EDITORIAL

Is It Time for Joint Health Technology Assessment in Asia? Opportunities and Challenges

This volume, *Value in Health Regional Issues (ViHRI)* Volume 12, is the first Asia issue since our journal was awarded with a higher international journal standard by being indexed in MEDLINE/PubMed. The achievement may not have been possible without the great contributions made by the authors of all of the previously published articles. This particular issue covers studies from the Asia-Pacific region, under the categories of patient-reported outcome, economic evaluation, preference-based assessment, systematic review, health policy analysis, policy perspective, and comparative effectiveness research. Diverse researchers from many countries have been engaged in producing this volume. The countries/regions include Singapore, China, Thailand, Taiwan, Australia, Iran, Indonesia, India, Japan, Philippines, and South Korea, where outcomes research and health technology assessment (HTA) has been used for decision making in one way or another.

The current issue, *ViHRI* Volume 12 Asia 2017, received 47 manuscript submissions in total. Of these, 18 have been accepted. The majority of studies in the 2017 Asia volume remain typical of health economics and outcomes research, including cost-effectiveness, budget impact, cost-benefit, burden of disease, and cost studies. Of this volume’s accepted manuscripts, 34% (6 out of 18) fall into these typical groupings, which is, however, somewhat lower than its proportion of 47% in the 2016 volume. Another major category of study reports accepted for publication comprises articles on patient-reported outcomes, accounting for 28% (5 of 18) of the total. The rest of the accepted articles (7 of 18) are evenly distributed among other categories, including health policy, systematic review, preference-based assessment, comparative effectiveness research, policy perspective, brief report, and commentary. The commentary article from China could be considered an article in the category of policy perspective. It is to be noted that an increasing number of policy-related manuscripts were submitted during the past year. We are pleased to carry a few of them as quality-proven and meaningful articles in this volume.

Overall, the submissions indicated that *ViHRI* has attracted high-quality manuscripts on health economics and outcomes research in the Asia-Pacific region. Upon publishing this volume, we would like to touch on an emerging issue, joint HTA, which could be interesting to most policymakers in this region of continuous development of HTA systems.

HTA is essential for the priority setting process in health care resource allocation [1]. Many countries in Asia have formally adopted HTA in their decision-making processes, especially when they are faced with costly technology, and some countries are considering taking or working toward the same direction. These countries need HTA because their total health care spending has increased drastically as a result of aging populations, increasing health risks (e.g., communicable and noncommunicable diseases), and use of innovative technologies. These needs have outgrown these countries’ efforts for overcoming two classic challenges—the limited number of scientists and limited resources for HTA in Asia. Primarily, each country tries to build its own HTA capacity. Some countries have experienced greater success compared with others. However, it is widely known that pharmaceutical companies have segregated their markets into regional areas and have used similar or relational pricing and marketing strategies in these markets. There is, therefore, a critical need for the countries in Asia to ask an important question: Is it time for joint HTA in Asia? We have posed this provocative question to the readers of *ViHRI* here, and we intend to discuss the opportunities and challenges for those who agree or disagree with the idea of joint HTA. It is our hope that we can persuade or generate further discussions among all stakeholders, including researchers and policymakers in Asia.

The joint HTA idea is not new, since it has been implemented in Europe as the European Network for Health Technology Assessment (EUnetHTA) for several years. It started with development of guidelines and tools. Recently, the effort has been advanced to include joint assessment. The joint HTA in Asia may not be the same as that in Europe, but the Asian countries can potentially develop a unique joint HTA platform based on their social, political, and economic backgrounds. In addition, joint HTA in Asia can benefit from the model of the EUnetHTA and move faster. For those who agree with the joint HTA idea in Asia, there are two major opportunities for the creation of joint HTA. First, there are existing networks or links for HTA across countries. Intuitively, the countries, including those inside and outside of Asia, with greater success in using HTA to contain health care costs are role models for the countries in Asia. The successful countries have provided assistance and shared resources through certain HTA networks or links, for example, International Network of Agencies for Health Technology Assessment (iNAHTA) and International Decision Support Initiative (iDSI). Among the countries in Asia, there are also existing HTA networks or links, for example, Asia-Pacific Regional Capacity Building for HTA (ARCH) and HTAsiaLink. Therefore, if the countries in Asia ever agree upon the idea of joint HTA, the existing networks or links would be useful for developing a joint HTA platform.
can be used as a great start. Another opportunity is that the social, political, and economic ties, such as ASEAN, ASEAN plus 3, or Regional Comprehensive Economic Partnership (RCEP), among the countries in Asia have grown rapidly. Such collaborations can lead to several commissions, including joint HTA for allocating health care resources.

Certainly, there are some challenges. First, although HTA networks or links do exist in Asia, currently this relationship is rather loose under some memorandums of agreement. They do not have strong support or formal recognition from the governments of those countries. Second, HTA agencies in some countries (e.g., South Korea, Taiwan, and Thailand) are more advanced than those in other countries. The countries with a more advanced HTA system tend to lead the existing HTA networks or links in Asia. Therefore, the balance of roles and powers in joint HTA can be a challenge. Third, the existing social, political, and economic ties across the countries in Asia (e.g. ASEAN) are relatively new and are different from the integrated approach in Europe, since the Asian countries may be held to the principle of noninterference in internal affairs. They may need time to know or understand each other and develop trust to tackle health care-related issues, such as joint HTA. Last, the sizes, levels of economic development, levels of democracy, standards of living, and standards of care in Asia are very diverse. One of the frequently stated and the biggest problems arising from this diversity is the issue of transferring analyses or data from one country to others [2]. It can be a major barrier for joint HTA.

In our opinion, joint HTA may become necessary for the countries in Asia to improve efficiencies. It will require a huge effort and level of commitment from member countries to start the process for establishing joint HTA, but it will likely generate long-term benefits for the countries involved. However, it is worth noting here that it took the European Union almost 20 years to focus its attention on HTA after the first HTA agency in Europe was established and it took approximately 5 more years to establish the EUnetHTA. We, therefore, should not assume that the path to joint HTA in Asia will be a bed of roses.

REFERENCES