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National Recommendations for Pharmacoeconomic Evaluations Reporting for Reimbursement and Procurement of New Pharmaceutical Applications in Egypt

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ABSTRACT

Introduction: To improve resource allocation within our healthcare system, the Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology (UPA) and Universal Health Insurance Authority (UHIA) established a joint economic evaluation process to support UHIA reimbursement decisions and UPA procurement decisions. The main objective of this study is to describe the developed national pharmacoeconomic guidelines in Egypt, especially for reimbursement and procurement for new pharmaceuticals. **Methods:** A focus group was formed as a national initiative activity by governmental authorities in Egypt. The aim of this focus group was to develop national pharmacoeconomic guidelines for the evaluation of innovative and high-budget pharmaceutical products. This group consisted of various stakeholders with experience in health economics, outcomes research, public health, and pharmacy practice. To develop our national pharmacoeconomic guidelines, three steps were taken. First, the focus group reviewed the European Network for Health Technology Assessment (EUnetHTA) methods for health economic evaluations for new pharmaceuticals as well as the Canadian Agency for Drugs and Technologies in Health (CADTH) guidelines and the Academy of Managed Care Pharmacy (AMCP) Format for Formulary Submissions. Second, the focus group used the EUnetHTA guideline as a reference and adapted it to our local context. The focus group added the value assessment component, using the CADTH and AMCP guidelines. Third, the focus group collected input and feedback from key stakeholders through a focus group by using the quasi-Delphi panel approach. **Results:** The results of the focus group are a main structure of national pharmacoeconomic guidelines for the evaluation of innovative and high-budget pharmaceutical products, consisting of seven main topics. **Conclusion:** Economic evaluation is a core element of Health Technology Assessment, (HTA); therefore, the UHIA and UPA were encouraged to produce unified joint pharmacoeconomic guidelines for innovative products as an initial step in their commitment to implement the use of HTA in decision-making. This standardization of guidelines not only ensures transparency but also guarantees an accurate and transparent process to support evidence-based decision-making. These guidelines are expected to help decision-makers improve their process and attain better health outcomes for Egyptian patients.

Keywords: Egypt, national recommendations, pharmacoeconomic evaluations, reimbursement

INTRODUCTION

Efficient spending in healthcare is increasingly recognized as a direct predictor of better health outcomes and national wealth. High-performing health systems contribute to economic development, social protection, social cohesion (political stability), and health security. Improved health contributes to social well-being through its impact on economic development, competitiveness, and productivity.[1]

Egypt has a current population of more than 100 million citizens with a gross national income of USD 2690 per capita according to the World Bank.[2] Public healthcare expenditure represented only 4.74% of the country's gross domestic product (GDP) in 2019, which is equivalent to USD 19 billion.[3] In addition, the out-of-pocket portion has drastically increased from 51 to 60% in the last 16 years.[4] Based on the aforementioned data, optimizing available resources is vital, especially given the pressing demands to improve healthcare services and minimize out-of-pocket spending. With limited resources available, the allocation should be optimal to allow for the maximum possible benefit. Thus, health technology assessment (HTA) is critical to perform evidence-based decision-making.

The Egypt 2030 vision highlights the importance of elevating the quality of life of Egyptian citizens, which cannot possibly be achieved without improving the quality of healthcare services provided. In an effort to improve resource allocation within the healthcare system, the Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology (UPA) and Universal Health Insurance Authority (UHIA) established a joint economic evaluation process to support UHIA reimbursement decisions and UPA procurement decisions as a way of cost containment for better resource allocation today and in the future to promote an equitable, efficient, and high-quality health system.[5]

Subsequently, the need to develop national recommendations for pharmacoeconomic evaluations reporting emerged. As one of the essential initial steps, a pharmacoeconomic submission template is needed and is one of the crucial demands from providers in Egypt as well as payers. Several national guidelines already exist; instead of reinventing the wheel, the adaptation of these guidelines would be the best effective path. However, one of the core elements of HTA guidelines, economic evaluation, is hardly transferrable. The issues and difficulties encountered in economic analysis transferability have been outlined by several publications.[6] Accordingly, our aim was the development of country-specific recommendations for pharmacoeconomic evaluations reporting as part of HTA implementation. Regulations, requirements, and evidence generation differ across different types of health technology, specifically new pharmaceuticals and biological versus medical devices and diagnostics. Our article focuses only on pharmaceutical economic evaluation reporting.

