USING HEALTH TECHNOLOGY ASSESSMENT FOR UNIVERSAL HEALTH COVERAGE AND REIMBURSEMENT SYSTEMS

Geneva, Switzerland

2-3 November 2015

WHO/EMP/PAU/2016.01

Executive summary

A two day meeting was held to discuss the use of health technology assessment (HTA) for universal health coverage and reimbursement, as a follow-up to a small consultation held in July 2015 (web address). The meeting brought together experts in HTA and pharmaceutical economics from academia; representatives from many countries that are using HTA in different ways as well as representatives from agencies and international organisations. (Annex 1). The aims of the meeting were to:

1. Provide an overview of the progress towards the WHA resolution from WHO's perspective
2. Establish the role of WHO in the global HTA landscape in terms of technical and process guidance
3. Gain consensus on how to move the HTA agenda forward in a cohesive manner

A number of areas of WHO work were presented to participants at the meeting. These included: the results of a global survey of Member States, assessing their current capacity, activities and needs with respect to health technology assessment; a brief description of some of the WHO normative guidance that contribute to health technology assessment in countries; and work on priority setting and cost effectiveness thresholds. The experience of the PAHO region with respect to capacity development in HTA was also provided.

Participants from different countries presented national needs with respect to development of health technology assessment, as well as short summaries of how existing systems in countries including Brazil, Estonia, New Zealand and Norway (as examples of different approaches to using HTA) have evolved. A review of the approach of countries in the OECD to using HTA was also provided. Country profiles that had been developed by WHO were provided as drafts to be used as a basis for possible further work on guidance for systems that want to use HTA in decision making.

Several international organizations presented their current activities and experience in relation to networking, capacity development and projects supporting the use of HTA. It was clear that other international professional societies, such as HTAi and ISPOR, and networks such as EUROSCAN and INAHTA, among others, have active programs supporting capacity development that reach many different regions. Many academic institutions are also providing capacity development and training programs that are relevant to HTA. Proposals for use of HTA by the Global Fund were also discussed.

Participants contributed to small group discussions that were asked to consider four questions:

- What guidance [in relation to HTA] needs to be developed and by which organizations? Is there a need for guidance on HTA processes or HTA methods?

- What structures and processes need to be put in place to ensure optimization for capacity development?
- What are the roles and responsibilities of different stakeholders [with respect to development of HTA]?
- How can we as the global community avoid duplication and enhance collaboration?

Based on the meeting discussion, the priority areas of further work for WHO were identified as:

1. *Supporting the development of appropriate principles to use HTA in health systems and decision-making*. It was noted that, notwithstanding the work by many international partners, there is considerable confusion about what health technology assessment is, what its strengths and limitations are, as well as how best to use it in decision-making, particularly for Universal Health Care (UHC). It was proposed that HTA needs to be seen as a set of skills, and tools, not just a report, and needs to be developed in countries in a way that it is – from the beginning - linked to decision making. The role of WHO in this area will therefore include ensuring understanding of health technology assessment, as well as promoting principles for its use in health systems, including fairness and equity and transparency in the context of developing universal health coverage. Other key principles include how to involve stakeholders at national level in health technology assessment systems, and if health technology assessment of topics is undertaken, how to ensure that the process of selecting topics is undertaken in a way that is consistent with good governance and transparency, as well as relevant to the countries current decision context.

2. *Defining the components required for health systems to use HTA effectively and appropriately to support universal health coverage.* Ensuring a culture of using evidence for decision-making in policy choices, combined with an appropriate legislative and policy framework and access to local data, especially for costs and resources, were considered to be key aspects. Having effective linkages between all these components and policy decisions is required to make a coherent system for UHC that includes effective design of a reimbursement (benefits) package with an appropriate funding model. It was noted that international partners have done some preliminary work on this area and it was agreed that it is important not to duplicate existing projects, but to develop them further to satisfy the requests from a number of countries for technical support in this area.

