The year so far ....

EuroScan started 2015 with a new Chair; Dr Roberta Joppi who leads the Italian Horizon Scanning Project (IHSP) in Verona. Roberta took over from Professor Brendon Kearney who successfully lead the network for four years. IHSP joined EuroScan in 2008 at a EuroScan meeting in Zurich. As well as being an active member, Roberta was previously the Registrar for EuroScan (January 2013 - December 2014). Our new Registrar is Dr Sungkyu Lee from NECA in South Korea.

EuroScan’s first meeting in 2015 was aptly in Zurich; hosted by the Swiss Federal Office of Public Health (SFOPH). The venue, a hotel on the Üetliberg mountain provided amazing views over Zurich. The fresh mountain air stimulated lots of discussion including ideas for EuroScan’s forward work programme. This will be agreed at the Autumn meeting.

Members also heard about progress with the new EuroScan website and database. The current website is showing its age (6 years old in July!) and the database no longer meets member requirements (and is even older!). We apologise to anyone who has recently visited the website and experienced problems but the good news is that EuroScan will have a new improved website in the next few months. The database is being designed to enable members to easily upload information on new and emerging technologies, This in turn will further address one of EuroScan’s goals - To improve the exchange of information about new and emerging health technologies and their potential impact on health services and existing health technologies.

We are now almost half way through the year. Many EuroScan members will be attending HTAi 2105 in Oslo and will give presentations on their organisations EAA systems. EuroScan will also hold a members meeting followed by a collaboration meeting with affiliated networks . This will give us the opportunity to discuss current activity, needs and expectations, and proposals for collaboration on early awareness and alert activities. EuroScan is also running a pre-conference workshop at HTAi on the afternoon of Saturday 13th June. The workshop will focus on the EuroScan Methods Toolkit with presentations from members on various aspects of early awareness and alert systems.

When we are in Oslo we will take time out to remember our friend and EuroScan member Dr Inger Norderhaug who sadly passed away on 25th May 2015. Inger first joined EuroScan in May 2002 and quickly became a valued member of the collaboration at a time when early awareness and alert activity was a relatively new discipline in the HTA world. Inger was the Registrar of EuroScan for 5 years, from January 2004 until December 2008, championing EAA activities at an international level and internally strengthening the collaboration.

Inger will be remembered fondly for her friendly, welcoming and enthusiastic approach; her constructive ways of finding solutions and agreements, and her insight into the field of new and emerging technologies that has been an inspiration to us all. Our thoughts go to her family and her colleagues at NOKC.
Are horizon scanning sources useful in identifying possible technologies for disinvestment?

Leigh-Ann Topfer, CADTH

Recently, the HTAi special interest group on disinvestment expanded to include horizon scanning and early awareness (Disinvestment and Early Awareness). This makes sense as both focus on particular, though distinct, stages of the technological lifecycle. But, is it possible to combine the tasks of identifying both new and emerging and potentially obsolete technologies? In particular, are the sources of information used for identifying new and emerging technologies also helpful for finding technologies that may be appropriate for disinvestment?

In a 2009 study, researchers from the Basque Office for Health Technology Assessment (Osteba) surveyed HTA agencies involved in disinvestment to identify and rank the sources used to identify potentially obsolete technologies.1 In general, the sources were similar to those used for health technology assessments, for example, The Cochrane Collaboration, other HTA agencies and association web sites, and key medical journals (JAMA and the BMJ).1 Most of the sources only indirectly identified obsolete technologies.1 One agency relied solely on the advice of experts to identify possible technologies for disinvestment.

The Osteba researchers also conducted a pilot study to examine the value of the EuroScan database as a source for identifying potentially obsolete technologies.2 Mainly, the database was helpful as a source of some possibly substitutive technologies, but consultation with clinical experts was ultimately seen as the most useful way to identify possibly obsolete technologies.3 From these studies, Osteba developed the complementary SorTEK-ZaharTEK databases (SorTEK for new technologies and ZaharTEK for potentially obsolete technologies).3

At the 2010 annual HTAi conference in Dublin, researchers from the UK’s National Institute for Health Research Horizon Scanning Research & Intelligence Centre presented a session entitled: Out with the old, in with the new: identifying health technologies for disinvestment – can early awareness and alert systems play a part?4 This work included a literature review and survey of health care decision makers and providers. They also found that the involvement of health professionals and other relevant stakeholders was of key importance in the identification of potentially obsolete technologies. Clinical practice guidelines, variations in practice and comparative effectiveness research have also been suggested as other potential sources of candidate technologies for disinvestment, but further confirmation of their value is still lacking.5

