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HTAsiaLink

NEWSLETTER TO STRENGTHEN COLLABORATION AMONG HTA AGENCIES IN ASIA

EDITORIAL

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In recent years, buzzwords such as universal health coverage (UHC), priority setting, and health technology assessment (HTA) have been mentioned in academic circles and recognized in the global health agenda. With support from HTA experts around the world, the World Health Organization (WHO) South – East Asia Regional Office (SEARO) Resolution SEA/RC66/R4 and the World Health Assembly (WHA) Resolution 67.23 on HTA were passed in 2013 and 2014 respectively. These international policies fostered collaborations among existing HTA organizations and moved forward the progress and diffusion of HTA globally.

In keeping with this momentum, in May 2016, members of HTAsiaLink Network and collaborating partners will join together for the 5th HTAsiaLink annual conference to discuss **"The role of health technology assessment in ensuring value for public investment"** in Singapore. The conference is co – organised by the Singapore Ministry of Health, the Health Services Research department of the Eastern Health Alliance and the Health Services Research Institute of SingHealth.

This 9th issue of HTAsiaLink newsletter focuses on **"Building HTA: The Road to Organizational Effectiveness and Efficiency"**. The issue teases out what it means to have organizational effectiveness and efficiency. We illuminate that effectiveness and efficiency is not limited to the establishment of a single HTA organization, but rather institutionalizing evidence – based policy decision making process in the setting. Inputting HTA into the policy process is like a jigsaw puzzle that requires time and effort to complete the picture.

In Asia, many countries are now on at the different levels of institutionalizing HTA to support UHC. In the following articles, we bring you stories of institutional arrangements for HTA in S – E Asia namely the HTA in Malaysia – the first country to pioneer HTA in Asia, and the experiences of the HITAP International Unit (HIU) and ASERNIP – S in facilitating the knowledge diffusion. In addition, this issue features special articles on fostering global links in Horizon Scanning – the story of HealthPACT and an expert interview with HTA guru – Mark Sculpher and Karl Claxton and more.

This issue of the HTAsiaLink Newsletter will not be possible without support from our members – MaHTAS, the Singapore Ministry of Health, ASERNIP – S, HealthPACT. It is our hope that the readers enjoy first – hand accounts of stories from writers in the network. We look forward to more articles and stories from our members and networks to make this newsletter "a story of the HTAsiaLink."

Best wishes,
The Editorial Team

Author: Keng Ho Pwee, Deputy Director (HTA), Ministry of Health, Singapore

5th HTAsiaLink ANNUAL CONFERENCE:

The role of health technology assessment in ensuring value for public investment

3 – 6 May 2016, Duke – NUS Graduate Medical School, Singapore

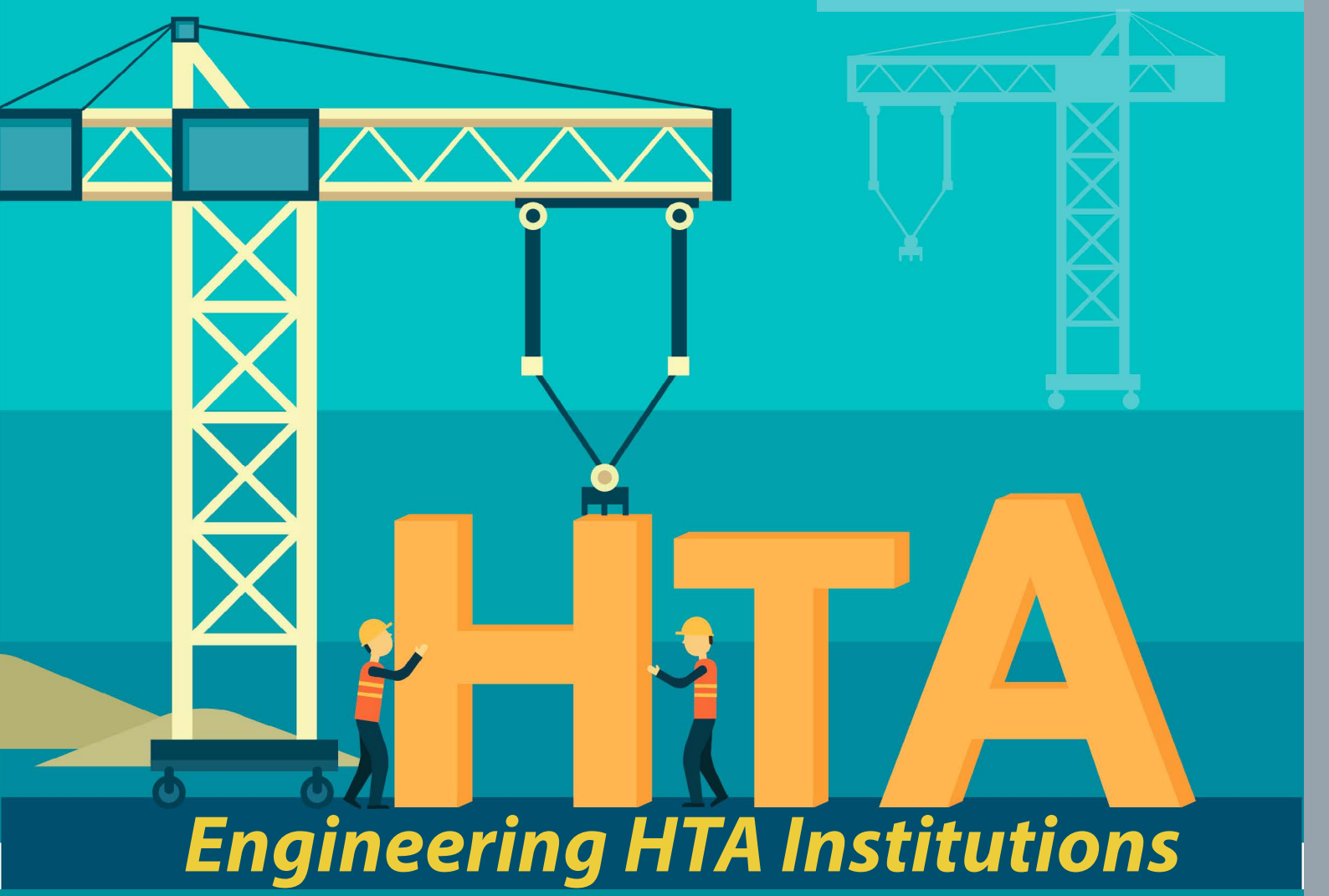
The Asia – Pacific region, which is home to half of the world's elderly population, faces the double burden of chronic and infectious disease among aging populations. Additionally, the rapid emergence of new and expensive drugs coupled with the growing public expectation for accessing such treatments at an affordable level has led to the pressure of delivering high quality healthcare with constrained public funds. These conditions heighten the importance of evidence – based decision making for resource allocation and strategic planning of policymakers and other key stakeholders.

It is therefore natural that the theme for this year's HTAsiaLink conference is "*The role of health technology assessment in ensuring value for public investment*". This will be explored through plenary sessions covering a diverse range of topics ranging from the experiences of a former deputy public health minister, to the role of health technology assessment in comparing hospital performance. Useful workshops are being offered in systems dynamics modelling, critiquing manufacturer's economic models, and a very practical workshop on how to prepare an abstract and presentation for a scientific conference. There will also be the popular oral presentations, with expert commentators on hand to provide constructive comments on improving the content and technique of presentation.

