

# **2015 Global Survey on Health Technology Assessment by National Authorities**

Main findings

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More information about the survey can be found on the newly developed HTA intercluster website, [www.who.int/health-technology-assessment](http://www.who.int/health-technology-assessment).

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## Abbreviations

AFR	WHO African Region <sup>1</sup>
AMR	WHO American Region <sup>1</sup>
EMR	WHO Eastern Mediterranean Region <sup>1</sup>
EUR	WHO European Region <sup>1</sup>
GNI	Gross National Income
HIC	High-income countries <sup>2</sup>
HTA	Health Technology Assessment
LIC	Low-income countries <sup>2</sup>
LMIC	Lower middle-income countries <sup>2</sup>
SEAR	WHO South-East Asian Region <sup>1</sup>
UMIC	Upper middle-income countries <sup>2</sup>
WHA	World Health Assembly
WHO	World Health Organization
WPR	WHO Western Pacific Region <sup>1</sup>

<sup>1</sup> Please refer to Annex I for the list of countries by region

<sup>2</sup> Please refer to Annex II for the list of countries by income

# 1. Introduction

As countries strive to deliver universal health coverage, the process of deciding which health technologies and interventions to invest in has become increasingly important. Countries face complex choices in deciding how to direct their finite health budgets to meet the priority health needs of their populations, and in selecting from the vast array of technologies and interventions on offer. Reaching a fair and efficient outcome requires a multidisciplinary process to evaluate the social, economic, organizational and ethical aspects of a health intervention or health technology. Health Technology Assessment (HTA) is a systematic approach to evaluate the properties, effects, and impacts of health technologies or interventions. It can be applied to medical devices, medicines, vaccines, procedures, health services, and public health interventions.

This report summarises the methods and main findings of the WHO 2015 Global Survey on HTA. This survey was aimed at HTA conducted by government or national institutes. It was undertaken in response to World Health Assembly Resolution 67.23. This resolution, 'Health intervention and technology assessment in support of universal health coverage' called on the WHO Secretariat to assess the status of HTA globally (see Annex III).

## 1.1 Method

All Member States were invited to participate in the survey through their Permanent Missions in Geneva. An official circular letter was sent from WHO requesting nomination of a national HTA focal point within the Ministry of Health and a response to the survey. To ensure the suitability of the nominated respondent, the request specified that the respondent would ideally be engaged in one or more of the following:

- Evidence-based decision making of public funding of health services;
- Determining priority health interventions;
- Planning resources allocation; or
- HTA in a committee, a unit, a department or an established HTA organization at a national or subnational level.

The survey had five broad sections that aimed to measure:

- Utilization of HTA in public sector decision making;
- Scope of HTA and availability of guidelines ;
- Institutional capacity and human resources supporting HTA;
- Governance of HTA process; and
- Requirements for strengthening HTA capacity.

The questionnaire was available in the six official languages of the United Nations: Arabic, Chinese, English, French, Russian and Spanish.

The survey questionnaire was piloted with personnel at WHO, who reviewed the contents of the questionnaire to assess the appropriateness of survey questions. Descriptive statistics were used to summarise the characteristics of the survey data. Where appropriate, data were presented by regions and national income categories.

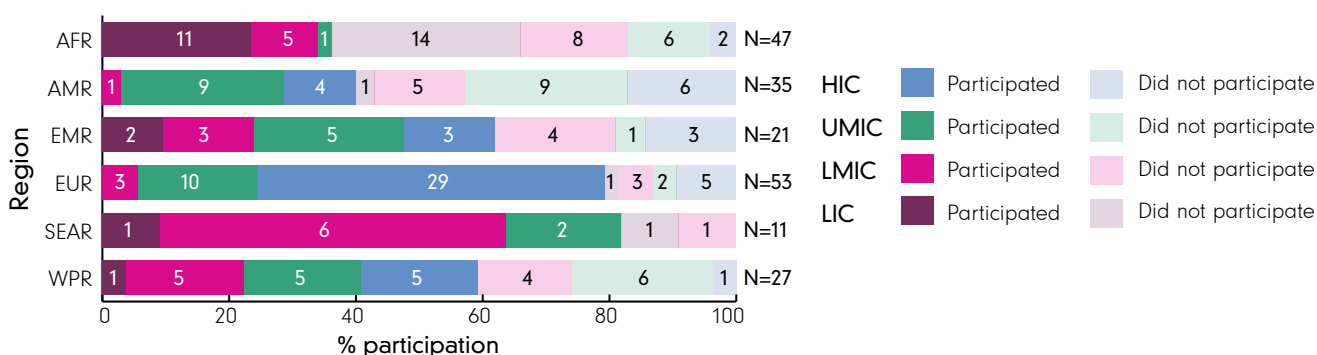
## 1.2 Survey responses

In response to the invitation to participate, 125 Member States nominated national HTA focal points. Of those, 111 responded to the survey questionnaire between 24 February 2015 and 31 August 2015 (Chart 1.1). Member States that responded to the survey are listed by regional and income groupings in Annexes I and II. This represents an overall response rate of 56.2% from 194 member states. There were respondents from all six WHO regions ('region'), and from all country income levels as classified by the World Bank<sup>4</sup> ('country income'). Participation rate varied by region and country income, with higher response rates from EUR (79.2%), SEAR (72.7%), EMR (61.9%) and WPR (59.3%), than AMR (37.1%) and AFR (36.2%).

The lower participation in these regions may be related to:

- Possible insufficient human resource and technical capacity to respond to the survey;
- Concurrent surveys at the regional level (i.e. AMR was undertaking a survey on HTA during the same period of time) as well as by other academic groups; and
- Could not establish suitable contact through the nomination process.

**CHART 1.1: Number and percentage of participation by region and country income**



### 1.3 Limitations

The findings of this survey must be interpreted with consideration of several potential sources of bias:

- **Non-response:** As noted, the participation from low-income countries and countries from AMR and AFR was low. This may have skewed the responses towards countries with more established systems for undertaking HTA.
- **Selection bias:** The recruitment method attempted to identify the most suitable respondents through official nomination. However, it was up to national authorities to select the person responsible for answering the survey.
- **Measurement bias:** The questionnaire did not provide definitions for the technical terms and survey respondents may have understood the terms differently.
- **Respondent bias:** Survey respondents were identified through official nomination and their participation was not anonymous. The lack of anonymity may have encouraged responses that would be viewed favourably by others.

### 1.4 Report structure

The report has been structured according to the five sections of the survey, as follows:

- **Chapter 2: Utilization of HTA in public sector decision making**

This section describes how widely respondents reported using HTA for public sector decisions, such as for planning and budgeting, reimbursement or to determine benefit packages and clinical practice guidelines.

- **Chapter 3: Scope of HTA and availability of guidelines**

This section describes how often responding countries reported using various aspects of HTA, such as assessments of safety; clinical effectiveness; economic considerations (e.g. cost-effectiveness analysis); budget impact analysis; organizational impact; equity issues; ethical issues; feasibility considerations (e.g. availability of budget, human resources, infrastructure); acceptability to health care providers; and acceptability to patients.

4 Classification was based on the Gross National Income (GNI) per capita using the World Bank Atlas method.



- **Chapter 4: Institutional capacity and human resources supporting HTA**  
This section reports the availability and expertise of human resources, and institutional capacity.
- **Chapter 5: Governance of HTA process**  
This section examines the governance structures and linkages between HTA units and authorities responsible for setting policy in relation to HTA.
- **Chapter 6: Requirements for strengthening HTA capacity**  
This section reports the respondents' perceived impediments to the improved use of HTA in health care policy.
- **Chapter 7: Conclusions**  
This section summarises the survey findings.

## **1.5 Note on terminology**

Countries were asked whether they had a formal process to inform decision making, in which they systematically collected data and considered the impacts of a particular health technology or intervention. Many did not refer to this process specifically as 'HTA'. For the purposes of brevity, in this report the term HTA will be used to describe this process.

# 2. Utilization of HTA in public sector decision making



Most countries reported having a formal process for compiling, analysing and synthesizing relevant information and scientific evidence systematically to support health care policy decision making. However, one-third of the responding countries did not refer to this process as ‘HTA’.

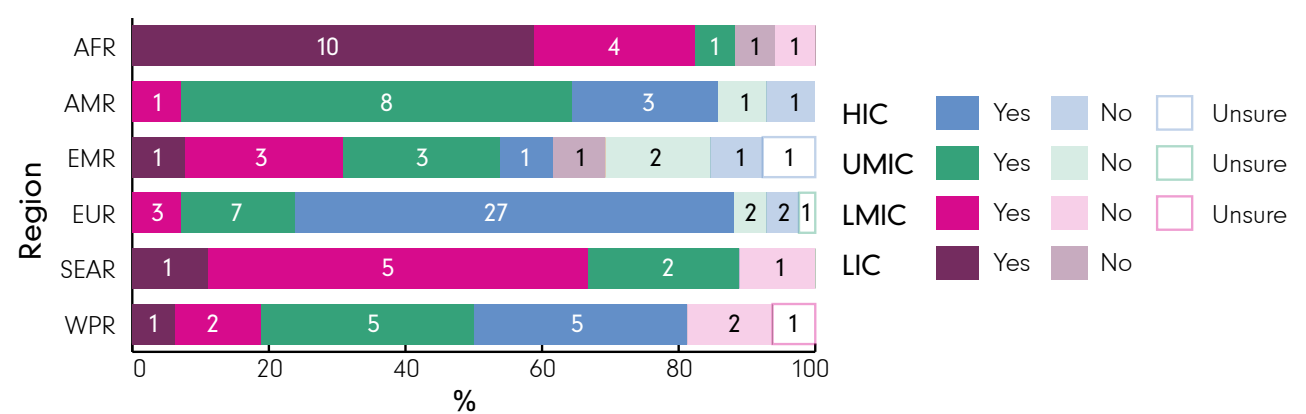
Fewer than half of the countries with a formal process had legislative requirements to consider the results of the analysis. Countries used HTA for different purposes depending on their income level, but most countries gathered the information for the purpose of planning and budgeting.

