

Development and implementation of health technology assessment in Argentina: Two steps forward and one step back

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Objectives: The objectives of this study are to review the financing and organization of the Argentine healthcare system, the licensing and drug price setting mechanisms, the benefit packages and coverage policies of pharmaceuticals and other medical technologies, as well as the development of HTA in Argentina, and the role of the Institute of Clinical Effectiveness and Health Policy (IECS) as an HTA agency. Finally, the perspectives and future of HTA as a tool to make resource-allocation decisions and priority setting in Argentina is discussed.

Methods: The study is a discussion/review based largely on the experiences of the authors, but supported by available literature.

Results: Argentina is an upper-middle income country with major healthcare problems related to both equity and efficiency. Its healthcare system consists of a multitier system divided in three large sectors: public, social security, and private, where the federal Ministry of Health has a rather limited role in national health policy stewardship. Many of Argentina's shortcomings are due in part to its pluralistic and fragmented healthcare system. In the past decade, Argentina, like many other Latin American countries, has undergone a profound reform of its healthcare system. Whereas some of the objectives of the reforms were specific to each country, a common issue among all of them was to establish a mechanism that ensured a more efficient allocation of scarce resources, and guaranteed a wider provision of healthcare services on the basis of the local population needs and equity. Although some signals from the national government and congress show that there are plans to formally incorporate HTA to inform reimbursement policies, these signals are still very weak. Paradoxically, even though Argentina was the first country in the region to require formal health economic evidence for the adoption of technologies into the mandatory benefit package of the social security, this "fourth hurdle" is no longer required. Nevertheless, there is an increasing interest and demand for a more explicit and transparent resource-allocation process that include HTA as a formal tool to inform decision making, in most of Argentine healthcare stakeholders.

Conclusions: In conclusion, what is needed in Argentina is a clear political will to push forward for a national agency of HTA that, similar to other developed countries, advance the regulation on the adoption of new health technologies to improve not only technical or

allocative efficiency, but also health equity. Until this milestone is accomplished, the HTA production and use to inform healthcare coverage policies will continue to mirror the current fragmented healthcare system.

Keywords: Health technology assessment, Health policy, History, Argentina

Argentina is an upper-middle income country with a population of 38 million, most of whom live in large cities (7). Like many other countries in Latin America, it has major healthcare problems related to both equity and efficiency. Compared with other countries in the region, the healthcare system performs well on several indicators. However, its outcomes are behind the country's potential, given that it ranks first in the region with respect to healthcare spending per capita and human development index. In fact, according to the World Health Organization (WHO) World Health Report 2000, Argentina fared very poorly according to their health and human resources, ranking 36th in health level after Cuba, Chile, and Uruguay, 89th in equity in financing, and 75th in overall health system performance, behind many countries in the region (28).

Many of Argentina's shortcomings are due in part to its pluralistic and fragmented healthcare system. In the past decade, Argentina, like many other Latin American countries, has undergone a profound reform of its healthcare systems. Although some of the objectives of the reforms were specific to each country, a common issue among all of them was to establish a mechanism that ensured a more efficient allocation of scarce resources, and guaranteed a wider provision of healthcare services on the basis of the local population needs and equity (16). During this period, Argentina sought to implement an ambitious range of reforms, strongly influenced by international bodies such as the World Bank, the Inter-American Development Bank, and the International Monetary Fund. These reforms were in line with those implemented in other middle-income or transitional countries, mainly focusing on decentralization and restructuring of social security systems. In 1996, while embedded in the reform process, Argentina started to take into account more explicit criteria for health priority setting. At this time, our country defined a package of benefits to be compulsorily covered by the Social Security system. Since then, health technology assessment (HTA), to make informed decisions on resource allocation, is increasingly being taken into account among policy makers in Argentina but is still not formally used for priority setting.

