OBSERVATORY
VENICE
SUMMER
SCHOOL
2009

Innovation and Health Technology Assessment:
Improving Health System Quality

Venice, Island of San Servolo 26 - 31 July 2009
How to design effective evaluation and decision-making processes and institutions on health system level

Lecture 9

San Servolo (Venice), 30 July 2009

Reinhard Busse and John-Arne Røttingen
Summer School Directors
Outline

• Quality improvement
• Mandate of HTA
• Mandate of institutions doing HTA
• International collaboration
• Resources for complex reviews
Tasks of a Health System

Functions the system performs

- Stewardship (oversight)
- Creating resources (investment and training)
- Financing (collecting, pooling and purchasing)
- Delivering services (provision)

Objectives of the system

- Responsiveness (to people’s non-medical expectations)
- Fair (financial) contribution

Health

WHO World Health Report 2000

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Professional/provider (re-)certification
Provider (re-)accreditation
Health Technology Assessment
Volume and quality standards

Nutrition/ agriculture
Other sectors

Population health status (need)

Human resources
Technologies
Financial resources

Patients: demand, access
Structures and organisation
Process

Health care outcome: satisfaction, complications etc.

“Do the right thing“: *ex ante* Guidelines/ disease management programmes; *ex post* Review/Medical audit

“Do the thing right“: Quality indicators, Patient safety

“Do the things better“: Quality improvement strategies

Health care system

Quality indicators; registers;
Patient surveys
Efficiency
HTA is only one part of the system

Knowledge Synthesis
  Systematic Reviews
  Health Technology Assessment

Funding
  Guidelines
  Standards

Knowledge Brokering/
  Electronic Health Library

Support for
  Implementation/
  Evidence based care

Health Service
  Clinical practice

Continuous
  Quality Improvement

Monitoring quality
  and patient safety

R&D

Quality indicators
  Performance measurement
  Adverse events/Safety incidents
Need to combine ideas from different ideologies/movements

- Evidence Based Medicine/Practice movement
- HTA movement
- Outcomes movement
- Quality Improvement movement
- Practice development movement
- Patient Safety movement
- User/Consumer movement
- Open access movement
Need to get the quality puzzle together
Need to get the quality puzzle together
Do we need HTA expansion?

SRs and HTA in the Knowledge chains

- Health system interventions
  - Health system assessment = "HPA"
- Organizational interventions
  - Organizational assessment = "OA"
- Population interventions (public health)
  - Population assessment = "PHA"
- Individual interventions (clinical practice)
  - Individual assessment = "CIA"
- Technologies (drugs, devices ...)
  - Technology assessment = HTA

(Evidence) Knowledge synthesis or HTA?
Need for horizontal and vertical expansion

SRs and HTA in the Knowledge chains

Policies analyses

Health system interventions

Organizational interventions

Population interventions (public health)

Individual interventions (clinical practice)

Technologies (drugs, devices ...)

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... but not necessarily by HTA agencies

SRs and HTA in the Knowledge chains

Health system interventions
- Research
- Appraisal
- Decision
- Utilization
- Evaluation

Organizational interventions
- Research
- Appraisal
- Decision
- Utilization
- Evaluation

Population interventions (public health)
- Research
- Appraisal
- Decision
- Utilization
- Evaluation

Individual interventions (clinical practice)
- Research
- Appraisal
- Decision
- Utilization
- Evaluation

Technologies (drugs, devices ...)
- Research
- Appraisal
- Decision
- Utilization
- Evaluation

HTA

HTA

HTA?
The added value of HTA
(compared to EBM, research utilization)

HTA

= 

Clinical/economic evidence + Social science evidence + Colloquial evidence + Deliberative process
Types of scientific evidence

- Ethical Evidence
- Economic/Econometric Evidence
- Impact Evidence
- Statistical Modelling
- Implementation Evidence
- Descriptive Analytical Evidence
- Attitudinal Evidence

From Philip Davies
Factors influencing policy making (colloquial evidence)

Pragmatics & Contingencies
Lobbyists & Pressure Groups
Habits & Tradition
Experience & Expertise
Judgement
Evidence
Resources
Values

From Philip Davies
The process of combining scientific evidence and contextual knowledge

\[ \text{HTA} = \]

Clinical/economic evidence + Social science evidence + Colloquial process

Assessment

Knowledge support

Mixed evidence systematic review

Systematic review + Narrative synthesis

Clinical -
Levels of *health, olicy, aking*

SRs and HTA in the Knowledge chains

- **Health system interventions**
- **Organizational interventions**
- **Population interventions** (public health)
- **Individual interventions** (clinical practice)
- **Technologies** (drugs, devices ...)