### 2.1 Formal ‘information-gathering process’ for decision making

About four in five respondents reported that their countries had a formal HTA process to inform decision making, in which they systematically collected data and considered the impacts of a particular health technology or intervention (Chart 2.1). However, one-third of the responding countries did not refer to this process as ‘HTA’.

The responses suggest that high- and upper middle-income countries, especially in EUR and AMR, were most likely to have this formal HTA process. Fifteen respondents said their countries did not have a well-defined process for considering evidence in decision making, but evidence was considered “informally”. Three respondents did not know if their country had a formal process.

**CHART 2.1:** Number and proportion of countries that responded, having a formal process for information compilation for decision making, by region and country income



## 2.2 Legislative requirements for considering HTA findings

Although countries reported frequently gathering and synthesizing relevant information and scientific evidence to support HTA, fewer than half had legislative requirements to formalize the incorporation of the results of HTA in health care decision making (Chart 2.2). Such legislative requirements were most common in EMR and EUR where 63% of countries had such requirements. Fifty-five percent of high-income countries also reported having legislative requirements to consider the results of HTAs.

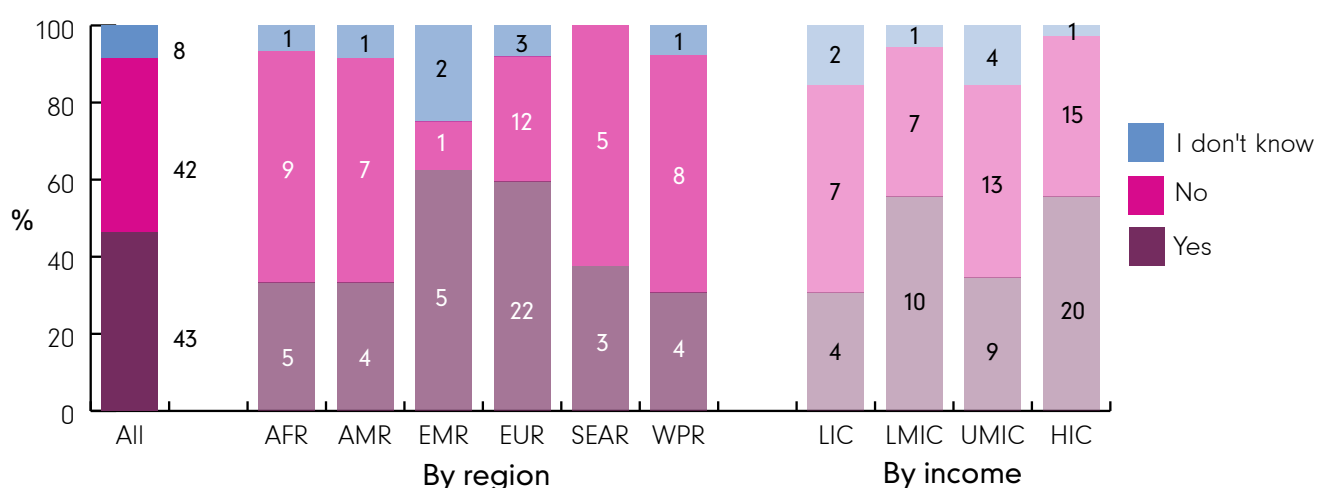
## 2.3 Purposes of undertaking HTA

All low-income countries and 85% of middle-income countries surveyed said they used HTA for planning and budgeting. Only 64% of high-income countries reported using HTA for this purpose.

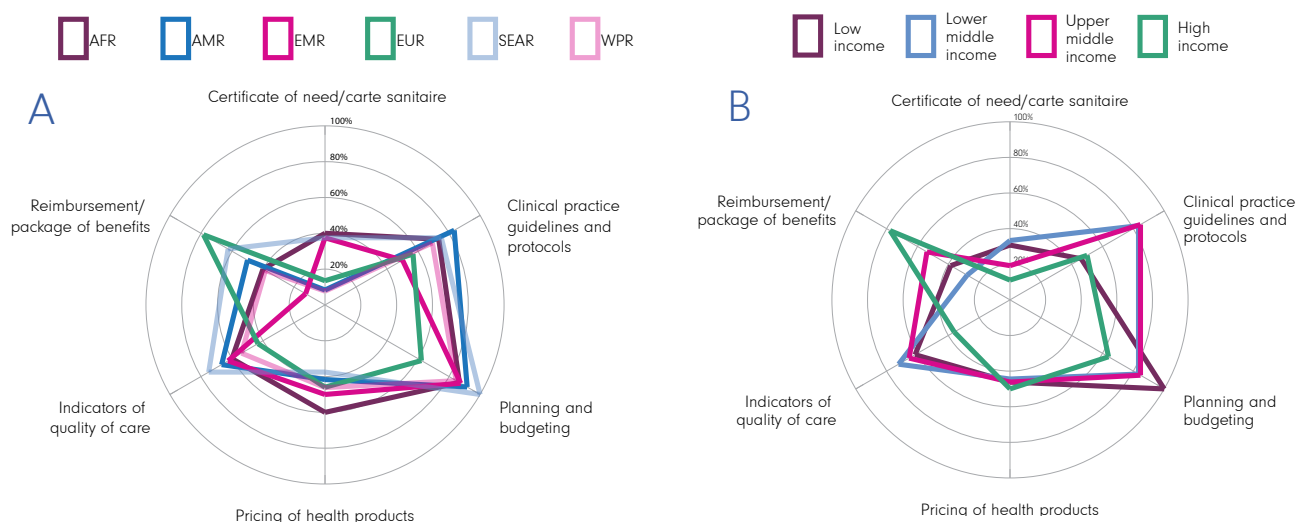
High-income countries were much more likely than low-income countries to use HTA for determining reimbursement or to decide what to include in a package of benefits. Middle-income countries used HTA to inform clinical practice guidelines and protocols (85%) more often than in high- and low-income countries (46% and 50%) (Chart 2.3). Less than 60% of countries in any income category used HTA for pricing of health products..

Analysis by region was consistent with this finding. For EUR – with more high-income countries than other regions – HTA findings were used more for determining reimbursement or package of benefits (80% of countries) compared with respondents from other regions (28%-62%). EUR countries also applied HTA findings less frequently for planning and budgeting than countries in other regions (Chart 2.3a).

**CHART 2.2:** Number and proportion of countries that responded, that had legislative requirements to consider the results of HTAs, by region and country income



**CHART 2.3:** Purposes of undertaking HTA, proportion of countries by (a) region and (b) country income

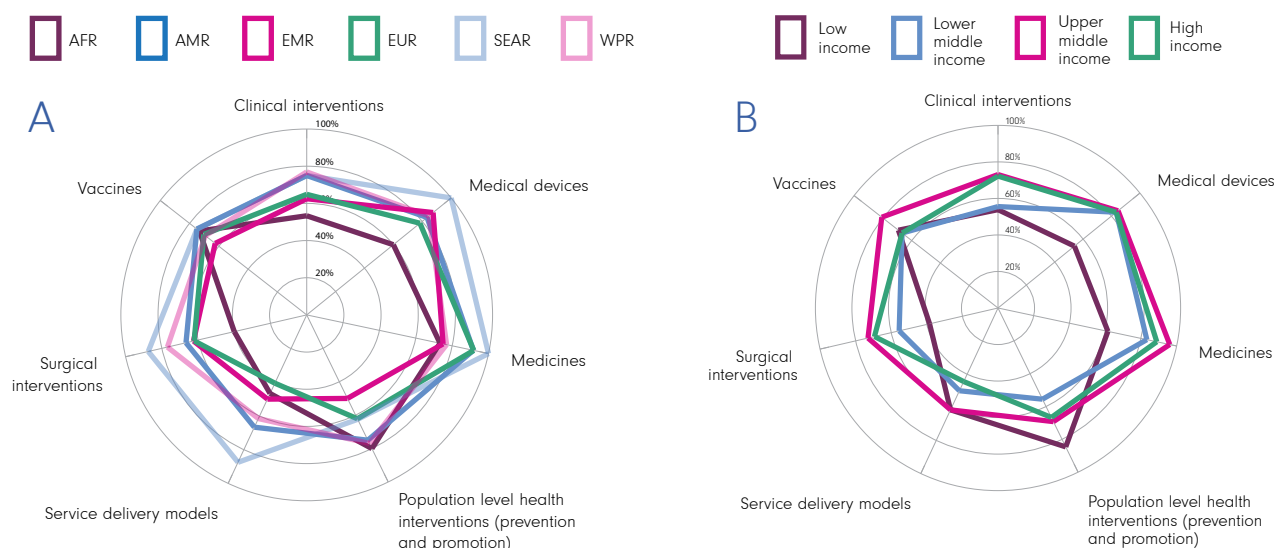


## 2.4 Types of technologies or interventions assessed

More than half of the respondents used HTA for all types of health technology (Chart 2.4a). The survey findings suggest a link between income level and the focus of HTA. For example, low-income countries reported a

tendency to use HTA for population-level health interventions (85%), but less often for decisions for medicines (62%), medical devices (54%) or surgical interventions (38%) (Chart 2.4b). On the other hand, a higher proportion of high-income countries reported using HTA for medicines (89%), medical devices (83%) or surgical interventions (69%) (Chart 2.4b).

