Report: Indonesian Delegation

Study Visit to HITAP

1 February, 2016

Reported by Health Intervention and Technology Assessment Program

Acronyms and Abbreviations Used

BP	Benefits Package
BPJS	Badan Penyelenggara Jamina Sosial (Agency for the Organization of Social Insurance)
CAPD	Continuous Ambulatory Peritoneal Dialysis, in this document referred to as “PD”
COF	Commissioning Outcomes Framework
CUA	Cost Utility Analysis
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
HD	Hemodialysis
HEWG	Health Economics Working Group
HITAP	Health Intervention and Technology Assessment Program, Thailand
HSRI	Health System Research Institute
HTA	Health Technology Assessment
HTAC	Health Technology Assessment Committee, Indonesia
iDSI	International Decision Support Initiative
MoH	Ministry of Health, Indonesia
MoPH	Ministry of Public Health, Thailand
MoU	Memorandum of Understanding
NHSO	National Health Security Office
NICE	The National Institute for Health and Care Excellence
NI	NICE International
NIHR	National Institute for Health Research, UK
NLEM	National List of Essential Medicines
PAH	Pulmonary Arterial Hypertension
PICs	Persons in Charge
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

The Indonesian government is strongly committed to Universal Health Coverage and acknowledges that health technology assessment (HTA) as an important tool for setting priorities for the health benefits package. Since the establishment of the HTA Committee, a number of Ministry of Health (MOH) and academic staff in Indonesia were trained and 3 HTA studies have been completed.

The presence of high level policy makers such as Dr. Untung Suseno Suharto, the Secretary General, in the Prince Mahidol Award Conference 2016 from the MOH affirms the commitment to HTA development. The conference highlights that the main challenge of UHC is to allocate scarce resources; as such, HTA is extremely relevant to the many low- and middle-income countries such as Indonesia.

International development partners including the World Health Organization, US Agency for International Development, and the International Decision Support Initiative (IDSI) led by NICE International and HITAP are fostering and building a strong collaboration with each other and the MOH to ensure long-term sustainable capacity development for HTA, which includes technical, policy and institutional capacity. It is important that HTA is effectively linked to policy, especially on the development of the national formulary and the UHC benefits package.

While NICE and HITAP, which are permanent HTA agencies in the UK and Thailand, are sharing their experiences to Indonesian partners, Indonesia must develop their HTA system in order to suit the local context, political economy, and government arrangement.

Introduction

At the beginning of 2014, Indonesia launched its universal healthcare program, the Jaminan Kesehatan Nasional (JKN), which will cover all Indonesians by 2019. By the end of the year, the Badan Penyelenggara Jamina Sosial (BPJS Health), became the administrator of the largest health insurance scheme in the world with over 133 million people enrolled[1]. In terms of financing, the JKN is a tiered premium-based system supplemented by government subsidies fully covering the poorest. The costs of the program are estimated to be around USD 13-16 billion per year until the JKN is fully rolled out[2]. The ambitious nature of the program, challenges for implementation and high costs associated with bringing healthcare to all brought priority setting to the fore and a Presidential Regulation in 2013 that called for the use of health technology assessment (HTA) in deciding the benefits covered by the scheme[3].

The Health Technology Assessment Committee (HTAC) was set up in the Ministry of Health (MoH) to serve as the secretariat for HTA activities. It has received support from various international partners including the International Decision Support Initiative (iDSI) through which the Health Intervention and Technology Assessment Program (HITAP) has been providing technical assistance. To date, three HTA studies have been completed as part of this collaboration, one on the treatment of End Stage Renal Disease (ESRD), another on the treatment of Pulmonary Arterial Hypertension (PAH) and the third, an economic evaluation of the Package for Non-Communicable Disease Interventions (PEN) in Indonesia. This year, a delegation from Indonesia, including high level policy makers, participated in the Prince Mahidol Award Conference (PMAC) at the end of January 2016.

In continuing this partnership, the Indonesian delegation attending PMAC stayed on to participate in a half day meeting at HITAP on Monday, 1st February 2016 at HITAP's office premises. The broad objectives of the meeting were to focus on learning about the topic selection process in Thailand, identify barriers to the sustainability of HTA in Indonesia and to discuss areas with which the delegates needed help from external partners. In addition to learning about the HTA process in Thailand along with comparisons with the UK model, the discussion brought up key issues around the status of HTA in Indonesia as well as the challenges going forward. The report is structured to provide details of this discussion followed by an update on the next steps and concluding remarks along with supporting information in the Annex.

Details of the Discussion

This section provides a detailed description of the issues discussed over the course of the half day meeting. Delegates from Indonesia included high level policy makers, staff from HTAC, BPJS as well as WHO and USAID. NICE International (NI), HITAP and high level officers from Thailand's Ministry of Public Health were also present (see Annex 1 for full list of participants). There were broadly three objectives of the meeting: one, to share HITAP's experience with the topic selection process, which had been found to

1 "Indonesia Economic Quarterly In times of global volatility", The World Bank Group, October 2015. Available at: http://www.worldbank.org/en/news/feature/2015/10/22/indonesia-economic-quarterly-october-2015
2 "Indonesia's universal health care goals", Oxford Business Group, 2015, Available at: http://www.oxfordbusinessgroup.com/overview/indonesias-universal-health-care-goals
3 "Regulation Of President Of The Republic Of Indonesia No. 12 Year 2013 Concerning Health Care Benefits", Translation – Presidential Regulation No. 12/2013 Social Protection Team, The World Bank, Jakarta Office. Available at: www.social-protection.org

be an issue that the Indonesian delegates wanted to learn more about, two, to identify the barriers to the sustainability of HTA in Indonesia and three, to discuss the areas in which iDSI, through NI and HITAP, could provide assistance (see Annex 2 for the agenda).

Opening remarks were made by Dr. Somsak, from Thailand and Dr. Untung from Indonesia, followed by a presentation by Dr. Yot. The main discussion points were around three issues: 1) *Understanding the HTA process in Thailand and its relevance to the situation in Indonesia*, including clarifications on the topic selection process which was presented, the process for implementation of HTA recommendations, treatment of public health interventions, the process for development of the drugs list as well as the role of the NHSO in comparison with BPJS. 2) *Discussion on elements of the HTA process and their practical application*, covering issues such as comparison of HTA systems across countries, seeing HTA as a multi-disciplinary, evidence based approach, and recognizing the importance of stakeholders. 3) *Tackling specific issues concerning HTA in Indonesia* such as the challenges and options for research in Indonesia, a presentation by Dr. Sudigdo on the HTA studies conducted in Indonesia, a discussion on the next steps of the HTA studies conducted and whether there is a "knowledge gap" or an "action gap", discussion on the development and application of guidelines for the HTA process and reflecting on country specific factors including a cultural and institutional change. These points are elaborated on below.