The main objective of this study is to describe the national recommendations for economic evaluation reporting in Egypt for the reimbursement and procurement of new pharmaceuticals. The products considered under these recommendations are newly introduced products to the Egyptian market.

METHODS

This study did not require ethical committee approval. A focus group was formed as a national initiative activity by governmental authorities in Egypt. The aim of this focus group was to develop national recommendations for economic evaluation reporting for innovative and high-budget pharmaceutical products. This focus group consisted of representatives of major stakeholders with expertise in health economics, outcomes research, public health, and pharmacy practice (Table 1).

To develop our national recommendations, starting in Oct 2020, an initial consensus meeting was held to reach a consensus and lay out an agenda and deliverables for the focus group activities. To be able to develop country-specific national recommendations, the focus group took into consideration the characteristics of local Egyptian practice, the Egyptian healthcare system, and the availability of data.

Several steps were taken in developing the recommendations. First, the focus group reviewed the commonly used, representative, and reputable pharmacoeconomic guidelines available in English: the European Network for Health Technology Assessment (EUnetHTA) methods for health economic evaluation, Canadian Agency for Drugs and Technologies in Health (CADTH) guidelines, and the Academy of Managed Care Pharmacy (AMCP) Format for Formulary Submissions,[7–9], as well as the Egyptian recommendations for pharmacoeconomic evaluations reported in 2013.[10] The focus group agreed to use the EUnetHTA methods for health economic evaluation as a base with additional inputs. Second, the EUnetHTA guidance was adapted to our local context, taking into consideration the 2013 Egyptian recommendations for pharmacoeconomic evaluation reports. The value assessment component was deemed necessary and was added to the guideline, using the CADTH guidelines and the AMCP Format for Formulary Submissions.[8,9] Third, the focus group presented the developed recommendations to key stakeholders representing the governmental entities involved in the healthcare system (UPA and UHIA), healthcare providers, and pharma. Inputs and feedback were collected by using value dossier template (Supplemental material, available online) through focus groups, using the quasi-Delphi panel approach, which consisted of an iterative series of interviews and meetings. Anonymous responses were collected and synthesized into statements. These synthesized statements were submitted to the focus group members for comment until convergence of opinion was identified in the fifth

Table 1. Focus group members information

Member of Focus Group	Degree	Title	Organization	Governmental Employee
Mary Gamal	Msc	Head of Central Administration of Health Technology Management	UPA	Yes
Amal Samir Sedrak	Msc, MD	Head of General Administration of Training and Community Awareness Associate Professor of Public Health	UPA Cairo University	Yes
Gihan Hamdy Elsisi	Msc, PhD	Managing Director Assistant Professor, Health Economics Former Head of Pharmacoeconomic Unit, Egyptian Drug Authority	HTA Office American University in Cairo	No
Ahmed Seyam	Msc	Director, Health Economics and Health System Research	UHIA	Yes
Mariam Eldebeiky	Msc, MBA	Head of General Administration of Health Technology Reassessment	UPA	Yes
Ahmed Elagamy	Msc	Head of General Administration of Planning	UPA	Yes
Randa Eldessoki	Msc, MD	Associate Professor of Public Health	Elfayoum University	No

HTA: Health Technology Assessment; UHIA: Universal Health Insurance Authority; UPA: Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology.

round. Fourth, focus group meetings were held within a year to develop the core requirements and prepare the final draft report.

