SOUTH-SOUTH COLLABORATION: EXPERIENCE SHARING ON HTA DEVELOPMENT

November 15-17, 2016

This report covers the experience-sharing workshop with representatives from countries in Africa and Asia as well as iDSI partners.

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Table of Contents

List of Acronyms

CGD	Center for Global Development
CNHDRC	China National Health Development Research Center
NLEM	National List of Essential Medicine, Thailand
DHR	Department of Health Research, India
DRG	Diagnosis-related group
EML	Essential Medicines List
FDA	Food and Drug Administration
GEAR	Guide to Health Economics Analysis and Research Online Resource
GHD	Global Health and Development Team, UK
HBP	Health Benefits Package
HEF	Health Equity Funds
HITAP	Health Intervention and Technology Assessment Program, Thailand
HIU	HITAP International Unit
HIV	Human immunodeficiency virus
HTA	Health Technology Assessment
HMIS	Health Management Information Systems, Cambodia
IC	(GHD), Imperial College, UK
ICER	Incremental cost-effectiveness ration
IPD	In-patient department
NHI	National Health Insurance, South Africa
ICMR	Indian Council of Medical Research
iDSI	International Decision Support Initiative
LMIC	Low- and middle-income countries
MOH	Ministry of Health
MoU	Memorandum of Understanding
MTAB	Medical Technology Advisory Board, India
NCD	Non-communicable disease
NDP	National Drug Programme, South Africa
NEMLC	National Essential Medicines List Committee, South Africa
NHS	National Health System, UK
NICE	National Institute for Care and Excellence, UK
NITI Aayog	National Institution for Transforming India
OOP	Out-of-pocket expenditure
OPD	Out-patient department
PRICELESS	Priority Cost Effective Lessons for Systems Strengthening South Africa
PMRS	Patient management and registration system, Cambodia
PTC	Pharmaceutical and Therapeutic Committees, South Africa
P4P	Pay for performance
RCMS	Rural Cooperative Medical Systems, China
STG	Standard Treatment Guidelines
UHC	Universal Health Coverage
UK	United Kingdom
WHO	World Health Organization

EXECUTIVE SUMMARY

From November 15-17, 2016, HITAP attended the South-South collaboration workshop in Irene, Pretoria, South Africa. Through the support of the international Decision Support Initiative (iDSI), representatives from countries all over Africa and Asia (namely Cambodia, China, India, South Africa, Thailand, and the UK) came to share lessons learned in HTA development in their countries.

They explored the following main topics: the overview of the HTA journey of a country; how HTA has influenced health policy decisions, health benefits package design, and quality improvement; what have been the major challenges and obstacles; how were these challenges overcome, in countries where HTA is more developed; what is the role or potential role of HTA in the country; what are support/mechanisms/knowledge that would be useful for the use of HTA in improving health policy, budget allocation, or HBP design; and, how countries may begin their HTA journeys with the lessons learned from others. The group also discussed the conducive factors to setting up an HTA agency and the process, opportunities, and challenges of the creation of a national or regional hub.

This meeting was intended to share the experiences of different countries and in what ways the iDSI can fill the gaps and needs regarding HTA development for evidence-informed priority-setting for healthcare. HITAP also came to support the creation of a South African national and regional hub to service sub-Saharan Africa. The group concluded on the usefulness of the workshop, with plans to convene annually or biennially. IC and PRICELESS will also be sharing the report detailing the outcomes and discussion points during the event.

Introduction

HITAP's work notably expanded to the international level in 2013 when HITAP International Unit (HIU) was established under HITAP with the main objective to provide support in building HTA capacity in low- and middle-income countries (LMICs). In collaboration with international partners such as NICE International (now the Global Health and Development team in Imperial College), UK, HITAP provides technical support and shares the Thai experience in generating and using HTA evidences to inform policy decision-makings to individuals from various developing countries such as Indonesia, Vietnam, Bhutan, etc. The support is provided in different forms, namely through study visits, technical workshops, trainings, internship and fellowship programs which may be on a one-off basis or part of a long-term collaboration, as in the case of Vietnam and Indonesia. In addition, knowledge transfer and exchange and experience sharing is also done through activities under HTAsiaLink, which is a network of HTA agencies in the Asia-Pacific region of which HITAP is a founding member. The network, established in 2010, is a means of building capacity of research staff from member organizations to strengthen HTA competency in the region.

