Question	Answer
Good Morning Dr. Miot, can you provide the name of the site where the HTA is housed? I didn't get the name clearly.	HTA is conducted in many places but the key public health HTA is housed within the Department of Health and the Essential Drugs Program. The National Essential Medicines List Committee is the main user of HTA and decision-making body.
'@Dr Miot: It is so interesting to hear about how you enhance transparency, by making the evaluations available online. Do know which stakeholders utilize this access most, i.e. clinicians, patients?	
For Dr Miot: in what extent does the HTA review accounts for and requires the inclusion of Asian patients to enable the reimbursement and coverage decisions in China, and in what proportion drugs have been approved by bridging and/or translating the evidence from non-Asian populations? As new drugs emerge from Asian companies as tested in Asia-based trials, such a situation is coming often in EU and US - notably the case of sintilimab in lung cancer.	High possibility to use non-Asian populuation RCT for those innovative drugs since they are accessing market quite recent. The other way to look at those dossiers is to have asian data as a sub-sample.
For Dr Miot: in what extent does the HTA review accounts for and requires the inclusion of Asian patients to enable the reimbursement and coverage decisions in China, and in what proportion drugs have been approved by bridging and/or translating the evidence from non-Asian populations? As new drugs emerge from Asian companies as tested in Asia-based trials, such a situation is coming often in EU and US - notably the case of sintilimab in lung cancer.	However, cost analysis is better to have local data.

For Dr Miot: in what extent does the HTA review accounts for and requires the inclusion of Asian patients to enable the reimbursement and coverage decisions in China, and in what proportion drugs have been approved by bridging and/or translating the evidence from non-Asian populations? As new drugs emerge from Asian companies as tested in Asia-based trials, such a situation is coming often in EU and US - notably the case of sintilimab in lung cancer.	thanks
(this is for Dr Chen - sorry)	
Saudamini & Dr. Miot : In LMIC there is a really high shift of personnel (people from public institutions are frequently moving to other jobs), as well as high work burden on public servant. So it is not only quite difficult to take people from theirs daily jobs to train them, but after only a couple of years after the training they may move somewhere else. Do you have any experience in tackling this? (I know Thailand host, based on a Japanese grant, some places for HTA masters degree, how long are the trainees stay afterward in their country public positions?)	live answered

Saudamini & Dr. Miot : In LMIC there is a really high shift of personnel (people from public institutions are frequently moving to other jobs), as well as high work burden on public servant. So it is not only quite difficult to take people from theirs daily jobs to train them, but after only a couple of years after the training they may move somewhere else. Do you have any experience in tackling this? (I know Thailand host, based on a Japanese grant, some places for HTA masters degree, how long are the trainees stay afterward in their country public positions?)	Thank you for raising this very important point - retention of staff in HTA in the public sphere is indeed one of the challenges. There have been varied strategies to ensure staff contribute to agencies where they are based chiefly by offering career development opportunities; for examples, scholarships for higher studies, with commitments to continue to work and mentor junior staff as well. We have also hosted interns internationally who have gone on to work in their home countries. One also needs to recognise that staff will move on to other opportunities and that one cannot be complacent is training and keeping the pipeline of future HTA researchers active. Hope this helps.
Super interesting panel. Thanks very much to the speakers for setting out the challenges AND opportunities for HTA playing an important role in ensuring sustainability of health care systems across the world. One 'party' not at the table today are 'patients' and their representatives. Surely, they would/could be a criticallty important advocate for the use of HTA in not only appraising the value of innovative technologies, but to support budget setting and choices in the health care system. What are your thoughts about bringing them in the debate more/better?	

In countries without a national health insurance, the context is different with high out of pocket expenditure before encountering the health system. I like the China experience where household budget implications are also taken into account. How does a government then decide on technology adoption if there is more than one payer?	Thank you for this question. A couple thoughts: 1) One potential way is to engage with each of the payers and have them coordinate on their benefits package development. Sometimes, there is variation in practice (ie a technology may be included by one payer but not by another); 2) On incorporating household costs, in Thailand, a societal perspective is used when conducting a cost-effectiveness perspective and a payer perspective for the budget impact.
From your experience, which policy should governments put in place to promote HTA?	
If we want to access the reports Dr. Miot can we get the site?	https://knowledgehub.health.gov.za/
Thank you for the interesting insights. A question to prof. Kanavos, what would be your recommendations in order to improve the evidence strenght/quality supporting approval and HTA decision making, for takling the problems you pointed out? How could the industry be engaged in producing better evidence? Thanks.	
What key components would you deem valuable for enhancing stakeholders' expertise in HTA training? Which specific groups should be considered in the design of the training (HCPs, payers, industry, HTA bodies, policymakers, patients)?	Thank you for raising this point. We typically consider providing technical training to researchers (from HTA agencies, academia, etc); symposia to discuss policy implications for policymakers (payers, ministries of health), incorporating HTA as a module for health care professionals, provide support to patient groups so that they can effectively participate in the HTA process (For example, in Thailand, be able to nominate topics for assessment), among others. Hope this helps.
Will dr Pichon-Riviere's slides be available as a post-meeting resource? thanks	Thanks, all slides will be made available after the session
Will dr Pichon-Riviere's slides be available as a post-meeting resource? thanks	Thanks so much!