The main structure of our national guidelines was based on published methods for health economic evaluations by EUnetHTA[7] and previously published Egyptian recommendations of pharmacoeconomic evaluations.[10] The value-added demonstration in terms of patient, medical, and healthcare system values was developed by using the CADTH guidelines and the AMCP Format for Formulary Submissions.[8,9]

RESULTS

The recommendations for economic evaluation reporting were developed by a consensus approach, considering current practices and capacities for conducting economic evaluations in Egypt. They are similar to the EUnetHTA guideline with slight modifications and consist of 2 main parts: 1) information related to the product and 2) economic evaluation. The value-added demonstration part is listed but not described, as this is beyond the scope of this report and will be published at a later stage.

Disease and condition background

Any pharmaceutical submission for value-based evaluation should include data on disease epidemiology and demographics, especially for the target population, burden of the disease, and current treatments. The burden of the disease for patients and society should include aspects such as economic burden in all countries, social aspects, disability, and mortality. Epidemiologic data for the Egyptian population are recommended; in the case of the unavailability of such data, the focus group can rely on an expert panel including clinicians from representative accounts. Alternatively, global data or data from neighboring countries with comparable economies could be used, but it must be accompanied by clear justification for not using local data.

Product background

Information about the product must be included. This information includes the pharmacologic class of the drug, the route of administration, type of formulation, dosing regimen, number of courses and their duration, medicines that are coadministered if any, and most importantly, the outcomes of previous clinical trials related to the product.[11] The proposed intervention should only be evaluated for a single approved indication. Information about contraindications in specific subgroups or conditions and its regulatory status should be included. For market generics, a bioequivalence study and its regulatory approval from the Egyptian Drug Authority (EDA) must be submitted. For a biosimilar applicant, an additional endorsement document from the EDA for the comparable physicochemical, biological, and functional characteristics as well as efficacy and safety or immunogenicity with the reference product should be submitted.

Target population

The target population should be patients eligible for the new intervention. The target population should be similar to the target patients in the clinical trial to extrapolate its efficacy and safety on the long term in any economic evaluation. The target population could be categorized by demographics (age, sex, etc.), treatment settings, disease state, past treatment, and any other characteristics if justified. Although stratification to test for change in outcome between different subpopulations is preferred, any subpopulation expected to have different cost-effectiveness results from the total population must be identified. Detailed statistical analysis and

evidence supporting the validity of the subpopulation effect should be included.[12]

Current use of the intervention

The clinical pathway of care for different stages and/or subtypes of the disease being considered in the assessment must be stated. If the intervention is used in other countries, the health conditions and populations, and the purposes for which the intervention is currently used in these countries must be stated, accompanied with any expected differences between the use of the intervention in those countries and Egypt. The state of reimbursement of the intervention in these countries must also be stated if available.

Investments and tools needed to use the intervention

Information about the equipment, procedures, and resources needed to use the intervention must be stated along with the difference between the intervention and the comparator in the needed resources. If there are any premises and/or personnel that will be required if the intervention is reimbursed, and premises and personnel that will no longer be needed, this should be stated. Furthermore, if there are any conditions or restrictions on the settings or personnel to use the intervention, this should be stated.

Synthesized clinical evidence

The best available clinical data are best captured from a published systemic literature review if available and primary data collection/clinical trials. Good-quality observational studies could be used if randomized controlled trials are not available. At the top of the hierarchy of evidence are meta-analyses, especially those based on randomized clinical trials with a large number of participants. In addition to clinical effectiveness and safety, differences in patient adherence and compliance between the products should be reported. However, for orphan drugs, if no randomized clinical trials exist, small, uncontrolled trials are acceptable. The relevant studies extracted must be stated along with their relevant information including the target population, inclusion and exclusion criteria, methodology, findings, and conclusion.