Though its researchers have visited the country for conferences, workshops, and meetings, HITAP does not have a specific project in South Africa. However, through the International Decision Support Initiative, HITAP will be supporting the development of a South African HTA hub in PRICELESS, which has designs to aid the rest of the continent in the future. The hub in South Africa will be modelled after the HTAsiaLink and HITAP will assist PRICELESS on its development. HITAP provided introductory HTA workshops in Ghana, Tanzania, and other countries with iDSI and other partners in previous years as a preliminary move towards this goal.

HITAP is also building the Guide to Economic Analysis and Research (GEAR) online web resource which aims to provide immediate solutions to researchers in low- and middle-income countries for their methodological challenges in economic evaluation. This resource will be connected to the PRICELESS work and network and will be launched during the iDSI board meeting in March 2017.

This South-South knowledge sharing meeting will be expected to cater to participants from various countries and not just Africa (namely Cambodia, China, India, South Africa, Thailand and the UK). Our participation is part of HITAP and the HIU's goal in addressing global and country needs for HTA development, facilitating networks and productive relationships, and planning for future work.

Objective:

1. To address global and country needs for HTA development by facilitating networks and productive relationships as well as planning for future work in Africa and Asia.
2. To assist in the formation of a South Africa hub and network for the sub-Saharan Africa.

South-South Collaboration Workshop

Introduction

Prof. Karen Hofman and Francis Ruiz introduced the event and the goal of sharing the lessons from the setting up of HTA institutions in various countries and settings. The first session discusses the use of HTA to inform the health benefits package (HBP) for China, Cambodia, and South Africa.

Country Sharing: China

In China, HTA has been applied to insurance coverage. Management of technologies are on three levels: 2-3 levels are decided by the national MOH and HTA as well the provincial MOH and HTA; level 1 is decided on the hospital level. This has been manifested through areas such as drug management and the adoption of the "green path" for innovative drugs in FDA which has its equivalent assessment and research. On top of this, HTA demands come from several areas, around 7 departments of MOH. As a result, there are 5 ministries that issued national documents for HTA on September 5, 2016. These address the building of the HTA system and setting up a national HTA center, capacity building, and promoting the translation of HTA results to policy making.

Country Sharing: India

In India, the requests for HTA come from the Department of Health Research (DHR) and the Indian Council of Medical Research (ICMR). The recommendation for HTA to inform policy is included in the 12th five-year plan by the Planning Commission (National Institution for Transforming India or NITI Aayog). The Parliament has committed to the establishment of an Medical Technology Advisory Board (MTAB) with the goals of reducing OOP and streamlining medical procedures through HTA and research. The first steps to establishing MTAB was the convention of a 200-delegate 3-day workshop in July 25-27, 2016, which explained HTA and its role as well as explored current efforts in the country. The participants included stakeholders from all sectors, including the armed forces. DHR and iDSI partners developed a concept note from the results of the discussions during the event, which included the strategic plans and structure of the MTAB. A situational analysis on the HTA's situation in India was also conducted during the workshop. They found that many institutes identified that their organization has skills and work related to HTA, with high quality of evidence produced (e.g. peer reviewed publications). Some institutes also came together to work informally or formally on HTA projects. The participants expressed that they expected to see HTA's development considering issues such as its role (whether advisory or statutory), the media's role and involvement, the private sector regulation in regard to the implementation of HTA results, its methodology and quality of research, how it is used for price negotiations, and the power of the state vs. national level healthcare implementation.

