A SHORT HISTORY OF INAHTA

David Hailey

Alberta Heritage Foundation for Medical Research, Edmonton

Devidas Menon

Institute of Pharmaco-Economics, Edmonton

Abstract

The need for better communication and collaboration between health technology assessment agencies led to the formation of an International Network of Agencies for Health Technology Assessment (INAHTA). The network now comprises 27 agencies and has been successful in improving exchange of information and in undertaking joint health technology assessment projects. Issues for the future include possible changes to criteria for membership and identification of resources for more extensive programs.

Keywords: International Cooperation, Technology Assessment Biomedical, Data Bases Bibliographic

THE FORMATION OF INAHTA

Over a number of years there has been an increasing trend toward international collaboration in health technology assessment (HTA). Reasons for international cooperation include a wish to reduce the duplication of studies, enable a more efficient sharing of expertise and information, and to advance the field of HTA (5). Part of this trend has been the increasing contact between HTA agencies in a number of countries that have been established to provide advice to governments. The number of such agencies has increased at both the national and regional level. They frequently find themselves confronted with similar assessment topics and issues.

It was with these trends in mind that in 1992 the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) organized a meeting between representatives from a number of official HTA agencies and others with similar interests, immediately prior to the Annual Meeting of the International Society of Technology Assessment in Health Care (ISTAHC) in Vancouver. Essentially, this was a "show-and-tell" session, with seven agencies from Canada, the United States, the United Kingdom, Australia, Sweden, and France giving details of their methods of operation, work program, and products (2).

This meeting generated considerable interest and started consideration of how HTA agencies might strengthen their links. The following year, at the ISTAHC meeting in Sorrento, a further short seminar was held, again with some focus on agencies' activities and responsibilities. It was realized, however, that there was now a need to move beyond the occasional exchange of information to a more

systematic approach. Detailed discussions between representatives of a smaller group of agencies (from Australia, Canada, Great Britain, France, Spain, and Sweden) then followed during the ISTAHC meeting, and a draft proposal was developed. This proposal outlined potential areas of activity for a formal grouping of agencies. A number of organizations were invited to a meeting to discuss implementing the proposal. The suggested name for a link between agencies was the International Network of Agencies for Health Technology Assessment (INAHTA).

The meeting at which INAHTA was established was hosted by ANDEM[1] in Paris in September 1993. Other organizations represented were AIHW, CCO-HATA, CAHTA, GR, NHSCRD, OHTA, Osteba, OTA, SBU, TNO, ZFR, the U.K. Cochrane Centre, the Swiss Public Health Institute, and the World Health Organization, Geneva. It was agreed that agencies would contribute funds to establish a moderate secretariat, to be located at CCOHTA in Ottawa. The membership would comprise organizations that were predominantly publicly funded and provided advice to governments. As a first collaborative activity, a database of structured abstracts of agencies' publications would be prepared. Future organization and activities of the network would then be discussed at a meeting to be held in conjunction with the 1994 ISTAHC meeting.

At the 1994 INAHTA meeting, held in Baltimore and chaired by a representative of the U.S. OHTA, further decisions on structure and activities were made. It was agreed that INAHTA would be open to organizations that operated ongoing HTA programs, produced HTA reports regularly, and received at least 50% of their operating funds from public sources. A three person Executive Board was elected to steer the administration of the network for the following year. This Board comprised representatives of AIHW as Chair, of SBU as Vice Chair, and of CCOHTA as Secretary/Treasurer. It was also agreed that the secretariat would continue to operate out of CCOHTA.

The first version of the database of abstracts was considered to be a success, and it was agreed to update and expand this over the next year.

SUBSEQUENT GROWTH OF THE NETWORK

The 1994 Baltimore meeting set the pattern of subsequent annual face-to-face meetings of the full INAHTA membership. Meetings have been held immediately before or after the Annual Meeting of ISTAHC. The Chairs of the Executive Board have since been held by representatives of SBU and Osteba.

In 1996 it was decided that the secretariat of the network would move from CCOHTA to another member agency. This move took place officially in the fall of 1996. The activities of the secretariat are now managed by a group of staff members of SBU in Stockholm. The network has continued to grow, and as of September 1998 had 27 members (Table 1). The membership includes agencies funded by national governments as well as those whose funding is from regional or provincial governments. Consequently, there are several agencies in the network from a single country (three in Canada and four in Spain, for example). Members of the network do not represent their governments. Each agency is a member because of its interests in developing and promoting interagency international cooperation and progress in HTA, and represents only itself within the network—this is the very essence of INAHTA.

