INDONESIA MISSION REPORT

Advancing Health Technology Assessments (HTA) Development in Indonesia
21 – 23 September 2015

HITAP International Unit (HIU)
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Executive Summary

Through the international Decision Support Initiative (iDSI) and the World Health Organization (WHO), HITAP has committed to several projects in Indonesia towards the development and establishment of HTA as part of the decision-making process for health care resource allocations in the country. HITAP visited the country for 3 meetings: a meeting with the WHO country office and relevant partners requesting assistance for an HTA on the economic burden of seasonal influenza in the county; a meeting with the Persons in Charge or PICs conducting two HTA studies (on pulmonary arterial hypertension or PAH and renal replacement therapy or RRT) in the country under the guidance of the HTA Committee (HTAC); a stakeholder consultation meeting on the roadmap of HTA for Indonesia, which was followed the next day by a meeting with high level stakeholders to discuss next steps. After these meetings, the various international partners operating in the country towards the same goal of HTA development met and discussed the collaboration and potential plan for the future.

For the first meeting on economic burden of seasonal influenza, a local research team will conduct the HTA and collect epidemiological data and direct and indirect medical costs representative of the East and West sides of Java. Coordination and administrative issues were discussed for the conduct of the assessment. It was stressed that this HTA will be shown to the Indonesian Ministry of Health as an academic exercise and part of capacity building for the researchers, and not a political movement or advocacy for changes in the national response to seasonal influenza. These preliminary results will be used to inform future research for seasonal influenza, and a useful demonstration of and capacity building exercise for HTA in the country.

HITAP is currently conducting two studies with the HTAC: the "Cost-utility analysis of sildenafil in Indonesia for the treatment of pulmonary arterial hypertension" and the "Cost-utility analysis between continuous ambulatory peritoneal dialysis (CAPD) and hemodialysis for patients with end-stage renal disease (ESRD)." Both of these HTA are in the analysis stage, and the PICs and research teams are requesting assistance on how to account for lack of or insufficient epidemiological and costing data as well as methodological issues. As these studies are aimed at current policies, a budget impact analysis is an imperative part of the analysis. The local research teams and HITAP agreed to analyse the data for economic evaluation and budget impact analysis, and writing up the report together. The next visit by HITAP to Indonesia is planned to support the local research team to complete the analyses and technical report. It is tentatively set in October, approximately for 5 full working days.

These "downstream" studies are expected to help inform and be part of the development of HTA and its national implementation for the next 5-10 years, which was discussed in detail

in the next two days. HITAP and NICE International shared their experiences in terms of the establishment of their institutions, working with relevant agencies, and garnering the support of policy makers and relevant stakeholders as well as maintaining high quality of work. The roadmap emphasized the following areas of work: curative health, public health needs, facilitating access of health technology to both public and curative health, and optimizing the use of safe, rational health technologies. The meetings were considered a success given the participation of relevant stakeholders, most importantly Dr. Donal Pardede, Dr. Sudigdo Sastroasmoro, and the Secretary General, as well as the collaboration with development partners, and the conduct of several HTA within the space of the year that iDSI has been working in Indonesia; however, several issues still need to be addressed, particularly in the use of results in policy-making, the lack of concrete steps (e.g. in terms of number of research to be done annually), the lack of funding for conducting studies and/or building the capacity of the PICs, and the full ownership of the local stakeholders of the process.

The WHO, PATH, and the iDSI have committed to work in Indonesia in the next 3-5 years, and the three organizations will be working closely on the technical and policy sides of HTA development in the coming years. While key people are more involved now so there is clearly progress being made in terms of awareness of the importance, local authorities are still unclear about how to make use of HTA nor have a good idea of locating it within the broader health care decision making process. Areas of focus for the partners' work should be in how to support HTA PICs who are currently doing the work and how to make use of evidence and push policy to practice. In addition, the implementing agencies for the results (e.g. PEN national program implementation in primary health care) were not part of the original plan but now may need to be engaged (drug procurement, financing department, medical education, guidelines development, etc.) in order to support the impact of HTA. To be successful, there is a need to understand the health system and the key players in the MoH as well as the role of all the units in the MoH and of BPJS.

Introduction

Universal Healthcare Coverage (UHC) to ensure equitable access to essential health services can be a challenge for governments, especially in resource-limited settings. As a result, health priority setting is an inevitable task. The World Health Assembly (WHA) endorses Health Intervention and Technology Assessments (HITA/HTA)[1] as a priority-setting tool and process for supporting governments making systematic, participatory, and evidence-based resource allocation[2]. It has become a priority for international organizations and institutions to assist countries in achieving UHC through the establishment of effective priority setting mechanisms such as (HITA/HTA).

NICE International and HITAP under the umbrella of the iDSI began working in Indonesia beginning 2013 as its pilot demonstration country for the development of HTA, with the hope of diffusing the mechanism throughout the region and/or with other low- and middle-income countries (LMICs). The WHO began supporting HTA in the country in 2014 with the Package of Essential Non-Communicable Disease Interventions (PEN) program national evaluation. PATH, under the United Nations Development Programme (UNDP) Access and Delivery Partnerships (ADP) also supported the establishment of HTA. These various organizations came together for the meetings in Indonesia to further the aforementioned goals. HITAP in particular came to Indonesia to provide technical assistance to the various HTA studies being conducted as well as oversight on the steps towards the development of HTA and linkage of research to policy.

Summary of the Meetings

The meetings for the high-level stakeholders was the main focus of HITAP's visit. On the second day, a full-day session with relevant stakeholders were conducted to provide information and background on HTA development in Thailand. Dr. Yot Teerawattananon from HITAP and Dr. Kalipso Chalkidou provided overviews of the development of HTA in their respective countries. Dr. Sudgigdo Sastroasmoro, the head of the HTAC, provided the background for HTA in Indonesia, highlighting that the main obstacles are: no full time staff; PICs or person-in-charge (staff from MoH and NHRC) are those mainly responsible for conducting HTA studies; 2 HTA studies (RRT and PAH) currently being conducted are a good start, though, there is a difficulties in collecting a primary data. Some of the main points of

[1] HITA and HTA are interchangeable depending on the user.

[2] World Health Organization (WHO), World Health Assembly (WHA), *Health Intervention and Technology Assessment (HITA) in Support of Universal Health Coverage (UHC)*, A/RES/67/24/15.7 (24 May 2014), available from http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R23-en.pdf

discussion included working with the agencies responsible for health care resource allocation in the beginning of HTA development, capacity, including pharmaceutical companies in the process, and using HTA for a country such as Indonesia, which has a wide variation in geography and resources. The presenters responded that it is a slow process, but there needs to be linkages with these agencies. For example, in the case of HITAP, they conducted a topic selection, and some of their subjects were related to the work of the NHSO. After several HTA studies, now HITAP works directly with the NHSO on preventive and curative interventions evaluation. In addition, the process must include how to deal with pharmaceutical industries. Capacity and use of HTA needs to be adapted to the setting; in the beginning, small-scale or few projects may be implemented. As HTA becomes more accepted, then more projects can be conducted and it will be increasingly involved in the decision making process.

Professor Budi Hidayat presented on the roadmap and inputs on how to create a process for the country. They aim to incorporate it into the MOH from 2017-2025. They conducted a situational analysis with several consultants, who gave information to the ministry with the following focal points: legal, low public budget for HTA, few health economists. The role of HTA in Indonesia should be set. They proposed that HTA could be made as a recommendation to MoH. They mentioned that NICE or HITAP approach may be a good role model; however, they found a difficulty to follow NICE or HITAP standard. This is because 1) a limitation on human and financial resources and 2) a challenge in political commitment. HITAP's international board, Drs. Suwit Wibupolprasert, Somsak Chunharas, and Churnrurtai Kanchanachitra, then gave advice to the stakeholders, particularly in knowing the system and making HTA work for it in terms of the broader aim of providing universal health coverage and making concrete actions towards this. In addition, the stakeholders were invited to the Prince Mahidol Award Conference (PMAC) 2016.

