

Osteba

OSASUNERAKO
TEKNOLOGIEN
EBALUAKETA
EVALUACION DE
TECNOLOGIAS
SANITARIAS



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REPORT

The Prioritisation of Evaluation Topics of Health

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REPORT

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I. Summary

CONTEXT

The rapid development of scientific and technical advances in the field of medicine is making available to the health system a large number of preventive, diagnostic, therapeutic and rehabilitative technologies, the effectiveness of which is not always known and the implementation of which forms an important part of health sector costs. Decisions relative to these areas must be based on current and scientific information, making use of explicit criteria because, done in another way, they would be based on incomparable implicit criteria with greater probability of bias and, therefore, difficult to justify.

At a time when resources become more and more limited and the needs of the public can arise on limitless occasions, the establishment of our own health policy for our autonomous community is made more and more necessary in order to achieve the best results at all times with the available resources and with effective cost control.

The Basque Autonomous Community (BAC) has complete autonomy in health issues to create and incorporate services that it considers appropriate in the sphere of the Basque Country. The authorisation of the Health Department regarding procedures and technologies and their implementation in the public and private network of our community, must be scientifically and technically based.

It is necessary, therefore, to take decisions based on priorities, as much in the development as in the adoption and diffusion of health technologies, which are subjected to evaluation and which guide the identification of medical research and health service needs.

Health Technology Assessment (HTA) determines the benefits and costs of a technology by comparing different alternatives. It also studies variations in its utilisation and appropriate use, including studies on social and ethical con-

sequences of its application and the factors that speed up or impede its diffusion. HTA, being directed towards decision-making, should be based on science and scientific methods.

Given the number of aspects to be considered, HTA is an interdisciplinary field. Its activities incorporate professionals from medicine, social sciences, health service research, engineering, ethics and economics. Also, public representatives take part more and more often.

One problem of HTA is the selection of topics to be evaluated or the projects to be developed, mainly when the resources for evaluation are limited and the quantity and scope of the topics to be dealt with is very large. Because of this it is necessary to develop an explicit, participatory and reproducible prioritisation process which allows identification of the most interesting areas. If the prioritisation is not developed explicitly, the selection would be made in an implicit way which would add to the influence of intuition, chance and bias.

The prioritisation process attempts to structure thought, to identify the relative importance of the different factors under consideration and to estimate the potential impact of an evaluation. Because of this, one of the main tasks is to define which criteria are of use in valuing health technologies or the clinical conditions to which they are applied.

METHOD

Of the results taken from the selected bibliography, Osteba valued positively the clarity and the simplicity of the presentation of the process proposed by the Institute of Medicine (IOM) described in 1992 by Donaldson and Sox. The IOM process is explicit, with well-differentiated stages and with a reasonable mathematical model. Because of this, it was decided to apply this method to our own context.

The IOM method consists of seven stages and takes into account seven weighted criteria. Some of which are quantitative (prevalence, costs, variation in the rates of use) while others are qualitative (burden of the disease and influence of the results of the evaluation on different aspects). It is based on consensus and on synthesis of information for the formulation of objective and subjective criteria as well as for scoring. In the cases in which it is not possible to have comparable objective data for all the technologies it is proposed that subjective scales are used. The final classification, in order of priority, is obtained by means of a mathematical model.

The prioritisation process was supervised by the Health Technology Assessment Office that co-ordinated the weighting, identification, selection and prioritisation stages, motivating the panels of experts and preparing the necessary material for the meetings and for the development of the consensus methods used.

The weighting of the seven criteria that are subsequently to be used in the mathematical equation applied to each technology, was effected by a multidisciplinary panel using consensus techniques (Nominal Group). The most important criteria was the variation in the rates of use and the least valued was the cost criteria.

A large number of health professionals, who were relied upon to identify the necessary topics to be evaluated put forward more than 120 proposals. This allowed the identification of a wide range of topics related to different levels of health care: primary care, diverse medical specialities, management and health planning. Finally, given the similarity between some of the proposals, the definitive list to which the formal process was applied contained 104 proposals which came from preventive, diagnostic and therapeutic areas of medicine and dealt with procedures already in use and also new technologies.

The Delphi Method with two consultations was used to obtain a reduced list of topics. 67 professionals from diverse areas and specialities took part. A system of "in and out" was applied in which a percentage of the technologies with the highest scores went onto the list for prioritisation. The final 50% were set aside and voting on the intermediate group was repeated. In this way, a list of 12 technologies was obtained which were the subject of the final part of the process.

After this, an active search of relevant information necessary to value each of the criteria applied to the technologies was undertaken. A dossier for each member of the scoring panel

TOPICS	SCORING
1 ^o Health care of the terminally-ill	21.83
2 ^o Use of antibiotics in primary care	20.30
3 ^o Periodic control of the chronically-ill. Protocol evaluation.	19.80
4 ^o In-patient and out-patient protocol for AIDS patients	16.99
5 ^o Out-patient surgery	16.12
6 ^o Menopausal care	15.87
7 ^o Laboratory and radiology tests in emergency services	15.70
8 ^o Home treatment	14.84
9 ^o Routine analysis in primary health care examinations	14.49
10 ^o Preanaesthesia Information	12.55
11 ^o Nuclear magnetic resonance. Protocol of use	10.59
12 ^o Training for personnel of health services.	9.89

was compiled and they went on to the following scoring stage.

On this occasion it appeared to be advantageous not to be as extensive as in the IOM model. So, a multidisciplinary panel of 10 experts was convoked with operational aims and. Those who took part were professionals from primary care, internal medicine, cardiology, quality management, ethics, health management, economics, education, nursing, epidemiology and, although they finally did not attend, consumers' representatives were also invited.

RESULTS

After the valuation of the criteria for each selected topic, the score was calculated, which resulted in the following list, classified in order of score.

CONCLUSIONS

The prioritisation process carried out by Oseteba involved the contextualisation of a method developed in the USA, a very different medium to our own, with this being one of the first experiences of implementation at a European level, as can be seen in the bibliography.

The unfavourable aspects of the process were related to the insufficient definition of the proposed topics and the lack of data to express criteria such as prevalence, cost and variation in the rates of use in a quantitative and homogeneous way.

The most positive aspect was working with an explicit, reproducible and transparent process. The project improved the service methodology itself and made it more systematic and it also may contribute to the introduction of working methods in which the recommendations are based on the maximum available evidence and on consensus.

The practical implementation of this prioritisation process allowed us to identify gaps and

deficits which made us reflect on which model to use in the future. In this report a model of "proposal of information/evaluation" is proposed with the intention of providing, in the future, a precise definition of the topics, to express in the most precise detail possible the reasons as well as the data and the necessary and available information sources. Given that the proposals come not only from formal but also from informal processes, these requested when needed, this application form can be a valid instrument to receive and limit the evaluation proposals or information.

One of the most relevant aspects of this process was the wide participation of professionals and the use of explicit criteria in the reflection process which, we believe, can contribute to an increase in the collective evaluation awareness in the health field.

At the same time, it is hoped that it is a valid and enriching contribution to the identification and synthesis process of the prioritisation models, as set out by EURASSESS.

II. Introduction

HEALTH CONTEXT

The Basque Autonomous Community (BAC) has a population of 2.3 million inhabitants. The Health System is basically public and guarantees total coverage. The total health expenditure is approximately 6.9 % of GNP while the public health expenditure is 4.9 % of GNP. In the last six years the increase in the health budget has been 14 %.