**Clinical policy making**
- Research
- Synthesis
- Appraisal
- Decision
- Utilization
- Evaluation

- **Health system policy making**
- **Managerial policy making**
- **Public health policy making**
Are clinical policies needed?

Bypassing policy

Outcome

Practice

Policy decision

Policy process

Acceptance

Awareness

Adapted from Ansgar Gerhardus
Is HTA a direct tool for clinical decisions?

- Health system interventions
- Organizational interventions
- Population interventions (public health)
- Individual interventions (clinical practice)
- Technologies (drugs, devices ...)

Health system policy making
Managerial policy making
Public health policy making

Clinical decision making
HTA Institutions

- Kind of technologies assessed
- Activities performed
- Links to policy making
- Outreach
Which technologies?

Health technologies “outside” health care

- Environment
- Nutrition/ agriculture
- Other sectors

Population health status (need)

- Human resources

Health care products (technologies “within” health care)

- Health care system
- Structures and organisation
- Patients: demand, access
- Process
- Health care outcome: satisfaction, complications etc.

Health gain/ Outcome

Regulation and policy (technologies “applied to”)
Institutions undertaking HTA

Non-drug HTA
- CAHTA
- NCCHTA
- DIHTA
- AETS
- AETSA
- FinOHTA
- SMM
- DAHTA
- UETS

Drug HTA
- PBAC
- PMPRB
- CFH
- EAK
- CT

Broad HTA
- DACEHTA
- NOKC
- KCE
- IQWiG
- NICE
- HAS

1987 89 91/92 93 94 95 96 97 98 99 2000 01 02 03 04 05

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# Institutions undertaking HTA

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Classical Non-Drug</th>
<th>Classical Drug Agencies</th>
<th>Broad Activity Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>Mainly procedures, devices, and organisational technologies</td>
<td>Exclusively drugs</td>
<td>Initially mainly procedures, devices, organisational technologies</td>
</tr>
<tr>
<td></td>
<td>Increasingly drugs</td>
<td></td>
<td>Increasingly drugs</td>
</tr>
<tr>
<td>Activities</td>
<td>HTA and its dissemination</td>
<td>HTA (effectiveness, cost-effectiveness)</td>
<td>HTA and its dissemination</td>
</tr>
<tr>
<td></td>
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<td>CPG-Development</td>
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<td></td>
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<td>Health Services Research</td>
</tr>
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<td></td>
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<td></td>
<td>Accreditation</td>
</tr>
<tr>
<td>Linkage to</td>
<td>Very limited</td>
<td>Explicitly linked to</td>
<td>Linked to coverage</td>
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<tr>
<td>policy-making</td>
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<td>coverage and/or pricing decisions</td>
<td>decisions (variable degrees of explicitness)</td>
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<td></td>
<td></td>
<td>Linked to planning,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>investment</td>
</tr>
<tr>
<td>Outreach</td>
<td>National, federal</td>
<td>National, federal</td>
<td>National, federal</td>
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<td></td>
<td></td>
<td></td>
<td>Regional</td>
</tr>
<tr>
<td>Other</td>
<td>INAHTA member</td>
<td>non INAHTA member</td>
<td>INAHTA member</td>
</tr>
</tbody>
</table>
The roles and responsibilities of NICE since 1 April 2005

NICE produces guidance in three areas:

- **Public health** – the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector.

- **Health technologies** – the use of new and existing medicines, treatments and procedures within the NHS.

- **Clinical practice** – the appropriate treatment and care of people with specific diseases and conditions within the NHS.
NICE structure

- Implementation
  - Quality Standards/QOF
  - Impact evaluation
  - Behaviour change

- Developing NICE guidance

- Patient and public involvement

- R&D

- Centre for Public Health Excellence
  - public health interventions
  - public health programmes

- Centre for Health Technology Evaluation
  - technology appraisals
  - interventional procedures
  - diagnostics & devices
  - Patient Access Schemes Unit

- Centre for Clinical Practice
  - clinical guidelines

Electronic portal
www.evidence.nhs.uk/
NHS Evidence

Observatory Venice Summer School 2009
Integrated activity for the quality of health

- **HTA**
  - Drugs, devices and procedures: assessment of clinical benefit and collective interest (reimbursement and good use)

- **Guidelines**
  - good practice, patient safety, public health

- **Quality improvement**
  - Accreditation of HCOs (mandatory)
  - Certification of Continuous Professional Development (mandatory)
  - Certification of information (web sites, prescription softwares…)
  - Chronic disease management
III. Organisation of the Haute Autorité de santé

HAS’ structure consists of an executive Board (chaired by Professor Laurent Degos), specialist Committees, a director and departments.

