



eunethta

# Survey report on HTA organisations

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## INTRODUCTION

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The institutionalization of Health Technology Assessment (HTA) has become a subject of discussion of the World Health Organisation (WHO). The experiences and options for institutionalizing HTA in different countries and health systems were explored and moreover, its further development encouraged during a meeting in 2000 convened by the WHO Regional Office for Europe. The institutionalization of HTA had been defined in that context as “promoting the structures and processes suitable to produce technology assessments that will be powerful in guiding policy and clinical practice towards the best possible health and cost outcomes”<sup>1</sup>.

In the past, HTA activities were described by a few research projects. **Perry et al. (1997)** examined worldwide HTA activities by means of an international survey conducted in 1994 and 1995, indicating that HTA organisations in the public sector have proliferated in industrialized nations, especially outside the United States, and further, that a greater diversity of public and private sector organisations have integrated HTA into their health care decision-making process<sup>2</sup>. In 2000 the **National Institute for Clinical Excellence (NICE)** reviewed the status of International Health Technology Assessment (IHTA). This project aimed to assess the work of not-for-profit organisations involved in HTA and its impact upon health care decisions and indicated that there are common methodological aspects to HTA, regardless of geographical or political barriers<sup>3</sup>. On behalf of the WHO, the Catalan Agency for Health Technology Assessment (CAHTA) provided an overview in 2002 of the implementation activities related to evidence based practice in a broad representation of world health organisation-collaborating centers<sup>4</sup>.

Even though HTA is in the process of becoming established and institutionalized both in individual countries and at the international level<sup>5</sup> the majority (70%) of the total number of countries in the European region, and more than a half of European Union (EU) countries do not have formal HTA yet (**Table 1**). This table shows the countries with and without HTA agencies that are a member of the International Network of Agencies for Health Technology Assessment (INAHTA), which is regarded as an indicator of a considerable stage of the institutionalization process. The INAHTA membership implies that the organisation was non-for-profit, relates to a regional or national government and funded at least 50% by public sources<sup>6</sup>.

**Table 1. Status of formal HTA in European Countries (May 2007)\***

EU Countries		EU Candidate Countries	Potential EU Candidate Countries	Other European Countries	
<i>With formal HTA (n=13)</i>	<i>Without formal HTA (n=14)</i>	<i>Without formal HTA (n=3)</i>	<i>Without formal HTA (n=4)</i>	<i>With formal HTA (n=2)</i>	<i>Without formal HTA (n=14)</i>
Austria	Bulgaria	Croatia	Albania	Norway	Andorra
Belgium	Cyprus	Macedonia	Bosnia-Herzegovina	Switzerland	Armenia
Denmark	Czech Republic	Turkey	Montenegro		Azerbaijan
Finland	Estonia		Serbia		Belarus
France	Greece				Georgia
Germany	Ireland				Iceland
Hungary	Italy				Kazakhstan
Latvia	Lithuania				Liechtenstein
Netherlands	Luxembourg				Moldova
Poland	Malta				Monaco
Spain	Portugal				Russia
Sweden	Romania				San Marino
United Kingdom	Slovakia				Ukraine
	Slovenia				Vatican

\* Formal HTA: Countries with HTA agencies that are INAHTA members

As HTA agencies and programs have been established, there has been an increasing attention to coordinate HTA activities at European and international level. In Europe this need was subsequently addressed by the following consecutive projects commissioned by the EU: The **EUR-ASSESS project (1994-1997)** disclosed that an efficient system for sharing information and exchanging experiences among those involved in HTA across Europe was needed <sup>7</sup>, the **HTA-Europe project (1997-1999)** further explored this issue and put emphasis on the need of the European Commission's assistance for the establishment of HTA coordinating structures <sup>8</sup>, and the **ECHTA/ECAHI (European Collaboration for Health Technology Assessment/ European Collaboration for Health Interventions) project, (1999-2001)**, concluded that HTA has become "a political priority and there is an urgent need for establishing a sustainable European network on HTA" <sup>9</sup>.

The current **EUnetHTA (European network for Health Technology Assessment) project (2006-2008)**, which is also funded by the EU, bases its work on the results of the previous European projects. It's overall purpose is to establish an effective and sustainable European Network for Health Technology Assessment that informs policy

decisions, and to connect national HTA agencies, research institutions and health ministries, enabling an effective exchange of information and support to policy decisions by Member States. The aims are expected to be achieved by means of eight separately managed work packages (WPs) that the project consists of <sup>10</sup>.

As previously mentioned the number of European countries that do have formal HTA is still limited. Moreover, little is known about the current state of HTA activities, in particular in new European Member States, candidate and potential candidate countries, and other countries in the European region as well as their endeavors towards establishing formal HTA. Knowledge on ongoing activities in the area of HTA as well as the barriers and solutions in both the establishment of the HTA units and in their daily work processes builds the basis for effective measures for its institutionalization. The **work package 8 (WP8)** of the EUnetHTA project, who strives for the development of appropriate support systems for HTA capacity building in countries with limited institutionalization, intends to consider such countries that either do not have formal HTA or are in the process of establishing formalized HTA. To accomplish the final aim of the WP8, which will be the supply of a handbook with practical guidance on HTA capacity building, a literature review was conducted and some meetings with HTA experts and stakeholders were held. In addition, an international survey on HTA organisations <sup>11</sup> was carried out, results of which will be presented in this report.

## **OBJECTIVE**

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The survey conducted within the framework of this WP was designed to gain knowledge on the current state of HTA worldwide and its institutionalization as well as insights in characteristics and processes of such organisations.

## METHODS

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Cross-sectional study by means of a semi-structured questionnaire of HTA organisations. The list of HTA organisations to be included was compiled by merging the information from various sources (that were supposed to be active or involved in HTA): Directory of EUnetHTA partners <sup>10</sup> and INAHTA members <sup>6</sup>; Websites of existing HTA units directories, agencies or programs <sup>12</sup>; Report on overview of the implementation of activities related to evidence based practice in a broad representation of world health organisation-collaborating centers<sup>4</sup>; Project report on the review of International Health Technology Assessment<sup>3</sup> and the 16 papers published as results of an international survey edited by Banta and Oortwijn in 2000<sup>8</sup>. The compilation was inspected for duplication of same HTA organisations due to co-existing old and new names, and English and national language names, respectively. Subsequently, the Internet were searched for the organisations' homepages, further contact data and in order to verify the organisations' involvement in HTA.

Any organisation regardless its location or financial profile (profit/ not-for profit) that were mentioned in one of these sources was included whenever it appeared to be engaged in HTA. Though, organisations without an email address to which the questionnaire could be sent were excluded.

For the purpose of the development of the questionnaire, the instruments of the surveys by NICE<sup>3</sup>, and by the Catalan Agency for Health Technology Assessment and Research (CAHTA), on behalf of the WHO<sup>4</sup> were reviewed and information was to some extent used for the basis.

A dichotomic filter question was integrated asking if the organisation had been performing HTA activities according to the definition given in the questionnaire. Those who declared being involved in HTA activities were invited to complete the survey. Those who answered negatively were requested to return the questionnaire together with the contact details.

In order to ensure that the questions being asked were clear, a pilot survey was conducted in August 2006 with 26 contacts working within HTA. Comments were returned by email and they were related to the format, wording of some questions and the inclusion of some items and a new question asking about the important aspects for the establishment process of a new agency. Comments were considered, consensus was reached and modifications to the questionnaire were made. The questionnaire (See **Appendix 1** and **Table 2**) contained 48 questions incorporated in six different sections with a total of 39 multiple choice and 10 open questions (**Table 2**) and it was sent to 149

institutions (See **Appendix 2**) located in 33 countries. It was administered in November 2006 via email as both a Word document and an Access file.

Reminding was carried out between November 2006 and March 2007 by means of sending emails (two waves to the previous e-mail addresses used) and later a further wave where it was endeavored to address the questionnaires exclusively to the attention of individual persons in charge of HTA in the organisation. Additionally, organisations with uncertainties concerning the e-mail address were phoned.

**Table 2. Structure and content of the Questionnaire**

SECTION	NUMBER OF QUESTIONS <sup>a</sup>	CONTENT
Establishment	5 (2)	Date, Initiative, Reasons, Barriers
Specific background	6 (1)	Profile, Collaborations, Existence of legal act
Aims and scope	9 (1)	Working level, Statutes and Strategies, Activity lines, Assessed technologies, Products and Services, Customers, Recommendations
Structure	9 (1)	Management, Staff (number and background), Facilities, Funding
Work process	15 (4)	Priority setting, Barriers, Assessment criteria, Quality assurance, Impact assessment
Visibility of the outcomes	4 (1)	Dissemination including target users, Important aspects for establishment

<sup>a</sup> The figures in brackets present the respective number of open-ended questions.

Standard descriptive analyses were conducted to characterize the organisations. The institutions were divided into tertiles according to the year of establishment: 1956-1989, 1990-1999 and 2000-2007. Relationships between main barriers, staff and year of establishment were examined using cross-tabulation. Cases with missing values were excluded from the statistical analysis. The response rate was described by geographical regions and by countries. SPSS 15.0 for Windows software was used for the statistical analysis

The content of the open-ended questions was analysed for each question separately through an iterative process of coding and analysis of the coded text. The results section shows either in tables or in comments in the text the results of the responses to the questions included in the questionnaire. All the detailed results are presented in tables and figures in **Appendix 3**. Information collected in the “other specify” category of each multiple choice question is shown in **Appendix 4**.

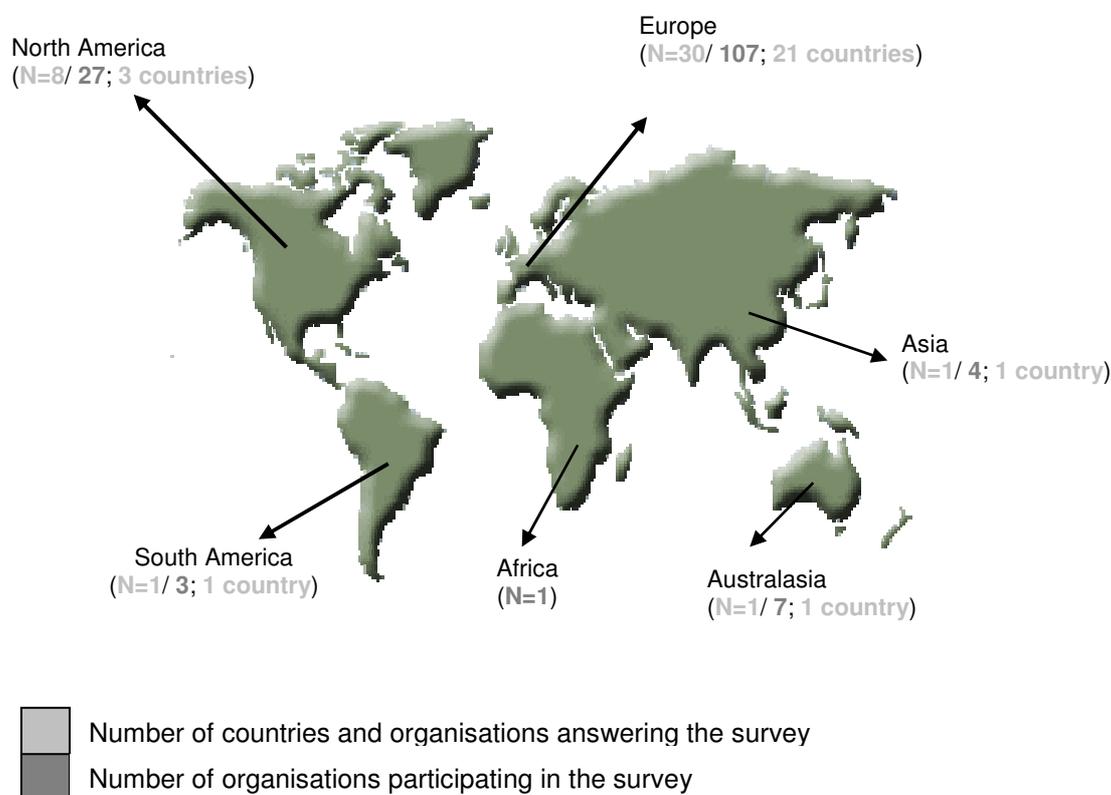
## RESULTS

### *Response rate and sample characteristics*

A total of 52 questionnaires were received representing a 34.8% response rate, including those agencies who replied that they had no involvement in HTA activities. From the fifty-two responses eleven were excluded from the analysis as they reported not being active in HTA activities. These forty-one questionnaires were geographically distributed from Europe (73.1%), North America (19.5%), South America (2.4%), Asia (2.4%) and Australasia (2.4%) (**Figure 1**); representing a total of 27 countries: Austria (2) Australia (1), Belgium (1), Brazil (1), Canada (3), Cyprus (1), Denmark (4), Estonia (1), Finland (1) Germany (6), Greece (1), Hungary (1), Iceland (1), Israel (1), Italy (2), Mexico (2), Netherlands (1), Norway (1), Poland (2), Portugal (1), Romania (1), Slovenia (1), Spain (6), Sweden (1), Switzerland (1), UK (4) and the USA (4).

The results reported in the following sections refer to the remaining 41 questionnaires.

**Figure 1. Response rate by geographical distribution (N=149)**



No answer could be achieved from six European countries (France, Ireland, Latvia, Lithuania, Luxembourg, Russia), three Asian countries (China, Japan, Malaysia), one South American country (Chile), one Australasian country (New Zealand) and one South African country (South Africa), representing a total of 12 countries.

### ***Establishment of the organisation***

The main initiative in the establishment of the organisation was governmental (61.0%) followed by health researchers (29.3%) and decision-makers (health professionals, patient associations, health care managers and professional organisations) (24.4%) (**Table 3**).

**Table 3. Initiative in the establishment of the organisation\***

<b>Initiative in the establishment</b>	<b>N</b>	<b>%</b>
Governmental	25	61.0
Only Governmental	21	51.2
Governmental + (Decision makers** or Health researchers)	3	7.3
Governmental + Decision makers + Health researchers	1	2.4
Health researchers	12	29.3
Only Health researchers	6	14.7
Health researchers + Decision makers	4	9.7
Decision-makers	10	24.4
Only Decision-makers	5	12.2

\*Multiple choice question which allows to select more than one correct answer.