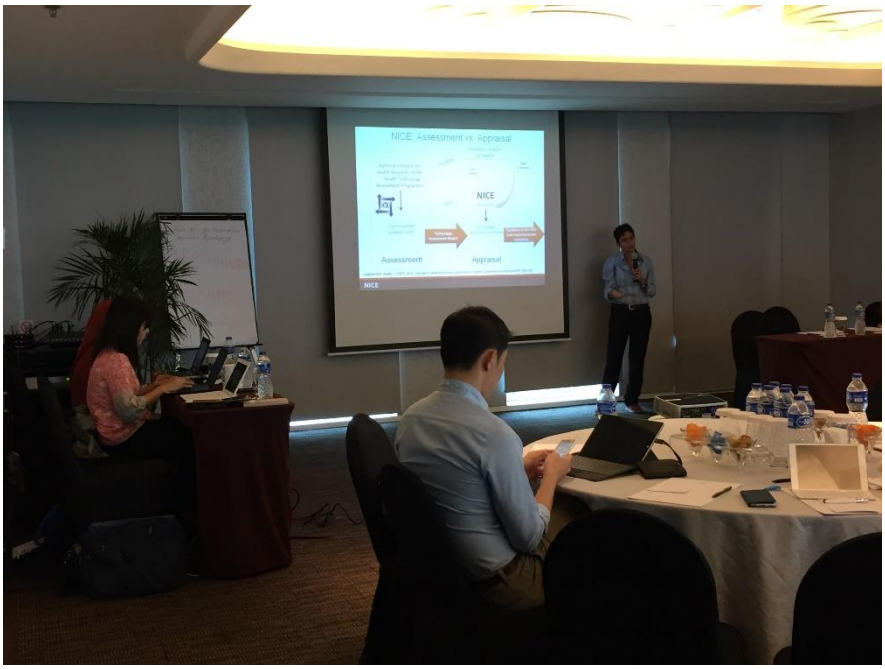

Figure 1: Dr. Kalipso Chalkidou giving an overview of the development of NICE International

Figure 2: The participants listen to presentations

Figure 3: Discussion session with Dr. Sudigdo Sastroasmoro and Dr. Kalipso

Figure 4: Dr. Suwit Wibupolprasert giving a discussion on the beginning of HTA in Thailand

On the third day, the future plan for the roadmap was presented by Professor Budi, who explained that the idea for the roadmap is to use it for the next 10 years, with assistance from partners. The issue on who will be the users of HTA was raised, which is intricately tied to how the priority setting process for resource allocation will be decided. In Thailand, for example, HTA is used mainly the results to develop studies for the BP and NLEM; on the other hand, there seems to be different structures and governance bodies for P2JK and BPJS. It is therefore important to see who to approach once the 3 studies right now have results available to translate into policy, which is yet to be decided in Indonesia.

For potential users and/or decision makers in public policy, there may be 5 or 6 areas. First is the aim to improve clinical practices (similar to the Philippines 20 years ago) even when doctors have their own separate clinical practices. Another one is the idea to use HTA to influence new technology approval, whether these technologies should be approved for use or not (usually was only for safety and efficacy but not cost-effectiveness). Another is the distribution of technology in certain areas, whether INA has a body to have this decision or not, and many things still based on the free market. The fourth area is the drug committee; previously it was just a list and did not have an impact on policy decisions, but now it is because they try to make medicine provision sustainable. The fifth area is the benefits package, the system can be more integrated into the UHC scheme, whether the new packages to be added have new mechanisms and the decision is not based only on the classical evaluation. Lastly, HTA can be used for general pubic planning purposes, e.g. 5-year public health planning as is the case in Thailand; now with HITAP they have cost-effectiveness results.

Potential areas of HTA is to assess drugs that are not in the reimbursement list e.g. not under the CBGs lists; this area needs to be strengthened. There are political issues that the HTA committee cannot deal with. For example, government decides on their own to include or exclude some drugs under CBGs lists. The HITAP team said that if the hospital prescribes, then they need to make it available. But if not, then they have to buy outside, like high cost ones, and then the hospital will check and reimburse, which is an important potential area for HTA. Dr. Suwit said that the issue after this is in compliance and audits. If hospitals breach the agreement, then they can be brought to court. This is not the problem of HTA and it cannot solve this. There needs to be a strong system in the ministry to address this. There must be a clarity about the role of HTA, but it cannot solve everything. If INA can make hospitals confirm to the national decision making, it is less useful to have hospital based HTA and could be a distraction, as INA government still needs to build capacity and structure for them. They can then pick 2-3 important items that are high priority, then establish the networks for conducting it, and then have a test for the political backing once HTA studies are finished. The next few studies and subsequent institutionalization will be easier. Professor Budi asked about the capacity needed. Kalipso replied that HITAP and NICE have stories of their development, from few people to medium/larger organizations. They can

make a plan to do 4 studies in the first year, then 10 the second, etc.; there is no need for too much capacity. On the action plan, once there is a general path or direction, there needs to be further expression of commitment from the government particularly in terms of financial support and capacity. Other areas include assistance from partners (many of us operate in different ways, which needs to be understood and coordinated), inclusion into the national curricula, partnering with international universities (e.g. Mahidol), having a module for presentation at the national level, (TOT approach).

The Secretary General arrived and was briefed by each main partner. Not only is it an expression of commitment, it is important for the decision makers such as him are present to understand and make use of evidence – a vital capacity. Dr. Churnrurtai invited the Secretary General to PMAC 2016, with its theme of priority setting, and the potential for him to speak in one of the PMAC's subtheme sessions.

Figure 5: Discussion of the roadmap with the Secretary General

Next Steps

The following outlines the plan for each organization:

iDSI	• INA will remain a key country (until 2018) for the partners so there is a need to think about the demand-side
	• Think about who the client is and who the results are delivered to for the 3 HTA projects
	  ○ Translating results and linking to policy
	• Topic selection and engaging stakeholders to elicit priorities is not done in INA but consider whether the environment is appropriate to initiate this process now
	• Process and methods guides to set ground rules on the methods and process so people begin to think about selecting the topic, the recipient of the results, the players in the systems which will lead to a macro-level process in a few years' time
	• Upstream: 3-5 topics from topic selection process chaired by Secretary General but this cannot be done without PICs
	• Downstream: renal replacement therapy results will be of interest to BPJS (and clinicians?), NCDs and PAH - put equal effort on downstream
	  ○ New academic units in INA should be included in the next round to expand network and increase awareness
	Aim to complete PAH and PD/HD studies by November 2015

NICE	• Hosting the Secretary General during a study to visit NICE in the next couple of weeks and will have opportunities to discuss further
PATH	• Continue work in INA until 2018
WHO	• Needs strengthening to take on the role that is expected of WHO • Will continue to support the work • Will follow up with the proposal
Other partners	**DFAT** **USAID**

Some reflections during the meeting were:

- Desire to use HTA for BP, public health packages, meso-/micro-level, etc.
- Concrete actions need to be taken, e.g. with the 3 HTA projects;
    - 3-5 people can be taken for the HePTA graduate program but have to take into consideration criteria/conditions for acceptance;
- Discussions on capacity building and training, etc. might result in a risk of developing HTA for HTA;
- Different projects can converge to impact on a particular policy issue;
- INA has an opportunity to institutionalize a unit due to the decree although it's not yet clear where they should go so it would help to re-draft or refine the decree to provide some solidity, with caution that by establishing the unit there might be a risk of losing the diversity of the work.

Partners' actions to be taken:

- HITAP will arrange a 5-day intensive workshop with PICs in October to finish the HTA studies, reports, policy briefs;
- All partners will work on downstream in Jan or Feb 2016:

    1. Conduct a 1-day RRT and PAH stakeholder consultation meeting (without high ranking decision-makers) with people implementing RRT to learn about their difficulties and problems with implementation (can bring others who do studies on this subject); 10-15 participants to discuss in detail;
        - WHO/MoH, PATH, and other partners (e.g. USAID) to consider arranging the workshop held in INA - back-to-back meeting for the two studies;
        - Workshops will be part of capacity building - maybe part of the proposal (based on feedback);
    2. Workshop or study visit, bringing RRT implementers to Thailand to learn about PD-first policy implementation for 5-6 people for 2-3 days.

- Work on upstream - suggest Professor Sudigdo to begin a topic selection process and get a more systematic process in early 2016;
- Have a possible workshop for academics from different universities to identify potentials? (with agreement from HTA committee to commission the work to different universities);
- There will be a review for the decree on the committee soon and there may be changes in the members of the committee.

