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### Table of Contents

**Letter from the Editors**

**Health Policy in Asia**

- Current Situation and Trends of HTA Development in CIS Countries (3-4)
- Issues and Challenges for a New Policy of HTA 2016 in Japan (4-5)
- Managing Costs and Improving Quality of Health Care in ASEAN Part 3: Health Policy in Indonesia (6-7)

**Regional Health Initiatives (7)**

- Modeling Workshop in Australia
- PEOR Conference in Indonesia
- Seminar in Malaysia
- Training Program in Taiwan
- PEOR Conference in Mumbai, India
- Convention on Role of PEOR in Health Care in Telangana, India
- Short Health Programs in UK

**Outcomes Research**

- Call for Papers: *Value in Health Regional Issues ViHRI Asia, Latin America and CEEWAA* (8)
- *Volume 9 (May 2016) Focusing on Asia—Synopses* (8-9)

**ISPOR Asia Consortium Activities**

- ISPOR 7th Asia-Pacific Conference: Abstract Submission Deadline Thursday March 17, 2016 (9)
- ISPOR BRICS Forum: Patient-Centered Health Care in BRICS (10)
- ISPOR Asia Consortium Forum: Use and Management of Big Data in HEOR in Asia-Pacific (10)
- Meetings during the ISPOR 21st International Meeting (10)

**Member-Reported News (11)**

- Single Application System for Combining Regulatory and New Health Technology Assessment Submissions in South Korea
- Home-Based Educational Intervention among Type 2 Diabetes Patients in the State of Penang, Malaysia
- Hot Issues about Drug Price in China: From the View of Internet Public Opinion Monitoring
Dear friends and colleagues:

It is our great pleasure to present News Across Asia Volume 4 Number 4 (January-March 2015). Before we get to the details of this issue, it was important to mention that Zandra Z. Yin, the Director of International Development at ISPOR for Asia-Pacific, Europe and Africa, recently left ISPOR in early February. During her 11 year tenure at ISPOR, Zandra did great work in helping to build up the regions and provided tireless support and leadership to ISPOR Asia Consortium and ISPOR regional networks. She will be sorely missed and we fully appreciate the legacy she leaves behind.

This issue has a hefty dose of health policy, with three health articles featured. The first article, “Current Situation and Trends of HTA Development in CIS Countries” by Dr. Alexandr Kostyuk, covers the HTA landscape for central Asian countries such as Kazakhstan. The second article, “Japan: Issues and Challenges for a New Policy of HTA 2016 in Japan” by Dr. Isao Kamae, discusses some issues arising from recent HTA policy developments in Japan. The final article, “Managing Costs and Improving Quality of Health Care in ASEAN Part 3: Health Policy in Indonesia” by Dr. Bayu Teja Muliawan, is the third part of our health policy series spotlighting health systems in ASEAN, with Indonesia featured.

In addition to health policy, this issue also features some upcoming and recent regional health initiatives. There are several HEOR educational activities that are being undertaken in several jurisdictions including Australia, Indonesia, Malaysia, Taiwan and India. For more information on these events, please visit the respective ISPOR regional chapter webpages. Regarding outcomes research in Asia, this issue features 7 article synopses from the upcoming ViHRI Volume 9 Asia issue which will be published in May 2016.

Member-Reported News includes several reports from experts in the region. The first piece of news, “Single Application System for Combining Regulatory and New Health Technology Assessment Submissions in South Korea” by Dr. Sang Soo Lee, introduces new processes for health technology submissions in South Korea. The second piece of news, “Home-Based Educational Intervention among Type 2 Diabetes Patients in the State of Penang, Malaysia” by Dr. Fahad Saleem, discusses a research study that measured Diabetes knowledge and medication adherence in Malaysia. The final piece of news, “Hot Issues about Drug Price in China: From the View of Internet Public Opinion Monitoring” by Dr. Fang Zhang, spotlights the use of public opinion monitoring on the internet to gauge drug pricing policies.

There are several important announcements mentioned in this issue, particularly the impending abstract submission deadline for the upcoming ISPOR 7th Asia-Pacific Conference in Singapore. The ISPOR 7th Asia-Pacific Conference is shaping up to be the largest ISPOR Asia-Pacific Conference ever, with over 1,300 attendees anticipated from the global HEOR community. The conference will provide an invaluable information-sharing platform on current and emerging issues facing health care in Asia. Abstracts submissions are currently open and the deadline for submission is Thursday, March 17, 2016. Please submit your abstracts by visiting the abstract submission webpage.

These are just a sample of the countless initiatives that ISPOR Asia Consortium members are involved in. We welcome you to participate and join us in making an impact for positive health outcomes in Asia.

