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Editorial

HTA IN CENTRAL-EASTERN-SOUTHERN EUROPE: FINDING ITS WAY TO HEALTH POLICY

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The number of publications on health technology assessment (HTA) from Central, Eastern, and Southern Europe (CESE countries) is still low compared with the north and west of Europe. It is not surprising, as the idea of HTA originated from high-income Western economies and was afterward adopted by the south-eastern part of Europe, which mostly consists of middle-income countries. These CESE countries, with less capacity and experience with HTA processes, must deal with even tougher decisions on financing health technologies than northwestern Europe. There may even be a lack of confidence to open discussions on their specific needs for HTA.

This special issue of IJTAHC includes invited articles from CESE countries looking at their experience and perspectives of HTA implementation. Authors from twelve countries describe their national healthcare systems and solutions for pricing and reimbursement decisions. Their observations and commentary lead to some interesting overall findings.

In recent years, the CESE countries have made significant progress toward transparent decision making. Two European Directives, 89/105/EEC (on the transparency of measures regulating the prices of medicines for human use and their inclusion in the scope of national health insurance systems), known as transparency directive, and 2011/24/EU (on the application of patients' rights in cross-border healthcare) seem to provide strong incentives for HTA implementation. Thus, most CESE countries that are EU members implement at least some elements of HTA.

CESE countries are determined to find the best way to couple their traditional style of handling issues, and their current capacities, with the demanding requirements of HTA methodology. These efforts, however, have different dynamics and lead to different results. This can be seen in articles presented here and earlier publications by Gulacsi et al. (1) and Kalo et al. (2).

Is a separate institution to perform HTA needed, or will a department in a Ministry of Health or in Health Insurance Fund suffice? Should assessments be overarching or shaped to the specific needs of, for example, out-patient or institutional care? How independent from decision makers can an institution providing recommendations be while still maintaining close enough connections to provide the right information timely and in the right format? How much power in price negotiations can be gained by a critical analysis of HTA reports provided by applicants; would it be enough to have these reports appraised by a group of experts with their perhaps somewhat narrow experience? Is an economic analysis, sophisticated and hard to understand intuitively, or perhaps not so relevant due to lack of local data, really helpful; would a simplified multicriteria decision tool or an even simpler scorecard give similar results? These all are very practical questions and not at all trivial.

Some countries with less capacity seek international support and increase their involvement in the joint production of HTA reports. For over a decade, European HTA cooperation in the EUnetHTA network has been active. Currently, scenarios of HTA cooperation after 2020 are being considered by the European Commission and discussed with different groups of stakeholders (3). Closer cooperation, however, often assumes similar procedures and similar mechanisms of decision making and implementation in healthcare systems, based on HTA methodology. Is this a valid presumption? The collection of articles presented here may raise some doubts. Should we also consider wider dimensions of European cooperation, as proposed by Kanavos (4): cross-border collaboration across settings from joint horizon scanning through joint HTA assessment to joint negotiations and joint procurement?

Some claim that the main obstacle to implementing HTA in CESE countries is lack of political will. True enough; a major social effort is needed to shift from simple, expert-based decision-making systems to deliberative, socially inclusive, evidence-based ones. But we do have a useful tool for assessing HTA implementation stage: the scorecard presented by Kalo et al. (2). It is practical both for tracking changes in HTA use and, even more importantly, for shaping the objectives for further system development according to healthcare priorities (which should be clearly provided, not a simple step itself). Further methodological research is needed on

how to adapt HTA analysis results from other settings, especially economic ones, to local needs. Closer regional and community cooperation should be encouraged, typically joint work on educational initiatives and the exchange of local experiences.

HTA is said to be a tool helping to deal with limited health budgets, but budget scantiness means something quite different in high-income than in middle- or low-income countries. How can we apply this tool effectively in a huge diversity of real life conditions? Further efforts should be focused on how to fit HTA-based methodology to local needs. Otherwise, our proposal may sound like saying: "I have an excellent knife for eating steaks; you could also use it to cut your dry bread".

The process of adaptation may take decades and, moreover, is a continuous evolution. When CESE countries continue their work to place HTA in their policy processes, we hope this special issue will help in defining the needs and constraints. New ideas can be shared and adapted across the world; CESE countries have a role in creating solutions for HTA implementation.

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