**CHART 2.4:** Type of technologies or interventions assessed, proportion of countries by (a) region and (b) country income



# 3. Scope of HTA and availability of guidelines





Countries reported that safety, clinical effectiveness, and economic and budgetary impact were the main components of HTA. The acceptability to health care providers and patients, equity issues, ethical issues and feasibility considerations were much less commonly considered.

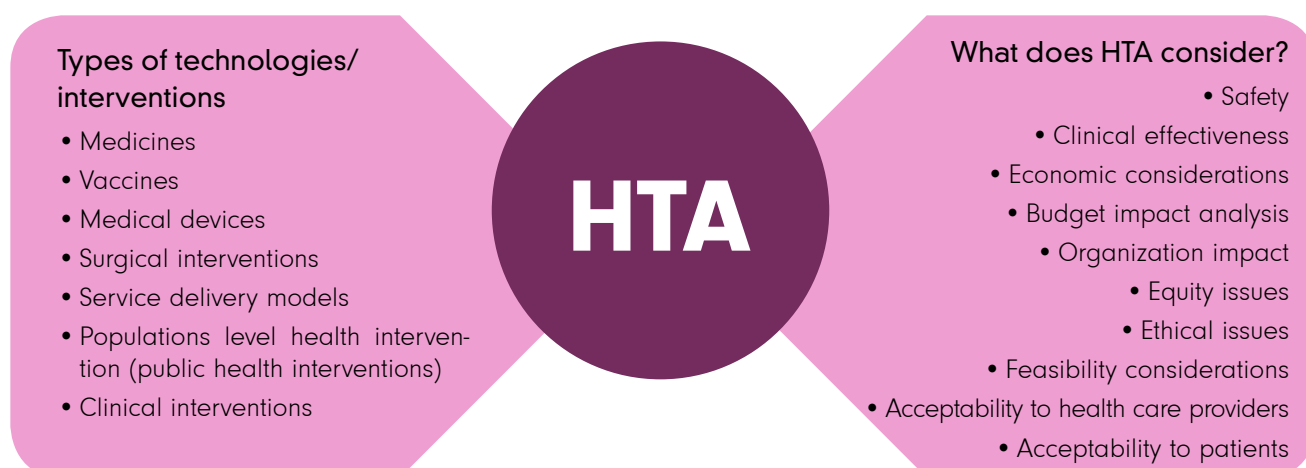
### 3.1 Aspects considered in HTA

The survey asked the respondents to estimate the frequency of considering 10 pre-specified aspects of HTA when evaluating seven types of technologies or intervention, as illustrated in Figure 3.1.

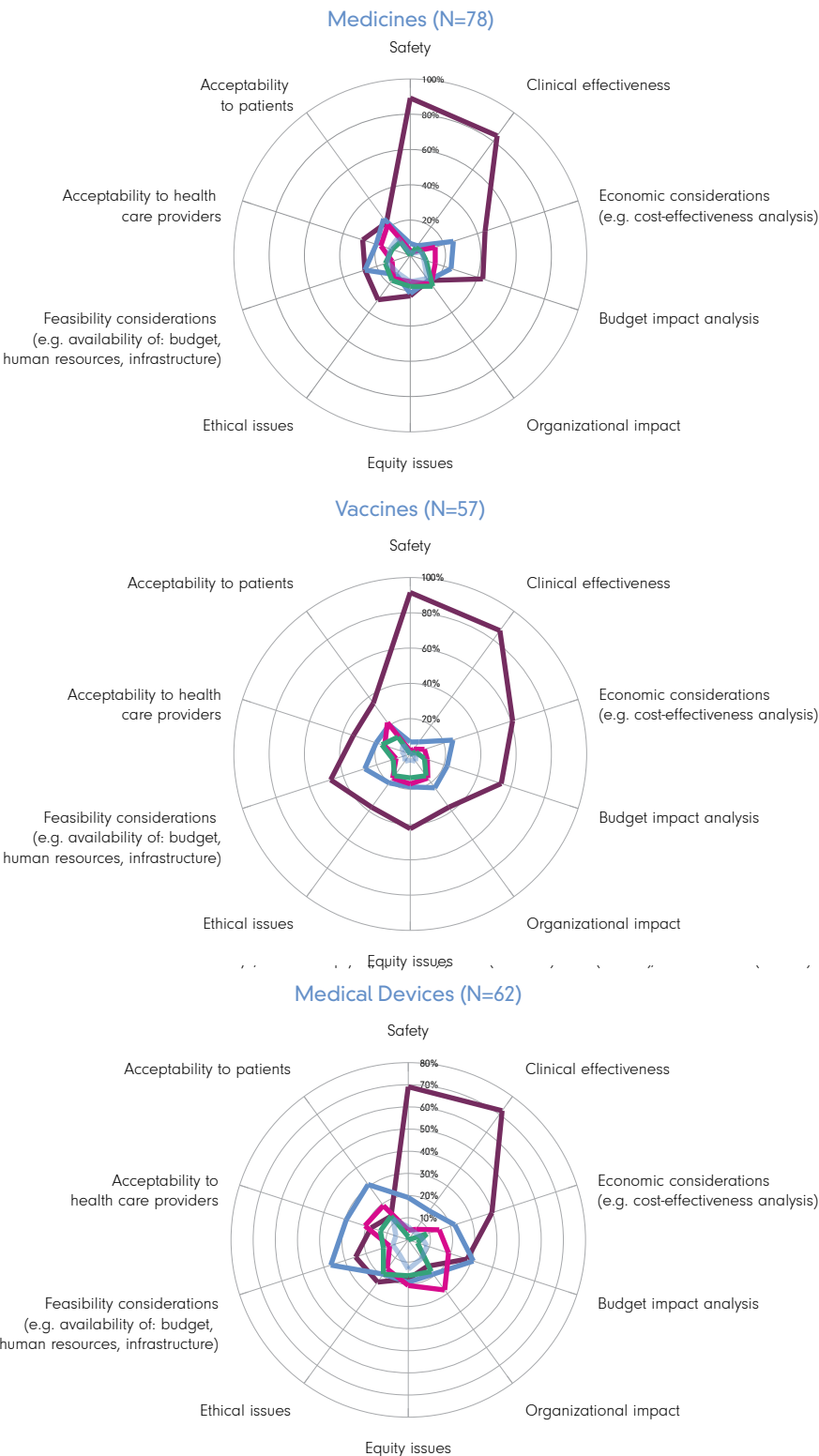
As shown in Chart 3.2, countries reported that emphasis was placed more on safety, clinical effectiveness, economic and budgetary considerations, rather than other

potential components of HTA. Acceptability to health care providers and patients, equity issues, ethical issues and feasibility considerations were not considered as often. Specifically, most countries (53%-92%) “always or almost always” considered safety across all types of health technology or intervention. Clinical effectiveness was also deemed important regardless of the type of technology or intervention, with between 65% and 85% of respondents reporting it as an important aspect of HTA.

