A Determination of Topics for Health Technology Assessment in Thailand: Making Decision Makers Involved

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This study is to describe experiences and findings from the topic selection process for health technology assessment (HTA) conducted by Health Intervention and Technology Assessment Program. The process comprised of 5 stages namely: 1) determining objectives, scope and involved stakeholders; 2) requesting potential topics for assessment from decision makers at the national health authorities; 3) reviewing related literature on and prioritizing the proposed HTA topics by HITAP researchers; 4) selecting the HTA topics by decision-makers; 5) analyzing the strengths and weaknesses of the current topic selection processes by HITAP staff. The strengths of the topic selection were systematic and transparent. It also required participation from stakeholders; however, the limitations were topics prioritization methods and time constraints. Lessons learnt from this procedure can be useful for improving the next HTA topic selection in order to increase the usefulness of the future HTA results.

Keywords: *Health technology assessment, Health policy, Health priority, Health care rationing, Biomedical technology*

Health Technology Assessment (HTA) is a comprehensive form of policy research that provides information on the consequences of the application of health technology. It is used primarily to guide health care resource allocation decisions[1,2]. Over the past few years, HTA programs have been introduced with strong commitment in many settings[3], and this is not exceptional in Thailand, where the Health Intervention and Technology Assessment Program (HITAP) was recently established in order to appraise a wide range of health technologies including pharmaceuticals, medical devices, procedures, individual and community health promotion and prevention interventions. Although the program is jointly funded by four public sources, namely; (1) the Thai Health Foundation, (2) the Health System Research Institute, (3) the National Health Security Office, and (4) the Ministry of Public Health, HITAP itself serves as a technical advisor for all public health authorities at national level who are responsible for the planning and management of health technology.

In general, the HTA process consists of three key features, (1) identification of technologies needing assessment, (2) assessment procedures and (3) technology appraisal (2). Given resource constraints in technology assessment, the procedure for the selection of HTA topics can be seen as a crucial part, because it is

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not only the first step of HTA, but also the topics for assessment themselves which need to be policy-relevant so that the assessment findings can properly assist decision-makers in making rational and effective policy decisions[4,5]. While there is a growing amount of literature addressing issues related to assessing and appraising health technology, very little literature demonstrates how the procedure for the selection of HTA topics works. For example, what criteria are actually used in the selection of HTA topics, and can the selection process be made in a transparent, scientific and socially acceptable way. The probable reason for this is that the methods of identifying priority areas for HTA are not well developed[6].

Goodman did the most extensive review on the potential criteria used for topic selection of HTA[2]. The criteria include disease burden, the cost of technology, variations in clinical practice, available findings not well disseminated or adopted by potential users, the need to make policy decisions, scientific controversy, public or political demand, sufficient research findings available upon which to base assessment, the timing of assessment relative to available evidence, the potential for HTA evidence to be adopted in policy and practice, and the feasibility for conducting HTA. Although his recommendations are comprehensive, many of the suggested criteria are subjective and, more importantly, he did not suggest how to apply these criteria to the selection procedure. Namely, who should be involved and how should they be involved in the selection process.

A growing concern is that all the processes of HTA, including the selection of HTA topics, are managed in a systematic and transparent manner. Teerawattananon and his colleagues demonstrated a poor distribution of research resources for HTA in Thailand, where HTA topics do not focus on major health problems, but rather are induced by the interests of individual scholars or private investment[7]. They requested a comprehensive and systematic way to prioritize areas of future HTA, to ensure that each investment would do the most good for society. In doing so, Batista and Hodge also suggested that the procedure should be well documented and involve end users and other relevant stakeholders[8]. Oxman and colleagues required openness and full participation from all parties in the group-decision-making process[9].