\*\* Decision-makers include health professionals, patient associations, health care managers and professional organisations.

The open-ended question on the main reasons for the establishment of the organisation was answered by 37 participants. Respondents explained predominantly the purposes of the establishment but provided also details on the initiative. Data revealed two types of organisations: those that were established to perform HTA and those that evolved later on their activity in HTA and were originally established for other purposes (**Table 4**).

**Table 4. Main reasons for the establishment of the organisation**

<b>Motives for the establishment</b>	
<b>Performing HTA from the beginning</b>	<b>Performing tasks different from HTA</b>
<b>Specific purposes:</b>	<b>Specific purposes:</b>

To perform research on various health technologies	To perform medical and health research
To perform research on specific health technologies	To perform economic evaluation
To support decision making in health care and promote appropriate resource allocation	To support education in the medical field
To support decision making at organisations' level	To support health care management / health systems management
To promote institutionalisation and capacity building in HTA	To manage health care quality
	To reveal research gaps and ensure that research outcomes are implemented in health services
	To investigate developments having an impact on the society
<b>Other motives:</b>	
Introduction of a law demanding HTA	
Health researchers' initiative	

Respondents provided data on main barriers in the establishment of the organisation; specifically 58% reported having had barriers. The main barriers centred on gathering trained staff (63.6%) and funding (45.5%) (**Table 5**).

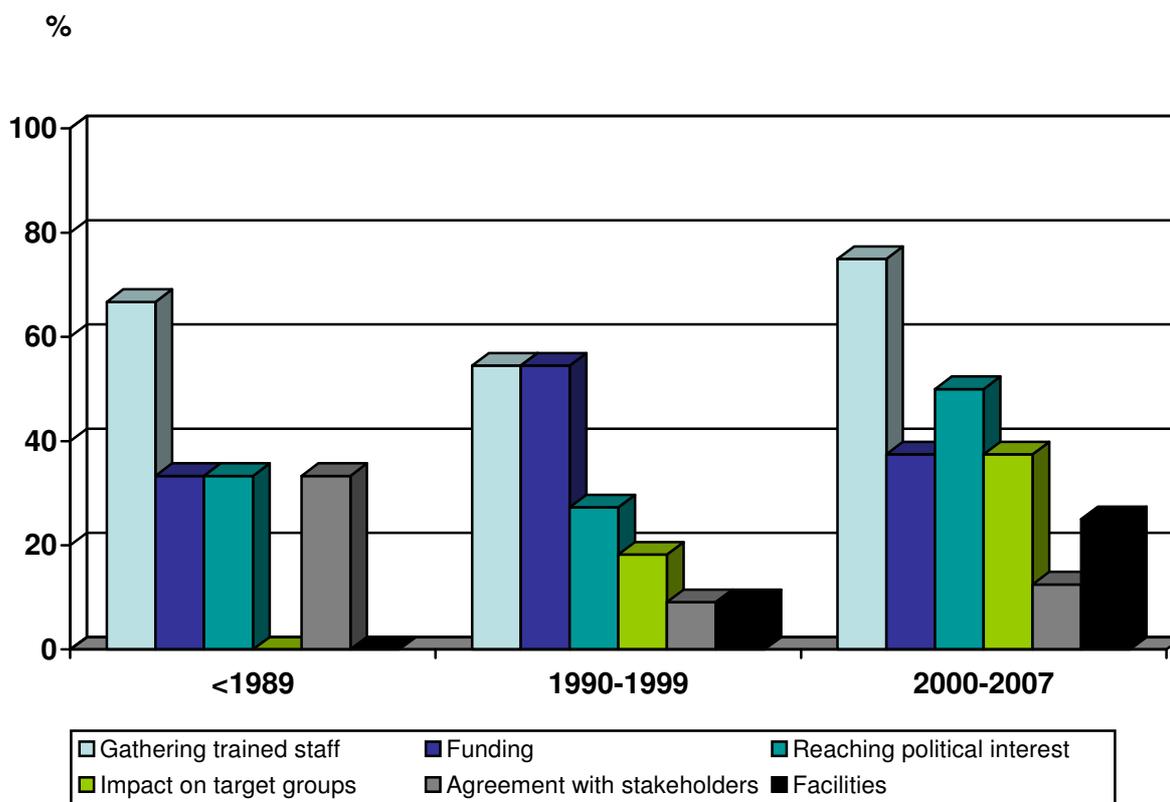
**Table 5. Barriers in the establishment of the organisation\***

<b>Barriers</b>	<b>N</b>	<b>%</b>
Gathering trained staff	14	63.6
Funding	10	45.5
Reaching political interest	8	36.4
Impact on target groups	5	22.7
Agreement with stakeholders	3	13.6
Facilities (building, personal computers)	3	13.6

\*Multiple choice question which allows to select more than one correct answer.

The institutions were divided into 3 groups according to the year of establishment. The relationship between barriers that the institutions experienced and the year of establishment were analysed. “Gathering trained staff” was the most highly ranked by the three groups of agencies. Almost all the categories were ranked higher by the group of youngest agencies (2000-2007) than by the other groups (**Figure 2**).

**Figure 2. Main barriers in the establishment of the organisation according to year of establishment (N=22)**



Of those respondents who experienced barriers, 79% provided solutions that were varying depending on the category. Noteworthy is that “networking, collaboration at different levels, and communication” appeared to be key mechanisms since they were mentioned as an approach for overcoming five of the six barriers. No solution was given to the barrier “facilities” which could be related to the fact that this category was the lowest ranked by all the respondents (Table 6).

**Table 6. Solution to barriers in the establishment of the organisation**

Barrier	Solution of Barriers in the establishment
<b>Gathering trained staff</b>	Provision of training for staff: <ol style="list-style-type: none"> <li>a. Provision of informal training for new or existing staff (by means of staff of the agency or external experts)</li> <li>b. Provision or support of official/ accredited training courses (e.g. master courses)</li> </ol> Intensive efforts for the recruitment of trained staff Collaboration with universities and hospitals
<b>Funding</b>	Commitment to networking and collaboration at all levels Intense activity in attracting various sources of funding (e.g. grants) Taking advantage of political attention towards prioritisation in health care

	Public relations endeavours made participants of trainings by the agency willing to pay them themselves
<b>Reaching political interest</b>	Networking and Collaboration (e.g. hospitals and universities) Communication with all stakeholders Timely and good quality work and products Demonstrating the needs for a HTA agency / Demonstration of the positive impact and advantages of HTA activities
<b>Impact on target groups</b>	Education on positive effects of HTA and Evidence Based Medicine (EBM) by means of communication with target users and stakeholders
<b>Agreement with stakeholders</b>	Networking and dialogue with relevant stakeholders
<b>Facilities*</b>	--

\* No solution was reported on this barrier

Participants considered as the most important aspect in the establishment of the organisation “funding” (**Table 7**) which affirmed the result mentioned previously where “funding” was considered as the second important barrier.

**Table 7. Important aspects in the establishment of the organisation\***

<b>Important aspects</b>	<b>N</b>	<b>%</b>
Funding	22	78.6
Engaged staff	22	78.6
Clear mission	19	67.9
Involvement of system stakeholders	15	53.6
Good anchoring and networking	13	46.4
Political opportunity	13	46.4
Director with a good reputation	11	39.3
Lack of conflict of interest	11	39.3
Education opportunities	5	17.9

\*Multiple choice question which allows to select more than one correct answer.

### ***Specific background, aims and scope of the organisation***

All the organisations were not-for-profit and 42.5% described their profile as Governmental agency and 32.5% as Academia/University. Most of the respondents reported collaboration with other organisations, either at national or international level. They declared to collaborate at national level with academia/university (97.4%) and with other governmental agencies (94.9%). The same pattern of collaboration was shown at international level although with relatively lower percentages (**See Table 6 in Appendix 3**)

Most of HTA organisations worked at national level (85.4%) followed by working at international level (56.1%) and at local-regional level (46.3%). The majority reported having approved statutes (67.6%) and a strategic plan (82.9) (**See Tables 9 and 10 in Appendix 3**).

The main lines of activity of the organisations were HTA (80.5%) followed by performing or doing some kind of research (63.4%) and clinical practice guidelines (36.6%) (**See Table 11 in Appendix 3**). The types of Health Technology (HT) most often assessed were pharmaceuticals (77.5%), medical (or surgical) procedures (75.0%) and medical devices (70.0%) (**Table 8**).

**Table 8. Types of HT that the organisation assess<sup>1,\*</sup>**

Most frequent type of HT assessed	N	%
Pharmaceuticals	31	77.5
Medical (or surgical) procedures	30	75.0
Medical devices	28	70.0
Public Health Interventions	14	35.0
Horizon Scanning System / Early warning/ Emerging technologies/	14	35.0
Support System	11	27.5

<sup>1</sup> The response categories are defined in the questionnaire (See Appendix 1).

\*Multiple choice question which allows to select more than one correct answer.

Assessment reports (97.6%) and academic and training activities (78.8%) were the two types of products that the organisations most frequently produced. The respondents answered that most of them produced recommendations (80.5%) (**See Table 14 in Appendix 3**); the main target people to whom they addressed the recommendations were policy makers (90.9%) and public health care providers (81.9%) (**Table 9**).

**Table 9. Main target people\***

Main target people	N	%
Policy makers	30	90.9
Public health care providers	27	81.8
Health professionals	24	72.7
Compulsory health care insurance (public)	17	51.5
Health researchers	15	45.5
Patients	12	36.4
Private health care providers	9	27.3
Private medical insurance	4	12.1

\*Multiple choice question which allows to select more than one correct answer.

### **Structure of the organisation**

The institutions were organised by having a Director, President or Manager (73.2%) followed by having a scientific or advisory committee (46.3%) (See Table 17 in Appendix 3).

Most organisations in the sample are small organisations (Table 10) and the amount of professionals working in the organisation ranked from 5 to 380 workers (See Table 19 in Appendix 3)

**Table 10. Size of the organisation according to headcount\***

	<b>N (organisations)</b>	<b>%</b>
Micro (<10 workers)	5	12.8
<b>Small (10-49 workers)</b>	<b>27</b>	<b>69.2</b>
Medium (50-249 workers)	6	15.4
Big (>250 workers)	1	2.6

\* Categorization according to the definition of small and medium-sized enterprises of the European Commission

Most organisations had administrative staff (94.6%), collaborating researchers (75.0%), and research assistants (55.9%). There was a wide range of collaborating researchers (from 0 to 150) and administrative staff (from 0 to 200) working in the institutions (Table 11). The median of economist and health service researchers was 1.5, for clinical specialist, information specialist and social scientist was 1 whereas the median for public health specialist was 0.5 and 0 for other specialist professionals such as epidemiologist, statistician, nurse, general practitioner, media professionals and psychologist (Table 12).

The proportion of researchers in the organisation ranked from 21% to 100%; the administrative staff ranked from 0% to 52.6% and the research assistant ranked from 0% to 26.3%. The mean proportions of staff in the organisations were 43.6% researchers, 27.0% administrative staff and 11.7% research assistants. (See Table 20 in Appendix 3)

**Table 11. Profile of the staff<sup>1</sup>**

	<b>HTA organisations according to number of staff</b>				
	<b>N*</b>	<b>Median (range)</b>	<b>None</b>	<b>1- 5</b>	<b>&gt;5</b>
			<b>N (%)</b>	<b>N (%)</b>	<b>N (%)</b>
<b>Internal staff</b>					
Administrative staff	37	2 (0-200)	2 (5.4)	26 (70.3)	9 (24.3)
Research assistant	35	1 (0-100)	15 (42.9)	14 (40.0)	6(17.1)

Trainee	35	1 (0-20)	16 (45.7)	16 (45.7)	3 (8.6)
<b>External staff</b>					
Collaborating researcher	36	8 (0-150)	9 (25.0)	8 (22.2)	19 (52.8)
Advisor	34	5 (0-100)	13 (38.2)	6 (17.6)	15 (44.2)
Associated researcher	35	0 (0-50)	18 (51.4)	8 (22.9)	9 (25.7)

<sup>†</sup> The response categories are defined in the questionnaire (See Appendix 1).

\*Number of respondents replying to each category

**Table 12. Background of the HTA researchers**

Background	HTA organisations according to number of staff				
	N*	Median (range)	None	1- 5	>5
			N (%)	N (%)	N (%)
Clinical specialist	38	1 (0-8)	11 (28.9)	23 (60.5)	4 (10.6)
Economist	38	1.5 (0-11)	12 (31.6)	20 (52.6)	6 (15.8)
Information specialist	38	1 (0-12)	13 (34.2)	23 (60.5)	2 (5.3)
Social scientist	38	1 (0-10)	18 (47.4)	17 (44.7)	3 (7.9)
Health service researcher	38	1.5 (0-43)	18 (47.4)	13 (34.2)	7 (18.4)
Public Health specialist	38	0.5 (0-12)	19 (50.0)	15 (39.5)	4 (10.5)
Epidemiologist	37	0 (0-9)	19 (51.4)	16 (43.2)	2 (5.4)
Statistician	38	0 (0-7)	20 (52.6)	17 (44.7)	1 (2.7)
Nurses/nursing scientist	37	0 (0-29)	22 (59.5)	12 (32.4)	3 (8.1)
General practitioner	37	0 (0-8)	23 (62.2)	13 (35.1)	1 (2.7)
Media professional	37	0 (0-28)	24 (64.9)	11 (29.7)	2 (5.4)
Psychologist	37	0 (0-6)	28 (75.7)	8 (21.6)	1 (2.7)

\*Number of respondents replying to each category

Concerning facilities and equipment available in the organisation the mean of total square meters was 520.20 (SD  $\pm$  844.7) with a range from 0 to 4.000 sqm (**See Table 19 in Appendix 3**)

The funding source of the institution came mainly from the Government (80.5%) followed by the Research funding bodies (46.3%) and private industries (24.4%) (**Table 13**). The private institutions sponsoring HTA activities were the industry (19.5%) and the Research funding bodies (14.6%) (**See Table 23 in Appendix 3**).