Country Sharing: Cambodia

Since 1995, Cambodia's system has been divided into central, provincial, and referral hospitals or health centers as well as community systems. Most of the services are not free under the current coverage of social health protection mechanisms. The government drafted a health financing policy that may be endorsed by 2020; as such, high level stakeholders are discussing about the future insurance scheme of the country. They are addressing the capacity constraints in the country regarding healthcare; however, they have made some strides in creating an information system through the Health

Management Information Systems (HMIS). It covers information systems throughout the whole country, through web based reports, for planning and program reviews. The first routine data quality assessment was conducted in 2011, patient management and registration system (PMRS) has been expanded (this system is likened to the Health Equity Funds or HEF). There is some basis for starting HTA. However, there is still limited use of information technology and no HTA work has so far been conducted.

Country Sharing: South Africa

In South Africa, HTA was established in accordance with the national drug policy. It falls under the national health insurance, which is a sector wide insurance (e.g. they have western and traditional medicines included as well). HTA has been and can be used for deciding on essential and affordable medicines (e.g. Essential Drugs Program, Contracting (Products and Services), Contract Management, Central Procurement System, and Licensing and Workforce Unit). South Africa also have formularies, which are derived from the Essential Medicines List (EML), managed by the Pharmaceutical and Therapeutic Committees (PTCs), reflects therapeutic needs of the province and institution, and promotes equity and rational medicine use. They also have Standard Treatment Guidelines (STGs), which deals with priority conditions, standardizes care, "guides" therapeutic practice (though not replacing expert advice), and promotes equity and rational medicine use. In 2015, they began a mobile use of these national guides for primary, secondary, tertiary, and quaternary care. Their current decision-making process for the National Essential Medicines List Committee (NEMLC) includes all stakeholders with representation from each province, even from academia. They have policies on conflict of interest and confidentiality. They have a peer reviewed process, with expert committee inputs, and invite their participants to submit evidence-based reviews. While they have come to many decisions, one of their greatest challenges is assessing compliance to guidelines and usability.

South Africa's system works on the principles of equity and evidence. Their main criteria for considering interventions include the need, safety, efficacy, quality, cost, and affordability (outlined in their guideline). They also look at whether there are formulations of the drugs available in the country. To add a new medicine to the EML, they must be submitted through the PTC or through a Notice for Comment. Then the submission must include a completed standard motivation form, provide supporting evidence, and submit evidence based medicine review. The National Drug Programme (NDP) provides for the establishment of PTCs, national PTC policy, and PTC guidance document in development. These PTCs can be useful for HTA and there have been many meetings with them to discuss HTA and how to incorporate it in their work. However, the challenges include: the process's dependency on committees; lack of skilled experts who are fully committed to HTA; limited development of technical medicine reviews by various stakeholders including PTCs; lack of alignment with other guidelines including Department of Health programmes, clinical societies, etc.; lack of "buy-in" to the process (sometimes cancelling meetings, slowing down the process); and, too much focus on pharmaceuticals and not enough on other areas. Next steps include: development of EML Electronic Access (EMLeLA) Tool; assessment of functioning of PTCs; mentorship and skills development; improvement of stakeholder buy-in; and, assessment of guideline compliance and development/implementation of rational medicine use tools. However, they also hope to move from the current process to incorporating HTA.

In addition to drugs, South Africa's National Health Laboratory Service (laboratories and diagnostics present in every hospital in the country) is also another possible HTA area. There are currently 268 laboratories, with diagnostics tests ranging from simple to complicated; they are funded outside of government sources. HTA can be used for identification and priority setting as well as laboratory/clinic based performance evaluation. There is currently an HTA unit with these roles, and they have conducted HTA, majority on the point of care (HIV and malaria rapid diagnostic tests or RDTs, glucometers, blood gas analyzers, CD4/viral load, others). However, most of the team are clinicians with no experience in economic evaluations. Experiences for HTA are scarce and not always systematic.