ORGANIZATION AND FINANCING OF THE HEALTHCARE SYSTEM

Argentina's healthcare system consists of a multitier system divided in three large sectors: public, social security, and private. The publicly funded sector is decentralized, giving

the federal Ministry of Health (MoH) a rather limited role in national health policy stewardship. In effect, the scheme of decentralization devolves the financing and delivery of healthcare from the national level to the provinces or municipalities. As a result, the federal level accounts for a minimal expenditure percentage, 2 of 9 percent, of the health expenditure as a proportion of the gross national product. The Federal Health Council (COFESA) convenes the federal minister and the provincial ministers of health, serving as an informal political space of exchange and negotiations between the national and subnational levels without a formal authority to make policy decisions. Public hospitals provide coverage to the population on demand and, in fact, act as reinsurance for the health insurance plans because they maintain a flow of free care for the insured population. Approximately 35 percent of the Argentine population has no insurance and relies solely on the public health sector of each province or district. In addition, the public hospitals are sometimes used by insured individuals requiring more complex and expensive diagnostic or therapeutic procedures (29).

The social health insurance sector (Obras Sociales) consists of many different funds, mostly managed by trade unions and generally composed of workers within the same labor activity. This sector consists of approximately 300 different Obras Sociales (OS) in scope and size, which covers more than 50 percent of the population. The National Obras Sociales are primarily funded by a compulsory payroll contribution from employees who each contribute with 3 percent of their salary while employers contribute with 6 percent. Each fund covers the employee and their direct dependents with the option to extend coverage to other family members. As a result, there are important differences among the OS, depending on the average wages and the number of dependents for each worker, which in turn vary following a social gradient. In brief, the contributions from wages of employers and employees are collected by the Federal Administration of Public Revenues (AFIP in its Spanish acronym) who in turn allocates approximately 85–90 percent of the monies back to the OS. To compensate for the differences that may result in potential health inequities due to the disparities in earnings for each of the OS, a "redistribution fund" (FSR) composed of 10–15 percent of each payroll contribution, transfers money from the more wealthy to the poorer OS. The minimum package guaranteed to all formal workers is called "Compulsory Medical Plan" or PMO in its Spanish acronym. As most of the social health insurance funds are too small to provide services directly, they subcontract private

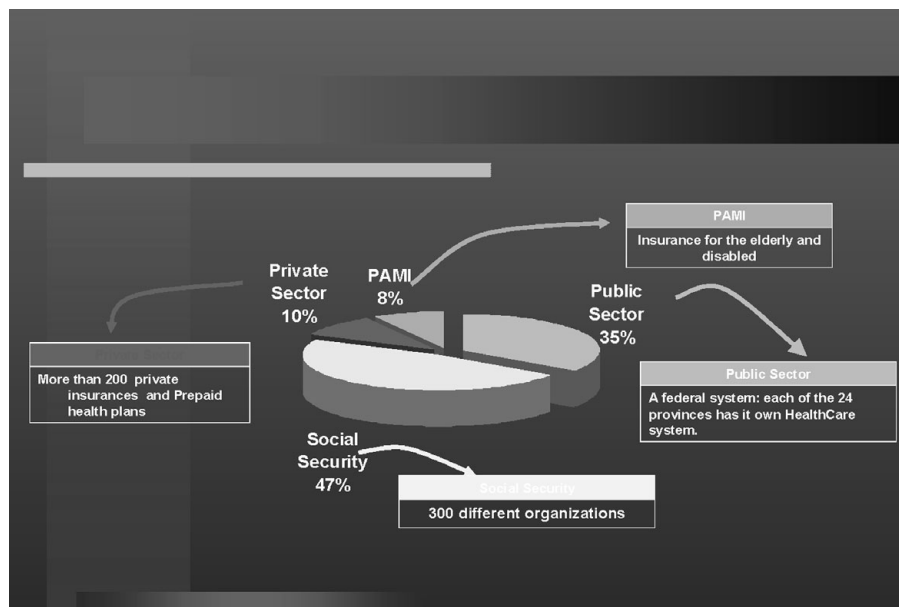


Figure 1. Healthcare coverage by source. PAMI, a nationwide social health insurance fund for retired workers.

clinics and hospitals, giving rise to a large private provision sector (29).

The Superintendence of Health Services of the Ministry of Health (SSS) is responsible for overseeing social insurance funds compliance with the PMO, guaranteeing system quality and coverage as well as cost recovery of public hospitals. In addition, the SSS minister has a special fund (special services administration or APE in its Spanish acronym) to reimburse the OS for most of the high-tech diagnostic, therapeutic procedures, expensive drugs, and many of the newer technologies.

Finally, 3.5 million elderly, as well as some people with disabilities are generally covered by a nationwide social health insurance fund for retired workers called PAMI, broadly comparable to the Medicare in the United States.