3. *Development of normative guidance that complements existing methodological standards as well as filling some of the gaps.* It was noted that there are numerous international and national methodological guidance documents in relation to HTA, and the challenge therefore is to ensure that there is access to these existing standards as well as no further duplication. It was considered that there is a need to consolidate WHO's standards on cost-effectiveness evaluation and ensure that they include advice on considering budget impact and affordability. In addition, providing countries guidance

on use of all of these methods for decision making, whether as decision rules or systems, was considered to be important. Localisation of existing standards was recognized as a key step to promoting their adoption and use. It was considered that WHO could promote the development of international guidance on using different data sources for measuring utilization of health technologies, and for disinvestment decisions, how to communicate decisions and how to link assessment of evidence with price negotiation and price setting for reimbursements packages.

Horizon scanning was identified as another particular area for WHO to consider especially given its existing collaboration with EUROScan. Having a global assessment of new health technologies or medicines in development, with prioritization of those likely to be essential, was seen as a potentially useful function. In addition, information about timing of the introduction of generics and biosimilars for medicines was also considered important for national decision making.

4. *Developing an approach to monitoring expansion and uptake of use of HTA.* Following on the WHA Resolution that requested the Director General assess the status of HTA in Member States, it was considered that monitoring future development would be essential. In areas such as capacity development for example, there are many activities that are ongoing. WHO could provide a clearing-house function, and work with many partners to ensure that capacity development meets countries' needs.

5. *Providing a mechanism for coordination of the work on HTA.* It was noted that there is a need for coordination of the work on HTA, especially in countries that are changing their systems to develop UHC but many networks and collaborations have already been established. WHO can provide facilitation for networks, and will concentrate on areas where there appears to be most need. It was also noted that there is a need to facilitate collaboration in other ways, such as the development of assessment reports that are global public goods, or making existing reports available. WHO will explore ways to make this possible.

This meeting was organized with the financial contributions of the Bill and Melinda Gates Foundation and the European Commission through the EU/ACP/WHO Renewed Partnership. The outcome of the HTA consultations will provide guidance to the 15 African ACP countries that were part of this project and more particularly those establishing reimbursement systems.

Background

The resolution on Health Intervention and Technology Assessment in Support of Universal Health Coverage (WHA67.23, 2014) called on the World Health Organization (WHO) to develop global guidance on methods and processes for Health Technology Assessment (HTA).

The definition of HTA, according to the WHO Executive Board paper EB134/30 is:

> *'.....is the systematic evaluation of properties, effects and/or impacts of health technologies and interventions. It covers both the direct, intended consequences of technologies and interventions and their indirect, unintended consequences. The approach is used to inform policy and decision-making in health care, especially on how best to allocate limited funds to health interventions and technologies. The assessment is conducted by interdisciplinary groups using explicit analytical frameworks, drawing on clinical, epidemiological, health economic and other information and methodologies. It may be applied to interventions, such as including a new medicine into a reimbursement scheme, rolling-out broad public health programmes (such as immunization or screening for cancer), priority setting in health care, identifying health interventions that produce the greatest health gain and offer value for money, setting prices for medicines and other technologies based on their cost–effectiveness, and formulating clinical guidelines.'*

The WHA resolution requested that the Director -General address several matters.

The first matter requested in the resolution was to assess the status of health intervention and technology assessment in Member States. WHO has carried out that assessment and the results are presented further below.

The second item requested of the Director General was *'to raise awareness, foster knowledge and encourage the practice of health intervention and technology assessment and its uses in evidence-based decision-making among national policy-makers and other stakeholders, by drawing best practices from the operation, performance and contribution of competent research institutes and health intervention and technology assessment agencies and programmes*.' From the preliminary consultation held in July 2015, it was clear that there are many models of systems that use HTA effectively, and there is no single correct approach for all countries. Following that meeting, WHO has undertaken preliminary work about 'pathways' to using HTA in decision-making systems and this is also presented below.

Item 3 in the resolution was ensuring that WHO itself uses principles of HTA in its own areas of work. An internal review has been carried out and many aspects of WHO normative work are using health technology assessment, such as the guidelines development process and the essential medicines list. However, there is a need to further develop some internal standards, to ensure capacity at all levels of WHO and this is also presented.