1. Opening and framing remarks

The session was opened and chaired by Dr. Yot. Tony spoke first and explained his role in the process going forward including communicating the needs of Indonesian delegates to NICE International and identifying partners. He also recommended that the Indonesian delegates consider sending people to York to study health economics as it is the oldest training center in Europe. Outlining what the next steps would involve, Tony said that it would be important to flesh out a menu of what needs to be done and how to ensure that researchers do work that will be useful giving the example of England where this has been done successfully and can be shared. In the course of the day, Tony asked the group to think about what were the big challenges for Indonesia and what the team could use external help with. For example, they could make sure that Indonesia was part of a network. There is a need to have mutual learning process and it would be beneficial to know what the main focus should be. Dr. Yot invited the speakers to discuss barriers to HTA in Indonesia.

Dr. Somsak, Deputy Permanent Secretary of Thai Ministry of Public Health (MoPH), welcomed the delegates and invited them to learn about Thailand's HTA system. Describing the study visit of a delegation from Cambodia to Thailand, he invited the Indonesian delegation to look at what Thailand has done. Dr. Somsak emphasized that both Thailand and Indonesia need to learn from each other. He noted that even though Thailand has had universal health coverage for the last fourteen years, there remain areas for improvement such as coverage of migrants from neighboring countries and how HTA could be a useful tool to address such issues. He suggested to Dr. Untung that both Indonesia and Thailand should try to build an ASEAN level HTA program as the next step.

Dr. Untung, Secretary General at the Ministry of Health (MoH) in Indonesia, thanked the team for having them. He introduced the head of the national health insurance scheme. He gave an overview of the partnership between the HTA Committee (HTAC) and HITAP and said that the results of the two HTA studies have been shared with the Minister who was happy to see the same. He added that there is an interest to extend this work to new topics that are relevant to the national insurance scheme, those that

have the highest cost. Saying that he hopes to continue working with HITAP and iDSI, Dr. Untung said that they want to learn from HITAP's experience and hope to build a similar unit. In terms of building capacity for research, they are relying on young staff and all team members have been "hand-picked", adding that he has supported Dr. Donald to get the people he needs to create a unit to develop the knowledge base.

Following these remarks, all participants introduced themselves and proceeded to explore the premises of HITAP. The participants then gathered for a presentation by Dr. Yot on the role of HTA in Thailand.

2. Presentation on HTA in Thailand with a focus on the process including issues encountered early on

Pointing to the initial lack of demand for HTA in the country, Dr. Yot said that there was a "do know gap" where programs were continued without knowing their impact. He illustrated this with an example of a screening program for diabetes for people 15 years and above on which the government spent THB 5 billion the previous year. The study showed that among those who tested positive, 25% of them didn't know that they had a problem and did not seek treatment. Thus there was no impact of the screening program. One cannot do everything at once and so it is important to select the right topic and work in a systematic manner. This can be done in an incremental and participatory way. Since these studies will impact policy, it is also necessary for the process to be transparent and accountable. Therefore, early on it was decided that not only HITAP, but other stakeholders would also be included and there would be three processes: 1) Selection of topic, 2) Assessment and 3) Appraisal by stakeholders. HITAP's role is limited to supporting the relevant stakeholders and providing information, but not in selecting the topic or making decisions.

Describing the topic nomination process, Dr. Yot said that no one knew about HITAP early on and so they had to advocate for policy changes. To involve a broad range of stakeholders, invitations were sent to 100-300 organizations form the public and private sectors. These organizations are asked to nominate topics once a year, typically at the end of the year. In its annual topic selection process, HITAP then reviews the topics and invites stakeholders to listen to the nominations. The timeline is to send invitations in August, receive responses by October, conduct reviews and then select topics by January. The topics selected are policy questions and need to be translated into research questions. This process too is not done by HITAP alone and it solicits responses from others. For example, civil society groups wanted the Thai people to get free eye glasses. Through the consultation process it was determined that instead of giving free glasses to the elderly who are typically aware of their condition and have the ability to pay, one can prioritize the younger population. Under the WHO 2020, the Thai government had promised to do screening of children but ten years on, this had not yet been done. Many people who are short sighted don't know that they are short sighted and this affects educational and work opportunities. Even once the need was identified, the question remained as to how this could be done since there was no system to deliver screening. In Taiwan, screening is done by ophthalmologists but Thailand doesn't have the resources to take the same route. It was then decided to train teachers to conduct the screening and this approach was found to be feasible as well as a good value for money. This goes to show how a research question is more specific than a policy question.

However, Dr. Yot noted, doing these analyses alone cannot ensure that HTA will have an impact and that they need to be considered by decision makers. For this, there needs to be a system in place to implement policy or there will not be any impact and having a group of decision makers to discuss and make recommendations is important. Earlier, this was done on an ad hoc basis but once people saw how

impact is made then one can make a difference. In Thailand, there are two processes whereby HTA is used, one is the development of the drugs list (NLEM) and the other, the development of the benefits package (BP).

Using the flow chart to show how the process for NLEM works, Dr. Yot explained that this list contains drugs that are part of the BP and includes new and expensive drugs. HTA is only part of the process and while economic evaluation plays a significant role in drug reimbursement, not all decisions are based on it. Decision makers may use their judgment based on social values, as NICE calls it. HTA is also used for price negotiation with companies. For example, in Thailand the price of oxaliplatin was almost THB 200,000 for all doses (about THB 8,000 per dose) even as the price per dose was higher in Vietnam. HTA showed that the price per dose should be less than THB 5,000 to be cost effective in Thailand. There were three companies involved in the bid and this process helped save the government budget approximately THB 152 million Thai Baht each year. This was a lifesaving drug and could extend the life years of patients by 1-2 years but at the time, the price was too high. Moving on to the development of the BP, Dr. Yot distinguished the NLEM and BP process saying that in the case of BP, stakeholders are allowed to nominate topics whereas in the case of drugs, only physicians or experts are allowed to nominate topics as not everyone knows which drugs should be included. In all, there are seven groups of stakeholders which nominate topics. In the last few years, more than 100 topics have been nominated.

While HTA informs decision makers about whether it is good value for money, it is up to the decision makers to include or exclude a technology. With the evidence on cost effectiveness and price, decision makers can put the onus on industry for keeping the price too high. Thus, to summarize the lessons, one needs a good strategy to get the right topic which involves more than just research. Additionally, there needs to be a sense of trust between policy makers and researchers. HTA can be used to inform not only decision makers, but also other stakeholders so that they understand the results and decisions made. This goes to make the process a sustainable one.

3. Discussion (Q&A):

Understanding the HTA process in Thailand and its relevance to the situation in Indonesia

3.1 Clarifications on HTA process in Thailand based on presentation

Dr. Sudigdo asked about the average number of topics assessed by HITAP per year to which Dr. Yot responded by saying that across the country about 60 topics are reviewed and only half of those are conducted by HITAP. Over nine years, several research units have been set up that can conduct HTA and another autonomous institute, IHPP, has been doing HTA for the past five years. Institutions like the University of Mahidol are not only doing HTA but also supplying professionals particularly in core pharmacy. Dr. Hasbullah followed up on Dr. Sudigdo's question and asked about the characteristics of full time staff at HITAP to which Dr. Yot responded saying that there are about 50 staff in this office and most work on a full time basis with a focus on HTA.