Several studies have examined the value of different information sources in horizon scanning for new and emerging health technologies.6-11 To date, searching for technologies for disinvestment has been largely reactive. “Moving to a more proactive model requires the use of horizon scanning ... known as “obsolescence forecasting” in the information technology industry...”12 An update on the experiences of Osteba and other agencies, in combining horizon scanning with scanning for disinvestment opportunities would be useful.

References

Cardiac Contractility Modulation (CCM) therapy: new results coming.

Antonio Migliore and Marina Cerbo, Agenas, Agenzia nazionale per i servizi sanitari regionali, Via Puglie 23 – 00187 Rome, Italy

In January 2015, a retrospective analysis of 81 patients implanted with a CCM device between 2004 and 2012 showed significant improvement of ejection fraction, from 23.1 ± 7.9% to 29.4 ± 8.6% (p < 0.05), decrease in mean NT-proBNP levels, from 4,395 ± 3,818 to 2,762 ± 3,490 ng/l (p < 0.05), and an overall clinical responder rate (at least one class improvement of NYHA within 6 months or last follow-up) of 74.1% [2].

Two studies are currently registered on clinicaltrials.gov:

**FIX-HF-5C** (NCT01381172): is a prospective, multicentre, randomised study to evaluate the safety and efficacy of CCM signals delivered by the implantable OPTIMIZER™ System in patients with NYHA class III/IV heart failure. The study will involve the recruitment of approximately 420 subjects at up to 50 sites across the USA. Estimated completion date is July 2017.

Recently (October 2014) the company announced the enrolment of the first patient in a new study, the IMPULSE-HF study, at the Karolinska Institute, Stockholm (Sweden). IMPULSE-HF is designed to provide additional evidence related to the clinical benefit of CCM therapy in symptomatic NYHA II/III patients having normal QRS complex and ejection fraction in the range 25-45% [3]. Results that will soon be published, starting from 2015, will contribute to define the real clinical effectiveness of this therapy.

**FIX-HF-5** (NCT00112125): is a prospective, multicentre, study to evaluate the safety and efficacy of CCM signals delivered by the OPTIMIZER™ System in patients with NYHA class III/IV heart failure. The study will involve the recruitment of 230 subjects at a total of up to 40 sites (USA, Czech Republic, and Germany). Estimated completion date is August 2015.

References


New report on artificial pancreas device systems in development for type 1 diabetes

Sara Trevitt, NIHR Horizon Scanning Research & Intelligence Centre (HSRIC)

In March the NIHR Horizon Scanning Research & Intelligence Centre (NIHR HSRIC) published a report on artificial pancreas device systems being developed for the closed-loop control of type 1 diabetes. Type 1 diabetes is a life-long autoimmune condition in which the normal mechanism for controlling blood glucose levels does not work. It usually begins in childhood, and affects over 250,000 people in the UK. The condition requires ongoing daily management, either by the person themselves or with the help of a carer (such as a parent).

An artificial pancreas device (APD) system is a small, portable medical device that uses digital communication technology to carry out the function of a healthy pancreas in regulating blood glucose levels. It has three functional components: (1) a continuous glucose monitor, (2) an insulin pump, and (3) a digital controller that links the other two to form a closed-loop. Continuous glucose monitors and insulin pumps are already available and are used by some people with type 1 diabetes. The innovative feature of closed-loop APD systems is the addition of the wireless digital controller (the ‘brain’) to these existing technologies. This new combination could potentially provide an option for automated self-management for people with type 1 diabetes. However, using such a system would require the person to wear several devices on their bodies which might raise issues around user acceptability.

Our research identified 18 APD systems, all of which are currently in the research stage of development (mainly in phase I and II clinical trials). Six of the systems are being tested in the home setting, whilst the others are being studied in clinic and outpatient environments. Some of the systems are fully automated whilst others still require a manual meal-time bolus. Most of the systems use insulin only, whereas some use a bi-hormonal approach, delivering both insulin and glucagon. Other key features of the systems are the type of algorithm that the controller is based on and their strategy for glycaemic control (treat-to-target or treat-to-range control). It is expected that the first systems will appear on the market from late 2016 onwards.