Kind regards,

Chee-Jen Chang, PhD, Director, Clinical Informatics and Medical Statistics Research Center, and Professor, Graduate Institute of Clinical Medical Sciences, Chang Gung University, Taoyuan, Taiwan

Bhagwan Aggarwal, PhD, MBA, MSc, Mphil, BSc, TEDMED Scholar for TED Talks, USA, & Assistant Director – NIOH, Indian Council of Medical Research, Ahmedabad, India

Soraya Azmi, MD, MPH, Managing Director, Azmi Burhani Consulting and Veras Research, Petaling Jaya, Malaysia
This article will provide an analysis of the current situation and trends of health technology assessment development in the Commonwealth of Independent States (CIS). The CIS is a regional organization of Central Asian countries formed during the break-up of the Soviet Union that cooperate on mutually concerned issues of trade, finance, lawmaking, and security. There are 9 full member states in the CIS, including Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, and Uzbekistan.

With regard to the role of HTA in health care innovation and financing, the HTA system seeks to ascertain the relative effect of technology on health, the availability and distribution of resources and other aspects of the health system. HTA helps to identify both cost-effectiveness and cost-ineffectiveness technologies and health services, and provides a range of stakeholders with evidence-based information for decision making on matters of reimbursement, pricing and priority-setting. Health Technology Assessment is being introduced in the CIS through the establishment of new agencies and institutes both in academic or government settings. Many countries have several bodies dedicated to HTA with clear and disparate roles and responsibilities, and the widespread heterogeneity of existing HTA bodies reflects the high differentiation between European and Asian health care systems.

At the present moment a large portion of CIS countries possess some introductory form of HTA. In Armenia there is a scientific center for drug and medical technologies expertise. Belarus has a scientific and practical center for medical technologies, but as of yet does not cover essential HTA activities. Kazakhstan possesses HTA units at the Republican Center for Health care Development and the Kazakh Agency for Health Technology Assessment, as well as academic centers in medical universities which provide implementation of hospital-based HTA. In Kyrgyzstan there exists a good foundation for the development of HTA because the country has a good systematic development of clinical practice guidelines and evidence-based approaches in the clinical practice. In Moldova currently there is a medicine and medical devices agency but it does not cover essential HTA. In Russia there are stakeholders involved in HTA that conduct appraisal at the main national center for HTA as well as other academic centers. Health Technology Assessment is currently not being conducted in Azerbaijan, Tajikistan, and Uzbekistan but these countries are involved in the introduction of evidence-based medicine for clinical practice and have a strong potential for future HTA development.

Regarding responsibility and membership of HTA agencies in the CIS, most national HTA bodies can be categorized as serving an advisory, regulatory or coordination role. For example, HTA in Russia serves an advisory role for reimbursement or pricing recommendations to the national and regional government bodies. Russia currently is in the process of establishing a new public body to provide HTA assessment. Examples of regulatory HTA bodies can be found in Belarus and Armenia, which are accountable principally to health ministries and assume the primary responsibility for listing and pricing drugs and medical devices. Kazakhstan’s HTA program, on the other hand, serves a good example of playing a coordination role, which is in the process of development HTA for the future including clinical guidelines and producing and disseminating reports.

Most HTA bodies either conduct an assessment in-house or contract independent reviews through external organizations such as an academic research institution. The use of independent reviews presents both advantages and challenges. Independent reviews lend greater transparency, help to prevent or resolve potential appeals, widen available expertise and bring broader perspectives to the process. But they also introduce disconnects between methodological approaches, coordination inefficiencies, and divergent agendas. The majority of HTA bodies involve a diverse array of health care stakeholders, including physicians, academicians, industry and patient group representatives. An increased role for industry in the process has also been promulgated. Greater stakeholder involvement can facilitate better overall assessment, lend to greater transparency, reduce appeal and result in improved implementation of recommendations and guidance.

The range of technologies evaluated is also subject to variability. In several CIS countries the HTA effort usually focuses just on medicines because of the remit of the HTA entity involved. Consideration of a broader range of technologies is more likely to lead to overall efficiency and provide a level playing field. In terms of topic selection, topic agendas are often set by national authorities or expert committees affiliated with an HTA body. This process involves various stakeholders such as industry, patient representatives, and care providers. Stakeholders may submit topic suggestions or comments on priorities for the extent of engagement as varied by country. While selection criteria differ across review bodies, they typically include health benefit, disease burden, resource impact, innovation capacity, clinical and political relevance, and feasibility of assessment. Several agen-
HEALTH POLICY IN ASIA

The type of evidence to be considered is also an important factor. For clinical evidence, some entities place a major emphasis on randomized control trials (RCT). Others may recognize the importance of observational data and economic modeling. Not many entities pay much attention to items such as productivity gains or patient and family costs. With respect to analytical design, while almost all countries first consider therapeutic benefits, other factors will also frame the analysis: disease burden, patient quality of life, cost-effectiveness, cost, budget impact, and availability of alternative treatments. Health related quality of life is deemed to be the most appropriate criterion for technology’s added value from the patient perspective, but currently this is only now beginning to be addressed within the CIS countries. To a lesser extent, the level of innovation, equity and social and ethical implications are also considered.