In terms of the timeline of the process, Dr. Fachmi noted that based on the flowchart presented, it takes 6 weeks to decide the priority list and 4 weeks for assessment and asked how long it took decision makers to make a decision. Dr. Yot said that guidelines set the timeline. Initially, he said, there were no timelines but industry representatives and clinicians complained and there were concerns that the HTA process could delay availability of drugs. Hence, a process was developed to make decision makers

accountable and all parties needed to comply with the schedule. For the committee making the decisions, however, it is difficult to make the decision one by one and it was recognized that the committee needed to take a broader perspective including the impact on the budget. So, it was decided that the committee would meet every six months and combine decisions for all HTA assessments together, ensuring that budget is available for the lot that is approved. HITAP, which serves as the secretariat, completes and submits its assessment in 4 weeks to the sub-committee in a set format. The committee then decides and makes the budget available. The decision will be signed by the health minister and announced in the decree which can take a few months. Appeals can be made by stakeholders and while the manufacturer cannot make an appeal, they can contest the decision during an intermediate stage. For example, in the case of treatment of an eye disease, an off label medicine was used. This was a controversial topic and industry lobbied against it. However, the National Health Security Office (NHSO) pushed the Ministry to sign the decree and the process took about 4 months. For its part, the NHSO saw the benefits and had already procured the medicines and wanted to make these available.

In response to a question on how much of the research is being used, Dr. Yot said that since the research conducted at HITAP is for use in policy, he would say about 90% of the research has been considered. HITAP informs the government and one should not consider it a failure if the government takes a decision contrary to the recommendation. Even if the decision maker doesn't use the evidence at the time of the study, there is a chance that it will be used in the future. For example, HITAP had completed a study 2 or 3 years ago and had presented the findings to the minister, who was not keen on it. However, a few years later, the minister changed. He was interested in the findings of this study and decided to take it up. Thus, even if the study is not implemented immediately, one can wait for a window of opportunity.

Regarding stakeholders, Dr. Sudigdo asked whether HITAP includes practitioners or core professionals in the team or only invites them at the time of dissemination. Further, of the 100 research topics, how many topics are involved in policy and where are these stakeholders from. Dr. Yot said that every decision comes from the stakeholders. One of the participants said that if there is a strong academic community across the country, they can do the assessments. Dr. Yot said that everyone can apply the HTA method and process. The key is to have transparency and accountability in the system. This is also the case with industry, where one may accept their evidence if they follow the methods and processes that have been determined. This year, five studies were conducted by industry of which two were included. The drug committee has a lot of demand but the public sector cannot supply or respond to this need which is not the fault of industry. Thus, one needs a strong mechanism to have quality studies.

3.2 Process for implementation of HTA recommendations in Thailand

With reference to the NHSO, Zohra asked about how to ensure that once technology is proven to be cost effective, that providers are following it and track the quality and population level outcomes. She pointed to how NICE looked at clinical pathways, etc. and asked whether HITAP did anything similar. She also brought up this issue in terms of system readiness to provide these services which she felt was especially relevant to Indonesia which is a very diverse country with varying costs.

Describing the implementation process of HTA, Dr. Yot explained that HITAP works closely with the NHSO, which is the equivalent of Indonesia's BJPS in Thailand. Once the NHSO makes a decision, it allocates budget for the intervention. In Thailand, there is a focus on expensive medicines which are

purchased centrally for market power and then sold to hospitals. There is a computerized system, BMI, in place so that if hospitals which have certain stock of drugs have more patients, they can receive the drugs within a stipulated time frame. Making a reference to one of the field trips during PMAC, Dr. Yot said that for expensive medicines, hospitals need to register a patient after which the medicines will be dispatched continuously from a central stock to ensure that the medicines are used when needed. Tony cited the example of South Africa where supply chains are long and inefficient giving an example of weighing machines which didn't work because no batteries were available. Noting the availability of new technologies, Dr. Yot suggested that one can now use mobile phones to streamline processes.

3.3 Process for development of the drugs list in Thailand

Dr. Dewi mentioned that in Indonesia, there are three lists of medicines, the national formulary, essential list and insurance products list. The sponsors of each list develop the items on the list in their own way and Dr. Dewi was interested in knowing how HITAP does this now and how it was done before. Dr. Yot said that earlier 22 experts proposed items so different specialists (such as neurologists) proposed some topics on their areas of expertise. These were submitted to a committee which considered information submitted by specialists and it is possible that they did not discuss cost as it was in the spirit of WHO Essential medicines list which recommended making medicines available but hospitals were not obliged to provide them. With the onset of UHC, the list gained more importance. Subsequently, costs were reviewed but only by the subcommittee and this was done in an arbitrary manner. Once the HTA process was established, the subcommittee asked HITAP to review the medicines one by one. The first medicine for review was atorvastatin and HITAP found that there was a cheaper alternative through the annual topic selection process. The committee decided to withdraw the original drug and saw that they could save a lot of money. The subcommittee realized this is something they want and now don't examine every medicine. If a cheaper drug is already available, it can consider taking it up without going to the Health Economics Working Group (HEWG). Thus only a small proportion of assessment of drugs, mostly for new and expensive drugs, come to HITAP for review.

Sari asked about whether only the twenty specialist groups that are identified can propose new medicines or can health facilities also propose topics to which Dr. Yot responded that medical schools and public facilities can propose. Often people ask whether industry can propose and Dr. Yot said that industry always proposes via health specialists and are therefore represented indirectly. On the work of the HEWG, Sari asked about the process followed if a medicine is less effective and has high costs and if one wants to remove it from the list. Dr. Yot responded that since most of the alternative drugs may already be available in the market and if the drugs are cheaper, the subcommittee comes to HITAP for confirmation including an evidence review or to see if a drug is equivalent in terms of efficacy but cheaper. To withdraw a drug, the change may be announced in a decree and then the medicines get taken off the list. At the moment, there are 800 medicines on the list, so drugs can be added and removed as needed. Unlike Indonesia, there is only one list in Thailand. In Vietnam, on the other hand, there are 14,000 medicines on their list which makes it hard to inform people about the changes.

3.4 Role of NHSO in the HTA process in Thailand and how it compares with BPJS in Indonesia

Zohra asked to elaborate on the role of NHSO with respect to the process on appraisal and assessment. This would help the Indonesian team situate BPJS in the process. Dr. Suwit said that the main challenge is to develop the decision mechanisms and the process for the national formulary. The BPJS doesn't make any decision whereas the NHSO makes decisions. However, the NHSO doesn't take the decision by itself.