An important part of the cost in the health sector comes from the use of technical procedures varying from low to high technology. The rapid development of scientific and technological advances in the field of medicine has made a large number of preventive, diagnostic, therapeutic and rehabilitative technologies available to the health system. It appears to be that the emergence of these new health technologies and the degree of use of the existing ones are the determining factors for the increase in health expenditure. These factors have necessitated the setting of priorities, as much in the development as in the adoption and diffusion of the medical advances that guide technology evaluation and the health services as well as the identification of the needs of medical research.

There are some factors that could regulate the use of the technologies that don't exist in our health system. For example, mechanisms of competition between insurance companies or a reimbursement policy. Currently, the principal elements that influence the decision to use a technology come from scientific magazines and the industry itself, as well as experience in a closer context.

From the legislative point of view it can be seen that the Maastricht Treaty created developmental limitations in the European public sector. In the health sector this means the creation of a list of services. This catalogue establishes a list of acceptable services to be provided by the he-

alth systems; a dynamic list which must incorporate the most effective or least costly, but also effective, procedures and eliminate the obsolete and ineffective ones according to the degree of development. Every country that has reformed its health system relied on evaluating bodies to produce opinions, based on the current scientific evidence, to provide these decisions at the time of entering services in its catalogue.

In our case, the Health Department has the responsibility for the diffusion of health technologies and in his project of Health Reform, approved by the Basque Parliament on 23rd June, 1993, **Osasuna Zainduz** was presented as one of the necessary strategies for that reform, "Evaluating and accrediting new technologies, treatments and medication" (Strategy no. 22). It is understood, therefore, that the evaluation of health technologies must form part of the decision-making process.

At state level, the Royal Decree 63/1993 on Arrangement of Health Services in the National Health System, created a Catalogue of Minimum Services for the above system for those evaluation mechanisms already in use and for the new ones that would be incorporated in the catalogue.

The BAC has complete autonomy in health issues to create and incorporate services that it considers appropriate in the sphere of the Basque Country. The authorisation on the part of the Health Department of requested preventive, diagnostic, therapeutic and rehabilitative practices, in the public as well as in the private network of our Community, makes the scientific and technical foundation of the selection, incorporation and diffusion of health technologies of the Basque Health System necessary. To this end, special emphasis must be placed on the equipment that, as yet, hasn't demonstrated its effectiveness in spite of its use, and on the potential adverse effects.

HEALTH TECHNOLOGY ASSESSMENT (HTA)

At a time when resources are more and more limited and the needs of the public can arise on limitless occasions, the establishment of our own health policies for our autonomous community is made more and more necessary to achieve the best results at all times with the available resources and with effective cost control. Because of this, health services and the technologies used must be evaluated with the aim of eliminating centres of inefficiency and optimising performance, assuring and improving their security, efficiency and effectiveness, within a system based on equality and accessibility for the total population. Evaluation of health technologies constitutes a valid instrument to make objective information available, based on scientific evidence. This supposes a link between scientific knowledge and the need for information for decision-making.

HTA determines the benefits and costs of a technology and compares different alternatives. It also studies variations in utilisation and appropriate use, including studies on social and ethical consequences of an application and the factors that stimulate or impede the diffusion. In the same way it analyses the responsibilities that can be derived from the application of their recommendations.

The role of HTA is not so much to investigate and to add to current understanding as to respond to important problems for society and to facilitate changes in the introduction of new

The objective of HTA is to support the appropriate use of the existing and future health technologies in terms of security, efficiency, effectiveness, accessibility and equality, providing the decision-makers with the appropriate means to make these decisions.

Health technology means not only the instruments and equipment but also the medical and surgical procedures, pharmaceuticals as well as organisational systems and support of the health services.

technologies or the abandonment of obsolete ones, which, on occasions, entails difficulties due to the real administrative inflexibility of health systems based on fixed budgets.

Given the amount of issues to attend to, HTA is an interdisciplinary field. Its activities incorporate professionals from medicine, social sciences, health services research, epidemiology, engineering, ethics and economics. More and more often community representatives also take part.

But, although it is directed towards decision making, HTA should be based on science and scientific methods. In this sense also the choice of topics to evaluate must be made in the most rigorous and sensitive way possible. Given the multitude of topics related to different areas of the health world to be tackled, it seemed logical to develop a contrasting method for evaluating the topics most in need that cause most uncertainty, argument or ignorance of effectiveness. All this process is developed within a framework in which the concepts of cost control, resource optimization, use or incorporation of the most effective and efficient technology, are some of the key parts of health administration.

NECESSITY OF ESTABLISHING PRIORITIES

Osteba has started an identification and prioritisation process to establish which technologies are desirable to be performed in the near future. With this initiative the objective is achieved of having experience based on the practical application of an explicit method, that supports and drives the group itself and the health organi-

sation to which it pertains, and a more systematic and objective culture and way of thinking in relation to the establishment of priorities for HTA.

In HTA the problem arises as how to select which topics to evaluate or which topics are in need of evaluation or which projects need to be developed, when resources to carry them out are limited and the quantity and scope of the topics to be dealt with is very wide. Because of this, it is necessary to develop an explicit, participatory and reproducible process that permits identification of the most interesting disease-related areas or technologies themselves. It is because of this that a wide-ranging consultation for the identification of topics was undertaken. If the prioritisation isn't clearly defined the choices would be made in an implicit way with a greater reliance on intuition, chance and bias.

Until now the evaluation proposals have basically come from the political and management contexts. But being conscious of the existence of evaluation needs in care areas that reflect problems in the system or professional interests related to different specialities, it appeared more advantageous to consult these parties in order to identify the evaluation needs of different topics arising from the opinions of a wide-range of health system professionals.

The costs, epidemiological criteria, quality of life, application uncertainty and other factors like access equality, prevention, organisation, quality of care and research needs must all be taken into account at the time of creating evaluation proposals. Since the evaluations have direct impact on the health service users, the ethical and social aspects must be considered as important.

For this, the phase of identifying topics for evaluation is crucial and must be done carefully but, at the same time, must be wide-ranging, with the aim of avoiding, when possible, the bias which inevitably comes with the profile of

people consulted and the diverse factors mentioned above must be taken into account.

Subsequently, priority assignment to an extensive list of proposals should produce a major impact on future evaluations since the available resources will be applied to those topics which it is necessary to evaluate and which will produce as many social as economic benefits.

In summary, a prioritisation process attempts to structure thought, identifying importance relative to the different factors under consideration and estimating the potential impact of an evaluation. For this, the principal task is to determine which criteria are useful in evaluating health technologies or the clinical conditions in which they are applied and how they can be defined.

EARLIER PRIORITISATION EXPERIENCE

Over the last few years, diverse works have been published with proposals for the prioritisation of HTA. The majority of these have adopted methods used in other countries in different health and scientific contexts. However, the experience of the application of methods on the part of evaluating agencies is hardly known. The most interesting aspect to review was the type of criteria used when specifically applied to HTA.

The Institute Of Medicine (IOM) has been developing a prioritisation method and has made various proposals over the last few years. The NHS, for its part, has also completed a prioritisation process. The most interesting aspect is the type of criteria used when specifically applied to HTA.

During 1994, in the framework of the Biomed programme of DG XII of the European Community the EUR-ASSESS project was started and is attempting to bring together the European HTA methods and promote its importance on the part of the diverse organisations of the European HTA.

The aim is to contribute to the effectiveness and cost-effectiveness of health care in Europe by stimulating and coordinating developments in the field of health care technology assessment in Europe. It is also to deal with the problems of proliferation and coordination of HTA in Europe.