Figure 6: Partner's meeting at the WHO offices

Appendices

Appendix 1: Agenda

Agenda of 21 September 2015
Meeting on the Economic Burden of Influenza study
Meeting for the PAH and RRT studies

Agenda of 22 September 2015
You are kindly request to be **at the meeting venue at 7:50** to meet the Secretary General, MoH.

Time	Activities
8:30 – 8:45	Remarks from WR Indonesia *Dr Khanchit Limpakarnjanarat*
8:45 – 9:00	Remarks from CEO of NICE, UK *Sir Andrew Dillon*
9:00 - 9:15	Welcome and opening remark *The Secretary General Ministry of Health (Dr Untung Suseno)*
9:15 – 10:00	"HTA in Indonesia: Policies and it's development" Chief of Centre for Health Financing and Security, MoH (Dr Donal Pardede)
10:00 –10:15	"The policy argument for an HTA function in an UHC system: the case of England and Wales" *Sir Andrew Dillon, NICE, UK*
10:15 – 10:30	Coffee break
10:30 – 11:00	The use of HTA to inform health policy-decision making in the UK *Kalipso Chalkidou, NICE, UK*
11:00 – 11:45	The use of HTA to inform policy-decision making in Thailand Dr.Yot Teerawattananon, HITAP, Thailand
11:45 – 12:45	Q&A
12:45 – 13:45	Lunch
13:45 – 15:15	Discussion on HTA development in Indonesia *Meeting participants*
15:15 – 15:30	Coffee break
15:30 – 16:00	Closing remark *The Secretary General Ministry of Health*

You are also invited to **welcome dinner at JS Luwansa Hotal at 18:30**.

Agenda of 23 September 2015

High level meeting at MoH Building, room 224.

Time	Activities
8:30-8:45	Welcome and opening remark *the Secretary General MoH*
8.45-9.30	Presentation on the future plan and roadmap for HTA in Indonesia *Representative from Indonesia*
9:30-11.00	Discussion on the future plan and the roadmap for HTA in Indonesia and how international partners can support it
11.00-11.15	Closing remark

HTA coordination meeting will be organized at WHO Office at 13:00 to 15:00.

Technical support on economic burden manual piloting on influenza in Indonesia

Venue: Jakarta, Indonesia

Date of visit: September 21st, 2015 at 9.00 – 12.00

List of participants:

	Name	Organization
1	Dr. Yot Teerawattananon	HITAP
2	Ms. Waranya Rattanavipapong	HITAP
3	Ms. Septiara Putri	Center for Health Economics and Policy Studies (CHEPS), University of Indonesia
4	Prof. Mardiati Nadjib	University of Indonesia
6	Dr. Julitasari Sundoro	The Indonesian Technical Advisory Group on Immunization (ITAGI), Ministry of Health, Indonesia
7	Ms. Asmaniar Saleh	WHO EPI Indonesia
8	Ms. Fina Tams	WHO EPI Indonesia

Technical support on health technology assessment (HTA) in Indonesia

Venue: Ministry of Health, Jakarta, Indonesia

Date of visit: September 21st, 2015 at 14.00 – 17.00

List of participants:

	Name	Organization
1	Dr. Yot Teerawattananon	HITAP
2	Ms. Waranya Rattanavipapong	HITAP
3	Prof. Mardiati Nadjib	University of Indonesia
4	Prof. Sudigdo Adi	Chairman of Health Technology Assessment Committee (HTAC), Indonesia
5	Ms. Septiara Putri	Center for Health Economics and Policy Studies (CHEPS), University of Indonesia
6	The local research team	Staff from Ministry of Health, Indonesia

International experience-sharing meeting with various stakeholders
Venue: Hotel JS Luwansa, Jakarta, Indonesia
Date of visit: September 22st, 2015 at 8.30 – 16.00

List of HITAP and partner participants:

	Name	Organization
1	Dr. Yot Teerawattananon	HITAP
2	Ms. Waranya Rattanavipapong	HITAP
3	Ms. Nattha Tritasavit	HITAP
4	Ms. Alia Luz	HITAP
6	Dr. Kalipso Chalkidou	NICE International
7	Ms. Mutsumi Metzler	PATH
8	Ms. Appolina Sidauruk	PATH
9	Prof. Mardiati Nadjib	University of Indonesia
10	Prof. Budi Hidawat	University of Indonesia
11	Prof.Iwan Dwiprahasta	Gadjah Mada University
10	Prof. Sudigdo Adi	Chairman of Health Technology Assessment Committee (HTAC), Indonesia
11	Ms. Septiara Putri	Center for Health Economics and Policy Studies (CHEPS), University of Indonesia
12	The local research team and as well as other stakeholders	Staff from Ministry of Health, Indonesia BPJS as well as hospital representatives
13	Carleigh Krubiner	Johns Hopkins University
14	Dr. Suwit Wibupolprasert	HITAP International Organizing Committee (IAC)
15	Dr. Somsak Chunharas	HITAP IAC
16	Dr. Churnrurtai Kanchanachitra	HITAP IAC
17	Zohra Balsara	USAID
18	John Leigh	DFAT
19	Professor Budi Hardja	AIPHSS
20	Dr. Salma Burton	WHO
21	Edhie Rahmat	USAID
22	Dr. Dewi Idriani	WHO

Roadmap Meeting with the Secretary General
Venue: Ministry of Health, Jakarta, Indonesia
Date of visit: September 23st, 2015 at 8.30 – 12.00

List of HITAP and partner participants:

	Name	Organization
1	Dr. Yot Teerawattananon	HITAP
2	Ms. Waranya Rattanavipapong	HITAP
3	Ms. Nattha Tritasavit	HITAP
4	Ms. Alia Luz	HITAP
6	Dr. Kalipso Chalkidou	NICE International
7	Ms. Mutsumi Metzler	PATH
8	Ms. Appolina Sidauruk	PATH
9	Prof. Mardiati Nadjib	University of Indonesia
10	Prof. Budi Hidawat	University of Indonesia
10	Prof. Sudigdo Adi	Chairman of Health Technology Assessment Committee (HTAC), Indonesia
12	Other stakeholders	Staff from Ministry of Health, Indonesia BPJS
13	Carleigh Krubiner	Johns Hopkins University
14	Dr. Suwit Wibupolprasert	HITAP International Organizing Committee (IAC)
15	Dr. Somsak Chunharas	HITAP IAC
16	Dr. Churnrurtai Kanchanachitra	HITAP IAC
17	Dr Donal Pardede	P2JK
18	Zohra Balsara	USAID
19	Victoria	GIZ
20	Dr. Salma Burton	WHO
21	Dr. Dewi Idriani	WHO

Partners Coordination Meeting
Venue: WHO office, Jakarta, Indonesia
Date of visit: September 23st, 2015 at 13.00 – 14.30

List of HITAP and partner participants:

	Name	Organization
1	Dr. Yot Teerawattananon	HITAP
2	Ms. Waranya Rattanavipapong	HITAP
3	Ms. Nattha Tritasavit	HITAP
4	Ms. Alia Luz	HITAP
6	Dr. Kalipso Chalkidou	NICE International
7	Ms. Mutsumi Metzler	PATH
8	Ms. Appolina Sidauruk	PATH
9	Dr. Salma Burton	WHO
10	Dr. Dewi Idriani	WHO
11	Dr. Suwit Wibupolprasert	HITAP International Organizing Committee (IAC)
12	Dr. Somsak Chunharas	HITAP IAC
13	Dr. Churnrurtai Kanchanachitra	HITAP IAC

Appendix 2: Daily summaries

Monday, September 21, 2015
For the study on the economic burden of influenza in Indonesia:

1) Technical issues
   - Surveillance/epidemiological data: the local research team lead by Ms. Septiara Putri needs support from Prof. Hasbullah Thabrany to request the data from MOH officials. The research team will gather the epidemiological data to be representative of the West and East sides of Indonesia. Surveillance data will be retrospectively collected from the past 3 months.
   - Costing: costs from a perspective of both healthcare provider and societal will be gathered. Direct medical cost will be collected at 2 hospitals (type C hospital) and 2 health centers in the West and East (30 samples each). Direct non-medical cost and informal care will be collected by interviewing the patients. The interview will be conducted by local trained enumerators. For direct medical cost, charges may be collected in case resource use is not available. In addition, costing may be collected from private hospital if there are Influenza cases. Costs (both ILI and SARI cases) can be collected from the past year to cover costs that occurred during the seasonal variation.
   - Incidence data will be collected from the catchment area. The results can therefore be extrapolated to others.