For drugs, it uses the NLEM developed by the National Drugs Systems Development committee chaired by the Prime Minister. This committee appoints a subcommittee, the secretariat, which is hosted in the FDA. The FDA has more than 2000 APIs that have been registered. However, the NLEM has less than one third of those that have been registered. The government pays for only those items on the essential drug list. For new and expensive drugs, HTA is a must whereas for old medicines, different indicators are used.

Sari said that they have a national formulary that needs to be used in the UHC. This has been done with a National committee which is responsible to the MoH. She said that they have regular meetings, 3-4 times every year, to discuss the proposed medicines or health facilities. Since 2013, it has met two times and has looked at efficacy but also effectiveness issues. Dr. Yot asked whether HTAC can work with the drugs committee which is being led by Prof. Iwan. To this Sari said that they already work together and Dr. Yot asked to elaborate on the ways in which they work together.

3.5 Public health interventions and the role of HTA

Zohra brought up a question on how HITAP assesses public health interventions and how the topic selection process around that goes, having noted the use of screening in programs, but that this may not have been a policy request and took the system a long time to take it up. To this, Dr. Yot responded saying that the topics don't come from HITAP but from stakeholders. There is an effort to ensure that topics for assessment are not only on medicines and vaccines to be covered and so request that at least 40% of topics nominated by partners are related to public health. The chair of the Health System Research Institute (HSRI) will also try to give a weight to public health issues. Under the NHSO budget, 20% is allocated for health promotion and disease prevention activities. Thus, curative and preventive activities are not mixed and a separate budget line is included.

Following up on this issue, Zohra said that one aspect of improving health is to reduce the curative costs and asked whether HITAP looks at disease burden and other data from NHSO. This point was resonated in Dr. Mardiati's question on how DALYs are used in Thailand. Dr. Yot responded by saying that HITAP uses evidence to select a topic, including information on how many patients are affects how severe the disease is as well as the DALYs lost. They also try and include information on whether effective interventions are available as if there are not, then an evaluation would not be applicable. They also look at whether there is variation in practice across the country, hospital types, or degree of household financial burden. Here, HITAP also tries to address equity issues and to see how the poor and marginalized are affected, according a higher priority to a topic in such cases. An attempt is made to include rare diseases as well, which may otherwise go unnoticed. A scoring system on various criteria are sent to the committee along with the results.

Another dimension of a public health intervention, Zohra noted is that Indonesia is a highly decentralized system both in terms of delivery as well as the budget. Dr. Yot said that based on his experience, public health issues have been decentralized. In Thailand, there are 13 regional authorities and in many of these places, there is a "do know gap" whereby policies are continued without knowing if they are working. He gave the example of dengue fever, a political issue and one on which the government spends a lot of money on space spraying without evidence on whether it works. In some regions, for prevention of breast cancer, self-examination is promoted which is not only unsafe but does harm. This necessitates a public health approach, especially in cases where already some work is being done and where people can be empowered at the local level. In Thailand, most often these interventions are cheap and so do not need to have economic evaluations as most of these interventions are cheap and do

not make a significant dent on the budget. Conditions like ischemic stroke, which is widespread, can be screened easily and effectively without additional money. Tony added that it depends on what type of system you want, using the analogy of an expensive car versus a regular family car. Dr. Yot added that most assessments in Thailand are not economic evaluations but are concerned with health service and policy research. If Indonesia has resources, they could collect primary data on this.

Prof. Budi said that they want the Ministry of Finance in Indonesia to know that public health is important. At the moment, they don't have money to fund these activities. The advocates of this approach want to go beyond this and so need to have more information. Further, he added that while the HTAC in Indonesia only looks at the BP, there is also a need to conduct HTA of public health issues. He asked whether, given what the partners know about Indonesia, it is good to focus only on BP or also at the same time also strengthen capacity of public health issues. He believes that public health is a public good and that the government should support it. Therefore there is a need to get information on this and communicate with policy makers which may be a bit difficult in Indonesia. Dr. Yot said that there is a need to translate findings for policy makers and gave the example of the alcohol study in Sri Lanka where the team compared the social costs to building of a major highway while communicating with decision makers. This, Zohra said would be a good argument for the tobacco tax.

In connection with this discussion, Dr. Mardiati asked how a program on HIV AIDS or TB could be integrated in the BP. Giving the example of Thailand, Dr. Yot said that the MoPH does not have the money to implement such vertical programs as it incurs overhead costs and that it would take money away from its other activities such as building hospitals. By law, the NHSO is responsible for funding curative programs. This is more of a political rather than a clinical issue. In the past the MoPH has passed on responsibility for vaccinations to the NHSO. Dr. Mardiati probed further saying that in the case of EPI (immunization), this becomes tricky if NHSO becomes responsible for coverage because heard immunity requires near universal coverage. Dr. Yot replied saying that in Thailand there is only one provider and that the source of the money does not matter to those providing the service as long as they are being paid for it. One needs to ensure that there are enough resources, that the logistics are taken care of and that the vaccinations are delivered to hospitals. Zohra said that in Indonesia, immunization is separately funded but believes that if integrated with BPJS, they can pilot a performance based financing system. If reimbursements are based on results, one can have a massive impact. This, she believed could be a missed opportunity.

Discussion on elements of the HTA process and their practical application

3.6 Comparison of HTA systems across countries with examples of Thailand, the UK and Canada

Dr. Fachmi asked about how to benchmark the process with respect to NICE and noted that there is a difference in structure between NICE and HITAP: in the former, assessment is done by a different organization and appraisal is done by NICE. While assessment is based on evidence, appraisal involves different issues. He asked to discuss what has been the effect of difference between NICE and HITAP.

In response to this question, Dr. Yot said that the NICE model may not be applicable to Thailand. At the time, Thailand did not have any assessment team whereas when NICE started, there were several universities with capacity and a supply of professionals. What England didn't have at the time was an independent decision making body. In Thailand, on the other hand, no one was doing HTA so there was a need to have a supply of HTA professionals and while there was no HTA, there were several decision

making bodies including committees which operated on an ad hoc basis. Everyone came with different types of evidence and so it was difficult to assess the evidence. There was a need to make friends and fit in the context in terms of being a supplier of evidence and working with a variety of bodies. HITAP works with at least three bodies and not all are consistent with each other. So there is an issue of organizational characteristics that need to be understood. For example, while the Minister will not make a decision without a pilot, the NHSO cares less about piloting activities.

Tony then gave the example of Canada where a federal level agency is in charge and does not only look at drugs. In their system, manufacturers seek approval for their drugs and this can be an expensive operation as the agency is charging them. He added that NICE may also introduce something similar whereby manufacturers contribute to the expenses of the process. In comparison with HITAP, NICE is both simpler and more complex. It is simpler in the sense that there is a one payer, the NHS. It is more complex in the sense that NICE is not just concerned with HTA but also the clinical guidelines, etc. NICE engages in two types of partnerships: it works with universities for programmatic support with a stream of work that is commissioned for 3 to 5 years and for the work on guidelines, they have a similar arrangement with the Royal Colleges. Tony said that very little of the technical work is done in NICE itself and that most of it is outsourced to various institutes.