**Table 13. Funding source of the organisation for HTA activities**

Source of funding	N	%
Government	33	80.5
Research funding bodies	19	46.3

Private industries (e.g. pharmaceutical industry)	10	24.4
Academia/University	10	24.4
Donor agencies ( foundations, patient associations, charity, others)	7	17.1
Public health care providers	7	17.1
Compulsory health care insurance (public)	6	14.6
Intergovernmental organisation	3	7.3
Private medical insurance	3	7.3
Private health care providers	3	7.3

\*Multiple choice question which allows to select more than one correct answer.

### ***Work process of the organisation***

The main responsibility for setting priorities in the organisation was with the Department/Ministry of Health (53.7%) followed by the Director (43.9%) and the Executive Board (29.3%) (**See Table 24 in Appendix 3**). About 52.3% of the organisations used an explicit process for priority setting and the main criteria used to set priorities were Burden of disease (85%) and the frequency of the clinical condition (85%) (**See Table 26 in Appendix 3**). The mechanisms available for the organisation to set priorities are shown in **Table 14**.

**Table 14. Sources available for the organisation to set priorities\***

<b>Available priority sources</b>	<b>N</b>	<b>%</b>
Policymakers/Government representatives	19	54.3
Experts on specific topics	17	48.6
Health care professionals	15	42.9
Patient representatives	5	14.3
Health care insurance (private or public)	3	8.6
Industries, manufacturers	3	8.6

\*Multiple choice question which allows to select more than one correct answer.

“Gathering trained staff” (51.3%) and “funding” (48.7%) were the main barriers that the organisations found in their daily work followed by “achieving impact on target groups” (**Table 15**).

**Table 15. Barriers in the daily work of the organisation**

<b>Main barriers in Daily work</b>	<b>N</b>	<b>%</b>
Gathering trained staff	20	51.3
Funding	19	48.7
Impact on target groups	16	41.0

Reaching political interest	10	25.6
Agreement with stakeholders	6	15.4
Facilities (building, personal computers)	5	12.8

\*Multiple choice question which allows to select more than one correct answer.

Of those respondents who reported experiencing barriers in daily work, a total of 37 provided data on how they intended to overcome them. Participants considered both the provision of internal training for the organisation's staff and support of external trainings as essential for sorting out the problem of lack of trained personnel. Concerning the barrier "funding" respondents declared that networking and collaboration (especially at international level) and also fundraising activities were two ways of overcoming this barrier. Besides, emphasis was placed on not being dependent on a single source of funding (**Table 16**).

**Table 16. Specific solution to barriers in daily work**

<b>Barrier</b>	<b>Solution of Barriers in Daily Work</b>
<b>Gathering trained staff</b>	Internal training of existing or newly hired staff (partly by external experts) Support or contribute to external training programs Intense endeavours in searching for trained staff
<b>Funding</b>	Great efforts to achieve funding from various sources through fundraising activities Intense networking and collaboration in particular at international level Advertisement of the potential benefits of the HTA agency
<b>Impact on target groups</b>	Increase of budget for and efforts in dissemination activities Communication and collaboration with external and internal experts and stakeholders Ambitions for changes in politics fostering the HTA institutionalisation in the Health Care System
<b>Reaching political interest</b>	Attempts to influence politicians and their advisors in a way that facilitates operation of the agency Establishment of contacts to key persons Active dissemination and communication
<b>Disagreement with other stakeholders</b>	Public Relations activities by means of communication, collaboration and publications
<b>Facilities</b>	Approaching potential stakeholders

The main issues that the organisation took into account in the assessment of HT were mainly the “efficacy/effectiveness” (95.1%) followed by “economic implications” (78.0%) (Table 17).

**Table 17. Issues taken into consideration in the assessment of HT<sup>1,\*</sup>**

<b>Issues considered in the assessment of HT</b>	<b>N</b>	<b>%</b>
Efficacy/effectiveness	39	95.1
Economic implications (budget impact)	32	78.0
Service requirements/ organisational implications	30	73.2
Safety	30	73.2
Economic evaluation	30	73.2
Equity	21	67.7
Ethical	25	61.0
Medical practice patterns	25	61.0
Social/cultural	21	51.2
Legal	18	43.9
Patient preferences	16	39.0

<sup>1</sup> The response categories are defined in the questionnaire (See Appendix 1).

\* Multiple choice question which allows to select more than one correct answer.

The “internal review of the reports” (92.7%) and the “external review of the reports” (78.0%) were the most used services in order to ensure the quality of the products (**See Table 29 in Appendix 3**).

The impact assessment of the recommendations were assessed occasionally (45.7%) and frequently (45.7%) and most of the organisations (69.7%) did not included indicators to assess the products impact. (More results on questions about recommendations in **Appendix 3**).

Twenty-six participants commented on the importance of the impact assessment and reported on their practice and intentions concerning impact assessment. Mentioned reasons for not assessing the impact were lack of financial resources, restrictions in the responsibilities as well as difficulties in the performance of impact assessment e.g. due to a lack of time (**Table 18**).

#### **Table 18. Attitude concerning impact assessment of recommendations**

Impact Assessment	
<b>Appraisals of the significance</b>	<p><u>Positive attitude</u> Eight comments supported the necessity of the performance of impact assessment Appraisals ranged from “useful”, “desirable”, “important” to “central”</p> <p><u>Sceptical attitude</u> Three sceptical comments ranged from “complicated, “problematic” to “very costly”.</p>
<b>Past and current practice</b>	<p>Six organisations described their approach in assessing the impact. The applied criteria were:</p> <ul style="list-style-type: none"> <li>- Approval of technologies</li> <li>- Presence in media</li> <li>- Web page downloads</li> <li>- Surveys of usage</li> <li>- Renewal of work commissions</li> </ul>
<b>Ambitions for the future</b>	<p>Four organisations planed to conduct impact assessment in future or to expand their activities.</p>
<b>Perceived barriers</b>	<p>Eight organisations revealed the barriers they perceive. Reasons for reluctance in assessing the impact related to:</p> <ul style="list-style-type: none"> <li>- Deficits in <i>funding</i></li> <li>- Limitations in the <i>responsibilities</i></li> <li>- Difficulties in the <i>performance</i> of impact assessments itself</li> </ul>

### ***Visibility of the organisation***

Respondents commented that they had a formal procedure to distribute their products (75%) and the methods or activities to distribute them were the website (92.3%), participation and organisation of academic, scientific and training activities (84.6%) and electronic and printed versions of reports (79.5%) (**See Table 37 in Appendix 3**). They specified their dissemination procedures by elaborating on the selection of the strategies, giving more information on who is responsible for the dissemination, the means and media, and groups they address with their distribution activities (**Table 19**).

**Table 19. Procedures of the organisation to disseminate the products**

<b>Procedure for Dissemination</b>	
<b>Strategy Selection</b>	<ul style="list-style-type: none"> <li>- Tailored strategy according the product to be disseminated</li> <li>- Certain products are disseminated by another / superior institution</li> </ul>
<b>External Disseminators</b>	<ul style="list-style-type: none"> <li>- Superior (governmental) institution</li> <li>- Commissioning agency</li> </ul>
<b>Methods</b>	<p>Passive Methods:            Provision of outcomes (reports, publication, etc) through</p> <ul style="list-style-type: none"> <li>- <i>print material</i></li> <li>- <i>via electronical media</i></li> </ul> <p>Active Methods:            Sending selected outcomes (reports, newsletter, publications etc) to certain key person and target groups</p> <ul style="list-style-type: none"> <li>- <i>print material</i></li> <li>- <i>via electronical media</i></li> </ul> <p>Participation in academic and educational activities            Informal and formal meetings with key persons and stakeholders</p>
<b>Target Groups</b>	<ul style="list-style-type: none"> <li>- “professionals and interested lay people.”</li> <li>- “all collaborators”</li> <li>- “non-specialist readers”</li> <li>- “hospitals”</li> <li>- “interested clinicians”</li> <li>- “local PH authorities”</li> <li>- “registered users”</li> <li>- “policy-making customers”</li> <li>- “hospitals, decision makers, professionals”</li> <li>- “hospitals with a contract to support them”</li> <li>- “health decision makers at three levels: policy, management, and clinical.”</li> <li>- “health care sector workers”</li> </ul>

“Public health care providers” (82.5%) followed by “policy makers” (77.5%) were the two main target users of the products of the organisations (**Table 20**).

**Table 20. Target users of the products \***

<b>Most frequent target user**</b>	<b>N</b>	<b>%</b>
Public health care providers	33	82.5
Policy makers	31	77.5
Health professionals (general practitioners and specialists)	31	77.5
Professional associations	25	62.5
Health related professionals	23	57.5
Health services researchers	21	52.5

Researchers	17	42.5
Compulsory health care insurances (public)	17	42.5
Pharmaceutical/ Devices industry	15	37.5
Patient groups / Carers	15	37,5
Private health care providers	11	27.5
Media	9	22.5
General Public	8	20.0
Private Medical Insurance	5	12.5
Consumer associations	4	10.0

\* Multiple choice question which allows to select more than one correct answer.

\*\* The question was measured by a ranking from 1 to 15; The category "Most frequent user" was obtained by grouping the answers from 1 to 5.

## DISCUSSION

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The results of this study indicate that the majority of HTA organisations contacted considered themselves governmental organisations and collaboration is largely either at national or international level. Pharmaceuticals were most commonly reported as forming the subject of HTA. Public health care providers and policy makers were cited by the organisations as the group targeted most frequently when disseminating the outputs of HTA and the most used method of product distribution was the website.

This study adds new information about which were the main barriers that an HTA organisation experienced during the establishment period. In addition it gives information that Funding and Gathering trained staff are the most important aspects for the organisations in the establishment of an HTA institution. The agencies established from 2000 to 2007 ranked the categories related with barriers experienced in the moment of establishment higher than did the other groups. Funding, especially, and Gathering trained staff were the highest ranked. The fact that the oldest agencies ranked lower all these categories could be due to a recall bias since they were established in the sixties or seventies and therefore they cannot accurately report the situation at that time. When agencies were asked about how to overcome these two types of barriers, they declared that it was solved by means of intense networking and collaboration in particular at international level or attracting research grants. The need of further collaboration either at national or international level has been described also in other previous research experiences and projects of HTA <sup>13,4</sup>.

The majority of HTA organisations are governmental inspired and not-for profit which is consistent with other previous surveys on HTA institutions<sup>3, 14</sup> or with the ECHTA/ECAHI project which reported that mostly agencies were funded by the national health ministry or by the local government <sup>9</sup>.

The general time trend in HTA agencies is that collaboration nationally or internationally is the rule rather than the exception. Nationally the trend is to do so with all types of institutions (Academia, Government, professional associations, hospital, industry and patient associations) whereas internationally collaboration is largely with Academia and Governmental bodies. The importance of collaboration among agencies has been described in other previous surveys <sup>3,4</sup> showing that successful collaboration especially at international level could lead to redundancy of effort, reduction of repetition and assurance of timeliness.

The results showed that most HTA organisations could rely on an HTA supporting policy act enacted by the government. This can be explained by the fact that most HTA organisations answering the questionnaire were mainly governmental where an explicit HTA supporting policy by the government can help in establishing the formal recognition of the need for HTA, secure funding and the independence of the HTA organisation.

The main lines of activity declared were HTA reports followed by performing or doing some kind of research and clinical practice guidelines whereas other studies<sup>3</sup> showed that HTA organisations produced HTA reports followed by the elaboration of guidelines. This can be explained by two main reasons. Firstly, the fact that there are other kind of institutions as scientific societies involved in the development of clinical practice guidelines and secondly HTA organisations can manage and perform research since they have a much wider range of funding sources. Pharmaceuticals were most commonly reported as forming the subject of HTA followed by Medical or Surgical procedures and medical devices. Assessments related to public health interventions, emerging technologies and support systems were still infrequent. In fact, Pharmaceuticals have been subject to systematic assessment for safety and efficacy for decades and they still represent and consume a great portion in any health care expenditure system. In addition, in general the system of pharmaceutical regulation does not deal with a number of important questions, such as cost-effectiveness, relative efficacy, and appropriate indications. So, HTA organisations are being increasingly called upon to fill such gaps.

Results showed that the higher the number of staff the greater of specialization and multidisciplinary of teams. The survey results revealed that the organisations had a core model staff of clinical specialists, economists and information specialists but there were also other type of specialists such as dentists, pharmacists, physiotherapists, lawyers, nurses, chemists, nutritionists and biomedical engineers among others. This is consistent with the results of another study<sup>15</sup> that showed the need of having a variety of staff expertise in order to ensure the capability of the institution to deal with the wide range of HTA topics. The number and staff background in an HTA organisation would depend in the end upon its purpose, funding sources and other factors.

The majority of HTA organisations were sponsored by the Government and Research funding bodies which showed consistency with the results of the question about the profile of the organisation. However, the results also showed as in other previous studies<sup>3</sup> that private funds were still very limited compared with the great presence of public

funding bodies. This lack of private funding in HTA activities can be explained by the potential conflict of interest in HTA reports. An HTA report should consider the potential for conflict of interest on multiple levels<sup>15</sup> and especially in the case of industry sponsorship of research which has been associated with restrictions on publication and data sharing<sup>16</sup>. Among the reasons for publication restrictions are that industry tends to withhold studies with negative results and also that industry is more likely to sponsor studies in which the results are likely to be positive.

Organisations did not mostly used an explicit process for priority setting. Only a little more than half of the agencies used an explicit process for priority setting. Some assessment programs had explicit procedures for setting priorities whereas others set priorities in an informal way; however it is important to articulate the use of guidelines or an explicit priority setting process<sup>17,7</sup>, in order to reflect the main objectives of the HTA program and the resources available.

Clinical effectiveness was the domain declared more often than any other in the assessment of health technology whereas other aspects as social/cultural, legal and patient preferences are still underrepresented. Patient preferences and patient values are often left out of the HTA process which may simplify a lot the process; However it should be noted that some organisations<sup>18</sup> have started including strategic health authorities to involve and consult patients in the process of technology appraisal.

These present results revealed that most HTA agencies had a specific procedure to distribute their products and the Website together with the participation and organisation of academic and training activities were the main ways of distribution. These findings are similar to other published data<sup>19</sup> which reported that active dissemination strategies have only occasionally been applied. The authors concluded that further efforts should be deployed with agencies to better articulate a shared vision and to devise strategies. However, another survey<sup>14</sup> on HTA organisations showed that the most common form of distribution was the paper report followed by the Website.