This year's HTAsiaLink conference will take place in the Duke – NUS Graduate Medical School, Singapore, from 3 to 6 May 2016. The elegant Duke – NUS GMS building is located on the Singapore General Hospital campus, right next to the historical College of Medicine building, which houses the Ministry of Health. Organisation of the conference is a collaboration involving the Singapore Ministry of Health, the SingHealth Health Services Research Institute, and the Eastern Health Alliance Health Services Research department.

Registration to the conference and pre – conference workshops is open to all organisational members of HTAsiaLink. The conference website with details of confirmed speakers and the latest programme will be found at www.htasialink2016.sg . Enquiries may be directed to htasialink2016@moh.gov.sg

Author: Karlena Luz, HITAP, Thailand



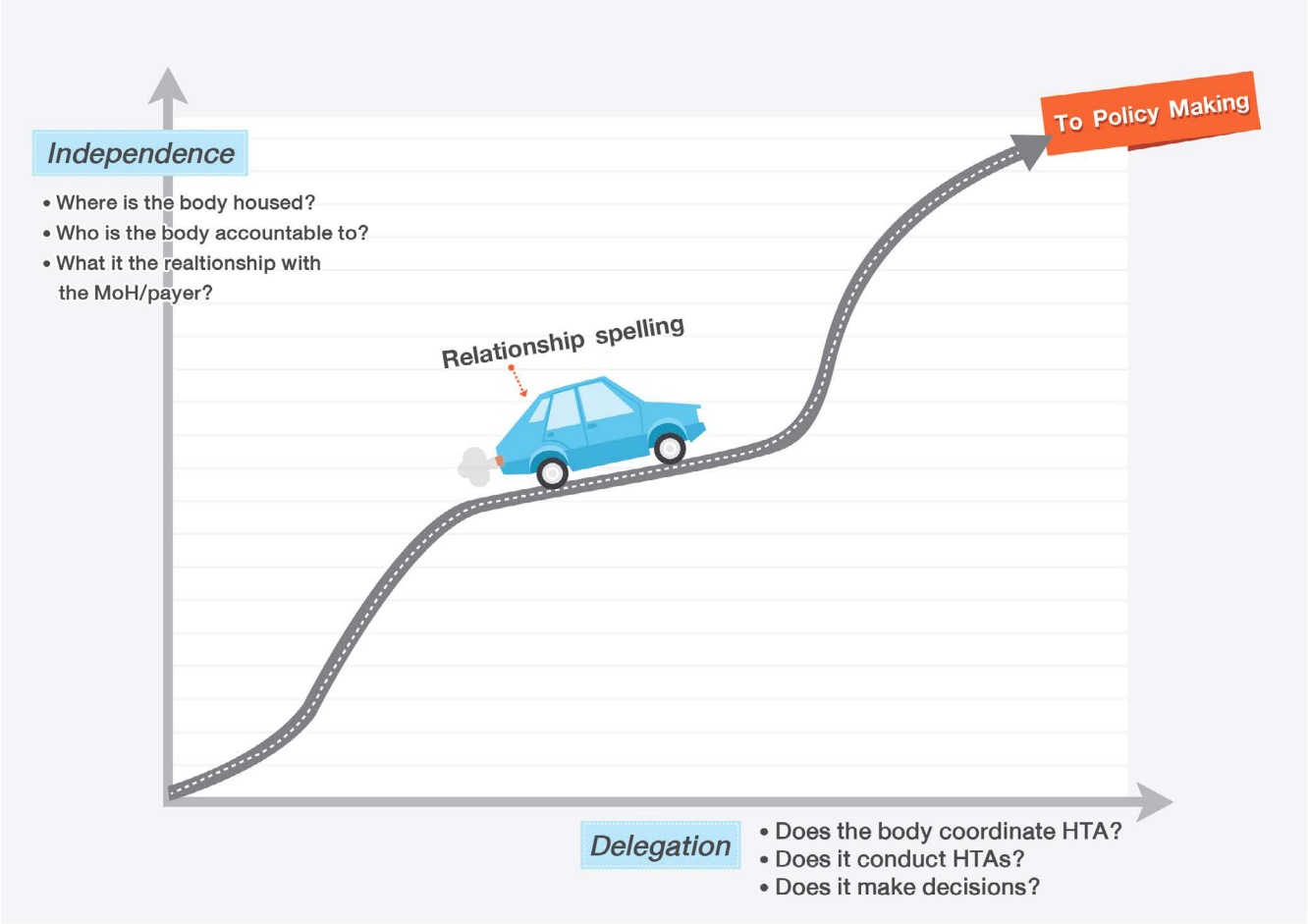
Engineering HTA Institutions

The rationale behind health technology assessment may be conspicuous but its introduction to countries might not be as easily conceived. In the following articles, our focus is geared towards examining institutional arrangements for HTA in S – E Asia. We explore further HTA in Malaysia, the first country to pioneer HTA in Asia. Looking more closely at the introduction of HTA to other countries, we highlight the experiences of the HIU and ASERNIP – S in facilitating the knowledge diffusion of HTA across Asia. Engineering a well – functioning HTA mechanism whose products form linkages to policy may very well take not simply HTA itself, but also a dedicated community of experts, collaborators and capacity builders.

Author: Ioana Vlad, Department of Global Health and Development, London School of Hygiene and Tropical Medicine, UK

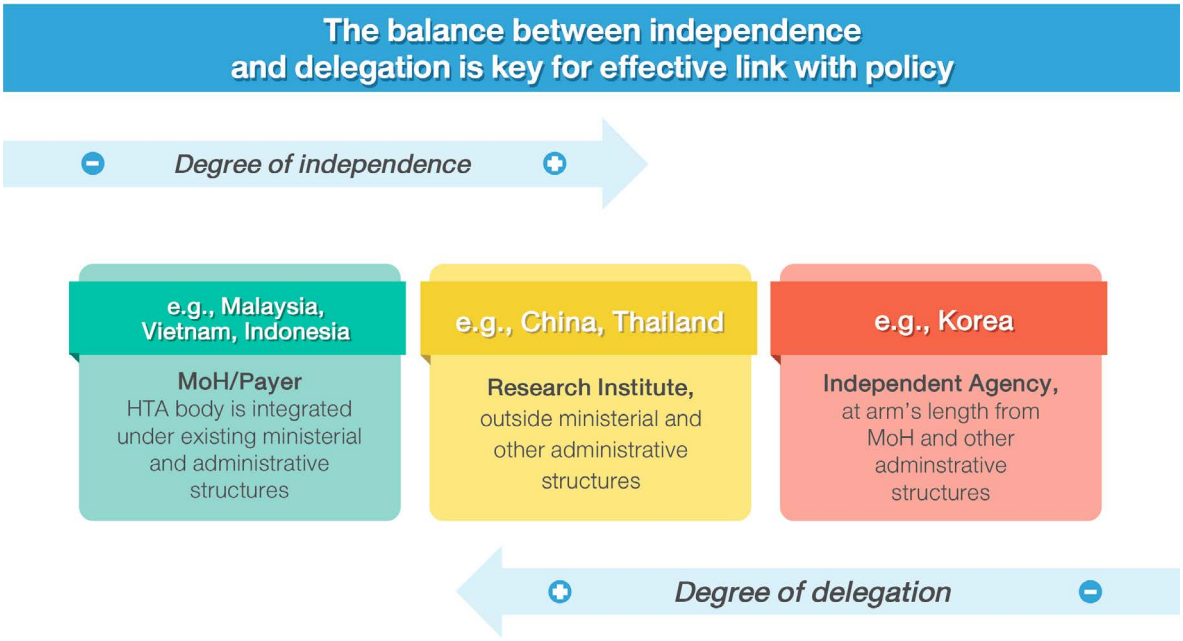
Existing institutional arrangements for HTA in S – E Asia:

How much difference institutional placement makes for effective links with policy – making?