Dr. Salma brought up the topic of the role of “champions” in the context of setting up a program for HTA in Indonesia. Providing the example of the UK, where Dame Sally was seen to have been responsible for establishing and supporting the system, she asked whether there was such a champion in HITAP and if so, who this was. With reference to Indonesia, she urged the team to discuss which areas or organizations could champion the use of HTA in the country. To this, Tony elaborated on the experience in England saying that the idea of NICE was developed by civil servants, and the senior most of the ministers was keen to see it through thus showing political will. At the local level, Tony said that Mike Rawlins, who had been appointed as the Chair of NICE was a champion and was dynamic as well as inventive in his approach, reaching out and talking to various people. Dame Sally, he said, was responsible for developing the research program which became complementary to what NICE was doing. He added that the question of leadership is critical. In the case of Thailand, he said that the role of two outsiders and two insiders has been crucial in its success as other efforts to institutionalize HTA had failed in the past. Dr. Yot added that two outsiders were really important, which, Tony explained were Dr. Suwit and Dr. Viroj both of whom had some common characteristics having worked in up-country areas dealing with rural communities and had seen the problems bottom up. The insider champions were Dr. Yot, who brought charismatic leadership capacity and Dr. Sripen, a deputy, with a different type of personality. This feet-on-the-ground approach made sure work was done. Thus, having inspirational external people but also exceptional people leading the organization was complementary for HITAP.

Dr. Untung commented that in thinking of HTA in Indonesia, one may have to develop a model that is partly like HITAP and partly like NICE; while some work can be done within the unit, they may need to collaborate with universities and work with decision makers.

3.7 HTA as a multi-disciplinary, evidence based approach

Dr. Donald said that while HTA is more about economics, when talking about health, one needs to consider equity and rights. The role of the government, he thinks, is still relevant in making this trade off and research does not override the political process. He reiterated that even if results of the HTA process are not approved, it does not mean that they have failed.

Dr. Yot responded to this point saying that HTA is not only about economics and is in fact more about evidence which may be both quantitative and qualitative on issues such as equity and human rights. He also gave examples of studies which did not include any figures. Some HTA results, upon completion of the study are easy to use to bring about consensus and implementation whereas in other cases, more effort is needed. In Indonesia, for example, implementation of a peritoneal dialysis (PD) first policy appears to be difficult to implement even though HTA suggests that this will be a good policy. It is not just a question of modelling but also about training staff and preparing logistics including a pilot in provinces without even Hemodialysis (HD). The other example is of Pulmonary Arterial Hypertension (PAH) where an off label medicine can be good for the country. Companies don't want to register for that indication as they don't see a profit but it is not the companies' job to think about public; it is up to the government to find a way to make it possible to access medicines. As of now this cannot be done because of legal issues but Dr. Yot asked the group to use this as a case study to make use of off label medicine legal in Indonesia so that the government can save money.

Adding to the discussion, Tony said there are more criteria than just maximizing the health impact including distributional issues and financial protection. The mistake is often to separate considerations of efficiency and equity which ought to be integrated. The other issue is that one lot of topics is evidence based whereas another lot is not based on evidence, so equity concerns take place in a vacuum. Using the example of equity in terms of geography, extending health services incurs costs and Tony recommended finding out what these costs are, whether these are acceptable and then see whether an intervention is doable, emphasizing the need to quantify where possible.

3.8 Importance of involving a range of stakeholders

Dr. Salma observed that HTA in Indonesia is not new and echoed the need to develop an "Indonesian way" as called by Dr. Untung. She said that they have had a chance to learn from NICE's experience and now from HITAP's, noting that there are differences. However, there is substantial misunderstanding that needs to be clarified in terms of what is done next in Indonesia not just in terms of learning for the core team but larger groups of stakeholders. Dr. Yot added that the WHO has committed to work with partners in Indonesia.

Regarding the point on misunderstanding, Tony said that the whole HTA process is subject to this including conceptions of HTA leading to setting up of "death panels". This underlines the importance of being clear of who the stakeholders are and how one communicates with them on how and what one is doing with HTA. He proceeded to list out some of the stakeholders: While politicians are one group to target, so are the parliamentarians (congress, etc) and it is very important that they understand what you are doing and that they are involved in it. Further, while everyone agrees that patients should be consulted, one must also involve family care givers and informal care givers on issues such as whether QALY/DALY are suitable. Tony noted that sometimes the care givers speak more completely than patients. Another segment to think about is the general public and, linked to that, the media. Tony cautioned that if the media doesn't understand why the HTA agency is doing what it is doing, especially the ethical aspects, it can create more misunderstanding. Clinicians and educators in general need to be consulted during the process. He said that one can think about what is the place for learning about HTA in medical school so as to create a generation of doctors who understand what it is and that becomes a mark of their reputation. Another group of stakeholders are the health service managers who have to implement the program and need to understand what this is about. Finally, the manufacturers, typically

private sector but also public sector need to be included. Their opposition can be damaging so it would be good to try to treat them as allies rather than enemies.

Tackling specific issues concerning HTA in Indonesia

3.9 Challenges and options for HTA research in Indonesia

Following the presentation, Tony had opened the discussion and asked the Indonesian delegation what they found challenging or difficult. He noted, for example, that most research is not done in Indonesia but elsewhere. He asked the group to think about the criteria one should develop to use results from another country in Indonesia. He pointed out that the research strategy may be one that capitalizes on systematic reviews and meta-analysis, which is the dominant type of research available, even as there may be a need for some specific primary research. He also said that given HITAP's proximity, its experience and expertise will be most relevant to Indonesia.

On who conducts the research, Tony noted that there already is a lot of research available. In the case of England, they already had a national research program and so did not need to create a new unit. However, this didn't happen instantly as the National Institute for Health Research (NIHR) takes advice from NICE and sets aside money for research out of its own budget. One doesn't have to feel that research needs to be done by the HTA agency and can encourage others to do it. Once you get established with the institutional processes (committees, etc), one doesn't have to pay people to chair or populate these positions. In England, people consider it to be a prestigious thing to do and so all NICE had to do was to pay for their expenses. Thus, the process does not have to be very expensive if volunteers are encouraged.

Prof. Budi asked the group to discuss how to ensure transferability. Dr. Yot emphasized the importance of context specific factors and recalled the eye screening program, for which usually one needs an ophthalmologist to do the screening but this was not feasible in Thailand. He added that one needs to test the accuracy of the health checkups done in this manner. In the same vein, Dr. Mardiati said that while they have learned how to do systematic reviews from HITAP, for modeling, they need to collect primary data for topics on BP as they cannot always use Thai data. She asked if this was a good process to continue and how could they plug the gaps in primary data. Tony suggested that the team identify what are the characteristics of the situation in Indonesia such as the cost structure as well as the cultural values which can be very specific. In such cases primary research which may be quantitative or qualitative in nature may be useful. Further, research centers may be encouraged to work on these issues.