A panel discussion outlined the following main points:

a. In China, what is the role of policy makers and their buy-in, as well as that from other ministers?
    i. China has a decentralized government, including their healthcare. The social medical insurance scheme is divided. For health governance, the advice for different areas comes from different ministries. However, they want to centralize this similar to Taiwan.
b. In South Africa, who decides and what is the pot of money for medicines? How do they decide to keep or remove the drugs? It is important to know who is deciding on the threshold and what the agreements are with the companies.
    i. When they add a drug, they must also remove a drug. Many departments don't know what the pot is.
c. In China, of the 95% of the population covered, what do they receive? Is there assessment done for these interventions?
    i. Rural populations have health insurance. Government pays for majority of this (under the Rural Cooperative Medical Systems or RCMS).
    ii. For the urban population, government has a pooling system.
    iii. For the urban poor, it is similar to RCMS, but slightly in terms of higher reimbursement.
    iv. For the different pooling, there is different insurance. They have the basic one for the i) and iii).
    v. However, they use low quality of evidence for this (e.g. they use expert groups).
d. In India and SA, what kind of HTA or legalized action can be implemented? For SA, how is the private sector involved?
    i. In India, it is always evolving. They have parliamentary debates. They have a structure for approving the process
    ii. In SA, they've started bringing in representatives to learn from each other and for them to be part of the process. Monitoring compliance is where they are having difficulties. The mobile application helps them to understand what the indication is on use of the guidelines. They are being accessed but there is no benchmarking.

A second session on experience sharing was conducted, which covered Thailand and the UK.

Country Sharing: Thailand

Netnapis Suchonwanich, on behalf of HITAP, shared the experience of HTA for NLEM and benefit package processes under the UHC in Thailand and provided the lessons learnt on HTA during UCS implementation such as appraisal results and decision making, generating cost savings from price negotiation. The experience sharing included a gap analysis for the present real world between government and industry and the lessons for more improvements in the future, for instance, induce OOP for uncovered indications due to restricted indication and experts for prescribing, delay access for some orphan diseases regarding to the threshold value of incremental cost effectiveness ratio (ICER) and underestimated for the number of target population, who under accessed, and laboratory investigation required effecting the budget affordability.

During discussion, one participant asked about the equity issue in the price negotiation process, to which Netnapis responded saying that the committee has negotiated the drug price for the people not only under UCS but all schemes. Moreover, the committee also considers social and ethical issues even though the drug is not cost-effective. If people cannot access this medicine, the committee decides to include to the essential drugs lists. Another participant asked a question about what other kinds of essential information is used for HTA analysis aside from the insurance data that they can get it in the national level. Netnapis explained that it depends on the stage of HTA development in each country i.e. if the country doesn't have a national database of medical services in individual records, maybe they have implemented the national survey in only some sites/provinces. In Thailand, the NHSO has a commitment to collect individual data to the central database and can use OPD and IPD data to negotiate with the bureau of the finance. It is very useful for HTA research for forecasting or estimating the burden of diseases.

The Thai experience is also covered in other study visits.[1]

Country Sharing: United Kingdom

In the UK, the main HTA agency, National Institute for Care and Excellence's (NICE) remit has grown. It now conducts technology appraisals, clinical guidelines, interventional procedures, medical technologies, and diagnostics HTAs; even pay for performance (P4P) schemes are included. NICE assesses a wide range of evidence: published studies (may include abstracts, registers, and audits), expert's advice, views of patients and carers, manufacturers, and other stakeholders. They have independent advisory committees, explicit and transparent processes, public consultation, and opportunity for appeal/resolution. One area of work is Technology Appraisal Guidelines, which looks at clinical aspects and cost-effectiveness ratios (with a threshold of 20,000 GBP). It is dominated by assessments of high cost/impact medicines and technologies, with some devices/procedures (e.g. hips, hernias, and stents), and the topic selection is agreed with the Department of Health (DoH). This is the only guidance in NICE that has a funding mandate; the drug or indication must also be made available in the National Health System (NHS) within 3 months after approval. It does not make recommendations but makes the decisions, which are done independently. Initially, this was difficult with the media. An example was the case of Relenza, which was not included in the Essential Drugs List. A study found that it would be cost-effective; NICE implemented it with government support,