For assessment methods, cost effectiveness and comparative clinical effectiveness are most often considered favored approaches for assessing relative benefits and costs. All countries deem RCTs to be the most reliable and objective evidence to classify a product benefit, while demonstrating safety, clinical effectiveness, adverse effects, and possible risks. However, there are also limitations to reliance on such evidence, as trials do not often collect the full range of economic data, the time horizon may be too short to detect longer term outcomes, they can restrict subgroup analyses, and they may have patient restrictions in monitoring comorbidity. Different types of studies should be combined or synthesized to best inform effective decision making. There are also assessment reports of observational studies, and these assessments are comparative in nature with choice of comparator being important in determining the outcomes of economic evaluations. Inclusion of relevant options is crucial to adequately inform decision making.

In assessing the types of costs the principle differences lies in the inclusion of direct and indirect costs. Most costs are based on national data. A high degree of transparency and cost calculation is thus imperative, and should include identification of all sources of data used and any assumption employed. HTA are used to inform a wide range of decisions. They shape the benefits catalog, plan resource capacities, develop clinical practice guidances, inform organizational investment decisions such as acquisition of new technologies, reimbursement, risk-sharing arrangements, procurement, and value-based copayment decisions. Some countries have a formal appeal process whereby stakeholders can be heard if they object to HTA evidence decisions. Re-evaluation is a key component of the HTA process. Allowing new data to be considered accounts for uncertainty during the initial evaluation process which is especially important for new products.

On the horizon, many challenges exist for the continued development in HTA in CIS countries. Core challenges revolve around urgent data requirements such as patient and disease registries, as well as data quality. Capacity building in key government regulatory agencies and universities is also necessary, which can be bolstered through clinical effectiveness or cost effectiveness training and international cooperation and information-sharing.

Issues and Challenges for a New Policy of HTA 2016 in Japan

Isao Kamae, MD, DrPH, Professor, Graduate School of Public Policy, The University of Tokyo, Research Director, The Canon Institute for Global Studies, Senior Faculty, Meiji Institute for Global Affairs, Meiji University, Japan

This article will address the key issues and challenges for a new policy of HTA in Japan for 2016. Japan is a country which established universal health coverage (UHC) more than half a century ago. In fact, it was the first country in Asia that established universal health coverage. In the years since UHC’s inception in the early 1960’s an archaic hybrid HTA system has been continually developed and utilized. In this sense, it can be said that Japan is a country which already has HTA, albeit an older, classical version of HTA. Hence the government decided to create a new HTA system focusing particularly on pricing and reimbursement systems of medical technologies in Japan which the current system doesn’t address fully.

So what’s new for Japan in terms of HTA? In the last 3 years the Ministry of Health, Labor and Welfare Committee has been discussing a new policy on HTA in 2016 surrounding economic evaluation for pricing reimbursement, and pricing and reimbursement decisions for medical technologies. This new initiative was authorized by Prime Minister Shinzo Abe’s administration under Japan’s Revitalization Strategies 2014 revised version. The details of new pharmacoeconomics requirements have not yet been determined, but some committee members suggest that economic evaluations in Japan might be applied for repricing decisions 2 years after the launching of new drugs. One reason for this resides in the current pricing and reimbursement
systems. The Central Committee known as Chu-i-kyo currently decides on reimbursement and pricing. According to the listing requests from a company, the Pricing Commission informs the company on price determination on 2 occasions as outlined on the right in Figure 1. The pink squares show the first Pricing Commission review and the second Pricing Commission review after appeal. After that, the companies are informed of the final price determined by the government which cannot be negotiated further. The new medical technologies and pharmaceuticals are then listed on the national list 4 times per year.

Looking further at the re-pricing issue the committee suggested, the current system now has 2 types of “quasi-value-based pricing.” If a new drug is proved to be superior to the comparators with respect to some value, a premium price is applied in addition to the base price. Thus I like to refer to this as “Japanese style quasi-value-based pricing type 1,” where “quasi” means that a scientific pharmacoeconomics methodology is not formally applied. Instead, the government primarily looks at the medical benefit and some additional economic aspects and then determines the price, essentially utilizing an ICER to make the decision. A challenge to this approach has arisen in the form of holistic budget-impact analysis and quality of life considerations. Of course, budget impact is considered in re-pricing situations as a mechanism for cost containment when a new drug attained larger amount of sales than the initial expectations at approval time (i.e. market expansion re-pricing). This is an example of a re-pricing formula for market expansions. The issue is that this formula does not have a clear rational basis in pharmacoeconomics, which poses a big problem for systematic and rational decision-making.

In cases where re-pricing is needed, a premium price is applied in addition to the base price. The mechanism for adding to the base price is known as the “Adjustment Premium Rate.” In determining the weight of the Adjustment Premium Rate, budget impact may be considered in the decision process in the Pricing Commission or Chu-i-kyo, but at this stage this process is not transparent or prescriptive. An example of this would be the budget impact of Crizotinib (XALKORI® Pfizer). This is an anti-cancer drug and it was approved for patients with advanced ALK-positive, non-squamous cell lung cancer. It was subsequently listed in May 2012 at two capsule sizes, with a price of around 10,000 Japanese Yen (100 USD). Drug spending per year would then be expanded to around 8,500,000 Japanese Yen. This wasn’t considered to be terribly big in comparison to other drugs due to the smaller population, which accounts for 4% of total lung cancer patients, or 1,400 patients per year. In this case, budget impact was regarded as affordable by the Japanese government.

