

Health technology assessment agencies: An international overview of organizational aspects

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Objectives: The aim of the study is to make an international comparison of Health Technology Assessment (HTA) Agencies, to show their similarities and differences.

Methods: An e-mail questionnaire was sent to thirty HTA agencies internationally. Questions related to the structure of the agency, the relationship with health-related institutions, the prescriptiveness of the decisions taken, the main core and the modalities to spread the assessment, and the type of funding.

Results: Twenty-four HTA Agencies answered the questionnaire: 25 percent in America, 4.2 percent in Australia, and 70.8 percent in Europe. Fifty-four percent of HTA Agencies are governmental institutions (83.3 percent have central government funding), while 62.5 percent have relationships with health-related governmental institutions. Of the agencies, 87 percent reported that their decisions are not prescriptive, while for 20.8 percent and 8.3 percent of them stated that this was the case totally or partially, respectively, especially for the governmental and American Agencies. Seventeen agencies (70.8 percent) declared their work on multiannual programs (77 percent of the

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The study is a part of a research program funded by the Italian Ministry of Health titled “Promozione di un Network per la diffusione di Health Technology Assessment per la gestione delle tecnologie nelle Aziende Sanitarie” [Promotion of a Network for the diffusion of Health Technology Assessment for the management of technologies in Health Authorities].

governmental HTA Agencies and 100 percent of the American ones). The assessments mainly addressed diagnostic procedures (85.7 percent) and pharmaceuticals (25 percent). The most common way to disseminate results is by means of paper report (91.7 percent), followed by the Internet (16.7 percent), and seminars to expert audiences (12.5 percent). **Conclusions:** The comparative analysis of HTA Agencies showed that governmental and American Agencies have a profound impact on the prescriptiveness of their assessment, and this could be linked to the fact that these types of Agencies work on multiannual programs. European and American HTA Agencies have many similarities in terms of type of assessment, funding, and dissemination of results.

Keywords: Health technology assessment, Agencies, Organizational aspects, International comparison

Health Technologies Assessment (HTA) agencies have been established in many countries internationally to address, at the national level, the containment of healthcare intervention costs, the assessment of benefits of healthcare interventions not previously evaluated, and the assessment of the impact of new technologies. Furthermore, HTA Agencies may aim to bridge the gap between the scientific world producing HTA studies and the decision- or policy-making national level, in a process known as appraisal (15). In previous works regarding a limited number of countries, the development of HTA activities has been studied to analyze the effects of those activities on policy making, or to make a cross-country review of different approaches to common specific topics (7;12).

Draborg and Andersen (4) studied 433 HTA reports published by eleven leading institutions or agencies in nine countries and found that the extent of policy and research recommendations in HTAs varies greatly from country to country. These researchers underline that the content and scope of HTAs have some impact on recommendations: on one hand, extensive assessment of the economic and organizational aspects increases the probability of it including policy recommendations. While on the other hand, extensive assessment of technological and patient aspects increases the probability of it including research recommendations, whereas extensive focus on the economic aspects is negatively related to research recommendations. Finally they found that the use of external partners for assessment increases the probability of including research recommendations in HTAs but not policy recommendations.

Battista very recently (3), while illustrating the research agenda for the future of HTA, reported that the particular organizational features of the body producing HTA reports may influence its diffusion through context or governance, thus the description of organizational aspects seems to be an interesting issue.

In Italy, the dissemination and utilization of HTA, as a means for supporting healthcare policy, remains limited. For this reason in 2003, the Ministry of Health financed the establishment of an HTA Italian network to foster the application of technologies' management principles in healthcare organizations. The present study, therefore, is a part of the

research program "Promotion of a Network for the diffusion of Health Technology Assessment for the management of technologies in Health Authorities" (17).

The aim of this study is to make an international comparison of HTA Agencies to show their similarities and differences. While some of the differences may be regarded as an expression of the variety of healthcare system's organizational structure, similarities or common practices could reflect and suggest an underlying common approach to the same issues in different countries.