In addition to providing a technology overview, our report also presents a qualitative analysis of the views expressed by healthcare professionals and members of the public with type 1 diabetes and their carers who we engaged with to provide input. This included conducting an open-access public survey using the social media platform Facebook. Comments were made about what benefits people thought this new form of technology might bring, what the key issues will be concerning its use and adoption into the healthcare system, and the important features that they would like to see in commercial products when they become available. In addition to emphasising the importance of safety, reliability and accuracy, preferences were expressed about the physical design, characteristics and functionality that these systems should have if they are to be acceptable to users.

The report is available at http://www.hsric.nihr.ac.uk/outputs/other-reports/
What’s on the horizon for COPD diagnostics and monitoring technologies?

Louise Dixon and Derek Ward, NIHR Horizon Scanning Research & Intelligence Centre (HSRIC)

Chronic Obstructive Pulmonary Disease (COPD) poses a large and increasing burden on patients, carers and health services. Despite being a disease with significant impact, there remain several key issues facing its management: diagnosis is often delayed until the disease is in its moderate to severe stages, resulting in patients missing out on appropriate care early in the development of their disease; and the empirical treatment of COPD exacerbations exposes some patients to inappropriate antibiotic and corticosteroid therapy, a particular concern given the increasing development of antibiotic resistance and the potentially significant side effects of corticosteroids. To determine whether technologies already in development could address these issues, the NIHR HSRIC undertook a review of new and emerging technologies for the diagnosis and monitoring of COPD, aiming to identify all technologies within 2 years of launch or in the early post-launch phases, and evaluate these for innovativeness, patient acceptability, and likelihood of health service and patient impact.

Comprehensive searches identified a total of 80 technologies covering a wide variety of technology areas, including telehealth, vital sign monitoring technologies, questionnaires, imaging, biomarker tests, spirometry and wearable technologies. Evaluation of individual technologies was undertaken by both a panel of clinicians and a panel of patients with COPD. The clinician panel incorporated views from across the multidisciplinary team (specialist nurses, general practitioners and specialist respiratory physicians) and an existing patient and public involvement group (Birmingham Lung Improvement StudieS, BLISS) was used in order to reflect potential users’ opinions and contrast these against those of the clinician panel.

Biomarker tests were the largest identified field, with tests using samples of sputum, saliva or blood in order to diagnose, monitor or identify exacerbations of COPD. Most innovatively, the Home Use Sputum Test (Aseptika Ltd., UK) aims to provide advance warning of an exacerbation of COPD through a small sputum sample at the point of care. This could enable treatment of exacerbations to begin earlier and limit antibiotic and corticosteroid use to where it is necessary. In addition, several novel molecular point of care tests aim to identify the specific bacterial or viral pathogen responsible for an exacerbation (such as RESPOC, developed by Ateknea Solutions, Hungary), a development welcomed by the clinician panel.

Telehealth technologies were also frequently identified. Devices were generally aimed towards patient self-monitoring, with the ability for one or two-way messaging between the patient and healthcare professionals. However, evaluation by the clinician panel was generally negative, concluding that although telehealth has been demonstrated to reduce the odds of A&E attendance and hospitalisation, it did not improve quality of life or mortality, and is not currently considered cost-effective. Wearable technology was also an area of significant development. Devices designed to be worn across the chest, such as the WHolter vest-like breathing monitor (iSonea Ltd., Israel), were not favourably rated by the patient panel, who commented that they were unwilling to wear a “cumbersome” looking device, and were concerned about “the idea of having the restriction of a band around [the] chest”. In contrast, wrist-based monitoring devices, such as the BuddyWOTCH (Aseptika Ltd., UK), were praised for their compact, wearable design and ability to record blood oxygenation, temperature, heart rate and physical activity. Such devices aim to detect the early signs of exacerbations, enabling early treatment and preventing unnecessary hospitalisation.

The most promising technologies identified by this review were recommended as a focus of future translational and clinical research funding, ultimately to facilitate their timely evaluation and adoption within the NHS. These diagnostic and monitoring technologies have the potential to meet an unmet need in COPD care through supporting earlier diagnosis, the provision of appropriate treatment and the timely recognition of acute exacerbations, while those with the potential to determine the cause of an exacerbation may enable treatment to be better targeted at the underlying pathology, potentially avoiding inappropriate use of antibiotics and corticosteroids.

