimbursement."

Biggest achievement so far: "My research, 'Priority Setting for Health Technology Assessment Research at NECA', got accepted and presented in HTAsiaLink Annual Conference this year. It's my first international presentation, my debut project."

She wants to solve this problem for South Korea: Balancing the expectations of the individual and controlling Korea health budget expenditure. As public health expenditure rises, the rate of health insurance will also rise. As such, the government will inevitably charge more for health insurance. Given that the citizens are paying a higher rate, it is only justifiable for them to expect more out of the treatments and services that their health insurance can provide. So how does the government manage the expectations of its citizens while making sure that they are controlling their budget expenditure?

South-Korea
Choi Sol-ji

Position: Associate Researcher at the Center for Drug Evaluation (CDE), Taiwan, since 2012 in Public Health research.

Why work for HTA: "HTA is multidisciplinary so it looks at things as a whole. It's different from other fields of research."

If HTA is a system: Neuron system. CDE, an HTA agency in Taiwan figuratively works as a neuro system in the healthcare system that is the whole human body. "Our HTA report is like a transmitter so if our government wants to do something, we tell the body to do so."

What is her role in the system: "A neuron, I'm a sensory neuron and I transmit HTA information."

Biggest achievement so far: The assessment of changing the API of Tamiflu. "We had to find solutions for Tamiflu powder oversupply in Taiwan. Back in 2008, influenza pandemic caused the Taiwanese government to stockpile the powder. However, the influenza declined sooner than they expected. CDE, then, came in to find out how to utilize the remaining powder before it expired. Finally, the drug needed to be manufactured in capsule form and stored for a certain percentage of the population according to the WHO recommendation."

She wants to solve this problem for Taiwan: Infertility. "Taiwan has the lowest birth rates in the world. Fertility rate of 0.9 (in 2011). Our government asked if they should spend on In Vitro Fertilization (IVF) that is very expensive especially for the procedure. Now we don't have the budget to evaluate it and nobody seems to be interested about it but I think we can do that."

Taiwan
Young-Chen (Luara)

Special Article:

HTAsiaLINK HOT SEAT:

HIGH-RANKING POLICY MAKERS ON HTA, PRIORITY SETTING AND UHC

By Chalarntorn Yothasmutra and Nattha Tritasavit

During the HTAsiaLink Annual Conference held in Taipei, Taiwan in May 2015, the unique session on Leaders Forum- Highlights from High-Level Decision Makers on HTA for UHC was set to feature the perspectives of high level policy makers from 4 countries toward the use of health technology assessment (HTA) to support universal health coverage (UHC). The forum featured 4 high-level decision makers namely, Dr. Ming-Neng Shiu, Vice Minister from Ministry of Health and Welfare (Taiwan), Dr. Suriya Wongkongkathep, Deputy Permanent Secretary of the Ministry of Public Health (Thailand), Dr. Seulki Kang, Deputy Director, Division of Healthcare Resources Policy, Ministry of Health and Welfare (Republic of Korea), and Mr. Tono Rusiano, Director, Research and Development, Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan (Indonesia). The session was moderated by Dr. Suwit Wibulpolprasert, Vice Chair of the Health Intervention and Technology Assessment Foundation (HITAF) Ministry of Public Health (Thailand).

The forum was set in a round table news-like interview session and the policy makers were expected to answer questions extemporaneously. With the officials in the hot-seat, the first question was drawn from the chair of the forum:

"As the brain of your countries' health sector, how do you deal with industry lobbying to include drugs or health interventions into the health benefits package or the national drug list?"

Every country official came up with the same answer – there is no chance for industry groups to use "in-direct" ways to include their drugs in the list as there are strict rules and regulations on how to register a new drug into the country's reimbursement list.

Mr. Rusiano of Indonesia: If you want to include a drug into the National List of Essential Medicines (NLEM) in Indonesia, you need to follow specific criteria and provide supporting evidence to the National Revisions Committee who is responsible for decisions regarding adding or removing drugs from the list. Additionally, a system called e-catalog is used as a price reference throughout the country. Therefore, it is impossible to intervene in the decision-making process, even if you are the minister's friend.

Dr. Kang of the Republic of Korea: It is impossible for the industry to intervene in the reimbursement system as they have a mandatory process and criteria in considering the inclusion of new technology. HTA is one of the main criteria to consider in the inclusion of a new drug to Korea's drug reimbursement list.

"If policy making is an art that takes into account the cultural, ethical and contextual circumstances of a country and HTA evidence is a rigid science that is based on logic and cost-effectiveness, how do you balance between the art and the science when you make your decisions?"