There are some limitations to our study. First it should be noted that the study sample used in this survey may not be representative of the general context of HTA. When merging the information from various sources in order to prepare the list of HTA organisations, we found that some countries and organisations were less represented in our sample, especially the eastern European countries. However this could also mean that HTA is less institutionalized in these regions. Contacting the organisation by phone

or via e-mail can result in more detailed information but the efforts to contact them were both time-consuming and required additional resources. So, organisations without email address were excluded.

Second, the response rate to this questionnaire almost certainly was increased due to the follow-up e-mail reminders that were issued. However despite these efforts, the overall non-response rate was still 65.2 percent. One reason for nonresponding may have been reaching the person actually in charge for HTA. There were difficulties in identifying the person that could be in charge for HTA or HTA related research. However, another reason for nonresponding could be the number of questions and the length of the questionnaire which are negatively correlated with the response rate <sup>20</sup>.

From the information obtained, characteristics of respondents were slightly different to non respondents; it should be noted that few organisations such as university research groups and clinical/research institutes answered the survey (about 81% of the non respondents sample size). This can be due firstly because they did not consider themselves as the right target organisation for answering the questionnaire, as HTA activities only covered a low percentage of their work tasks which is based not only in HTA reports but in primary data collection and research projects. On the contrary large HTA organisations are much more involved in decision-making and policy making due to their governmental background. It should be also noted that from the non responding institutions about 27.8% were INAHTA member organisations.

In addition, from some countries none of the addressed organisations of our sample answered. Due to that reason Ireland, Latvia, Lithuania, Luxembourg, Russia and Malaysia are not represented in the results.

Cross-tabulations analysis to compare relationships were not possible due to the small sample size. However, there were some results extracted from different questions that showed consistency, for instance this is showed in the results of questions number 18 and 47 where policy makers and public health care providers were the main kind of organisations asking for HTA products and at the same time these two categories were also the main target users of the organisation.

## CONCLUSIONS

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- The model of HTA organisation regarding the characteristics of establishment, background, structure and work process seems not to have changed significantly in the past 10 years.
- The results of this survey indicate that there are common aspects and barriers experienced by the HTA organisations regardless of their geographical setting or years of experience conducting HTA activities.
- Collaboration among HTA organisations either at national or international level could help to overcome resistance to barriers such as training staff
- Given the variety of HTA addressed and the range of methods that may be used in an assessment, multiple types of experts are needed in HTA. Depending upon the topic and scope of assessment, these may include a wide selection of specialists.
- It is worth taking advantage of the new technologies and promote and being more active in planning dissemination strategies in order not to be fixed to the most common and known visions of distribution (website, participation and organisations of academic and training activities).
- Networking among HTA organisations play an important role in the development and sharing of HTA activities. However, it is worth mentioning that only a small proportion of an HTA agency's work is likely to be involved in international projects. Thus, the initiative of national and international collaboration by means of international projects and specific programmes needs better coordination and communication among HTA programs.

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This questionnaire uses different terms related to complex health care constructs. To facilitate a common understanding the following definitions will be used. Please read them carefully.

- **Evidence-based Medicine and Health Care.** The conscientious, explicit and judicious use of current evidence in making decisions about the care of individual patients. The practice of evidence-based medicine and health care means integrating individual expertise with the best available external evidence from systematic research. The term includes all professions associated with health care, including purchasing and management.
- **Clinical Practice Guidelines.** A systematic, developed statement designed to assist clinician and patient decisions about appropriate health care for specific clinical circumstances.
- **Health intervention evaluation and evaluation research.** The assessment of the (health and resource) effects of a health intervention compared to other interventions or to doing nothing. The emphasis is on formal assessment rather than informal evaluation using experience and judgement. It refers to any activity primarily aimed at improving people's health. This broad definition includes (A) health care organisation and delivery systems as well as drugs, devices and procedures, (B) health promotion and prevention activities as well as health care treatments, and (C) interventions aimed at improving public health and safety in policy areas outside the health care sector, such as income distribution, education, legal services, water and sewage, housing, transport and the environment.
- **Health Technology Assessment (HTA).** A form of policy research that systematically examines short and long term consequences in terms of health and resource use, of the application of a health technology or health intervention, a set of related technologies, or a technology-related issue. The goal of health technology assessment is to provide input to decision making in policy and practice. Health technology includes drugs, devices, and medical and surgical procedures used in the prevention, diagnosis, and treatment of diseases, and for rehabilitation, including traditional medical technologies; the knowledge associated with these; and the organisational and supportive systems within which the care is provided including facilities that house both patients products; as well as environmental, food and information technologies; and technologies used in health promotion.

**Before you begin to complete this questionnaire, please answer the following question:**

Do you consider that your organisation is performing HTA activities?

Yes

No

If **NO**, please complete only contact details of the questionnaire and return it to us.

If **YES**, please complete all the questionnaire and return it to us.

**Many thanks for your co-operation.**

**If the HTA activity of your organisation is developed for a specific unit, please answer the question taking into account only this HTA unit**



<b>ID</b>	
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(Please, don't write here)

## Contact details

Name of the organisation
Address
City
Country
Telephone number
Fax number
Website
Name of the person who is answering the questionnaire (surname and name)
Position of the person who is answering the questionnaire (e.g. director, manager, etc.)
E-mail

## Section 1. Establishment of the organisation.

The following questions are to get some information about its establishment.

### 1. Give the date that the organisation was established

Please, specify month and year of establishment: mm/yyyy

### 2. Who took the main initiative in the establishment of the organisation?

<input type="checkbox"/> Government*	<input type="checkbox"/> Decision-makers <input type="checkbox"/> microlevel (health professionals, patients associations, etc.) <input type="checkbox"/> mesolevel (health care managers, professional organisations, etc.)	<input type="checkbox"/> Health researchers
Others. Please specify:		

\* Regional or national

### 3. What were the main reasons for the establishment of the organisation?

Please, describe the reasons.

#### 4. Which were the main barriers in the establishment of the organisation?

Please specify the most prominent problems for the establishment of your organisation.

<input type="checkbox"/> No barriers (please, go to question 6)	<input type="checkbox"/> Funding	<input type="checkbox"/> To gather trained staff
<input type="checkbox"/> Agreement with other stakeholders	<input type="checkbox"/> To reach political interest	<input type="checkbox"/> To impact on target groups*
<input type="checkbox"/> Facilities (building, personal computers, etc.)	Others. Please, specify:	

\* To have an impact on the activities of target groups.

#### 5. How these barriers were resolved?

Please describe which solutions helped your organisation to overcome the foundation barriers.

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## Section 2. Specific background of the organisation

This section asks you to provide information about your organisation background.

### 6. Which of the following best describes your organisation?

<input type="checkbox"/> Not-for profit	<input type="checkbox"/> For-profit
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### 7. Which of the following profiles best describes your organisation?

<input type="checkbox"/> Governmental agency	<input type="checkbox"/> Professional association	<input type="checkbox"/> Academia/University
<input type="checkbox"/> Compulsory health care insurance (public)	<input type="checkbox"/> Private medical insurance	<input type="checkbox"/> Other private company
Other. Please specify:		

### 8. Has your organisation collaborated or is it currently collaborating with other organisations?

Consider both networking and specific collaborations whenever your organisation is involved in the development of a project, or a grant.

<input type="checkbox"/> NO. (please, go to question 12.)
<input type="checkbox"/> YES, with organisations from our country.
<input type="checkbox"/> YES, with organisations from other countries.

### 9. Which are the kind of institutions from YOUR COUNTRY your organisation has collaborated or is it currently collaborating with?

<input type="checkbox"/> Governmental agency	<input type="checkbox"/> Hospital
<input type="checkbox"/> Academia / University	<input type="checkbox"/> Industry
<input type="checkbox"/> Professional associations	<input type="checkbox"/> Patient associations
Others. Please specify:	

**10. Which are the kind of institutions from OTHER COUNTRIES your organisation has collaborated or is it currently collaborating with?**

<input type="checkbox"/> Governmental agency	<input type="checkbox"/> Hospital
<input type="checkbox"/> Academia / University	<input type="checkbox"/> Industry
<input type="checkbox"/> Professional associations	<input type="checkbox"/> Patient associations
Others. Please specify:	

**11. Is there an HTA supporting policy or act in place that has been enacted by your government?**

<input type="checkbox"/> NO
<input type="checkbox"/> YES. Please specify:

### Section 3. Aims and scope of the organisation

This section asks you about the objectives and the scope of the organisation with relation to: lines of activity, area of influence, type of products, and stakeholders.

#### 12. At which of the following levels works your organisation?

<input type="checkbox"/> Local-regional	<input type="checkbox"/> National	<input type="checkbox"/> International
<input type="checkbox"/> Other. Please specify:		

#### 13. Does your organisation have an approved statutes?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
------------------------------	-----------------------------

#### 14. Does your organisation have a strategic plan?

<input type="checkbox"/> NO
<input type="checkbox"/> YES. Please specify its mission, outlook, and values:

#### 15. Which are the main lines of activity of your organisation?

<input type="checkbox"/> HTA	<input type="checkbox"/> Funding research	<input type="checkbox"/> Quality assessment and patients safety
<input type="checkbox"/> Clinical practice guidelines	<input type="checkbox"/> Performing or doing research	<input type="checkbox"/> Management organisation on health care
<input type="checkbox"/> Health policy activities	Others. Please specify:	

## 16. Which types of health technology (HT) does your organisation assess mainly?

Please rank them from 1 (most frequent HT assessed) to 5 (less frequent HT assessed). Use a 0 if there are some HT your organisation never assess, then consider the ranking from 1 to the number of HT your organisation assess.

0 Pharmaceuticals	0 Medical devices	0 Medical (or surgical) procedures
0 Support system	0 Emerging technologies	0 Public Health Interventions
Others. Please specify:		

- **Pharmaceuticals.**- Any chemical, biological substance that may be applied in order to prevent, treat, or diagnose disease or other medical conditions
- **Medical devices.**- Any physical item, excluding drugs, used in medical care. Included are diagnostic and therapeutic equipment, prosthesis, surgical and medical instruments, dental equipment, and ophthalmic goods
- **Medical (or surgical) procedures.**- A practice of a healthcare provider that generally involves a combination of special skills or abilities with drugs, devices or both
- **Support system.**- A system that provides the environment of health care (facilitating the provision), but is not the focal technology in a medical regimen, administrative system, surgical procedure or other form of health care (laboratory, radiology services, medical information systems, blood banking services, hospital facilities)
- **Emerging technologies.**- Identification of new technologies
- **Public Health Interventions.**- Community-based health interventions

## 17. Which types of products and services does your organisation do?

<input type="checkbox"/> Reports: <ul style="list-style-type: none"> <li>▪ Assessment reports</li> <li>▪ Technical queries</li> <li>▪ Quick response service</li> </ul>	<input type="checkbox"/> Research projects (with primary data)	<input type="checkbox"/> Consultation
<input type="checkbox"/> Academic and training activities	<input type="checkbox"/> Clinical practice guidelines	<input type="checkbox"/> Establishment of research needs
<input type="checkbox"/> Managing or commissioning research (both research calls done in your organisation and done out)		
Others. Please specify:		

### Reports:

- 1) **Assessment reports** are documents stemming from the process of assessment, based on systematic revisions of scientific evidence focusing on aspects such as the efficacy, safety, effectiveness and efficiency of medical technologies, adapting the assessment to the health scenario analysed and depending on the requirements of the commissioning organisation
- 2) **Technical queries** are documents generated from processes of assessment when the commissioning or requesting party needs to obtain an answer in less time than would normally be required for a complex, exhaustive and extensive assessment report
- 3) **Quick response service** are short reports that respond quickly and concisely to very specific queries

**Research projects.**- Primary research projects conducted to start up the assessment process, when the evidence is insufficient or there are no data

**Consultation.**- Service that entails physical presence and technical support, be it temporary or permanent, by your organisation to different health structures in the public and private sectors

**Academic and training activities.**-Those geared towards transmitting knowledge and skills in the methodology and practice of health technology and health services assessment, contributing to the dissemination of the assessment and research products generated

**Clinical practice guideline.**- Development, implementation, methodological review or advisory role in guidelines.

**Establishment of research needs.**- Identify the gaps in knowledge

**Managing or commissioning research.**- Organise a research call or to collaborate in the assessment of grants or its outcomes reports

**18. What kind of organisation is mainly asking for reports, technical queries, assessment reports, consultations...?**

<input type="checkbox"/> Compulsory health care insurance (public)	<input type="checkbox"/> Public health care providers	<input type="checkbox"/> Private medical insurance
<input type="checkbox"/> Health researchers	<input type="checkbox"/> Health professionals	<input type="checkbox"/> Policy makers
<input type="checkbox"/> Patients	<input type="checkbox"/> Private health care providers	Others. Please, specify:

**19. At which of the following levels are your organisation's recommendations usually distributed?**

<input type="checkbox"/> We don't produce recommendations	<input type="checkbox"/> International
<input type="checkbox"/> National	<input type="checkbox"/> Regional / Local

**20. To whom does your organisation address its recommendations?**

<input type="checkbox"/> We don't produce recommendations	<input type="checkbox"/> Compulsory health care insurance (public)	<input type="checkbox"/> Public health care providers
<input type="checkbox"/> Private medical insurance	<input type="checkbox"/> Private health care providers	<input type="checkbox"/> Health researchers
<input type="checkbox"/> Health professionals	<input type="checkbox"/> Policy makers	<input type="checkbox"/> Patients
Others. Please, specify:		

## Section 4. Structure of the organisation

This section request information about some structural characteristics of your organisation.

### 21. How has been organized the management of your organisation?

<input type="checkbox"/> Executive or governance board / Executive committee	<input type="checkbox"/> Scientific or advisory committee / Research coordinating committee	<input type="checkbox"/> Director / President / Manager
Others. Please specify: _____		

### 22. Who nominate the members of the executive board and scientific / advisory committee of your organisation?

--

### 23. How many people in each of these categories does your organisation have?

_____ Collaborating researchers	_____ Associated researchers	_____ Advisors / Consultants
_____ Administrative staff	_____ Research assistants	_____ Trainees / Interns

Collaborating researchers.- Those that can collaborate occasionally non-for-profit with your organisation  
 Associated researchers.- Those who from time to time collaborate with your organisation earning money as free-lance  
 Research assistance.- Those who help researchers with a technical task (e.g., writing scientific reports, coordinating research activities, etc.)