The review report will be published on the HSRIC website in mid-June 2015 (www.hsric.nihr.ac.uk). Further information can be obtained from Dr Derek Ward d.j.ward@bham.ac.uk
Focus on new and emerging treatments for Hepatitis C Virus

Joppi R, Pase D, Poggiani C, IHSP

Epidemiology of the disease

Hepatitis C Virus (HCV) is a single stranded, positive sense RNA virus first described in 1989. It infects more than 180 million people worldwide, corresponding to about 3% of the global population, with high prevalence (>3.5%) in central and eastern Asia, North Africa, and the Middle East; moderate prevalence in South and South East Asia, sub-Saharan Africa, Central and South America, Australasia, and Europe [1]. The prevalence of HCV in Europe is nearly 1%, but this varies geographically along a north-south gradient, ranging from approximately 0.5% in Northern countries to 2% in Mediterranean areas [2].

Hepatitis C becomes chronic in 75% of adults, and 80% of children. Others will spontaneously clear their infection, usually within months. Reinfection is possible in people who spontaneously cleared HCV, or were successfully treated. Consequences of untreated chronic HCV infection include depression, cardiovascular and autoimmune disorders and liver scarring. After 20 years of infection, 16% of adults develop cirrhosis; this increases exponentially to 40% after 30 years. People with cirrhosis are at risk for hepatocellular carcinoma and liver failure. Each year, 700,000 people die from HCV-related causes.

Hepatitis C genotypes

There are seven known HCV genotypes, each with dozens of subtypes. The high genetic variability of HCV (>30% nucleotide difference between genotypes, 15% to 30% nucleotide difference among subtypes) has made it difficult to develop universally effective vaccines and treatments.

Globally, genotype 1 predominates (46.2%, or 83.4 million cases), followed by genotype 3 (30.1%, or 54.3 million cases), genotype 2 (9.1%, or 16.5 million cases), genotype 4, (8.3%, or 15 million cases), genotype 6 (5.4%, or 9.8 million cases), and genotype 5 (<1%, or 1.4 million cases); there is a single known case of genotype 7 [3,4].

Treatments: goals and evolution

The goal of HCV treatment is cure (also referred to as sustained virologic response [SVR]). Being cured reduces the risk of liver-related and all-cause morbidity and mortality. The standard of care for HCV has improved dramatically. Pegylated interferon and ribavirin - a partially effective regimen with potentially debilitating side effects - is being replaced by safe, tolerable oral direct-acting antivirals (DAAs). These drugs have cured >90% of people in clinical trials, in only 12 weeks [5].

The HCV encodes three structural and seven non-structural proteins. DAAs can inhibit three major non-structural proteins: the NS3/4A protease, the NS5A protein, and the NS5B RNA dependent RNA polymerase [1].

New and emerging drugs for patients with Chronic HCV

Due to the predominance of HCV genotype 1 - especially in high-income countries - it has been the focus of DAA development. All DAA classes work against genotype 1. The most common strategy for treating HCV genotype 1 is using DAAs from multiple classes, to shorten treatment and increase cure rates. Although cure rates in trials combining DAAs from 3 classes have topped 95%, those who are not cured may be left with few options.

Currently, sofosbuvir is the optimal drug for a first-line regimen, since it is pan-genotypic, can be used in cirrhosis, has a low propensity for drug-drug interactions, and a high resistance barrier. Pairing it with a pan-genotypic NSSA inhibitor obviates pre-treatment genotypic testing, and will minimise safety and efficacy monitoring during and after treatment. The weakness of NSSA inhibitors is baseline or emergent drug resistance that may limit their effectiveness.

Candidates in phase II development (AbbVie’s ABT-530, Achillion’s ACH-3102, and Merck’s MK-8408) are purported to be more potent, and active against drug resistant virus [5].

Tables 1a and 1b summarise the new drugs recently approved along with the combinations in phase III of development to be used in naive and previously treated patients, respectively.

Emerging treatments for HCV continued...