**FIGURE 3.1:** Aspects considered in HTA for different types of technologies and interventions

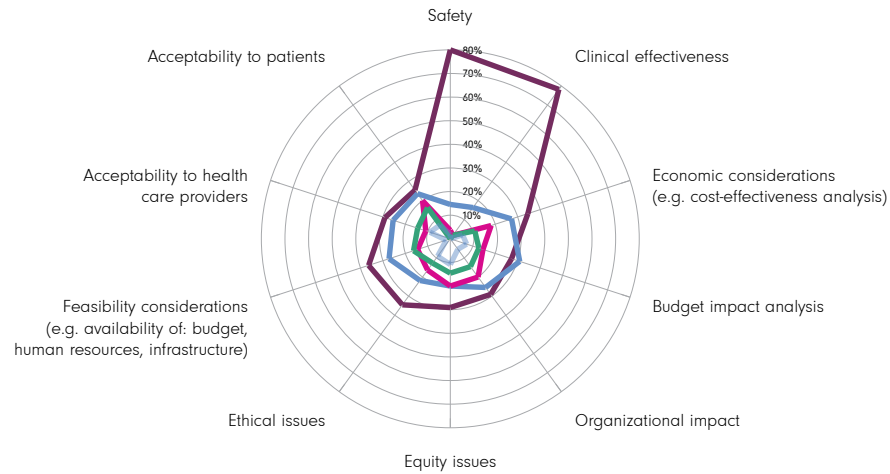


**CHART 3.2:** Frequency of covering different aspects in HTA, proportion of countries by type of technology

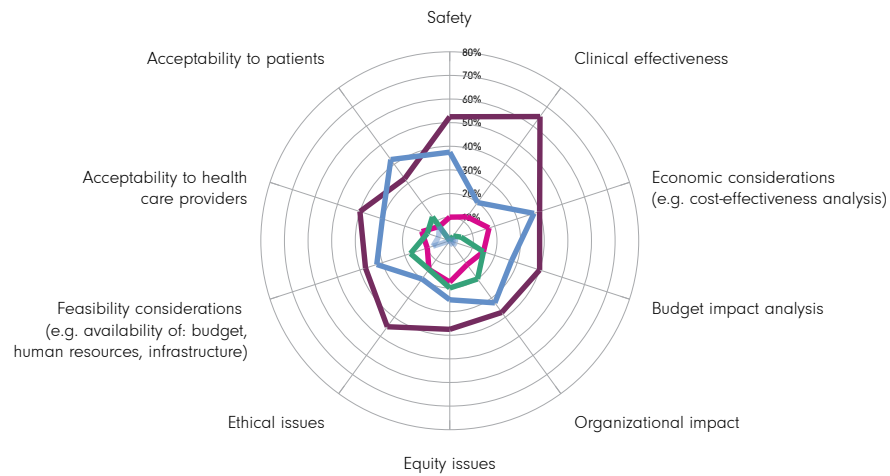




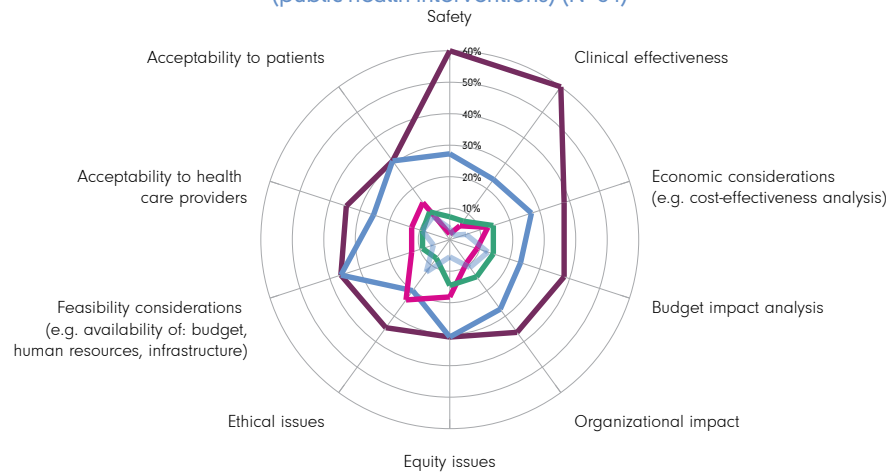
### Surgical interventions (N=52)

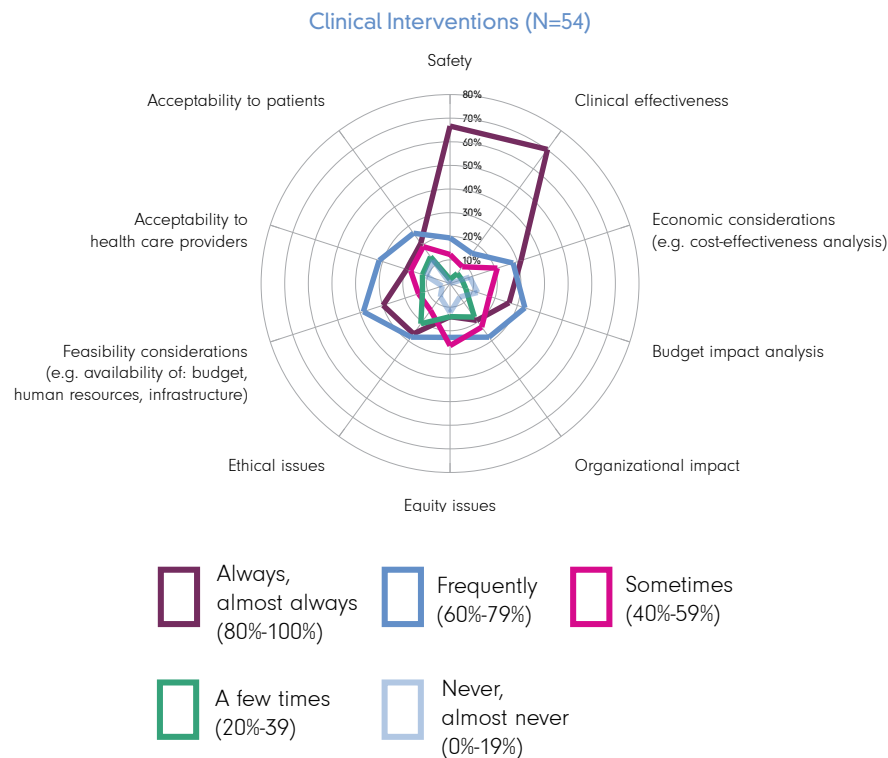


### Service Delivery Models (N=40)



### Population level health interventions (public health interventions) (N=54)



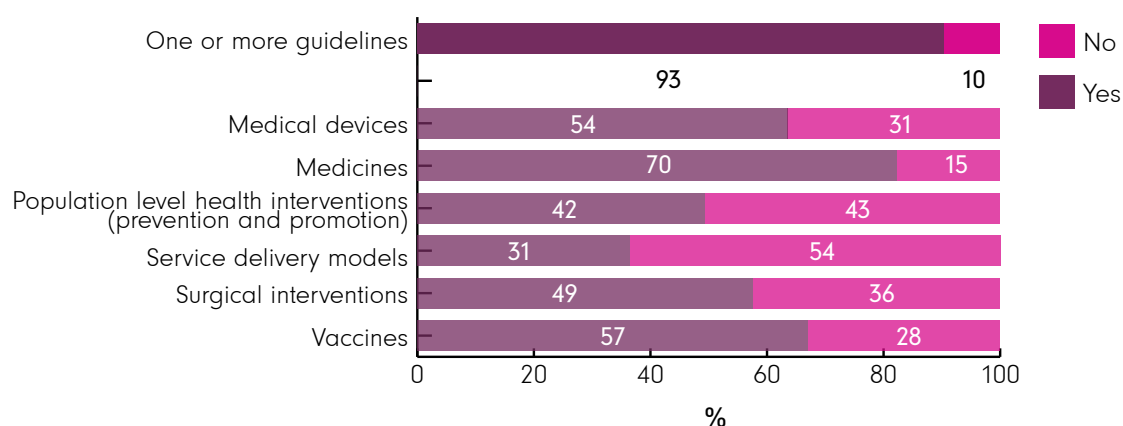


## 3.2 Guidelines for developing HTA

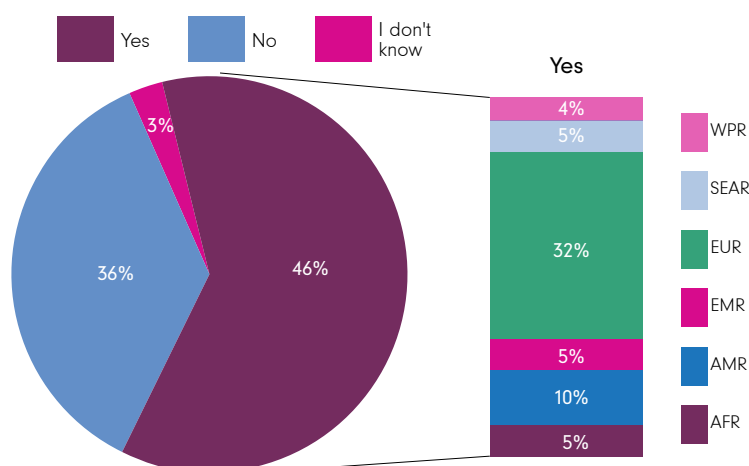
Most respondents reported having a guideline for preparing HTA reports, submissions or dossiers for at least one type of technology or intervention (Chart 3.3). Guidelines were most common for medicines (82% of

the countries), vaccines (67%), medical devices (64%) and Guidelines for HTA of service delivery models were the least common, with only 36.5% of countries reporting to have such a guideline. Sixty-one percent of countries, mostly countries in EUR, said their HTA guidelines were publicly available (Chart 3.4).