Dr. Shiu of Taiwan: Without the controlling system, the increase in medical expenditure each year would have put Taiwan National Health Insurance at financial risk. Under the current decision making process, the HTA division under the Center for Drug Evaluation (CDE) reviews dossiers from drug manufacturers and finally provide a HTA report to the CDE committee consisting of experts and stakeholders. This is where science, evidence and policy decision can meet during the decision process. In addition, decision makers also use other techniques such as price negotiation and finding resolutions on how to implement scientific recommendations in the best way possible.

Dr. Wongkongkathep of Thailand: As a policy maker, whether in a high or a low-income country, you have to prioritize in budget allocation. From the overall country budget, government does not only pay for health. It also pays for other sectors such as education, state welfare, military, environment, etc. In order to make a reasonable decision, there is a need for rigid and scientific evidence to support your decision in setting priorities for the country's budget. Moreover, HTA should not be based solely on hard-evidence (hard science). It should also consider the soft science, i.e. the social and cultural context of the country.

"How much can HTA contribute to the achievement of establishing universal health coverage?"

Mr. Rusiano of Indonesia: Currently, Indonesia just reached 60 percent of universal health coverage and expects to get full coverage by 2019. I foresaw that HTA was going to be a crucial tool in gathering information to expand and manage Indonesian UHC. It will help policy makers to decide on what should be included in the benefits package and at what cost it should be reimbursed.

Dr. Wibulpolprasert, the chair of this session, added that HTA helps policy makers to decide on new drugs to be included in the system, and HTA evidence might help in terms of price negotiation. Although, the price of the drug may reduce the cost of the drug might not be reduced at the same time. The total cost will increase as we included the new drug into the benefit package.

"Can HTA results be transferred and used in other countries?"

Dr. Kang of the Republic of Korea: Countries in Asia are unlike Europe as Asian countries are very different and diversified. Therefore, it is not easy to directly transfer one country's study to another. However, what HTAsiaLink members can share and transfer is the HTA methodologies and tools which fit best to the Asian context.

"What do policy makers want from HTA researchers?

Mr. Rusiano of Indonesia: As Indonesia is in the starting point of UHC and developing the HTA program, we strongly support the HTAsiaLink collaboration and we expect to learn from other countries' experiences on HTA development.

Dr. Wongkongkathep of Thailand: Producing HTA evidence should not be an automated process where you just push a button and the results would come out. There is a need for both scientific evidences and contextual evidences in order to balance science and the art of decision making for the benefit of the patients.

Dr. Kang of the Republic of Korea: NECA could learn from other countries as well as expand more collaboration internationally.

Dr. Shiu of Taiwan: HTAsiaLink is a very good platform for all Asian countries to share experiences in HTA. In the future, Taiwan is aiming to expand the use of HTA not only for drugs, but also for the assessment of health policy such as long term care, national prevention services and social welfare programs. I expect that the information and experiences of other countries would be very helpful to Taiwan.

Finally, Dr. Wibulpolprasert, the chair of the session, concluded that policy makers, like himself, always have some bias. When HTA results and recommendations are presented, if the recommendations go along with the policy maker's preference, then he tends to make a decision according to the recommendations. However, if the recommendations do not go along with what he has in mind, he tends to ask more questions which is a parting lesson for HTA leaders is that this is simply the reality of politics.

"Don't try to use the science of evidence to tie down a policy makers' hand. Present the information you have and leave some room for policy makers to decide."

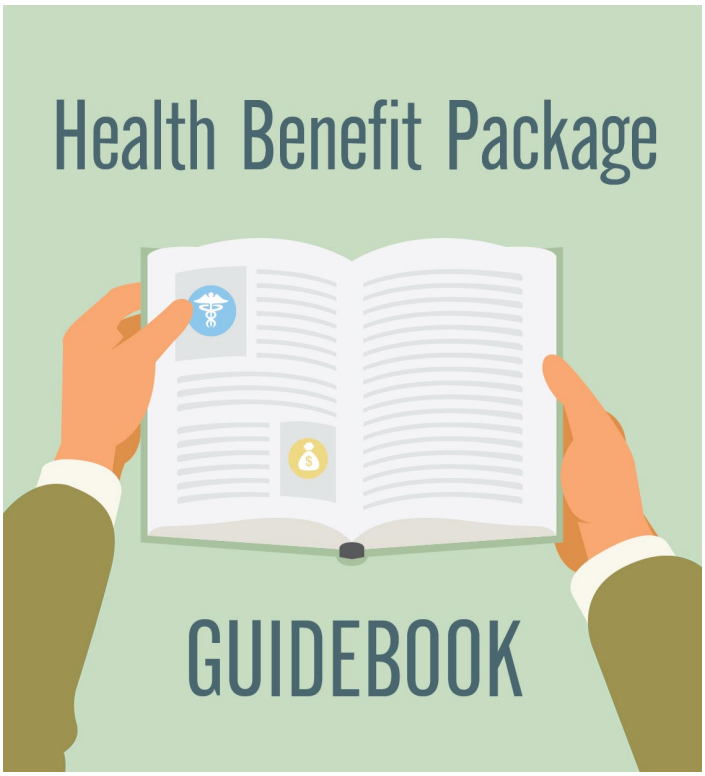
Dr. Suwit Wibulpolprasert

WHAT SERVICES SHOULD HEALTH SYSTEMS PROVIDE?