### 24. Please give information about your staff.

Write the number of people, for each condition, into the boxes (consider your staff at first of June of 2006)

_____ Full time permanent staff	_____ Part time permanent staff	_____ Fellowship
_____ Temporary	_____ Free lance	_____ Visiting researcher
_____ Internship		
Others. Please, specify:		

**Permanent staff.-** Contracted for at least 3 years  
**Fellowship.-** In training earning money from a research project  
**Temporary.-** Contracted for a specific project or for less than 3 years  
**Free lance.-** Working for the organisation with a service contract  
**Visiting researcher.-** Researchers from other organisations in a stay  
**Internship.-** Students / recent graduates not paid or paid very little for their work

**25. Please give information about the professionals background of your staff and its respective number.**

Write the number of people, for each condition, into the boxes (consider your staff at first of June of 2006)

____ Clinical specialist	____ Media professional	____ Economist
____ Epidemiologist	____ Health service researcher	____ Information specialist
____ Nurses / nursing scientist	____ General practitioner	____ Psychologist
____ Public Health specialist	____ Social scientist	____ Statistician
Others. Please, specify ____ ____		

**26. Please number the facilities and equipment that is available in your organisation.**

Total square meters ____	____ Number of individual offices	____ Number of shared offices
____ Number of free offices (for visiting researchers, interns, others)	____ Number of training rooms	____ Staff/Common room*
____ Library	____ Own reception	____ Number of meeting rooms
____ Personal computers	Computer networks <input type="checkbox"/> Yes <input type="checkbox"/> No	Others. Please, specify:

\* Staff / Common room.- A space where staff can have lunch or coffebreaks.

**27. Who sponsors / funds your organisation for HTA activities?**

<input type="checkbox"/> Government	<input type="checkbox"/> Research funding bodies	<input type="checkbox"/> Private industries (e.g. pharmaceutical industry)
<input type="checkbox"/> Intergovernmental organisation	<input type="checkbox"/> Donor agencies (foundations, patient associations, charity, others)	<input type="checkbox"/> Academia/University
<input type="checkbox"/> Compulsory health care insurance (public)	<input type="checkbox"/> Private medical insurance	<input type="checkbox"/> Public health care providers
<input type="checkbox"/> Private health care providers	Others. Please, specify:	

**If your organisation receives private funding or has private sponsors, please, answer questions 28 and 29. If not follow with question 30.**

**28. From the global budget, what percentage of PRIVATE funding/sponsor did your organisation receive in 2005 for HTA activities?**

%
---

**29. What PRIVATE institutions sponsor / fund your organisation?**

<input type="checkbox"/> Industry	Please, specify the percentage of your global HTA budget
<input type="checkbox"/> Research funding bodies	Please, specify the percentage of your global HTA budget
<input type="checkbox"/> Health care providers	Please, specify the percentage of your global HTA budget
<input type="checkbox"/> Academia/University	Please, specify the percentage of your global HTA budget
<input type="checkbox"/> Donor agency	Please, specify the percentage of your global HTA budget
<input type="checkbox"/> Medical insurances	Please, specify the percentage of your global HTA budget
Others. Please specify:	

## Section 5. Work process of the organisation

This section asks you about the way that your organisation organizes and realizes its work.

### 30. Who is responsible for setting the priorities for work undertaking by your organisation?

<input type="checkbox"/> Internally (Please specify)	<input type="checkbox"/> Scientific committee <input type="checkbox"/> Executive board <input type="checkbox"/> Direction <input type="checkbox"/> Other:
<input type="checkbox"/> Externally (Please specify)	<input type="checkbox"/> Department / Ministry of Health <input type="checkbox"/> National Health Service <input type="checkbox"/> Other:

If your organisation is responsible for setting priorities, please answer the following questions. If not, please go to question number 35.

### 31. Does your organisation use an explicit process for priority setting?

Does your organisation have a written document describing the priority process?

<input type="checkbox"/> NO
<input type="checkbox"/> YES

### 32. Which criteria does your organisation use to set priorities?

<input type="checkbox"/> Frequency of the clinical condition	<input type="checkbox"/> Health care cost	<input type="checkbox"/> Medical practice variations
<input type="checkbox"/> Burden of disease	<input type="checkbox"/> Chances to change interventions	<input type="checkbox"/> Chances of change in costs
<input type="checkbox"/> Ethical, legal or social implications	<input type="checkbox"/> Political concern	<input type="checkbox"/> Public and media concern
Others. Please specify:		

- **Frequency of the clinical condition.**- Prevalence, incidence
- **Health Care cost.**- The direct cost of the health care of an individual per year
- **Medical practice variations.**- Those not related to demographic differences
- **Burden of disease.**- Mortality, morbidity and quality of life related to a clinical condition (DALYs, QALYs, etc)
- **Chances to change interventions.**- Administrative decisions, medical practice or health outcomes
- **Chances of change in costs.**- Related to the potential changes in the health care attention of a clinical condition
- **Ethical, legal or social implications.**- Chances to overcome problems from these areas. Equity is included here
- **Political concern.**- Needs of information of policy makers
- **Public and media concern.**- Social interest to overcome specific clinical conditions

**33. What process does your organisation follow for priority setting?**

You don't need to describe the process if you have a document describing it, please just attach or send it to us.

--

**34. Are there any advisory mechanisms available for your organisation to help you to set priorities?**

<input type="checkbox"/> Experts on specific topics	<input type="checkbox"/> Policymakers / Government representatives
<input type="checkbox"/> Health care professionals	<input type="checkbox"/> Patient representatives
<input type="checkbox"/> Health care insurance (private or public)	<input type="checkbox"/> Industries, manufacturers
Others. Please specify:	

**35. Which are the main barriers your organisation finds in its daily work?**

Please specify the most prominent problems of your organisation.

<input type="checkbox"/> Facilities (building, personal computers, etc.)	<input type="checkbox"/> Funding	<input type="checkbox"/> To gather trained staff
<input type="checkbox"/> Disagreement with other stakeholders	<input type="checkbox"/> To reach political interest	<input type="checkbox"/> To impact on target groups*
Others. Please, specify:		

\* To have an impact on the activities of target groups.

### 36. How is your organisation trying to resolve these barriers?

Please specify the solutions your organisation use in order to resolve these barriers.

--

### 37. Which issues does your organisation consider in the assessment of health technology?

<input type="checkbox"/> Safety	<input type="checkbox"/> Efficacy/effectiveness	<input type="checkbox"/> Economic evaluation
<input type="checkbox"/> Medical Practice patterns	<input type="checkbox"/> Service requirements / Organisational implications	<input type="checkbox"/> Economic implications (budget impact)
<input type="checkbox"/> Ethical	<input type="checkbox"/> Legal	<input type="checkbox"/> Social / Cultural
<input type="checkbox"/> Patient preferences	<input type="checkbox"/> Equity	Others. Please, specify:

- **Safety.**- A judgement of health technology acceptability of risk in a specific situation.
- **Efficacy.**- Health benefit derived from the use of a technology for a specified population with a given medical problem under ideal conditions of use
- **Effectiveness.**- Health benefit for a specified population with a given medical problem provided by a technology for average conditions of use
- **Economic evaluation:**
  - **Cost.**- Of using the technology for an individual application, including charges or prices
  - **Cost-benefit.**- The cost of a technological application compared to the resultant benefits, with both costs and benefits expressed in the same units (usually monetary)
  - **Cost-Effectiveness.**- The cost of a technological application compared to the resultant benefits/effectiveness not expressed by the same unit . Costs are usually expressed in monetary unit, and benefits/effectiveness in terms of lives saved, disability avoided, quality adjusted life years, or a similar measure
  - **Cost-utility.**- The cost of a technology application compared to the results benefits/effectiveness are expressed by the same unit (QALYs or DALYs)
- **Service Requirements.**- For using the technology in practice, such as its placement and distribution within a health care system, organisational arrangements within a faculty, need for technologist or staff training
- **Medical Practice Patterns.**- The treatments that different clinicians follow for a health condition
- **Economic implications (budget impact).**- The cost of the technology in the aggregate, and its impact on factor prices, medical cost, alternative uses of national or industrial resources, etc.
- **Ethical.**- e.g., challenges to ethical issues within a society
- **Legal.**- e.g., challenges to legal principles
- **Social / Cultural.**- e.g., potential impact on a society or cultural values
- **Patients Preferences.**- Patient satisfaction about services received from an organisation (health plan), hospital, physician or health care provider and patients requirements
- **Equity.**- e.g; access opportunities to health services

**38. How does your organisation ensure the quality of its products / services?**

<input type="checkbox"/> External review of the reports	<input type="checkbox"/> Internal review of the reports
<input type="checkbox"/> Check list	<input type="checkbox"/> Quality management system
<input type="checkbox"/> Certified quality management system	Others. Please, specify:

**Check list.**- Document describing how you are going to work or develop each specific product  
**Quality management system.**- Document describing a way of working for your organisation, not only HTA work but also management  
**Certified quality management system.**- Official certificate (ISO, others) for your quality management system

**39. What is the attitude of your organisation about assessing the impact of its recommendations?**

Please specify your opinion about assessing the impact of your organisation recommendations.

**40. How often does your organisation assess the impact of its recommendations?**

<input type="checkbox"/> Always	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
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**Always.**- Assessing the impact of all the recommendations  
**Frequently.**- Assessing the impact of most of the recommendations  
**Occasionally.**- Assessing the impact of few of the recommendations  
**Never.**- Don't assess the impact of none of the recommendations

**\* If your organisation doesn't assess the impact of its recommendations, please go to question 45.**

**41. Does your organisation include indicators to assess the impact into its products?**

<input type="checkbox"/> Yes
<input type="checkbox"/> No

**42. Which of the following criteria are used by your organisation to assess the impact of its recommendations?**

<input type="checkbox"/> Changes on organisation or facilities (training staff, buying materials, etc)
<input type="checkbox"/> Variation in practice before and after recommendation
<input type="checkbox"/> Variation between current practice and recommended practice over time
<input type="checkbox"/> Level of technology diffusion over time
<input type="checkbox"/> Change in health outcomes over time (clinical changes)
<input type="checkbox"/> Changes in the cost of the medical practice over time
<input type="checkbox"/> Changes in legislation
<input type="checkbox"/> Changes in health from the point of view of the patients (perceived health, satisfaction, others)
Others. Please, specify:

**43. What is your opinion about the general impact of the recommendations from your organisation?**

Please, estimate the overall impact you think the recommendations of your organisation has.

<input type="checkbox"/> High	<input type="checkbox"/> Moderate	<input type="checkbox"/> Few	<input type="checkbox"/> None
Please, justify your answer:			

**44. Which strategies do you think are the most important for your recommendations have a high impact?**

<input type="checkbox"/> Supporting Organisational Structures	<input type="checkbox"/> Updating process	<input type="checkbox"/> Timeliness
<input type="checkbox"/> Dissemination strategies	<input type="checkbox"/> Involving stakeholders	<input type="checkbox"/> High readability of products/reports
<input type="checkbox"/> Quality of products	<input type="checkbox"/> Reputation & credibility of HTA unit	Others. Please, specify:

**Supporting Organisational Structures.**- Decision making structures (e.g., standing or ad hoc committees) and / or communication channels and networks in place, established by the requesting organisation or individual  
**Updating process.**- specific aspects of the process for requesting and developing the product ( e.g. request and updated of products or considering regular update of products on high priority topics )  
**Timeliness.**- Information provided by your organisation which has a current interest for your costumers / requires  
**Dissemination strategies.**- Distribution of your products to specific target audiences  
**Involving stakeholders.**- Inclusion of some users in the developing group  
**Narrative appropriateness.**- Writing the products in a readability way  
**Quality of products.**- Thorough and unbiased research

## Section 6. Visibility of the outcomes of the organisation

This section requests information about how your organisation disseminates the results of its work .

### 45. Does your organisation have a formal procedure to disseminate\* its products?

<input type="checkbox"/> NO
<input type="checkbox"/> YES. Please specify:

**Dissemination.**-To send reports, outcomes, others to selected target groups; not sending reports indiscriminately

### 46. Which of the following methods or activities are undertaken by your organisation to disseminate its products?

<input type="checkbox"/> Electronic and printed versions of newsletters	<input type="checkbox"/> Electronic and printed versions of reports	<input type="checkbox"/> Website
<input type="checkbox"/> Papers published in national scientific journals	<input type="checkbox"/> Papers published in international scientific journals	<input type="checkbox"/> Participation in academic, scientific and training activities (presentations, posters, teaching activities)
<input type="checkbox"/> Organisation of academic, scientific and training activities (meetings, seminars, congress)	<input type="checkbox"/> Collaboration with media (press release and interviews)	<input type="checkbox"/> Opinion leaders
Others. Please specify:		

#### 47. Who are the target users of the products of your organisation?

Please, rank them from 1 (most frequent user) to 15 (least frequent user). You can use 0 for those you never address your recommendations, then consider the rank from 1 to the number of your users.