METHODS

The questionnaire and Setting

An e-mail questionnaire relating to the characteristics of the HTA Agencies was sent to thirty Agencies internationally. The questions regarded the structure of the agency, the relationship with and the audience of health-related institutions, the prescriptiveness of the decisions taken, the main core and the modalities to spread the assessment, and the type of funding.

In particular, it include the following items: (a) Which are the main stakeholder of HTA Agency? (b) Is it the Agency a governmental institution? (c) Has the Agency relationship with health related governmental institutions (of own country)? (d) Does the Agency interface with (i) Central/regional/local Government, (ii) Health professionals, (iii) University, (iv) Research Institutions, (v) Industry, and (vi) Patients. (e) Who is the audience of the Agency? (f) Agency's reports, decision or conclusions are prescriptive for someone? (g) When was the Agency officially born? (h) Does the Agency plan its work using multiannual programs? (i) How does the Agency address the issue of objectiveness/independence of the evaluator? (j) How are topics chosen by the Agency to evaluate? (k) Which are the main competence areas? (l) How many people work in the Agency (full and part-time)? (m) What are agency's products? (n) How does the Agency disseminate the results of the assessment? (o) Sources of funding. (p) Annual allocated Budget. The questionnaire was validated in a research program

funded by the Italian Ministry of Health, and coordinated by the Catholic University of the Sacred Heart, Rome (13).

Moreover, we were interested in assessing whether the type of healthcare system (social insurance, National Health Service, Medicare + private insurance) and gross domestic product (GDP) could influence the organizational aspects of the HTA Agencies. For the latter variable, we used the median as a cutoff value for identifying two GDP groups (over and below \$31,300).

Statistical Analysis

Differences between the groups were tested using parametric and nonparametric tests, where appropriate, for quantitative and qualitative variables, respectively. The statistical significance was set at $p < .05$. Statistical Package for Social Sciences (SPSS 12.0) was used for data processing and analysis.

RESULTS

Twenty-four HTA Agencies (80 percent of the eligible) answered the questionnaire, 25 percent in America, 4.2 percent in Australia, and 70.8 percent in Europe. In Table 1, some of the agencies' more noteworthy characteristics are shown.

Fifty-four percent of the HTA Agencies are governmental Institutions (83.3 percent are supported by central government funding), while 62.5 percent have relationships with health-related Governmental Institutions. It is interesting to note that 91.7 percent and 8.3 percent have an interface with Central and Regional Government, respectively, 20.8 percent with universities, 16.7 percent with healthcare professionals, and 8.3 percent with patients' organizations or industries.

Seventy-one percent of the Agencies reported that their decisions are not prescriptive, while for 20.8 percent and 8.3 percent of them declared that this was the case totally or partially, respectively, especially for the governmental HTA, American Agencies, and in countries with a private insurance system (66.7 percent). Incidentally, it must be noted all the organizations describing their reports as prescriptive were set up during the years 1995–2000.

In terms of the full-time Agencies' workforce (Table 2), most of them are of medium (6–15) or large size (>50), 27.3 percent, while 18.2 percent of the Agencies employed 31–50 personnel and Agencies with 1–5 and with 16–30 employees represent 13.6 percent of the agencies surveyed each. There are no substantial differences in the proportions between governmental and non governmental Agencies ($p = .827$), between Europe and America ($p = .739$), between countries with different health systems ($p = .253$), and with different GDP per capita ($p = .855$). Statistically significant differences emerged for the pattern of part-time consultants between continents, with Europe showing a strong propensity to have more consultants ($p = .030$). Moreover, health systems based on social insurance schemes tended to en-

gage the largest number of full-time and part-time personnel/consultants (>50 individuals: 44.4 percent; $p < .005$).

Seventeen agencies (70.8 percent) stated that they work on multiannual programs (77 percent for governmental HTA Agencies and 100 percent for those surveyed in America), and the assessments undertaken relates mainly to diagnostic procedures (85.7 percent; 91 percent for governmental HTA Agencies) and pharmaceuticals (25 percent; 30 percent in Europe).