One of the objectives is to improve methods of priority-setting in health care technology assessment programs in Europe. Also to develop, formulate and apply a common method for assessing technology, with a focus on increasing the international applicability of findings and to assure effective dissemination of HTA products in Europe and evaluation of the effects of such dissemination.

They are all undertaken in order to improve decision-making by health insurance organizations and other payers by stimulating wider use of technology assessment in such decisions.

The work that has been done, in turn, by 4 sub-groups has tackled evaluation methods, diffusion of evaluation products, health care coverage and priority establishment for evaluation. This last project, in which Ostebais taking part, is responsible for methods of priority setting. For this a literature review and a survey of HTA agencies was undertaken to find out the principal theories and the existing practical experience in this field. Thus, a first step has been taken in the development of a tool-kit (the aim of the project). The results of this group have not yet been published although preliminary information is available. Ostebea, which is participating in this, also decided to put into practice a prioritisation process and chose to apply the method proposed by the IOM, adapting some of the aspects to the characteristics of the Basque health organisation and its operating capacity. This experience is presented in the next chapter.

III. Method Used

BIBLIOGRAPHY REVIEW. IOM ADAPTATION

A literature review was undertaken using Medline, ranging from 1986 to 1994, and other books and publications that presented proposals for setting priorities and analysed the methods and criteria to use in determining priorities for HTA. We search for articles and documents published in English, French and Spanish although there could be more in other languages.

The most relevant proposals which specifically apply to the HTA field and reflecting practical experience were those of Eddy DM in 1989, Lara ME and Goodman C. in 1990, Donaldson MS and Sox HC in 1992 and the British Standing Group on Health Technology in 1994. The most studied aspects were those which are related to the criteria used to grade technologies and their evaluation impact.

David M. Eddy presented a technology assessment priority-setting system called TAPSS prepared by the **Methods Panel, Council on Health Care Technology, Institute of Medicine**. He proposed a model which contained various factors that are of influence on the selections to be made. These factors were developed by diverse HTA organisations in the USA and dealt with the importance of illness and the costs in terms of individuals and the population.

In the same way he described a framework and a quantitative method to determine which technology should be given priority.

It is as much the process as the calculations that are explicitly developed because it reduces the use of subjective judgement. The results, however, could not provide precise answers, although they are the best estimates possible before doing an assessment.

In 1990 **Lara ME and Goodman C** presented the proposal of the **Council on Health Care Technology of the IOM**. This organisation star-

ted a pilot study with the aim of producing a method for priority setting. This proposal used two approximations, clinical and technological, that take into account the type, implementation and application of the technology or condition.

This process is based on three key elements:

- explicit and acceptable criteria
- the possibility of including in the process as many clinical conditions as technologies
- the quantitative method and consensus.

They classified the criteria as primary if they are quantifiable and as secondary if they are naturally subjective, although no less important for decision-making.

In 1992 **Donaldson and Sox** published the proposal of the **IOM for the OHTA-Agency for Health Care Policy and Research (AHCPR)** based on the earlier proposal of Lara and Goodman. It supposed a substantial improvement because it is a more elaborate, explicit and objective method. The essential principles of this method are:

- The prioritisation process must be suitable for the organisation that uses it.
- It must consider the information needs of the users.
- It must be efficient.
- It must take existing data into account and, if there isn't any, to use subjective judgements.
- It must be sensitive to political and organisational context.

The method proposed by the OHTA-AHCPR is based on the weighting of criteria, is composed of seven stages and takes seven criteria into account. It is based on consensus and on synthesis of information for the formulation of the objective and subjective criteria and for scoring. The final classification for the ordering of priorities is obtained by means of a mathematical model.

The OHTA-AHCPR presents a method to weight and assign values to seven criteria that

will be applied to analyse each proposed technology. Three of these are objective:

1. Prevalence of the specific condition.
2. Unit cost of the technology normally used for a clinical condition or unit cost of a technology and its alternatives.
3. Variation in the rate of use of a technology for handling a clinical condition or variations in the use of a technology and its alternatives. In these cases it is proposed that quantitative data is always used, when possible.

The subjective criteria are:

4. The burden of the illness for the individual patient.

The potential of the results of the evaluation:

5. To change health results.
6. To change cost.
7. To change production of ethical, legal and social information.

These criteria are ranked using a scale which ranges from 1 to 5.

The process is developed following seven very different stages, with the participation of different groups or panels of experts which use consensus methods.

In 1994 the report of the **Standing Group on Health Technology** of Great Britain was presented. One of the principal objectives of this group is the assessment of British national priorities in HTA with the aim of applying research funds to areas that can produce the best benefits to society.

The adopted method for prioritisation is the one used by other advisory groups of the Central Research and Development Committee (CRDC). It consists of three stages:

1. Identification of problems through a wide consultation that encompasses the interests of the professionals, the research community, the patients and the industry.

2. The panels review the proposals and identify those problems that can possibly be improved by being evaluated.
3. Agreement is reached on the relative priorities of the proposals. For this a series of criteria are developed, focusing on the process of attaining benefits in terms of population health.

Oortwijn W J et al of Holland subsequently published (1994) a review of the criteria, used by different organisations in setting priorities for HTA, taken from 18 publications. With the resultant 43 criteria they produced a six category classification, which are burden of illness, potential effectiveness, potential costs, uncertainty regarding the application of the technology, research and politics. They worked on the first four areas, in which 23 criteria are included, which was subsequently reduced to 10 in order to achieve coherence and avoid overlap. This list was used to check the use of these criteria in a random and anonymous sample of research proposals. The result of this synthesis and evaluation exercise is very interesting to deepen and advance the definition and use of social criteria in HTA.

CONCLUSION

Osteba valued positively the clarity and simplicity of the presentation of the process described by Donaldson and Sox for being explicit, with very different stages and a reasonable mathematical model. Because of this it was decided to create a practical application adapted to our context. This process was supervised by the Health Technology Evaluation Service that co-ordinated the weighting, identification, selection and prioritisation stages, motivating the panels of experts and preparing the necessary material for the meetings and for the development of the consensus methods used (Figure 1). The method used and the results of this method are described in the next chapter.

***IV. Results:
IOM adaptation.
Description of the process***

1ST STAGE: IDENTIFICATION OF THE CANDIDATE TECHNOLOGIES AND CONDITIONS

In the same way as decisions can be taken on different levels like strategy (macro), planning and management (meso) and clinical (micro), evaluation needs are different depending on the application. HTA attempts to respond to the most relevant questions, independent of their origin. For the identification of topics by means of a process, wide participation is necessary, with a certain role being given to distinct parties from the health system. The compilation of a wide list of technologies to evaluate in the Basque Country could have been made following a discussion with the directors of the Health Department and the management from the Basque Health Service/Osakidetza from arranged proposals that are regularly received. It was considered, however, to be desirable to have the widest possible participation of health professionals, since the intervention of management bodies is already guaranteed as much in the prioritisation process itself as in the working process of the Basque Office for Health Technology Assessment (Osteba). In this way, the proposals would reflect the different interests and levels of care. To do this, proposals were requested from diverse expert health areas, such as, ethics, quality methodology, epidemiology, pharmaceutical services, primary care, public and private health administration, insurance, etc.

To identify proposals and to create an exhaustive list of items to be evaluated, during the first quarter of 1995, more than 700 consultation forms were sent out, accompanied by a list of reasons that justified their proposals (See Appendix 1). At the same time, it was sent to members of the different panels of experts who had collaborated in the Osteba evaluations and other professionals distinguished by their experience or their representation.