Table 1. Members of INAHTA

	Agency	Year of membership
AETS	Agencia de Evaluación de Tecnologías Sanitarias, Madrid (Spain)	1995
AETSA	Agencia de Evaluación de Tecnologías Sanitarias de Andalucia, Seville (Spain)	1997
AHCPR	Center for Health Care Technology, Agency for Health Care Policy & Research, Rockville, MD (USA)	1993 (Originally as Office of Health Technology Assessment, OHTA)
AHFMR	Alberta Heritage Foundation for Medical Research, Edmonton (Canada)	1996
(AHTAC)	Australian Health Technology Advisory Committee, Canberra	1994 (Abolished 1998, functions subsumed by Medicare Services Advisory Committee)
(AIHW)	Australian Institute of Health & Welfare, Canberra	1993 (Left in 1995 after a change in mandate)
ANAES	Agence Nationale d'Accréditation et d'Evaluation en Santé, Paris (France)	1993 (Former title: Agence Nationale pour le Développement de l'Evaluation Médicale, ANDEM)
CAHTA	Catalan Agency for Health Technology Assessment, Barcelona (Spain)	1993
CCOHTA	Canadian Coordinating Office for Health Technology Assessment, Ottawa	1993
CEDIT	Comité d'Evaluation et de Diffusion des Innovation Technologiques, Paris (France)	1994
CETS	Conseil d'Évaluation des Technologies de la Santé du Québec, Montreal (Canada)	1995
DIHTA	Danish Institute for Health Technology Assessment, Copenhagen	1998
DSI	Danish Institute for Health Services, Copenhagen	1995
ETESA	Unidad de Evaluación de Tecnologías de Salud, Santiago (Chile)	1998 (provisional)
FinOHTA	Finnish Office for Health Care Technology Assessment, Helsinki	1996
GR	Health Council of the Netherlands, Rijswijk	1993
ICTAHC	Israel Center for Technology Assessment in Health Care, Tel-Hashomer	1998 (provisional)
MSAC	Medicare Services Advisory Committee, Canberra (Australia)	1998
NCCHTA	National Coordinating Centre for Health Technology Assessment, Southampton (UK)	1997
NHSCRD	NHS Centre for Reviews and Dissemination, York (UK)	1993
NZHTA	New Zealand Health Technology Assessment, Christchurch	1998
Osteba	Basque Office for Health Technology Assessment, Vitoria-Gasteiz (Spain)	1993

(Continued)

Table 1. *(Continued)*

	Agency	Year of membership
(OTA)	Office of Technology Assessment, Washington, DC (USA)	1993 (Left in 1995, abolished)
SBU	Swedish Council on Technology Assessment in Health Care, Stockholm	1993
SFOSS	Swiss Federal Office of Social Security, Bern	1993 (Original member was Swiss Public Health Institute)
SHPIC	Scottish Health Purchasing Information Centre, Aberdeen	1996
SMM	Norwegian Centre for Health Technology Assessment, Oslo	1998
TNO	TNO Prevention and Health, Leiden (The Netherlands)	1993
VATAP	Department of Veterans' Affairs Technology Assessment Program, Boston, MA (USA)	1996
ZFR	ZiekenfondsRaad, Amstelveen (The Netherlands)	1993

There have been two bodies with which it has been very important for INAHTA to develop linkages. EUR-ASSESS was a time-limited project funded by the European Union to promote the coordination of HTA among its member states. All of the European member agencies of INAHTA were also in EUR-ASSESS and the relationship between the two networks was open and cordial. EUR-ASSESS created several working groups that developed a series of reports dealing with important issues in HTA. Topics addressed included priority setting, dissemination, coverage, and methodological guidance (1). On the other hand, INAHTA has been concentrating on the exchange of information on the work programs and products of its members and in undertaking collaborative assessments.

The relationship between INAHTA and ISTAHC has also been constructive. It was made clear at an early stage that INAHTA saw itself as complementary to the Society and not in competition or duplicating activities. Also, the network was not itself a source of financial support for ISTAHC, having resources only for a modest secretariat, though individual member agencies provided substantial support, for example, through multiple memberships of the Society.

OUTPUTS OF THE NETWORK

Newsletter

A basic newsletter was established in the early days of the network to help keep members in touch with developments. This was subsequently developed further, with an improved format, by the secretariat at SBU and has been circulated more widely. Recent issues have included details of member agencies and selected assessment publications. English, French, and Spanish language versions are available.

Home Page

An INAHTA home page has been developed by the secretariat, and includes a listing of publications produced by member agencies. It is expected that in the

Table 2. INAHTA Projects

Completed

The effectiveness of bone density measurement and associated treatments for prevention of fractures:

- *Statement of findings.* September 1996 (Summary document also available).

- *Background paper one. Methods used in the measurement of bone density.* July 1996.

- *Background paper two. Predictive value of bone densitometry.* July 1996.

- *Background paper three. A review of the evidence of hormone replacement therapy and calcitonin in reducing bone loss and fractures.* September 1996.

(Author agencies AHFMR, AIHW, CAHTA, NHSCRD, OSTEBA, SBU).

In progress

Prostate-specific antigen screening. *A project based mainly on five systematic reviews published by INAHTA agencies* (coordinator, SBU).

Positron emission tomography. *Updated systematic reviews of the clinical PET literature* (coordinator, VATAP).