The private insurance sector covers approximately 4 million people, approximately 10 percent of the population, whereas 60 percent is contracted individually and the remaining is derived from social health insurers' provision and supplementary coverage plans. Private health insurance is funded through direct and voluntary prepayments by insured members (3). Benefit packages depend on the contribution of the people insured. Unlike the Social Security sector, the private insurance sector still lacks an effective regulatory framework to define benefits and plans. Sources of health coverage can be seen in Figure 1. Regarding equity in healthcare insurance, there is a marked income gradient in insurance coverage, as seen in Figure 2, where more than 60 percent of the poorer 20 percent of the population has no insurance as compared to less than 10 percent in the wealthier 20 percent.

Almost all parts of the health system suffer from a heavy bias toward expensive specialist curative services through high-tech interventions, overlooking primary care as a central level in the whole system and only restricting this strategy to vertical programs aimed only at the vulnerable populations. This tendency is exemplified by the health professional workforce mix of almost two to three specialists per primary care physician and almost ten doctors for every qualified nurse (25).

In the 1990s, Argentina went through a health sector reform that was part of a wider economic and social restructuring project based on a neo-liberal process. The reform placed particular emphasis on decentralization and the restructuring of the health insurance system (8).

Argentina spent 9.5 percent of its gross domestic product in health care in 2006 (10) representing a per-capita health expenditure of US\$455 at peso-dollar parity, or I\$1274 in purchase parity power dollars, making it the leading spender in health care in Latin America (27). A significant portion of the health expenditure, 34 percent, is channeled through the Obras Sociales, which were established to cover specific groups of formal workers. However, the private sector (private providers and private insurances) is also important and accounts for 44 percent of total health expenditure, almost two thirds of which comes from out-of-pocket payments from households (63 percent), which in turn account for 28 percent of the total health expenditure (28).

LICENSING AND DRUG PRICE SETTING

The Drug, Food, and Technology National Administration (ANMAT) is the national regulatory body responsible for

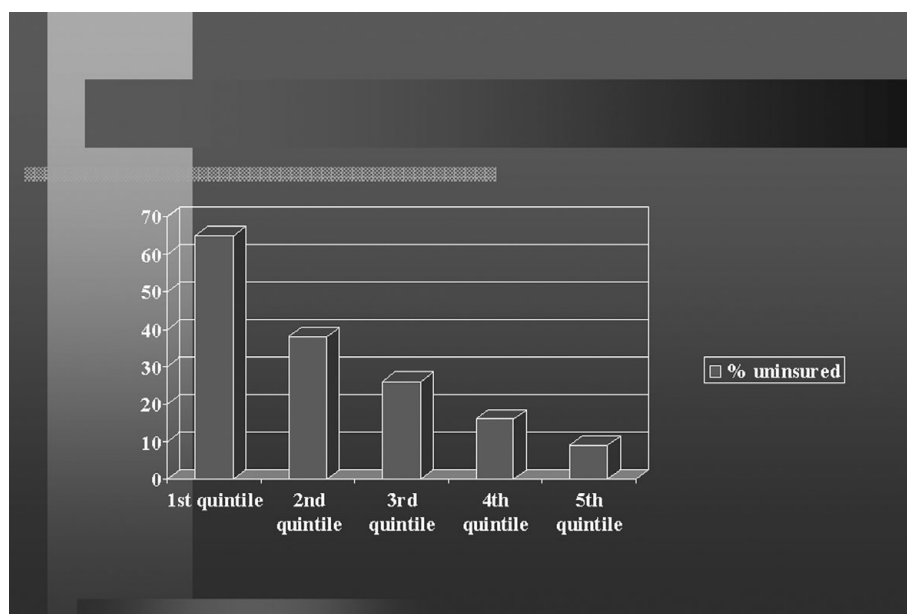


Figure 2. Uncovered population and earnings (by lower to higher quintiles). Source: Secretaría de Desarrollo Social 1999.

drug marketing and authorization. It is a decentralized agency of the Ministry of Health that regulates licensing of new technologies. Like most regulatory agencies, drug approval and marketing is based on quality, safety, and efficacy. It has been only recently that cost-effectiveness has begun to be considered, but not yet required, by the SSS as a “fourth hurdle” between the drug marketing authorization and the coverage or reimbursement of new pharmaceuticals or devices. There is no formal drug price regulation in Argentina, and sale prices are set according to market demands. Argentina, unlike Brazil, does not currently have cross-referencing pricing mechanisms. Nevertheless, there are several mechanisms that actually regulate drug prices. Regarding national reference pricing, around 200 essential drugs are included in the mandatory positive list regulated by the SSS (PMO). Also, generic prescribing has been strongly enforced by congressional Law enacted in 2004 (15).