Regarding topic selection, Dr. Hasbullah said that in Indonesia, they are prioritizing in response to regulation which requires them to make decisions on inclusion or exclusion of benefits based on HTA. He said they are thinking of how to support their national agency to make decisions and what topics should they be including first. They have prioritized high claim procedures since these consume a lot of money. While this may not be similar to the HTA process in the beginning, they are open to proposals from outsiders. Their main objective, he said, is to ensure that benefits included are covered by HTA. Tony responded by saying that the process is related to the relevance in the country and may be ad hoc or arbitrary. He said that in the early days, it is important to convince policy makers. One may need to have some demonstration projects to get the process moving and then think about how to institutionalize it. Some of these counterparties are very important and could go against the HTA agency. In the case of

NICE, one of the main groups threatened were manufacturers and so while developing the methodology, they involved everyone including health economists from industry. They were then able to reach a consensus in a matter of six months and because their people were involved, it was difficult for manufacturers to reject the process. Thus, Tony highlighted the importance of identifying who these groups are, both friends and foes alike.

Dr. Mardiati said that they have learned about threshold, DALYs and other concepts. At PMAC, however, they also learned that one does not need to accept one or two GDP per capita and that one must also look at budget constraints, not just the budget impact, while determining the threshold. Linked to the discussion on using health data in the topic selection process, Tony said that very often, prioritizing is done according to the magnitude and severity of the disease which can be misleading. In itself an intervention may or may not be cost effective but that is not sufficient as one needs to look at how the intervention fares compared to others. One can compare in pairs or conduct group wise comparisons. If an intervention is already included, there is an issue of disinvestment but if looking prospectively, one can decide by including the relatively cost effective option. This raises questions of what an intervention is as well as what is the role of a threshold in setting a level of cost effectiveness that determines what should be in and what should be out, with an intervention in the program not performing worse than the threshold. He added that one need not get too hung up about the level of the threshold but it is something that should be discussed and considered. Saying that a threshold can be context specific and that the link between the budget and threshold is direct, he recommended that the group resist subscribing to a common standard, and instead think about the issue and ask their experts to review the literature that is available.

3.10 Presentation by Dr. Sudigdo on the HTA studies conducted in Indonesia as well as plans going forward

Dr. Sudigdo presented on the role of HTA in Indonesia. He noted that UHC was introduced in early 2014 and several months later, the HTA Committee was set up by ministerial decree. Acknowledging problems with starting the work of the Committee, he said that they have received support from several international partners. Upon requesting training in Bangkok, 14 PICs were sent and trained at HITAP in February 2015. They have completed HTA of two topics, one on ESRD and the other on PAH. He then proceeded to describe the studies and their findings. On the findings, he raised the question on whether one should go ahead with a PD first policy, which is the recommended option but required much preparation in terms of systems. He said that PD was more appropriate as it requires less human resources and facilities. One effect of the study is that the Indonesian Renal Association has decided to increase the proportion of PD to 30% over five years. For the PAH study, even though sildenafil is regarded as being clinically more effective, it cannot be used as it is not registered for this indication.

Stating that these are the first studies using modeling, Dr. Sudigdo said that they have been duly supported by PATH and HITAP. They have involved various stakeholders and so it has been a collaborative process. Further, results have been disseminated to various partners. There are however, a few limitations. While the unit can conduct literature reviews there is difficulty in finding local data which are either incomplete or not available. Instead, they have had to use data from other countries such as Thailand. This has been a good learning experience as has the experience of developing guidelines. He added that Dr. Hasbullah is developing a roadmap for 10 years. The most important aspect, he said, is building capacity. Until now, there were no full time staff, and all are working on a part time basis.

Further, the development of three guidelines is in progress. He said that during the next couple of weeks, they need to discuss which and how many topics need to be conducted. He thinks that two topics may be feasible even if these may be too few. He expects topics on medical devices, drugs as well as public health research.

3.11 Discussion on the next steps of the HTA studies conducted and whether there is a "knowledge gap" or an "action gap"

Dr. Yot reminded the group of HITAP not doing research for the sake of research, noting that they ensure that the topics they work on are from outside the organization so that it will be of interest to society. He asked the delegates about how they plan to use the HTA studies that have been completed on treatment of ESRD, PAH and the PEN package. These studies already have results that can lead to a decision. Dr. Yot summarized the results and said that even though off label medicines can't be used, the work on PAH can be used as a case study. On the ESRD study, Dr. Yot said that while we know that at least 53% have had at least once accessed dialysis, we don't know if it was the only time that patients were able to access dialysis or what the quality of the treatment was. These studies may shed light on the situation on other islands as well. The study on PEN showed that the intervention will not be a good value for money for the entire population. He thus urged the group to discuss this issue.

Dr. Mardiati said that the results were presented to the Minister of Health and they received a positive response. However, they are still in the process of developing the institutional set up. For example, there is a need to conduct some follow up studies. The clinicians, for example, say that they are not ready to provide PD first immediately. They have learned from HITAP's experience in terms of training and conducting other feasibility studies. Further, working on guidelines has been very useful. In order to improve the skills and knowledge of the academicians, they are wondering if they can partner with Mahidol to boost the process for capacity building. Dr. Mardiati added that, in terms of using the two studies, they were happy to have had Dr. Somsak, Thanaporn and Benjarin participate in the dissemination program in December. Echoing what Dr. Sudigdo said, getting the buy-in of clinicians is very challenging in Indonesia. Through this process, they have been able to come on board but it is not enough to bring them in as stakeholders.

Tony followed up by saying that there are two types of processes: one of them is to think about what are the implications of these two studies and how will these be implemented. The second, if the group is convinced to go ahead, then one can think about what the next steps are for institutionalizing. Tony thinks that for this, there are two options: the first option would be to embody a unit in the existing structure of the ministry with bureaucratic reporting lines which will have links to the health service. The second option is to set up organizations like NICE/HITAP at an arm's length with less direct control on how things are done but with control over what they are doing and have an interaction between that organization and the ministry.

Building on the discussion, Dr. Yot said that HTA provides evidence that can support decision making. These two studies on treatment of ESRD and PAH have been completed but clinicians are still reluctant to go forward with recommendations. This suggests that there may be a gap in knowledge. He asked the group to bridge that gap by conducting more studies so as to go forward with recommendations in a confident way. So, if knowledge is the barrier, then one can do additional studies. If the barrier is about

management, then one must talk to others. Regarding the knowledge gap, he proposed a study on the legal aspects that need to be changed for use of off label medicines.