Two months later a second mailing was done to Area Directors, Service Chiefs, District Directors, Area Co-ordinators and Medical Directors of public and private hospitals.

Osteba found and compiled other candidate technologies that normally came from other accredited bodies and services, and professional associations in the many seminars given in the different hospitals of Osakidetza and from other sources.

Information was accumulated on relevant legal and economic aspects that could influence the future weighting, like the appearance of a new technology or new experiences in relation to the protocols of practice of an established technology the fact of which, evaluations made by other agencies as well as the publication of new scientific evidence exist.

The value of this first list is based not only upon the sources that produce the topics to evaluate but also on the fact that it can be used as a classification of the technologies that have produced interesting results and can encourage other evaluations or new fields of research.

First we start with a series of social criteria to justify the inclusion of a technology or condition in a list of candidates for evaluation. So, we asked those surveyed to justify the need to evaluate their proposal. 122 proposals were received and are classified in areas of application although some of these may belong to more than one group. According to the replies, the reasons cited to support the need of the proposed topics were evaluated, and are the following:

Impact on the health system	19%
Unproven efficiency	15%
New technology	15%
Doubtful efficiency	15%
Variability of use	15%
Access equality	9%
Ethical-legal problems	7%
Safety	5%

They are classified in these areas:

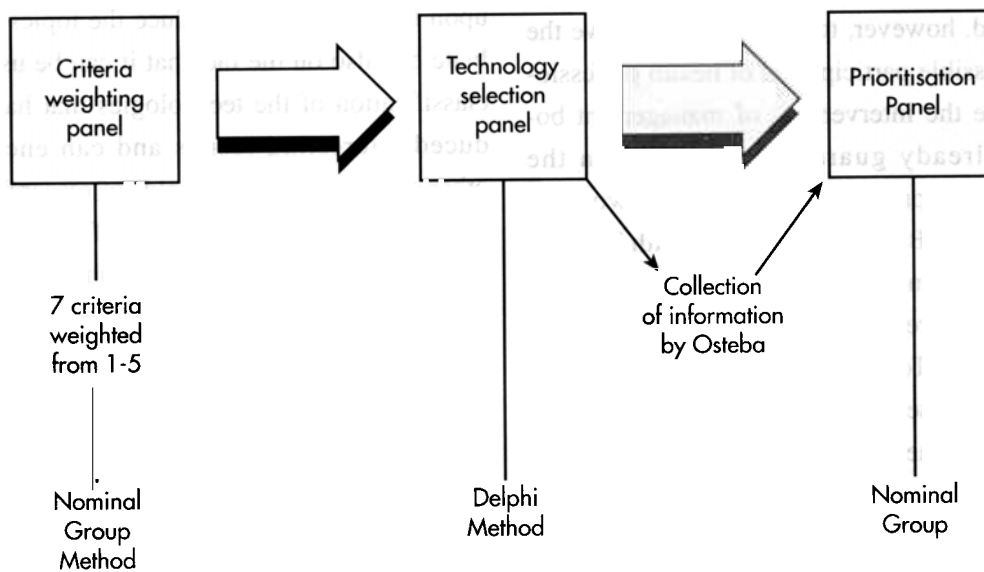
Therapeutic technologies	43%
Diagnostic	30%
Preventive	14%
Organisation and use of services	16%
Ethical-legal aspects	3%

A topic identification process was carried out by a Swedish technology assessment agency (SBU) in 1989 in which it was found that 65% of the proposals referred to treatments, 25% related to diagnosis and the remaining 10% to organisational and methodological routines.

From this first, exhaustive list we started the true process of prioritisation which can be illustrated as follows:

Figure 1

PRIORITISATION PROCESS



2ND STAGE: CRITERIA AND WEIGHTING SELECTION

It was decided to discuss the seven criteria proposed by the IOM, even knowing that the lack of data would make it difficult to measure the epidemiological criteria. These criteria deal with a wide spectrum of elements and takes social values and health policy into account. The

principal disadvantage of epidemiological criteria is the difficulty of finding sufficient information to quantify it, using the same units of measurement in each case. The interpretation was made anyway that, although it wasn't possible to measure them quantitatively, this didn't invalidate their suitability. However, it could diminish the precision of the process by influencing the subjective valuing in the final score.

It is because of this that was decided to use the IOM proposal and to maintain the same classification for the criteria:

Objective criteria:

- Prevalence
- Cost
- Variation in rates of use

Subjective criteria:

- Burden of illness for each individual patient
- Potential of the evaluation results to produce changes in
- Health results
- Costs
- Ethical-legal and social aspects

After the criteria were chosen, the next step was to weight them. Each of them was given a number in order to reduce bias and subjectivity which may occur in the final stage when each of the technologies are scored.

For this stage, a multidisciplinary panel, that worked using a consensus technique, was established. The number of participants in this criteria weighting panel should be wide but not so wide as to affect productivity. The defining characteristic of the panel should be the representation of diverse viewpoints, not only from medicine but also from society itself. In our case the panel consisted of ten professionals who came from different health areas: primary care, hospital care, epidemiology, economics, law, ethics, quality and management. The detailed composition of the panel appears in Appendix 2.

The process utilised in the meeting was the following:

- Presentation of the process to follow and working method.
- Explanation of the criteria on the part of Osteba and some of the arbiters with the aim of standardising language and expediting understanding for the later discussion and scoring.
- Discussion: arguments of each participant.

- Identification of the least valuable criteria by means of a consensus process using the nominal group technique.
- Discussion of the results.
- New individual voting and voting on the scores awarded to the rest of the criteria in relation to those which have been considered of least value.
- In the cases in which consensus was not reached, the discussions and the individual voting were repeated.

A simple method was proposed in which the key item was the assignment of the numbers and the scale to use:

The panel chose, by means of a formal vote, the least significant criterion and, therefore, the one that had the lowest score. It was weighted with a one. After this the panel members assigned numbers to the rest of the criteria in relation to this lowest one. So, if criteria A is considered the least significant with agreement that a number one is assigned to it, then if criteria C is considered three times more important than criteria A the value of criteria C should be a three.

The scale of numbers can be arbitrary, but it was decided to give the highest criteria in the scale a five. It is not necessary that this is attained but they must not exceed five. They do not have to be whole numbers; for example, 2.5 is acceptable. Also the same number could be

Weight 1

CRITERIA	MEAN	ORDER
Variation on the rates of use	2.94	1 ^o
Importance of the illness	2.80	2 ^o
Prevalence	2.66	3 ^o
Possibility that an evaluation changes health results	2.55	4 ^o
Possibility that an evaluation changes ethical and legal aspects	2.22	5 ^o
Possibility that an evaluation changes cost	1.83	6 ^o
Cost	1	7 ^o

used more than once. If a panel member believes that no criterion is more important than another he should assign a one to each of the criteria.

After each of the panel members had individually assigned the numbers, those which were disputed, and depending on the amount of initial consensus, were voted on once or more times again. The average number given by each of the individual panel members, taken in the final vote, was the number for the criteria that was used in the final equation.

The result of this weighting stage can be seen in the following table. 'Cost' received a weight of 1, the minimum possible, and the others were then assigned weights in relation to this. 'Variation in rates of use' was the criterion that received the highest weight.

3RD STAGE: SELECTION OF THE CANDIDATE TECHNOLOGIES.

This phase attempts to reduce the list of technologies to evaluate, identifying the most important, in a way that the later scoring is made ma-

nageable. The fundamental reason is the need to reduce the collection of the necessary information to score the selected technologies in relation to each criteria, so that the process is feasible.