HCV Treatment Criteria and Strategies

Each year, 700,000 people die from complications of HCV, a curable virus. HCV treatment has individual and public health benefits [6]. Current HCV treatment rates are low, ranging from 1% to <5%, in part due to the high cost of DAAs [7-10]. This has led to restrictions and prioritising people with the most advanced liver disease; a strategy that will reduce HCV-associated illness and death, but won’t stop the epidemic from spreading [11-13].

Although there are several barriers to universal HCV treatment access, high DAA prices are the greatest obstacle. The same steps that have led to drastic reductions in the price of HIV antiretrovirals can be used with DAAs. In fact, they can drive down prices in a dramatic fashion [7,14].

Using a public-health approach to HCV treatment, one regimen for everyone, will simplify procurement and delivery of treatment, especially if duration does not vary by genotype, subtype or cirrhosis. Some regimens do not require genotyping and subtyping, which are expensive and not always available [5].

Future research

HCV drugs have been developed primarily by pharmaceutical companies, driven by commercial interest, instead of collaborating with public health authorities to identify optimal DAA regimens in best-in-class drugs and therefore delayed development of, and access to promising regimens. This leaves many questions about DAA safety and efficacy in certain populations (although registries will provide additional information on DAA use and outcomes outside of clinical trials) [5]. Some of the remaining questions include: need for ribavirin in certain populations; treatment safety and efficacy in understudied or excluded populations; clinical relevance of drug resistance; treatment sequencing; pharmacogenomics; genotypes 5 and 6; DAAs in acute HCV infection; best treatment regimens in HCV-HIV; and best treatment for recurrent HCV in liver transplant recipients [1,5].

Table 1a

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<th>Naïve patients</th>
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<td>Active participant</td>
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<td>SORAFINIB / ABRAFINIB</td>
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References

Over 1,000 HTA practitioners and policymakers will discuss ‘Global Efforts in Knowledge Transfer: HTA to Health Policy and Practice’. Lancet Editor-in-Chief Richard Horton and Norwegian Knowledge Centre researcher Andrew Oxman will share the stage with the Norwegian Health Minister Bent Høie, high profile plenary speakers, 30 panels, and hundreds of oral and poster sessions. On June 13-14, HTAi will also host two-days of pre-meeting workshops.

With the support of the Norwegian Knowledge Centre and HTA agencies from Sweden, Denmark and Finland, HTAi is preparing to welcome delegates from over 55 countries.

Behind the scenes, HTAi Interest Groups are also planning for delegates to arrive. The ten HTAi Groups serve as experience-sharing hubs among HTA producers and users worldwide and they have a powerful role in promoting HTA in the areas of Conditional Coverage/Access with Evidence Development, Disinvestment and Early Awareness, Ethics, Hospital-based HTA, HTA-Regulatory Interactions, HTA in Developing Countries, Early Career Network, Information Resources, Patient and Citizen Involvement and the Impact of Public Health Interventions and Nutrition.

Several of these Groups and their members have provided expert input into the Annual Meeting’s scientific program. But the impact of the work of the interest groups goes beyond this. Of special note is HTAi’s Patient/Citizen Involvement group. They have developed practical tools for the implementation of Values and Quality Standards for patient involvement in HTA. They are going to present these at a panel to discuss progress made over the past year in implementing these values and standards in both established and emerging HTA agencies, across various countries.

HTAi also asks members to consider attending our Annual General Meeting on June 15 in Oslo. HTAi’s President, Carole Longson will be presenting the HTAi 2015-20 Strategic Plan and welcoming several new people to the HTAi board, including Vice President Sean Tunis, Treasurer Don Juzwishin, Secretary Americo Cicchetti and Director David Grainger. President-elect Guy Maddern will also take over as President following this meeting.

Finally, do not forget about the fantastic social events planned, including HTAi’s Welcome Reception, free to all registrants, to be held at the Oslo City Hall or Oslo Rådhus. This building is considered the city’s "Structure of the Century", and is best known for hosting The Nobel Peace Prize Ceremony every December.
Standardisation of European HTA – Application of the EUnetHTA HTA Core Model for Rapid Relative Effectiveness® in Austria

Dr. Med. Anna Nachtnebel, MSc, LBI-HTA

The European HTA Network, EUnetHTA, has developed several tools for the production of “reliable, timely, transparent and transferable information”. Amongst them are the HTA Core Model for Rapid Relative Effectiveness Assessments (REA)® and guidelines on methodological challenges frequently encountered by assessors of rapid REAs [1].