**CHART 3.3:** Availability of guidelines for developing HTA, proportion and number of countries by type of technologies or interventions



**CHART 3.4:** Availability of the guidelines in the public domain



# 4. Institutional capacity and human resources supporting HTA



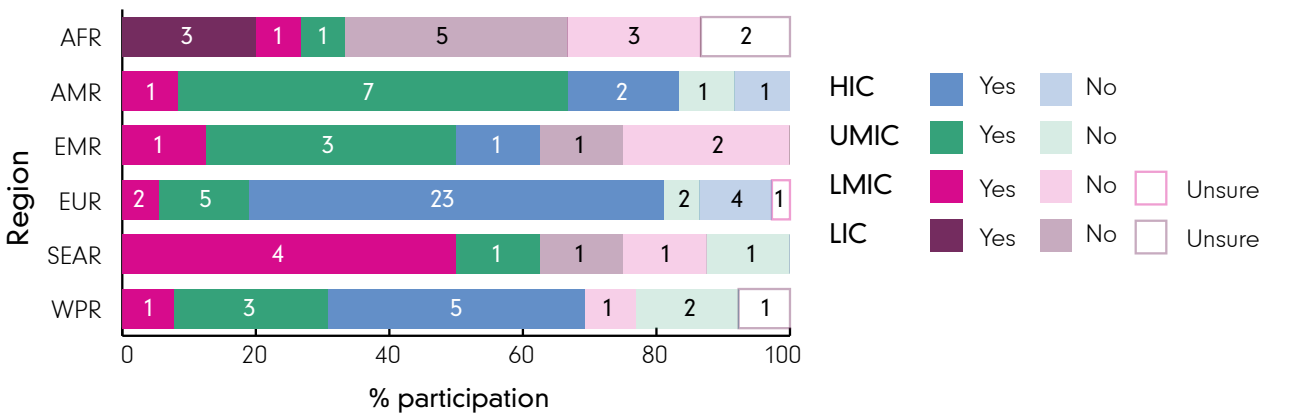
Most countries reported having a national entity of more than six staff members that produced HTA reports for the ministry of health. Staff members were usually public health and clinical science professionals. Organizations in high-income countries were better resourced than those in low-income countries.

### 4.1 National HTA organization

Two in three countries reported having a national HTA organization or department, unit or committee that produced HTA reports for the ministry of health (Chart 4.1a). This was more likely in AMR and EUR countries (81%-83%) than in countries in other regions (33%-77%). In

terms of the structure of the national organizations, 17 countries had a standalone HTA agency, and 19 had a national unit or department within the ministry of health (Chart 4.1b). Three countries reported having a unit affiliated with a university or committee that was not within the ministry to support HTA activities in the public sector.

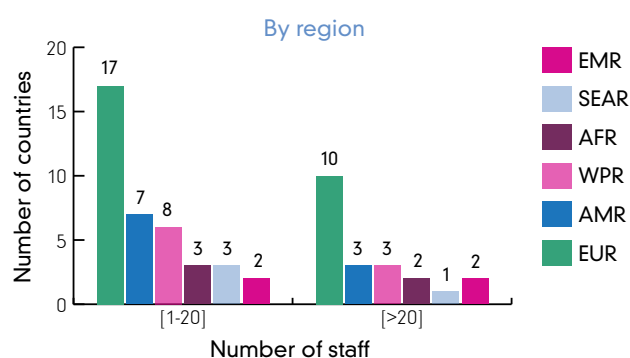
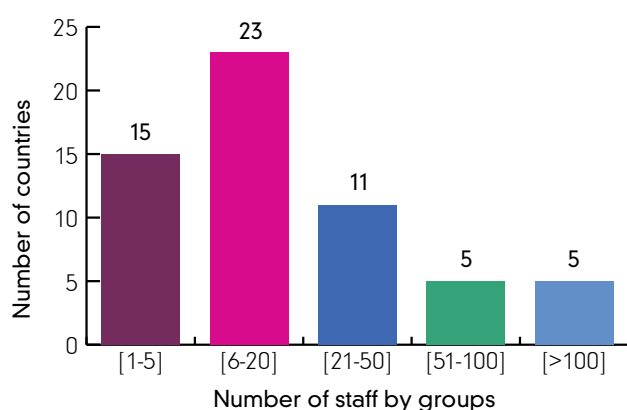
**CHART 4.1:** Number of organizations that produce HTA reports for the Ministry of Health, by region and country income



## 4.2 Number of staff members in HTA organizations

Three in four countries reported having more than six staff members in the HTA unit/agency/committee. HTA agencies or committees in EUR and in high-income countries had more professional human resources to support HTA activities than in other regions and national income groups (Chart 4.2).

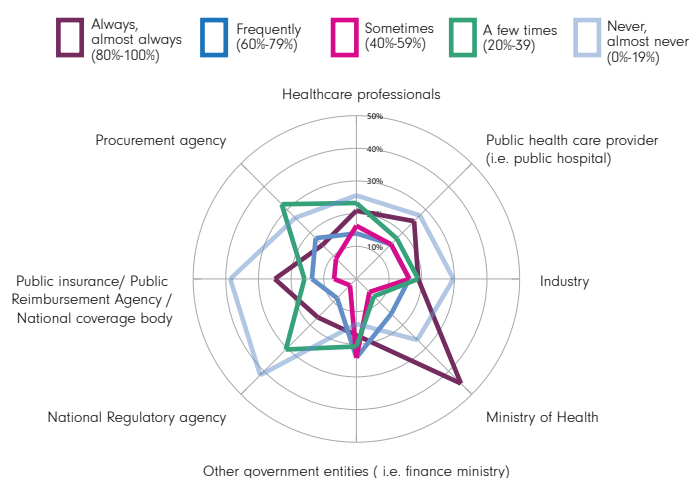
**CHART 4.2:** Estimated number of professional staff in the HTA organization, by region and country income group



## 4.3 Requests for HTAs

Countries reported that in the 12 months before the survey, HTAs were requested mainly by the ministry of health or public insurance ("always or almost always" in 45% of respondents) or reimbursement bodies ("always or almost always" in 25% of respondents). Requests were not as common from other sources, such as procurement agencies, public health care providers or national regulatory agencies. As shown in Chart 4.3, a significant number of respondents reported that the requests for HTAs "never or almost never" came from organizations outside of the ministry.

**CHART 4.3:** Organizations requesting HTAs in the past 12 months, proportion of countries by type of technologies or interventions

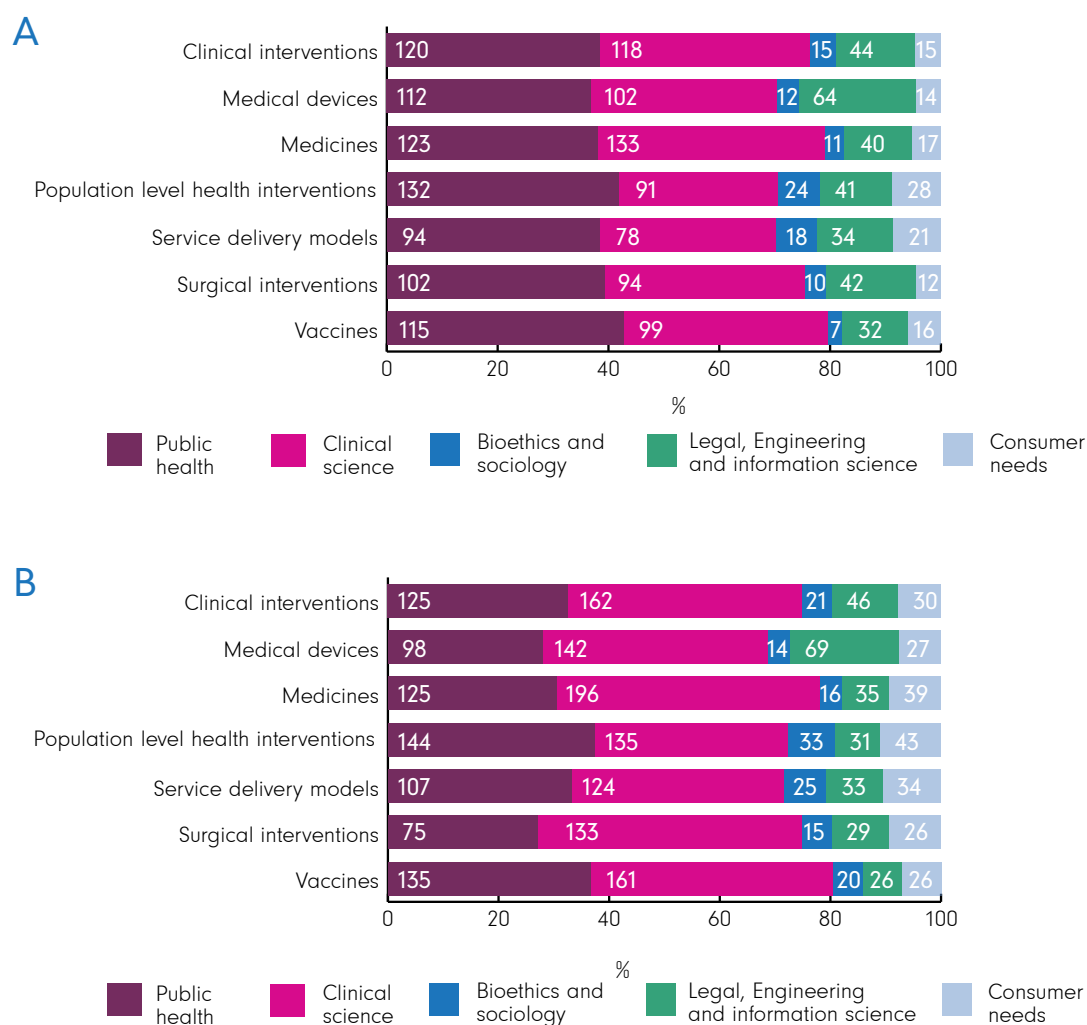


## 4.4 Professionals involved in HTA preparation and decision making

Respondents reported that the preparation of HTA reports and the decision-making process had high level of involvement from public health professionals (including

epidemiologists, biostatisticians, health economist and others) and experts in clinical sciences (medical doctors, nurses, pharmacists, and health professional organizations) (Chart 4.4a). The involvement of different professionals in HTA did not vary markedly across technologies or interventions (Chart 4.4b).