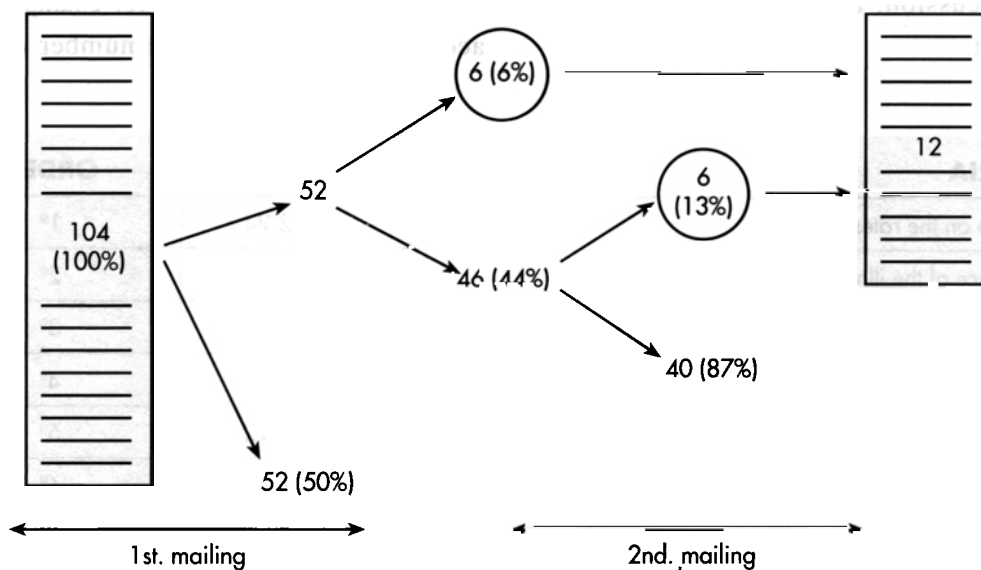
Ideally, this selection process should incur little cost and, like the whole of the priority determination process, must fulfil the following prerequisites:

- to be free from bias
- to resist control of private interests
- to be open to scrutiny
- to be easy to understand
- to have a simple development

Three types of approaches would exist for this first selection: to make a classification by preference or necessity, to make it in relation to preliminary criteria, or to do the ranking in relation to the opinions of a panel:

- *Ranking by intensity:* The person or organisation in charge must be asked to express some grade of intensity or preference of appearance of each of the technologies that have been identified. Osteoba could add or take away some topics before arriving at a complete classification of the list.

Figure 2 SELECTION PROCESS OF TECHNOLOGIES TO BE EVALUATED



– *Ranking based on preliminary criteria:*

The organisation that co-ordinates the process must classify all the conditions or technologies in accordance with the understanding of previously established criteria. They must eliminate some topics on this basis and after that proceed to classify the remaining list.

– *Ranking based on panel data:* Panels can be used to provide subjective lists of all or some of the candidate technologies. Only the most valuable topics remain in the classification process.

These three approaches have been discussed by IOM which recommends the final method, that is, the one based on preliminary recommendations by panels. This method uses one or more panels to provide subjective preliminary classification of the nominated technologies. To minimise costs these activities are done using a postal vote or, by electronic mail. Various systems, based on the Delphi method, with one or two panels have been described.

Osteba decided to apply the system of “in and out” of the list, (Figure 2). In this system

- Health care of the terminally-ill
- Efficiency of periodic control of the chronically-ill. Protocol evaluation.
- Laboratory and radiology tests in hospital emergency services
- Menopausal care
- Utilisation protocol of magnetic resonance
- Routine analysis in primary care health examinations
- Use of antibiotics in primary care
- Home treatment
- Personal health education
- Out-patient surgery
- In-patient or out-patient care protocol for patients with AIDS
- Preanaesthesia information.

only one panel was used in which 67 professionals, from a wide range of health sector and specialist medicine fields, took part, (Appendix 2). Using the modified Delphi method, the average of the scores was obtained and a list composed of 6% of the most valuable technologies was made. The topics on this list were automatically selected for the next prioritisation phase. After this, the list containing the next most valuable 44% was sent to panel members (Appendix 3). The rate of response was 76.1 in a first phase and 75.6% in a second phase. The process cycle was repeated and the top 13% of scores was selected again. In this way a list of the following twelve technologies was compiled.

4TH STAGE: DATA COLLECTION

The task of collecting the information that contains the scores in the next stage is necessary but arduous due to the wide dispersal or absence of current and adequate data about the specific needs of the topic. This fact is complicated even further when the proposed topics are very wide or the technologies are applied to different clinical conditions.

When the starting point of the prioritisation process is a clinical condition, all the alternative technologies that can be used to tackle this clinical condition must be defined. “This can include technologies aimed at primary screening and prevention, diagnosis, treatment, rehabilitation, palliative care and other similar elements of health care. For each topic under consideration, the data that is required for each criteria must be accumulated.

Similarly, when the starting point is a technology, the clinical conditions for which this is most relevant need to be specified, accumulating the required data to score each criteria. This data includes numbers (prevalence, cost) and facts that can form subjective judgements (current state of social, legal and ethical aspects).

Once the twelve topics were selected, Osteba collected the available information on each one of them in relation to the criteria that were going to be scored: prevalence, costs, variability of use, etc., with the aim of expediting, in the next stage, the work of the scoring panel, which consists in the ordering of priorities on the selected list.

Then those who had scored the selected topics the highest and the people who had initially proposed the topics were asked to send data, information and references that supported their scoring and also expressed the aim of the evaluation in the most specific and fixed way possible, since the presented topics suffered from being too general in definition. A meeting also took place at which an epidemiologist, a quality manager and a physician participate, together with members of Osteba tried to identify gaps in the information and possible data sources.

A search was also made for information about epidemiological data, care activities, etc. in different registers and other information sources of the Basque Health Service/Osakidetza, Health Department, hospitals etc. (Appendix 4).

A dossier for each topic, with all the available data, was compiled and sent to the members of the Scoring Panel. The definition of the 12 selected topics are in Appendix 5.

5TH STAGE: GRADING OF THE TECHNOLOGY ACCORDING TO CRITERIA: SCORING

At this stage, the most important elements are the clear definition of the topics and the existence of sufficient information to grade the objective criteria in a quantitative way and to understand the implications of the subjective criteria, especially those regarding the importance of the evaluation itself in the production of changes, more than in the characteristics of the technology itself or the candidate topic.

A multidisciplinary panel of ten experts was convoked with operational aims and it appeared to be advantageous for it not to be as extensive as in the IOM model. Those who took part were professionals from primary care, internal medicine, cardiology, quality management, ethics, health management, economics, education, nursing, epidemiology and, although they were invited, consumers' representatives didn't attend (Appendix 2).

The function of the panel was to grade and score the criteria applied to each of the proposed technologies. Firstly, the criteria already weighted by the earlier panel were put forward and the presented topics were extensively discussed in an attempt to define them in a clear and standardised way.

The scores were given, criteria by criteria, for each technology, by means of the nominal group technique. The most relevant topic was graded with a five, scored by means of an individual vote, using a scale of 1 to 5 for each criteria; and, afterwards, the least relevant with a one. Then, the remaining criteria with intermediate values were scored.

In each round of voting consensus was sought but, if this was not achieved, new discussions were had in order to validate the results and limit the difference of opinion among the panel members.