One of the problems to follow drug prices is that not all prescription drug costs are provided to publicly available sources (Manual Farmacéutico, Kairos, IMS). For example, high cost drugs are handled by direct sales and as such escape any price control or monitoring (i.e., imatinib, saquinavir, bevacizumab, sorafenib) (4;11). A recent proposal by the SSS of MoH was to create a drug observatory of the National Health Insurance System (26). Over the past few years, some agreements between the government and pharmaceutical industry have led to reducing the price of more than 200 drugs, and regulating gradual increases over time. Nevertheless, there is no clear evidence that these agreements have resulted in lower drug prices.

BENEFIT PACKAGES AND COVERAGE POLICIES OF PHARMACEUTICALS AND OTHER MEDICAL TECHNOLOGIES

Pharmaceuticals and other medical technologies are reimbursed depending upon the source of financing. In the tax-funded public system, hospital and ambulatory services are generally free at the point of care and delivered on demand, with a large variation in the complexity and the quality of services according to each district, where wealthier provinces have better quality services than poorer ones. Essential pharmaceuticals are included in a positive list delivered to all of the public primary care centers, that is, more than 6,000 through a countrywide program (Program “Remediar”). For the Social Security sector, there is a compulsory package of benefits (PMO) for which all funds are obliged to guarantee its coverage to their beneficiaries. Ambulatory drugs are subsidized in a proportion depending on the condition treated and may vary from 40 percent (some acute conditions) to 100 percent of a reference price. Since 2004, the coverage of most drugs for chronic conditions was increased from 40 or 60 percent to 70 percent of a reference price. In addition, more than 87 drugs (only 20 before 2004) are now under a subsidy of 100 percent (i.e., insulins, antiretrovirals, cancer drugs) (5).

In 2002, the Minister of Health passed a law stating a new national policy for medicines including a reference price for essential drugs covered by the social security system and an obligation for physicians to prescribe by generic name and not brand name. Additionally, a nationwide program

Box 1.

One of the more important and inspiring events for some of us to start thinking in HTA was a 3-day meeting organized in the year 2000 by PAHO, ISTAHC, and the Argentine Ministry of Health in Bariloche, a marvelous spot in the lake region of Patagonia, which convened local researchers and policy makers with influential people in the field of international HTA such as David Banta, Chris Henshall, and Alicia Flamarin. This was the first time that some of us actively participated in an HTA activity and certainly was a landmark occasion for the creation of the Institute of Clinical Effectiveness and Health Policy (IECS) in Buenos a few years later.

(Program REMEDIAR) was established to guarantee the supply of essential drugs among public primary care centers.

Box 2.

In 2001, a couple of years before the Institute of Clinical Effectiveness and Health Policy (IECS) was constituted, some of us were commissioned by the SSS to appraise a list of 500 controversial services included in the positive list of the PMO for evidence of clinical effectiveness, potential cost-effectiveness, and budget impact (20). After a preliminary analysis, it was concluded that a high percentage of the services should be revised through a formal process of HTA. As a result of this initial experience, 10 percent of the technologies were excluded because of lack of effectiveness, and for 2/3 of them, the coverage was limited to specific clinical conditions or patient groups. It was thought that the coverage of many services should be restricted to specific clinical conditions along the need to define a formal and explicit process to adopt and incorporate new health technologies (21).

DEVELOPMENT OF HTA IN ARGENTINA

The World Bank report, as well as other articles that followed this report, focused on the design, content, and financing of essential national packages of health services and built the fundamentals to incorporate explicit economic criteria for resource-allocation decision making in developing countries (2;30). As a consequence, many of the health reform initiatives in the 1990s in Latin America included the concept of a “minimum” package of benefits to be guarantee to the whole population based on burden of disease, availability of effective interventions, cost-effectiveness, and sustainability (22).