A BOOK ON THE "HOW-TO" OF HEALTH BENEFITS PLANS IN LOW- AND MIDDLE-INCOME COUNTRIES

By Yuna Sakuma

Overview of a book edited by Amanda Glassman (Center for Global Development), Ursula Giedion (Center for Global Development and Inter-American Development Bank), and Peter Smith (Imperial College London)



What services should health systems provide—to whom, and in what circumstances? These are questions that healthcare policymakers grapple with every day.

Health Benefit Plans (HBP)—a policy instrument used to set priorities for public spending on health—answer these very questions. It is therefore at the core of all publicly funded healthcare and ultimately progress towards universal health coverage. HBP are those services, activities, and goods reimbursed or directly provided by publicly funded statutory/mandatory insurance schemes or by national health services. Ideally, a HBP is not merely a list or a set of decisions, but should also be understood as an on-going process that shapes resource allocation and its outcomes now and in the future.

While commonly invoked as a policy recommendation and used in practice, HBP and associated processes share a surprising lack of scrutiny and evaluation. Thus far, comparative analysis and forward-looking guidance specifically targeted to low- and middle-income country (LMIC) settings has been limited (but growing: e.g., Health benefit plans in Latin America by Giedion et al. (2014); work by the HITAP and NICE International). Tightly linked literature and experience on priority-setting and resource allocation—including HTA, cost-effectiveness analysis, and clinical guidelines—and HBP-related processes and practices have not yet been bridged.

Linked literature and experience on priority-setting and resource allocation—including HTA, cost-effectiveness analysis, and clinical guidelines—and HBP-related processes and practices have not yet been bridged. CGD, in partnership with the international Decision Support Initiative (iDSI)—a global initiative to support decision makers in priority-setting for universal health coverage—has been developing a "how-to" of HBP, a practical book and set of options for decision making intended to be published in 2016.

In Turkey, officials ask: "How should we use HTA to improve the way pharmaceuticals are added to the formulary?" In India, policymakers wonder: "When is it appropriate to outsource cost-effectiveness analysis? When is it not?"

As a policymaker, you might be wondering about the options available to decide what's in and what's out, and what other countries have done. The book will attempt to answer at least a few of your questions, or point readers in the right direction to more or better resources, with the goals of providing practical information and options and analysis of the design, adjustment, and evaluation of HBP. While the book will be aimed at LMIC policy audiences, it will draw on low- and high-income country experiences to enrich the discussion and the examples provided.

Some questions policymakers may have:

- On balance, is a HBP a good idea in my health system?
- What processes and institutions are needed?
- What methods and criteria should underpin decisions, and how should or can these criteria be balanced?
- How will the plan be kept up to date?
- How will the standard package be defined legally? What legislative and other approaches should apply, and how will these relate to definitions of services for payment purposes?
- How will disputes in relation to the scope and content of the standard package be resolved?
- How should we manage the complex political economy and ethical terrain in which HBP decisions are taken and implemented?
- How can we make HBP work in practice, aligning with other enabling health system functions like payment?
- How do we know if HBP are delivering on the motivations that led to their creation and implementation?

The book will start with an introductory section that provides an overview of explicit priority-setting and briefly motivate its focus on HBP. It will define and discuss HBP and set forth a framework for the rest of the book including a HBP policy cycle and introduction of the cross-cutting thematic sections (presented in the table below.)

Possible Sections / Topics

Section	Summary
Governance	Explain why HBP are not only about explicit priority setting, methods and data but also about the processes and institutions that go into the design and adjustment of health benefits provided by health systems and other payers.
Institutional arrangements	Discuss institutional arrangement options available to HBP design and adjustment with attention to the varying institutional arrangements possible and have been adopted in practice and strategies undertaken to get around obstacles to better institutional design.
Fiscal and budgetary	Connect HBP to the fiscal, budgetary and payment/commissioning process, reviewing the extent to which countries use HBP to structure resource allocation, budgets and transfers, and related.
Methods	Assess technical and methodological challenges to be addressed when defining HBP and will evaluate the pros and cons of available evaluation methods with respect to these challenges.
Monitoring and evaluation	Explore what data, monitoring, and analytics are needed on an ongoing basis to monitor the effectiveness of a HBP and feed into its update.
Political economy	Map common features of political and economic interests related to HBP processes and identify practical strategies and leverage points used to address these issues and dynamics while assuring a fair process.
Ethics and equity	Examine current practice and provide practical guidance on navigating the equity and ethical challenges of HBP, safeguarding against egregious moral harms resulting from inappropriately devised resource allocation, and supporting the development of morally defensible benefits plans.
Legal / rights	Discuss legal and rights based factors and considerations in the design and adjustment of HBP.