The fourth request of the Director General was '*to provide technical support to Member States relevant intergovernmental organizations and global health partners*'. Given the extensive amount of guidance in relation to HTA that already exists, it is important for WHO to not duplicate existing efforts. The aim of this current meeting, therefore, was to identify areas where WHO guidance would be relevant. Finally, the resolution requested the Director General '*to support the exchange of information, sharing of experiences and capacity-building in health intervention and technology assessment through collaborative mechanisms and networks at global, regional and country levels, as well as ensuring that these partnerships are active, effective and sustainable*'. Noting the many networks in existence, the purpose of this meeting was to identify how WHO could best contribute to furthering the current activities.

Meeting objectives

The objectives of the meeting were to:

1. Provide an overview of the progress towards the WHA resolution from WHO's perspective
2. Establish the role of WHO in the global HTA landscape in terms of technical and process guidance
3. Gain consensus on how to move the HTA agenda forward in a cohesive manner

Summary of presentations

[Slides presented are available on request]

Brief update of the work of the WHO

1. Assessment of the status of health intervention and technology assessment in Member States

The result of the survey undertaken by WHO were presented. The full report of that assessment is available on WHO website[1]. One hundred and eleven Member States responded to the survey questionnaire between 24 February and 31 August 2015. The main findings from the survey are reproduced below, in Box 1.

[1] http://www.who.int/health-technology-assessment/MD_HTA_oct2015_final_web2.pdf?ua=1

Box 1: Main findings of the 2015 Global Survey on Health Technology Assessment by National Authorities

Human resources and institutional capacity

- Most countries have a process of collecting and analysing information about health technologies or interventions and assessing their impact. However, few countries referred to this process as HTA.
- Two in three countries reported having a national HTA organization or department, unit or committee that produced HTA reports for the ministry of health.
- Most countries reported having more than six staff members in the HTA unit/agency and committee.

Methodology

- HTAs in most responding countries appeared to focus primarily on safety and clinical effectiveness, followed by economic and budgetary considerations. Little consideration was given to issues of ethics, equity and feasibility.

Governance and linkage between HTA units/ networks with policy authorities

- Ministries of health or national health insurance bodies were the main initiators of most HTAs.
- Public health professionals (including epidemiologists, biostatisticians, health economists and others) and experts in clinical sciences (medical doctors, nurses, pharmacists, and health professional organizations) were commonly involved in HTA preparation and decision making.
- Civil society representatives were given the opportunity to comment on the recommendations of an HTA report in half of the countries.

Utilization of results

- Findings from HTA-related organization(s) played an advisory, rather than mandatory, role for policy decisions in a majority of the responding countries.

Impediments to strengthening capacity

- A lack of qualified human resources appeared to be the main barrier for producing and using HTA.
- Most countries did not have academic or training programmes to build HTA capacity.

WHO will continue to undertake activities to raise awareness promote knowledge and encourage the practice of HTA, and its uses in evidence-informed decision making.

WHO will share and discuss the findings of this survey with country representatives, academia, and with HTA networks.

2. Work on priority setting

WHO presented the conceptual basis for ongoing work on priority setting, efficiency and fairness in the pathway to UHC. Priority setting and HTA are intrinsically linked. Priority setting considers many criteria, such as fairness, efficiency, financial risk protection and pro-poor policies. The quantitative evidence base for priority setting includes economic evaluation in all its forms – cost-effectiveness analysis, cost-benefit analysis and investment case analysis. Theoretically priority setting could be considered as a separate exercise to decision making in health, however often these are overlapping constructs in real life.

Priority setting asks the question "what is the best that can be done?" This question should be asked in the absence of constraints, and not at the margin. The WHO-CHOICE programme at WHO undertakes a form of cost-effectiveness analysis useful for priority setting, by removing any existing constraints, such as budget, human resource availability, lack of supply chain etc. Priority setting can address questions across all the dimensions of the UHC framework. The decision making process then works in small time frames to advance the current situation toward the long-term priorities.