The purpose of this present paper is to report findings from the HTA topic selection process recently initiated in Thailand. It is intended to improve approaches in identifying priorities for HTA that are systematic, efficient and transparent. This is also part of HITAP activities in which its aim is to develop appropriate national strategies and plans for the future establishment of formal systems for the assessment, procurement and management of health technologies in Thailand. Recognizing rare literature on this, HITAP is expected to provide useful information to those involved in identifying candidate assessment topics in other settings.

Material and Method

This study makes use of the action research method with a view to understanding the social situation to improve for improving the strategies and practices of priority setting of research topics for HTA in Thailand. The overall procedure consists of five steps. First, HITAP consulted its staff to set the objectives and scope of the HTA topic process. This process was done with a series of meetings between August and November 2006 and agreement was reached that the procedure needs to be made in an explicit and transparent manner. It should also involve the intended users or target groups of an assessment. However, because the users of HTA can be very varied, ranging from clinicians, researchers, company executives, hospital directors, healthcare program managers and third party payers, who have different levels of expertise, interests and concerns about the effects or impacts of health technology, it was the intension of HITAP to involve, at this stage, only participants from groups of potential HTA users at the national level (healthcare program managers and third party payers).

Secondly, HITAP sent out an official letter dated December 27th, 2006 inviting public health agencies at the national level (Box 1) to submit their lists of 'interventions' including medicines, medical devices and procedures, and individual and community health promotion and prevention interventions, in which they consider they required assessment. Three sets of documents, namely a brochure introducing HITAP, and open-ended and close-ended self-administered questionnaires to gather the information, such as type of health interventions and their comparators, the impact on financial burden and health problem, and the magnitude of the problem, were enclosed with the invitation letter. The deadline for returning the completed questionnaires was set at January 19th, 2007. The representatives of these fifteen agencies were also invited to participate in a workshop which aimed at prioritizing the proposed health interventions in order

to select the top ten most important items for the HITAP assessment process in 2007.

Thirdly, telephone calls were made to follow up on the questionnaires from the agencies. After receiving the returned questionnaires, HITAP researchers shortened the list of proposed HTA topics by excluding some interventions if they were: (1) interventions that should be assessed by the responsible authorized organizations rather than HITAP, (2) interventions that were recently assessed by other researchers, and (3) interventions that were not directly related to health. We also excluded some proposed topics which had no clear research questions e.g. giving unreasonable comparator(s) or not enough specific research questions.

Subsequently, each HITAP researcher was assigned to review literature related to the short-listed topics using PubMed and the database from The Centre for Reviews and Dissemination (CRD). The review was to set up a priority list of HTA topics for assessment using preset criteria in which each intervention item would be considered by 6 criteria: (1) the potential policy implications of the assessment results, (2) the magnitude of health problems to be addressed by the intervention, (3) the financial burden generated by the introduction of the intervention, (4) the duplication of assessment, (5) the variation in professional practice,

and (6) the feasibility to use the assessment results to alter professional practice. A special meeting was held for all HITAP researchers on January 30th, 2007 when the results of the literature review were presented by each responsible staff member. Then HITAP researchers scored (only '0' and '1') each intervention item against the criteria set. The overall score was then summed up to make priority list 'A', which represents only the viewpoint of the HITAP staff.

Fourthly, the aforementioned workshop was convened on February 9th, 2007 from 9 am to 4 pm. According to the agenda, the following activities would be undertaken in series:
- Presentations of the background and importance of interventions by the proponent agencies, which was followed by comments and discussion by the audiences. An equal amount of time (2 minutes per item) was allocated to the proponents and discussants.
- Prioritization of interventions by the representatives of each participating health authority to make the priority list 'B' from the participants' perspective. This was planned to be carried out by scoring each item against the criteria set by the HITAP researchers.
- Presentations of priority list 'B', in comparison to priority list 'A', done by HITAP researchers.
- Discussion among the workshop attendants and the HITAP researchers, focusing on the differences in the top-ten priorities from the two lists, and potential modification.
- Final decision on the list of ten interventions to be appraised by HITAP in 2007.