[1] Indonesian Delegation Study Visit to HITAP, pages 7-8: http://www.globalhitap.net/resources/reports-publications-2/

strengthening their position. However, investment does not always mean that there are returns and it is important to also consider the compliance and monitoring. Factors of NICE's success include political and stakeholder buy-in and engagement as well as trust and credibility in the process.

The discussion points afterwards included the following main points:

- In Thailand, how much staff is needed to support price negotiation? How do you incorporate equity considerations in the decisions? When should HTA be considered - should it be at a specific % of coverage of population because it is difficult to have the insurance information?
    i. There are only 3 persons who work on price negotiations due to lack of capacity or skill. Most of them move to drug companies after they participate in the process. It is difficult to keep staff and make it sustainable due to better incentives in the private sector. Ethical issues are incorporated before the HTA was done.
    ii. In the beginning, they did not have good data, but in 2008, they had 100% of in-patient data centralized. After this, they could negotiate with the budget agency. However, OP data is still a problem.
- The HITAP and NICE model seem to be similar but they have differences on assessment and implementation of results. NICE outsources assessments (HITAP does in-house assessments) while HITAP only recommends and has an advisory vs statutory role (which NICE does). NICE started with technology appraisals and expanded. What would be the advice for countries like SA on where to start? Should you start with HTA only or all possible activities? What kind of staff requirements are needed?
    i. For HITAP, it does conduct research, but can also outsource. However, HITAP sets the standards for how to conduct the research. They also try to send these to private researchers. If there is clear guidance and this is assured in terms of quality, there is no problem.
    ii. Think about credibility. When thinking about these issues highlighted, it is important to incorporate credibility and capacity issues.
    iii. NICE operating costs are high annually in terms of process. In context, the cost is 0.01% of the total spending so in terms of value for money it's a great buy.
- There's been a lot of discussion around treatment and cure. NICE has been involved more in terms of health promotion and prevention. What are the areas that are good to start on, from the view of NICE and HITAP?
    i. HITAP: in the beginning, HITAP worked mostly on prevention of high cost medicines' inclusion in the National List of Essential Medicines (NLEM). But now, it starting to turn to health promotion given the national health security committee is increasing the budget and focus for health promotion. But the budget determination is not clear. For vaccinations, Thailand must set more steps. These needs to be approved from the national advisory board for vaccines. Another area is on screening, which is complicated and must include all aspects.
    ii. NICE: it is a similar trajectory with NICE and HITAP. It was a matter of politics, and the government believed in population level policies.

Panel:
The role of HTA

A panel on the role (or future role) of HTA in different settings was also conducted.

In India, priority setting will have to happen at all levels. It should go through central government financing, perhaps through the National Health Mission. Though this is a possible area for HTA, most of the evidence used is from expert opinion, and they are looking at HTA from the program perspective. They also want to cost hypertension treatment and management, given that non-communicable diseases (NCDs) are a major issue in the country.

In China, they have at least three ministries working on HTA. They have an issue on aging and NCDs, like India. HTA may focus on a single technology and thinking about the clinical pathway.

In Ghana, they've been implementing the National Health Insurance for a long time now. With its expansion, the government is struggling to cope with the expenditure involved. Now they have HTA as part of the medicines committee. They also have standard treatment guidelines that they are expected to review every 2 years. They have some rudimentary assessment on which medicines should be included. However, it is a difficult decision for them on where to include the committee.