1. THE BOARD ("COLLEGE")

Board members are appointed for a 6-year term, renewable once. Half the Board is renewed every 3 years.

2. THE SPECIALIST COMMITTEES AND THEIR MISSIONS

There are seven specialist committees (see Box 1). In addition to the Transparency Committee (article R. 163-15 of the Social Security Code) and the Committee for the Assessment of Devices and Health Technologies (CEPP) (article R. 165-18 of the Social Security Code), five other committees were created by the Board, which decided their composition and their common rules of operation. Each Committee is chaired by a member of the Board and has its own internal regulations. Each Committee Chair is supported by a corresponding head of department, who reports directly to the director.

Box 1. 7 specialist Committees

- Transparency Committee (assessment of medicinal products)
- Committee for the Assessment of Devices and Health Technologies
- Committee for the Assessment of Diagnostic and Therapeutic Procedures
- Committee for Healthcare Cover for Chronic Conditions
- Committee for Practice Guidelines and Practice Improvement
- Committee for Medical Information Quality and Dissemination
- Committee for Accreditation ("certification" in French) of Healthcare Organisations.
NHS Quality Improvement Scotland

Purpose

To lead the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland
What we do

- set standards of care
- provide advice and guidance on effective clinical practice (clinical guidelines, HTA)
- scrutinise the performance of the NHS, publishing our findings (performance assessment, clinical audit, accreditation)
- drive implementation of improvements in quality (Scottish Patient Safety Programme, clinical outcome data)

Within this remit we have central responsibility for patient safety and clinical governance across NHSScotland.
Norway: Merging HTA agency into a broader institution

01.01.2004

Ministry of Health: Mandate and budget

Directorate for Health and Social Affairs

Norwegian Knowledge Centre for the Health Services

Suggestions
- Ministries
- Hospitals
- Clinicians
- Patients

Products:
- HTA reports
- Early warning reports
- Systematic reviews (Cochrane)
- Electronic health library
- Performance Indicators
- Clinical indicators
- Quality improvement advice
- Patient safety
- Priority setting (secretariat)

Monitoring quality

Governmental centre
NOKC’s role:
A knowledge broker/translator
Different aspects of quality: who is responsible for what?

“Do the right thing“: *ex ante* Guidelines/ disease management programmes/ reminders; *ex post* Review

“Do the thing right“: Quality indicators
Universal coverage, limited cost-sharing

England

Professional certification
Provider (re-)accreditation
Health Technology Assessment
Competition of services

Quality

Postgraduate Med. Educ. and Training Board
Care Quality Commission (CQC), ex-Healthcare Com., ex-Com. Health Improvement

“Do the right thing” – NICE

DoH („National Service Framework“)

Health care services

Environment
Nutrition/agriculture
Other sectors

Population health status (need)

Human resources
Technologies
Financial resources

Patients: demand, access

Structures and organisation

Process

Health care outcome: satisfaction, complications etc.

Health gain/Outcome

Health Technology Assessment
Universal coverage, limited cost-sharing

France

Professional certification, re-accreditation
Health technology assessment
Concentration of services

Quality standards; patient surveys

Health care services

"Do the right thing": ex ante guidelines/ disease management programmes/ reminders; review

"Do the thing right": Quality standards

Health gain/ Outcome

Population health status (need)

Human resources

Technologies

Financial resources

Patients: demand, access

Structures and organisation

Process

Health care outcome: satisfaction, complications etc.
Universal coverage, limited cost-sharing

**Germany**

Health care setup

- Population health status (need)
- Human resources
- Technologies
- Financial resources

- Patients: demand, access
- Structures and organisation
- Process

Health care outcome: satisfaction, complications etc.

Quality indicators

States/Physician chambers

Fed. Joint Com./IQWiG

Fed. Joint Com.

Fed. Joint Com./Quality Institute

Prof. societies/Fed. Ass. of Phys./Central Office Med. Quality

"Do the right thing": evidence-based management reminders, etc.