The most common form of dissemination of results is by means of paper report (91.7 percent, with no statistically significant difference between any of the groups), followed by Web sites (16.7 percent, less frequent for nongovernmental Institutions, 9 percent, and social insurance health systems, 11.1 percent) and seminars to experts within the related fields (12.5 percent). The newsletter and media tools are mainly used by HTA Agencies in countries with Social insurance health Systems (66.7 percent and 77.8 percent, respectively).

As far as the annual budget is concerned, the most agencies receive funding that is less than 1 million euro (29.2 percent, mostly in Europe, in countries with social insurance and with a GDP per capita <US\$31,300), followed by 7–14 million euro (20.8 percent) and 1–3 million euro. Only 8.3 percent of HTA agencies (all European) have an annual budget over 14 million euro. Countries with social insurance health systems and National Health Services show the highest prevalence of annual budgets. It is interesting to underline that 60 percent of the HTA Agencies in countries with a GDP per capita over US\$31,300 have an annual budget under US\$7 million.

DISCUSSION

Within the healthcare services of many countries, HTA is playing a key role, even if different aims and areas of applications are evident (7). The comparative analysis of HTA Agencies showed that governmental and American Agencies have a profound impact on the prescriptiveness of their assessment, especially those set up in the late 1990s, and this could be linked to the fact that these types of agencies work on multiannual programs. Another explanation related to this finding is that in several cases the agency's formal date of birth does not reflect the existence of previously established HTA units. In those cases, there is a longer history of health technology assessment and appraisal activities, and this may have pressed health policy makers to create an independent structure with some regulatory powers. Interestingly, this situation is different from that found in the mid 1990s. In fact, Perry and Thamer (16) presenting the results of the first comprehensive international survey to catalogue health technology assessment (HTA) activities, highlighted that HTA in the USA was decentralized, fragmented, and duplicative, while in Europe the countries generally had one or two federal or provincial HTA programs each, and in Canada there was an extensive network of federal and regional organizations

Table 1a. Main Characteristics of the Participating HTA Agencies

Name	Country	Governmental institution	Relationship with health-related governmental institutions	Prescriptiveness of decision/conclusions	Year of birth	Main competence areas	Full-time workforce	Part-time workforce	Products	Sources of Funding	Annual budget
Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS)	Canada	Yes	Yes	No	1988	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh, Telem	6–15	31–50	TAR, technical notes, preliminary reports	Central government	1–3 M€
Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S)	Australia	No	Yes	No	1998	DP, Th, Prof, MD, Equ, Inst	6–15	6–15	TAR horizon scanning reports, audit reports	Central government	<1 M€
Catalan Agency for Health Technology Assessment and Research (CAHTA)	Spain	Yes	Yes	No	1995	Web	31–50	6–15	TAR bulletins methods & guidelines	Regional government external funds (grants or contracts with private organizations)	1–3 M€
Center for Medical Technology Assessment, Dept. of Health and Society	Sweden	Yes	No	Yes, partially	1985	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh	16–30	1–5	TAR bulletins	Regional government	<1 M€
DSI Danish Institute for Health Services Research	Denmark	No	Yes	No	1975	Th, Prof, EE, Prev	31–50	6–15	TAR journal articles	Regional government, organizations that contract projects	<1 M€
Finnish Office for Health Care Technology Assessment (FinOHTA)	Finland	Yes	Yes	No	1995	DP, Th, MD, GS, Reh	15		Full reports, a popular journal, scientific articles in peer-reviewed journals	Central and regional government, scientific organizations	1–3 M€
Health Council of the Netherlands (Gezondheidsraad)	Netherlands	No	Yes	No	1992	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh, Alter		>300	Technology Assessment Reports	Central government	4–6 M€
Unit of Health Economics and Health Technology Assessment Corvinus University of Budapest	Hungary	Yes	No	Yes, totally	2000	Th	1–5	1–5	Bulletins	Central government	