WHO has developed a set of guidelines on "Making Fair Choices on the Pathway to UHC" which identifies a framework for incorporating fairness considerations into decision making. This work suggests that services should be categorized into priority classes using the criteria of cost-effectiveness, priority to the worse off and financial risk protection. Priority interventions should first be expanded to all those who need them, with subsequent expansion to other interventions and populations.

3. Work on cost effectiveness thresholds

WHO presented a brief overview of the history and use of GDP-based cost-effectiveness thresholds, and views on the use of these thresholds. Many countries currently use cost-effectiveness analysis and CERs as an input into resource-allocation decisions, in theory enabling comparison of the efficiency of alternatives. Deciding what is an 'acceptable CER', however, requires a criterion i.e. a cost-effectiveness threshold (CET).

GDP based thresholds arose from the Commission on Macroeconomics and Health report, presented to the WHO Director General in 2001, and were adopted by WHO-CHOICE, for use in normative, global cost-effectiveness analysis. These global level cost-effectiveness studies are intended to indicate interventions which a country may consider, but are not intended to be prescriptive lists of interventions which should be funded. Subsequently many countries have developed CETs which are based on GDP, which is considered to be a mis-use of this form of threshold setting.

Using cost-effectiveness information in decision-making remains challenging. The view of the WHO Secretariat is that fixed cost-effectiveness thresholds should not be used as an isolated criterion for decision-making. Above all, countries should generally **not** use '3 x GDP per capita' for national funding decisions or for setting the price of interventions,

including new pharmaceutical products. WHO-CHOICE has never recommended this practice at the country level for budget decisions, which is a distortion of the intention and meaning of the thresholds proposed by the Commission on Macroeconomics and Health. Fixed thresholds in and of themselves are not very informative, except perhaps in narrowing the field of options for consideration when used in conjunction with other criteria.

4. Work on 'pathways'

WHO presented a preliminary framework on "Pathways to building evidence-informed decision making to strengthen health systems". The presentation first outlined the findings of a targeted literature review on relevant existing guidance documents, and circulated case studies on the historical pathways of HTA system development in eight countries.

The framework outlines the main components and steps in establishing or enhancing existing HTA systems, where HTA would interact with other parts of the health system (e.g. health information, service delivery). The presentation emphasized that the framework must not be interpreted as prescriptive, exhaustive or linear because system development would be influenced by a myriad of contextual, political and system factors. The presentation also described the strengths and weaknesses of adopting system changes incrementally as opportunity arises, and through strategic planning. It suggested that setting strategic intermediate actions would prevent the risk of stalling due to a lack of clear goals from the outset, as commonly observed in opportunistic system changes. In contrast, setting strategic intermediate actions would also prevent inaction due to setting unachievable goals.

The preliminary framework consisted of five process steps (environment scan, identifying and prioritizing, planning, implementing, and monitoring); six components (health system, political-legal environment, stakeholders, service delivery, health information, and resources); and a number of outputs (e.g. strategic plan, working groups, transparent processes, implementing HTA informed decision, review of governance and processes, routine reporting of technology use and expenditure). Six components under environment scan were presented in detail to outline the main issues for consideration (e.g. assessing ownership of responsibility in the Health System, and stakeholder mapping and engagement). During the discussion, it was emphasized that HTA system development should be broader than simply setting up a physical institution.

Update on country needs

The presentations from four countries[2] with HTA systems in development highlighted the following issues.

[2] Ghana, Indonesia, South Africa and Chile

Developing a system to use HTA requires not only methodological capacity such as health economics, but also governance structures, including legislation, and clear lines of accountability for decision-making. Political support and leadership is essential. There was discussion about whether a single 'institution' was useful; it was agreed that each system needs to develop a structure that best meets local needs and this may or may not be a single independent organization. It was noted that developing partnerships with academic institutions was a useful strategy.

Advice on how to fund a HTA process and what the roles of the various stakeholders (for example, the pharmaceutical industry and patient groups) should be, is needed. If components that are relevant to HTA, such as local clinical guideline development processes already exist, then it is important to work out how to link them to further decision-making, such as defining a benefits package. Information about local cost and resource use is also essential, especially when considering how to invest in new technologies or disinvest from existing products.