Looking ahead to later this year, it is likely that the Japanese government will introduce an assessment system similar to the single ICER threshold in the UK’s NICE, utilizing Japanese Yen per QALY, but many challenges still remain. One of the challenges is that many Japanese health care decision makers are still not aware of the role of pharmacoeconomics in HTA. How will they scientifically and systematically define value, and how will an ICER capture all of the necessary inputs and address the Japanese premium system? While a single threshold ICER is easier for decision makers to apply, it may allow them to easily overlook other important factors and criteria. How will the government determine appropriate comparators for controls? Also, how will they define boundaries as well as limitations of the ICER? These are important questions to answer if the established ICER is going to be credible to the local Japanese communities. Another future approach may involve the use of multi-decision criteria which would provide a more sophisticated and holistic way of considering high cost drugs, but this comes with its own set of challenges such as determining proper weights and the criteria themselves.

In light of the successes of the established HTA practices in Japan, it begs the question, why bother to change? Even if the current government-managed system is not particularly scientific or transparent, it achieved a positive outcome in managing costs and services. Shouldn’t that be enough? The answer to this question is that while it has worked in the past, in the long run there remains a risk for future insolvency and affordability for the system, especially if economic troubles continue to persist for the country. It is recognized that pharmacoeconomics will be an essential tool to ensure the future viability of the system. To conclude, pharmacoeconomics methodology must be properly integrated into the current Japanese-style HTA systems. And the NICE’s approach for single threshold ICERs may or may not be ideal for the Japanese HTA system based on the local needs of the country. But with the lack of data, budget and technical capacity that the country is facing, finding an ideal solution will prove difficult. It will also be necessary for Japan to engage in mutual learning opportunities with other countries, particularly in the Asia-Pacific which share similar situations.
HEALTH POLICY IN ASIA

Managing Costs and Improving Quality of Health Care in ASEAN Part 3: Health Policy in Indonesia

Bayu Teja Muliaawan, Director, Pharmaceutical Service, Ministry of Health of the Republic of Indonesia, Jakarta, Indonesia

Indonesia is undergoing a major effort in managing costs and improving quality of health care in the country. From many perspectives this is not an easy feat, least of which from a geographic standpoint, as the nation has more than 17,000 islands and a population of over 200 million. Approximately 58% of the population lives on the island of Java which creates a unique situation for governance and decision making. To insure the sufficient health status, Indonesia has several different types of health facilities including more than 1,500 public and private hospitals, along with more than 9,700 public health centers distributed across the whole country. Health care is regulated by the Law No. 40/2009 regarding the National and Social Security System. The Law mandates that Universal Health Coverage (UHC) is the main objective of the health system in Indonesia. Therefore, National Health Insurance was implemented on January 1, 2014, which is known as Jaminan Kesehatan Nasional (JKN).

The National Health Insurance aims to cover the medical benefits for all people by 2019 under the Government. The Ministry of Health of the Republic of Indonesia has already been working steadily to lay the foundation for this policy objective over the last 10 years. From 2005 to 2012 Indonesia’s total expenditure in health tripled to 252.5 trillion Indonesian Rupiah (IDR). Total expenditure on health per capita in 2012 was $284.8 USD based on GDP at current price. Compared to the impressive national growth in GDP of over 6% in 2012, the growth of health spending in Indonesia has been more muted, actually temporarily decreasing to around 1% of GDP in that time period. But with the recent implementation of National Health Insurance (JKN) there will be an increase in public investment to improve access to and quality of care, so the health system must be strengthened with support from the private sector to increase efficiency and mitigate rising costs.

Under JKN the Government has developed some tools to support its implementation which includes a new payment system developed by the National Case-mix Center (NCC), an established HTA Committee, a National Formulary Committee, Clinical Advisory Board under the Ministry of Health. It is also followed by a medical audit process by the Medical Advisory Board, and credentialing for health facilities and utilization review by the Healthcare and Social Security Agency (BPJS). To control the health care costs under the JKN scheme, provider payments are categorized separately between secondary and tertiary health facilities (e.g. hospitals and specialist care clinics) and primary care facilities (e.g. public health centers and general practitioner clinics). Secondary and tertiary facilities will reimburse the health care payment based on a diagnosis related group system named INACBG (Indonesian Case Base Group), except medication for some chronic diseases such as stroke, and also catastrophic diseases including oncology, haemophilia and thalassemia, which are reimbursed separately. While primary facilities will be based on capitation excepting maternal treatment and medicines for chronic illnesses. With this payment system, the Government expects that the provider will maximize the quality of health services while controlling the costs. For the management of medicines in universal health coverage, particularly for medicine use, it is regulated that the medicine selected and listed in the national formulary is established by the Ministry of Health. The list is followed by pricing regulation in the electronic catalog of medicine (e-catalog). Pricing can be set by various methods including electronic tendering and negotiation and also risk sharing arrangement for some innovative drugs. This catalog is also used by hospitals or district health offices for electronic procurement.