The question of institutional design is an important one for the development of health technology assessment (HTA) as a formal priority – setting mechanism. Terminology referring to existing organizational structures for HTA is quite diverse. Some of the terms used are, for example, "agency", "institute", "body", "committee", "unit", "entity", even HTA "infrastructure" or "systems". Organizational structures for HTA are perhaps more often called "agencies". However, the term agency assumes a specific placement for an HTA organization: an independent body, at arm's length from government, to which central government delegates different degrees of power.

While many HTA bodies are indeed agencies, other models of organizational placement for HTA exist. This placement is a function of the balance between the body's **degree of independence** (being protected from or exposed to political interference) and the **degree of delegation** (the tasks and level of authority the body is charged with)



to government and other administrative structures and the body might be vulnerable to contestation, too far and it might not have effective links with policy.

While it is clear that a balance between independence and delegation must be struck, there is no one – size – fits all entry point for HTA or ideal placement of a new HTA body. Rather, any new body must answer questions as to its preferred and appropriate degree of independence and delegation. It must be understood that while independence is important for impartiality of evidence generation and appraisal as well as for the sustainability of the body – given unavoidable political turn – over, links with policy – making are important for the evidence to be useful and applied to policy, which is the ultimate purpose of HTA. This understanding might then guide other decisions, referring to **a)** the structure of the HTA process, its timelines, the sources of evidence, which technologies to target for economic evaluations and budget impact assessments (and criteria for prioritizing); and **b)** the organization itself (e.g., human resources, degree of transparency, access to data sources).

To exemplify this complex balance, HTA bodies' placement in six South East Asian countries, namely, China, Indonesia, the Republic of Korea, Malaysia, Thailand, and Vietnam are illustrated above. The figure uses data from a recent analysis on conducive factors to HTA development in Asia, focusing on focal points for HTA in each country.

In reality, the relationship between independence and delegation is context – specific and more complex than suggested in the figure; there can be bodies with a both high degree of independence and high degree of delegation or whose placement inside or outside administrative structures is not so clear cut. Consequently, in – depth analyses such as the APO policy brief are helpful in understanding the context – specificity of organizational arrangements. For example, HITAP in Thailand developed as a "semi – autonomous" organization, initially with no formal links to policy – making. Currently, its links to policy decision – making have a degree of formal recognition and HITAP is recognized as a part of the Ministry of Health, although its status as "semi – autonomous" has not changed. As another example, the HTA Committee in Indonesia does not have a clear organizational structure yet, but its existence is formalized through legislation (as is the case for the body in Korea) and the Secretariat of the new HTA Committee is provided by a Ministry of Health department. How the newly established HTA committee will balance its independence and its degree of delegation remains to be seen, particularly in the context of support from the international Decision Support Initiative (iDSI), an innovative global partnership providing technical assistance in the field of priority – setting. As this and other bodies develop, decisions about organizational arrangements should be guided by the need of having strong methodological and process guidelines, as well as a recognition that what "ought to be" needs to be adapted to what is feasible and appropriate for each context.

"In reality, the relationship between independence and delegation is context – specific and more complex than suggested in the figure; there can be bodies with a both high degree of independence and high degree of delegation or whose placement inside or outside administrative structures is not so clear cut."

Author (s): Izzuna Mudla Mohamed Ghazali, Junainah Sabirin, Noormah Mohd Darus, Mohd Aminuddin Mohd Yusof, Roza Sarimin, Malaysia Health Technology Assessment Section (MaHTAS), Ministry of Health Malaysia

HTA in Malaysia: 20 years and beyond

The Malaysian health care system which has evolved from colonial years is generally considered as a dual health care system between the public and private sector. The public health sector is highly subsidised by the government and funded through taxation. It provides a strong health care infrastructure, thus making it universally accessible to the population. Whereas in the private sector, payment is either provided paid out of pocket, by private health insurance or by employers. The private sector provides options for health care to the population.

The health care system is centrally governed by the Ministry of Health Malaysia who plays a major role in funding and managing the health care system at national, state and district level. This is reflected in how Health Technology Assessment (HTA) program was established in Malaysia.

August 2015 marked 20 years of the HTA programme established in Malaysia. The Malaysian Health Technology Assessment Section (MaHTAS) was established in August 1995 under the Medical Development Division, Ministry of Health Malaysia which makes Malaysia the first country in Asia to establish a formal HTA program. The main drive for HTA establishment in Malaysia then, was the increasingly evident on the need for a more effective mechanism for the selection and introduction of technologies into the healthcare system. Moreover, the economic growth in the early 1990s translated to having much increased resources to acquire sophisticated technologies and at the same time, the demand to obtain the best and the latest technology from the public as well as the health care professionals have been greater than before.

Evolution of HTA in Malaysia

MaHTAS was given the mandate to conduct HTA especially on new health technologies that have never been introduced in the Ministry of Health facilities which may have implications on national programme and policy, and existing health technologies where there are concerns about safety, efficacy or effectiveness, and economic implications. The scope of the health technologies includes drugs, medical devices, diagnostics, procedures, organisational and support system. This was stipulated in a policy document signed by the Director General of Health in year 2000. As the main purpose of HTA is for Ministry of Health Malaysia consumption, the request for HTA can only be made by Ministry of Health personnel or other government agencies, and not from industries.

The role of MaHTAS has expanded to include the development of evidence – based Clinical Practice Guidelines (CPG) in 2001. These evidence – based CPGs promote good clinical practice by reviewing, rating, and synthesizing large amount of literature and then making an unbiased, evidence – based series of recommendations on clinical problems. In this manner, CPGs reduced the variation in clinical practice, and eventually improved physician performance and patient outcomes. The transparent, structured process used to develop CPGs makes them easy to use and difficult to abuse. Evidence – based CPGs are direct means of quality improvement and are being used to develop quality measures.

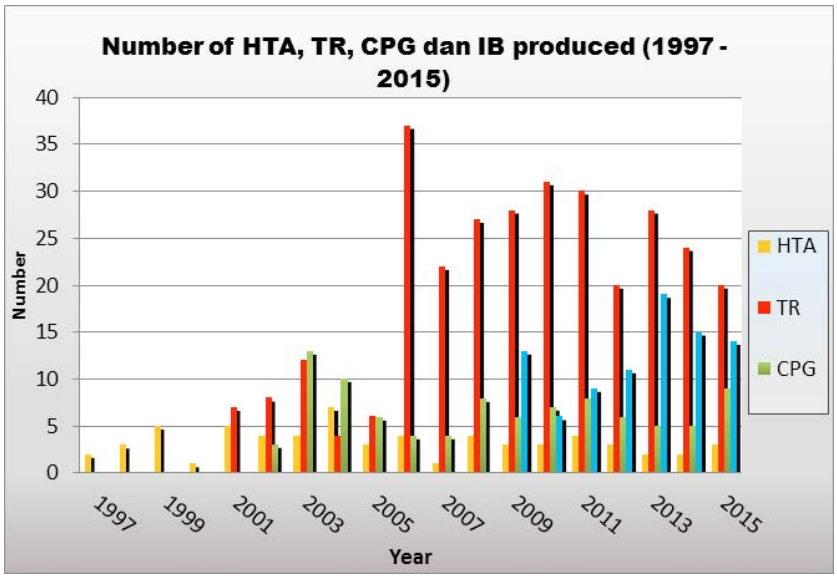
At the same time, MaHTAS started to produce mini – HTA known as Technology Review. This is to cater to the urgent need of the policy makers. In 2009, Information Brief, a rapid assessment report was introduced to cater the need for more urgent information, usually by the top level managers.