0 General Public	0 Health services researchers	0 Professional associations
0 Patient groups / Carers	0 Public health care providers	0 Health professionals (general practitioners and specialists)
0 Health related professionals	0 Private health care providers	0 Consumer associations
0 Policy makers	0 Compulsory health care insurances (public)	0 Pharmaceutical/ Devices industry
0 Researchers	0 Media	0 Private Medical Insurance

#### Finally, please, answer this last question

#### 48. Which of the following aspects do you consider important in the establishment of a new agency?

Please, select the three most relevant ones

<input type="checkbox"/> Clear mission	<input type="checkbox"/> Engaged staff	<input type="checkbox"/> Funding
<input type="checkbox"/> Good anchoring and network	<input type="checkbox"/> Education opportunities	<input type="checkbox"/> Director with a good reputation
<input type="checkbox"/> Political opportunity	<input type="checkbox"/> Involvement system stakeholders	<input type="checkbox"/> Lack of conflict of interest
Others. Please specify:		

If you have any question filling in the questionnaire, please contact us at:

Mònica Cortés  
e-mail: [mcortes@aatrm.catsalut.net](mailto:mcortes@aatrm.catsalut.net)

#### **Catalan Agency for Health Technology Assessment and Research**

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## Appendix 2. Organisations participating in the survey on HTA organisations

Organisation	Country	City	Active HTA
Adelaide Health Technology Assessment, University of Adelaide (AHTA)	Australia	Adelaide	Yes
Hauptverband der Österreichischen Sozialversicherungsträger	Austria	Vienna	Yes
Institute of Social Medicine and Epidemiology, University of Graz	Austria	Graz	Yes
K.U.Leuven	Belgium		No
Department of Science and Technology, Brazilian Health Technology Assessment General Coordination (Coordenação Geral de Avaliação de Tecnologias em saúde) - (DECIT-CGATS)	Brazil		Yes
Canadian Agency for Drugs and Technologies in Health (CADTH)	Canada	Ottawa	Yes
Institute of Health Economics (IHE)	Canada	Edmonton	Yes
Medical Advisory Secretariat (MAS)	Canada	Toronto	Yes
Cyprus Ministry of Health	Cyprus	Nicosia	No
Centre for Applied Health Services Research and Technology Assessment (CAST) - (Center for Anvendt Sundheds-tjeneste-forskning og Teknologi-vurdering)	Denmark	Odense	Yes
Danish Centre for Evaluation and Health Technology Assessment (DACEHTA)	Denmark	Copenhagen	Yes
Danish Institute for Health Service Research (DSI)	Denmark	Copenhagen	Yes
Health Evidence Network, WHO Regional Office for Europe	Denmark	Copenhagen	No
University of Tartu	Estonia	Tartu	No
Finnish Office for Health Care Technology Assessment (FINOHTA/ STAKES)	Finland	Helsinki	Yes
Centre of Competence for Clinical Studies Bremen (Kompetenzzentrum für Klinische Studien Bremen)	Germany	Bremen	Yes
Federal Association of Regional Health Insurance Funds (AOK Bundesverband)	Germany	Bonn	Yes
German Agency for Quality in Medicine (Aqumed) – (Ärztliches Zentrum für Qualität in der Medizin - AEZQ)	Germany	Berlin	Yes
Institute for Social Medicine, University of Lübeck	Germany	Lübeck	Yes
Office of Technology Assessment at the German Parliament (Büro für Technikfolgen-Abschätzung beim Deutschen Bundestag) - (TAB)	Germany	Berlin	No
Research Centre for Biotechnology, Society and Environment (BIOGUM), University of Hamburg	Germany	Hamburg	Yes
Institute of Biomedical Technology (INBIT)	Greece	Patras	Yes
Hungarian Agency of Health Technology Assessment (HunHTA)	Hungary	Budapest	Yes
Directorate of Health in Iceland	Iceland	Seltjarnarnes	No
Israeli Center for Technology Assessment in Health Care (ICTAHC), The Gertner Institute	Israel	Tel-Hashomer	Yes
-Health Technology Assessment Unit – Medical Directorate, “Agostino Gemelli” Hospital, Catholic University of the Sacred Heart ( Università Cattolica del Sacro Cuore)	Italy	Rome	Yes
Regione Veneto - Health and Social Secretariat (Direzione Piani e Programmi Socio Sanitari Regione Veneto)	Italy	Venice	Yes
Centro Nal. de Excelencia Tecnológica en Salud (CENETEC), Secretaría de Salud	Mexico	Mexico	Yes
Health System Division (IMSS), Health Policy Coordination, Mexican Institute of Social Security (Division de Sistemas Salud del Instituto Mexicano del Seguro Social)	Mexico	Mexico	Yes

Advisory Council on Health Research (Raad voor Gezondheidsonderzoek, RGO)	Netherlands	Den Haag	No
Norwegian Knowledge Centre for the Health Services (NOKC)	Norway	Oslo	Yes
Agency for Health Technology Assessment in Poland (AHTA / AOTM)	Poland	Warsaw	Yes
Central and Eastern European Society of Technology Assessment in Health Care (CEESTAHC)	Poland	Krakow	Yes
Institute of Molecular Medicine (Instituto de Medicina Molecular)	Portugal	Lisbon	No
Institute of Public Health Iasi (IPH Iasi)	Romania	Iasi	Yes
Institute of Public Health of the Republic of Slovenia (Institut za varovanje zdravja)	Slovenia	Ljubljana	No
Andalusian Agency for Health Technology Assessment (Agencia de Evaluación de Tecnologías Sanitarias de Andalucía) – (AETSA)	Spain	Seville	Yes
Basque Office for Health Technology Assessment (Osteba)	Spain	Vitoria-Gasteiz	Yes
Catalan Agency for Health Technology Assessment and Research (CAHTA)	Spain	Barcelona	Yes
Cochrane Collaboration (Centro Cochrane Iberoamericano)	Spain	Barcelona	No
Galician Agency for Health Technology Assessment (Axencia de Avaliación de Tecnoloxías Sanitarias de Galicia) – (AVALIA-T)	Spain	Santiago de Compostela	Yes
Healthcare Technology Evaluation Agency, Madrid (Agencia de Evaluación de Tecnologías Sanitarias Instituto de Salud "Carlos III) - (AETS)	Spain	Madrid	Yes
Center for Medical Technology Assessment (CMT)	Sweden	Linköping	Yes
Swiss Center for International Health / Swiss Tropical Institute (SCIH)	Switzerland	Basel	Yes
Centre for Reviews and Dissemination (CRD)	UK	York	Yes
EuroScan, National Horizon Scanning Centre (NHSC), Department of Public Health and Epidemiology, University of Birmingham	UK	Birmingham	Yes
National Coordinating Centre for Health Technology Assessment (NCCHTA)	UK	Southampton	Yes
National Perinatal Epidemiology Unit, University of Oxford	UK	Oxford	Yes
ECRI Institute	USA	Plymouth Meeting, PA	Yes
Institute for Clinical Systems Improvement (ICSI)	USA	Bloomington	No
Medical Technology and Practice Patterns Institute, Inc. (MTPPI)	USA	Bethesda	Yes
VA TAP - Department of Veterans Affairs (VA) Technology Assessment Program (TAP)	USA	Boston	Yes

### Appendix 3. Detailed Results of the survey on HTA organisations

#### RESULTS ON HTA ORGANISATIONS

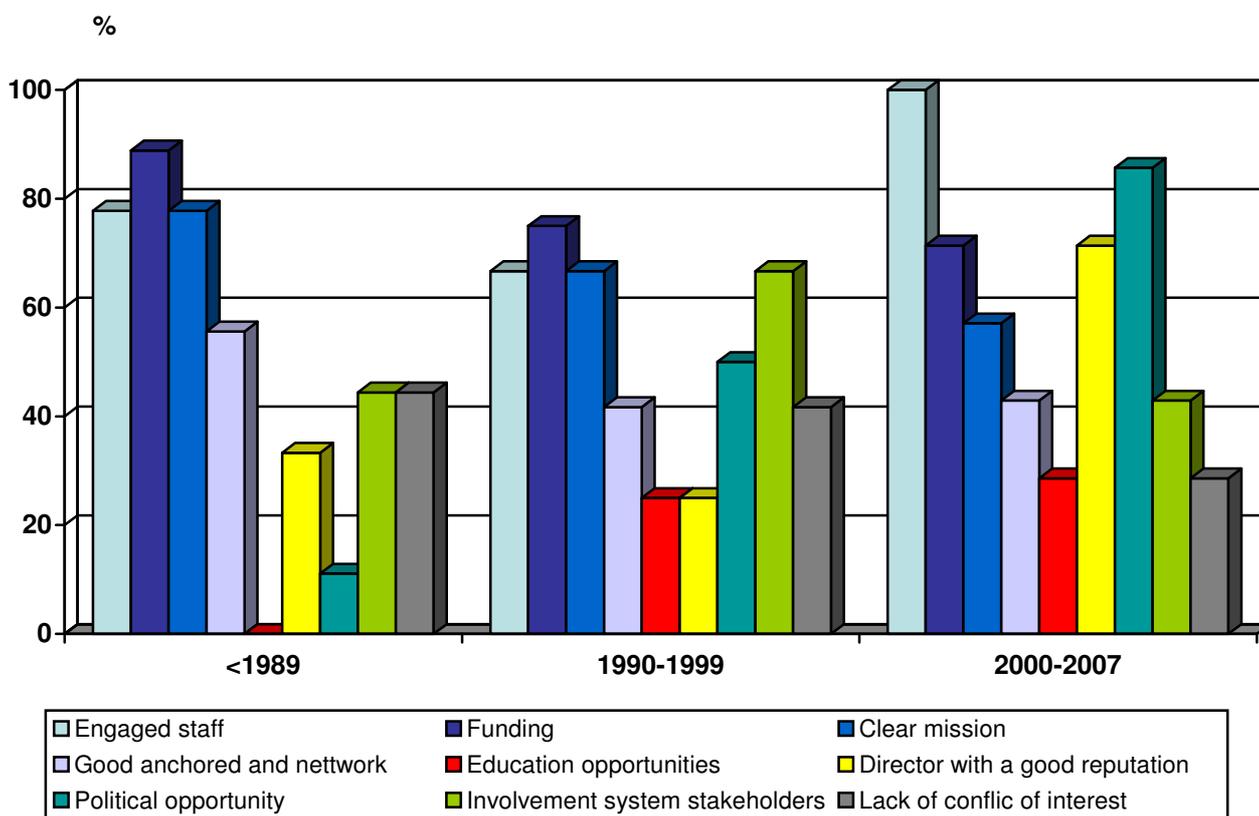
(Please take note: some questions contained check boxes allowing more than one answer; missing cases have been excluded for the statistical analysis )

#### SECTION 1. Establishment of the organisation

**Table 1 Barriers in the establishment of the organisation (N=38)**

Existence of barriers in the establishment	N	%
Yes (Barriers were existent)	22	57.9
No (Barriers were not existent)	16	42.1

**Figure 1 Important aspects in the establishment of the organisation according to year of establishment (N=28)**



## SECTION 2 Specific background of the organisation

**Table 2 Profile of the organisation (N=40)**

	N	%
Not-for profit	40	100

**Table 3 Profile of the organisation\* (N=40)**

Profile of the organisation	N	%
Governmental agency**	17	42.5
Academia/University	13	32.5
Compulsory health care insurance (public)	2	5.0
Other private company	2	5.0
Professional association	1	2.5
Private medical insurance	0	0
Other	5	12.5

\*Multiple choice question which allows to select more than one correct answer.

\*\*One out of 17 agencies declared the profile as being a Governmental agency + Academia/university.

**Table 4 Collaboration with other organisations\***

Collaboration of the organisation	N	%
Collaboration with other organisations	40	100
Collaboration at National level	39	97.5
Collaboration at international level	40	100

\*Multiple choice question which allows to select more than one correct answer.

**Table 5 Collaboration at national level\***

Type of National collaboration	N	%
Academia / University	38	97.4
Governmental agency	37	94.9
Professional associations	30	76.9
Hospital	27	69.2
Industry	17	43.6
Patient associations	14	35.9

\*Multiple choice question which allows to select more than one correct answer.

**Table 6 Collaboration at international level\***

Type of international collaboration	N	%
Academia / University	31	79.5
Governmental agency	26	66.7
Professional associations	9	23.1
Hospital	5	12.8

Industry	2	5.1
Patient associations	1	2.6

\*Multiple choice question which allows to select more than one correct answer.

**Table 7 Existence of an HTA supporting policy or act in place enacted by the government (N=39)**

Existence of an HTA supporting policy	N	%
Yes	28	71.8
No	11	28.2

### Section 3 Aims and scope of the organisation

**Table 8. Working at national, international or local-regional level\***

Type of working level	N	%
Local-regional	4	9.7
National	12	29.3
Local-regional and National level	1	2.4
International	1	2.4
National and International	8	19.5
Local-regional, National and International level	14	34.2

\*Multiple choice question which allows to select more than one correct answer.

**Table 9. Existence of an approved statutes (N=37)**

Existence of statutes	N	%
Yes	25	67.6
No	12	32.4

**Table 10. Existence of a strategic plan (N=41)**

Existence of strategic plan	N	%
Yes	34	82.9
No	7	17.1

**Table 11. Main lines of activity of the organisation\***

Lines of activity	N	%
HTA	33	80.5
Performing or doing research	26	63.4
Health policy activities	15	48.4
Clinical practice guidelines	15	36.6
Quality assessment and patients safety	12	29.3
Management organisation on health care	9	22.0
Funding research	7	17.1

\*Multiple choice question which allows to select more than one correct answer.

**Table 12. Types of products and services that the organisation performs\***

<b>Types of products and services</b>	<b>N</b>	<b>%</b>
Reports (assessment report; technical query; Quick response service)	40	97.6
Academic and training activities	32	78.0
Consultation	30	73.2
Research projects (with primary data)	27	65.9
Establishment of research needs	19	46.3
Managing or commissioning research (both research calls done in your organisation and done out)	16	39.0
Clinical practice guidelines	13	31.7

Reports:

1) **Assessment reports** are documents stemming from the process of assessment, based on systematic revisions of scientific evidence focusing on aspects such as the efficacy, safety, effectiveness and efficiency of medical technologies, adapting the assessment to the health scenario analysed and depending on the requirements of the commissioning organisation

2) **Technical queries** are documents generated from processes of assessment when the commissioning or requesting party needs to obtain an answer in less time than would normally be required for a complex, exhaustive and extensive assessment report

3) **Quick response service** are short reports that respond quickly and concisely to very specific queries

**Academic and training activities.**-Those geared towards transmitting knowledge and skills in the methodology and practice of health technology and health services assessment, contributing to the dissemination of the assessment and research products generated

**Consultation.**- Service that entails physical presence and technical support, be it temporary or permanent, by your organisation to different health structures in the public and private sectors

**Research projects.**- Primary research projects conducted to start up the assessment process, when the evidence is insufficient or there are no data

**Establishment of research needs.**- Identify the gaps in knowledge

**Managing or commissioning research.**- Organise a research call or to collaborate in the assessment of grants or its outcomes reports

**Clinical practice guideline.**- Development, implementation, methodological review or advisory role in guidelines.

\*Multiple choice question which allows to select more than one correct answer.