The HTA Core Model for Rapid REA® includes four different domains (see figure 1). Within these four domains, generic research questions have been formulated which are usually contained in HTAs. Authors go through these generic research questions and select those which are considered relevant for the intervention under assessment. Most other aspects usually comprised in comprehensive HTAs such as ethical, organisation, legal or administrative aspects are covered within a brief checklist. Cost considerations were specifically excluded based on recommendations of the High Level Pharmaceutical Forum.

By standardising the elements contained in HTAs, a shared understanding of HTA is facilitated and the international use of results promoted. The HTA Core Model for Rapid REA® therefore aims at guiding the production of joint assessments in European collaboration. These assessments should then serve as a basis for local HTAs; by using the joint assessments and by integrating context-specific information on, for example, data on prevalence, incidence or costs, the fast production of local HTAs should be facilitated and concurrently duplications reduced.

Besides guiding collaborative assessments within EUnetHTA, these tools can also be used for the production of national or local HTAs. Applying common methods in the local context could further contribute to the re-use of HTA results and thus to the reduction of redundancies and to a more efficient use of scarce scientific resources.

In 2015, the Austrian Ludwig Boltzmann Institute for Health Technology Assessment (LBI-HTA) used the HTA Core Model for Rapid REA® for the first time for compiling reports on new hospital interventions. On an annual basis, the Ministry of Health commissions the LBI-HTA to assess resource-intensive interventions, such as costly surgical procedures or high-tech based interventions, for which inclusion in the catalogue of benefits is sought. The application of the HTA Core Model for Rapid REA® led to structural changes in terms of presentation of the results and layout of the reports, and also to a change of the publication language; to increase the likelihood of re-use, the reports were for the first time written in English supplemented by a detailed summary in German. All reports will be publicly available on our website starting from the 15th of July [2].

Overall, our experiences with using the HTA Core Model for rapid REA® were positive, since authors found the structured way of producing answers to the individual research questions very helpful. Accordingly, a second programme line of the LBI-HTA that is “Horizon Scanning in Oncology” will also be adapted to the HTA Core Model in 2015.

References


![HTA Core Model DOMAINS](image)
The 4th HTAsiaLink annual conference with the theme of “Sharing Experiences of Health Technology Assessment (HTA) for Universal Health Coverage (UHC) in Asia” successfully took place in Taipei, Taiwan on 13-15 May 2015, preceded by the pre-conference on 12 May 2015. A welcome speech from Dr. Ming-Neng Shiu, Vice Minister of the Ministry of Health and Welfare, Taiwan introduced the first day of the conference.

There were four important plenary sessions, one of which was the Leaders Forum, highlighting issues from high-level decision-makers on HTA for UHC. Decision-makers from Taiwan, Thailand, Korea, and Indonesia were invited to discuss various issues related to HTA including the role of politicians, how to engage with industries and patient groups, and how to ensure transparency in the HTA process.

Dr. Ryan Li from NICE International, United Kingdom presented on policymaker and academic collaboration in HTA based on UK experiences and International Decision Support Initiative (iDSI) activities. iDSI was launched by NICE International in November 2013 in order to support low and middle income governments in making better healthcare spending decisions. It is an innovative global partnership between government institutes, universities such as the University of York, and Meteos, which is a not-for-profit think tank and strategy company.

The HTAsiaLink conference has a unique format customised to develop member agency’s capacity from its inaugural conference. All the presentations except plenary and issue panel sessions were presented by junior staff from each member agency, followed by in-depth feedback from international expert commentators in order to promote the quality of HTA projects presented. There were approximately 60 presentations regarding economic evaluation or healthcare systems. Experts from the University of York, University of Toronto, University of Glasgow, University of Adelaide, and Australian Safety and Efficacy Register of New Interventionsal Procedures-Surgical (ASERNIP-S) were invited as commentators.
Health care decision making requires the right evidence at the right time. Every day there are new health technologies available that can improve patient outcomes and refine health system efficiency. Health technology assessment (HTA) is a multidisciplinary tool to review technologies and provide evidence of the value these technologies can deliver to patients and their families, health system stakeholders, and to society more broadly.

The International Network of Agencies for Health Technology Assessment (INAHTA) was established in 1993, and today connects 54 publicly-funded HTA agencies that support evidence based decision making that affects the lives of nearly 1 billion people in 34 countries around the globe.