Pharmacoeconomic evaluation

A full economic evaluation comparing costs versus benefits across alternatives is the standard. The method of pharmacoeconomic evaluation must be clearly stated and justified. Cost-utility analysis (CUA) is the preferred method, as the quality of life of patients is an essential variant that can guide decision-makers and increase comparability between studies. Whenever applicable, budget impact analysis (BIA) should be conducted along with a full economic evaluation study. In BIA, the economic model should match the comparator(s), market shares, target population, perspective, resource use, and costs. The cost components with and without the intervention should be stated, along with the total annual cost for each intervention throughout the chosen time horizon. Finally, the cumulative cost components and cumulative differences throughout the time horizon should be stated. No discounting is to be performed in the BIA, and the results should be externally validated by comparison to other published BIAs. The time horizon of a BIA should be 5 years. The following items describe the key features in any pharmacoeconomic evaluation (Table 2).

1. Perspective

For reimbursement applications, the study should be conducted from payer perspective to ensure the maximum transparency and the added benefit to the patient. In Egypt, multiple payers exist.

2. Comparator(s) in the study

Information about the chosen comparator must be included along with justification of the choice. The comparator should be the standard of care or the most used product in this condition. Preferably, the comparator should be the one currently reimbursed; if not, then the most frequently used intervention for the specific group of patients who are targeted by the new product. Finally, interventions and comparators should be used in the same line of therapy (first, second, third line of therapy).

3. Time horizon

The time horizon should be long enough to capture all the relevant outcome measures, whether efficacy or health outcomes, to demonstrate the complete effects and consequences of the intervention on the patient journey. All clinical parameters and costs should be applied to the same chosen time horizon.[13] If a short time frame was chosen, a justification should be included. If the time horizon must be longer than the study and extrapolations must be made, assumptions on disease progression and intervention effects in the extrapolated period should be outlined.[14]

4. Market share (in budget impact analysis only)

The market share(s) of the comparator(s) should be identified, and then the planned rate of uptake of the intervention should be stated throughout the chosen time horizon.

5. Outcome measure (in cost-utility analysis only)

The outcome parameter must be linked to the study question, and it should be valid and sensitive. Preferably a primary endpoint is chosen, but if an intermediate marker is chosen, it must have a clear correlation to the final endpoint and should be justified. The outcome measurements should include, if available, mortality, morbidity, function, health-related quality of life (HRQoL), and patient satisfaction. HRQoL is the preferred outcome measurement for reimbursement to facilitate decision-making and comparability. If the HRQoL is assumed to be constant over the time horizon of the cost-utility analysis, it should be mentioned. Otherwise, details of how it changes over the course of the disease or condition should

Table 2. Key elements of the Egyptian pharmacoeconomic guidelines for pharmaceuticals

Key Elements	The Egyptian Guidelines	Comparison of EUnetHTA Guidelines Versus Egyptian Recommendations	Rationale for Inclusion in the Egyptian Setting
Perspective	Payer perspectives	Similar	It is important to capture all the costs and the benefits of the intervention and evaluate how they could affect the payer
Comparator	The standard of care or the most similarly used product in the particular condition	Similar	We should use the available technologies in Egypt to evaluate the added value of the intervention versus the standard of care selected by the experts
Time horizon	The time horizon should be as long as possible, capturing all the relevant outcome measures	Similar	To accurately simulate the patient journey and the total effects of the intervention
Market share	The planned rate of uptake of the intervention should be stated through the chosen time horizon	Different	It was not mentioned in EUnetHTA guidelines but it needs to be identified as it could affect the results
Outcome measure	The outcome parameter (QALYs) must be linked to the study question	Similar	It depends both on the type of analysis and on the study question
Resource use and cost inputs	Direct medical and indirect costs should be reported separately. All unit costs and resource use should be captured from national sources	Similar	The inclusion or exclusion of cost items may depend on chosen perspective or analytical approach
Discount rate	3.5%	Different	More realistic duration-dependent models of time preference are needed, which reflect societal preference
Modeling	The model should be simple, clear, and reflect the real-world practice, with detailed documentation of the model structure and the input data	Similar	The modeling type chosen (e.g., decision tree, Markov model) should be justified and validated
Assumptions	All assumptions used in the model should be documented and justified	Similar	All assumptions need to be clearly presented and analyzed by using different scenarios
Presenting results	The ICERs must be calculated. Interventions should be presented in the order of increasing costs, excluding on the basis of simple dominance technologies	Similar	Detailed information should be provided to facilitate the interpretation of results, thus allowing for more transparency
Sensitivity analysis	DSA is the method of choice for performing sensitivity analyses, while PSA remains optional	Different	Results of PSA are complicated to interpret by personnel reviewing the studies
External validity	The results are to be compared with results of other clinical trials and if there are any differences between them they should be justified. Cross-validation should include comparing the model results with other models	Similar	Owing to the presence of wide regional differences in healthcare practice, external validity of the results should be discussed