**Table 13. Main requester\***

Main requested of products and services	N	%
Policy makers	38	92.7
Public health care providers	31	75.6
Health professionals	24	58.5
Compulsory health care insurance (public)	21	51.2
Health researchers	15	36.6
Private health care providers	8	19.5
Patients	7	17.1
Private medical insurance	6	14.6

\*Multiple choice question which allows to select more than one correct answer.

**Table 14. Organisations producing recommendations (N=41)**

Production of recommendations	N	%
Yes	35	85.4
No	6	14.6

**Table 15. Level of distribution of the recommendations\***

Level of distribution	N	%
Regional / Local	18	51.4
National	30	85.7
International	9	25.7

\*Multiple choice question which allows to select more than one correct answer.

**Table 16. Organisations producing recommendations (N=41)**

Production of recommendations	N	%
Yes	33	80.5
No	8	19.5

## Section 4. Structure of the organisation

**Table 17. Management of the organisation\***

Management structure of the organisation	N	%
Director/President/Manager	30	73.2
Scientific/advisory committee/Research coordinating committee	19	46.3
Executive governance board/Executive committee	14	34.1

\*Multiple choice question which allows to select more than one correct answer.

**Table 18. Information about the staff**

	Number and percentage of HTA organisations according to the staff				
	N*	Median (range)	None	1- 5	>5
Full time permanent staff	38	8 (0-380)	1 (2.6)	9 (23.7)	28 (73.7)
Part time permanent staff	37	2 (0-20)	14 (37.8)	14 (37.8)	9 (24.4)
Temporary	37	1 (0-18)	16 (43.2)	12 (32.5)	9 (24.3)
Internship	37	0 (0-40)	21 (56.8)	13 (35.1)	3 (8.1)
Fellowship	37	0 (0-35)	25 (67.6)	8 (21.6)	4 (10.8)
Free lance	36	0 (0-6)	29 (80.6)	6 (16.7)	1 (2.7)
Visiting researcher	37	0 (0-6)	33 (89.2)	3 (8.1)	1 (2.7)

\*Number of respondents replying to each category

**Permanent staff.-** Contracted for at least 3 years

**Temporary.-** Contracted for a specific project or for less than 3 years

**Internship.-** Students / recent graduates not paid or paid very little for their work

**Fellowship.-** In training earning money from a research project

**Free lance.-** Working for the organisation with a service contract

**Visiting researcher.-** Researchers from other organisations in a stay

**Table 19. Number of workers, specialities and their proportion to the total number of staff in the organisation**

Size	Id number	Number of total workers	Number of specialities	% of specialities in the organisation
<b>Micro</b>	1	5	4	80.0
	5	6	2	33.3
	3	8	3	37.5
	4	8	3	37.5
	2	9	4	44.4
<b>Small</b>	12	10	2	20.0
	17	10	3	30.0
	9	11	7	63.6
	23	11	6	54.5
	8	12	9	75.0

	24	12	6	50.0
	7	14	4	28.5
	21	14	6	42.8
	19	16	5	31.2
	13	17	8	47.0
	14	17	4	23.5
	27	19	7	37.0
	20	21	10	47.6
	6	22	7	31.8
	30	22	5	22.8
	11	26	6	23.0
	15	26	9	34.6
	16	27	6	22.2
	25	31	6	19.3
	26	31	6	19.3
	31	32	6	18.8
	10	34	9	26.4
	32	37	9	24.3
	18	39	5	12.8
	29	41	7	17.0
	22	48	11	23.0
	28	48	6	12.5
<b>Medium</b>	34	52	13	25.0
	38	59	11	18.6
	36	83	9	10.8
	33	100	15	15.0
	37	100	5	5
	35	196	13	6.6
<b>Big</b>	39	380	7	1.8

**Table 20. Number of workers, administrative staff, researchers, assistant researchers and their proportion to the total number of staff in the organisation**

<b>Id number</b>	<b>Number of total workers</b>	<b>Number of administrative staff</b>	<b>% of administrative staff in the organisation</b>	<b>Number of researchers</b>	<b>% of researchers in the organisation</b>	<b>Number of assistant researchers in the organisation</b>	<b>% of assistant researchers in the organisation</b>
1	22	1	4.5	17	77.3	4	18.2
2	12	0	0	12	100	0	0
3	100	18	18.0	60	60.0	12	12.0
4	11	3	27.2	8	72.7	0	0
5	26	3	11.5	13	50.0	0	0
6	10	1	10	8	80.0	2	20.0
7	5	0	0	4	80.0	1	20.0
8	380	200	52.6	80	21.0	100	26.3
9	17	2	11.7	10	58.9	5	29.4
10	17	2	11.7	13	76.5	0	0
11	27	2	7.4	13	48.1	3	11.1
12	10	2	20	5	50.0	1	10.0
13	39	5	12.8	32	82.0	2	5.1
14	16	1	6.2	14	87.5	0	0
15	9	2	22.2	7	77.8	0	0
16	21	2	9.5	15	71.4	2	9.5
17	14	2	7.1	12	85.7	0	0
18	8	3	37.5	3	37.5	3	37.5
19	48	25	52.0	14	29.2	9	3.5
20	52	1	1.9	51	98.0	0	0
21	11	1	9.0	9	81.2	1	9.0
22	196	20	10.2	54	27.5	20	10.2
23	12	2	16.7	10	83.3	0	0
24	31	2	6.4	18	58.0	3	9.6
25	6	1	16.7	3	50.0	1	16.7
26	19	2	10.5	16	84.2	0	0
27	48	26	54.2	22	45.8	0	0
28	8	2	25.0	5	62.5	1	12.5
29	83	5	6.0	28	33.7	0	0
30	41	7	17.0	26	63.4	0	0
31	22	3	13.6	11	50.0	0	0
32	32	8	25.0	15	46.8	2	6.2
33	100	39	39.0	26	26.0	0	0

**Table 21. Facilities and equipment**

	<b>Number and percentage of organisations according to square meters</b>			
<b>Square meters</b>	<b>≤100</b>	<b>≤200</b>	<b>≤500</b>	<b>&gt; 500</b>
	5 (19.2%)	8 (30.8%)	9 (34.6%)	4 (11.8)

**Table 22. Facilities and equipment**

	<b>Number and percentage of HTA organisations according to number facilities/equipment</b>	
<b>Offices</b>	<b>0-20 offices</b>	<b>&gt;20 offices</b>
Individual offices	30 (81.1)	7 (18.9)
Shared offices	33 (89.2)	4 (10.8)
<b>Other facilities</b>	<b>Without</b>	<b>With</b>
Free offices	29 (74.4)	10 (25.6)
Training rooms	23 (59)	12 (41)
Staff/common room	8 (20.5)	28 (79.5)
Library	13 (32.5)	25 (67.5)
Own reception	25 (61)	12 (39)
Meeting room	9 (22.5)	28 (77.5)
Personal computers	2 (5.3)	34 (94.7)

**Table 23. Funding source of the organisation for HTA activities \***

Source of funding of HTA activities	N	%
Government	33	80.5
Research funding bodies	19	46.3
Private industries (e.g. pharmaceutical industry)	10	24.4
Academia/University	10	24.4
Donor agencies ( foundations, patient associations, charity, others)	7	17.1
Public health care providers	7	17.1
Compulsory health care insurance (public)	6	14.6
Intergovernmental organisation	3	7.3
Private medical insurance	3	7.3
Private health care providers	3	7.3

\*Multiple choice question which allows to select more than one correct answer.

**Table 24. Percentage of PRIVATE funding/sponsor received 2005 for HTA activities**

% of private funding	N	%
0%	28	71.8
0,1-15%	7	18.0
>15%*	4	10.3

\* Four institutions were receiving 30%; 65%; 80% and 95% of private funding for HTA activities

**Table 25. Private institutions sponsoring / funding the organisation\***

Private institutions funding the organisation	N	%
Industry	8	19.5
Research funding bodies	6	14.6
Health care providers	3	7.3
Academia/University	2	4.9
Donor agency	2	4.9
Medical insurances	0	0

\*Multiple choice question which allows to select more than one correct answer.

## Section 5. Work process

**Table 26. Responsible for setting the priorities\***

Responsible for setting priorities	N	%
Department/Ministry of health	22	53.7
Direction	18	43.9
Executive board	12	29.3
Scientific committee	10	24.4
National health service	6	14.6

\*Multiple choice question which allows to select more than one correct answer.

**Table 27. Use of an explicit process for priority setting (N=38)**

Use of process	N	%
Yes	20	52.6
No	18	47.4

**Table 28. Criteria used to set priorities \***

Criteria used to set priorities	N	%
Burden of disease	17	85
Frequency of the clinical condition	16	80
Health care cost	15	75
Medical practice variations	12	60
Ethical, legal or social implications	12	60
Changes to change interventions	11	55
Political concern	10	50
Chances of change in costs	7	35
Public and media concern	5	25

**Burden of disease.**- Mortality, morbidity and quality of life related to a clinical condition (DALYs, QALYs, etc)

**Frequency of the clinical condition.**- Prevalence, incidence

**Health Care cost.**- The direct cost of the health care of an individual per year

**Medical practice variations.**- Those not related to demographic differences

**Ethical, legal or social implications.**- Chances to overcome problems from these areas. Equity is included here

**Chances to change interventions.**- Administrative decisions, medical practice or health outcomes

**Political concern.**- Needs of information of policy makers

**Chances of change in costs.**- Related to the potential changes in the health care attention of a clinical condition

**Public and media concern.**- Social interest to overcome specific clinical conditions

\*Multiple choice question which allows to select more than one correct answer.

**Table 29. Process of priority setting followed by the organisation**

Priority Setting			
<b>Frequency</b>	Once a year (three organisations) Once a month (one organisation)		
<b>Participating Bodies</b>	<p><b>Development of a priority list:</b>            Staff Stakeholders            Collaborating experts Professional societies            Policy makers Scientific Advisory Boards</p> <p><b>Final decision making:</b>  <i>Internal bodies</i>                      <i>External bodies</i>                      <i>HTA agency jointly with</i>  <i>external bodies</i>            Executive Board                      Ministry of Health                      Advisory Committee            Direction                      Consultative Council                      National Board of Health            Staff                      Scientific Board                      Health Department</p>		
<b>Examples of approaches for priority setting</b>	<p><b>1. Approach:</b> (one organisation)</p> <p>Application of <i>Delphi technique</i></p>	<p><b>2. Approach:</b> (one organisation)</p> <p><i>Ad hoc acceptance for Rapid Assessments</i></p>	<p><b>3. Approach:</b> (one organisation)</p> <p><i>Situational analysis</i> ↓  <i>Evaluation of resources</i> ↓  <i>Appraisal of relevance and feasibility</i> ↓  <i>Definition of objectives</i> ↓  <i>Development of implementation plan</i> ↓  <i>Proposal of future steps</i></p>
	One organisation declared that the set priorities are not static but rather change frequently in response to the Health Ministry.		
<b>Criteria</b>	<ul style="list-style-type: none"> <li>- Health needs</li> <li>- Health Ministries program and policies</li> <li>- Frequency of requests from end users</li> <li>- Agency's response activity / Capacity</li> <li>- Patient safety</li> <li>- Clinical effectiveness</li> <li>- Costs</li> <li>- Researcher interest</li> <li>- Future known projects</li> <li>- Varying criteria depending on the staff involved in the specific research</li> </ul>		

**Table 30. Mechanisms available for the organisation to set priorities\***

Mechanisms available	N	%
Policymakers/Government representatives	19	54.3
Experts on specific topics	17	48.6
Health care professionals	15	42.9
Patient representatives	5	14.3

Health care insurance (private or public)	3	8.6
Industries, manufacturers	3	8.6

\*Multiple choice question which allows to select more than one correct answer.

**Table 31. Assurance of the quality of the products/services\***

Assurance of the quality of the products	N	%
Internal review of the reports	38	92.7
External review of the reports	32	78.0
Check list	17	41.5
Quality management system	7	17.1
Certified quality management system	0	0

\*Multiple choice question which allows to select more than one correct answer.

**Check list.**- Document describing how you are going to work or develop each specific product

**Quality management system.**- Document describing a way of working for your organisation, not only HTA work but also management

**Certified quality management system.**- Official certificate (ISO, others) for your quality management system

**Table 32. Attitude of the organisation about assessing the impact of the recommendations**

Impact Assessment	
<b>Appraisals of the significance</b>	<p><u>Positive attitude</u> Eight comments support the necessity of the performance of impact assessment Appraisals range from “useful”, “desirable”, “important” to “central”</p> <p><u>Sceptical attitude</u> Three sceptical comments range from “complicated, “problematic” to “very costly”.</p>
<b>Past and current practice</b>	<p>Six organisations described their approach in assessing the impact. The applied criteria are:</p> <ul style="list-style-type: none"> <li>- Approval of technologies</li> <li>- Presence in media</li> <li>- Web page downloads</li> <li>- Surveys of usage</li> <li>- Renewal of work commissions</li> </ul>
<b>Ambitions for the future</b>	<p>Four organisations plan to conduct impact assessment in future or to expand their activities.</p>
<b>Perceived barriers</b>	<p>Eight organisations revealed the barriers they perceive. Reasons for reluctance in assessing the impact relate to:</p> <ul style="list-style-type: none"> <li>- Deficits in <i>funding</i></li> <li>- Limitations in the <i>responsibilities</i></li> <li>- Difficulties in the <i>performance</i> of impact assessments itself</li> </ul>

**Table 33. Frequency of the impact assessment of the recommendations**

Frequency	N	%
Always	4	11.4
Frequently	7	20.0
Occasionally	16	45.7
Never	8	30.0

**Always.-** Assessing the impact of all the recommendations

**Frequently.-** Assessing the impact of most of the recommendations

**Occasionally.-** Assessing the impact of few of the recommendations

**Never.-** Don't assess the impact of none of the recommendations

**Table 34. Inclusion of indicators to assess the impact of the products (N=33)**

Inclusion of indicators	N	%
No	23	69.7
Yes	10	30.3

**Table 35. Opinion on the general impact of the recommendations (N=26)**

Degree of impact of the recommendations	N	%
High	4	15.4
Moderate	13	50
Few	1	3.8
None	8	30.8

**Table 36. Criteria used by the organisation to assess the impact of its recommendations \***

Criteria use to set priorities	N	%
Variation in practice before and after recommendation	16	42.1
Variation between current practice and recommended practice over time	12	32.1
Changes on organisations or facilities	11	28.9
Changes in legislation	10	26.3
Level of technology diffusion over time	8	21.1
Changes in the cost of the medical practice over time	6	15.8
Change in health outcomes over time (clinical changes)	3	7.9
Changes in health from the point of view of patients	1	2.6

\*Multiple choice question which allows to select more than one correct answer.