Will dr Pichon-Riviere's slides be available as a post-meeting resource? thanks	HTA may be an effective tool, but does not resolve the issue of prioritization or indicate what is essential or an unmet need. BRICS countries are totally gravitating towards innovation, not necessarily health needs. The allocation of resources decisions is thus a critical complement to HTA per se. Not only value for money but health needs.
Many of the problems in evaluating complex health technologies come from not having enough data, rather than from the technologies being too complicated. As more and more complex technologies are developed, there's a greater need for new ways and rules to help make decisions about them.	Can't echo more - and this is just 'the rule' for medical technologies, including diagnostics.
Another group of challenges relates to structural features of the healthcare system. These include central or local restrictions on the use of HTA, differences in how reimbursement decisions are made in different systems, differences in the current standard of care in different systems, the need for decision-making procedures to remain confidential in competitive systems, and local stakeholder objections to the use of HTA.	Yes, there are systems related barriers as well. We have found that Universal Health Coverage mandates have bolstered the need for use of HTA. As you suggest, understanding the health system of a country is important to be able to address the policy question with an appropriate research method (cost utility analysis or other).
How can we interpret the fact that the threshold is lower than the GDP in low income ountries and how can comany do to make their products avaulable in the presence of this challenge	live answered

How can we interpret the fact that the threshold is lower than the GDP in low income ountries and how can comany do to make their products avaulable in the presence of this challenge	Our study, like other recently published threshold studies, found lower thresholds (relative to GDP) in LMIC. There are several factors that explain this. In LMICs there are still many very effective and very efficient technologies and interventions (for example vaccines) that are not yet included in the benefits package or are not being covered by the health system. For these reasons, LMICs can still achieve important health improvements by incorporating relatively inexpensive technologies into the benefits package. That is why the threshold is lower. The opportunity cost of every dollar spent is high in terms of health lost in LMICs. On the contrary, HICs are already covering all the most efficient interventions, therefore to achieve improvements in health they have no choice but to cover more expensive and less efficient technologies, and for these reasons their threshold is higher. For technology producing companies, one option is to define the price in each country taking these factors into account.

Efforts to ensure access to medicines are mainly driven by an ethical imperative: people should not be denied access to life-saving or health-promoting interventions for unfair reasons, including economic or social causes. Within the African context, certain limitations exist concerning their access to basic medicines. Many people living in Africa have a problem with accessing medicines and this undoubtedly contributes to the poor health metrics of most countries in the region. Throughout the years, the African region has witnessed an alarming shortage of vital medications in the public sector, forcing patients to pay higher costs in the private sector or forego medicines to treat their symptoms and diseases. The cause is partly due to African countries lack acceptable, weak, or no methods for monitoring and assessing critical medicine accessibility.	
Agree to include more societal wtp in the assessments, my question to the panel is how far we are to consider societal surplus to modelate society benfit?	
The problems in the medical system range from disorganized medicine distribution and unregulated prices to inequality in medical facilities, staff, and drug delivery. There's also a lack of cooperation between the government and private/public sectors, and a failure to follow treatment guidelines and use medicines responsibly. Creating a list of essential medicines doesn't ensure access to them, so it's crucial to develop policies and allocate funds to make them available. These issues all stem from poor governance and a lack of coordination between health system leadership and operations.	

EU is moving toward a centralized HTA 'data' assessment, while keeping the modelling and cost considerations for reimbursement still at country level. Is it such a thing - a global HTA for data analysis - a reliable and facilitating process for high-level data evaluation, or would it be too generic, to address context and have a relevant role for all countries, in all settings?	If we consider CORE Model, some domains may be transferable but others are for the sole remit of the country HCS. We do see more trends in collaboration but still unknown the type of collaboration
EU is moving toward a centralized HTA 'data' assessment, while keeping the modelling and cost considerations for reimbursement still at country level. Is it such a thing - a global HTA for data analysis - a reliable and facilitating process for high-level data evaluation, or would it be too generic, to address context and have a relevant role for all countries, in all settings?	This might be a very good start to establish core elements for collaboration and start the dialogue on a global HTA - at least 'elements' of it.
EU is moving toward a centralized HTA 'data' assessment, while keeping the modelling and cost considerations for reimbursement still at country level. Is it such a thing - a global HTA for data analysis - a reliable and facilitating process for high-level data evaluation, or would it be too generic, to address context and have a relevant role for all countries, in all settings?	Let's not forget that Joint Clinical Assessment (JCA) is about assessment, while Member States will do the 'appraisal' themselves, based on considerations that are relevant to their context. In other words, JCA will only provide guidance in terms of data quality and relevant gaps, rather than providing a firm coverage recommendation based on submitted clinical evidence. To that end, some of the criteria that we use in making decisions (based on appraisals) are certainly transferrable across settings, but, ultimately, countries decide for themselves what is relevant to them