HTA Agencies: international comparison

Table 1a. Continued

Name	Country	Governmental institution	Relationship with health-related governmental institutions	Prescriptiveness of decision/conclusions	Year of birth	Main competence areas	Full-time workforce	Part-time workforce	Products	Sources of Funding	Annual budget
Health Technology Assessment group of Institute of Applied Health Sciences, University of Aberdeen	Scotland	No	No	No	2000	DP, Th, MD, Screen	1–5	6–15	Technology assessment reports		<1 M€
HTA-Unit at the Institute of Technology Assessment at the Austrian Academy of Sciences	Austria	No	No	No	1990	Th, Prof, MD, GS, EE	1–5	1–5	Bulletins	Industry/industry associations	
National Coordinating Centre for Health Technology Assessment University of Southampton	England	No	Yes	No	1996	Web	16–30	16–30		Central government	7–14 M€
Norwegian Health Services Research Centre. HTA, Reviews and Dissemination Department	Norway	Yes	Yes	No	1998	Th, Prof, Prev	>50	101–150	Methods & guidelines		7–14 M€
Swiss Centre for Technology Assessment	Switzerland	Yes	No	No	1992	DP, Th	6–15	6–15	Technology assessment reports	Regional government	<1 M€
DACEHTA (Danish Centre for Evaluation and Health Technology Assessment)	Denmark	Yes	Yes	No	1997	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh	16–30	16–30	Technology assessment reports	Academic	4–6 M€
Alberta Heritage Foundation for Medical Research	Canada	No	Yes	Yes, totally	1995	DP, Th, MD, EE, Reh	6–15	16–30	informal - unpublished - papers	Central government	<1 M€
Canadian Coordinating Office for Health Technology Assessment	Canada	No	Yes	No	1989	DP, Th, MD, EE, Telem	>50	1–5	Technology Assessment Reports	Central government	7–14 M€
Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Coverage and Analysis Group CMS	USA	Yes	No	Yes, partially	1965	DP, Th, MD,	31–50	1–5	Technology Assessment Reports	Regional government	1–3 M€

Health Care Insurance Board	Netherlands	Yes	Yes	No	1949	DP, Th, MD, EE	>50	>300	Bulletins	Industry/industry associations	<1 M€
National Horizon Scanning Centre	England	No	No	No	1998	Th	6–15	6–15	Technology Assessment Reports	Central government	>14 M€
National Institute for Clinical Excellence	England	No	Yes	Yes, totally	1999	DP, Th, Surg, EE	>50	0	Bulletins	Central government	>14 M€
ANAES (Agency for accreditation and evaluation in health care)	France	Yes	Yes	Yes, totally	1996	DP, Th, Prof, MD, Equ, EE, Screen	>50	>300	Technology Assessment Reports	Central government	>14 M€
ZonMw	Netherlands	No	No	No	1999	DP, Th, Prof, EE	>50	>300	Bulletins	Regional government	7–14 M€
The Swedish Council on Technology Assessment in Health Care	Sweden	Yes	No	No	1987	DP, Th, Prof, MD, EE, Prev, Reh, Altern	31–50	300	Bulletins	Industry/industry associations	7–14 M€
VA Technology Assessment Program	USA	Yes	Yes	Yes, totally	1994	Web	6–15	31–50	Methods & guidelines		1–3 M€

DP, diagnostic procedures; Th, professional practices; MD, medical devices; Equ, equipment and facilities; Inst, instruments; GS, genetic screening; EE, organizational & economical evaluation; Prev, styles of life and prevention; Reh, rehabilitation; Altern, alternative treatments; Pharm, pharmaceuticals; TAR, Technology Assessment Reports; Telem, telemetry; VA, Veterans Administration; Surg, surgery.

coordinated by a central body. The impact of HTA at the policy level could be seen especially when the HTA agency makes a technology assessment “whose target audience is the same as those making the request” (9;10;18).