On the ESRD study, Dr. Sudigdo said that there is already a move to increase the number of patients under PD from 2 to 20-30% in West Java. Speaking to the lack of confidence in adopting results, he said that the data used in economic evaluations has been taken from large cities in Java and so, they believe, the findings cannot be generalized. Dr. Yot then asked if the HTAC can do more work to implement the studies in other cities and whether HITAP can provide technical support to do this with the aim of scaling up. Tony said that there is not just a knowledge gap, but also an action gap. In England, he said that NICE creates obligations. This allows organizations to forecast additional budget as “consequences of NICE”. The civil service knew what to do but needed a technique to know what the appropriate adjustment would be. There would have been an action gap if that wasn’t done. If there is a knowledge gap, then it is not just HTA research but other things. Tony advised to identify the “right things” as against getting people to do the “right things” which may be related to management issues and there could be a knowledge gap there. This is context specific and only the delegates from Indonesia can respond to it.

3.12 Discussion on the next steps in terms of development and application of guidelines

On guidelines, Dr. Mardiati said that they are in the process of developing three guidelines. The first is on how to institutionalize the systematic process of HTA which Dr. Hasbullah is working on, the second guideline is on measuring the outcomes and the third is for conducting economic evaluations. These would serve as standards to conduct analysis. They are wondering whether, in pursuing the “Indonesian way”, they need to do complex analyses such as CUA etc or whether they can do other types of analyses.

Dr. Hasbullah provided an update on what he is working on. He has planned a ten year process to establish a fully independent, autonomous organization which would develop slowly as there is not enough capacity in the system. This would be a combination of the HITAP approach, conducting studies as well as the NICE approach, by building capacity in universities. In the next five years, they plan to send students from the MoH but also from universities to pursue higher studies. A draft of these guidelines has been developed and discussed with stakeholders.

Dr.Yot asked Dr. Hasbullah for whom these guidelines are being prepared to which Dr. Hasbullah said that it is for the MoH. Sharing his personal experience, Dr. Yot said he wanted to publish the guidelines he had worked on as a book for people to use. However, Dr. Suwit, who was the chair of the government committee at the time, suggested that he should get the guidelines authorized by the government. This gave the guidelines legitimacy which could then be enforced otherwise the MoH would not consult it. Dr. Hasbullah said that they discussed the same with invited stakeholders three times. Dr. Yot stressed on getting the guidelines authorized by the government, which is what the Indonesian team said it has in mind. Prof. Budi added that the process should be completed by the end of February. Dr. Yot cautioned that a personal approval is not enough, and there should be a formal announcement.

On guideline development, Dr. Suwit provided his perspective saying that if the work will be used by authorities, then they need to approve the guidelines and once this is done, then they can work according to these guidelines and the results can be considered without question. This is for the drugs, but there is another subcommittee for the benefits package that goes through the same process. There should be a study on the political economy of the national drug formulary as well as for the development of non-drug benefits. This is big public money and is a political process, which we need to accept, he

said. Further, HITAP has to keep in mind that it is not the authority even though it is authorized to recommend. These recommendations help authorities legitimize their decisions using evidence as authority without legitimacy will go nowhere and HTAC in Indonesia will help achieve that. The question, Dr. Suwit said, is how HTAC can be linked to the policy making process and how can it convince the public that this is the legitimate process to spend public money.

3.13 Reflecting on country specific factors, culture and institutional change in Indonesia

Dr. Suwit discussed about culture and country specific factors. He said that if the system they are working with fits Indonesia and they find that the drugs are cost effective and not too costly, then they can do that. He recommended the team to refer to the study conducted by HITAP for PMAC on the conducive factors for HTA development in the Asia Pacific. He discussed the role of HEWG, which is responsible for HTA saying that while it is a "subsidiary", it functions independently. So, even as members of the HEWG are independent, they are appointed by the national drug formulary. This is the group that considers whether or not to include expensive new drugs and not an independent organization. However, the buck stops at the decision maker who has to legitimize the process and prioritize items on the list based on the recommendations of the sub-committee. Thus, he encouraged the Indonesian delegation to find their own way and if they are fine with the process they should go ahead and try to improve it. Dr. Hasbullah said that they have learned from various experiences, including visits to different countries, and are adapting it to their needs. Dr. Yot said per his understanding, the HTAC does not have a strict TOR or strict mandate. This is much like HITAP, which can be more flexible. Sometimes, NHSO asks for research on implementation and HITAP can help with that.

Dr. Sudigdo said that being a clinician himself, he understands their behavior, saying that clinicians are happy with the current situation and do not want to change. He recognized and supported the Renal Association's push to increase the use of PD. He added that doing formal studies for implementation is not HTAC's job. Dr. Yot said that while NICE and HITAP are very different, both make difficulties for clinicians and industry. He cited the examples of anti-retroviral drugs in the case of NICE and one of the first studies conducted by HITAP that removed atorvastatin from the BP. These decisions made clinicians angry. There was a similar situation with the HPV vaccine when industry was upset but eventually came around. This can show to decision makers that you are there to fight and help them in addressing difficult policy decisions. HTA will not please everybody, certainly not the clinicians or industry. Instead, he said, one needs to think of the public and decision makers who work for the public.

Tony said that there is a need for a culture change and this is not easy. In England, it was made easier because of a series of events. One set of events related to scandals in hospitals especially concerning children that had an enormous public impact. So, the idea of evidence based practice on which Cochrane built his work had a big impact. Second, a new government come in and instituted "clinical governance" where every hospital had a clinical director. NICE was created to provide information to underline the policy. However, it was about a culture change and those who implemented it had to have believed in it. He acknowledged that it is hard and very much context specific but there are some principles that can guide the process.

Zohra said that this is where BPJS comes in as strategic purchaser given that it is the repository of the claims database. Referring to the Commissioning Outcomes Framework (COF) that NICE uses to monitor

providers, she added that it is worthwhile thinking of how technology can be used strategically to get providers on board.

Prof. Budi, on the other hand, pointed to a motivation gap among stakeholders. Even without the study, he said, people knew that PD is more effective. This is also the case for the drug industry. He wonders how to close this gap. He is inspired by Dr. Yot who uses the public perspective to push policy. Dr. Hasbullah added that they are trying to do HTA for rational decision making. He said that this is a public tool for a huge reform process that has faced many difficulties including protests from employees of affected organizations. He said that they need to continue to work with the public and take a people centered approach. Dr. Fachmi said that it is a complex situation as it can be hard for various parties to come to an agreement. However, it is important to have a permanent institution that does technical work. In connection with the discussion around “champions” and commitment, Dr. Yot had said that in Indonesia as well, there is a need for champions and this is something stakeholders and leaders need to decide on. Dr. Fachmi said that since 2000, the committee has made progress and that the political will has increased. Zohra added that the Secretary General as well as those who were sitting in the room were testament of the commitment to HTA.

Dr. Suwit commended Dr. Sudigdo, Dr. Hasbullah and Dr. Fachmi saying they had done a good job. He shared Thailand’s experience which had tried to establish HTA since the nineties but had failed and only in 2007 were they able to link HTA to the decision making process. He added that Indonesia has a young generation of people to carry the work forward. Using the example of the US, where one cannot negotiate prices, he said that they should not compare themselves to other countries. He added that they should not try to do what HITAP is doing and that they ought to find their own way.