These two tools are expected to support the cost containment and quality improvement effect of the medicines used. The main criteria for these selected medicines are achieving the highest benefit risk ratio and benefit cost ratio in considering the safety, quality, efficacy, cost-effectiveness, affordability and availability of medicines according to the most updated evidence (evidence based medicine). It consists of generic products and patented products used for primary, secondary and tertiary healthcare. However the formulary list only includes the name of the active compounds and not brand drug names. The potential roles of the national formulary include: reducing the number of drug items, reducing variable and unnecessary prescribing, improving patient compliance, improving the health care budget by making it more efficient in allocation, and serving as an educational tool for both the provider and consumer (Figure 1).

As outlined in Figure 2 on the right, after the 4 months of implementation in 2014 the ratio of branded to generic prescriptions improved, which indicates that there is positive impact of the implementation of the national formulary and e-catalog within the JKN scheme. These data were analyzed based on IMS hospital audits between the third quarter
HEALTH POLICY IN ASIA

In conclusion, Indonesia already has a system that is responsible for covering national health security and is working toward managing costs and improving health quality. However, there are some major challenges still to be faced including capacity and readiness of the supply side, decentralization, geographic disparity, private sector enforcement (coordination of benefits), and membership of informal sector. Some possible ways forward could include mapping the supply side by formalizing procurement, greater contribution of profit to the government and establishment of more independent HTA communication.

REGIONAL HEALTH INITIATIVES

Upcoming Events

Modeling Workshop in Australia
The ISPOR Australia Chapter will host a workshop entitled “Contemporary Economic Modelling – State of the Art Workshop” on March 17, 2016 in New South Wales, Australia. For more information on this event, please visit the ISPOR Australia Chapter website.

PEOR Conference in Indonesia
ISPOR Indonesia Chapter will hold the ISPOR Indonesia Chapter Conference on Pharmacoeconomics and Outcomes Research to Enhance Health Decision Making on 7-10 May 2016. For information, visit ISPOR Indonesia Chapter.

Seminar in Malaysia
ISPOR Malaysia Chapter will host a 1-day seminar on 22 March, 2016. For more information, please contact nyspor2016@gmail.com.

Past Events

Training Program in Taiwan
ISPOR Taiwan Chapter hosted an HTA Training Program for NHIA new drug application in March 2016. This 5-day 40 hour training course provided coverage on topics such as HTA theory, application, policy and evaluation. There were 41 participants from areas including pharmaceutical industry, academia and government. For more information please visit ISPOR Taiwan Chapter.

PEOR Conference in Mumbai, India
ISPOR India-Mumbai Chapter held a successful 1st Conference of Pharmacoeconomics and Outcomes Research on 31 January 2016. The conference was attended by over 60 attendees from academia/industry/consultancies who learned about health economics and outcomes research, and how to conduct systematic reviews and meta-analysis. For details, visit ISPOR India-Mumbai Chapter.

Convention on Role of PEOR in Health Care in Telangana, India
ISPOR India-Telangana Chapter in association with St. Peter’s Institute of Pharmaceutical Sciences, Hanamkonda and Rohini Super Specialty Hospitals held 1st Convention of International Society of Pharmacoeconomics and Outcomes Research (ISPOR) India – Telangana Regional Chapter on Concept & Role of Pharmacoeconomics & Outcomes Research in Health Care on 25 Jan 2016. For details, visit ISPOR India-Telangana Chapter.

Announcement

Short Health Programs at Imperial College Business School, London in collaboration with the University of Lisbon
ISPOR Portugal President, Professor Carlos Gouveia Pinto invites you to participate in an educational opportunity designed for Pan-European health care professionals. The program is organized around five modules, and participants are free to choose which modules best suit their objectives and level of experience. Foundation modules and the one day challenge event bring participants together to apply the program learning and tackle a real-world health innovation problem. Groups will engage in consensus-building and collaborative design techniques to define a real solution to a real problem being faced by either the NHS or by a technology supplier. They will report back to the problem-owner on the day and benefit from their feedback. An executive certificate of attendance will be awarded to participants who have completed a minimum of five days across the program and benefit from a special price offer.
Apply here: www.imperial.ac.uk/ib-healthcare
OUTCOMES RESEARCH

Call For Papers!
Submit your research to ISPOR's region-specific, peer-reviewed journal, Value in Health Regional Issues (ViHRI). ViHRI submission and editorial review process is year-round.
To be considered, submit your manuscript using our online system!

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For manuscript preparation and submission guidelines, please see the ViHRI Guide for Authors. To view or download articles from past issues, visit the ViHRI webpage.