In 2008, MaHTAS started CPG implementation programme by producing Quick References, Training Modules and Patient Information Leaflet. Training of the Core trainers were also conducted using the Training Modules developed. All the CPGs developed were also launched to heighten the awareness among all the target users.

Realising that some technologies bypassed the assessment process and were introduced into the market prematurely, in 2014, Horizon Scanning of emerging health technologies were introduced and set up as part of MaHTAS.

Economic evaluation of health technologies which is an important component of health technology assessment is also under the purview of MaHTAS. MaHTAS works closely with academicians and researchers in conducting local economic evaluation of health technologies. Recently, Ministry of Health has recommended one Gross Domestic Product (GDP) per capita as the threshold value for economic evaluation of health technologies in Malaysia. The threshold value will be used as a guide on the affordability for reimbursement of the selected treatment. This will enable Ministry of Health to plan health care budget in a more transparent and efficient way for the advantage of our nations.

Since its establishment, MaHTAS has produced 63 Health Technology Assessment reports, 304 mini – HTA (Technology Review) reports and 87 Information Briefs. MaHTAS has also developed 94 evidence – based CPGs, 21 Quick References, 19 Training Modules, 8 Patient Information Leaflets and has conducted 19 Trainings of the Core Trainers.



TOTAL NO. OF PRODUCTS up to 2015

- *Health Technology Assessment (HTA) reports =* ***63*** *(1997 – 2015)*
- *Technology Review (Mini – HTA) reports = 304 (1997 – 2015)*
- *Clinical Practice Guidelines (CPGs) = 94 (2001 – 2015)*
- *Information Brief =* ***87*** *(2009 – 2015)*

In continuity of its role in advocating informed decision making, MaHTAS conducts awareness programs and training on evidence informed decision making, HTA and CPG for policy makers and other health care professionals. Since 2007, MaHTAS has conducted 14 Systematic Reviews (SR) for Development of Evidence – based CPG workshops, 11 HTA Trainings and 11 Evidence – based Medicine and Critical Appraisal Workshops. In total, more than one thousand health professionals have been trained.

On top of that, the utilisation of HTA and CPGs are continuosly monitored and evaluated through feedback form and periodical survey. This is to ensure the recommendations in the HTA and CPGs are consistently being implemented. At the same time, improvement of the programmes are made based on the feedback received.

Dr. Rugayah Bakri - Head of Malaysian Health Technology Assessment Section (MaHTAS) - presenting in one of HTA training conducted by MaHTAS. Such training is organise at least once a year.)

Groupwork during HTA training conducted by MaHTAS

National HTA Seminar in 2008

Impact of HTA in Malaysia

The rigourous, systematic and transparent methodology applied in the conduct of HTA is the key in ensuring the decisions made are objective and non – biased. Without good evidence, the uptake and diffusion of health technologies is likely to be influenced by a range of social, financial and institutional factors. This may result in suboptimal health outcomes and inefficient use of resources.

Health Technology Assessment findings may directly affect patient's health and lead to more efficient use of scarce resources. HTA assess the safety, effectiveness, cost – effectiveness, organizational and other impacts of the technology to the patients and the health care system.

Many of these reports have been translated into Ministry of Health policy. For example, the National Thalassaemia Prevention and Control Programme, National Cancer Control Programme, and Childhood Immunisation Programme.

A survey on the impact of HTA reports produced from 1997 to 2013 was conducted in December 2014 and January 2015. Follow – up on impact was done via emails, letters or telephone calls to the requestors or programme officers. Data was compiled and analysed using the INAHTA – Framework for reporting on the impact of HTA reports. There were 58 HTA reports (full report) produced from 1997 to 2013 and the impact status was available for 57 reports (98.3%). The survey showed that all the HTA recommendations/ conclusions were accepted (100%), 42.1% of HTA demonstrated that technology met specific programme requirement, 31.6% of HTA material were incorporated into policy or administrative documents, 93% of HTA reports were used as reference material and 87.7% of HTA linked to changes in practice.

The survey reinforced the veracity that HTA reports produced by MaHTAS have a strong impact on the health system in Malaysia.

Way Forward

In line with the dynamic health care environment locally and globally, MaHTAS will enhance its role, as the forefront in advocating informed decision making in Malaysia through various strategies including training, collaboration with strategic partners and the use of social media. At the same time, MaHTAS will continue to strengthen its capacity and capability in producing quality reports.

Author: Nattha Tritasavit, HITAP International Unit, Thailand

The South – South Experience:
HTA Knowledge Transfer and Institutionalization

Disparities in access to health care, health – related financial catastrophe, and chronic illness are only a few of the many adversities faced by society's impoverished and marginalized groups. Universal health coverage (UHC) aims to ensure access to health care, financial protection, and improved health for all, especially important for the poor and socially excluded. Since 2010, the year marking the publication of the World Health Report on the path to universal coverage, commitment to UHC has been increasingly recognized as a priority global agenda. Multiple events exhibiting commitment to UHC by multilaterals and governments followed not long after: adoption of the 2012 United Nations (UN) resolution on UHC and the 2016 Prince Mahidol Award Conference Bangkok Statement on priority – setting for UHC, and a target of the Sustainable Development Goal 3 on achieving UHC.

The introduction and sustainability of UHC, however, is not without its challenges. As countries face ever – growing needs for already scarce resources, governments are obligated to determine the best use of available resources to gain the greatest amount of benefits for the population. Health technology assessment (HTA) is one of the tools used in health care priority – setting, especially for determining appropriate allocation of resources for health care interventions or technologies, taking into consideration clinical effects, health outcomes, social, economic, and ethical issues. Yet, fully established HTA agencies are still few and far between, particularly in regards to those in developing countries. It becomes particularly important, then, for HTA agencies in low – and middle – income countries (LMICs) that already have a clear link to policymaking to offer assistance to facilitate and develop such mechanisms in other LMICs.

The Health Intervention and Technology Assessment Program (HITAP) International Unit (HIU), has work that focuses on South – South collaboration (SSC), encouraging LMICs in the region to institutionalize HTA for UHC and supporting HTA capacity building at the individual and organizational levels. On a broader level, South – South Cooperation fosters communication between developing countries and, as countries may share borders or economic interests, strengthens the voice and bargaining power of developing countries for negotiations. The advantage of our SSC on HTA is such that certain types of information are transferable and generalizable, to an extent, across settings; for example, the South – east Asia region may have similarities in disease burdens and countries in the region may be better able to understand sociocultural similarities and differences, which helps to strengthen partnerships. We learn from each other through experience sharing and knowledge transfer and exchange, raising awareness of HTA and gauging a country's HTA need, demand, and supply. Further along the process, we encourage principles of transparency and participation, and reinforce methodological rigor and robustness by supporting the development of process and methods guidelines. Most importantly, we build trust, professionalism, and camaraderie in our partnerships.

> "Nevertheless, there is always room for improvement for SSC, not only in our work, but also globally. More established coordinating mechanisms in and between countries would increase the efficiency and effectiveness of long – distance support."