European and American HTA Agencies have many similarities as far as the type of assessments undertaken, funding, and the dissemination of their results are concerned. A common point across all of the agencies is the care reserved to the point of independence of evaluation. Even if this question could be divided into two parts, one regarding the independence of the organization (especially financially), and the other relating to the organization’s researcher objectiveness, it remains that all of the Agencies are faced with the same issue of being able to declare themselves as “independent” organizations (where the stated independency can be seen as financial, hierarchical, or both); Banta and Jonsson (1), in their commentary to the study of Battista, show that this point is crucial, witnessing that national HTA agencies realized that sitting within the Ministry of Health is not a good long-term solution. A better way of making HTA, at the national level, would be to have independent programs, even if funded by public money, such as the Swedish Council for Health Care Technology Assessment (SBU) and the Catalan Agency for Health Technology Assessment (CAHTA).

Most Agencies ask for a statements regarding conflicts of interest to be given by participants to the process evaluators. Additionally, strictly relating to the issue of independence is the choice of the evaluation topic: this question has no common answer, because many agencies undertake evaluations using stakeholder commissions (typically government), but it is also suggested in the research that this could also be undertaken by internal boards, and other sources.

The impact of HTA on policies and technology diffusion could be interesting. A study conducted by Jacob and McGregor (9) in Canada reported, using documents, interviews, questionnaires, and the use of data banks, that there was evidence that all but three reports influenced policy and that cost-minimization studies caused savings of between \$16 million and \$27 million annually. On the other hand, we have to recognize, as suggested by Draborg et al. (5), that policy recommendations are only present in approximately half of the HTA reports and that if collaborations between the hospitals and the HTA agencies exist, then they could favor the integration of recommendations into practice (6).

Banta and Oortwijn (2) state HTA has been institutionalized in several Member States of the European Union and has a growing impact on health policy. The recently constituted HTA-European Network (EUnetHTA, European network for Health Technology Assessment) has the aim of more effectively using the national resources put into HTA, through the better coordination of HTA activities resulting in less duplication, and responding to the urgent need for the establishment a sustainable European network for HTA (Report of the EU Commission’s High Level Group on Health Services and Medical Care (HLG) dated 30 November 2004).

Table 1b. Main Characteristics of the Participating HTA Agencies

Name	Country	Governmental institution	Relationships with health-related governmental institutions	Prescriptiveness of decision/conclusions	Year of birth	Main competence areas	Full-time workforce	Part-time workforce	Products	Sources of funding	Annual budget
Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS)	Canada	Yes	Yes	No	1988	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh, Telem	6–15	31–50	TAR, technical notes, preliminary reports	Central government	1–3 M€
Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP–S)	Australia	No	No	No	1998	DP, Th, Prof, MD, Equ, Inst	6–15	6–15	TAR, horizon scanning reports, audit reports	Central government	<1 M€
Catalan Agency for Health Technology Assessment and Research (CAHTA)	Spain	Yes	Yes	No	1995	web	31–50	6–15	TAR bulletins methods&guidelines	Regional government external funds (grants or contracts with private organizations)	1–3 M€
Center for Medical Technology Assessment, Dept. of Health and Society	Sweden	Yes	No	Yes, partially	1985	DP, Th, Prof, MD, Equ, EE, Prev, Reh	16–30	1–5	TAR bulletins	regional government	<1 M€
DSI Danish Institute for Health Services Research	Denmark	No	Yes	No	1975	Th, Prof, EE, Prev	31–50	6–15	TAR journal articles	Regional government, organizations that contract projects	<1 M€
Finnish Office for Health Care Technology Assessment (FinOHTA)	Finland	Yes	No	No	1995	DP, Th, MD, Reh	15		Full reports, a popular journal, scientific articles in peer-reviewed journals	Central and regional government, scientific organizations	1–3 M€
Health Council of the Netherlands (Gezondheidsraad)	Netherlands	No	No	No	1902	DP, Th, Prof, MD, Equ, Inst, GS, EE, Prev, Reh, Altern, ME, HL		>300	TAR bulletins	Central government	4–6 M€
Unit of Health Economics and Health Technology Assessment Corvinus University of Budapest	Hungary	Yes	No	Yes, totally	2000	Th	1–5	1–5	TAR bulletins; methods & guidelines	Central government; industry/industry associations	<1 M€