We hope to demonstrate the most common questions and dilemmas as well as successes, through practical country case studies or examples—and welcome your submissions to ***ysakuma@cgdev.org.*** *For updates on the book and further information, please visit* ***www.idsihealth.org.***

WORK HARD, PLAY HARD:
THE 4TH HTASIALINK CONFERENCE

By Alia Luz

The HTAsiaLink Conference at the Chang Yung-Fa Charity Foundation (CYFCF), Taipei, Taiwan, kicked off with a bang from May 12th – 15th, 2015. The pre-conference gave an introduction to HTA, with its process, various research areas, and applications. The conference itself was an intense mix of: research presentations on health systems and economic evaluation, with reviews from leading health authorities and professors; expert discussions during the plenary sessions with decision makers and key persons for UHC provision, with topics ranging from HTA for UHC to regional collaborations to country-level HTA development; and tête-à-têtes between participants during sumptuous snack breaks. As the 4th annual conference, new and current junior and senior researchers met each other, providing a venue for learning and growth. This energetic bunch brought enthusiasm and drive not only to the conference but also to the after party for an exciting night of dancing, singing, and laughs.

With the HTAsiaLink conference's emphasis on academic rigor, capacity building and growth of HTA researchers in Asia, as well as building connections and strengthening knowledge transfer and exchange between agencies, the participants praised the uniqueness of the conference as well as its ability to create a tight-knit community of researchers that bonded as quickly over talking about improving health systems and building Markov models as they did over semi-synchronized maneuvers on the dance floor. Exclamations of excitement for next year's conference in Singapore abounded.

HTA calendar

Jan-Jun 2016

UPCOMING EVENTS

JAN 8-10

Event: 2nd Biennial Asia-Pacific Conference

Place: Chinese University of Hong Kong, Hong Kong

For more information, please visit **www.smdm.org**

FEB 26

Event: 2nd ATHEA-Conference for Health Economics: Efficiency and equality in health systems

Place: Institut fÜr HÖhere Studien (IHS), Wien, Austria

athea
austrian health economics association

For more information, please visit **www.athea.at/conferences/**

MAR 17-18

Event: 8th Annual Society for Benefit-Cost Analysis Conference

Place: Washington, D.C.

For more information, please visit **http://benefitcostanalysis.org/2016-annual-conference**

MAY 3-6

Event: 5th HTAsiaLink Annual Conference

Place: Duke-NUS Graduate Medical School, Singapore

For more information, please visit **www.htasialink.org**

HTAsiaLink
HTAsia link is a network to support collaboration between Asian health technology assessment (HTA) agencies. It focuses on facilitating HTA research by accelerating information and resources sharing and developing an efficient methodology for HTA in the region.

MAY 10-12

Event: HTAi 2016 Annual Meeting

Place: Tokyo, Japan I Keio Plaza Hotel

For more information, please visit **www.htai.org/news-events/upcoming-events.html**

JUN 20-23

Event: 15th Annual International Conference on Health Economics, Management & Policy

Place: Athens Institute for Education and Research (ATINER), Athens, Greece

For more information, please visit **www.atiner.gr/health.htm**

Athens Institute for Education and Research
A World Association of Academics and Researchers

JUN 12-15

Event: Sixth Biennial Conference of the American Society of Health Economics (ASHEcon)

Place: University of Pennsylvania, USA

For more information, please visit **https://ashecon.confex.com/ashecon/2016/cfp.cgi**

ASHEcon 2016
6th Biennial Conference of the American Society of Health Economists Hosted by The Leonard Davis Institute for Health Economics
June 12 - 15, 2016 on the campus of the University of Pennsylvania

ASHEcon
American Society of Health Economists
Penn LDI

JUN-JULY 20-6

Event: York Summer Workshops in Health Economic Evaluation

Place: Foundations and Advanced Workshops: The Grand Hotel & Spa, York city centre

For more information, please visit **www.york.ac.uk/che/courses/short/york-summer-workshops/**

HTAsiaLink

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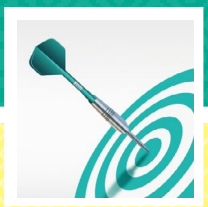

HTAsiaLink was founded in September 2010, the network operates on a voluntary basis, no requirement for membership fees, and no compulsory engagement in particular networking activities.

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