

Uptake of HTAs and information needs  
of hospital managers:  
Utilization and usability of HTA products

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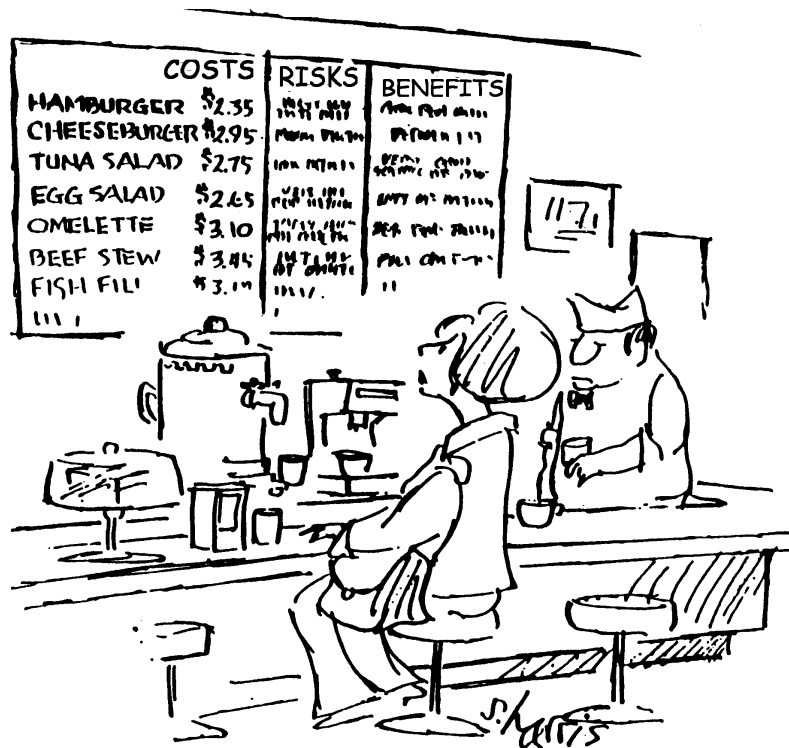
# Content

- Use of HTA by policymakers
- Hypothesis regarding decision making and information needs
- Barriers for uptake
- Solutions; Bridging the gap
- Summary & Discussions

# Methodological approach

- Prestudy: exploring the field
- Literature review, not systematic
- Project members
  - Maastricht University, Department of International Health (Chibuzo Opara, Kai Michelsen)
  - DIMDI (Hans-Peter Dauben)
  - Maastricht University, Department of Health Organisation Policy and Economics (Saskia Knies, Silvia Evers)
- Financed by DIMDI

# Use of HTA by policymakers

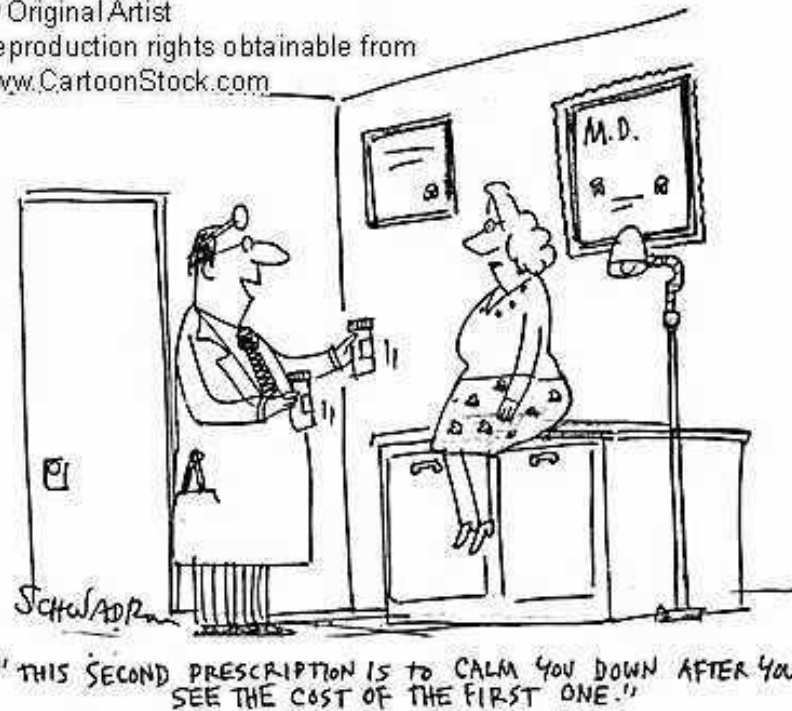


## Use

- Uptake is limited
- Comparison of different level of decision-makers, micro (individual health care provider), meso (health care facility), macro (national government)
- HTA studies are most used a meso level, and especially for pharmacy (hospital formulary) and for managed care decisions