However, during the workshop the actual process was modified slightly to accommodate the attendants' suggestions; namely, ten interventions were selected and listed by each participating agency, without scoring and ranking.

Finally, HITAP organized an internal meeting among its researchers and supporting staff to discuss the strengths, weaknesses and other aspects concerning the priority-setting and selection methods. All were encouraged to share their observations, analyses and recommendations. In addition, comments and suggestions made by the representatives of participating agencies, as well as empirical evidence on particular issues, came from evidence reviewed and inserted as results of this study.

Results

(Fig. 1) Illustrates the HTA topic selection process in Thailand. Of the 15 questionnaires sent out, 12 health authorities responded with 52 candidate HTA
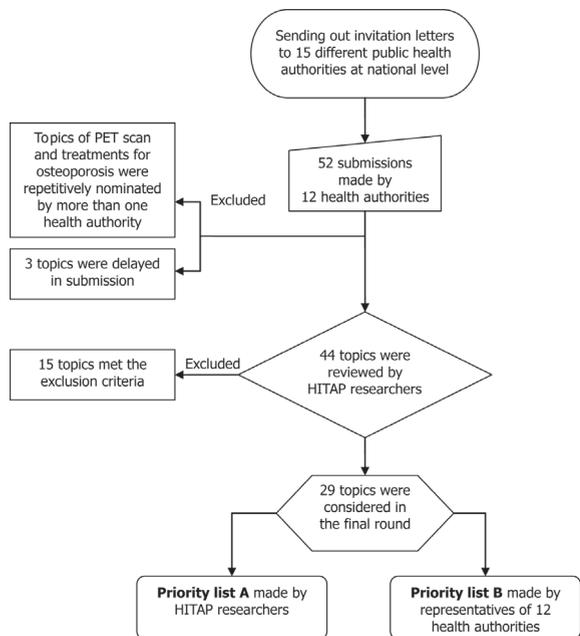
Fig. 1 Prioritization of health technology assessment topics in Thailand in 2007

topics submitted. However, two of them, namely the Department of Mental Health and the Thai Health Foundation, submitted no topic. The largest amount of submissions for the topics proposed for assessment were for pharmaceuticals and medical devices, accounting for 60% of the overall submissions (Table 1). Most pharmaceuticals topics (10 topics) were proposed by the subcommittee for development of the National

List of Medicines (NLM), which is responsible for establishing a list of pharmaceutical products for public reimbursement, while all nine topics concerning health policy issues were submitted by Ministry of Public Health Departments. There were two topics; the Positron-Emission-Tomography-(PET) scanner and medical treatments of osteoporosis that were nominated by more than one public health authority (five nominations were made for the PET scanner and two nominations for the treatment of osteoporosis).

Three candidate topics proposed by one organization were initially excluded in the prioritization process due to the delay in submission (two weeks behind the deadline), resulting in only 44 designated to be put forward for further consideration. Consequently, after be reviewed by HITAP staff, 15 topics were excluded due to the following reasons:

- the proposed intervention and its comparators for assessment were not comparable *e.g.* 'Cardiac catheterization vs. echocardiography for investigating coronary arthrosclerosis';

- there were organizations that are formally responsible for the assessment *e.g.* 'the quality of condoms sold in Thailand' (Medical Device Control Division);

- the proposed topics had been recently assessed by researchers and the results would be available soon *e.g.* 'assessing cost-effectiveness of using nucleic acid amplification technology for screening blood components';

- the proposed interventions were not directly related to health e.g. 'cost-effectiveness analysis on interventions for mobile phone battery disposal';

Table 1. Proposed topics classified by types of agency and intervention

	Third party payers	Healthcare program managers	Subcommittee for development of the National Drug List	Funding organizations	Total (%)
Pharmaceuticals	6	-	10	1	17 (33)
Medical devices	6	7	-	1	14 (27)
Procedure	5	-	-	-	5 (10)
Service delivery	1	2	-	-	3 (6)
Health policy	-	9	-	-	9 (17)
Not applicable	-	4*	-	-	4 (8)
Total	18	22	10	2	52 (100)

i.e. health impact assessment of using insecticide in orange plantations in Thailand, cost-effectiveness analysis on interventions for mobile phone battery disposal, development of a method for assessing school child development, and assessing the impact of reporting false-positive or false-negative testing results (given no specific test)

- the scope of the study was not specific enough e.g. 'the use of antibiotics in Thailand'.