**CHART 4.4:** Number and proportion of professionals involved in (a) preparation of HTA reports and (b) making decision



# 5. Governance of HTA process





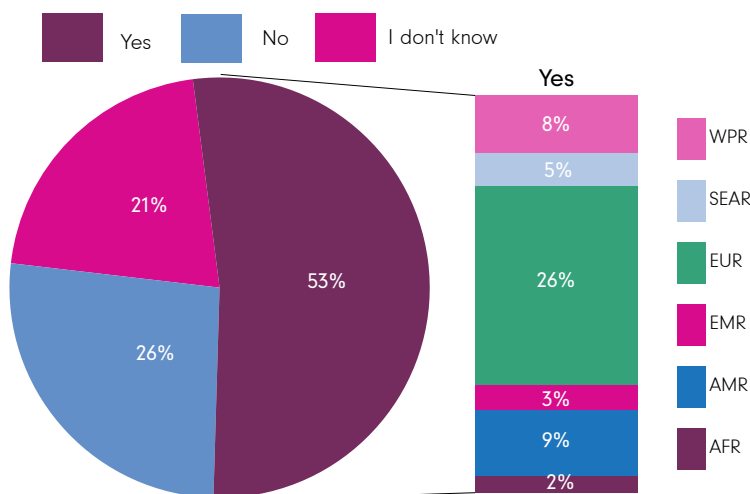
Around half of the responding countries’ HTA systems required conflict of interest declarations. HTA outcomes and subsequent policy decisions were made public in around half of the responding countries.

As indicated in responses to the survey’s questions about legislative requirements, findings from HTA-related organization(s) played an advisory, rather than mandatory, role for policy decisions in a majority of the responding countries. Civil society representatives were given the opportunity to comment on the recommendations of an HTA report in half of the countries.

5.1 Conflict of interest declaration

Chart 5.1 shows that about half of the respondents reported that personnel involved in preparing HTA reports were required to declare conflicts of interest. This requirement was most common in EUR. Just under half of the responding countries either did not require such declarations (26%) or did not know if such a requirement existed (21%).

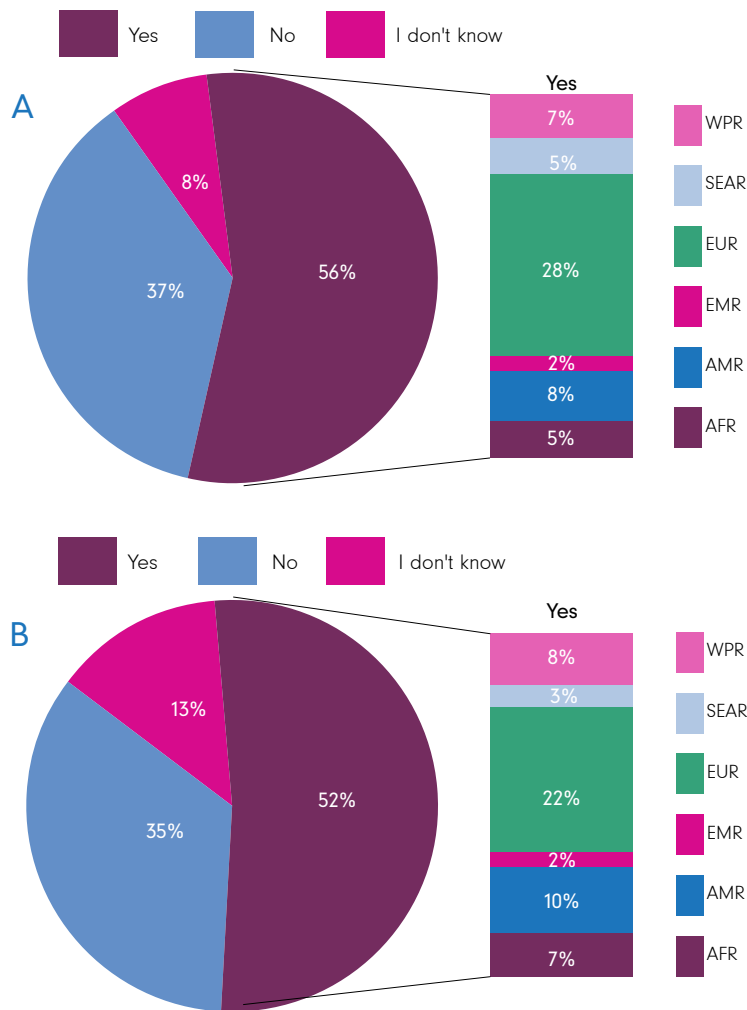
CHART 5.1: Proportion of countries requiring conflict of interest declaration, by region



## 5.2 Communicating the outcomes of HTA

The findings of HTA reports were published in more than half of the countries (Chart 5.2a). Similarly, the policy outcomes based on the findings of HTA reports were also made publicly available in around half of the responding countries (Chart 5.2b). This transparency of process was most common in EUR countries.

**CHART 5.2:** Proportion of countries communicating (a) the findings of HTA reports and (b) policy outcomes in the public domain, by region

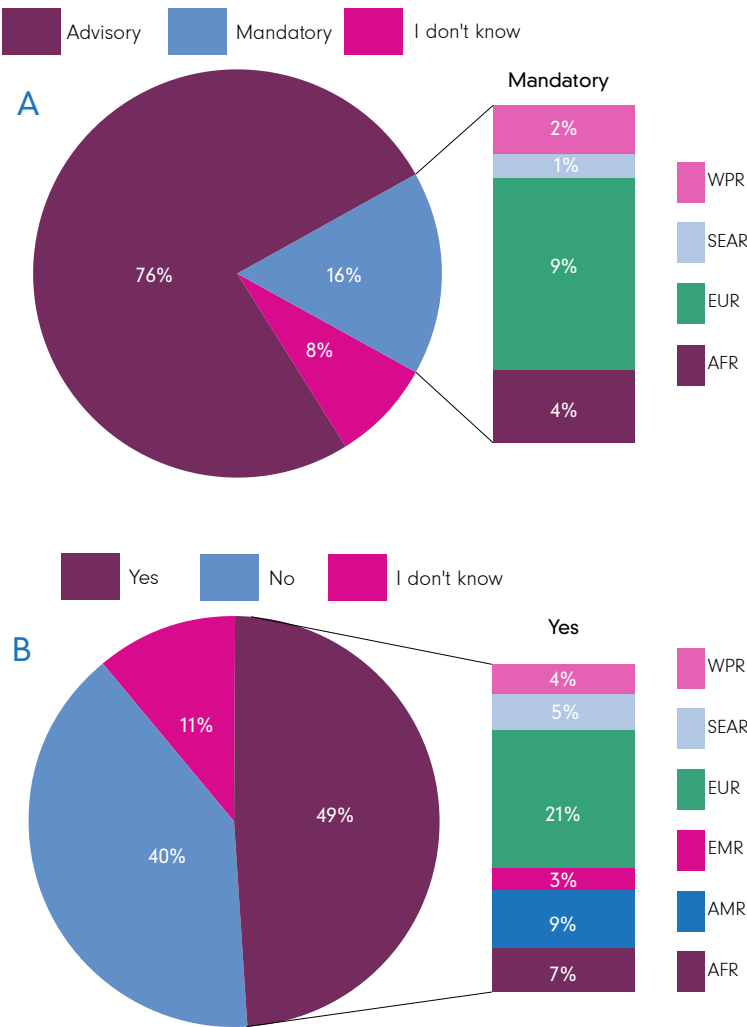


### 5.3 Connection between HTA and decision making, and civil society participation

In most of the countries that responded to the survey, the findings of HTA-related organization(s) played an advisory, rather than mandatory, role in policy decisions. Among those countries for which the respondent reported a mandatory role, a majority (57%) were from

EUR countries (Chart 5.3a). In about half of the countries, civil society was given the opportunity to comment on the recommendations of the HTA entity (Chart 5.3b). However, the extent to which their inputs influence the final decision is not known.

**CHART 5.3:** Status of the findings of the HTA-related entity (a) HTA related entity’s role in policy decision (b) Civil society’s role in commenting on recommendations of HTA report



# 6. Requirements for strengthening HTA capacity



Fewer than half of all responding countries had academic or training programmes to build HTA capacity. This appears to be a major barrier to increasing use of HTA.