The degree of duplication of assessments was also raised. Even in high income settings, it was noted that there are many agencies and organizations who appear to re-do assessments. The question of whether this use of resources could be redirected to collaboration was raised.

Finally, it was noted that HTA should not be seen as a 'magic bullet'; that it would not alone lead to a sustainable system for universal health coverage and that it needed to be seen as one of several tools necessary for ensuring improving health outcomes.

Experience from existing systems

Representatives from some countries with well-established systems provided their perspectives on how systems develop. These presentations reinforced the view that systems need to evolve to suit local contexts and require political will and legislative support. The importance of linking HTA to decision-making was emphasized.

The Pharmaceutical Management Agency (PHARMAC) in New Zealand: PHARMAC was created in 1993 intended as "a special purpose, stand-alone vehicle with qualified people to develop processes and make funding decisions, with nation-wide consistency and good governance… ready to defend the inevitable court cases". The current legislative objective underpinning PHARMAC was "to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided". PHARMAC has a wider role in managing pharmaceuticals used in the community, hospital medicines and medical devices, and monitors outcomes in terms of indices on cost, subsidy, volume and mix of pharmaceuticals. PHARMAC intends to manage hospital devices from the current system of national contracting to market share procurement.

The Norwegian Medicines Agency (NOMA): NOMA was established more than 50 years ago and the mandatory use of HTA in decision making was introduced in 2001. Currently,

NOMA selects pharmaceuticals for inclusion on the positive list for use in outpatient and inpatient settings based on criteria on: (1) disease severity; (2) needs; (3) clinical relevance; and (4) cost of medicine compared to its therapeutic benefits and the costs of alternatives. The presentation noted challenges in (1) the timeliness of undertaking HTA especially when clinicians and the patients have expectation to access new medicines immediately; (2) negotiation of sustainable and affordable prices; (3) managing budget impacts; and (4) interpretation of cost-effectiveness evidence with consideration to budgetary consequences.

The Estonian Health Insurance Fund (EHIF) was established in 2001 as a public independent legal body with Supervisory Board lead by Minister of Labor and Health to be a single strategic purchaser of services. The legal framework for evaluating cost-effectiveness for pharmaceuticals was established in 2002, with subsequent or planned expansion to include health services, new medical devices. Main challenges included (1) lack of human and time resources (currently mitigated by outsourcing); (2) insufficient awareness and motivation to accept HTA among clinicians and interest groups (mitigated by having legislatively supported transparent rules) and (3) balancing the notion of justice and ethics in decision making (e.g. in orphan diseases and oncology medicines). The presentation emphasized the importance of partnership and cooperation, sustainable processes and financing, legislative support, and capacity building. The Estonian system is currently strengthening the link between HTA components by fostering strategic leadership (e.g. in topic selection, awareness raising, EBM training), establish Estonian Healthcare Quality Center, and promoting transparency and accountability.

The **SUS Collaborating Centre on Technology Assessment and Health Excellence** (CCATES) presented a video[3] that described its role and HTA in decision making. These include undertaking HTA, promoting the quality of prescribing, and use of drugs, procedures and other health technologies, and the use of computerized systems for electronic health register.

Existing guidance, and additional areas for possible guidance development

Several organizations provided information about the existing guidance documents for HTA. The EUNetHTA guidelines were described as well as those provided by ISPOR. Other society guidelines including those from HTAi and INAHTA were also recognized. It was noted that national organizations also provided local guidelines on HTA that were adapted to the local context and system.

It was recognized that guidelines on determining budget impact and affordability were also needed, as well as the existing guidelines on cost-effective analysis. International societies in epidemiology and pharmacoepidemiology provide methodological guidance in CEA and budget impact analysis, but they may not be linked explicitly to reimbursement decisions,

[3] http://www.ccates.org.br/content/index.php?l=en

and they also may not meet the needs of LMIC. It was agreed that it is important to establish systems of local data collection and analysis to form the basis or benefit package design.