6TH STAGE: CALCULATION OF PRIORITY SCORES (APPENDIX 6)

The sixth element of the process is the calculation of the scores. Once the points and values of the weighting determined in the second stage have been collected, the priority of each technology or condition can be calculated, combining the objective and subjective criteria. The scores obtained by each technology, according to the criteria, were taken into account, and adjusted by the number assigned to each of them.

The result of the final grades and order was

Topics	Score
1ª. Health care of the terminally-ill	21.83
2ª. Use of antibiotics in primary care	20.30
3ª. Periodic control of the chronically-ill. Protocol evaluation	19.80
4ª. In-patient and out-patient protocols for AIDS patients	16.99
5ª. Out-patient surgery	16.12
6ª. Menopausal care	15.87
7ª. Laboratory and radiology tests in emergency services	15.70
8ª. Home treatment	14.84
9ª. Routine analysis in primary health care examinations	14.49
10ª. Preanaesthetic information	12.55
11ª. Magnetic Resonance Imagin. Protocol of use	10.59
12ª. Training for personel of health services	9.89

Once calculated, the conditions or technologies were listed according to their score. To the highest score goes the highest priority.

Osteba calculated the scores by means of the following formula proposed by IOM:

$$\text{Priority scoring} = P_1 \ln V_1 + P_2 \ln V_2 + \dots + P_7 \ln V_7 = \sum_{i=1}^7 P_i \ln V_i$$

where V is the score, P is the number assigned to each criteria, and Ln is the natural logarithm.

- Use of antibiotics in primary care
- Nuclear magnetic resonance. Protocol of use
- Periodic control of the chronically-ill. Protocol evaluation
- Laboratory and radiology tests in emergency services
- Health care of the terminally-ill
- Routine analysis in primary health care examinations

7TH STAGE REVIEW BY THE MANAGING COMMITTEE OF OSTEBE (BOARD OF DIRECTORS)

Finally, the results were presented to the management of Osteba. The results were reviewed at this level and were modified according to criteria of political opportunity and recommendations that value other aspects like equal access, stability between different types of technologies, etc, were made.

After this, the first six issues to be evaluated by Osteba were classified as follows.

V. Discussion

DISCUSSION

In a context in which decision-making can be influenced by very diverse factors, such as political influences or costs, the development of this method can be accused of being academic. It can also be considered slow in relation to the appearance of new needs, these being influenced by rapidly evolving events. On future occasions, these problems could be corrected by developing the process in a more simple and dynamic way.

Even so, this project involves an improvement and more systematic way to work and it also contributes to the introduction of working methods on which the recommendations are based on the maximum available evidence and consensus.

The prioritisation process carried out by Osteba involved the contextualisation of a method developed in a very different context from our own (USA), this being one of the first implementation exercises at a European level, as is shown in the bibliography.

The identification of problems could guide the definition of not only future evaluations but also of those topics for which there isn't sufficient or adequate information or, also, new research and programme design needs, as well as to improve the information output of existing registers.

The strange fact which was revealed was that the primary care topics were valued very favourably by hospital personnel, which reflected the worry of our professionals about the topics of major relevance, independent of the sphere in which they operate.

In the same way, the professionals who selected the topics scored various themes related to the organisational aspects of the services and the new alternatives for health services very highly. This demonstrated a great sensitivity to-

wards the health care-quality topics. In the criteria weighting phase, 'cost' was the least valued factor with 'variation in rates of use' being the most important.

It was difficult, as much in the criteria weighting phase as in the scoring phase, to conceptualise the difference between the possible impact of undertaking an evaluation and the impact of the technology itself, in terms of health results, costs or ethical-social aspects.

In summary, the **limitations** of the process were:

- Process: academic, slow.
- Insufficient definition of the proposed topics.
- Lack of data: Prevalence, QALYs. On occasion difficult to solve.
- The non-fulfillment of the expectations generated among the medical personnel of the large quantity of topics planned and the tackling of only a small number of them.

The **favourable aspects** were:

- Improvement of working methods in the service itself (Osteba).
- The fact of involving the professionals in the first part of the process, together with the consolidation of Osteba in our health system means that medical personnel will have a better understanding of the objectives and framework of the HTA in subsequent prioritisation processes. This will result in greater involvement in the process and will add to the impact of the selected evaluations.
- An explicit, reproducible and transparent process with limited bias was used.

VI. Conclusion

CONCLUSION

Due to the constant and rapid evolution in the health field, added to the influence that the Osasuna Zainduz health reform can exert on the organisational systems and/or on the provision and financing of services, the identification and prioritisation processes of health technologies should be produced every two or three years.

At this time, an explicit and reproducible prioritisation process has been produced, based on abundant information and on the consultation of multidisciplinary panels, reducing the imprecision or bias that can occur in implicit processes or in the consulting of experts.

As well as this, the wide participation of professionals and the use of explicit criteria in the consideration process contributed to the increase of collective evaluation awareness in the health field.

In future processes, not only evaluation topics should be requested but also a precise justification of the reasons with a complete definition. Because of that a new model is proposed to identify the proposals in a thorough way (Appendix 7).

Concepts of equality (not only the accessibility but also other considerations related to the distribution of resources according to needs and respect for autonomy) and other ethical-social aspects must be defined better.

To produce a good definition of the topics and the possible impact of the evaluations it would be necessary to have abundant information that takes into account the fact that the population would effect the changes produced by an evaluation.

Another very interesting aspect is the development and definition of the prioritisation criteria, so that they are adequate for the object to be measured and that it is possible for them to be measured in a quantitative and qualitative way.

For this, the information from registers, databases and other sources should be suitable for these needs.

A problem in our context, of which we are already aware, and that also came to light on this occasion is the weakness of public participation in the decision making. At the present time, there are no representative organisations and no effective means for the expression of public opinion. Even the official consumer protection agencies themselves are not really prepared to take on the role in this process.

Finally, the results of the working group on prioritisation of EURASSESS will undoubtedly be a help in improving methods and a guide to unify these processes among the organisations in our European environment.

VII. Appendices

APPENDIX 1

PROPUESTAS DE EVALUACIÓN

Nombre: _____

Centro: _____

Servicio: _____

TEMAS	JUSTIFICACION*	OBSERVACIONES

* Anotar código del/los motivos que justifican la necesidad de evaluación:

- Novedad tecnológica.....1
- Dudosa efectividad.....2
- Variabilidad en el uso, o uso inapropiado.....3
- Seguridad en la utilización.....4
- Eficiencia no probada (costes).....5
- Equidad, accesibilidad.....6
- Problemas éticos o legales.....7
- Impacto en el Sistema Sanitario.....8

Enviar a: Evaluación de Tecnologías Sanitarias. *Osteba*
 Dpto. de Sanidad. Gobierno Vasco
 Calle Alava 5
 01006 Vitoria-Gasteiz
 Fax: 945-145973