Despite the advantages of SSC, recognition of agencies in the Global South is not necessarily as high as those in the Global North. Stakeholders may view agencies in the Global North with higher esteem, and therefore may prefer North – South collaboration. Furthermore, we have found common challenges inherent in introducing HTA to countries that have not yet formalized it. Frequently, we hear that there are inadequate financial resources or a lack of political will and commitment to make evidence – informed decisions. Such challenges are prominently quoted, and fairly so, but our greater concern is to ensure demand – driven, inclusive, and sustainable HTA development in – country. Adapting technical and policy support to be context – specific, garnering local commitment, and information sharing work toward establishing HTA systems; on the other hand, focusing only on technical aspects of HTA and inadequately emphasizing the significance of the policy process, and also bureaucratic leadership delay the institutionalization process. Additional challenges include unrealistic expectations for observable, high impact of HTA institutionalization within a short period of time and misconceptions that the number of HTAs produced is more meaningful than the consideration and/or use of HTA results and recommendations in the decision – making process. Moreover, there is no one – size – fits all model of institutionalizing HTA so each partnership requires two – way learning and adaptation of models to suit the local context.

We have seen significant progress in our SSC, in particular, with Vietnam and Indonesia. The greatest success to date is the request for evidence to inform the Basic health Benefit Package (BBP) by the Ministry of Health (MoH) in Vietnam, and the synergic efforts put forth by several international organizations to support HTA institutionalization in Indonesia as well as the high – level commitment from MoH authorities and the HTA committee assigned to oversee this endeavor. These accomplishments have arisen as a result of approximately two years of SSC, a relatively short amount of time.

Nevertheless, there is always room for improvement for SSC, not only in our work, but also globally. More established coordinating mechanisms in and between countries would increase the efficiency and effectiveness of long – distance support. More worrying is the greater demand for support in LMICs compared to the supply of well – established HTA agencies in these settings. Raising awareness of the need for and increased attention to strengthening HTA agencies in developing countries is needed to secure support from global donors and international organizations without vested interests. Other approaches that may help strengthen HTA agencies include the establishment of regional networks (e.g. HTAsiaLink) or regional hubs (one of the efforts under the international Decision Support Initiative). Finally, collaborations between HTA agencies are not limited to bilateral partnerships – South – South collaboration does not necessarily lead to exclusion of supplemental support from the Global North; in fact, employing a multitude of disciplines, perspectives, and skillsets is at the heart of knowledge transfer and exchange.

Author (s): David Tivey, Jani Mueller, Wendy Babidge, Tom Vreugdendurg and Guy Maddern
Royal Australasian College of Surgeons (ASERNIP – S)

Royal Australasian College of Surgeons, ASERNIP – S: forging collaborative training links to build capacity in Health Technology Assessment (HTA).

A demand for new and quality medical products and services is rising worldwide. Introducing health innovations into practice requires policy and decision makers to accept only safe and effective technologies; this requires timely generation of accurate evidence. Multi – disciplinary health technology assessment (HTA) teams provide such evidence through transparent and reproducible methods.

In order to conduct and understand reports using the methodology and formal processes of HTA it is imperative to transfer knowledge from experts to current and future generations of researchers and decision makers. Although formal training and educational programs on HTA are available in industrialized countries, they are less available in many low to middle – income countries. As such, there is an urgency to provide quality training that is appropriately costed and readily accessible, especially when financial and human resources are limited.

An international collaborative effort is required to identify and deliver HTA training. This transfer of knowledge and experiences will sustain, grow and promote acceptance of HTA. To play our part, ASERNIP – S is actively engaged with international and national HTA organizations and research groups.

Creating a repository of global HTA training opportunities: ASERNIP – S staff have taken a lead role in coordinating the development of an online database to support global training in HTA for the International Network of Agencies in Health Technology Assessment (INAHTA) and Health Technology Assessment international (HTAi). This initiative aims to develop an organized, up – to – date database of HTA training resources that is freely accessible. This includes training in general HTA methods, as well as specific areas of interest such as health economics, health policy, and scientific writing.

To have an impact this resource needs regular maintenance. To achieve this, the development team have sought out and engaged with passionate and skilled HTA educators to take on the role *Regional Ambassadors*. Our volunteer *Regional Ambassadors* will search for local training activities and extract relevant courses information. To reduce duplication in effort, we have shared these tasks based on region and language.

We welcome input from individuals and providers of HTA training. If you are interested in contributing to this project, please email the HTAi Vortal Section Editor – Training (tom.vreugdenburg@surgeons.org).

Developing training to upskill healthcare professionals: ASERNIP – S has joined with the Charlotte Maxeke Medical Research Cluster (CMeRC) to develop a 12 – month fellowship program that provides participants the opportunity to learn from experts. To maximize our development time and avoid duplication we will call upon the database of HTA training resources.

During the fellowship we will challenge Fellows to put theory into practice by producing and using HTA reports. They will achieve this through a combination of face – to – face and online sessions that will involve active support from the mentors. Fellows will produce an HTA report on a technology relevant to their clinical setting and present their findings at a yearly conference to culminate the program. These HTA reports will inform decision and policy makers at the local, regional and national health care system levels.

The first presentation of this fellowship will commence in June this year. If you are interested in learning more about the program, please email the training coordinator (david.tivey@surgeons.org).

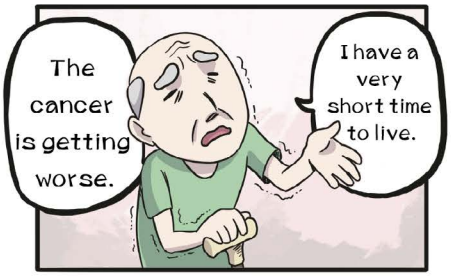
"An international collaborative effort is required to identify and deliver HTA training. This transfer of knowledge and experiences will sustain, grow and promote acceptance of HTA. To play our part, ASERNIP – S is actively engaged with international and national HTA organizations and research groups."

Author: Warut Lertsarawut, HITAP, Thailand

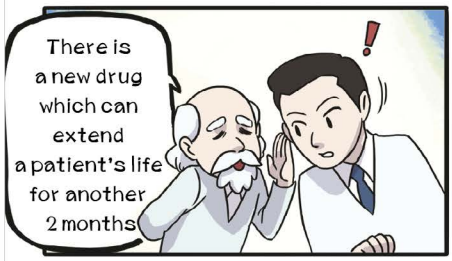
Bittersweet
Tough C

In a country named *"great health"*, ***Dr. Mana*** was appointed as the new health minister.

While Dr. Mana declared his policy on providing the best health services for everyone, the finance minister was uneasy about Dr. Mana's decisions.



In front of the stage, ***uncle Boon-mee*** who is suffering from lung cancer, came to ask Dr. Mana to include a new cancer drug in the benefit package.



At that time, the new cancer drug that is said to be able to extend patient lives was available. However, this drug was also extremely expensive.

Dr. Mana suddenly approved the new cancer drug and included it in the benefit package.

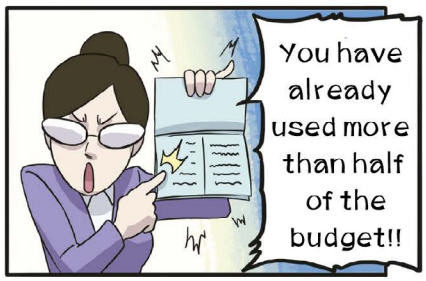
After seeing how fast Dr. Mana approved the new drug, ***patients with obesity*** also requested for Bariatric surgery.