It was also recognized that to be effective, use of HTA requires involving appropriate stakeholder groups. Guidance on how to engage stakeholders including patients and consumer representatives, is also needed, as well as guidance on how to appropriately engage with technology and pharmaceutical manufacturers.

Existing networks and experience in capacity development

The experience of several existing HTA networks was described as well as the experience in capacity development. Cochrane described their experience over the past two decades of building capacity globally in systematic review methodology. The PAHO experience and new tools for capacity development were mentioned in the context of the European funded project, Advance HTA. The work of the HTA AsiaLink group and also the IDSi partnership were also presented. Many other networks and experiences relevant to HTA capacity development were identified even if not presented in detail. The Global Fund, for example, is examining options to support capacity development in HTA at country level as part of its 'concept note' process, where countries determine their priorities and prepare a 'concept note, to apply for funding, reviewed by technical experts, and approved on merit. The challenges of avoiding duplication and ensuring effective coordination, especially when supporting individual countries, were clearly identified.

Given the large number of networks and activities, it was considered relevant for WHO to support existing networks, including expanding the existing scope of work, but also to initiate new activities. It was also considered useful for WHO to explore ways to promote collaboration and effective information sharing, especially with regard to access to HTA reports. Sharing of capacity development between the major professional societies, for example, might harmonise approaches and optimize use of existing resources and ensure an appropriate quality standard. A clearing-house function for information sharing would potentially be useful as well. As summarized by the ADVANCE HTA project, the needs should be addressed for HTA capacity development are:

- Role, governance, scope, processes, stakeholder engagement
- Fragmentation in the conduct of HTA (MoH, insurers, universities)
- Focus (drugs, devices; policy-making, research only)
- Human resources
- Financial resources
- System resources (data often not available)
- Fragmentation of HCS
- Link between HTA and decision-making (coverage decisions)
- Link between HTA and the rest of the health care system
- Legal framework/HTA legally mandated?
- HTA tools & transferability of HTA results

Priorities for WHO

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4. *Supporting the development of appropriate principles to use HTA in health systems and decision-making*. It was noted that, notwithstanding the work by many international partners, there is considerable confusion about what health technology assessment is, what its strengths and limitations are, as well as how best to use it in decision-making, particularly for Universal Health Care (UHC). It was proposed that HTA needs to be seen as a set of skills, and tools, not just a report, and needs to be developed in countries in a way that it is – from the beginning - linked to decision making. The role of WHO in this area will therefore include ensuring understanding of health technology assessment, as well as promoting principles for its use in health systems, including fairness and equity and transparency in the context of developing universal health coverage. Other key principles include how to involve stakeholders at national level in health technology assessment systems, and if health technology assessment of topics is undertaken, how to ensure that the process of selecting topics is undertaken in a way that is consistent with good governance and transparency, as well as relevant to the countries current decision context.

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ANNEX 1: LIST OF PARTICIPANTS

Participants who joined via WebEx are marked with an asterisk.