2) Administrative issues
   - The local research team consists of Ms. Septiara Putri and two enumerators.
   - The local research team requires funding because they may have to pay for the data access.
   - Dr. Julitasari Sundoro from the Indonesian Technical Advisory Group on Immunization (ITAGI), Ministry of Health, Indonesia and Dr.Vivi Setiawaty from Biomedical Center (BTDK kemenkes) should be informed about this project.
   - TOR should be revised by Ms. Septiara Putri and sent to WHO by September 22nd, 2015.

3) Policy issues
   - The objectives and details of this project should be explained clearly to MoH that the project is an academic exercise rather than a political movement on Influenza vaccination as part of WHO's plans to develop and pilot the WHO guidelines and build up capacity on health economics in LMICs. At the same time, Indonesia would have a benefit from this project by getting preliminary data/results that can be used to plan for a full scale study in the future.
   - It should be emphasized to the MOH that this research activity is not aimed to be used to push Indonesia's government to adopting the influenza vaccine.

For the pulmonary arterial hypertension (PAH) and renal replacement therapy (RRT) studies in Indonesia:

1. Technical support on economic evaluation studies

"Cost-utility analysis between continuous ambulatory peritoneal dialysis (CAPD) and hemodialysis for patients with end-stage renal disease (ESRD)"

- HITAP helps the local research team to solve the problem of survival analysis.
  - There is no local data on age related mortality rate; therefore, the mortality rate used in the model is fixed at 60 years of age due to lack of availability of local data.
  - The local data (unpublished study conducted by Indonesian professionals) was based on 6 years of follow-up.
  - The probability of dying applied in the model is revised.
- The local research team consults on costing.
  - They cannot identify the resource used to calculate the direct medical costs; as a result, charges instead of costs can be acceptable.
  - Comorbidity costs are combined with the direct medical cost because these are inseparable bills.
- There was a discussion about the ICER value that should be used in the decision making process in Indonesia. There is an agreement that the ICER should depend on their policy makers.

"Cost-utility analysis of sildenafil in Indonesia for the treatment of pulmonary arterial hypertension"

- The local research team consults on the following issues:
  - There is no local data for conducting survival analysis. Therefore, the data from a study in Thailand may be applied into Indonesian study.
  - There is no head-to-head study (Sidenafil versus Beraprost) to compare effectiveness data; therefore, relative risks (Sidenafil versus Standard care and Beraprost versus Standard care) were used in the model to compare indirectly clinical outcomes between Sidenafil and Beraprost.
  - The number of patients in each function class (FC) is not equal. In this case, standard deviation put in the model analysis may be set as equal to an average value. This is to allow a maximum range of data uncertainty.
  - Drug prices should be based on the generic drugs if they are available use in Indonesia.
  - In the model, standard care treatment incur no costs.

- There is no data on hospitalization in patients with FC 4.
- Utility data is classified based on FC status; however, Indonesian experts did not agree with this approach. As a result, it was suggested comparing the utility of two patients groups (Sidenafil and Beraprost groups) with the same FC to observe the similarity and difference.

2. Budget impact analysis

HITAP team gave a presentation and shared experiences of how to conduct budget impact analysis. The local research team was suggested to perform budget impact analysis alongside economic evaluation. HITAP team will provide technical support to the team.

3. Tentative plan for the next step

The local research team and HITAP agree to make a plan for the data analysis for economic evaluation and budget impact analysis, and writing up the report together. The next visit by HITAP to Indonesia is planned to support the local research team to complete the analyses and technical report. It is tentatively set in October, approximately 5 working full days.

Tuesday, September 22, 2015

Morning session from 8:30 to 12:00

There were five presentations for the morning: HTA for UHC: Better decisions for better health by Kalipso Chalkidou; HTA in Thailand by Yot Teerawattananon; NICE by Kalipso Chalkidou; HTA in Indonesia by Sudigdo Sastroasmoro; and HTA and pharmaceuticals by Iwan Dwiprahasta. There was also a speech from the Secretary General and open discussion.

- They are now in the process of developing guidelines and need a credible and standardized process. There are 3 components for guidelines: EE, measuring outcome, process (formulary already involves a little bit of HTA but problem in INA is fragmented process). These are the issues raised:
  1. Political issue with disinvestment of expensive drugs so there the question on whether there is a separate process for dis/investment or a more comprehensive process for disinvestment;
  2. For guidelines for assessment and appraisal, the proposal involves HTA agents including universities and by doing this, is it possible to accelerate the process of HTA but consequently have guidelines for appraisal and as such, the experience of NICE and HITAP on this;
  3. For involvement of the patient, it's a challenge in Indonesia because the patient expects that all BP are covered regardless of expenses; and,
  4. How to use or interpret qualitative information.

Dr. Yot replied that:

1. For the process for dis/investment, it depends on the governance structure of the country. Based on Thai experience, there is no separate process. Disinvestment definition includes trying to carefully consider the use of new technologies in public insurance schemes.
2. Guidelines for assessment will allow other organizations and academic institutes to be part of the PIC team as the core PIC team will not be enough.
3. Patients can also be involved in appraisal and many times and they will have useful perspectives/views.
4. Case studies and qualitative information can be used, but if used it should be documented, transparent (accessible to the public or used to inform to the public e.g. why the drug is available to the public based on the committee's decision)

Kalipso replied that:

1. For question 3, there's a time and place for patients to be involved so the process needs to be mature before engaging patients meaningfully. It may not be good to involve patients in the analysis e.g. review model or meta-analysis. However, patient involvement in the results (panel-level) is possible but it is necessary to consider what it means to represent patients.

- The most important question answered by HTA is whether the intervention should be included in the BP; on the other hand, it is difficult to find valid, good data from hospitals in INA and this may be an issue for an extended period of time. Is it acceptable to borrow data from other countries in the region to do analysis?

The panel responded that lack of data is not the only problem of HTA but it is also an issue for health systems. HTA can be used to identify information that is needed to better the program.

- How do you work with pharma industry and NHSO?

The panel responded that most programs are funded by NHSO (likened to BPJS) and they are the decision-makers. Regarding pharma, companies are a big part of the process but they never fund the work - they are involved in a systematic, transparent manner. Evidence is effective in discussions with pharma companies.

- DRGs right now are bundled so reimbursement for medicines and drugs are using tariff and BPJS doesn't get data for Rx's from hospitals so it's difficult to control expenditure for drugs in the system and BPJS system doesn't allow for tracking of this expenditure so the point is where results of HTA assessment will impact the budget in a way that can be managed?

The panel responded that Thailand is quite similar to INA because tracking is not made on drugs for particular indications or usages but there are a limited number of drugs that hospitals can buy depending on the level of the hospital and the funding for the hospital is provided (70% of the budget must be used for medicines in essential drug list).

- Is there any way to invite pharmaceutical company to propose something for inclusion?
- What experiences did they have where the recommendation was not to include but the government included the intervention?

The panel responded that there are experiences with both because the government also has to take into consideration other factors. If there are good reasons for going against the recommendation and the decision is transparent then the decision can still be legitimate. HTA has never been done on alternative medicines but in the essential medicines list around 30 drugs are traditional medicines (out of 800) but most are cheaper than Western medicines. There is no need to do HTA for these traditional medicines but safety and clinical evidence is still needed in order to be included. Acupuncture for lower back pain seems to be working in clinical trials but alternative medicines is not regularly reimbursed in the UK. For cancer drugs fund, they have said they will fund it but ended up not; they overspent so this is not so much an issue.

- Was screening for new born for certain diseases (PKU and thyroid) done?

Dr Yot responded that Thailand recently assessed one of the procedures, which they found was not cost-effective to implement the screening. They found that they should invest in some interventions but not others.