At final, 29 HTA topics were included in the final round of prioritization which was made independently on two different occasions by both HITAP staff and representatives from 15 health authorities, as specified previously in the methodology section.

Table 2 reveals results of the two top ten priority lists made by HITAP staff (list 'A') and representatives from 15 health authorities who participated in the workshop (list 'B'). There were six candidate-HTA topics that were in both priority lists. These included the PET scanner, medical management of osteoporosis, advanced management of Hepatitis B and C infection, medical management for Dementia/ Alzheimer's disease, lipid lowering medications, and the use of erythropoietin for the treatment of advanced stage cancer. The HTA topics namely, percutaneous transluminal coronary angioplasty for the treatment of coronary heart disease, magnetic resonance imaging, commercial factors for treatment of Hemophilia and clopidogrel, were in the top ten of the list 'A', but not the list 'B'. In contrast, bone marrow transplantation in acute myeloid leukemia, cochlear implantation, HIV oral fluid testing for HIV diagnosis and insulin analogues were only in the top ten of list 'B'.

The anticipated utility of HTA from the perspective of the workshop participants varied across interventions. Economic evaluation and budget impact analysis of drugs and medical equipment and their comparators were generally requested by representatives of third party payers, with the purpose of recommending if particular interventions should be included in the benefit packages. Another use of HTA results was to inform the decision-markers of the most appropriate indications of health interventions, for example under what conditions the use of the PET-CT scan is appropriate given current available evidence. In addition, the assessments were anticipated to be helpful in devising effective measures for disease management as well as to regulate the distribution of high-cost equipment. The demands for management and financing mechanisms to promote the rational use of expensive technologies were also discussed.

Discussion

Although decision-makers, health professionals and academics are admirably interested in HTA[10], there is a general shortage of resources for

Table 2. Comparison health technology assessment topics identified by HITAP researchers (list A) and representatives from 15 national health authorities (list B)

	Priority list A			Priority list B	
Ranking	Topic for assessment	Ranking of list B	Ranking	Topic for assessment	Ranking of list A
1	PET scanner	1	1	PET scanner	1
1	Medical management of osteoporosis	2	2	Medical management of osteoporosis	1
1	Advance management of Hepatitis B and C infection	3	3	Advanced management of Hepatitis B and C infection	1
1	Medical management for Dementia/Alzheimer's disease	4	4	Medical management for Dementia/Alzheimer's disease	1
1	Lipid lowering medications	6	6	Lipid lowering medications	1
8	Erythropoietin for treatment of advanced cancer	6	6	Erythropoietin for treatment of advanced cancer	8
1	Percutaneous transluminal coronary angioplasty for treatment of coronary heart disease	16	4	Bone marrow transplantation in acute myeloid leukemia	11
1	Magnetic resonance imaging	22	6	Cochlear implantation	15
8	Commercial factors for treatment of Hemophilia	16	6	HIV oral fluid testing for HIV diagnosis	19
8	Clopidogrel	27	6	Insulin analogues	19

health research and it is not possible to undertake assessment for every single health technology. HTA studies often reflect the narrow interests of individual scholars and studies are sometimes initiated and supported by commercial sponsors[7,11]. As a consequence, it is necessary to ensure that HTA studies focus on topics that are relevant to the perspectives of its users, namely decision makers, and could subsequently have a substantial impact on decision making. This current paper offers a critical overview of plausible strategies and mechanisms employed by HITAP to advocate the involvement of the potential users in the prioritization process of HTA topics.