Health Technology Assessment group of Institute of Applied Health Sciences, University of Aberdeen	Scotland	No	No	No	2000	DP, Th, MD, SCR	1–5	6–15	Technology Assessment Reports	Central government	<1 M€
HTA-Unit at the Institute of Technology Assessment at the Austrian Academy of Sciences	Austria	No	No	No	1990	Th, Prof, MD, GS, EE	1–5	1–5	Technology Assessment Reports	Regional government	
National Coordinating Centre for Health Technology Assessment University of Southampton	England	No	Yes	No	1996	web	16–30	16–30	Technology Assessment Reports	Central government	7–14 M€
Norwegian Health Services Research Centre. HTA, Reviews and Dissemination Department	Norway	Yes	Yes	No	1998	Th, Prof, Prev	>50	101–150	TAR bulletins	Central government	7–14 M€
Swiss Centre for Technology Assessment	Switzerland	Yes	No	No	1992	DP, Th	6–15	6–15	TAR bulletins	Central government	<1 M€
DACEHTA (Danish Centre for Evaluation and Health Technology Assessment)	Denmark	Yes	Yes	No	1997	DP, Th, Prof, EE, Prev, Reh	16–30	16–30	TAR bulletins; methods & guidelines	Central government	4–6 M€
Alberta Heritage Foundation for Medical Research	Canada	No	Yes	Yes, totally	1995	DP, Th, MD, EE, Reh	6–15	16–30	TAR bulletins	Regional government	<1 M€
Canadian Coordinating Office for Health Technology Assessment	Canada	No	Yes	No	1989	DP, Th, Prof, MD, EE, Equ, Pharm	>50	1–5	TAR bulletins; methods & guidelines	Central and regional government, scientific organization	7–14 M€
Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Coverage and Analysis Group CMS	USA	Yes	No	Yes, partially	1965	DP, Th, MD	31–50	1–5	Decisions	Central government	1–3 M€

Table 1b. Continued

Name	Country	Governmental institution	Relationships with health-related governmental institutions	Prescriptiveness of decision/conclusions	Year of birth	Main competence areas	Full-time workforce	Part-time workforce	Products	Sources of funding	Annual budget
Health Care Insurance Board	Netherlands	Yes	Yes	No	1949	DP, Th, MD, EE		>300		Central government	
National Horizon Scanning Centre	England	No	No	No	1998	Pharm	6–15	6–15	Horizon scanning technology briefings	Central government	<1 M€
National Institute for Clinical Excellence	England	No	Yes	Yes, totally	1999	DP, Th, Prof, EE	>50	0	Technology appraisals, clinical guidelines, assessments of the safety and efficacy of interventional procedures.	Central government	>14 M€
ANAES (Agency for accreditation and evaluation in health care)	France	Yes	Yes	Yes, totally	1996	DP, Th, Prof, MD, Equ, EE, Screen	>50	>300	Technology Assessment Reports	Central government	>14 M€
ZonMw	Netherlands	No	No	No	1999	DP, Th, Prof, EE	>50	>300	Bulletins	Regional government	7–14 M€
The Swedish Council on Technology Assessment in Health Care	Sweden	Yes	No	No	1987	DP, Th, Prof, MD, EE, Prev, Reh, Altern	31–50	300		Industry/industry associations	7–14 M€
VA Technology Assessment Program	USA	Yes	Yes	Yes, totally	1994	Web	6–15	31–50	Methods & guidelines		1–3 M€

DP, diagnostic procedures; Th, professional practices; MD, medical devices; Equ, equipment and facilities; Inst, instruments; GS, genetic screening; EE, organizational & economical evaluation; Prev, styles of life and prevention; Reh, rehabilitation; Altern, alternative treatments; Pharm, pharmaceuticals; TAR, Technology Assessment Reports; Telem, telemetry; VA, Veterans Administration.