"Do the thing right": Quality indicators
Collaboration to improve efficiency and quality:

- Too much duplication, triplication, quadruplication.....
- Resources are wasted, should be used to broaden and increase the number of interventions being assessed
International collaboration

6. Unity (one coverage decision)
5. Unification (one decision making entity)
4. Joint actions (collective decisions)
3. Coordination (individual agency decisions)
2. Mandated information sharing
1. Voluntary information sharing

EU-Coverage Agency "Euro-NICE"
EUnetHTA project
EU-HTA agency
INAHTA HTAi
INAHTA HTAi
INAHTA HTAi

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The HTA house
Building blocks used
(core assessment elements)
Additional blocks
(contextual assessment elements)
New HTA house!
## International vs. national/regional

<table>
<thead>
<tr>
<th>Clinical/economic evidence</th>
<th>Social science evidence</th>
<th>Colloquial evidence</th>
<th>Deliberative process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Knowledge support</strong></td>
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<tr>
<td><strong>Global</strong></td>
<td></td>
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<tr>
<td><strong>Core information</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**HTA** =

**Appraisal**

<table>
<thead>
<tr>
<th>Decision support</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local (national/regional)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Non-core information</strong></td>
<td></td>
</tr>
</tbody>
</table>
Information sharing across countries

- Common database
  - suggested topics
  - selected topics
  - assessments started
  - preprints of reports (before publication, intranet)
  - final reports
  - decisions taken
  - monitoring uptake
  - monitoring effectiveness
  - hase IV. registries
Priority setting/deciding topics international collaboration

- HTA priority setting
  - emerging technologies: common scanning
  - new technologies: common system
    - first evaluation
  - existing technologies: coordinated system
    - reevaluation
  - other assessments coordinated system
    - continuous evaluation

- Who and how to decide?
  - independence – no, dependence needed!
Existing international collaboration

<table>
<thead>
<tr>
<th>Technologies within</th>
<th>Technologies within</th>
<th>Technologies outside</th>
<th>Technologies to/on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs/devices</td>
<td>Clinical interventions</td>
<td>Public health</td>
<td>Health system</td>
</tr>
<tr>
<td>Data/ primary research</td>
<td>Supply driven, not demand driven</td>
<td>Supply driven, not demand driven</td>
<td>Too limited</td>
</tr>
<tr>
<td>Assessments (ex ante)</td>
<td>EUneHTA Cochrane</td>
<td>EUneHTA Cochrane GIN</td>
<td>? Cochrane</td>
</tr>
<tr>
<td>Data/ monitoring</td>
<td>? Product registries</td>
<td>? Clinical registries</td>
<td>WHO EU OECD</td>
</tr>
<tr>
<td>Evaluation (ex post)</td>
<td>?</td>
<td>?</td>
<td>? Observatory</td>
</tr>
</tbody>
</table>
Additional websites/databases on:
Health Evidence Network (HEN)

Home

Public health and health care policy-makers need a trustworthy source of evidence on which to build health policy. WHO/Europe addresses this need with HEN, which gives rapid access to independent and reliable health information and evidence.

HEN provides:

- answers to policy questions in the form of evidence-based synthesis reports and summaries;
- easy access to sources of evidence and information from a number of web sites, databases and documents; and
- in conjunction with the European Observatory on Health Systems and Polices, policy briefs focused on health systems and of relevance to the European Region’s Member States.

HEN is conceived as network of technical members and financial partners, involving United Nations agencies with a mandate related to health, organizations working with evidence-based health policy and health technology assessment, other institutions and governments interested in funding advanced projects related to public health issues.
Evidence Base for Influenza Intervention

Recent releases by HEN technical members

- Effects of maternal diet during pregnancy on birth weight of the infant, June 2002 [external link]
  National Institute for Public Health and the environment (RIVM)

- CRD Databases: Evidence Base for Influenza Intervention, May 2009 [external link]
  Centre for Reviews and Dissemination (CRD)

- The physical environment for people with dementia, May 2009 [external link]
  Norwegian Knowledge Centre for the Health Services, Norway

- Effects of psychotherapy for adults with depression, April 2009 [external link]
  Norwegian Knowledge Centre for the Health Services, Norway

- Is biomedical research a good social investment? The evaluation of the social impact of medical research, April 2009 [external link]
  Catalan Agency for Health Technology Assessment and Research (CAHTA)

- Scientific cooperation for a healthier Europe, April 2009 [external link]
  Health Council of the Netherlands (Gezondheidsraad)

- Smoking cessation in general practice - a Health Technology Assessment, April 2009 [external link]
  Danish Centre for Evaluation and Health Technology Assessment (DACEHTA)