Dr. Mana pondered awhile... approved! Laparoscopic surgery for every obesity patient!

Somewhere in the corner, ***Alzheimer patients*** demanded access to a new drug which claimed to cure the illness.

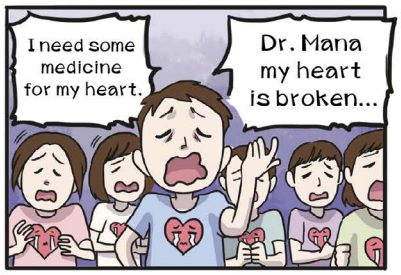
Although there was evidence that the drug does not actually cure the disease, but only delays the patient's decline. Dr. Mana approved the drug for all stages of Alzheimer patients.

t Decisions
Choices



The finance minster warned Dr. Mana that he needs to carefully control the country's health budget, as they will be in danger of overspending.

Dr. Mana suddenly immersed in deep thoughts as he weighed between balancing budget constraints and meeting patient needs.



At that time, ***patient with Cardiovascular disease*** also ask for the new treatment.

Again, Dr. Mana approved the new Cardiovascular treatment. The finance minister was not happy.

She stated that the health budget surplus is now negative

But there are still many patients waiting for help. ***Kids with refractive errors*** are waiting for their new glasses to help them see things clearly.

Meanwhile, ***patients with hypertension*** also need new drugs.

As a decision maker, will there be any way to help Dr. Mana come up with a better decision on how to best use public resources?

What is ***HTA***? and how will it support policy makers in the efficient use of resources?
To be continued in the next issue.

Author: Linda Mundy, Health Policy Advisory Committee on Technology (HealthPACT), Australia and New Zealand

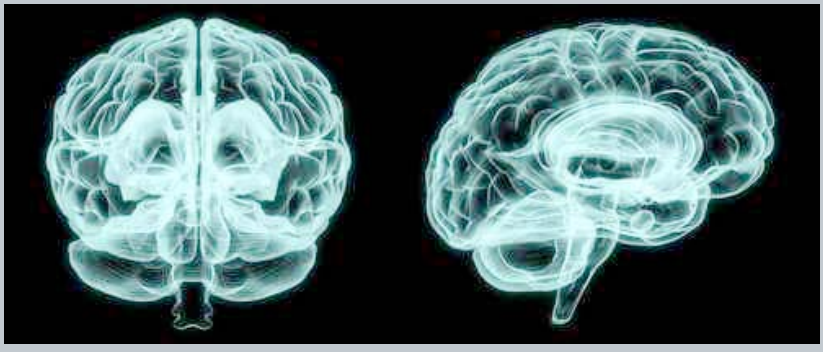
Fostering global links in Horizon Scanning

HealthPACT was created in late 2003 to become Australia and New Zealand's only horizon scanning agency for new healthcare technologies. HealthPACT has been an active contributing member of EuroScan since 2005. During HealthPACT's first operational year our horizon scanning methodology was developed and underwent some fine tuning: What were the best sources to scan? What did we want our product to look like? Who was our target audience? It was reassuring to us, as a new operating network within Australasia, that we could benchmark ourselves against other horizon scanning agencies that were also members of EuroScan. Membership of EuroScan gave us confidence that our methodology was world's best practice, which is reflected in the recently published EuroScan toolkit for the identification and assessment of new and emerging health technologies. In addition, membership gave us confidence that we were, in fact, identifying technologies that were on the horizon and likely to impact on the public health systems of Australia and New Zealand.

Above all, the links that we fostered through attending EuroScan meetings and HTAi, made us realise more than ever that we are all grappling with the same issues in our health systems: the impact of high – cost disruptive technologies, the need to spend the public health care dollar wisely in times of fiscal restraint, and the ultimate goal of providing appropriate care to all patients.

Of most value to HealthPACT is the ability to search the EuroScan database for assessments performed by other agencies. Like most other agencies involved with health technology assessment, HealthPACT's day – to – day operating budget is constantly under review to ensure that we deliver value for money. Unlike the majority of EuroScan member agencies, HealthPACT does not assess pharmaceuticals. However, the number of technologies of relevance to HealthPACT added to the EuroScan database remains high and by sharing these assessments, we reduce duplication of effort. More and more HealthPACT is looking to make use of this valuable resource, and although at times the context of the technology's use may vary, assessments can usually be adapted to reflect the local, Australasian context. We also know that many of HealthPACT's assessments are found to be useful to other member agencies. More recently, EuroScan members have begun to share information around disinvestment, which although is not strictly horizon scanning, it remains an important issue for all the health services that EuroScan members report to.

In short, EuroScan provides a collegiate atmosphere in which to discuss issues around the assessment of new health Care technologies. With a broader membership from the Asia – Pacific region, who knows, we may even get the name changed to AsiaScan!



Author: Karlena Luz, HITAP, Thailand

Mark Sculpher
Professor
Centre for Health Economics
University of York

Karl Claxton
Professor of Economics
Centre for Health Economics,
University of York

TWO-CENTS IN

In the recent Prince Mahidol Award Conference (PMAC) 2016, the featured theme was devoted towards strengthening health priority setting in support of resource allocation and policy development to reach universal health coverage (UHC). The conference was packed with health practitioners, policy makers and most especially experts on health technology assessment (HTA) and priority setting. In an informative session on *Advanced Workshop on Methods for HTA*, analysts of the National Institute for Health Care and Excellence (NICE) Technology Appraisal Committee, Mark Sculpher and Karl Claxton, put in their two cents on the experiences of HTA in the UK.

Despite the differences in terms of the health context in high – income countries (HICs) and low – and middle – income countries (LMICs), the longevity of HTA in HICs, especially in Europe entail great lessons for countries that are at the nascent stage of institutionalizing HTA. Mark and Karl, no holds barred, share their thoughts on HTA in LMICs on the following topics:

What definition of HTA do you subscribe to?

Mark: HTA is a term that is used quite loosely. It seems that the formal definition is to provide an assessment of medical technologies using different perspectives including clinical, economic, ethical and technical. But I think the meaning that it has developed in some parts of the world relates to its use in supporting resource allocation decisions, particularly when technology should be funded from available resources.

So when you're talking about HTA it's about prior to decision making, but what about after the decision has been made? Will there be HTA afterwards, looking at policy and programs that has been implemented and to see whether it's really working and it's really value – for – money?

Mark: If you work on that principle to describe it as research to support decisions, then the question is when the decisions are made. For most types of resource allocation, there isn't just one decision that is binding for the rest of time and indeed there is often flexibility on the part of health systems about how they make decisions overtime so it is entirely possible and indeed desirable to guide decisions overtime.

What do you think are the top priority methodological issues of HTA?

Mark and Karl: Opportunity Costs & Uncertainty

Unless you know how much you can afford to pay for the benefits that a development might have to offer, you don't know the value of the investment, i.e. **the issue of opportunity cost**. So it then becomes relevant to benefits package designs, to prices that health care systems can afford to pay for technologies, to pharmaceutical pricing, tiered pricing, and especially to issues around development in the sense of apprising the right development given resource constraints.

When health care systems make decisions about medical technologies, the evidence is often highly immature, i.e. **the issue of uncertainty.** So apart from just saying, well it's too uncertain, we can't do anything, what should a decision making body say about uncertainty. How should we help a decision making body think about uncertainty?

Do you think HTA institutionalization should be approached in a top – down manner or a grassroots bottom – up approach?