- The HTA process has taken a long time (15 years) and the NHS is much older but there was no HTA at the beginning of NHS; what are the steps that Indonesia needs to take in order to move toward the vision for UHC?

The panel responded that when the NHS was set up there weren't that many technologies but the idea was to saturate demand. When NICE began, there wasn't much money and the idea was to spend money efficiently so starting small and doing things incrementally makes sense. Also, link the payment system to guidelines, standards, technology decisions, etc. (e.g. BPJS, the payers, need to be at front stage). The UK spent 50 years from NHS to NICE, Thailand had 5 years from UHC to HITAP/HTA but Indonesia is now starting HTA before having UHC so it is a benefit for INA. Hopefully HTA can develop in the near future because

lessons can be taken from many international experiences and there is already infrastructure and support within the country.

- HTA uses societal perspective and learned HITAP uses societal and government perspective but INA has a wide variation (geographically) so when calculating transportation costs it is very different depending on location so should a government or payer perspective be used instead of societal perspective?

The panel responded that it is better to use both perspectives because it gives more information. It's important to do good costing to know who are bearing the costs and for what.

Afternoon session from 13:15 to 16:00

Professor Budi Hidayat presented on the roadmap and inputs on how to create a process for the country. They aim to incorporate it into the MOH from 2017-2025. They conducted a situational analysis with several consultants, who gave information to the ministry with the following focal points: legal, low public budget for HTA, few health economists. The JKN premium-setting was independent, and for this they want a comprehensive evaluation to be conducted and presented to them. Inclusion of Avastin and Bevacizumab was not approved until empirical evidence showed otherwise; drug costs tend to increase due to unbundled CGBs. The question on whether there really be a comprehensive HTA was raised, as HTA is limited and it could be an issue. Another issue was whether HTA should be delivered on the national level only, or should local HTA be considered. They also asked whether INA should follow NICE and HITAP's approaches. They have strategic areas they want to address: curative health needs, public health needs, facilitating access to health for both, and optimizing services.
Professor Mardiati, Mr. Donald, and Dr. Salma welcomed the Thai delegates (Drs. Suwit, Somsak, and Churnrurtai). Dr. Suwit gave a speech on development of HTA: Thailand did not have a roadmap when initiating HTA and the WHO supported the initiation of HTA at its beginnings. HTA is to make the best use of limited resources and negotiations. Key before HTA roadmap is to have committed (young) people. The roadmap is a good move but action is more important than having a roadmap. HITAP with support from NICE and development partners such as BMGF and DFID are going to support Mahidol University to start a world class graduate program on HITA - the few good, committed people should be proposed for the Mahidol graduate program (committed people can be pharmacist, doctor, health or non-health personnel) to study and come back and implement HTA in INA.

Dr. Somsak shared his experience on HTA. Brief historical context and efforts in Thailand: HTA began in 1988, which was the same time as interest in health economics began although these events were separate. This influenced clinical decision-making because technology

assessment started as a discipline in clinical decision-making. Once it was established, they institutionalized HITAP in a broader health systems context whose main function is to build capacity of the country in HTA (so NHSO can have its own mechanism to develop the UC scheme). The question for INA is whether the roadmap for HTA only for the UC system or for the health system/whole country. He agreed with Dr. Suwit that action without roadmap is much better than a roadmap without action. He also said it is important to look at how to institutionalize a unit on HTA that has the possibility of doing macro-system level (UC-linked) but need to make sure to give good enough support and has potential to diversify. In addition, a unit to support UC has a threat because there are always political factors when making decisions.

Dr. Churnrurtai shared information on opportunities to explore. Mahidol university will have a graduate program that will be managed by the Faculty of Pharmacy, but will be a university-wide program (drawing from experts from other faculties and internationally). It aims to be high-quality and policy relevant and build capacity of students with a practical approach for priority setting. PMAC is an international annual conference and the theme for January 2016 is on Priority Setting for Universal Health Coverage, which is linked to Indonesia's current activities. She extended the invitation to all who are interested to attend and asked them to send names to Dr. Yot or NICE as the conference is by invitation-only. Committed people can attend the PMAC 2016 and also discuss possibilities of attending the Mahidol graduate program.

During the discussion session, the following points were highlighted: for the roadmap, there will be regulations but it is currently undecided or unknown at and to what level it will be; development of formulary is different from the bundling process, and in the past there was no system to control the price of the medicine; and it is important to negotiate and use purchasing power because INA is a big country and can benefit much from it. High priced medicines also have bundled payment and there are problems and challenges in Thailand. Hospitals don't want to take risk on high-priced commodities so purchasing is centralized. As a result, millions of baht are saved annually on high-priced drugs and devices. All high-priced drugs need to go through HTA, NLEM committee, and price negotiation committee. The organizers then thanked the participants and closed the meeting.

Wednesday, September 23, 2015

For the meeting the Secretary General:
The future plan for the roadmap was presented by Professor Budi, who explained that the idea for the roadmap is to use it for the next 10 years, with assistance from partners. While not many institutions are involved but there is support, donors can assist in the work but there should not be overlaps. Dr. Mardiati also said that access to international networks for HTA is important. Kalipso mentioned that it is good to promote networks, e.g. work with HTAi, and also clarified that, while it is good to mention NICE International with potential partners, their role is mainly to support HITAP, as they are all part of iDSI.

Dr. Yot asked on who will be the users of HTA and how each will use HTA. In Thailand, HTA is used mainly the results to develop studies for the BP and NLEM; on the other hand, there seems to be different structures and governance bodies for P2JK and BPJS. It is therefore important to see who to approach once the 3 studies we have right now have results available to translate into policy. Professor Budi said they must refer to the current MOH minister's decision. The two organizations will work together and integrate the system including other types of services. Dr. Mardiati said that Professor Iwan is focusing more on registration of the drugs and the national formulary, but it seems to be independent from the HTA. In addition to this, there must be a way to involve the universities working on other areas, or should there be a comprehensive plan for health.

Dr. Yot said that the formulary is only for registration and not for provision and availability to the public, and this is done by the FDA in Thailand as well as mostly by industries. But talking on other bundles such as the subcommittee for essential drugs list, they consider safety, efficacy, and budget impact plus the ethical and social issues. Of these drugs (with new ones available that may be expensive but have good impact) to be assessed by HTA team, they consider around 100 drugs every year but only choose 10 for HTA study. There is a committee meeting every 5 months, but the research takes between 7-10 months, then these are presented to doctors, policymakers and experts for verification of results, and the decisions are made by policymakers in the end.

Dr. Somsak said that for potential users and/or decision makers in public policy, there may be 5 or 6 hurdles. First is the aim is to improve clinical practices (similar to the Philippines 20 years ago) even when doctors have their own separate clinical practices. Another one is the idea to use HTA to influence new technology approval, whether these technologies should be approved for use or not (usually was only for safety and efficacy but not cost-effectiveness). Another is the distribution of technology in certain areas, whether INA has a body to have this decision or not, and many things still based on the free market. The fourth area is the drug committee; previously it was just a list and did not have an impact on policy decisions, but now it is because they try to make medicine provision sustainable. The fifth

area is the benefits package, the system can be more integrated into the UHC scheme, whether the new packages to be added have new mechanisms and the decision is not based only on the classical evaluation. Lastly, HTA can be used for general pubic planning purposes, e.g. 5-year public health planning as is the case in Thailand; now with HITAP they have cost-effectiveness results. Dr. Mardiati asked if for the 6 different types of users, they work differently or they are under the same umbrella. Dr. Somsak said that there are different users. If you have clinical based HTA, then these can be conducted by hospitals. For technology approval, the FDA and drug committee can do it (in Thailand, this type of research is done under the FDA). Then there is the health insurance office, the BP, use HTA to guide procurement on the national level, etc.

In Indonesia, it is not just a list, it has an implication in the way the government decides because they have to ensure that it is available also and that the supplier works within the needs of the market. The current situation in Indonesia is that they have a CBGs list and national formulary with separate functions. Potential areas of HTA is to assess drugs that are not in the reimbursement list e.g. not under the CBGs lists; this area needs to be strengthened. There are political issues that the HTA committee cannot deal with. For example, government decides on their own to include or exclude some drugs under CBGs lists. Dr. Yot said that if the hospital prescribes, then they need to make it available. But if not, then they have to buy outside, like high cost ones, and then the hospital will check and reimburse, which is an important potential area for HTA.

