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HEALTH TECHNOLOGY REASSESSMENT: SCOPE, METHODOLOGY, & LANGUAGE

Health systems are challenged continuously to provide the highest quality universal health care within their means. While for 30 years, health technology assessment (HTA) has contributed to the process of evidence-informed decision making and the managed entry of new technologies, its remit has not expanded to include assessment of technologies currently in use, as a means of managing their use and potentially their exit. We propose that health technology reassessment (HTR) become standard practice, an integral part of all health technology assessment agencies, and that we develop standardized models and methodologies for reassessment drawing from what we have learned from HTA.

The goals of HTA and HTR are the same: the optimal use of health technologies. In both cases, "optimal" refers to the proposition of value for money of technologies. However, HTR distinguishes itself by its concern with technologies currently in use, and particularly, their scope of use. Accordingly, we propose this definition of HTR: "a structured, evidence-based assessment of the clinical, social, ethical, and economic effects of a technology currently used in the healthcare system, to inform optimal use of that technology in comparison to its alternatives."

Surveying our contacts, in an effort to determine who is engaged in HTR, it would appear that at least eight countries are involved in such work, with the first program starting in the United Kingdom in 2002, as well as foundational work done in Spain and Australia. Despite this, there are still no published and widely accepted models or methodologies for HTR. Until recently, there has been little international discussion or knowledge exchange targeting these shared cross-border issues. With the fiscal challenges facing all publicly funded healthcare systems, it can be expected there will be a substantial increase in interest, research, and policy formulation in this field and in the near future.

There can be much to learn from other industries that have been constantly facing reassessment, such as information and communication technologies, which have developed deliberate and sound methodological approaches. Reassessment in pharmaceuticals also offers lessons for reassessment of nonpharmaceutical technologies.

Broadly speaking, a HTR starts with a demonstrable opportunity to reduce waste and eliminate obsolescence, not only of that technology, but in the way that technology is used in practice. Once a technology's use is diffused, the intended use of a technology broadens in scope, which is not always based on sound clinical or cost-effectiveness evidence. This scope creep may permit over-use, under-use, misuse of technologies, or an unjustifiable scope of use, which is potentially amenable to practice and policy alterations. Identification, priority-setting, and reassessment methodology has to be applied to the specific policy/practice in question. The outcome of the reassessment is meant to influence policy/practice toward optimal use of that technology.

While HTR is based on principles and methods of HTA, the methodology has to go further to account for the reality that the technologies being assessed are in current use. Hence, they have a cadre of users and recipients, who would be expected to have perspectives on that technology. These perspectives may include an assumption of benefit for patients; or alternatively, a source of income, identity, stature, or autonomy for the provider of care. Accordingly, the potential of reduced use, or decommissioning and disinvestment, portends controversy and disentitlement, likely to evoke resistance. This, in turn, may influence the methodology of reassessment, which has to include a realistic assessment of feasibility; and, a robust analysis of consequences, intended and unintended, some desirable and some not.

This field has had excellent and foundational groundwork done but usually conducted and described as "disinvestment." We would propose that "disinvestment" is not a preferred term; any more than "investment" is the correct label for HTA of new technologies. Disinvestment may be seen by some as polarizing and pejorative, determining the outcome of reassessment before it is complete. This may act as a substantial barrier to enlisting the support of clinicians in identifying and eliminating waste, and to adopting reassessment practices as integral to optimal technology utilization.

Preferably, the outcome of HTR, beyond optimizing a technology's use, is a sensible, well-managed reinvestment program. This would entail a cost-accounting process to capture, and a financial strategy and analysis to return, a pre-agreed portion of real savings. This offers a means of incenting those who provide health care to seek and find waste and obsolescence in technologies, and their uses—hence, Health Technology Reassessment & Reinvestment.

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CONFLICT OF INTEREST

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