- Accidental falls in elderly people, March 2009 [external link]
  Swedish National Institute of Public Health (SNIPH)

- General vaccination against hepatitis B revisited, March 2009 [external link]
  Health Council of the Netherlands (Gezondheidsraad) (HCNET)

  European Commission Health and Consumer Protection Directorate-General (DG SANCO)

- Indirect Evidence: Indirect Treatment Comparisons in Meta-Analysis, March 2009 [external link]
Centre for Reviews and Dissemination

CRD RESEARCH BRIEFING

Issued online: 1 May 2009

CRD DATABASES: EVIDENCE BASE FOR INFLUENZA INTERVENTION

The outbreaks of H1N1 swine influenza in Mexico and its spread to other countries have raised the World Health Organisation pandemic alert level to phase 5. A number of cases have now been confirmed across the UK.

In this statement, we collate the most up to date evidence on prevention and treatment from the internationally renowned CRD Databases. We focus on the effectiveness of two drugs used to prevent and treat influenza - oseltamivir (Tamiflu) and zanamivir (Relenza).

Prevention

The most up to date record included in DARE on prevention is from a Health Technology Assessment report of the prophylactic use of antiviral drugs published in February 2009. ¹

The systematic review reported a 7% absolute reduction in the risk of contracting influenza with oseltamivir and zanamivir when compared to placebo, in people from mixed households that had been in contact with an influenza-like illness, reducing the risk of contracting influenza from approximately 9% to 2%. ¹

Evidence was limited for the prevention of complications, hospital admissions and in minimizing length of illness and time to return to normal activities. There were no data relating to mortality. ¹

Treatment

¹
Full list of published briefs

Each joint policy brief covers and synthesizes available research evidence to deliver a message on potential policy options for good practice. Briefs consist of: key messages delivered in bullet points; an executive summary; and a core section providing the evidence and substance of the report itself.

Disclaimer

The joint policy briefs published on this web site are commissioned works and the contents are the responsibility of the authors. They do not necessarily reflect the official policies of WHO/Europe, HEN or the Observatory. All reports undergo rigorous external peer review, as well as internal review.

- How can European states design efficient, equitable and sustainable funding systems for long-term care for older people?
  HEN-OBS joint policy brief No.11 (2009)

- How can health systems respond to population ageing?
  HEN-OBS joint policy brief No.10 (2009)

- Do lifelong learning and revalidation ensure that physicians are fit to practice?
  HEN-OBS joint policy brief No.9 (2008)

- How can optimal skill mix be effectively implemented and why?
  HEN-OBS joint policy brief No.8 (2008)

- How can the migration of health service professionals be managed so as to reduce any negative effects on supply?
  HEN-OBS joint policy brief No.7 (2008)

- How can chronic disease management programmes operate across care settings and providers?
  HEN-OBS joint policy brief No.6 (2008)

- When do vertical (stand alone) programmes have a place in health systems?
  HEN-OBS joint policy brief No.5 (2008)

- How can the settings used to provide care to older people be balanced?
  HEN-OBS joint policy brief No.4 (2008)
Systematic reviews can save managers and policymakers a great deal of time by providing a synthesis of the research literature on a given topic that has been prepared in a systematic and transparent way. To help managers and policymakers find and use these reviews, we’ve identified as many management- and policy-relevant reviews as possible, categorized them in ways that will make it easy to retrieve citation details and summaries of them (whenever possible), and made the database available online. We call the database the PPD/CCNC database because it was produced by McMaster University’s Program in Policy Decision-Making (PPD), in partnership with the Canadian Cochrane Network and Centre (CCNC).

If this is your first time accessing the database, please review a brief description about how to search the database and what your database search will retrieve. For more details about the creation and updating of the database, as well as its sponsorship and funding, please review a brief description about who and what is behind the database.

The database was last updated on 30 June 2009.

PPD/CCNC database contains >800 systematic reviews about health system arrangements, plus review-derived products.
If this is your first time accessing the database, please review a brief description about how to search the database and what your database search will retrieve. For more details about the creation and updating of the database, as well as its sponsorship and funding, please review a brief description about who and what is behind the database.

The database was last updated on 30 June 2009.