In South Africa, it is important for them to consider high cost technologies as HTA areas. The national treasury did assessments in-house to address these kinds of interventions, e.g. maternal and child health projects. They would rather this be done external to the department. There are also HIV etc. projects. They can negotiate for more budget. Another area is the National Health Insurance (NHI) benefits package development. They try to support PRICELESS in different ways, and their head is part of the board. There is also a pricing association for pharmaceutical companies, which can be a starting point. There is a level above HTA where decisions happen on the political level.
From the WHO/global perspective, they have the mandate to support countries and develop policies to understand and implement HTA. The biggest difference for HTA is the mindset and having an explicit HTA process and a system based on evidence. This can protect countries when making unpopular decisions. The political and administrative structure of each country will need to be evaluated on how HTA can be incorporated and what their power is. The dissemination of information will be more difficult in the lower tiers of the system. There is no benchmark yet but WHO thinks that the process is more important. There are also questions on fragmentation and pooling.

Support/mechanisms/knowledge useful to support the use of HTA in improving health policy, budget allocation, and HTA design were explored afterwards, with the following main ideas: pilot HTAs with support from NICE/HITAP; improving institutionalization and buy-in from stakeholders; increased interest and awareness from many committees and departments; guidelines compiled from different countries; and, capacity building in the short- (e.g. workshops and trainings) and long-term (extensive technical and/or academic support for potential champions and researchers). Not all data is necessary, e.g. in Thailand, they have a minimum data requirement or core set (minimum for the DRG so all this can be used for HTA and provided to other countries). There needs to be harmonizing of guidelines and health information (e.g. minimum data set is useful, like in Thailand). However, one of the biggest challenges remains the funding of the agency/group.

The group concluded with the potential of working together. Each country's growth can also spur on other countries in the region and globally, with HTA as a useful tool to move towards UHC and evidence-based decision making.

Group Work: iDSI Assistance

The second and third days were more on the practical side, with many group work sections. HITAP shared the case study on the HTA developments in Indonesia. Alongside Francis Ruiz, HITAP also shared the factors conducive to the development of HTA in Asia, which can be helpful to other countries beginning HTA.[2]

The meeting started with the presentation about the factors influencing national and/or regional HTA hub development by Francis Ruiz and HITAP. The presentation on conducive factors to HTA development in the Asia Pacific region and country case studies for iDSI-led support was provided, followed by a framework to think about hub development, with theexample of the NICE reference case and the proposed plan of breakout sessions. Francis proposed that the theory of change to understand cause and effect in priority-setting. Next, HITAP provided the 6 contextual factors that frequently exist where HTA capacity has been developed, the key barriers identified to the development of HTA agencies, final key recommendations and the examples of iDSI support for HTA development in Indonesia and Vietnam. Following the presentation, Francis shared the example of a 'Reference Case' for economic evaluation. There was a question from the floor on how HITAP balances between the domestic and international work. HITAP supports the local partners in developing capacity but also do their domestic work i.e. training, helping them to understand the HTA, or economic evaluation concepts and advocacy in HTA process. Afterwards, the participants were encouraged to discuss in the group breakout sessions on conceptualizing hub development and thinking about challenges and solutions. They began by completing the framework through identifying common challenges/barriers to hub development in identifying the goals and vision, organizational form, human resource capacity, information systems and data, procedural and technical approaches, and any other ideas.

The discussions also revolved around what iDSI can provide to the partners, particularly in the creation of hubs that would provide support on HTA studies, institutionalization, and awareness-raising to other countries in the region. These functions are fulfilled by HITAP in Asia, PRICELESS in Africa, CGD in the Americas, and NICE in the UK.

Dr. Damien Walker discussed that there should be a focus on the purpose of the hub, whether regional or national, and explore what success looks like. While there is no one blueprint for doing HTA and having the system, there are common ingredients. It is important to identify which of those are relevant and ensure that the lessons learned are shared with the network.

Some of the suggestions included:

- Including pre- and post-implementation lessons learned in the reference case,
- Exploring having videos introducing HTA for beginners (with HITAP),

[2] Conducive Factors of HTA Development in Asia: http://www.hitap.net/en/news-document/documents#document-reportresearch.