A review from international literature done by the authors indicates that many HTA agencies have attempted to include stakeholders into process for HTA topic selection (Table 3). While health care ad ministrators or public health insurers are the major sources for HTA topic nomination, only few HTA agencies allow industries to be involved. National Institute for Health and Clinical Excellence (NICE) of England and Wales is the most comprehensive that include the majority of stakeholders into its process for HTA topic selection.

The study suggests that this initiative was warmly welcomed by the responsible health authorities in Thailand, with twelve out of fifteen organizations returning the questionnaire and representatives from all fifteen health authorities participating in the workshop. Furthermore, during the workshop many participants expressed their gratitude and support of the good intentions of HITAP. They were aware that HITAP was trying to make HTA topic selection transparent and participatory. Also, they were willing to make the selection process worked, and learn together to improve it.

It was also found that the consultations were undertaken in a non-contested atmosphere even though the different health authorities had different perspectives and interests and they proposed different lists of interventions. For example, the subcommittee for development of the National Drug List submitted the topic of pharmaceuticals only and there was no one health authority that proposed topics covering all types of interventions. This may be explained by the fact that the short-time allocation allow to each presentation made it difficult for the workshop participants who were not familiar with some particular issues to follow and debate the content. As one workshop participant offered, one the way to improve the selection process was that HITAP should gather necessary information to support the assessment of certain

Table 3. Comparison of the sources of suggestions for health technology appraisals among various health technology assessment agencies

Settings	Health care administrators/ public health insurers	Health professional bodies	Industries	Academics/ Research institutes	General publics	Reference
Gezondheidsraad	✓					[13]
DAHTA		✓		✓	✓	[14]
SBU	✓	✓		✓	✓	[15]
CADTH	✓	✓			✓	[16]
VATAP	✓				✓	[17]
DACEHTA	✓			✓		[18]
MSAC	✓		✓		✓	[19, 20]
NICE	✓	✓	✓	✓	✓	[21]
HIRA	✓				✓	[22]
MRC	✓					[23]
HITAP	✓			✓		

Gezondheidsraad = Health Council of the Netherlands, **DAHTA** = German Agency for Health Technology Assessment, **SBU** = Swedish Council on Technology Assessment in Health Care, **CADTH** = Canadian Agency for Drugs and Technologies in Health, **VATAP** = Veteran Administration's Technology Assessment Program, **DACEHTA** = Danish Institute for Health Technology Assessment, **MSAC** = Medical Service Advisory Committee, **NICE** = National Institute for Health and Clinical Excellence, **HIRA** = Health Insurance Review Agency, **MRC** = Interim National Steering Committee on Health Technology Assessment, Medical Research Council, **HITAP** = Health Intervention and Technology Assessment Program

interventions from proponent agencies, and then circulate this information to all the attendants to study prior to the consultations.

In the workshop the presentations and discussion were closely relevant to the priority criteria set by HITAP, which mostly focused on: epidemiology, including the prevalence of diseases and estimations of demands for particular technologies in Thailand, current practice recommended by international associations and experts, clinical effectiveness in comparison with conventional interventions, variation in access to or coverage of technologies in the country, and anticipated financial burdens of the proposed interventions if provided to patients in need. The high costs of drugs and medical equipment were highlighted as crucial rationale to support the assessment priority. For some technologies, evidence on treatment outcomes and potential expenditure was drawn on studies in developed countries and Thai experience according to expert opinion.