Volume 9 (May 2016) Focusing on Asia—Synopses

Value in Health Regional Issues Volume 9 will be published in May 2016 and 7 article synopses are featured in this issue written by the authors. The full article and abstracts are available here: http://www.sciencedirect.com/science/journal/22121099/9

Budget Impact Analysis of Peritoneal Dialysis vs. Conventional In-Center Hemodialysis in Malaysia
Sunita Bavanandan, Ghazali Ahmad, Ai-Hong Teo, Lillian Chen, Frank Xiaoping Liu

Synopsis: This study investigates a five-year health care budget impact of various distributions of adult patients treated with peritoneal dialysis (PD) versus in-center hemodialysis (ICHD) on government funding for dialysis treatment in Malaysia. Using an Excel®-based budget impact model, increasing the utilization of PD was estimated to generate substantial cost savings for the Malaysian government. This information is important in view of the pressing need for cost containment and sustainable dialysis plans in the face of burgeoning numbers of patients with Chronic Kidney Disease in the country. A PD Preferred policy for clinically appropriate patients in the setting of an integrated dialysis approach might also be a good strategy to address inequity in dialysis access.

Cost-Utility Analysis of Human Papillomavirus Vaccination and Cervical Screening on Cervical Cancer Patient in Indonesia
Didik Setiawan, Franklin Christiaan Dolk, Auliya A. Suwantika, Tjalkie Arend Westra, Jan C. Wilschut, Maarten Jacobus Postma

Synopsis: Researchers from PharmacoEpidemiology & PharmacoEconomics (PE2) Unit, Department of Pharmacy, University of Groningen, The Netherlands and Faculty of Pharmacy, University of Muhammadiyah Purwokerto, Indonesia conducted the first cost-utility analysis of human papillomavirus vaccination and cervical screening on cervical cancer patient implementing a markov static model in Indonesian setting. The study determined that the combination of HPV vaccination and cervical screening (ICER IS1.863) is very cost-effective according to WHO recommendation. In addition, more than 50% reduction on cervical cancer incidence and death were produced by those combination. Our study recommend a wider coverage on cervical screening and implementation of HPV vaccination for young girls in Indonesia to prevent unnecessary loss caused by cervical cancer from both society and government in the next few years.

Lifestyle-Related Metabolic Disorders, Osteoporosis, and Fracture Risk in Asia: A Systematic Review
Toshitsugu Sugimoto, Masayo Sato, Francis C. Dehle, Alan J.M. Brabac, Adele Weston, Russel Barge

Synopsis: The prevalence of both lifestyle-related metabolic disorders and osteoporosis is increasing in Asia. A systematic review of the published literature was conducted to identify studies examining disorders of glucose and lipid metabolism as risk factors for osteoporosis and fracture in Asian populations.

Cost-Effectiveness Analysis of Tocilizumab in Comparison with Infliximab in Iranian Rheumatoid Arthritis Patients with Inadequate Response to tDMARDs: A Multistage Markov Model

Synopsis: Rheumatoid Arthritis (RA) is a chronic inflammatory disease and considering the pattern of aging in Iran and therefore an increasing trend in burden of this disease is expected in the future. In this study, we analyzed the cost-effectiveness of two common treatment strategies in Iran, comparing tocilizumab plus methotrexate to infliximab plus methotrexate in patients with RA with inadequate response to tDMARDs. In the base-case analysis, the ICER of the tocilizumab-containing regimen was US$ 60,800 per quality-adjusted life-year (QALY) as compared to the infliximab-containing regimen. It is higher than cost effectiveness threshold of Iran (3 times of GDP per capita). We concluded that although tocilizumab and methotrexate provide a larger gain in QALYs, their current price is quite high as compared with those of other interventions currently in practice in Iran.

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The EQ-5D-5L is More Discriminative Than the EQ-5D-3L in Patients with Diabetes in Singapore
Pei Wang, Nan Luo, E.S. Tai, Julian Thumboo

Synopsis: We aimed to compare the discriminative power of the EQ-5D-5L (5L) and the EQ-5D-3L (3L) in patients with diabetes in Singapore. We found that the 5L index score showed higher RE in seven of eight clinical conditions (mean RE value: 1.87) and the 5L classification system had higher H’ in all dimensions: mobility (1.17 vs. 0.70), self-care (0.57 vs. 0.41), usual activities (1.01 vs. 0.72), pain/discomfort (1.47 vs. 1.02), and anxiety/depression (1.36 vs. 1.10). Hence, we conclude that the EQ-5D-5L is more discriminative than the 3L in patients with T2DM in Singapore, supporting the use of 5L in the population.

Utilities for Type 2 Diabetes Treatment-Related Attributes in a South Korean and Taiwanese Population
Narayan Rajan, Kristina S. Boye, Meaghan Gibbs, Yoon Ji Lee, Peter Davey, Mark Ball, Steve M. Babineaux

Synopsis: In order to understand the effect that treatments for diabetes have on patients’ well-being, the study elicited utilities associated with type 2 diabetes medications related attributes from South Korea and Taiwan populations. The results showed that mean utility for basic health state was 0.75 and respondents showed a preference for weekly over daily administration (average increase in utility of 0.043 across all health states with weekly, versus daily, administration). Treatment-related attributes, in particular dose frequency and the potential for nausea, had a measurable effect on utility and should be considered when selecting treatment regimens for South Korean/Taiwanese patients with type 2 diabetes.