Karl: I think it depends on who's got the problem; who's got a difficult decision and whether that's high – level or whether that's at the grass – roots level, I think it depends on the context of the health system, on the context of which decision – makers have got really problematic issues to solve who are open to the possibility of being informed by the work that we do.

In terms of promoting HTA, what do you suggest for countries that don't have this kind of system to move towards that stage?

Karl: It's about key people who've got important problems where we believe that we could help them or provide analysis that could help them work through those problems; identify those key people and demonstrate early the value of taking a systematic approach.

For the full interview transcript, visit http://www.globalhitap.net/blog/ where Mark and Karl discuss on issues surrounding uncertainty and the applicability of HTA in LMICs.

Author: Keng Ho Pwee, Deputy Director (HTA), Ministry of Health, Singapore

A/Prof Richard King with the senior management and medical device committee of Ng Teng Fong General Hospital

Visiting Expert in Hospital – based Health Technology Assessment (HTA), Associate Professor Richard King, recommends HTA to support decision – making in Singapore hospitals

A/Prof King consulting with the Singapore General Hospital medical device committee

A/Prof King with staff from Eastern Health Alliance Health Services Research

The Eastern Health Alliance Health Services Research Department, in collaboration with the Singapore General Hospital, hosted a week – long visit by Associate Professor Richard King from 19 to 23 October 2015. Associate Professor King, Senior Medical Director in Monash Health, Australia, was brought in under the Ministry of Health's Health Manpower Development Programme as the 2015 visiting expert in hospital – based health technology assessment (HTA). During the week, Associate Professor King visited several public sector hospitals and consulted with senior management, medical device committees (MDCs) and their supporting staff. At each hospital, staff shared their processes for introducing technologies, and Associate Professor King shared his work on chairing the New Technologies Committee of Monash Health and the importance of HTA in the decision – making process.

Associate Professor King lectured on "*Evidence Based Introduction Of Health Technology and Disinvestment – Two sides of the same coin*". Associate Professor King also conducted two workshops on hospital – based HTA, one targeted at MDC members and hospital decision – makers, who use HTA in their decision – making; and the other targeted at staff supporting MDCs and doing the HTA. The workshop for decision – makers was exceptionally well – received, with many staying back to continue discussion with Professor King.

Following his visit, Associate Professor King made valuable recommendations on how MDCs could be improved and recommendations in relation to HTA support for hospitals.

Author: Apinya Mattadet, HITAP, Thailand

HTA Calendar

May – December 2016

Cochrane Colloquium Seoul 2016

Brief: An annual flagship events of Cochrane, bringing together Cochrane contributors from around the world to discuss, develop and promote Cochrane, and help shape its future

Date: 23 – 27 October 2016

Location: Grand Hilton Seoul, Korea

Who should attend: Researchers and scientists, health practitioners, Policy makers, consumers and patients, Cochrane contributors and staff

Registration dates: 1 April: registration opens, 10 August: early registration closes, 10 October regular registration closes and 11 October: late and on – site registration.

Fee: Price varies with types of registration

More details: https://colloquium.cochrane.org

Cochrane Colloquium Seoul
Oct 23 – 27 2016
Grand Hilton Seoul, Korea

5th Annual ARCC Conference: Canada's Applied Research in Cancer Control Conference

Brief: This conference is to bridge a connection between researchers and decision–makers, using health economics, services, policy and ethics research to improve cancer control and the delivery of cancer care.

Event Date: May 8, 2016 – May 9, 2016

Location: Toronto, Ontario

Organizer: The Canadian Centre for Applied Research in Cancer Control (ARCC)

More details: http://cc – arcc.ca/arcc – conference – 2016/

Valuing the Signal and Noise in Health Care Horizon

Brief: A session by Emergency Care Research Institute (ECRI) at the DIA 2016 52nd Annual Meeting that aims to discuss how horizontal scanning methodologies like hits, misses and others can provide a useful view of emerging technologies and the future healthcare landscape.

Date: 28 June 2016

Location: Pennsylvania Convention Center

Organizer: DIA (Develop, Innovate, Advance), a global forum for knowledge exchange in health.

Registration: http://www.diaglobal.org/Flagship/DIA – 2016/About/Register

More details: https://www.ecri.org/events/Pages/stewart_dia – 2016.aspx?tab=5

Priorities 2016 Conference – New frontiers of priority setting

Brief: 11th meeting of the International Society for Priorities, a venue for researchers, clinicians, policy makers and managers involved in priority setting come together to exchange research, ideas and experiences

Date: 7 – 9 September 2016

Location: Medical School, University of Birmingham, UK

Organizer: Health Services Management Centre (College of Social Science) and the Department of Health Economics (College of Medical and Dental Sciences), University of Birmingham

Conference registration: Early bird is now – 3rd June 2016

Fee: Price varies with types of registration

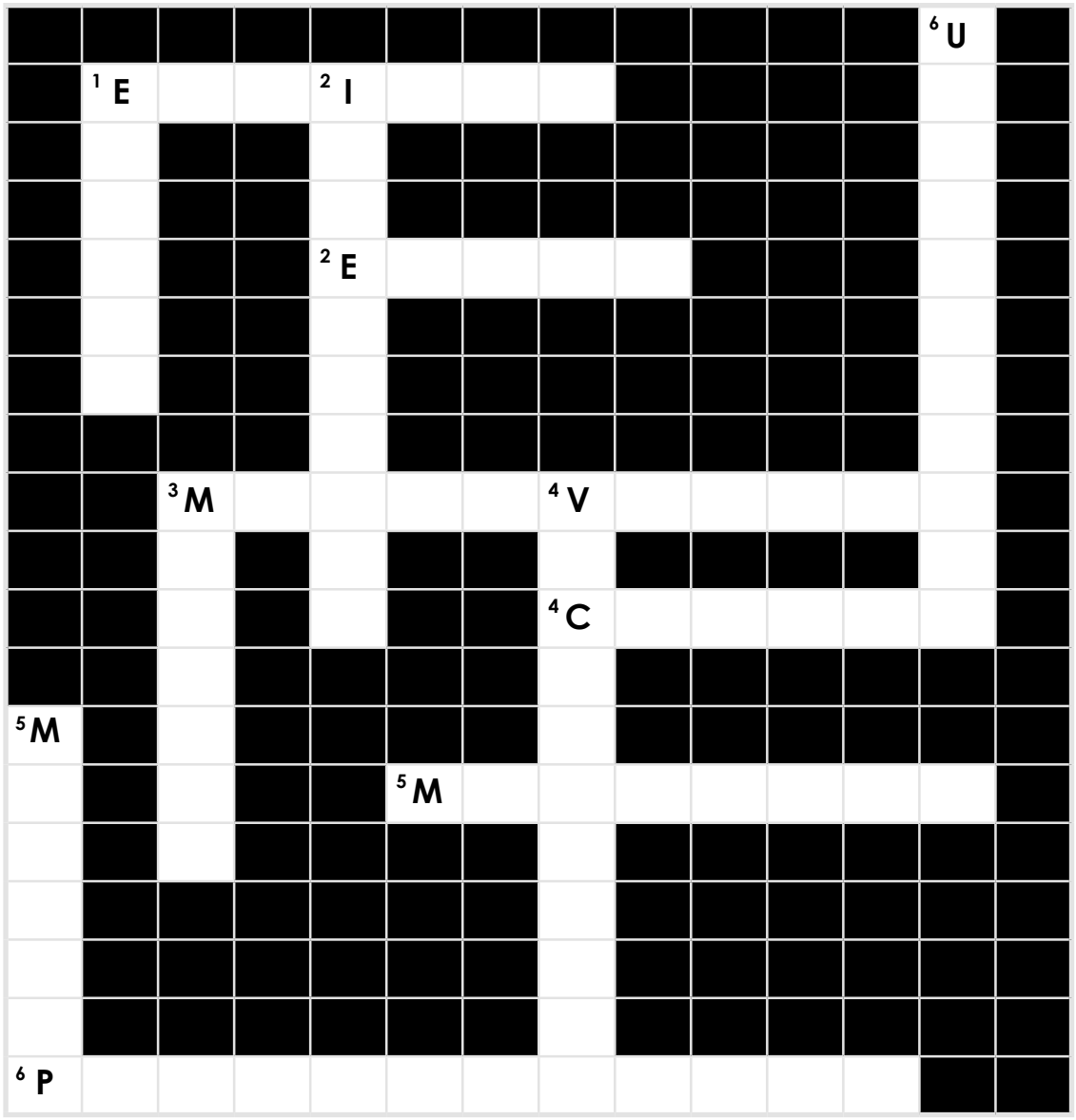
Contact: priorities2016@contacts.bham.ac.uk