**Table 37. Most important aspects to reach a high impact of the recommendations\***

<b>Important aspects to reach a high impact</b>	<b>N</b>	<b>%</b>
Reputations and credibility of HTA unit	25	61.0
Involving stakeholders	24	58.5
Timeliness	22	53.7
Quality of products	22	53.7
Dissemination strategies	20	48.8
High readability of products	15	36.6
Supporting organisational structures	12	30.8
Updating process	10	24.4

**Involving stakeholders.**- Inclusion of some users in the developing group

**Timeliness.**- Information provided by your organisation which has a current interest for your costumers / requires

**Quality of products.**- Thorough and unbiased research

**Dissemination strategies.**- Distribution of your products to specific target audiences

**High readability of products.**- Writing the products in a readability way

**Supporting Organisational Structures.**- Decision making structures (e.g., standing or ad hoc committees) and / or communication channels and networks in place, established by the requesting organisation or individual

**Updating process.**- specific aspects of the process for requesting and developing the product ( e.g. request and updated of products or considering regular update of products on high priority topics )

\*Multiple choice question which allows to select more than one correct answer.

## Section 6. Visibility

**Table 38. Existence of a formal procedure to disseminate its products (N=40)**

Existence of a formal procedure	N	%
Yes	30	75
No	10	25

**Table 39. Methods or activities taken by the organisation to disseminate the products\***

Methods used to disseminate the products	N	%
Website	36	92.3
Participation in academic, scientific and training activities (presentations, posters, teaching activities)	33	84.6
Organisation of academic, scientific and training activities (meetings, seminars, congress)	31	79.5
Electronic and printed versions of reports	31	79.5
Papers published in national scientific journals	28	71.8
Papers published in international scientific journals	25	64.1
Electronic and printed versions of newsletters	25	64.1
Collaboration with media (press release and interviews)	16	41.0
Opinion leaders	15	38.5

\*Multiple choice question which allows to select more than one correct answer.

## Appendix4. Collection of answers to the questions “Others please, specify”

### Section 1. Establishment of the organisation

**Table1. Initiative in the establishment of the organisation**

<b>Initiative in the establishment</b>
The dean of the Health Sciences Faculty of the University
The initiative in the establishment of an HTA unit was taken by 2 health care managers (a medical directorate's physician and an expert of health care organisation and management)
Established as the federal association of the then thousands of regional health insurance funds, not as a HTA organisation; HTA is but one of the many tasks of the organisation
Regional government
The Institute has not been established as an HTA agency. In fact the institution is not an explicit HTA agency. The institute was founded in 1943 as an institute in tropical medicine. Later on it developed competences in Public Health, International Health and Health Systems Development. Today the conducted work in the wider frame of HTA (Guidelines development, Technology assessment, Introduction of Quality Assurance Systems, Capacity building (training) in EBM/HTA). This is mainly done in the frame of International Projects but also on behalf of the Government for the Health system in certain areas.

**Table 2. Barriers in the establishment of the organisation (N=38)**

<b>Existence of barriers in the establishment</b>
There were no major barriers as this was decision made at a high policy level. Some groups/institutions were sceptical to gathering what could be seen as too much power in one place
To convince the hospital management of utility of the HTA-unit establishment
Consensus was difficult to reach with areas of the Health Ministry that were performing some of the activities that the agency acquired

**Table 3. Important aspects in the establishment of a new agency (N=28)**

<b>Important aspects taking into account in the establishment</b>
/*

\* No answered was reported on this aspect

### SECTION 2 Specific background of the organisation

**Table 4 . Profile of the organisation (N=40)**

<b>Profile of the organisation</b>
HTA unit is part of the university hospital medical directorate and is directly supervised by medical director.
The organisation is a corporation under public law
The institution is a non-profit organisation owned by the a Medical Association and by the National Association of Statutory Health Insurance Physicians.
The organisation is wholly governmental funded, but is established as a not-for-profit independent agency
The organisation is a public decentralized organisation. The best way to understand it is like a public enterprise that answers to a tripartite council integrated by entrepreneurs, union leaders and government officials.

The institute is a non-governmental organisation; but based on a government act. Further there are close links to the University and conduct courses on behalf of the University.
The agency is integrated inside the Department of Assurance and Health planning and belongs to the regional health ministry
A non for Profit Agency
Private research institute
Independent organisation partly funded by regional authorities

**Table 5. Collaboration at national level (N=39)**

Type of National collaboration
Ministry of health, regional government; regional health agencies
Public payers (compulsory sickness funds, pension funds)

**Table 6. Collaboration at international level (N=40)**

Type of international collaboration
International organisations, as HTAi, INAHTA, OECD, Euroscan, WHO
International organisations such as WHO, ILO
EUnetHTA, InnoHTA (European research project)
Other HTA agencies from outside Canada
EuroHealthNet
EUnetHTA
Other HTA units

### Section 3 Aims and scope of the organisation

**Table 7. Working at national, international or local-regional level (N=41)**

Type of working level
Meso-level; the hta unit works at health care organisation level

**Table 8. Main lines of activity of the organisation (N=41)**

Lines of activity
Training projects in HTA; Quality improvement activities (focused on: institutional accreditation for services and operative units' excellence)
HTA is only one of 3 programmes within the agency. Response to this survey focus only the HTA programme
Horizon Scanning
Dissemination of studies on HTA; qualification and formation of human resources from the Unified Health System; definition of methodological guidelines; elaboration of rapid reports.
Answer to questions regarding PH system assessment, evaluation, priority lists for PH activities, including health promotion, education. Interventions in special epidemiological context. Evaluation of activities of PH local authorities.
Conducting training courses, providing services (system assessment, evaluation of programmes, technology assessment, clinical trials, project planning, etc.
The organisation for HTA, which is part of the Institute for Health Research and Development at the University, coordinates the HTA programme on behalf of the Department of Health's

Research and Development at the University, coordinate the HTA programme on behalf of the Department of Health's Research and Development Division.
Planning Health Care activities (including everything connected with patients, hospitals, at a Regional level)
Mediating information produced by other HTA agencies, tailored and translated into the official language

**Table 9. Types of health technology (HT) that the organisation assess (N=40)**

Type of HTA assessed
1 Main biomedical equipments (es. TAC, PET, MRI, ultrasound)
Pharmaceutical assessment mainly for tropical diseases.
Methods of organizing health care.
2 : Screening programmes

**Table 10. Types of products and services that the organisation does (N=41)**

Types of products and services
University Hospital's 2004-2006 Investment Plan; Research projects finances by the Ministry of Health or by CE ( these projects are usually carried out in collaboration with the faculty of medicine and Surgery's institute of Hygiene); Newsletter; Organisation of meetings and conferences
The guidelines given for the whole Health Care regional setting are made through deliberations of Executive Committee that represents the executive body of the local (regional) government
Support for primary HTA projects for including systematic reviews or economic analyses

**Table 11. Main requester (N=41)**

Main requesters of products and services
The University Hospitals Management; hospital's office in charge of technological choices
The organisation is contracting projects from other organisations, in those the respective groups place their suggestions for projects
Development banks, development organisations
We usually do not produce this kind of report

**Table 12. Main target people to whom the recommendations are addressed (N=35)**

Main target people
The University hospitals management; hospitals offices in charge of technological choices
Recommendations are published as part of the report at may be taken into read by anyone
Sometimes it is appropriate for us to produce recommendations and sometimes it is not.
Hospitals-action plan in nosocomial infection outbreak
Hospitals, patients, providers

## Section 4. Structure of the organisation

**Table 13 . Organisation of the management**

<b>Organisation of the management</b>
The HTA unit is not an oligarchic structure. it has 1 responsible for executive activity and one responsible for research activity and staff from various backgrounds. It is directly supervised by the hospital director.
University Institute, is "managed" universities administrative bodies
The organisation is embedded in institutions with executives etc.
It is directly part of the structure of the medical directorate. Depending of the Health Policy Coordination. There is a staff group to whom the results are presented. This is directly headed by the Director of the Medical Directorate of the Institute of Social Security.
Though in the everyday work, the organisation is independent from governmental decisions, there is an executive board, that is the maximal authority. This board is presided by the Health Minister and other areas of the health sector that take part in it
The organisation has a number of boards: Commissioning board;HTA Clinical Trials Board; Editorial board
Regional Governor; Governance Board, legislative body; Executive Committee, executive body.
The organisation is part of a larger research organisation and some of the management takes place through it, for example personnel services, premises.

**Table 14. Information about the staff**

<b>Profile</b>
HTA-unit: 1 permanent staff (physician), 1 temporary researcher, part time (psychologist), 1 temporary documentation specialist, 2 free lance (physician, social scientist)
40 Internship in the last 3 year
3 full time professional staff, 1 administrative/support person
2 grant co-PIs
<b>Background</b>
Dentists, Pharmacists, Physiotherapists
1 expert of public relations and operative activities coordination; 1 electronic engineer, 2 biomedical engineers; 2 students in economics
Pharmacists, lawyers, biotechnology engineer
Administrative
Nurse and social science in one person
In our organisation, there are about 100 academic professionals from many different backgrounds, including economists, lawyers, physicians, social scientists etc. The number of physicians is about 15, mostly clinicians from different fields, some of them with epidemiologic ans / or public health

qualification.
3 secretaries, 5 documentation specialist, 1 nutrition specialist, some of the academics have double qualifications: 1 physician/social scientist; 1 physician(public health specialist; 1 psychologist/statistician; nutrition specialist/public health specialist;
Molecular Biologist 2
Pharmacist 2; Administration 1
1MD, Phd in Obstetrics; 1 Nutritionist, MSc in Public Health; 1 Nutritionist, MSc in Nutrition; 1 Physical Therapist; MSc in Biomedical Engineering; 1 Speech and Language Therapist, MSc in Public Health; 1 Internal MD; 1 Pharmacist, 1 Pharmacist and Biochemist and 1 Executive Secretary.
Computer programmes (3) Webmaster (1)
Veterinary technician (1), cleaners (4) electrician (1)
Medical Engineers, Pharmacists
5 Biomedical Engineers and Medical Physicists
secretarial/admin/financial = 11 computer support/database programming =2
2 biomedical engineers 1 health lawyer
Political Science: 3, Anthropology: 2, Adm. science: 2
chemist, physicist
10 Biomedical engineers
4 secretaries with commercial training

**Table 15. Facilities and equipment available in the organisation**

<b>Facilities and equipment</b>
facility of the mother organisation is available proper facilities for 300 employees
12 Workstations
we have no free offices but a variable number of free places in shared offices
Beamer; Media-utilities
Testing equipment
The organisation has offices in two cities. In the mother organisation's respective offices. There are use reception services, an extensive library, training and meeting rooms. The offices are 8-12 m2 each,

**Table 16. Funding of the organisation for HTA activities (N=41)**

<b>Source of funding of HTA activities</b>
Participants of the symposium and courses
Our incomes: expertise, laboratory diagnosis, recommendations, notifications, private companies sponsor scientific meetings
Researchers from the national ministry of health.
EU funding for selected projects

**Table 17. Private institutions sponsoring / funding the organisation (N=39)**

<b>Private institutions funding the organisation</b>
No private institutions sponsor .
Public funds (government) 90%, Industry 10%

**Section 5. Work process****Table 18. Responsible for setting the priorities (N=41)**

<b>Responsible for setting priorities. <i>Internally</i></b>
HTA unit's executive responsible
The Health Technology Advisory Committee
HTA working group
Director

<b>Responsible for setting priorities. <i>Externally</i></b>
We ARE government
Donor agencies

**Table 19. Criteria used to set priorities (N=20)**

<b>Criteria used to set priorities</b>
Good research opportunities with sufficient financial support.
Diffusion pressures (Provincial, national & International); Intuitive response; Whether alternative technologies exists
Priority setting around internal research activities- criteria vary with the staff initiating and supervising the research.
Priorities of the public health programs.
We consider all the variables listed above even if we do not explicit them.
Need of information among practioners or policy makers

**Table 20. Mechanisms available for the organisation to set priorities (N=35)**

<b>Mechanisms available</b>
Advisory Scientific Board
Policymakers and Consultative Council appointed by the minister that is competent for health issues

This does not refer to priority setting for the organisation
The above are consulted during the process of topic selection
The Advisory Board meets twice a year to provide support for broad priority and other policy decisions.

**Table 21 . Main Barriers in daily work**

<b>Main Barriers</b>
People culture

**Table 22. Issues taken into consideration in the assessment of health technology (N=41)**

<b>Issues considered in the assessment of HTA</b>
variable, depends on the question posed by the commissioning body

**Table 23. Assurance of the quality of the products/services (N=41)**

<b>Assurance of the quality of the products</b>
Collaboration with external experts in each field
Use of templates.
Certified quality management system should be implemented

**Table 24. Criteria used by the organisation to assess the impact of its recommendations (N=38)**

<b>Criteria used to set priorities</b>
Variations in recommendations made by expert body
Changes in health policies
payback gained from the funded projects in five dimensions: knowledge; benefits to future research and research use; political and administrative benefits; health sector benefits; and broader economic benefits. This can be measured in terms of the publication produced, the conference presentations given, numbers of research students trained, the projects that have followed on from the initial one, and the wider impacts on health policy.
Policy changes

**Table 25. Most important aspects to reach a high impact of the recommendations (N=28)**

<b>Important aspects to reach a high impact</b>
/

## Section 6. Visibility

**Table 26. Methods or activities taken by the organisation to disseminate the products (N=39)**

<b>Methods used to disseminate the products</b>
The commissioning agency does dissemination
The organisation does not own the copyright of much of the work produced and are therefore subject to considerable controls by the paymaster on what should be disseminated.
Forums and meetings with strategic partners and social actors.