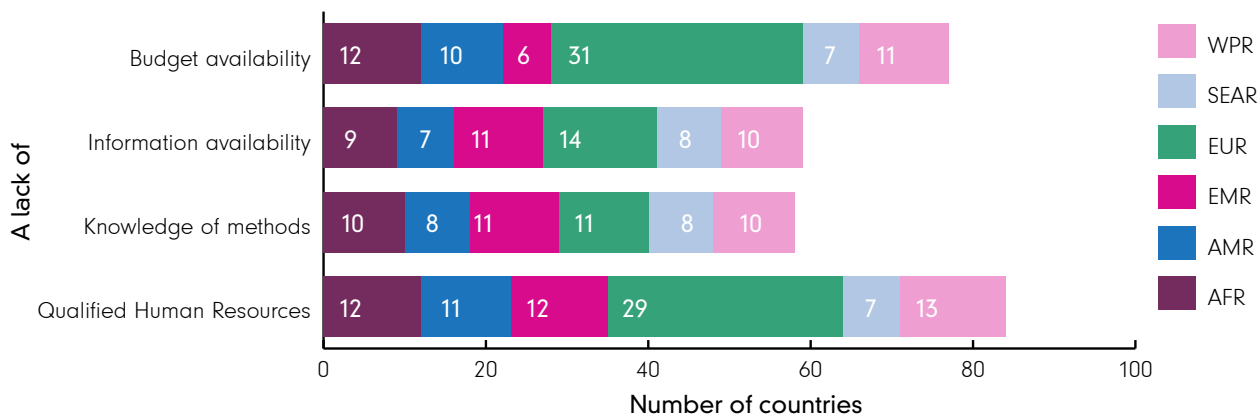
Relative to other potential barriers, fewer countries reported political support and mandate from policy authority as impediments to using HTA in health care policy decision.

6.1 Main barrier for producing HTA and using HTA findings in decision making

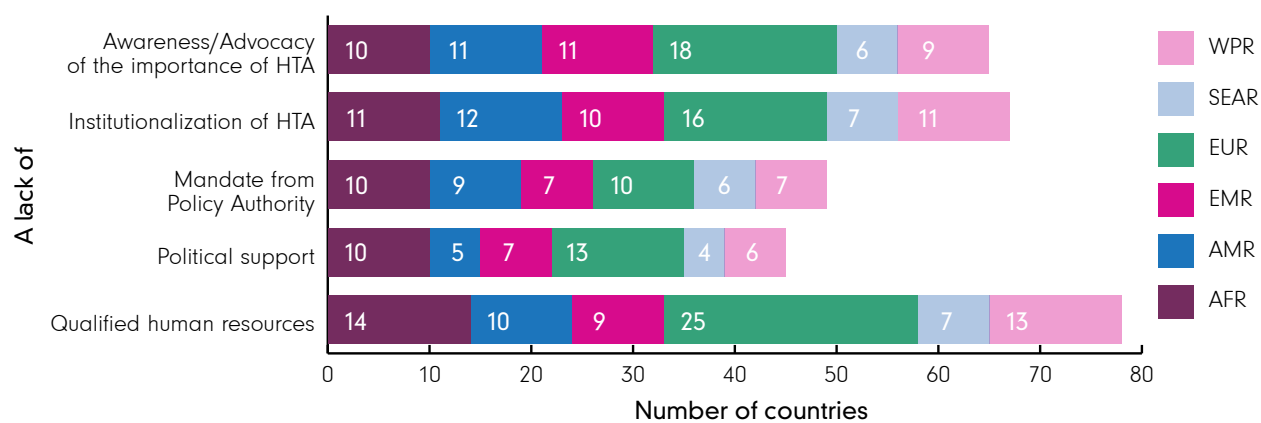
A lack of qualified human resources appeared to be a main barrier for producing and using HTA to inform decision making, as shown in Chart 6.1 and Chart 6.2. All regions reported similar barriers to HTA: lack of funding for undertaking HTA (77 countries), a lack of information (59 countries) or knowledge of methods (58 countries).

In terms of barriers to using HTA for decision making, respondents from 67 countries cited a lack of institutionalization of HTA as a barrier (Chart 6.2). Respondents from 65 countries suggested that raising awareness about the importance of HTA would help improve the incorporation of HTA findings in decision making. Relative to other potential barriers, fewer countries reported political support and mandate from policy authority as obstacles for using HTA in health care policy decisions (Chart 6.2).

CHART 6.1: Impediments to HTA production



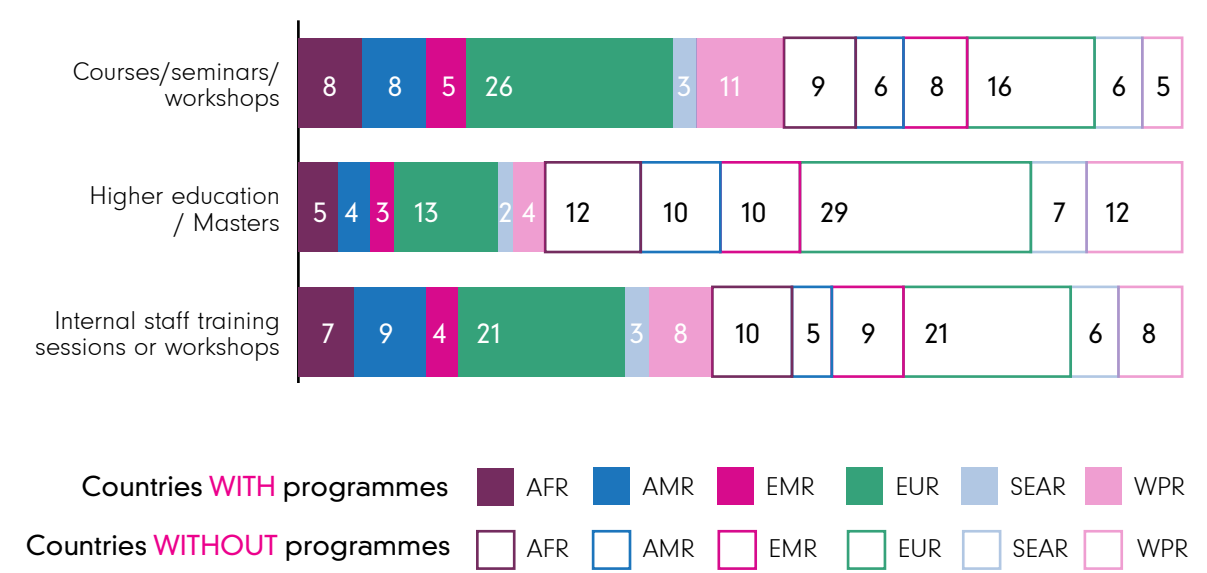
**CHART 6.2:** Impediments to using HTA to inform decision making in health care policy



## 6.2 Academic or training programmes to support capacity building for HTA

Fewer than half of all responding countries had academic or training programmes to build HTA capacity. About half of all countries that responded ran internal staff training sessions or external courses/seminars/workshops.

**CHART 6.3:** Number of countries with academic or training programmes to support capacity building for HTA, by region



# 7. Conclusions





The WHO 2015 Global Survey on HTA provides the first systematic description of the work relating to HTA carried out by national or government institutions in WHO Member States.

## 7.1 Main findings

The main findings are:

- **Human resources and institutional capacity**
  - » Most countries have a process of collecting and analysing information about health technologies or interventions and assessing their impact. However, few countries referred to this process as HTA.
  - » Two in three countries reported having a national HTA organization or department, unit or committee that produced HTA reports for the ministry of health.
  - » Most countries reported having more than six staff members in the HTA unit/agency and committee.
- **Methodology**
  - » HTAs in most responding countries appeared to focus primarily on safety and clinical effectiveness, followed by economic and budgetary considerations. Little consideration was given to issues of ethics, equity and feasibility.
- **Governance and linkage between HTA units/networks with policy authorities**
  - » Ministries of health or national health insurance bodies were the main initiators of most HTAs.
  - » Public health professionals (including epidemiologists, biostatisticians, health economists and others) and experts in clinical sciences (medical doctors, nurses, pharmacists, and health

professional organizations) were commonly involved in HTA preparation and decision making.

- » Civil society representatives were given the opportunity to comment on the recommendations of an HTA report in half of the countries.

- **Utilization of results**

- » Findings from HTA-related organization(s) played an advisory, rather than mandatory, role for policy decisions in a majority of the responding countries.

- **Impediments to strengthening capacity**

- » A lack of qualified human resources appeared to be the main barrier for producing and using HTA.
- » Most countries did not have academic or training programmes to build HTA capacity.

WHO will continue to undertake activities to raise awareness, promote knowledge and encourage the practice of HTA and its uses in evidence-informed decision making. WHO will share and discuss the findings of this survey with country representatives, academia, and with HTA networks.

## Annex I: WHO regional groupings

**Source:** World Health Statistics 2015.

**N.B:** These groupings only include countries that responded to the survey.

**WHO African Region (AFR):** Benin, Cameroon, Cape Verde, Central African Republic, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Mali, Mozambique, South Africa, Tanzania, United Republic of.