Next steps

The partnership between organizations will continue and this meeting will be followed by a capacity building workshop that will be held at the end of April in Jakarta. Hosted by the MoH and WHO, NI, HITAP and other partners will also be involved in the planning of the workshop. With a focus on about 50-60 participants from universities in Indonesia, the workshop will aim to raise awareness on HTA in the country, build HTA capacity in the participating universities, help the MoH identify partners and enhance national and international networks on HTA.

Conclusion

The meeting helped clarify several issues around the HTA process which included understanding the HTA process in Thailand and its relevance to the situation in Indonesia, learning about the elements of the HTA process and their practical application and tackling specific issues concerning HTA development in the country. The attendance of high level policy makers, staff and partners from Indonesia as well as the rich discussion reflects the commitment to the HTA process. With an emphasis on the country specific cultural and institutional factors in Indonesia, the meeting highlighted the need of developing a model that was consistent with the country’s social, economic and political processes. The idea of an “Indonesian way” that would probably be a combination of the HITAP and NICE models was floated and the workshop in April would be a means of gauging the feasibility of this approach.

Annex 1: List of Participants

Meeting to Discuss HTA Development in Indonesia in 2016 and Beyond
HITAP, Meeting Room 1
6th Fl. 6th Bldg. Department of Health, Ministry of Public Health
Nonthaburi, Thailand

No.	Delegate Name	Job Title	Organization	Email Address	Signature (Attendance)
1	Dr. Untung Suseno Sutarjo, MKes	Secretary General, MoH	MoH	suseno2002@gmail.com	Yes
2	Dr. Donald Pardede, MPPM	Chief of Centre for Health Financing and Health Security, MoH	MoH	donaldpardede@gmail.com	Yes
3	Drs. Bayu Teja Muliawan, Apt, M.Pharm, MM	Director of Pharmaceutical Services, MoH	MoH	btejamuliawan@gmail.com	Yes
4	Sari Mutiarani, Apt	Director of Pharmaceutical Services, MoH	MoH	sarimutiarani@yahoo.com	Yes
5	Drg. Armansyah, MPPM	Head of Quality control and development of service network	MoH	aarmansyah@yahoo.com	Yes

No.	Delegate Name	Job Title	Organization	Email Address	Signature (Attendance)
6	Prof. Dr. dr. Sudigdo Sastroasmoro, SpA (K)	Chairman of HTA Committee	HTA Committee/MoH	s_sudigdo@yahoo.com	Yes
7	Prof. Hasbullah Thabrani	Member of HTA Committee	HTA Committee/MoH	hasbullah.thabrany@cheps.or.id	Yes
8	Prof. Budi Hidayat, SKM, MPPM	Member of HTA Committee	HTA Committee/MoH	bhidayat72@gmail.com; b_hidayat@hotmail.com	Yes
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14	Herijanto	Head of Internal Audit of BPJS	BPJS		No
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19	Edi Hardjati, dr	Secretary General	Admin, Ministry of Health	edihardjati@gmail.com	Yes
20	Salma Burton	Team leader of HSD	WHO	burtons@who.int	Yes
21	Dewi Indriani	HTA Focal point	WHO	indrianid@who.int	Yes
22	Priska A Primastuti	NPO NCD	WHO	primastutip@who.int	Yes

No.	Delegate Name	Job Title	Organization	Email Address	Signature (Attendance)
23	Phyllida Travis	International Expert/ Director of the Department of Health Systems Development	World Health Organization Regional Office for South-East Asia	travisp@who.int	No
24	Zohra Balsara	Deputy Director of Health	USAID	zbalsara@usaid.gov	Yes
25	Edhie Rahmat	Health System Specialist	USAID	erahmat@usaid.gov	No
26	Prof Tony Culyer	Emeritus Professor of Economics Centre for Health Economics	NICE/ University of York, Heslington York YO10 5DD	tony.culyer@york.ac.uk Tel: (0)1904 321420 Fax: (0)1904 4333759	Yes
27	Somsak Akksilp	Deputy Permanent Secretary	MoPH	akksilp_s@yahoo.com	Yes
28	Dr. Suwit Wibulpolprasert	Vice Chair	HITAP Foundation		Yes
	HIU, HITAP				
29	Dr. Yot Teerawattananon	Program Leader	HITAP		Yes
30	Sripen Tantivess	Senior	HITAP		No

No.	Delegate Name	Job Title	Organization	Email Address	Signature (Attendance)
		Researcher			
31	Nattha Tritasavit	Head of HIU	HITAP		No
32	Alia Luz	Project Assistant	HITAP		Yes
33	Benjarin Santatiwongchai	Researcher/ Project Assistant	HITAP		No
34	Saudamini Dabak	Fellow, ODI	HITAP		Yes
35	Ekanong Fungladda	Project Coordinator	HITAP		Yes
36	Nisa Yothasmutr	Project Coordinator	HITAP		Yes
37	Ioana Vlad	PhD candidate	LSHTM		Yes
38	Waranya Rattanavipapong	Researcher	HITAP	waranya.r@hitap.net	Yes

Annex 2: Agenda

PMAC 2016 and Meeting at HITAP on 1 February 2016

Objectives (PMAC)

1. To advocate and improve awareness of Indonesia policy makers and other stakeholders on evidence-informed priority setting and policy decisions to achieve UHC goals;
2. To gain supports for the global movement and collaborations to strengthen the priority setting of health interventions and technology in the long-term;
3. To share knowledge, experience, and viewpoints on health-related priority setting among organizations and countries; and
4. To build capacity of policymakers and respective stakeholders for development and introduction of contextually-relevant priority setting mechanisms in support of UHC
5. For the meeting on 1 February 2016, the main objective is to learn from Thailand's experiences on topic selection process, priority setting, decision making process and implementation support strategy.

Methods

1. Provide financial supports for the participation of Indonesian delegation (15 people) to the PMAC 2016.
2. Experiences sharing meeting at HITAP Office on 1 February 2016. The meeting will be organized into presentations (from HITAP/MoPH and Indonesia MoH) and discussions. The meeting will be held from 09:00 to 14:10.

Agenda

PMAC Agenda

Agenda of Experiences sharing meeting at HITAP Office on 1 February 2016

Time	Agenda
09:00 – 09:20	Welcome remarks by: HITAP/MoPH Thailand MoH Indonesia
09:20 – 09:50	• Thailand's experiences on topic selection process and priority setting for HTA • Linkage of HTA with decision making process in Thailand and it's implementation support strategy

09:50 – 10:50	Discussion
10:50 – 11:10	Progress of HTA development in Indonesia
11:10 – 12:00	Comments from experts and discussions
12:00 – 13:00	Lunch
13:00 – 14:00	Comments from experts and discussion (continued)
14:00 – 14:10	Conclusion