# Hypothesis regarding decision making and information needs

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## Hypothesis regarding the context of decision maker (1)

- Differences between health systems (allocation of resources (budgets vs reimbursement), responsibilities)
- Different provider structures
  - private vs. public, for profit vs. not for profit) and
  - decisions making process (single unit (e.g. a hospitals) or within a provider network

## Hypothesis regarding the context of decision maker (2)

- Different kinds of decisions or decision making situations
  - implicit, based on established paradigms or practical wisdom
  - formal obligation
  - political or technical character
- Classical HTA quite technical

## Hypothesis regarding information needs (1)

- Responsibilities for the management of a hospital are divided – at the top between senior managers for medical services, care, and economic administration
- Different hospital managers have different information needs, health professionals in effectiveness and economic managers in costs

## Hypothesis regarding information needs (2)

- Other needs
  - Patient safety and quality of services
  - Spending of the budget in time
  - Further development of the hospital
  - Being attractive for employees
  - Academic hospitals: Being successful in research and education
- In theory HTA should cover all aspects in practice they never do

# Barriers for uptake



# HTA-study barriers accessibility

Methodology

Lack of relevance

Applicability, transferability, implementation

Next: Decision makers barriers,  
acceptability

## HTA-study barriers, Methodology

- HTA is new, methods not so validated, large number of assumptions, much uncertainty
- Decision makers in essence have to deal with “a go or not go” question, while the results of a HTA-study are often expressed in probability of X percent that intervention A is more cost-effective than B.
- HTA looks at efficiency, while patient, physician, and managers also like to look at equity and fairness. Related to this is that the public wants to give priority to patients with life-threatening treatment or to children or disabled, even when the intervention is not cost-effective

## HTA-study barriers, Lack of relevance

- Timeline and perspective of HTA-studies differ, HTA from a societal perspective, which means that all costs and effectiveness of the intervention are included, regardless of for whom this relevant. Lifetime perspective.
- Budget impact is neglected HTA an intervention is cost-effective is should be implemented, regardless of the number of patients which make use of this intervention. As a result HTA-studies neglect the budget impact of the intervention on hospitals
- HTA Integral cost versus hospital managers marginal cost prices

## HTA-study barriers, Applicability, transferability, implementation

- HTA studies experimental or optimal setting. Hospital routine care, difference in applicability, difference practice variation
- Availability and timeliness. Not for every intervention a HTA-study available. Majority of HTA-studies focus on pharmaceutical interventions HTA-studies takes years i.e. short-term nature of the making process versus the long-term nature of research
- Transferability (see lecture Saskia Knies)

## Decision makers barriers, acceptability

- Importance of other factors
- Limited HTA-knowledge
- Organisational barriers
- Lack of credibility
- Lack of legal and regulatory factors
- Dissemination of information

## Decision makers barriers, acceptability (1)

- Importance of other factors: dominance of the effectiveness, distaste of scarcity, and the budgetary impact. Deep-seated distaste of limits, people do not really believe that resources are limited, centre of excellence, teaching hospitals
- Limited HTA-knowledge
- Organisational barriers: Lack of staff and resources limits the hospital managers in using HTA studies. Inability to move funds from one budget to another limits the usage of HTA-studies

## Decision makers barriers, acceptability (2)

- Lack of credibility: The motives for performing an HTA-study are often questioned (big financial gains are at stake, i.e. pharmaceutical companies)
- Lack of legal and regulatory factors: Not obliged to look at the cost-effectiveness of intervention before they are implemented. The influence of HTA-studies is often indirect, through guidelines and not direct. As a result, for hospital managers there is also no (legal) obligation to look at HTA-studies

## Decision makers barriers, acceptability (3)

- Dissemination of information: The results of HTA-studies are mostly published in specialised journals. Overall these are not the journal which are consulted by hospital managers

# Solution: Bridging the gap



## Bridging the gap

- Methodology: teaching, development
- Credibility: research by independent organisations
- Applicability: Presentation of the results and focus, real life trials
- Agency with authority examine the cost effectiveness of interventions

## Knowledge brokers

- One key way of improving the “receptor capacity” of both communities to each others’ ideas, may be through the use of knowledge brokers; individuals with some training in the technical aspects of health technology assessment (economic evaluation), but also in a policy-making environment. They can help filter the many different types of information that constantly bombard the political and policy-making processes.