APPENDIX 2

PANEL MEMBERS

Weighting	Scoring
Sr. D. Jose A. Agirre. Dirección Área Gipuzkoa. Economics	Sr. D. Jose A. Agirre. Dirección Área Gipuzkoa. Economics
Dr. D. Arrizabalaga. H. de Txagorritxu. Radiology	Dr. D. José Ignacio Barrenetxea. H. Cruces. Cardiology
Sr. D. Fernando Toña. Dpto. de Sanidad. Legal Services	Dr. D ^a Ana Gorroñoigoitia Iturbe. C.S. Rekalde. Primary Care
Dr. D. Barrenetxea. H. de Cruces. Cardiology	Dr. D. Txema Kintana Lopez. H. de Galdakao. Epidemiology
Dr. D ^a Ana Gorroñoigoitia. C.S. Rekalde. Primary Care	D ^a Maite Bacigalupe. Osakidetza. Quality Management
Dr. D ^a Marivi Egurbide. H. de Cruces. Medicina Interna	D ^a Sagrario Martínez. H. de Txagorritxu. Quality-Ethics
Dr. D. Jon Iza. H. de Aránzazu. Traumatología	Dr. D. Oscar Moracho. H.S. Juan de Dios. Health Manager
Dr. D. Txema Kintana. H. de Galdakao. Epidemiology	Dr. D. Pedro González Zárate. H. de Cruces. Internal Medicine
Dr. D ^a Maribel Marijuan. UPV, H. Basurto. Medico Legal	D ^a Mercedes Ferro Montiu. H. Txagorritxu. Nursing School
Dr. D. Oscar Moracho. H.S. Juan de Dios. Health Manager	Of. del Ararteko, en consumers representatives (Absent)

SELECTION PANEL MEMBERS

Speciality	Name	Centre	Speciality	Name	Centre	
Éthics	Santi Esnaola	Dpto. Sanidad	Internal Medicine	J. Antonio Vázquez	H. Cruces	
	Txema Kintana	H. Galdakao		Pedro Martul	H. Cruces	
	J.I. Empanaza	H. Aránzazu		Pedro Gzlez. Zárate	H. Cruces	
	J.I. Pijoan	H. Cruces		Alfonso Alvarez	H. Cruces	
	Mabel Marijuan	UPV Basurto		Marivi Egurbide	H. Cruces	
Economics	Sagrario Martínez	Txagorritxu (Calidad)	Psychiatry	José Manuel Agud	H. Txagorritxu	
	Eduardo Cobo	Osakidetza		Miguel Gutiérrez	H. Santiago	
Quality	Jose A. Agirre	Dtor. Area Gipuzkoa	Surgery	Imanol Kerejeta	H. Gipuzkoa	
	Andoni Arzelai	Osakidetza		Ignacio Santidrian	H. Cruces	
	Eduarne Eginu	D. Area Gipuzkoa		Andrés Valdivieso	H. Galdakao	
Law	Elena Sánchez	H. Basurto	AIDS/Infectious.	Koldo Agirrebengoa	H. Cruces	
	Isabel Portillo	H. Gipuzkoa	Microbiology	Jorge Barrón	H. Cruces	
	Fernando Toña	Dpto. Sanidad	Laboratory	Carmen Zugaza	Txagorritxu	
Management	José Blasco	H. de Cruces	Gynaecology	Natxo Corral	H. San Eloy	
	Carlos Pereira	H.S. Eloy		José Luis de Pablo	H. Txagorritxu	
	Mikel Alvarez	H. Basurto		Angel Alfajeme	H. Txagorritxu	
	Javier Orbegozo	H. Aranzazu		Jon Iza	H. Aránzazu	
Family Medicine	Oscar Moracho	H.S. Juan de Dios	Traumatology	Fito Alvarez	H. Galdakao	
	Luis de la Torre	H. Galdakao		Reumatology	A. Alonso	H. Cruces
	Jesús M. Fdez.	Dpto. Sanidad	Emergency		J.M. Aramburu	H. Basurto
	Iñaki Berraondo	Soc. Med. Familia		Josu Darpón	C. Trans. Bizkaia	
	Miren Aizpuru	Amb. Rekalde	Pediatrics	Gabriel Gutiérrez	H. Cruces	
	Ana Gorroñoigoitia	Amb. Rekalde		J. Aspiazu	H. Txagorritxu	
	Jesús Torcal	E.A.P. Basauri		M ^a José Azcárate	Amb. Basauri	
	Agurtzane Ortego	Amb. Galdakao		Aurora Navajas	H. Cruces	
	Respiratory	Juan Salgado	Usansolo M. Familia	Neurology	J.C. García Mancó	H. Galdakao
		Esteban Sampedro	C.S. Andoain		J.J. Zarranz	H. Cruces
Antxon Arbulu		Pasajes S. Pedro	Nursing	Esther García García	H. Cruces	
Alberto Capelastegui		H. Galdakao		M ^a José Alvarez	H. Txagorritxu	
Victor Sobradillo		H. Cruces		M ^a Jesús Barandiarán	H. Gipuzkoa	
Cardiology	Fernando Arós	H. Txagorritxu	Plastic Surgery	Javier Gabilondo	H. Cruces	
	J.I. Barrenetxea	H. Cruces		Oncology	Guillermo L. Vivanco	H. Cruces
Radiology	Ramón Arrizabalaga	H. Txagorritxu	Rehabilitation	M ^a José Fdez. Agirre	H. Gipuzkoa	
	José A. Rekondo	Osatek				

APPENDIX 3

	Nº	SUMA	PROMEDIO
Atención sanitaria al enfermo terminal	45	331	7,37
Utilización de antibióticos en At. primaria	47	341	7,26
Eficiencia del control periódico enfermos crónicos. Evaluación de protocolos	44	319	7,25
Pruebas de laboratorio y radiología en los servicios de urgencia hospitalarios	44	312	7,09
Atención en menopausia	45	315	7,00
Hospitalización a domicilio	47	329	7,00
Protocolo de utilización de la resonancia magnética	45	314	6,98
Análisis de rutina en exámenes de salud en Atención primaria	43	297	6,91
Formación de personal sanitario	45	307	6,82
Cirugía sin ingreso	47	310	6,60
Protocolo de seguimiento hospitalario e extrahospitalario de pacientes con SIDA	46	303	6,59
Información preanestesia	46	303	6,59
Profilaxis antibiótica quirúrgica	47	308	6,55
Protocolo de utilización del Scanner	45	294	6,53
Protocolo de controles analíticos en enfermos crónicos	48	312	6,50
Transfusiones	45	292	6,49
Citología cervical, protocolización	45	292	6,49
Utilización de antiulcerosos en At. primaria	43	273	6,35
Profilaxis tromboembólica quirúrgica	46	292	6,35
Autotransfusión perquirúrgica	47	296	6,30
Evaluación del Dolor de Espalda	48	296	6,17
Viabilidad del diagnóstico prenatal en gestantes < 35 años	43	265	6,16
Educación diabetológica. Protocolo de autocontrol en pacientes diabéticos	47	288	6,13
Prótesis de cadera	44	266	6,05
Profilaxis antimicrobiana	44	266	6,05
Protocolización del seguimiento pacientes con IAM o angina	48	289	6,02
Marcadores tumorales bioquímicos y moleculares en cánceres concretos (mama, ovario...)	45	270	6,00
RX de rutina en urgencias de traumatología	44	263	5,98
Efectividad y coste de la densitometría	44	261	5,93
Protocolización de la Jaqueca	45	264	5,87
Colecistectomía: Técnica tradicional versus laparoscopia	44	258	5,86
Ecografía ginecológica en screening a mujeres asintomáticas	44	257	5,84
Desinfección y esterilización de material	44	256	5,82
Asma infantil	44	254	5,77
Terapia sustitutiva con metadona	43	248	5,77
Uso de las técnicas de PCR (amplificación in vitro de ácidos nucleicos) en laboratorios	42	242	5,76
Análisis de efectividad de RX Gastroduodenal y enema opaco	44	252	5,73
Componente económico de la evaluación	43	243	5,65
Diferente utilización de técnicas de diálisis: Hemodiálisis (vs) CAPD (Vs) Diálisis periton.	45	254	5,64
Protocolización de la radiología intervencionista	44	248	5,64
Evaluación de la Psicoterapia	43	242	5,63
Vacunas Hemophilus influenzae tipo B	43	241	5,60
Helicobacter Pylori y ulcus	43	240	5,58
Gammagrafía ósea. Precisar indicaciones	42	240	5,58
Marcadores de Hiperplasia Benigna de Próstata. Utilidad profiláctica y terapéutica	43	240	5,58
Atención al SIDA. AZT	42	234	5,57
AAS versus ticlopidina. Coste-efectividad	41	224	5,46
Aumento demanda de colonoscopias, prueba molesta para los pacientes	43	233	5,42
Tiras reactivas para medir glucemias/sangre	43	232	5,40
Obtención de órganos y tejidos para el trasplante renal y hepático	43	232	5,40
Neuroreflexoterapia en lumbalgias.	41	204	4,98