The connection between EuroScan and INAHTA traces back many years, and many EuroScan members are also members of INAHTA. In 2010, a formal Memoranda of Understanding was signed between EuroScan and INAHTA. The work of these two Networks is complementary: both promote the adoption and use of safe, effective and cost-effective health technologies through different approaches.

EuroScan focuses on emerging technologies through the Early Awareness and Alert Systems (EAAS) and INAHTA focuses on the promotion of health technology assessment at different points along the technology lifecycle, including early adoption, optimal use, obsolescence, and disinvestment within health systems. Many INAHTA agencies use horizon scanning to inform their topic identification and prioritisation processes.

Last year, INAHTA launched a new strategic plan for the years 2014-2017. This plan outlines a model tailored to support the ‘network way of working’. This emphasises and supports the connections between members to produce both tangible and intangible results. INAHTA has defined four value networks that span topic areas that are of interest to their wide range of membership:

1. Member Agency Assessment Programs, Processes & Methods
2. Knowledge Transfer, Uptake and Impact of HTA Reports
3. Education and Training for INAHTA Member Agency Staff
4. Agency Development and Capacity Building

Over the past year in each of these value networks, both tangible and intangible results have been – and continue to be – produced. Several internal policies and processes (tangible outputs) have been developed through collaboration in task groups, webinars, and email exchanges, which build familiarity and trust (intangible outputs) amongst contributing members. The intangible outputs are further amplified since supplemental information is often shared through these groups and activities - not about the project at hand, but about separate topics and personal exchanges about member agencies and individuals who work there.

For the coming year, INAHTA will focus on supporting the formation of communities of practice (CoPs) amongst members. These are groups of peers held together by a common sense of purpose, where sharing knowledge and experiences across members of a CoP is of benefit to the daily work of the members. There is a very rich storehouse of tools, expertise, and front-line experience in INAHTA member agencies for the production and dissemination of HTA products, for example, and the CoPs will help to facilitate the circulation and exchange of these tangible and intangible assets in a network way of working.
The Canadian Network for Environmental Scanning in Health (CNESH) has released its Top 10 New and Emerging Health Technology Watch List for 2015 (see https://www.cadth.ca/environmental-scanning/cnesh/top-10-new-and-emerging-health-technology-watch-list).

The purpose of the list is to identify new and emerging health technologies that have the potential to transform the delivery of health care through their impact on clinical effectiveness, patient survival, quality of life, patient safety, or costs to the health care system. The list includes drugs, diagnostics, devices, and procedures that are soon to be launched, are recently approved, or are in the early stages of diffusion.

The process for selecting the CNESH’s Top 10 involved inviting stakeholders to submit technologies, a filtration stage carried out by a small group to ensure only technologies meeting the inclusion criteria were included, a verification stage and prioritization stage.

Technologies included in the 2015 Top 10 are:
- andexanet alfa for bleeding episodes,
- electrically stimulated underwear for pressure ulcers,
- eravacycline antibiotic for multidrug-resistant infections,
- LCZ696 for heart failure,
- nivolumab for melanoma,
- molecular breast imaging system with cadmium zinc telluride detector,
- pediatric vision scanner for detection of strabismus (misaligned eyes) and amblyopia (lazy eye) in preschool children,
- remote monitoring of cardiac devices,
- secukinumab for psoriasis,
- toraymyxin for sepsis.

EuropScan International Network is committed to work with a high level of transparency and professionalism, and in partnership with researchers, research centres, governments and international organisations to produce high quality information and effective early awareness and alert systems for our respective constituencies.

We are also committed to support the development of existing and new not-for-profit public agencies working in the early awareness and alert field.

Visit http://www.euroscan.org.uk to find out more about EuroScan, its work and how to become a member.

Executive Committee

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<td>Dr Roberta Joppi, IHSP</td>
<td>31/12/16</td>
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<td>Vice Chair</td>
<td>Dr Marianne Klemp, NOKC</td>
<td>31/12/15</td>
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<td>Registrar</td>
<td>Dr Sungkyu Lee, NECA H-SIGHT</td>
<td>31/12/16</td>
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<td>Treasurer</td>
<td>Dr Anna Nachtnebel, LBI-HTA</td>
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<td>Dr Claire Packer, NIHR HSC</td>
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