**WHO Region of the Americas (AMR):** Barbados, Brazil, Canada, Colombia, Costa Rica, Cuba, Ecuador, Guatemala, Jamaica, Mexico, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, United States of America.

**WHO Eastern Mediterranean Region (EMR):** Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic.

**WHO European Region (EUR):** Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, Georgia, Germany, Hungary, Iceland, Italy, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Moldova, Republic of, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Turkey, United Kingdom.

**WHO South-East Asia Region (SEAR):** Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste.

**WHO Western Pacific Region (WPR):** Australia, Cambodia, China, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia, Federated States of, Nauru, New Zealand, Philippines, Korea, Republic of, Singapore, Tuvalu, Viet Nam.

## Annex II: Income groupings

**Source:** World Bank list of economies (July 2015). Washington, DC: World Bank; 2015 (<http://data.worldbank.org/about/country-and-lending-groups>).

**N.B:** These groupings only include countries that responded to the survey.

**Low-income:** Afghanistan, Benin, Cambodia, Central African Republic, Comoros, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Madagascar, Mali, Mozambique, Nepal, Somalia, Tanzania, United Republic of.

**Lower middle-income:** Armenia, Bangladesh, Bhutan, Cameroon, Cape Verde, Côte d'Ivoire, Egypt, Georgia, Ghana, Guatemala, India, Indonesia, Kenya, Kiribati, Lao People's Democratic Republic, Micronesia, Federated States of, Philippines, Moldova, Republic of, Sri Lanka, Sudan, Syrian Arab Republic, Timor-Leste, Viet Nam.

**Upper middle-income:** Albania, Azerbaijan, Belarus, Brazil, Bulgaria, China, Colombia, Costa Rica, Cuba, Ecuador, Fiji, Iran (Islamic Republic of), Iraq, Jamaica, Jordan, Kazakhstan, Lebanon, Libya, Malaysia, Maldives, Mexico, Montenegro, Nauru, Peru, Romania, Saint Vincent and the Grenadines, Serbia, South Africa, Thailand, The former Yugoslav Republic of Macedonia, Turkey, Tuvalu.

**High-income:** Australia, Austria, Bahrain, Barbados, Belgium, Canada, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, Germany, Hungary, Iceland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Poland, Portugal, Qatar, Korea, Republic of, Russian Federation, San Marino, Saudi Arabia, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Trinidad and Tobago, United Kingdom, United States of America.

## Annex III: WHA resolution 67.23

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY

WHA67.23

Agenda item 15.7

24 May 2014

Health intervention and technology assessment in support of universal health coverage

The Sixty-seventh World Health Assembly,

Having considered the report on health intervention and technology assessment in support of universal health coverage;<sup>4</sup>

Recalling resolutions WHA52.19 on the revised drug strategy, WHA58.33 on sustainable health financing, universal coverage and social health insurance, WHA60.16 on progress in the rational use of medicines, WHA60.29 on health technologies, WHA63.21 on WHO's role and responsibilities in health research, and WHA64.9 on sustainable health financing structures and universal coverage;

Recognizing the importance of evidence-based policy development and decision-making in health systems, including decisions on resource allocation, service system designs and translation of policies into practice, as well as reaffirming WHO's roles and responsibilities in provision of support to strengthen information systems and health research capacity, and their utilization in Member States;

Noting that the efficient use of resources is a crucial factor in the sustainability of health systems' performance, especially when significant increases in access to essential medicines, including generic medicines, to medical devices and procedures, and to other health care interventions for promotion, prevention, diagnosis and treatment, rehabilitation and palliative care are pursued by Member States, as they move towards universal health coverage;

Noting that The *world health report 2010*<sup>5</sup> indicates that as much as 40% of spending on health is being wasted and that there is, therefore, an urgent need for systematic, effective solutions to reduce such inefficiencies and to enhance the rational use of health technology;

Acknowledging the critical role of independent health intervention and technology assessment, as multidisciplinary policy research, in generating evidence to inform prioritization, selection, introduction, distribution, and management of interventions for health promotion, disease prevention, diagnosis and treatment, and rehabilitation and palliation;

Emphasizing that with rigorous and structured research methodology and transparent and inclusive processes, assessment of medicines, vaccines, medical devices and equipment, and health procedures, including preventive intervention, could help to address the demand for reliable information on the safety, efficacy, quality, appropriateness, cost-effectiveness and efficiency dimensions of such technologies to determine if and when they are integrated into particular health interventions and systems;

Concerned that the capacity to assess, research and document the public health, economic, organizational, social, legal and ethical implications of health interventions and technologies is inadequate in most developing countries, resulting in inadequate information to guide rational policy, and professional decisions and practices;

<sup>4</sup> Document A67/33.

<sup>5</sup> The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

Recognizing the importance of strengthened national capacity, regional and international networking, and collaboration on health intervention and technology assessment to promote evidence-based health policy,

1. URGES Member States:<sup>6</sup>

(1) to consider establishing national systems of health intervention and technology assessment, encouraging the systematic utilization of independent health intervention and technology assessment in support of universal health coverage to inform policy decisions, including priority-setting, selection, procurement supply system management and use of health interventions and/or technologies, as well as the formulation of sustainable financing benefit packages, medicines, benefits management including pharmaceutical formularies, clinical practice guidelines and protocols for public health programmes;

(2) to strengthen the link between health technology assessment and regulation and management, as appropriate;

(3) to consider, in addition to the use of established and widely agreed methods, developing, as appropriate, national methodological and process guidelines and monitoring systems for health intervention and technology assessment in order to ensure the transparency, quality and policy relevance of related assessments and research;

(4) to further consolidate and promote health intervention and technology assessment within national frameworks, such as those for health system research, health professional education, health system strengthening and universal health coverage;

(5) to consider strengthening national capacity for regional and international networking, developing national know-how, avoiding duplication of efforts and achieving better use of resources;

(6) to consider also collaborating with other Member States' health organizations, academic institutions, professional associations and other key stakeholders in the country or region in order to collect and share information and lessons learnt so as to formulate and implement national strategic plans concerning capacity-building for and introduction of health intervention and technology assessment, and summarizing best practices in transparent, evidence-informed health policy and decision-making;

(7) to identify gaps with regard to promoting and implementing evidence-based health

policy, as well as improving related information systems and research capacity, and considering seeking technical support and exchanging information and sharing experiences with other Member States, regional networks and international entities, including WHO;

(8) to develop and improve the collection of data on health intervention and technology assessment, training relevant professionals, as appropriate, so as to improve assessment capacity;

2. REQUESTS the Director-General:

(1) to assess the status of health intervention and technology assessment in Member States in terms of methodology, human resources and institutional capacity, governance, linkage between health intervention and technology assessment units and/or networks with policy authorities, utilization of assessment results, and interest in and impediments to strengthening capacity;

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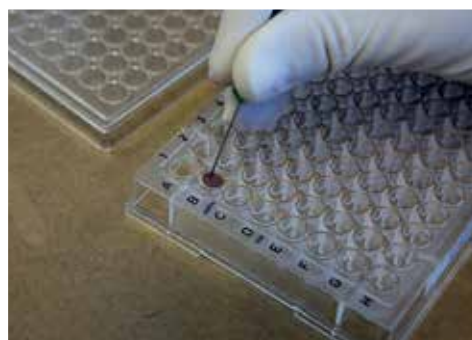
<sup>6</sup> And, where applicable, regional economic integration organizations.

- (2) to raise awareness, foster knowledge and encourage the practice of health intervention and technology assessment and its uses in evidence-based decision-making among national policy-makers and other stakeholders, by drawing best practices from the operation, performance and contribution of competent research institutes and health intervention and technology assessment agencies and programmes, and sharing such experiences with Member States through appropriate channels and activities, including global and regional networks and academic institutions;
- (3) to integrate health intervention and technology assessment concepts and principles into the relevant strategies and areas of work of WHO, including, but not limited to, those on universal health coverage, including health financing, access to and rational use of quality-assured medicines, vaccines and other health technologies, the prevention and management of noncommunicable and communicable diseases, mother and child care, and the formulation of evidence-based health policy;
- (4) to provide technical support to Member States, especially low-income countries, relevant intergovernmental organizations and global health partners, in order to strengthen capacity for health intervention and technology assessment, including, when appropriate, the development and use of global guidance on methods and processes based on internationally agreed practices;
- (5) to ensure adequate capacity at all levels of WHO, utilizing its networks of experts and collaborating centres, as well as other regional and international networks, in order to address the demand for support to facilitate evidence-based policy decisions in Member States;
- (6) to support the exchange of information, sharing of experiences and capacity-building in health intervention and technology assessment through collaborative mechanisms and networks at global, regional and country levels, as well as ensuring that these partnerships are active, effective and sustainable;
- (7) to report on progress in the implementation of this resolution to the Sixty-ninth World Health Assembly.

Ninth plenary meeting, 24 May 2014

A67/VR/9





# 2015 Global Survey on Health Technology Assessment by National Authorities

## Main findings

Department of Essential Medicines and Health Products  
World Health Organization

[htechassessment@who.int](mailto:htechassessment@who.int)

[www.who.int/health-technology-assessment](http://www.who.int/health-technology-assessment)

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