DSA: deterministic sensitivity analyses; EUnet HTA: European Network for Health Technology Assessment; ICERs: incremental cost-effectiveness ratios; PSA: probabilistic sensitivity analyses; QALYs: quality-adjusted life years.

be stated. Variation in the health state should be reported by the patient or their caregiver.[15] The patient's HRQoL is usually expressed in either quality-adjusted life years (QALYs) or disability-adjusted life years.[16] Furthermore, if there is an additional broader novel value for the product, it needs to be demonstrated. A list of novel added values that can be demonstrated are presented in Table 3.[17]

6. Resource use and cost inputs

Identifying resource use and nit costs is a must.[18] The following items should be included: each resource used, the natural unit of measurement for each resource, the unit cost used to value the resource in the model, and the source/reference of the unit cost. Prospective real-world data collection from Egypt is the main source

Table 3. Novel values in healthcare for demonstration using CADTH and AMCP guidelines[8,9]

A. Effect on labor productivity
B. Reduction of uncertainty (to help poor responders move more quickly to better alternative treatments)
C. Insurance value (financial risk protection)
D. Fear of contagion (limits the spread of disease to others)
E. Severity of treatments (end-of-life treatments)
F. Value of hope (provide an opportunity for a cure)
G. Value of real option (provide an extendability in life, thus creates a chance for the patient to benefit from other future emerging treatments)
H. Equity value (provides the same outcome with the same quality across the population regardless of characteristics such as gender, ethnicity, geographic location, and socioeconomic status)
I. Value of scientific spillover (interventions with new mechanism of action)

AMCP: Academy of Managed Care Pharmacy; CADTH: Canadian Agency for Drugs and Technologies in Health.

for resource use data. In case these data are unavailable, collecting data from secondary sources (retrospective data), such as accounting data, patient chart reviews, and local administration, can be accepted.

The unit costs of the products should be obtained from an officially published payer tender list. Both the resource use and the costing data should be obtained from local sources. As the primary goal of these evaluations is resource allocation and cost containment, all direct medical costs should be included (i.e., the cost of medications, and medical services such as follow-up visits, diagnostic tests, laboratory tests, and hospital and emergency room services). Indirect costs, if reported separately, should include the loss of productivity whether for the patients or the primary care givers (captured from local data if available or international data) multiplied by the annual wages. The annual wages will be estimated from the Egyptian published GDP per capita. Direct nonmedical costs are not needed, as they are out-of-pocket expenses, which is not within the payer perspective.

All costs should be presented as the mean values with clear presentation for the calculations performed and if the same resource is used in varying quantities, it should be stated.[19] Macrocosting is the preferred method for cost calculation as opposed to microcosting owing to the unavailability of the latter approach in our local hospitals with different payment mechanisms.[20] The sources of cost inputs should reflect the costs of the specified year for which the cost is being calculated; thus, the consumer price index or GDP deflator must be used to inflate past costs to the desired year. All parameters of costs and outcomes used beyond 1 year should be discounted. For the policy-maker to be able to compare the results of different studies, the same discount rate should be used in all pharmacoeconomic evaluations in Egypt. The chosen discount rate for Egypt is 3–5%. The discount rate should be varied by using a plausible range in the sensitivity analyses.