While HITAP researchers scored each intervention item against the preset criteria, an important development of this workshop was that the attendants disagreed with HITAP's proposal to prioritize the interventions by scoring them in accordance with the six priority criteria. Many participants argued that such a process would not work well since it was subjective and not evidence-based, as the information provided in the presentations and discussion was brief and inadequate. Moreover, some participants commented that the methods were inappropriate because only two categories, 0 and 1, were allowed in the evaluation of interventions in each facet. As pointed out by one MOPH official, since most of the participants had a conflict of interest, they tended to give priority to their preferred lists, especially in the absence of sound methodology to prevent these biases. Therefore, the actual process allowed respondents from each health authority to name the top ten most important interventions without scoring or ranking them.

It can be seen that results from the two different approaches, of which one was done by HITAP researchers and the other by representatives from the fifteen health authorities, were similar, with six out of top ten items in priority list 'B' were in the top twenty of priority list 'A'. As a result, it was agreed that HITAP would select the topics identified by the representatives of the national bodies in priority list 'B' as its topic for further assessment.

And when we consider whether the priority topics have targeted major health problems based on the disease burden study in Thailand[12], it was found that five of ten priority topics for list 'A' and 'B' focused on diseases that were the twenty leading causes of disease burden (Fig. 2). Illustrates the proportion of overall disease burden, the proportion of economic evaluation publications that were published in PubMed, EMBASE (Ovid) and Academic Search Elite (EbscoH) between January 1982 and December 2005 for the top 20 major health problems, and HTA topics in priority list 'A' and 'B'. It is noteworthy that this priority setting could help HTA to focus on some particular health conditions where there were only a few (relatively to its disease burden) or no existing HTA studies.

There are some concerns regarding the HTA topic selection in this study. Firstly, that there were too many topics included in the final round of selection resulting in a short time allocation for presentation and discussion of each HTA topic. Also, this could prevent participants from understanding and debating the topics. Since this study found that all top ten in priority list 'B' were in the top twenty of priority list 'A', the final round of topic selection would have included only the top twenty of priority list 'A'. As a result of this, a longer time could have been spent on the presentation and discussion stages.

Secondly, since this is the first time that HTA topic selection was processed with involvement from potential users (national health authorities), it can be seen that there was some confusion regarding the scope of HTA conducted by HITAP. Even though this was the case, majority of health authorities have done well. There is a need for those health authorities to be well informed on the objectives and methods for HTA topic selection as well as the scope of the assessment. In addition, further research is also required to understand the ways in which each health authority identified its own priorities for HTA, and who were involved in the process.

Thirdly, the decisions made in the workshop are subject to potential bias in favor of health interventions that might benefit only health authorities at the national level. Because of this, it is probable that a wider group of stakeholders, for example, health professionals, patient groups or representatives from the public, need to be involved in setting the agenda for HTA to ensure that HTA can improve health technology resource allocation decisions with respect to various viewpoints from stakeholders in society.

Conclusion

The Thai health care system needs HTA to be
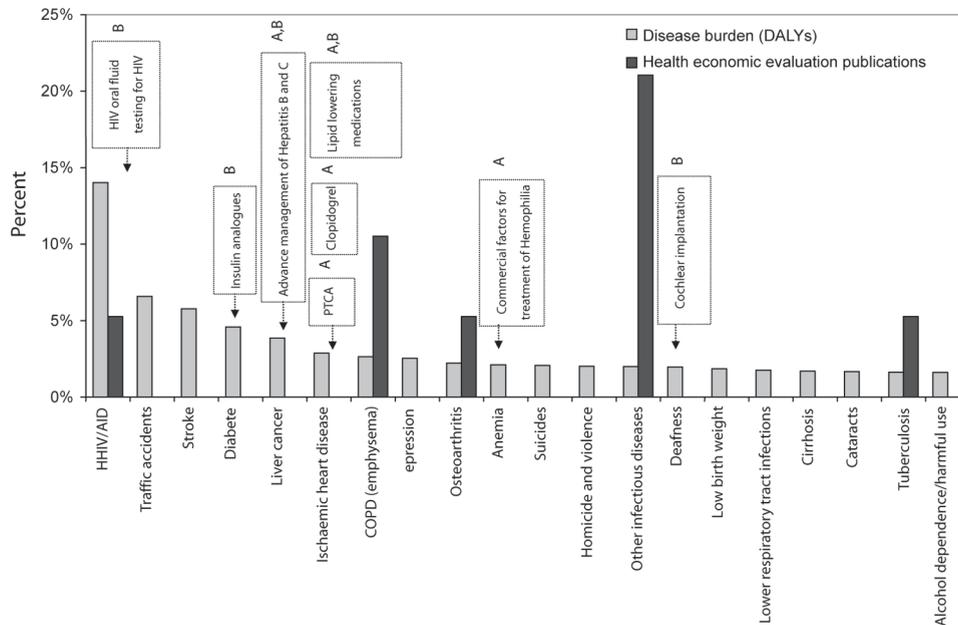
Fig. 2 Comparison of the proportion of disease burden of the top 20 major health problems, the proportion of economic evaluation publications and health technology assessment topics determined by HITAP researchers (A) and representatives from 15 national health authorities (B)