One of the first steps that gave rise to the development of HTA in Argentina was the implementation of the first package of mandatory benefits to social health insurance beneficiaries (PMO) in 1996 (12). Even though the PMO had become a reference standard to follow coverage policies in other health sectors, most of the technologies that were included at that time came forth to validate customary interventions without being formally evaluated for clinical effectiveness and cost-effectiveness. Promoted by the World Bank and other international bodies such as PAHO/WHO, a series of meetings to sensitize health decision makers toward HTA was held in Argentina at the end of the 1990s and the beginning of this decade (see Box 1) . These events were followed by the first experiences in coverage decisions informed by HTA (see Box 2) (14;20).

Started at the beginning of the recession in 1999, but mainly after the economic and financial plummeting of late 2001 that dramatically affected the social and health services, Argentina sought to explicitly consider rationing healthcare technologies for the first time. This new scenario made it

possible for some regulatory agencies, such as the Superintendency of Social Security (SSS) that oversees and regulates the national social security system, to begin to encourage explicit priority setting by promoting the formal evaluation of technologies to be included in its PMO. This was the basis to create the emergency PMO (PMOE) (9), which was a reformulation of the package of benefits taking into account the new scenario of serious financial restrictions. An HTA committee was created in the SSS to define the PMOE considering clinical and cost-effectiveness criteria to adopt or maintain a technology into the PMOE. In 2003, the National Ministry of Health passed a decree requiring the sponsors of technologies to present information about clinical effectiveness, cost-effectiveness, potential budget impact and local studies if existed, for every new drug, device, clinical or surgical practice or procedure requested to be incorporated in the PMO (13). This regulatory intervention created a more transparent setting to negotiate the inclusion of new technologies in the PMO. During the time the resolution was in effect, from 2003 to 2006, 163 drugs were sent for review by the producers and more than 80 percent of them were not accepted based on “low clinical and cost-effectiveness.” Unfortunately, in 2006, this decree was revoked after a change in the authorities of the SSS, leaving the adoption of new technologies without a regulatory mechanism to monitor clinical or cost-effectiveness.

In 2003, the Ministry of Health and the Federal Health Council (COFESA), composed of all of the provincial ministers of health, developed the Federal Health Plan 2004–07 (21). Among its many aims, one was to regulate health technologies and another was to develop clinical practice guidelines through the creation of a national agency of health

Table 1. Description of Referenced Institutions, Funds, and Programs Within the Argentine Healthcare Sector

Institution/fund	Responsibilities/definition	Acronym or name in Argentina
Ministry of Health Federal Health Council	Federal health authority Council composed of the federal minister of health and the provincial ministers to exchange and negotiate between the national and subnational levels that are without a formal authority to make policy decisions	MoH COFESA
Social Health Funds/Insurance	Fund contributed to by employee and employer generally belonging to a similar trade or professional group	Obras Sociales
Compulsory Medical Plan Superintendence of Health Services of the Ministry of Health	Minimum package of services guaranteed to all formal workers Responsible for overseeing social insurance funds compliance with the PMO	PMO SSS
Social insurance Redistribution fund Special Services Administration	A fund to transfer money from the more wealthy to the poorer Responsible for a special fund that reimburses the Obras Sociales for most of the high-tech diagnostic, therapeutic procedures, expensive drugs, and many of the newer technologies	FSR APE
Social health insurance fund for retired people	Fund that covers elderly, people with disabilities, or retired workers, roughly comparable to the Medicare in the USA	PAMI
The National Drug, Food and Technology Administration Program Remediador	National regulatory body responsible for drug marketing and authorization A countrywide program to deliver essential pharmaceuticals to the public primary healthcare centers	ANMAT
Federal Administration of Public Revenues	Tax collection authority at federal level	AFIP

technology assessment. Even though the HTA agency was supposed to take effect in 2006, it has yet to be realized.

A list of names, functions, and Spanish acronyms of some referenced institutions and programs within the Argentine healthcare sector can be seen in Table 1.