The tariff does not explicitly consider the medicine price, in INA there is still about 20% of OOP, and out of these, 70% is driven by drugs. Some drugs may be in the formulary or not. Dr. Suwit said that the first thing is to ensure that the national formulary is within the UHC scheme. There should be certain ground rules that if it is in the national formulary, then the hospital has to make it available or pay for it should it not be. And patients need to know. Dr. Mardiati and Professor Budi said they are doing this now.

Dr. Suwit said that now the issue is in compliance and audits. If hospitals breach the agreement, then they can be brought to court. This is not the problem of HTA and it cannot solve this. There needs to be a strong system in the ministry to address this. In Thailand, not every drug registered is put in the 'formulary.' The ISaFF score will determine whether they will be included in the NLEM. They have a second indicator, called EMCI, which has cost, but not cost-effectiveness or BIA. They take off expensive things if need be. Only after 6 years did they start to include cancer drugs. They have a new term called multiple criteria decision analysis. HTA is not a panacea to solve everything. There must be a clarity about the role of HTA, but it cannot solve everything.

If INA can make hospitals confirm to the national decision making, it is less useful to have hospital based HTA. Dr. Suwit said it might be useful to work with hospitals to have a national

system. Kalipso said that hospital based HTA could be a distraction, as INA government still needs to build capacity and structure for them. They can then pick 2-3 important items that are high priority, then establish the networks for conducting it, and then have a test for the political backing once HTA studies are finished. The next few studies and subsequent institutionalization will be easier.

Professor Budi asked about the capacity needed. Kalipso replied that HITAP and NICE have stories of their development, from few people to medium/larger organizations. They can make a plan to do 4 studies in the first year, then 10 the second, etc. There is a need to ensure that there are action points for HTA studies and capacity. Academic networks use them. There is no need at this point in time to build fancy models. The capacity needed is enough for the first few HTA. Dr. Suwit said that there are 2 levels of capacity: the first is the evidence generation and management; second is the capacity of the decision maker to understand the evidence and make decisions informed by the evidence. He said also that all should be keen to know what the concern for the BPJS is because there are some concerns that can only be addressed while taking into account all (especially the financial) aspects. Professor Budi said it is important to strengthen BPJS capacity also for data collection because many issues coming from them, also addressing the social and equity issues. Dr. Suwit said for example, for use of RRT in Thailand, HTA will be used to present the budget impact. Professor Budi said this was also presented in Indonesia, which has around 200,000 cases each year. BIA says that it is better to conduct kidney transplantation compared to dialysis.

The question on how HITAP works with the NHSO was raised. Dr. Yot said that on the first year of HITAP, they did not want to work with HITAP, so the latter used Thai research fund for their initial work. They did research for 3 years with $1 million, and HITAP asked those in the healthcare system to submit and prioritize topics. HITAP selected 10 topics to do in the first year. Fortunately, there were some research topics related to the NHSO, first one is on cervical cancer and control (comparing screening and HPV vaccine) and they informed the NHSO. It was not very successful in the beginning but improved after. The technologies were decided by sub-board and sub-committees. Fortunately, Dr. Suwit was the chair of the subcommittee, and HITAP started working with him. He found that the subcommittee met every month, and several interested groups came to the, which prompted the formulation of a policy to manage this. Now 6 years after and the NHSO funds HITAP regularly, funding another 5 million. A main criticism for HITAP is that they say “no” to technologies et al 80% of the time; as such, HITAP can become a prime target for industry if they do too much research (the NHSO proposed more research for them worth $15 million). They then involved other organizations and HTA units in conducting research for their clients. Now there are many targets for the pharmaceutical industries but using the same standards because HITAP helps to do quality assurance and acts as a secretariat. There is a permanent relationship between HITAP and the NHSO now, they have many packages (curative and also preventive) and HITAP helps with many of their research. Preventive interventions now

have its own subcommittee and HITAP evaluates them, such as health promotion (usually systems based). The relationship with NHSO is good, but HITAP asked them not to give research questions, but involve stakeholders in a process of topic selection; in this way, the NHSO can also escape criticism by being transparent and evidence-based. The NHSO is now spending around 20B$ for preventive measures and they want to ensure the real impact.

Dr. Salma said it helps to have a vision and proper coordination. It is important to have priorities for human resource development. On the action plan, for A-D, once there is a general path or direction, there needs to be further expression of commitment from the government particularly in terms of financial support and capacity. Other areas include assistance from partners (many of us operate in different ways, which needs to be understood and coordinated), inclusion into the national curricula, partnering with international universities (e.g. Mahidol), having a module for presentation at the national level, (TOT approach). The GIZ, for example, is a technical agency and not a big funder. They have a pragmatic approach in focusing on programs. They will be working on data and collection with the BPJS for the next year, when they have new budget and plan. They will work through BPJS mainly, but are in favour of working on a long-term strategy as well as cross organizational coordination. Harvard developed a course with the WB for the social policy, which can also be used. They stressed the point from Kalipso, to focus on some specific cases and emphasize the value of HTA.

The Secretary General arrived and was briefed by each main partner and Professor Budi. Dr. Suwit said that commitment is present with his presence. It is important for the decision makers such as him to understand and make use of evidence – a vital capacity. Drs. Somsak and Suwit happy to help from their background. They are happy to help and learn from the MOH in Indonesia, exchange lessons learned between Thailand and Indonesia. Dr. Churnrurtai invited the Secretary General to PMAC 2016, with its theme of priority setting, and the potential for him to speak in one of the PMAC's subtheme sessions.

<u>For the partners' coordination meeting:</u>
Dr. Salma said that for the WHO, there is a long-standing engagement with these partners, particularly with HITAP, and also have support from other partners including the USAID. It's been a long process of building this process gradually. They have achieved much through this mission, as evidenced also by the interest in the INA high level officials visit to NICE. She suggested the group recap and put some thoughts together in the direction they will be working towards. This coordination was begun with the PEN study last year; unfortunately some of them are not available for today. Dr. Salma said that USAID however has said they are in line with the WHO. Dr. Dewi asked what each partner thinks of the next steps and the meeting, as well as how the collaboration will go forward. Dr. Yot introduced Dr. Somsak, Dr. Suwit, and Dr. Churnrurtai, who are part of HITAP's international advisory committee and provides independent advice and steering to its international work.

Alia said that in this meeting, there has been increased participation from the government and development partners and the next steps would be to consider how the results can be used for policy. Waranya said that while working with the Indonesian staff, there was good spirit and desire to conduct HTA, but there needs to be more support from higher levels to continue the work. Lina said she learned a lot from the past few days, it has taken a long time, and there is a tendency in INA to speed things up which then fizzle out. The roadmap being presented seems to be rushed. Mutsumi: lots of things that are very viable. PATH started working last year, invited HITAP and had a good workshop, there has been progress, perhaps not steady but slow. Dr. Donald and Sec Gen showed up and imply stronger commitment than before. The roadmap is still very high level, and she would like to see some more prioritization, and understand the gaps they have.

Dr. Dewi said there is much progress, given that this process was started last year. They even had the funding from USAID for hospital accreditation. But during the process, they tried to approach the MOH, often there wasn't good result and there was no buy-in from the ministry of health. They have to bring a broader agenda, as HTA is only one of the entry points to improve health. But with a coordinated effort, there was more improvement. Kalipso said that HITAP is leading the work in SEA. Currently, iDSI is renewing the grant with the Gates Foundation to continue supporting policymakers to make better healthcare resource allocations. DFID, following the review in November, will also hopefully support iDSI. Indonesia is a priority country, for both (though less so for latter). As such, iDSI is very keen to continue working together in the next few years. For the meetings, she said that the key stakeholders were there there were good discussions. While everything listed on the roadmap may not happen (still needs to have specific next steps in the agenda), this is positive for the future.