- Staff exchanges,
- Producing and refining hubs business cases,
- Improving policymaker engagement,
- Having an online platform to link relevant HTA information, e.g. case studies from different countries (on a separate area, linking the Guide to Economic Analysis and Research webinar on the iDSI website),
- Improving information on thresholds,
- Facilitating information on state and provincial level thresholds,
- Improving the education opportunities for HTA (e.g. the course in Mahidol University, as well as having 3-month or shorter basic courses, specifically also for economic evaluations, and connecting with existing programs such as the distance-learning course in Sheffield),
- Collaborating on research,
- Sharing country materials through the online platform,
- Coordinating a costing consortium,
- Creating brochures, files, and documents for learning,
- And having trainings and placements.

In the afternoon, each group presented the reflections on group work and the reflections from the potential benefits or opportunities afforded by an established iDSI Hub support. The Cambodia representative said that they learned a much from each country i.e. HITAP model and how to strengthen HTA by supporting from hub and ensure that they can support each other. Moreover, if the hub can share the guideline, Cambodia may apply if it and be able to move forwards. Other suggestions were conducting price negotiation to the drug company together as a group of network or hub. Therefore, annual meetings are very important because it can facilitate trust and learning from each other. In addition, the Ghana representative said that the important issues were improving information systems and building capacity.

The group aimed to have another experience-sharing workshop annually or biennially.

Appendices

Appendix 1: Agendas

iDSI South-South Knowledge Sharing Workshops

DAY 1

Use of Health Technology Assessment (HTA) to inform health benefit package design

Timing: Tuesday 15 November 2016, 09:30am – 16:00pm

Venue: **St Andrews Room**, Irene Country Lodge

Agenda:

Session	Timing	Topic	Contributors
1	09:30	**Opening of workshop**	Karen Hofman and Yogan Pillay
2	09:40	**Welcome and Introductions** - Run through Day 1 objectives and agenda	Karen Hofman and Francis Ruiz
3	09:45	**International experiences of HTA: Country partner presentations (15m each)** - Overview of HTA journey and current status - Has HTA to date influenced health policy decisions / health benefits package design / quality improvement, and if so, how? - What have been the major challenges / obstacles to establishing an evidence to policy framework using HTA information? - Planned next steps in the HTA journey - Specific questions/issues would like the wider group to consider?	**China:** Representative from CNHDRC **India:** Vijay Gauba **Cambodia:** Vichearavouth Ly **South Africa:** Janine Jugathpal, Sarvashni Moodliar
	10:45	**Group discussion** - Reflections, discussion and response to country partners' questions	**All** Francis Ruiz (Chair)
	11:45	**Coffee Break**	
4	12:00	**International experiences of HTA: Lessons learnt (15m each)** - Description of HTA journey and how this has influenced HBP design / quality improvement / health policy decisions? - What have been the common challenges / obstacles (e.g. decentralised governments, role of private sector, political factors, availability of local data)? - How were these challenges overcome (e.g. importance of implementation tools, stakeholder engagement etc.)? - How might countries starting out on their HTA journeys leapfrog some of the common challenges for HTA development / to promote use of HTA in HBP design?	**Thailand (HITAP):** Netnapis Suchonwanich **UK (Imperial College):** Laura Downey, Kalipso Chalkidou
	12:30	**Q + A session**	**All** Karen Hofman (Chair)

Page **1** of **5**

	13:30	**Lunch**	
5	**14:30**	**Reflections for policy: Implications for wider implementation (1hr 15m)** - What role does HTA play / do you see for HTA in the design of health benefit packages, quality improvement, cost decisions in your own country? - What support/ mechanisms/ knowledge would be useful to support the use of HTA in improving health policy / budget allocation / HBP design?	**Panel –** **South Africa** Yogan Pillay **India** Charu Garg **Ghana** Edith Gavor **China** Kun Zhao **WHO** Tomas Roubal **Chair –** Anthony Kinghorn
6	**15:45**	**Final comments / take home messages**	**Kalipso Chalkidou and/or Karen Hofman**
	16:00	**End of meetings**	
	18:30	**Dinner at Irene Country Lodge**	