7. Modeling

The model should be simple, clear, and reflect real-world practice, with detailed documentation of the model structure and the input data. The modeling type chosen (e.g., decision tree, Markov model) should be justified and validated.[21] As the chosen model aims to present the collected data with the most appropriate method and time horizon, events that are expected to be identical or show insignificant variations between the intervention and comparators could be excluded. Unless it is a key feature of the model (e.g., mortality, adverse events), the time horizon should also be appropriate for the nature of the disease; for instance, in the Markov model, cycle length should be determined to ensure that multiple events do not occur within the same cycle. The internal validity of the model should be tested to ensure that the model is robust.

8. Assumptions and extrapolation

The data used to build the model are extracted from different sources, so there is a potential risk for bias and uncertainty. Therefore, all assumptions used in the model should be documented and justified. For instance, if the time horizon is longer than the study from which the clinical parameters are extracted and extrapolations must be made, assumptions on disease progression and intervention effects in the extrapolated period should be outlined.

9. Presenting results

The incremental cost-effectiveness ratios (ICERs) must be calculated. Interventions should be presented in the order of increasing costs, excluding pharmaceutical products that are more costly and less effective than the alternatives, from the calculations based on simple dominance. The initial ICER should then be calculated by comparing each product with the one above it, excluding those products that are dominant. The final ICER is then calculated after eliminating products that are subject to extended dominance.

10. Sensitivity analysis

ensitivity analyses must be conducted on critical variables, using best-case and worst-case scenarios to explore their effect on the study results. The results of the sensitivity analyses should be presented in a diagram. The sensitivity analysis tests the internal validity of the model and ensures that it is robust. Deterministic sensitivity analysis (DSA) is a stochastic approach that uses variable point estimates to test the change in the results by varying a parameter, and it is the method of choice for performing sensitivity analyses owing to its simplicity and its interpretation to policy-makers. However, probabilistic sensitivity analysis (PSA), which is the distribution of a value through a range instead of various point estimates, is optional, as it is more complicated to interpret.

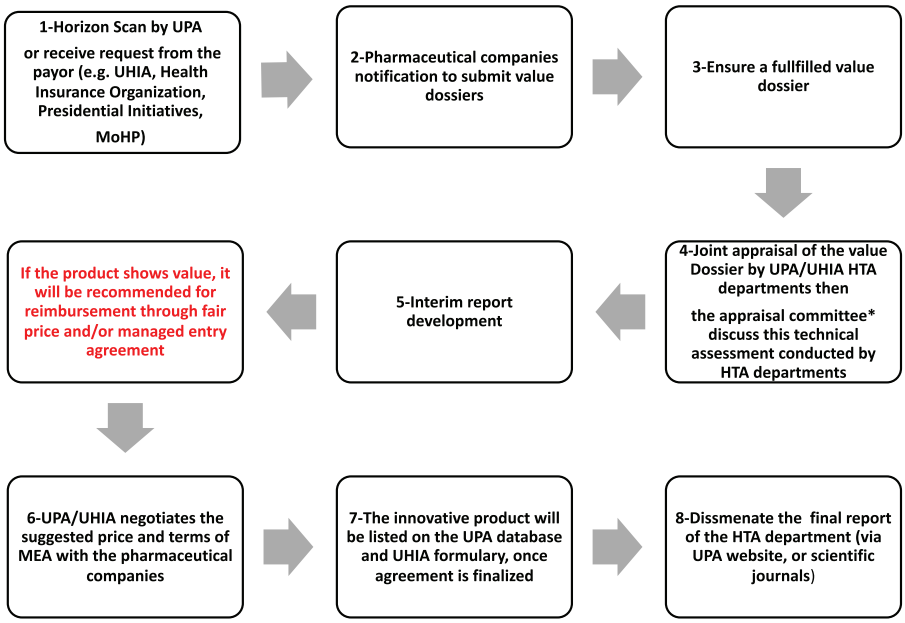

Figure 1. *Appraisal committee is formed of clinical experts and key stakeholders from, for example, UHIA, MoHP, and other organisms. HTA: Health Technology Assessment; MEA: Managed Entry Agreement, Value Dossier—the HTA dossier of the pharmaceutical product; MoHP: Ministry of Health and Population; UHIA: Universal Health Insurance Authority; UPA: Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology.

