What Drives Subsidy Success in Singapore? Key Determinants of HTA Decision-Making by the Agency for Care Effectiveness (ACE)

HTA27

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Objective

To evaluate the Agency for Care Effectiveness (ACE)'s decision-making factors and subsidy outcomes across a range of HTA appraisals, covering cancer/non-cancer, rare diseases, vaccines and gene therapies.

Background

- In 2021, ACE introduced a company-led submission (CLS) process in oncology, enabling subsidy decisions to be made close to regulatory approval. Non-oncology drugs continue to undergo the physician-led pathway, although some are selected for the CLS process.

Methods

- ACE appraisals published between January 2024–April 2026 were identified. Indication reviews, withdrawn appraisals and documents not reporting committee discussion were excluded.
- Included appraisals were reviewed for decision-making factors (clinical need, clinical value, economic value, budget impact), and subsidy outcomes.

Results

- 54 HTA appraisals evaluating 77 regimens (69 drugs/5 gene therapies/3 vaccines) were reviewed. Over half were cancer (31; all CLS) and rare disease (15) regimens (**Figure 1**).
- 30/77 regimens were recommended for subsidy-listing (15 on first assessment, including 5 for rare diseases; 15 more upon pricing revision, including 2 for rare diseases).
- Fewer cancer vs non-cancer regimens were recommended on first assessment (1 vs 14; 10 vs 5 more upon pricing revision; **Figure 2**).

Clinical Need

- 4 regimens (2 cancer, 2 non-cancer) were judged to have a low clinical need due to the availability of subsidised alternatives, as well as limited expected incremental value of the regimens in the local treatment pathway, driven by prior use of treatments from the same class.
- The Committee issued negative recommendations for all 4 regimens, citing low clinical need, uncertain/unfavourable clinical evidence and/or unfavourable cost-effectiveness.

Clinical Effectiveness

- 23 regimens were deemed to have uncertain clinical evidence, commonly due to data immaturity or lack of robust comparative evidence.
- Nonetheless, uncertain clinical evidence did not preclude subsidy-listing – 2/23 of these regimens (a pneumococcal vaccine and a cancer regimen) still received subsidy recommendation based on their clinical need, cost-effectiveness and acceptable budget impact (**Table 1**).
- Taken together, these examples demonstrate that uncertain clinical evidence did not preclude subsidy-listing, and that subsidy decisions by ACE were made with a degree of flexibility based on other decision-making factors.

Cost-Effectiveness

- 16 regimens (including 2 cancer and 5 rare diseases) were considered cost-effective on first assessment. Economic evaluations conducted for these regimens included cost-utility analyses (CUA; 3), cost-minimisation analyses (9) and price comparisons with overseas reference jurisdictions (4). Acceptable ICERs of the 3 CUAs were between S$15,000–45,000 per QALY; ICERs were not reported for the remaining regimens. All but one cancer regimen (evaluated through a CUA) were recommended on first assessment.
- Among regimens not cost-effective on first assessment, subsidy-listing was only achieved where pricing revisions improved cost-effectiveness. This highlights cost-effectiveness as a key driver of ACE subsidy recommendations (**Figure 3**).

Budget Impact

- Among the 15 regimens recommended for subsidy-listing on first application, a large majority had budget impacts <S$3M in the first year (**Figure 4**). Higher budget impacts of S$5–10M were accepted for treatments of rare (spinal muscular atrophy) and highly prevalent (atopic dermatitis) diseases,[1,2] while the budget impact of the pneumococcal vaccine was >S$10M.

Conclusion

Singapore HTA subsidy decisions are driven by the interplay between clinical need, clinical effectiveness, cost-effectiveness and budget impact. Clinical uncertainty did not necessarily preclude subsidy-listing where economic value could be demonstrated. Higher budget impacts may be acceptable in rare or highly prevalent diseases. Pricing resubmissions improved recommendation outcomes, particularly for cancer regimens.