Name	Title and organization
Stakeholders	
Jeonghoon **Ahn**	Secretary, HTAsiaLink. Senior Director, National Evidence-based healthcare Collaborating Agency (NECA), Republic of Korea
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Marina **Cerbo**	Executive Committee Member, EUnetHTA
Kalipso **Chalkidou**	Director, NICE International, National Institute for Health and Care Excellence, The United Kingdom
Americo **Cicchetti**	Secretary, Health Technology Assessment International
Steffan **Crausaz**	Chief Executive, PHARMAC, New Zealand
Sylvia **De Haan**	WHO Coordinator, Communications and External Affairs Department, Cochrane
Rassoul **Dinarvand**	Deputy Minister of Health, President, Iran Food and Drug Administration, Islamic Republic of Iran
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Name	Title and organization
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Christine **Leopold***	Post-Doctoral Research Fellow Department of Population Medicine | Drug Policy Research Group Harvard Medical School & Harvard Pilgrim Health Care Institute
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Kamila **Malinowska**	Head of Analysis and Strategy Division | President's Office Agency for Health Technology Assessment and Tariff System, Poland
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Valérie **Paris**	Senior Health Policy Analyst – Project leader (Pharmaceuticals, Value for Money), OECD
Adriana **Platona**	Assistant Secretary, Pharmaceutical Evaluation Branch, Department of Health, Australia
Libby **Roughead**	Research Professor, School of Pharmacy and Medical Sciences, University of South Australia
Sudigdo **Sastroasmoro**	Chairman, Health Technology Assessment Committee, Ministry of Health, Republic of Indonesia
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J. L. (Hans) **Severens***	Professor of Evaluation in Health Care, Institute for Health Policy and Management (iBMG), Institute for Medical Technology Assessment (iMTA), Erasmus University Rotterdam; Vice-President, Health Council (the Netherlands), the Netherlands
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David **Tovey**	Editor in Chief, Cochrane Editorial Team
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Name	Title and organization
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Julia **Watson**	Senior Health Economist, Department for International Development, The United Kingdom
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Alexander **Winch**	Health Economist, The Global Fund, Geneva
Anna **Zawada**	Director at Agency for Health Technology Assessment, Agency for Health Technology Assessment and Tariff System, Poland
Frank **Zongo***	Assistant UFR Sciences santé chez Université Ouagadougou, Burkina Faso
Regional Offices	
Guillaume **Dedet***	Technical Officer, Health Technologies and Pharmaceuticals, EURO
Alexandre **Lemgruber**	Regional Advisor, Health Technologies, Department of Health Systems and Services, AMRO/PAHO
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Jane **Robertson***	Technical Officer, Health Technologies and Pharmaceuticals, EURO
Klara **Tisocki***	Team Leader, Essential Medicines and Health Technologies, WPRO
WHO Headquarter	
Melanie **Bertram**	Technical Officer, Health Systems Governance and Financing, Costs, Effectiveness, Expenditure and Priority Setting, Geneva
David **Clarke**	Health Systems Adviser Law and Governance, Health System Governance, Policy and Aid Effectiveness Health Governance and Financing Department, Geneva
Kees **De Joncheere**	Director, Essential Medicines and Health Products, Geneva
Gilles **Forte**	Coordinator, Essential Medicines and Health Products, Policy Access and Use, Geneva
Suzanne **Hill**	Senior Advisor, Essential Medicines and Health Products, Policy Access and Use, World Health Organization, Geneva
Matthew **Jowett**	Senior Health Financing Specialist, Health Financing Policy, World Health Organization, Geneva
Joseph **Kutzin**	Coordinator, Health Financing Policy, World Health Organization, Geneva
Marie-Paule **Kieny**	Assistant Director General, Health Systems and Innovation, World Health Organization, Geneva
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Name	Title and organization
Agnes **Soucat**	Director, Health Systems Governance and Financing, Costs, Effectiveness, Expenditure and Priority Setting, World Health Organization, Geneva
Tessa **Tan-Torres Edejer**	Coordinator, Health Systems Governance and Financing, Costs, Effectiveness, Expenditure and Priority Setting, World Health Organization, Geneva
Kiu Siang **Tay-Teo**	Technical Officer, Essential Medicines and Health Products, Policy Access and Use, World Health Organization, Geneva
Adriana **Velazquez Berumen**	Essential Medicines and Health Products, Policy Access and Use, World Health Organization, Geneva

ANNEX 2: Meeting agenda

Consultation on Using Health Technology Assessment for Universal Health Coverage and Reimbursement Systems
2-3 November 2015
Salle B

Meeting aims

1. Provide an overview of the progress towards the World Health Assembly resolution
2. Establish the role of WHO in the global HTA landscape in terms of:
    a. Technical guidance
    b. Process guidance
3. Gain consensus on how to move the HTA agenda forward in a cohesive manner

Agenda

Monday 2 November 2015

Session 1: HTA at WHO

9.00-9.15	Opening remarks and objectives of the meeting Assistant Director General, Health Systems and Innovation (HIS), Dr Marie-Paule Kieny
9.15-9.45	Introduction of participants Information on administrative and logistic issues
9.45-10.00	HTA at WHO: The World Health Assembly Resolution and mandate Director, Essential Medicines and Health Products (EMP), Dr Kees De Joncheere
10.00- 10.15	HTA and Universal Health Coverage Director Health Systems Governance and Financing (HGF), Dr Agnes Soucat
10.15 – 10.30	Findings of WHO 2015 Global Survey on HTA by National Authorities Ms Adriana Velazquez Berumen, EMP
10.30 – 11.00	Coffee break

Session 2: Needs of countries
Chair: Prof Hans Severens (the Netherlands)

11.00 – 12:30 What are the current needs of countries in developing and implementing HTA?