HTA AND DECISION MAKERS IN ARGENTINA

After Argentina's sovereign debt default in late 2001 and 2002 the financial crisis critically affected health expenditures and triggered acute rationing. In 2003, we decided to explore Argentine decision-makers' attitudes and views regarding the use of HTA and economic evaluation (EE) to prioritize resource-allocation decisions and to inquire whether HTA was increasingly used as a result of the financial crises (23). The first conclusion was that decision makers were mostly unaware of HTA and that the most important criteria to adopt a treatment or a coverage policy were evidence of efficacy and effectiveness, social and stakeholder demand, or resource availability. Even when economic considerations to prioritize resource allocation were increasingly accepted, and even though this phenomenon has become faster after the crisis, the use and application of EE/HTAs were still very limited.

Additionally, we conducted a systematic review with researchers from the Center for Health Economics at the University of York regarding the availability of health economic evaluations in Latin America. Results showed that, although

Argentina was one of the countries in the region with the most production of economic evaluations, along with Brazil and Mexico, the quality of the publications were generally too poor for decision-making purposes (1). Another important actor in Argentina's health evaluation process is the pharmaceutical industry, which is slowly encouraging the use of local health economic evidence and HTA activities, partly by fostering educational activities directed to key decision makers and by commissioning local field studies.

SUPPORTING THE IMPLEMENTATION OF HTA IN ARGENTINA: THE ROLE OF IECS

The Institute of Clinical Effectiveness and Health Policy (IECS) serves as the main agency of HTA in Argentina and one of the few International Network of Agencies for Health Technology Assessment (INAHTA) members from Latin America. Even before its creation as an HTA agency, IECS closely collaborated with a handful of projects promoted by the Ministry of Health through the SSS. Most of these projects that started in 2000, aimed to implement HTA to inform policy decisions on coverage of technologies, when the PMO was first revised for clinical effectiveness criteria. Additionally, IECS has been the Argentina site for a region-wide collaboration, the Latin American Health Economic Evaluation Network (NEVALAT), that started in 2002 (6). Later in 2003, the SSS, with the technical support of IECS, issued a guideline for submission of new technologies that

required local data, not only on effectiveness, but also on cost-effectiveness and potential budgetary impact (13).

Over the past few years, IECS has been a leading institution in Latin America with regard to developing HTA reports and economic evaluations to study the impact and financial implications of the adoption of technologies on healthcare systems. In fact, IECS has a unit focused on the analysis of clinical, economic, and social impact resulting from the use of drugs, devices, practices, and healthcare services. The HTA unit is composed of 10 investigators, including epidemiologists, health economists, social scientists, and a librarian, who produce more than 30 HTA reports and EEs per year. These documents, assessing the effectiveness, safety, costs, and cost-effectiveness of interventions and technologies, are intended to inform managers, policy makers, health professionals, patients, and users on resource-allocation decisions concerning healthcare coverage and policies for the reimbursement of technologies. The publications are in electronic and printed format with a specific ISSN number. We disseminate these reports over the Web site and to those on the IECS mailing list, as well as through a monthly electronic newsletter targeted to policy makers and managers. The IECS Web site currently receives nearly 10,000 visits each month and has a network of 5,000 registered users who are decision makers and researchers from more than twenty countries, who receive our monthly HTA e-newsletter. Abstracts from all the documents prepared may be accessed free from the IECS Web site and are indexed in the United Kingdom Health System Centre for Reviews and Dissemination (CRD) hosted by The University of York, the INAHTA database, and the IECS local database.

To promote the generation of local economic evidence, IECS has developed and maintains a free academic database of healthcare service unit costs in Argentina for use in cost-effectiveness analysis and burden of disease studies (19).

Technical Cooperation With Policy Makers at a National Level

In 2003, after Argentina began the recovery from the crises of 2001, IECS built a consortium composed of healthcare organizations integrated by decision makers from different health sectors of the government (Ministry of Health, health secretariats of provinces and municipalities), social security, and private health insurances. To date, almost forty different government health secretariats and agencies, social security funds, hospitals, and private healthcare organizations are members of this consortium that commissions IECS to prepare HTA reports on an as-needed basis, based upon specific priorities of the agency. The HTA reports assist the organizations in the decision-making process of new technologies that are not yet included or defined in the PMO (17). Also, the HTA Unit of IECS performs horizon scanning activities looking for technologies that could have a financial impact if demanded by health services or users for reimbursement

in the near future. Policy makers and IECS investigators meet once a month to agree on which interventions and technologies are to be prioritized for assessment and the time frame needed to conduct the research.