**Keyword**

- Governance arrangements (57)
  - Policy authority (7)
  - Organizational authority (22)
    - Ownership (13)
    - Accreditation (3)
    - Networks/multi-institutional arrangements (3)
    - Strategic management (2)
  - Commercial authority (9)
  - Professional authority (11)
  - Consumer & stakeholder involvement (15)
- Financial arrangements (70)
- Delivery arrangements (874)
  - To whom care is provided & with what efforts to reach them (205)
  - By whom care is provided (432)
  - Where care is provided (290)
  - With what information & communication technology is care provided (154)
  - With what level of quality & safety is care provided (26)
<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison of mortality between private-for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis</td>
<td>Devereaux PJ; Schunemann HJ; Ravindran N; Bhandari M; Garg AX; Choi PT; Grant BJ; Haines T; Lacchetti C; Weaver B; Lavis JN; Cook DJ; Haslam DR; Sullivan T; Guyatt GH;</td>
</tr>
<tr>
<td>Payments for care at private for-profit and private not-for-profit hospitals: A systematic review and meta-analysis</td>
<td>Devereaux PJ; Heels-Ansdell D; Lacchetti C; Haines T; Burns KEA; Cook DJ; Ravindran N; Walter SD; McDonald H; Stone SB; Patel R; Bhandari M; Schunemann HJ; Choi PTL; Bayoumi AM; Lavis JN; Sullivan T; Stoddart G; Guyatt GH;</td>
</tr>
<tr>
<td>What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?</td>
<td>McIntyre D; Thiede M; Dahlgren G; Whitehead M;</td>
</tr>
<tr>
<td>Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature</td>
<td>Patouillard E; Goodman CA; Hanson KG; Mills AJ;</td>
</tr>
<tr>
<td>A comparison of the performance of for-profit and nonprofit U.S. psychiatric inpatient care providers since 1980</td>
<td>Rosenau PV; Linder SH;</td>
</tr>
<tr>
<td>Performance Evaluations of For-Profit and Nonprofit U.S. Hospitals since 1980</td>
<td>Rosenau PV;</td>
</tr>
<tr>
<td>Foreign direct investment and trade in health services: A review of the literature</td>
<td>Smith RD;</td>
</tr>
<tr>
<td>A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals</td>
<td>Devereaux PJ; Choi PT; Lacchetti C; Weaver B; Schunemann HJ; Haines T; Lavis JN; Grant BJ; Haslam DR; Bhandari M; Sullivan T; Cook DJ; Walter SD; Meade M; Khan H; Bhatnagar N; Guyatt GH;</td>
</tr>
<tr>
<td>Nursing home profit status and quality of care: a systematic review and meta-analysis</td>
<td>Hillmer MP; Wodchis WP; Gill B;</td>
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<tr>
<td>continued...</td>
<td>continued...</td>
</tr>
</tbody>
</table>
Reviews of quality improvement interventions

- **QQUIP**
  - Quest for Quality and Improved Performance
  - The Health Foundation, UK
  - [www.health.org.uk/qquip](http://www.health.org.uk/qquip)

- **EPOC**
  - Effective Practice and Organisation of Care Group
  - Collaborative Review Group of the Cochrane Collaboration
  - [www.epoc.cochrane.org](http://www.epoc.cochrane.org)
EPOC
(Rx for change builds on this)

• Interventions orientated toward health professionals
• Financial interventions
  – Provider interventions
  – Patient interventions
• Organisational interventions
  – Structural interventions
  – Staff-oriented interventions
  – Patient-oriented interventions
• Regulator interventions
Resources for knowledge synthesis

- Cochrane Effective Practice and Organisation of Care Group (EPOC):
- Campbell Collaboration (more on other welfare areas than health):
  - http://www.campbellcollaboration.org/
- McMaster University’s Program in Policy Decision-Making (PPD):
  - http://www.researchtopolicy.ca/search/reviews.aspx
- European Observatory on Health Systems and Policies. Policy briefs:
  - http://www.euro.who.int/observatory/Publications/20020527_16
- The Alliance for Health Policy and Systems Research, WHO:
- EVIPnet initiative
- The SUPPORT collaboration
  - http://www.support-collaboration.org/
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  - http://www.lshtm.ac.uk/ihc
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HTA to Optimize Health Technology Utilization – Using Implementation Initiatives and Monitoring Processes

Optimization of technology use
HTA paradoxes

- Nick Mays’ paradox
- Bernhard – Finn paradox
Nick Mays’ paradox

1. HTA is constructed to rationalize a fuzzy and interests based decision process

2. Success of HTA depends on degree of stakeholder involvement and taking the reality into account
Bernhard – Finn paradox

1. HTA should be coordinated and harmonized to have the necessary content and value for money.

2. Success of HTA depends on degree of local applicability, contextualization and stakeholder involvement.