Importance of Economic Evaluation in Health Care: An Indian Perspective
Amit Dang, Nishkarsh Likhar, Utkarsh Alok

Synopsis: In this article the objective was to put forward the current status of economic evaluation embedded in health technology assessment and its implementation in India. The article also illustrates the cost containment techniques and analytics model in the Indian health care system. It is seen that India is currently pursuing several strategies to improve health services for its population, including investing in government provided services as well as purchasing services from public and private providers through schemes. Prospects for future growth and development in this field is required in India as rapid health care inflation, increasing rates of chronic conditions, aging population, and increasing technology diffusion will require greater economic efficiency into the health care systems.

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Upcoming Events during the ISPOR 21st International Meeting in Washington, DC

ISPOR BRICS Forum
Title: Patient-Centered Health Care in BRICS
Date: Monday May 23, 2016
Moderator: Jitendar Sharma, PhD, Head, WHO Collaborating Centre for Priority Medical Devices & Health Technology Policy, NHSRC, New Delhi, India
Speakers: Shelley McGee, BPharm, BEc, MHealth Ec, Healthcare Policy and Patient Access Manager, Sanofi Pharmaceuticals, Pretoria, South Africa; Gabriela Tannus, MBA, MSc, Owner & Health Economics Director, Axia.Bio Group, Miami, FL, USA; Kun Zhao, MD, PhD, Professor & Director, Division of Health Technology Assessment, China National Health Development, Research Center, National Health and Family Planning Commission (NHFPC), Beijing, China; Pavel A. Vorobjiev, MD, MSc, PhD, Chair of Haematology and Geriatrics, I. M. Sechenov First Moscow State Medical University, Moscow, Russian Federation
Description:
The trend toward patient-centered health care in the BRICS (Brazil, Russia, India, China and South Africa) is accelerating as these countries grapple with increasingly complex challenges in their health systems. With the broader shift from communicable to non-communicable disease burdens, more complex patient disease states with multi-morbidities, ageing populations, and the greater need for long-term chronic care, health systems are exploring patient-centered care as a way to control ballooning health care costs while preserving quality of care and patient preferences. Some possible solutions include greater coordination of multidisciplinary care programs, greater utilization of health information systems (electronic medical records), adoption of customized or personalized medicine, a greater emphasis on preventative care, use of HEOR in evidence-based decision-making, and greater linkage between points of care (pharmacies, laboratories, clinicians and hospitals). This forum will outline the current challenges facing the BRICS in moving toward greater “patient-centeredness” in their health care systems, and the progress that has been made.

ISPOR Asia Consortium Forum on Big Data Usage and Management
Title: Use and Management of Big Data in Health Economics and Outcomes Research for Creating Best Practices in Asia-Pacific—Part 1: Experiences and Lessons Learned in Australia, Japan, Singapore, South Korea and Taiwan
Date: Tuesday May 24, 2016
Moderator: Libby Roughead, PhD, Director & Research Professor, Quality Use of Medicines and Pharmacy Research Centre, University of South Australia, Adelaide, SA, Australia
Speakers: Bruce Crawford, MA, MPH, Senior Principal, Real-World Evidence Solutions, Japan & APAC, IMS Japan K.K., Minato-ku, Tokyo, Japan; Seungjin Bae, PhD, Associate Professor, Pharmacoeconomics and Outcomes Research, College of Pharmacy, Ewha Womans University, Seoul, South Korea; Chee-Jen Chang, PhD, Director & Professor, Clinical Informatics and Medical Statistics Research Center, Chang Gung University, TaoYuan, Taiwan; Hwee Lin Wee, PhD, Associate Professor, Saw Swee Hock School of Public Health, National University of Singapore, Singapore, Singapore
Description:
As the usage of Big Data broadens rapidly, some countries in Asia-Pacific are already advancing its uses in health care. Australia, Japan, Singapore, South Korea and Taiwan all have big data implementations which we can learn from. This forum aims to start the conversation about the use and management of big data in the field of health economics and outcomes research in Asia-Pacific and the conversation will continue at the ISPOR 7th Asia-Pacific Conference in Singapore. The discussion items in the forum include the accessibility of the data, the introduction of the available data, and the application of the outcome results derived from the data; with case studies and experiences shared from Australia, Japan, Singapore, South Korea and Taiwan practitioners.