Dr. Yot sad that firstly, it is clear that local authorities are uncertain what they will use HTA for. This is good to know as we are now aware of the gap to be fulfilled. Secondly, at the time, it was very difficult to meet with high level officials like Donald Pardede. But the progress is that there is enough awareness that they are interested and attending meeting. Thirdly, working with the WHO was initially hard because there was also lack of awareness; this relationship is much improved. The situation now seems to be that the most supportive international partners are iDSI, PATH, USAID, DFAT and WHO, PATH and iDSI might be here until 2018, USAID may as well. He said it needs to be clear which areas we will work on together and how to support the PICs doing ground work. He learned from these workshops that we are not working on HTA institutes/units, but we are helping them to make use of evidence to push policy. This may never be part of our idea or plan. We need to think seriously about how to start engaging with drug procurement, medical education, practices and guideline development. By next year, we should at least have some report(s). As we are also supporting HTA capacity building for decision makers, with Kalipso's help for decision

makers (2.5 days with the Secretary General next week in NICE International), demand and supply will come at the same time hopefully.

Dr. Suwit said that it's clear that to be successful in working in INA, there is no choice but to understand the health system and who is who in the MOH, the clear role (and for UHC, the BPJS's role), and every unit. Good knowledge of the system is needed so as not to overcommit (micro and macro levels). Good knowledge of the interest of development partners as well, though this seems to be doing well as far as seen today. The first key challenge is asking challenging questions. The second is that HTA is more than UHC; looking at health ministers or senior officials, many of them are professors and clinical professionals. There is a need to work with influential people, those who are spiritually good and have cross-linkages with the presidents or else they may be the ones to go against HTA in the end. If an outcome/assessment contradicts the result they seek, then the HTA agency/team needs protection from advocates that are influential and supportive. There is a need to start concrete actions, 3 projects for example. If the WHO can mobilize iDSI support and Mahidol, then they can accept this year 3-5 good people for the graduate program, some will have partial scholarship, they must do their thesis based on Indonesian case. In this way, the network will gradually be built up after 5-6 years. ASEAN is a good mechanism to work with because it is easy to cut across the region.

Ajarn Boom said that her first impressions is that there is a lot of commitment. It seems they have a good plan for the process. But even with the commitment, there are still lots of problems implementing and thinking clearly on the next steps, and she is not sure they clearly understand the process. If they select the staff to come study for PhD, from her experience, then they send in the students to come in with full scholarship, sometimes they did not select the right person. The student may or may not be qualified to study, e.g. he or she cannot pass the exam, etc. It is a waste of time on both sides, and waste of money as well. They need to have a good process, and the selection should not depend just the person who will be responsible for the program, but also one who will do well and go forward.

Dr Somsak said he has 3 observations. First, it is good that they come up with a roadmap that is not donor or development partner driven. However, the question is to what end they want the plan for, e.g. HTA per se or to improve UHC, equity and efficiency (even though HTA is part of the focus). With sharing experiences, this can be refined. Second, there needs some kind of starting point, and while it would be very important to ground the point in the demand side (training, capacity building, set up a unit). However, it might be HTA for HTA's sake and it is not very clear how it will be used. For UHC policy development, the 3 studies should be grounded in policy goals. It might be an important goal for the HTA team to have a good leader. It would be good to see how HITAP and NICE handle this. Third, maybe Indonesia has a better opportunity to organize this unit. It would be a good opportunity to draft and define and establish this unit with the foothold they have. The only caution, with

establishment of this unit, it may take away from the dynamism of the work and so development partners may have a hard time.

Kalipso said that for the next phase of iDSI, where Indonesia remains a priority country, there needs to be responsiveness on the demand side, and a bit more consciousness for finding and serving it. It is a good opportunity to start thinking about who the client is, the levers are and the system, as well as how to translate findings, establish a response for them, doing topic selection, engage stakeholders and elicit priorities. It is important to bring the stakeholders and senior clinicians, so the projects should be something to gain buy-in, e.g. have some key policy makers to have action points they had. Another is setting out ground rules for methods, process – if the relevant stakeholders are made to think about the process of selecting the topic, thinking about the different institutional processes is another step away. In addition, Mahidol, HTAsiaLink, ASEAN, and the steering meeting in Beijing (half a day dedicated to stroke management) – all these meetings are opportunities to engage senior leaders from Indonesia. It is good to concentrate on activities that are about driving or shaking demand a bit, especially in thinking about what will be next for HTA studies. The target client should be the HTAC, though dealing with the HTAC is not easy. The commitment from Sudigdo is difficult, particularly for them to get an understanding of the economic path. We need to insist that there is no need to do comprehensive work for every study. Initially, Sudigdo wanted to do 5-10 topics, but talked yesterday of about 3-5 studies, maximum. This is coming from the topic selection initiated, chaired by the Health Secretary. But without the PIC, this cannot be done and there needs be a funder or MOH to support the PICs. This is upstream, for downstream there are the HTA projects: for RRT and treatment of PAH, there needs to be a response from clinicians. In the national formulary, they cannot support drugs that are not registered (e.g. sildenafil). The 3 studies don't need to have uniform or similar platforms but targeting and individualizing studies, we need more effort, resources and time, not only to provide technical support but to move beyond technical issues and organize awareness raising.

Dr. Yot said that the PEN study can wait until next two studies are finished. HITAP will try to find time to stay in INA for 5 days intensive course next month and finish by November.

Dr. Salma said that we can see more commitment since she came. The Secretary General came for at least one hour for the past two days, and he is acting for 3-4 DGs. This is the budget period, and it is a good opportunity to put this in budget discussions. For the work plan, we needed a high level person to push it forward. There is gradual improvement and impetus – we should not let it slide, both the upstream and downstream work. Important not to make mistakes made in the past. They need support as well, the WHO. If Dr. Suwit has the chance to speak to Dr. Poonam, during the South-South, triangular cooperation meeting, then it would be good. There is a need for the WHO team to be stronger as part of this initiative. It would be good to invite WHO staff to the NICE meeting. For iDSI, the pressure from funders

to work with WHO, there should not be another technocrat to fight with and not get anything on the ground. Dr. Salma said that the WHO will follow up with Donald and his group. Dr. Yot said that Dr. Dewi will work with HITAP to provide support for downstream. PATH and iDSI can work together, but GIZ may not have enough support. Dr. Salma left.

Dr. Yot said there needs to be something more concrete, which will be HITAP's responsibility for the next few months to complete work (2 by November) with HTA PIC. After working on downstream, for RRT and PAH, there should be a stakeholder consultation meeting. They will not be like the SC for the PEN, there must be stakeholders who are implementing RRT, and the PIC and team will need to learn about their difficulties and identify key activities. These SCs can perhaps be done here in the WHO, with around 10-15 people to discuss in detail the results and also another workshop to discuss implementation. For example, how a PD first policy can be implemented, e.g. in Thailand and Bangkok. It will be a good opportunity to address equity issues, for RRT. In Thailand, they give the choice to clinicians and have FFS, but in INA there may need to do some kind of initial implementation model. Clinicians have incentives to provide expensive treatments and have patients pay OOP. Law does not allow BPJS to pay for something off-label or not registered, which may be an area to consider for HTA. Aspirin has never been registered before. Perhaps it can be good to push the WHO to put sildenafil on the EML, and Dr. Suwit will ask the ADG Mary Paul to act on it.

Another issue is that Sudigdo (by law responsible for HTAC, but doesn't want to collaborate with universities) and Donald (decision maker, doesn't mind if HTA work done by university) are not on the same level. Kalipso can work on this next week. If Dr. Donald says go in this direction, then it will be the case as Sudigdo's power not so broad. Dr. Dewi will brief Kalipso next week on what to say to Donald and Sudigdo. Next year, MOH can host the activities and facilitate. The team can be mobilized and brought to HTAsiaLink and PMAC next year. Early next year, many activities about priority setting, as well as improvements in the business model and direction of the HTA unit. Alia et al to share minutes, photos, and slides.