## Mini HA

- See earlier lecture “Professions and perspectives, the Mini-HTA experience (Kristian Kidholm)”

# Summary and discussion



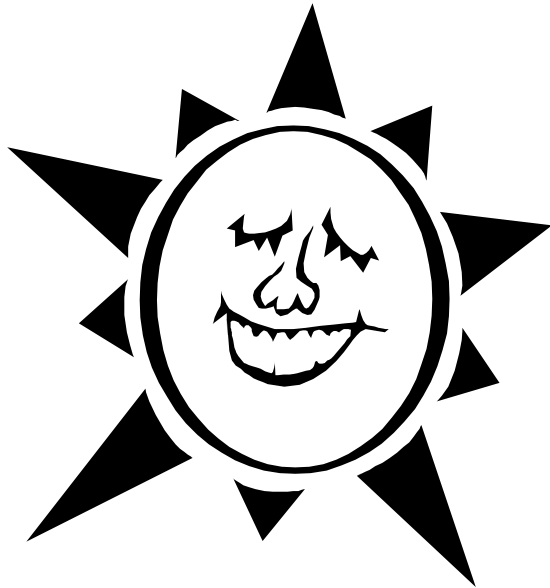
## In summary

- HTA is increasing
- HTA is not often used by policy makers due to certain barriers
- Bridging the gap has to come from 2 sides, managers and HTA-researchers
- Possible solution mini-HTA and knowledge brokers

## Discussion

- Difference of use and barriers between jurisdiction (relevant for cross border care)
- Are there possible solution? Decision makers interest?
- Which solutions

Thanks!



**Questions ?**



# What is a mini-HTA

- A form or a checklist with several questions concerning the prerequisites for and consequences of using (new) health technology, in which:
- The questions are grouped according to the four HTA perspectives: technology, patient, organization, and economy;
- The answers to the questions provide a brief, written basis for decisions (2–5 pages) and takes, based on experience, 5–15 hours, excluding the time spent on information retrieval and assessment and economic calculations;
- The purpose is to provide (part of) the decision-making basis for a proposal to introduce a specific new health technology or in connection with changes in the indication for the use of existing technology;
- Both the preparation and the use of the decision-making basis may take place at the local or regional level and be

## Questions 1–3: Introduction

1. Who is the proposer (hospital, department, person)?
2. What is the name/designation of the health technology?
3. Which parties are involved in the proposal?

## Questions 4–12: Technology

4. On which indication will the proposal be used?
5. In which way is the proposal new compared to usual practice?
6. Has an assessment of literature been carried out (by the department or by others)?
7. State the most important references and assess the strength of the evidence.
8. What is the effect of the proposal for patients in terms of diagnosis, treatment, care, rehabilitation, and prevention?
9. Does the proposal suggest any risks, adverse effects, or other adverse events?
10. Are there any other ongoing studies in other hospitals in Denmark or abroad of the effect of the proposal?
11. Has the proposal been recommended by the Danish National Board of Health, medical associations, etc.? If YES, please state institution.
12. Has the department previously or on any other occasions applied for introduction of the proposal?

## Questions 13–14: Patient

13. Does the proposal entail any special ethical or psychological consideration?
14. Is the proposal expected to influence the patients' quality of life, social or employment situation?

## Questions 15–20: Organization

15. What are the effects of the proposal on the staff in terms of information, training, or working environment?
16. Can the proposal be accommodated within the present physical setting?
17. Will the proposal affect other departments or service functions in the hospital?
18. How does the proposal affect the cooperation with other hospitals, regions, the primary sector, etc. (for example, in connection with changes of the requested pathway)?
19. When can the proposal be implemented?
20. Has the proposal been implemented in other hospitals in Denmark or internationally?

## Questions 21–26: Economy

21. Are there any start-up costs of equipment, rebuilding, training, etc.?
22. What are the consequences in terms of activities for the next couple of years?
23. What is the additional or saved annual cost per patient for the hospital?
24. What is the total additional or saved cost for the hospital for the next couple of years?
25. Which additional or saved costs can be expected for other hospitals, in other sectors, etc.?
26. Which uncertainties apply to these calculations? Other comments

## Mini-HTA used for different purposes

- Purchase new devices or equipment
- Approval of new treatment
- Budget planning
- Technology utilization agreement between counties and hospitals

## Quality of mini HTA

- Many Mini HTA
- Especially in Denmark
- Quality rather low
  - 25% include size clinical effectiveness presented
  - 81% include organisational aspects
  - 92% include cost estimate
- So main problem is 75% do not include effectiveness information

## Pros and cons mini HTA

### Pro

- Mini-HTA include all the aspect of HTA
- Form checklist is helpful tool
- Tool is flexible, open and timing

### Cons

- Insufficient evaluation of the evidence
- Lack of quality control
- Who should do the mini-HTA?