FIGURE 1

Type of regimens evaluated

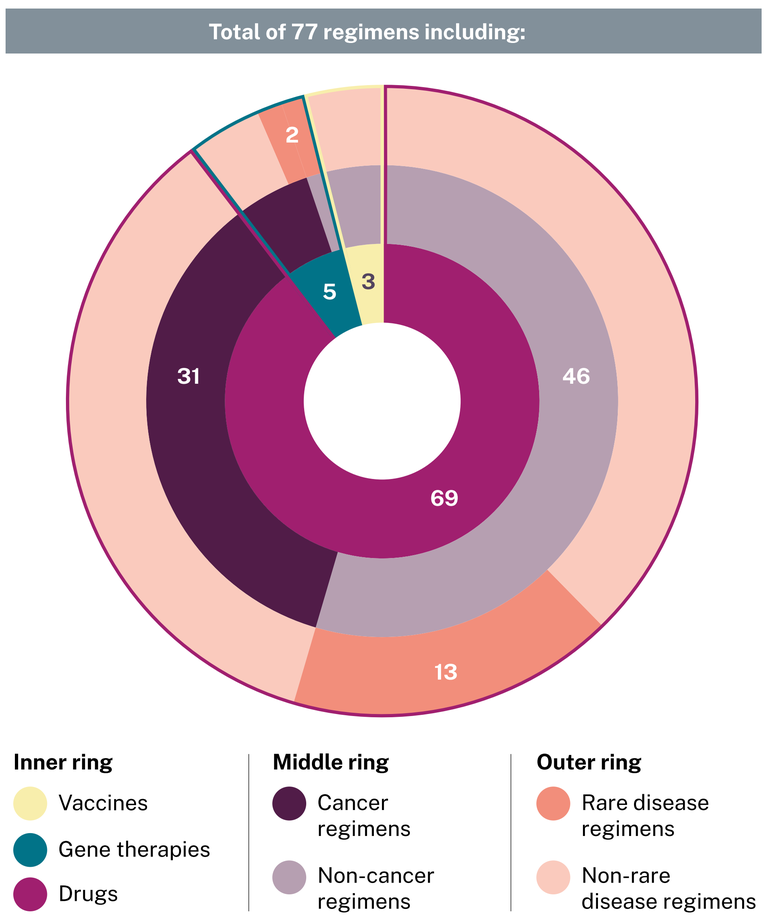


FIGURE 2

Subsidy-listing outcomes for cancer versus non-cancer regimens

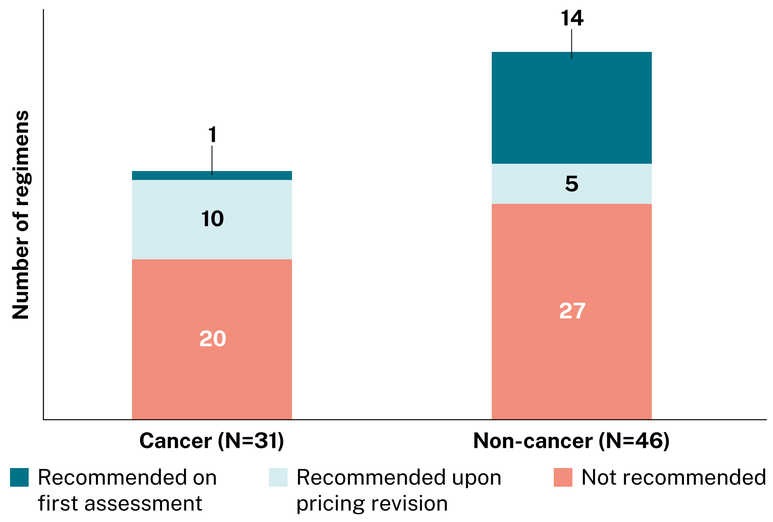


TABLE 1

Case study: Regimens with positive subsidy outcomes despite uncertain clinical evidence

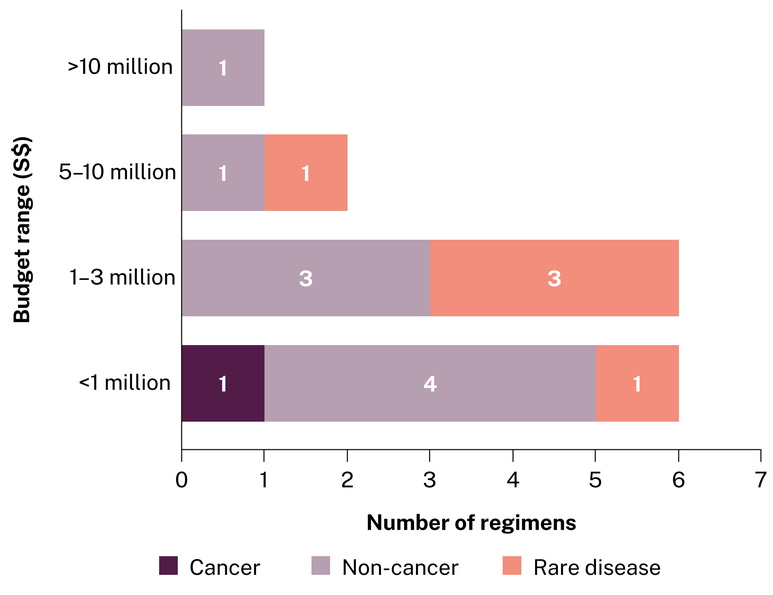
Decision-making factor	Case 1: Pneumococcal vaccine	Case 2: Cancer regimen
Clinical need	✓ Fulfilled clinical need	✓ Fulfilled clinical need
Clinical evidence	? Insufficient evidence on comparative effectiveness	? Superiority claim inadequately supported
Cost-effectiveness	✓ Deemed cost-effective based on a cost-minimisation analysis	✗ Unfavourable at first assessment
Budget impact	✓ Acceptable	✗ Assessed as overestimated
Pricing revision	— Not required	✓ Resubmission with revised price
Subsidy outcome	✓ Recommended for subsidy at first assessment	✓ Recommended after pricing revision

FIGURE 3

Subsidy-listing outcomes by cost-effectiveness status on first assessment and after pricing revision

FIGURE 4

First-year budget impact by disease category



Abbreviations: ACE: Agency for Care Effectiveness; **CLS:** company-led submission; **CUA:** cost-utility analysis; **HTA:** health technology assessment; **ICER:** incremental cost-effectiveness ratio; **PVA:** price-volume agreement; **QALY:** quality-adjusted life year.

References: [1]Yew YW. et al. Dermatol Ther (Heidelb). 2025;15(4):997-1008; [2]Rare Disorders Society Singapore (2020). Rare & Genetic Facts. Available at: https://rdss.org.sg/rarefacts/ [Last accessed 16 Jul 2026].

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