Telemedicine. *A project covering the current status of telemedicine, with emphasis on assessment, organizational, and planning issues* (coordinator, AHFMR).

---

future it will provide linkages to the Web sites of member agencies as well as other organizations.

Collaborative Projects

INAHTA has completed one joint HTA project and three others are currently in progress (Table 2). The first joint project considered an area (bone density measurement and treatments for prevention of fractures) of considerable interest to many health authorities. Features of the project included preparation by five agencies of working papers and a statement of findings, all of which were subjected to peer review. Details of the assessment process and outcomes have been published elsewhere (3,4).

The projects now in progress are also addressing topics of major importance in health care. Following experience gained with the first joint assessment, in each case an agency has been identified to act as coordinator (SBU for prostate-specific antigen screening, VATAP for positron emission tomography, and AHFMR for telemedicine).

Database/Registry of Reports and Projects

The approach to the database of publications has changed, with the secretariat now focusing on preparation of lists of completed publications and of projects in progress. Abstracts of INAHTA member reports are available in the DARE database, which is managed by NHSCRD. In addition, most of them are also retrievable from the National Library of Medicine's HealthStar bibliographic database. A separate database for the abstracts may be created by NHSCRD, which will be freely available over the Internet.

SOME CONTINUING ISSUES

INAHTA started off as an experiment that resulted from a perceived need for better communication and coordination among HTA agencies. As is the case with individual HTA agencies, there are no simple ways to evaluate the success of an

organization like INAHTA. However, some conclusions could be drawn that suggest that INAHTA has attained some degree of success.

First, there is the fact that the membership has been constantly growing. Given that the typical HTA agency has a rather small discretionary budget, it is meaningful that such agencies are prepared to invest some of this in a membership fee, and for travel to and participation in INAHTA meetings. Further, no members undertaking HTA have yet dropped out of the network (though some have ceased to exist or have had a change of mandate, as shown in Table 1).

Second, communication between agencies, both in quantity and quality, has improved. It is fair to say that before the network was established, contact between HTA organizations was minimal. Now, based at least on accounts from individual agencies, it has improved considerably. There is more communication about new projects and sources of information between the member agencies. The network's newsletter has helped this process.

Third, as mentioned elsewhere in this paper, collaborative projects have been initiated. The network has provided the forum for subgroups of member agencies to identify their interest in specific projects. To an extent, this is already serving to reduce duplication of effort in the assessment of specific technologies.

As the network continues to develop, it faces a number of issues that will affect its nature and the way it operates. Not least of these is the question of the level of resources that will be made available by members for joint activities. So far, the comparatively modest annual fee has been sufficient to support the secretariat, annual meetings, printing costs for the newsletter, and to provide minor assistance for projects. The collaborative assessments have depended heavily on the input provided by individual member agencies, which have undertaken these assessments as an addition to their own work programs.

Clearly, there are limits to such activities, even with a strong commitment to support INAHTA. The nature of the agencies making up the network is very diverse. Substantial increases in the membership dues would be likely to present difficulties for a number of organizations, both with regard to their budgets and in terms of what they might regard as value for money. The question of resources will clearly affect the extent to which INAHTA can move to new areas of activity, such as support for HTA in developing countries, which is a topic currently receiving consideration.

Another topic that has been debated is whether the criteria for membership of the network should be modified. There is general agreement that INAHTA should continue to be made up of organizations that are actively involved in HTA and which do not have commercial/financial interests in health technologies and services. Also, in general, INAHTA agencies provide advice to governments. Discussion is continuing on whether the criterion for sources of funding might be modified to permit private support in situations where an organization is acting as a source of advice for large sectors of the population which are not covered by government-funded HTA.

Finally, there is the question of how the network should be administered as it grows larger, when the relatively informal arrangements used so far may become less satisfactory. The next few years promise to offer both further opportunities for international links in HTA and some substantial administrative challenges.

NOTE

¹ Names of agencies referred to by acronym are shown in Table 1.

REFERENCES

1. Banta, H.D. Report from the EUR-ASSESS project. *International Journal of Technology Assessment in Health Care*, 1997, 13, 133–340.
2. Clark, E., & Marshall, D. (eds.). *Technology assessment: National and international perspectives on research and practice. Summary of proceedings.* Ottawa: Canadian Coordinating Office for Health Technology Assessment, 1992.
3. Hailey, D., Marshall, D., Sampietro-Colom, L., et al. International collaboration in health technology assessment. A study of technologies used in management of osteoporosis. *Health Policy*, 1998, 43, 233–41.
4. Hailey, D., Sampietro-Colom, L., Marshall, D., et al. *INAHTA project on the effectiveness of bone density measurement and associated treatments for prevention of fracture. Statement of findings.* Edmonton: Alberta Heritage Foundation for Medical Research, September 1996.
5. Menon, D., & Marshall, D. The internationalization of health technology assessment. *International Journal of Technology Assessment in Health Care*, 1996, 12, 45–51.