11. Validation

To test the external validity of the study, the results are to be compared with the results of other clinical trials, and if there are any differences between them, they should be justified. Cross-validation should include comparing the model results with those of other models. The face validity of the study must include expert panel validation.[22] Pharmaceutical companies are required to submit these types of validation for the "HTA for Procurement and Reimbursement Committee" to review.

12. Real-world evidence

If the model has uncertainty in its parameters, real-world evidence (RWE) could be used on an appropriate sample size if available. If RWE is presented, the sources of real-world data and limitations must be stated. Real-world data sources include data derived from electronic health records, medical claims and/or billing data, product and/or disease registry data, and other data sources that can inform health status. Finally, all possible limitations in the analysis must be stated.

DISCUSSION

As Universal Health Insurance (UHI) is being gradually implemented in Egypt, the assessment of interventions from both clinical and economic perspectives is much needed. Since the UHIA is expected to be almost the sole payer in Egypt, competition is expected to be fierce for reimbursement, and the need for cost containment will be of the utmost importance. Given that Egypt's portion of the GDP assigned for healthcare is limited and owing to the limited resources available, the UHIA and UPA established HTA departments and codeveloped a national joint HTA process and recommendations for economic evaluation reporting to assess innovative pharmaceutical products being introduced to the Egyptian market. These pharmacoeconomic assessments aim to provide scientific, evidence-based guidance for decision-makers. Figure 1 shows the structure of this joint process codeveloped by the UHIA and UPA.

The pharmacoeconomic submission will be required for new products that are being introduced to the Egyptian market for reimbursement, and the HTA departments in the UHIA and UPA are requested to evaluate such products. Therefore, recommendations for economic evaluation reporting are highly needed to ensure transparency and fairness between the submitted products. Furthermore, standardization of reporting is expected to cause progressive improvement in the quality of submissions over time and provide the Egyptian healthcare system with data often unavailable in the past. Given the inclusion of the novel value demonstration component in these recommendations, they are expected to enrich the Egyptian market and encourage manufacturers to invest in innovative and better-quality treatments.[17]

These recommendations were constructed from the cumulative knowledge reflected in the EUnetHTA methods for health economic evaluations.[7] In doing so, multiple repeated efforts and wasted time and resources were avoided. Considering that implementing recommendations from international HTA bodies

without local adaptation may do more harm than good,[23] our guidelines were tailored to the current settings and environment in Egypt and were validated by various stakeholders. This report is intended as a guide for both those who conduct pharmacoeconomic evaluations and manufacturers/pharma companies to ensure good quality of the submissions and a fair evaluation process of different products.

Implementation of these recommendations is not a smooth ride, and various challenges are expected. For instance, the availability of data such as resource use and epidemiologic data is less than satisfactory, if not lacking. However, the amount and quality of the available data are expected to drastically improve after UHI is fully implemented in Egypt. Once the digitalization of health records is complete, most of the population data will be available to the UHIA. In the meantime, to compensate for the fragmented Egyptian healthcare system, RWE is preferable and encouraged in manufacturer submissions. As economic evaluation methods progress over time, it will be appropriate to revisit these guidelines every 3 years.

CONCLUSION

Economic evaluation is a core element of HTA; therefore, the UHIA and UPA were encouraged to produce unified joint recommendations for economic evaluation reporting for innovative products as an initial step in their commitment to implement the use of HTA in decision-making. This standardization of recommendations not only ensures transparency but also guarantees an accurate and transparent process to support evidence-based decision-making. These recommendations are expected to help decision-makers improve their process and attain better health outcomes for Egyptian patients.

Supplemental Material

Supplemental materials are available online with the article.

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