ISPOR Asia Consortium Meetings During the ISPOR International Conference
- Asia Consortium Business Meeting
- Asia-Pacific Conference Committee Meeting
- Young Professionals Group Meeting
- Meet ViHRI—Asia Editor
- Asia Consortium Reception
South Korea: Single Application System for Combining Regulatory and New Health Technology Assessment Submissions

Sang Soo Lee, MBA, Corporate Affairs Director, Medtronic Korea, Ltd., Seoul, South Korea

The Ministry of Health and Welfare (MoHW) and the Ministry of Food and Drug Safety (MFDS) in South Korea jointly announced that they will initiate the single application pilot program for combining regulatory and new health technology assessment (nHTA) processes effective February 22, 2016 [1]. The health authorities plan to implement an all-out single application program in July, 2016. This pilot program is a follow-up action to the announcement at ‘the 4th Regulatory Reform Committee (RRC)’ to “streamline and expedite nHTA process” on November 6, 2015. The RRC is the control tower for the government’s regulatory management whose main focus is "happiness of citizens" and "revival of economy" and is trying to take a lead on the reform of the regulation system by communicating with the citizens and expedite decision making with the regulatory reforms [2].

The single application program is limited to the new medical technologies eligible for both regulatory and nHTA applications which require clinical study evidences for regulatory approval and have the clarity of indication for use. The MFDS officials in charge are able to attend the ‘Committee for nHTA’ [3] run by the National Evidence-based Healthcare Collaborating Agency (NECA), an HTA agency supervised by MoHW and voice the opinion from MFDS. MoHW (NECA) is also able to attend pre-IDE (investigational device exemption) meetings in discussing clinical trial protocol designs and provide its consultation on clinical evidentiary requirements from the nHTA perspective. Along with the single application system, the IDE clinical evidences (regarded as grey literature so far) for regulatory approval purposes will be eligible for nHTA approvals. The MFDS will deliver the final decision made by both MFDS and MoHW to the applicants (mainly manufacturers). The authorities plan to further streamline the nHTA process with extra regulatory improvement efforts and enhance communication with the industry. The authorities plan to waive the nHTA process for the in-vitro diagnostic technologies which have the same mode of action with technologies in the market. By these means they will extend nHTA waiver frequency to twice what it is now. This single application system requires medical technology manufacturers to submit the application package covering regulatory and nHTA evidentiary documents to MFDS simultaneously. Upon receipt of the application, the authorities collaborate and coordinate distinctive approval process in parallel and finally issue a combined approval for the medical technologies. The health authorities expect to shorten market access lead-time ranging from 3 to 9 months through this pilot program. However, there is a risk from the manufacturer’s perspective in this single application program. If the manufacturer fails to get a positive nHTA review result, the regulatory approval from MFDS is not granted and market access is completely blocked.

References
[3] The committee comprises of 20 members who are mainly healthcare professionals and makes final decision for HTA approval by reviewing clinical evidences and deliberating safety and efficacy (effectiveness) of new medical technologies.

Home-Based Educational Intervention among Type 2 Diabetes Patients in the State of Penang, Malaysia

Dr. Fahad Saleem, Senior Lecturer, Universiti Sains Malaysia, Malaysia

Patient education is a key component for the management of acute and chronic conditions. However, the majority of such educational sessions are reported from the health care settings. The study therefore aimed to evaluate whether a home-based intervention can result in a better understanding about Diabetes Mellitus Type 2 and can increase medication adherence to the prescribed therapies. A non-clinical randomized control trial was conducted where participants received a home-based educational intervention through a registered pharmacist in the state of Penang, Malaysia. Diabetes knowledge and medication adherence were measured by means of self-administered questionnaires. One hundred and fifty patients were randomly assigned to two groups (75 patients in each arm). No significant differences were observed in either group for demographic variables. There was, however, a significant increase in the participants’ levels of knowledge about Diabetes Mellitus type 2 and medication adherence among the home-based intervention group at the completion of the intervention (p<0.001). Significantly lower HbA1c levels were also observed among the home-based intervention group after completion of the intervention (p<0.001). We observed that a pharmacist-led home-based intervention can significantly increase disease-related knowledge and medication adherence in patients with type 2 diabetes mellitus. This study here-by concludes that home-based interventional programs should be utilized as a compelling method of patient education and counselling.

Hot Issues about Drug Price in China: From the View of Internet Public Opinion Monitoring

Fang Zhang, Associate Professor, Shenyang Pharmaceutical University, Shenyang, Mainland China

By using Shunsu Internet public opinion monitoring software, the whole network was monitored every other day with the key words of drug, price and pricing. Collected data were verified by two researchers to ensure timeliness and usefulness. The monitoring lasted for a year from October 2014 to September 2015. The objective was to obtain and analyze the “hot issues” surrounding drug price in China through Internet public opinion monitoring and provide references to the Chinese Government in the relevant decision-making processes. A total of 560 pieces of valid information were extracted focusing on maximum retail price adjustment, zero markup, drug price regulation, essential drugs, different prices for the same drug, traditional Chinese medicine, centralized tender for drug purchase and corruption in the pharmaceutical industry. Large differences existed between provinces on the amount of information. The amount of public opinion about any issues was closely linked with government policy of that time. In the field of health service research, “Internet Public Opinion Monitoring” is an emerging concept, but it has been proved to be an effective tool for Chinese government to know the public reflection to policy. Future work should focus on connecting monitoring results and policy decision-making.
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