The HTA documents that are prepared for policy makers and managers of these healthcare organizations are classified according to the depth and comprehensiveness of their contents in: *HTA documents*, which constitutes a complete evaluation, including an economic analysis; *Brief Technical Reports*, consisting of a preliminary evaluation of a particular health technology mainly focused on its efficacy, effectiveness, and safety; and, *Rapid Response Reports*, consisting of a rapid response to an information request by a policy maker to make timely informed decisions. As an example of our experience, from 2003 to 2006, IECS completed 117 HTAs. In the first stage of the program, most of the documents were not complete HTAs or health economic evaluations. In most cases, they were brief documents that supported contingent decisions that had to be made timely. Only 7 percent of the documents were complete HTAs assessing technologies such as drug-eluting stents, laparoscopic surgery, new antipsychotics, and vaccines; 64 percent of the reports were rapid response documents that were mainly based on secondary sources of information such as HTA reports from other agencies, systematic reviews and meta-analysis, clinical practice guidelines, and coverage policies from other countries; and 23 percent were brief technical documents that are more comprehensive reports based on a primary literature search and a critical review of the most up-to-date evidence. Interestingly in recent years, the number of reports on pharmaceuticals has been increasing from 8 or 12 reports per year in 2003 and 2004, to 21 reports in 2006. They represented only one third of all the reports published in 2003 and now they represent almost half (18). In the past 3 years, the number of HTA reports on pharmaceuticals, compared with other medical technologies, has steadily increased, as can be seen in Figure 3.

Technical Cooperation With Policy Makers at an International and Regional Level

Since 2005, IECS is a member of INAHTA and maintains close ties with the other Latin American HTA agencies belonging to INAHTA: CENETEC/Health Secretariat of Mexico and the HTA Unit from the Ministry of Health of Brazil. We also provide technical cooperation and training in HTA and EEs to the governments of Brazil (through ANVISA, the Regulatory Agency of Health surveillance of the Brazilian MoH), the government of Uruguay (through the Ministry of Public Health, the Social Security, and the Fondo Nacional de Recursos, which is in charge of publicly finance reimbursements for high cost technologies), and more recently, the Minister of Health of Chile as a consultant to evaluate the impact of health coverage of new conditions into the benefits to be guaranteed to their citizens. These activities

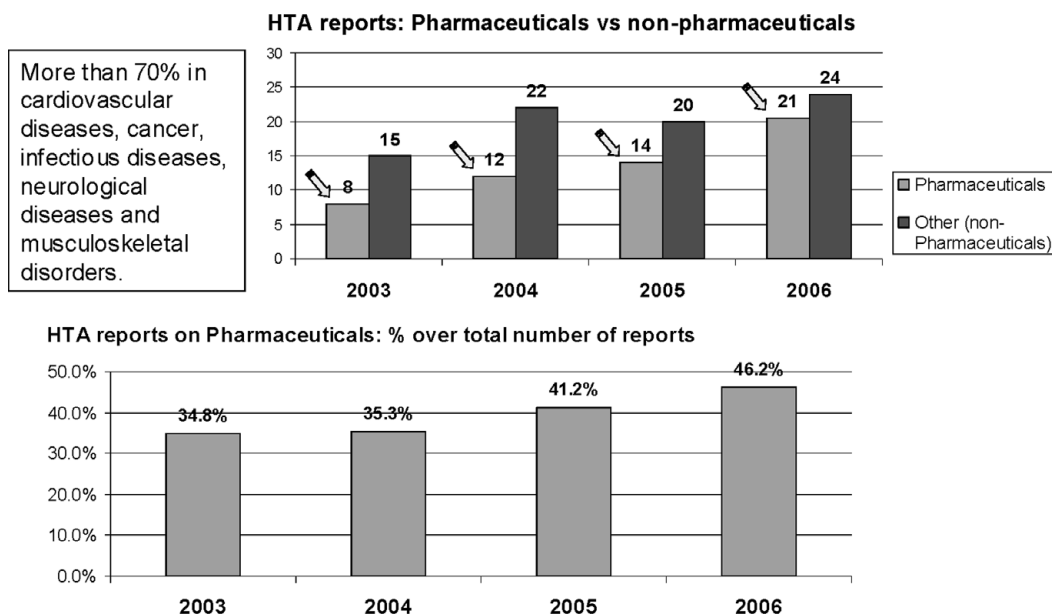


Figure 3. Health technology assessment (HTA) reports performed by Institute of Clinical Effectiveness and Health Policy (IECS) on pharmaceuticals versus nonpharmaceuticals.

are focused on providing policy makers of these countries access to IECS's HTA documents as well as consultancy and aid to develop capacity-building programs in evidence-based public health.