Appendix 3: Relevant Slides from the Meetings

Translating Roadmap into Funding and Partners

Budi Hidayat*
Jakarta, 22 September 2015

*Member of the Indonesian HTA committe (b_hidayat@hotmail.com)

2

Roadmap of the Indonesian HTA

The next slide describe the main contents of the Indonesian HTA Roadmap:

- **Strategic Areas & Key Indicators**
- **Approaches**
- **Action Plan**
- **Funding**

BHidayat 22/09/2015

3

Strategic Areas 2015-2020/25

- To address the Indonesian current condition (see situational analysis), the Indonesian HTA team has identified four strategic areas for the future works:
  1. **Addressing curative health needs** → facilitation the revision and development of JKN benefits basket by taking into account all HT's criteria (safety, efficacy, quality, **effectiveness and affordability**)
  2. **Addressing public health needs** → stimulating the development of health technology for unmet medical needs;
  3. **Facilitating access of health technology to both public health and curative health** → reduce the productivity gap that currently exists in the development of health technology.
  4. **Optimizing the safe and use of rational health technology** → minimizing the risks to public and curative health that are inherent in the 'real-world' use of health technology

BHidayat 22/09/2015

4

Approach [Draft]

The above strategic areas can be fulfilled without having appropriate approach. So, we propose a comprehensive approach to HTA and the incorporation of health technologies into health systems with the following elements:

- Integration of HTA into Public Policies on Health Technologies
- Establishment of an Institutional Framework for HTA-based Decision-making
- Human Resources Development
- Promote the Production of Evidence and Dissemination of Information
- Rational use of Health Technologies
- Promotion of Network Collaboration

These HTA Approaches are then translated into "Action Plan" [Next slide]

BHidayat 22/09/2015

Collaboration with the Potential Partners

5

NO	APPROACH & STRATEGIC ACTION	PARTNERS*					
		1	2	3	4	5	6
A	**Human Resources Development**						
	• Strengthen institutions and human resources, including assessment teams and decision-makers, in the use of HTA, methods for the implementation of HTA studies in the critical analysis of assessment results						
	• Building internal capacity within the HTA Team at P2JK						
	• In-house training for PIC and the HTA team in collaborations with other institutions/universities						
	• Preparing manuals and standard operation for HTA						
	• Capacity building for Core HTA Team and PIC						
	• Conducting short term trainings (1-6 months) for at least 15 persons in the MoH and 30 persons outside MoH						
	• Educating Master and Doctoral Degree concentrating on HTA/Economic Evaluation in health services (10-15 per year) for the team at the MoH and the centers outside MoH						
	• Strengthen education institution (universities levels) concentrating on Economic Evaluation						

LIST of Potential Partners: (1) WHO; (2) DFAT; (3) PATH; (4) NICE; (5) GIZ; (6) IDSA; (7) GIZ; (8) HITAP

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Collaboration with the Potential Partners (2)

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NO	APPROACH & STRATEGIC ACTION	PARTNERS*					
		1	2	3	4	5	6
B	**Integration of HTA into Public Policies on Health Technologies**						
	• Support the establishment of decision-making processes for the incorporation of HT based on HTA						
	• Support the use of HTA to inform public health policies						
	• Encourage the prioritization of assessments based on needs (HTA works areas)						
C	**Establishment of an Institutional Framework for HTA-based Decision-making**						
	• Promote efforts to analyze and strengthen institutional frameworks for the incorporation of health technologies up to the 5th hurdle						
	• Encourage the establishment of transparent processes and linkages with responsibilities defined among the different stakeholders						
	• Revising JKN regulations to ensure 0.0005-0.001% of the fund could be used for HTA -- in the MoH and the centers elsewhere in the countries						
	• Securing APBN and funding from BPJS Kesehatan, gradually increase						

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Collaboration with the Potential Partners (2)

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NO	APPROACH & STRATEGIC ACTION	PARTNERS*					
		1	2	3	4	5	6
D	**Promote the Production of Evidence and Dissemination of Information**						
	• Encourage the establishment of transparent processes and linkages with responsibilities defined among the different stakeholders						
	• Promote the production and dissemination of HTA results among stakeholders and those responsible for decision-making						
E	**Promotion of Network Collaboration**						
	• Strengthen national and regional HTA networks to promote exchange among institutions and countries						
	• Participate in the Health Technology Assessment Network						
	• Promote Study Exchange and Dissemination Process with other HTA in other countries						

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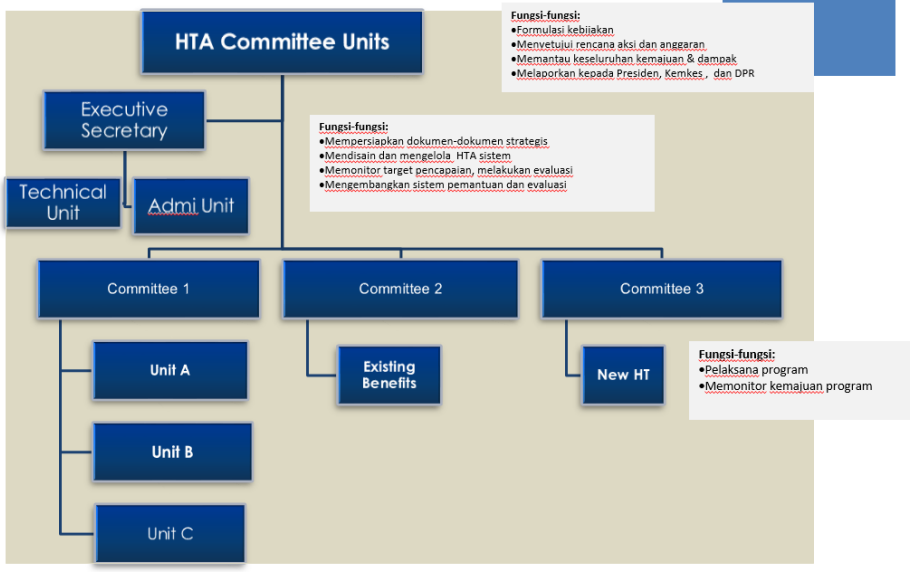
Pooling Resources into Single Pool: Institutional Set-up (Alternative 1)



Action Plan 2015-2020:

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1. **support the establishment of decision-making processes for the incorporation of health technologies based on HTA**, including safety, effectiveness, affordability and other relevant criteria [*Social, Equity??*;
2. **support the use of HTA to inform public health policies**, including public health system coverage decisions and the development of clinical guidelines and protocols for existing and new technologies;
3. **promote efforts to analyze and strengthen institutional frameworks** for the incorporation of health technologies up to the 5th hurdle;
4. **encourage the establishment of transparent processes and linkages with responsibilities defined among the different stakeholders**, including regulatory authorities and entities responsible for the assessment and incorporation of health technologies;
5. **strengthen institutions and human resources**, including assessment teams and decision-makers, in the use of HTA, methods for the implementation of HTA studies in the critical analysis of assessment results;

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Action Plan 2015-2020 (2):

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7. **encourage the prioritization of assessments based on needs** (national and regional, strengthening systems for the collection of quality data, and adapting existing HTA studies to avoid duplication;
8. **promote the production and dissemination of HTA results** among stakeholders and those responsible for decision-making;
9. **encourage public procurement transparency**, including non-proprietary purchase price information and the sharing of the findings of HTA at the national and regional levels to generate information for decision-making;
10. **strengthen the rational use of health technologies, the development and use of drug formularies, clinical practice guidelines** that govern use (including by level of care), as well as systems for monitoring use in integrated health service delivery networks;
11. **strengthen national and regional HTA networks to promote exchange among institutions and countries**, and the dissemination and comparison of studies and national experiences;
12. **actively participate in the Health Technology Assessment Network**

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SCENARIO HTA		IMPLEMENTER HTA STUDY	
		Internal HTA team	External HTA team
PROPOSED HTA TOPIC	Internal HTA team	SCEN HTA-1	SCEN HTA-2
	External HTA team	SCEN HTA-3	SCEN HTA-4

Applied standardize methods as proposed by the HTA team, refer to the guideline prepared by Dr. Mardiati

- SCEN HTA-1: The HTA topic is proposed, and implemented by HTA team.
- SCEN HTA-2: The HTA topic is proposed by HTA team, but its implementation is contracted out to external party (universities, center, etc)
- SCEN HTA-3: The topic is proposed by external HTA team, and they asked the HTA team member for carried out the study. In this case, during the transition phase, HTA team may also request to external party to carry it out the study.
- SCEN HTA-4: The HTA topic is proposed and implemented by external HTA team. The study may be done by the proposer itself or contracted out to universities, centers.

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Terima Kasih

Inputs are welcome