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As I see it, societal participation tends to be very prone to outside influences because consultations favor (in design) patient groups keen on very expensive new technologies. HTA is an effective tool, but only when an adequate prioritization process is in place and allocation of resources is ewuitable.	
Thank you!	
Governance problems make it hard to produce medicine locally. When the government gives money to certain producers, it can mess up the market by protecting one producer over a better one. Politicians might even give production contracts to their friends using aid money. Thus, the need for laws, regulations, and better policies for the continued growth and success of local pharmaceutical manufacturing. Additionally, inventory management in African countries is tough because of different laws and restrictions, and difficulty predicting supply and demand. There are differing consumption/prescription habits and there's not much information available, so they need to keep extra stock to handle uncertainty, which ends up costing a lot.â€‹	
Dr Ochalek, thank you for your presentation. Are you aware of a specific framework describing country-specific factors that may influence the threshold (demographics, burden of disease, etc.) that you were mentioning ?	echoing -

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Dr Ochalek, thank you for your presentation. Are you aware of a specific framework describing country-specific factors that may influence the threshold (demographics, burden of disease, etc.) that you were mentioning ?	I am not aware of a framework, but this is discussed in a few existing publications. I will link these below. It would be fascinating to have this kind of framework though the data requirements probably make it near impossible. https://www.york.ac.uk/che/news/2015/che-research-paper-122/ https://pubmed.ncbi.nlm.nih.gov/27553208/ This paper discusses determinants of changes in the threshold. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8478606/
Dr Ochalek, thank you for your presentation. Are you aware of a specific framework describing country-specific factors that may influence the threshold (demographics, burden of disease, etc.) that you were mentioning ?	Thank you for this resource
thanks for your answers	
I have another question: How can we adopt HTA assessments conducted by one country for use in another? Additionally, how can we rely on these assessments given that many countries lack the resources to conduct their own evaluations?	To add, there are a few approaches for transferring studies from other countries (eg adaptive HTA). In some regions (europe, and now we are also exploring in ASEAN), are also looking at harmonisation of HTA to reduce duplication of HTA studies and also limited capacity. In terms of using data from other countries for economic evaluations, there are some guidelines for transferability of data as well.

I have another question: How can we adopt HTA assessments conducted by one country for use in another? Additionally, how can we rely on these assessments given that many countries lack the resources to conduct their own evaluations?	Thanks... can you share some of thise guidelines
Effectively, 'lived experience' of cancer is currently priority for WHO!	
#NothingAboutUsWithoutUs - thanks Dr Panos Kavanos for raising that point. Patients and CSOs should have a seat at the table from the start and not enter from the back door as an after thought.	so well said!
Thank you for the great presentation, I hope to have another opportunity to share experience with all of you. For example, we are trying to see the possibility of estimating a threshold.	Along with HITAP in Thailand we are hosting a webinar "Methods for estimating health opportunity costsâ€ this month on February 27th, https://us06web.zoom.us/webinar/register/WN_93MPz5dXRNCG4fdhesPdDg
Thank you for the great presentation, I hope to have another opportunity to share experience with all of you. For example, we are trying to see the possibility of estimating a threshold.	Thank you very much, it would be possible to contact you to talk about these issues, I from Chile.
Thank you for the great presentation, I hope to have another opportunity to share experience with all of you. For example, we are trying to see the possibility of estimating a threshold.	Thank you, I've sent you some additional information regarding methods around this, let's keep in touch.
Thank you for the great presentation, I hope to have another opportunity to share experience with all of you. For example, we are trying to see the possibility of estimating a threshold.	Of course, you can contact me at jessica.ochalek@york.ac.uk
Thank you for the great presentation, I hope to have another opportunity to share experience with all of you. For example, we are trying to see the possibility of estimating a threshold.	I researcher, Ministry of Health, in Santiago, Chile
BENALUXA uses joint HTA assessments. These provide countries with better negotiating power. The countries that collaborate though need to have strong political will, and similar characteristics	

I from Chile	
I think countries with different health systems can also learn from each other.	
Title	**Link**
Knowledge Hub - Department of Health, South Africa	https://knowledgehub.health.gov.za/
Cost per DALY averted thresholds for low- and middle-income countries: evidence from cross country data	https://www.york.ac.uk/che/news/2015/che-research-paper-122/
Determinants of Change in the Cost-effectiveness Threshold	https://pubmed.ncbi.nlm.nih.gov/27553208/
Empirical Estimates of the Marginal Cost of Health Produced by a Healthcare System: Methodological Considerations from Country-Level Estimates	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8478606/