Table 2. Type of Dissemination, Budget, and Workforce of HTA Agencies, According to Type of Institution, Continent, GDP, and Type of Health System

Type of dissemination	Type of institution		Continent		GDP per capita		Type of health system		
	Governmental	Not governmental	Europe	America	<US\$31.300	>US\$31.300	Medicare	NHS	Social insurance
Paper reports	92.3%	90.9%	88.2%	100%	100%	86.7%	100%	91.7%	88.9%
Web site	23.1%	9.1%	17.6%	16.7%	22.2%	13.3%	33.3%	16.7%	11.1%
Newsletter	38.5%	63.6%	52.9%	33.3%	66.7%	40%	33.3%	41.7%	66.7%
Media	61.5%	54.5%	58.8%	50%	66.7%	53.3%	66.7%	41.7%	77.8%
Research presentation	23.1%	0%	11.8%	16.7%	22.2%	6.7%	33.3%	16.7%	0%
Type of budget	Governmental	Not governmental	Europe	America	<31.300 \$	>31.300 \$	Medicare	NHS	Social insurance
<1 million €	15.4%	45.5%	29.4%	16.7%	11.1%	40%	33.3%	33.3%	22.2%
1–3 million €	30.8%	0%	11.8%	33.3%	22.2%	13.3%	33.3%	16.7%	11.1%
4–6 million €	7.7%	9.1%	11.8%	0%	11.1%	6.7%	0%	8.3%	11.1%
7–14 million €	15.4%	27.3%	17.6%	33.3%	22.2%	20%	0%	8.3%	22.2%
>14 million €	7.7%	9.1%	11.8%	0%	11.1%	6.7%	0%	8.3%	11.1%
Not reported	23.1%	9.1%	17.6%	16.7%	22.2%	13.3%	33.3%	8.3%	22.2%
Full-time workforce	Governmental	Not governmental	Europe	America	<31.300 \$	>31.300 \$	Medicare	NHS	Social insurance
1–5	7.7%	18.2%	23.5%	0%	11.1%	13.3%	0%	16.7%	11.1%
6–15	15.4%	27.3%	11.8%	33.3%	11.1%	33.3%	33.3%	16.7%	33.3%
16–30	15.4%	9.1%	11.8%	16.7%	11.1%	13.3%	0%	25%	0%
31–50	23.1%	9.1%	17.7%	16.7%	22.2%	13.3%	33.3%	25%	0%
>50	23.1%	27.3%	29.4%	16.7%	33.3%	20%	0%	16.7%	44.4%
Not respondent	7.7%	9.1%	5.9%	16.7%	11.1%	6.7%	33.3%	0%	11.1%
Part-time/consultant workforce	Governmental	Not governmental	Europe	America	<31.300 \$	>31.300 \$	Medicare	NHS	Social insurance
1–5	23.1%	18.2%	17.6%	33.3%	22.2%	20%	33.3%	16.7%	22.2%
6–15	15.4%	36.4%	29.4%	0%	11.1%	40%	33.3%	41.7%	11.1%
16–30	7.7%	18.2%	5.9%	33.3%	0%	20%	0%	16.7%	11.1%
31–50	7.7%	0%	0%	16.7%	0%	6.7%	0%	0%	11.1%
>50	30.8%	18.2%	35.3%	0%	55.6%	6.7%	0%	16.7%	44.4%
Not respondent	15.4%	9.1%	11.8%	16.7%	11.1%	6.7%	33.3%	8.3%	0%

HYA, health technology assessment; GDP, gross domestic product; NHS, National Health Service.

But on the other hand, there is a strong need to strengthen the link between HTA and healthcare policy making, taking into account the support needed by countries with limited experience in HTA (14;19), and to integrate the sociopolitical dimensions of healthcare technologies into assessments (11).

Finally, we have to take into account, as pointed out by Hivon and colleagues (8), that significant organizational, scientific, and material limitations hinder the use of scientific evidence. From this viewpoint, to ensure better uptake of HTA and to avoid the situation whereby the influence of HTA on policy making remains marginal (15), it should become a shared responsibility between HTA producers and all of the various types of users.

CONTACT INFORMATION

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