- Dr Martha Gyansa-Lutterodt, Ghana
- Prof Sudigdo Sastroasmoro, Indonesia
- Prof Fatima Suleman, South Africa
- Ms Marianela Castillo, Chile

12.30-13.30 Lunch break

Session 3: Standards and Methodological Guidance
Chair: Dr Martha Gyansa-Lutterodt (Ghana)

13:30- 13:50 WHO products that contribute to HTA
Dr Tessa Tan Torres Edejer, HGF/WHO

13:50-15:30 Specific standards and methodological guidance: what currently exists and what is needed

- EUNeHTA Guidelines - Dr Marina Cerbo
- Priority setting, equity and efficiency – Dr Jeremy Lauer, HGF/WHO
- Cost-effectiveness Thresholds - Dr Melanie Bertram, HGF/WHO
- Expenditure and utilization data – Prof Libby Roughead, Australia
- Patient input to HTA - Ms Alison Lightbourne, International Alliance of Patients' Organizations

15:30 – 16:00 Coffee break

Session 4: The landscape of international networks and funding agencies
Chair: Ms Adriana Platona (Australia)

16:00 – 17:30 Capacity development for evidence based decision-making and HTA – needs, experience and current plans

- Cochrane - Dr David Tovey or Ms Sylvia de Haan
- PAHO experience – Mr Alexandre Lemgruber
- HTAsiaLink - Dr Jeonghoon Ahn
- Advance-HTA - Prof Panos Kanavos
- IDSi - Dr Kalipso Chalkidou
- An academic perspective- Prof Lou Garrison
- The OHE reports - Prof Adrian Towse/Prof Chris Henshaw
- The Global Fund - Dr Michael Borowitz

17.30-17.45 Summary of day one - Secretariat

18.00-19.00 Reception

Tuesday 3 November 2015

Session 5: National HTA Systems – options for systems, processes and structures
Chair: Prof Rassoul Dinarvand (Iran)

9.00 - 9.30 Using HTA to define benefits packages - OECD review of experience in countries
Ms Valérie Paris, OECD

9.30 – 10.15 National systems for evidence based decision-making for UHC – examples of how they have developed
- Dr Steffan Crausaz, PHARMAC, New Zealand
- Ms Mari Mathiesen, Estonian Health Insurance Fund, Estonia
- Ms Kristin Helene Svanqvist, Norwegian Medicines Agency, Norway
- Dr Augusto Guerra, CCATES, Brazil

10.15- 10.30 Discussion

10.30-11.00 Coffee break

Session 6: Process Guidance
Chair: Prof Fatima Suleman (South Africa)

11:00-11.30 Pathways to building evidence-informed decision making to strengthen health systems – Preliminary framework for discussion.
Dr Kiu Tay-Teo, EMP

11.30 -12.30 Small group discussion:
What guidance needs to be developed and by what organisations? Process vs methods?
What structures and processes need to be put in place to ensure capacity development?
What are the roles and responsibilities of different stakeholders?
How can we avoid duplication but enhance coordination?

12.30-13.30 Lunch break

Session 7: Looking ahead – what is needed?
Chair: Prof Lou Garrison (USA)
13:30-14:30 Continue small group discussion

14.30 – 15.30 Report back

15.30-16.00 Coffee break

Session 8: Closing
Chair: Dr Kees de Joncheere, WHO

16.00-17.00 Secretariat summary of the meeting and proposed next steps
Dr Sue Hill

17.00 Closure of meeting