DAY 2

Sharing experiences of iDSI Hub Development

Timing: Wednesday 16 November 2016, 09:30am – 15:45pm

Venue: **Library Room**, Irene Country Lodge

Agenda:

Session	Timing	Topic	Contributors
1	09:30	**Welcome and Introductions** - Run through Day 2 objectives and agenda	Francis Ruiz (Imperial) Alia Luz and Suthasinee Kumluang (HITAP)
2	09:45	**iDSI HTA Hubs and factors that may support development (45m)** - iDSI HTA hubs – what are they and what do they seek to achieve? - Presentation of relevant high-level factors and issues for consideration when developing context specific hubs to support national and regional decision making - E.g. governance, human resources, information systems, methods development	**Imperial College (UK):** Francis Ruiz **HITAP (Thailand):** Alia and Suthasinee
3	10:30	**Hub development: Country partner presentations (15m each)** - Plans for HTA Hub development; progress so far - What have been/do you envisage as the key barriers/challenges to establishing / developing a local/regional Hub? - What do you see as the opportunities that can arise from establishing a local/regional hub in your own country setting?	**PRICELESS (South Africa):** Tommy Wilkinson and Ingrid Obery **CNHDRC (China):** Representative from CNHDRC **DHR/PGIMER (India):** Shankar Prinja
	11:15	**Coffee Break**	
4	11:30	**Group breakout sessions:** - **Part 1: Outlining/building on the principles of hub development –** identifying the right factors (30 min) - **Part 2: Identifying common challenges** / barriers to Hub development and implementation (30m) - **Part 3: Identifying potential solutions**; including how South-South partnerships and the iDSI network could be leveraged to support development of hubs? (30m)	**HITAP and Imperial colleagues to facilitate**
	13:00	**Group feedback and discussion (15m)**	**All**

		- Participants will populate a slide set or table framework for iDSI Hub development	
	13:15	**Lunch**	
5	**14:15**	**Brief reflections on group work and the resulting slide set/framework**	**All** (facilitated by HITAP and Imperial)
	14:30	**Reflections from potential beneficiaries /recipients of iDSI Regional Hub support (30m)** - Reflections on the iDSI Hub model and framework - What do you see as the potential benefits / opportunities afforded by an established iDSI Hub in the Sub Saharan Africa or South East Asia region?	**Ghana:** Edith Gavor **Cambodia:** Vanthy Ly
	15:00	**Group discussion**	**All** Damian Walker (Chair)
6	**15:30**	**Final comments / take home messages**	**Damian Walker**
	15:45	**End of Meetings**	
	18:30	**Dinner at Irene Country Lodge**	

DAY 3

Closed meetings for iDSI colleagues from South Africa, China, India and UK, Thailand

Timing: Thursday 17 November 2016, 09:30 – 11:30am

Venue: **Suite 118**, Irene Country Lodge

Agenda:

Session	Timing	Topic	Contributors
1	09:30	**Welcome, introductions and overview of meeting**	**Karen Hofman** (Chair)
2	09:40	**Reflection on the two-day workshop** How can the iDSI framework on hub development be taken forward? What further support is needed from the broader iDSI network around hub development? **Discussion around common themes** What opportunities are there for collaboration among the hub country partners?	**All** **Karen Hofman** (Chair)
	10.30	**Coffee Break**	
3	11:00	**Wrap up and agreement on next steps**	**Karen Hofman and Kalipso Chalkidou**
	11:30	**Close of meetings**	

Appendix 2: Photos


Goals and vision


Topic areas
• Prevention
• Chronic disease management, including multi-morbidities
• Anti-microbial resistance
• Public engagement
• Pharmaceutical expenditure
• Health benefit package design
iDSI