More details: http://www.birmingham.ac.uk/priorities2016

PRIORITIES 2016
International Society on Priorities in Health Care
7 - 9 SEPTEMBER 2016

COLUMN GAME

Author: Apinya Mattadet, HITAP, Thailand



Across

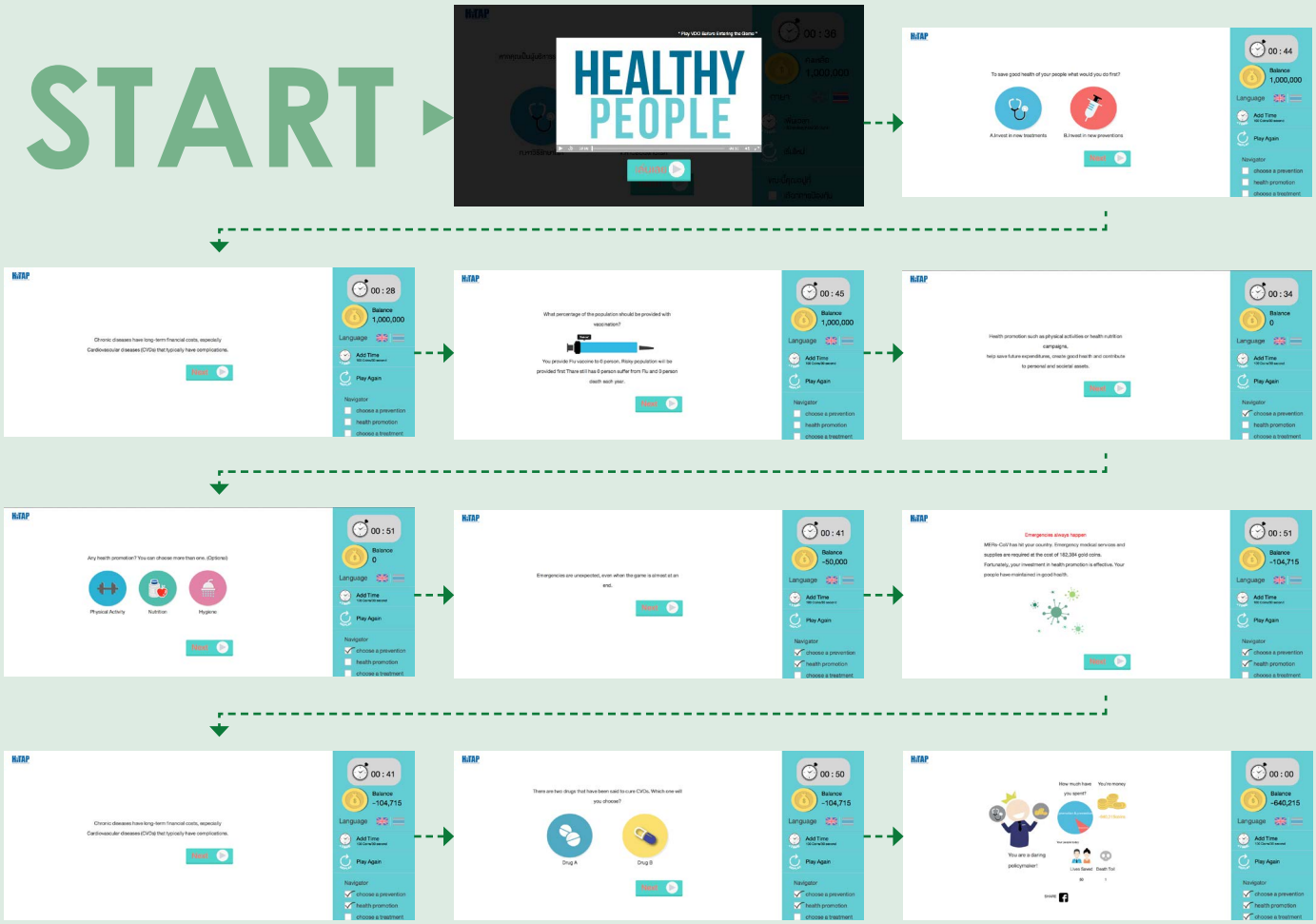
1. HTA investigates not only cost – effectiveness but also considers societal, legal, and ….. viewpoint.
2. An easy way to send a request asking to be a HTAsiaLink member is….
3. Modelists do this to demonstrate that future states of events you are interested in depend only on the present state.
4. It is another word for "tree top" walk. When you join HTAsiaLink Annual Conference 2016 in Singapore, you should visit MacRitchie Reservoir Park for an experience of tree top walk.
5. In what country is this HTAsiaLink member located? (Hint: see page 13 of the previous issue)
6. Badan ….. Jaminan Sosial (BPJS) is a Healthcare and Social Security Agency in Indonesia newly established in 2011.

Down

1. … is an important ethical consideration in HTA.
2. This group of proteins has a name whose meaning is having ability to interfere with viral proliferation. It has a nick name too, IFN.
3. HSPI and HITAP is doing a HTA research on diffusion, investment and utilization of… Resonance Imaging in Vietnam.
4. According to WHO providing…….against influenza viruses is the most effective way to prevent infection and severe outcomes.
5. It is a learning technique in a radiant manner rather than linier like listing.
6. ….. affects discounting.

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 (10th issue, Jan-Jun 2017)

Author: Chalarntorn Yothasmutra, HITAP, Thailand



The Price of Life Game:

Once a coin is spent on one choice, it cannot be spent on another. How many lives can you save?

The Price of Life Game – the first online game for HTA and priority setting field. The game will let you make life and death decision to save the nation.

Once upon a time, there was a country where people never lived happily ever after because health problems fell upon the town from time to time. To save people's lives, you must invest in various solutions through the UHC benefit package. You are the policy maker and you have to make the appropriate decision to spend gold coins to save the lives and the country.

Click here to play the game **www.thepriceoflife.net**

HTAsiaLink Newsletter

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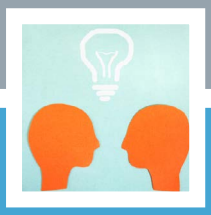


HTAsiaLink is a network to support collaboration between Asian health technology assessment (HTA) agencies. It focused on facilitate HTA research by accelerating information and resources sharing and developing an efficient methodology for HTA in the region.

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