constructive to enable decision makers to make informed decisions with regard to the adoption of health technology. The development and promotion of clear criteria for selection of HTA topics is, therefore, essential to promote the efficient use of HTA information for decision making with respect to setting ultimate goals for HTA. Findings from this study illustrated the possibility of making the HTA topic selection process systematic, transparent and participatory. This will eventually increase the usefulness and credibility of HTA. In addition, it has emphasized a notion that HTA topic selection should not be seen as the sole responsibility of researchers but that decision-makers also need to be included in deciding upon the appropriate use of health technology.

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การคัดเลือกหัวข้อสำหรับการประเมินเทคโนโลยีและนโยบายด้านสุขภาพในประเทศ : กรณีศึกษาของการมีส่วนร่วมโดยผู้กำหนดนโยบาย

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รายงานนี้มีวัตถุประสงค์เพื่อนำเสนอประสบการณ์และสังเคราะห์บทเรียนจากการคัดเลือกหัวข้อเทคโนโลยี
และนโยบายด้านสุขภาพสำหรับการประเมินในประเทศไทย ที่ได้รับการพัฒนาโดยโครงการประเมินเทคโนโลยี
และนโยบายด้านสุขภาพ การคัดเลือกหัวข้อสำหรับการประเมินในครั้งนี้ประกอบด้วย 5 ขั้นตอน ได้แก่ 1) การกำหนด
วัตถุประสงค์ ขอบเขต และผู้เข้าร่วมการคัดเลือก 2) การส่งแบบสอบถามให้หน่วยงานที่เกี่ยวข้อง เสนอหัวข้อ
ที่ต้องการประเมิน 3) การจัดลำดับความสำคัญและคัดเลือกหัวข้อโดยทีมนักวิจัย 4) การจัดประชุมเพื่อคัดเลือกหัวข้อ
โดยตัวแทนจากหน่วยงานต่าง ๆ และการตัดสินผลการคัดเลือก และ 5) การจัดประชุมภายใน เพื่ออภิปรายจุดแข็ง
จุดอ่อน และข้อสังเกตต่าง ๆ ผลการศึกษาในครั้งนี้แสดงให้เห็นว่าการคัดเลือกหัวข้อมีจุดเด่น ที่เป็นระบบโปร่งใส
และมีส่วนร่วมของผู้มีส่วนได้-เสีย อย่างไรก็ตามวิธีการคัดเลือกยังมีข้อจำกัดด้านวิธีการให้คะแนนและเวลา
ทั้งนี้บทเรียนที่ได้สามารถนำไปใช้เป็นแนวทางปรับปรุงวิธีการคัดเลือกหัวข้อเทคโนโลยีด้านสุขภาพให้มีความเหมาะสม
ซึ่งจะส่งผลให้ผลการประเมินมีแนวโน้มในการนำไปใช้ประโยชน์ในเชิงนโยบายได้มากขึ้น