IECS hosts a coordinating center in Argentina of the Iberoamerican Cochrane Network of the Cochrane Collaboration, which encompasses the Cochrane centers of Latin American countries, Spain, and Portugal. It is also a Clinical Epidemiology Research and Training Centre (CERTC) of the Clinical Epidemiology Network-LatinCLEN, the Latin American branch of INCLEN Trust, a global academic organization composed of clinical epidemiology units from all over the world,

Capacity Building in HTA/EE

IECS offers the Master Program in Clinical Effectiveness of the Faculty of Medicine of the University of Buenos Aires inspired by the Master's Program of Clinical Effectiveness at Harvard University School of Public Health, where most of the founders of IECS were trained (24). Our program in turn, trained most of the investigators that are now working in the HTA unit at IECS. Since 2004, IECS has organized courses in HTA, EE methods, Systematic Reviews, and Evidence-Based Medicine in Argentina, which had an important presence of students from most of the Latin American countries. Moreover, IECS has held courses in Brazil, Colombia, Panamá, Peru, and Uruguay, reacting to the growing interest of these issues in the region. With the support of a grant from the Global Health Research Initiative from Canada (CIDA, CIHR, and IDRC), IECS is at the moment designing the first HTA e-learning course in Spanish and Por-

tuguese aimed at Latin American researchers and decision makers. This course will be available in early 2009.

HTA IN ARGENTINA: A WAY TO MOVE FORWARD

As observed in a recent survey, there is an increasing interest in introducing economic evaluations of healthcare technologies as a formal tool to inform decision-making processes within most Latin American countries (6). However, although in some countries things have formally advanced toward an explicit process (mainly Brazil and Mexico), in Argentina the path has been less straightforward.

Although some signals from the national government and congress show that there are plans to formally incorporate HTA to inform reimbursement policies that include the creation of an HTA agency, these signals are still very weak and seem to be obscured by the surrounding noise. Paradoxically, even though Argentina was the first country in the region to require formal health economic evidence for the adoption of technologies into the PMO of the social security, this "fourth hurdle" is no longer required, showing a "staggering" balance, sometimes moving forward, and sometimes moving backward with respect to explicitness and transparency in decision making. Additionally, the poor stewardship exerted by the MoH, due to the almost total decentralization of health services to the subnational levels, and the pluralistic and fragmented healthcare system in our country, makes it difficult to enact a common policy to make decisions on healthcare coverage policies. Having said this, it is important to note that HTA in Argentina is "on the move,"

but growing in a dispersed model composed of hundreds of payors and policy makers taking decisions mostly on a contingent basis. Accordingly, the main drivers of HTA used in our country are several public and private health financiers from different health subsectors who “desperately” are looking for a formal way of containing the skyrocketing costs of new expensive technologies. Of interest, the regional and local pharmaceutical and medical technology companies, following the strategies of their global headquarters, are getting increasingly involved in commissioning HTA reports to support their market access policies.

Unfortunately, if policy makers in developed countries are considered low users of scientific evidence to inform policy decisions, their counterparts in Argentina may be considered as nonusers of scientific or economic evidence. One of the main challenges in our country is to make interventions with demonstrated efficacy widely available to underserved populations, that is, to close the “know-do gap.” While a significant amount of resources in Argentina is allocated to provide coverage for complex and costly technologies with unproven or marginal benefits, many basic and highly beneficial interventions lack adequate coverage and become poorly accessible for a large proportion of our population. Although HTA demand increased substantially over the past 5 years with overlapping needs from different stakeholders across the health sector, further steps are needed to strengthen the formal link between HTA and decision making and, more importantly, to foster the adaptation of HTA into the local context.

In conclusion, what is needed in Argentina is a clear political will to push forward for a national agency of HTA that, similar to other developed countries and some Latin American countries, advances the regulation on the adoption of new health technologies to improve not only technical or allocative efficiency, but also health equity. Until this milestone is accomplished, the HTA production and use to inform healthcare coverage policies will continue to mirror the current fragmented healthcare system.

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