APPENDIX 4

INFORMATION SOURCES

Subdirección de Calidad Asistencial de Osakidetza	<ul style="list-style-type: none">• Actividad asistencial en Unidades de Cuidados Paliativos• Actividad asistencial en Hospitalización a domicilio• Actividad asistencial en Cirugía sin Ingreso
Subdirección de Atención Primaria	<ul style="list-style-type: none">• Consultas domiciliarias de enfermería para cuidados paliativos• Consultas a crónicos en Atención Primaria• Peticiones de analítica y RX en At. Primaria
Encuesta de Salud de la C.A.V.	<ul style="list-style-type: none">• Actividades de control de la tensión arterial• Perfiles de consumo de medicamentos
Memoria anual de Actividades de Osakidetza	<ul style="list-style-type: none">• Actividad asistencial en Servicios de Urgencias.• Actividad asistencial en hospitalización a domicilio, cirugía sin ingreso, hospitalización parcial, cirugía de corta estancia• Actividad quirúrgica y tipo de anestesia en los hospitales de la CAV. Coste de los hospitales por área de actividad
Estadísticas de Servicios de Urgencias Hospitalarios	<ul style="list-style-type: none">• Prestaciones y diagnósticos más frecuentes.
Informe Osteba sobre Osteoporosis en la CAV.	<ul style="list-style-type: none">• Consumo y costes de terapias en prevención de Osteoporosis postmenopáusica. Nº de fracturas, estancia media y costes.
Memoria de Actividades de OSATEK	<ul style="list-style-type: none">• de exploraciones RMN y costes
Subdirección de farmacia	<ul style="list-style-type: none">• Consumo y coste de antibióticos a través de receta médica.
Registro del SIDA	<ul style="list-style-type: none">• Epidemiología y costes de los casos de Sida en la CAV.

APPENDIX 5

DEFINITION OF THE 12 SELECTED TOPICS

Health care of the terminally-ill

- Relevance and sufficiency of the health resources employed in this area.
- Criteria for the admittance of the terminally-ill.
- Definition of the term “terminal”: Is this a person whose illness has a rapid and fatal evolution? Is this a person who fundamentally requires palliative care and whose prognostic may be fatal in the medium to long term?
- Costs of the different alternatives:
 - *Where*: specific hospital unit, general hospital, home care unit, home or combination.
 - *Who*: care personnel (health professionals, volunteers, multidisciplinary groups, etc).
 - *How*: general lines of action.

Factors to emphasise :

- Difficulty due to the variety of pathologies of the terminally-ill: oncological, polytraumatic, etc.
- The ageing of the population. Increase in the survival rate of illnesses with a fatal prognosis: cancer, AIDS, neurological pathology of pulmonary chronic diseases.
- Definition of the characteristics of chronic degenerative diseases.
- Variability in clinical practices and in the levels of organisation of those in attendance.
- Voluntary associations composed of professionals and/or those affected who look for better health care and a dignified.
- Ethical and legal dilemmas in respect of information related to the terminally-ill patient, medical decisions and the patients.

- Recent introduction of active, medically-assisted euthanasia in countries in our region (Holland)
- Education of the professionals.

Efficiency of the periodic control of chronically-ill patients.

Evaluation of protocols

- Appraising the control and detection of chronic illnesses in influencing the evolution of the disease (quality of life) and in the evolution of complications (irreversibility of the process).
- Are better clinical results achieved by having a protocol of clinical activity?
- Quality criteria in protocol elaboration.

Laboratory and radiology tests in emergency services

Evaluation of the efficiency of routine use of blood and urine tests in medical emergencies and a single X-Ray in traumatic emergencies.

- Radiology guidelines for ankle injury.
- Complementary tests for thoracic pain.
- Study guidelines for emergency coagulation.

Factors to emphasise:

More and more often emergency services tend to ask for complementary tests (laboratory and X-Ray), almost before seeing the patient. This is especially frequent in trauma injuries.

Negative influence of indiscriminate use:

- Increase of costs.
- Increase of secondary effects.
- Prolonged stay in emergency unit.
- Collapse of radiology and laboratory services.
- Dehumanisation of care.

Positive influence:

- Avoids conflict with certain patients through compliance with their wishes.

- Permits diagnoses to be made which are not supported by clinical evidence.
- Can be used as a defence in legal actions.
- Avoids the visit of a second doctor to find a test that wasn't carried out.

Menopausal care

- In the last few years there has been a lot of debate on the need to treat the symptoms experienced by women during the climacteric and on treatment or prevention of the menopause in the medium and long term.
- The time when importance was not given to the problems created by this circumstance has now gone and has been replaced by an interventionist attitude. The menopause is now considered as the start of certain health problems in old age.
- The use of Hormone Replacement Therapy (HRT) is advocated to alleviate symptoms, prevent cardiovascular risk, osteoporosis and improve quality of life, etc. There are other therapeutic alternatives for the prevention of the loss of bone mass: calcitonine, biphosphonates, etc..
- Some professional sectors support the protocolisation of therapeutic and preventive treatments and the creation of specific care units.
- The effectiveness and the risks of the alternatives are not known.
- However, more and more often there is greater support for the belief in the necessity to treat all menopausal women with HRT.
- The Osteoba report on the Management of Osteoporosis presented a care protocol for the prevention of post-menopausal osteoporosis based on a review of current scientific evidence and the opinions of the panel of experts brought together for this purpose. The taking of health and dietary mea-

asures during the whole of one's life and the use of pharmaceutical treatments in those cases of higher risk were advised.

Protocol for use of magnetic resonance

- Analysis of diagnostic efficiency.
- Effectiveness of this technique when the identification of pathologies depends on the quality and type of definition, which is only possible with the use of magnetic resonance, or when it is used to clarify doubts.
- Is duplication of tests a problem?
- Are the guidelines appropriate?

Analysis of routines in primary health care examinations

- The justification of analysis requests when we want to do them or when a thorough examination is asked for.
- What can a routine analysis detect?
- Identification of interesting tests to evaluate : cholesterol, glucose, etc.
- Consecutive tests.
- Age and population at risk.

Use of antibiotics in primary care

- Evaluation of the high level of consumption of antibiotics in primary care and the frequent use of a wide range of strong antibiotics which perhaps should be reserved for hospital use.
- Criteria of quality in the guidelines for antibiotic therapies : Is it recommended? Is its use appropriate?

Home treatment

- Analysis of direct, indirect and intangible costs of home treatment in comparison to in-patient care (family responsibilities, social help).
- Estimation of demographic tendencies, la-

bour market etc. capacity needs, abilities and social help for the families.

- Repercussions for primary care.

Education of health personnel

Different types of situations :

- Continuous individual clinical education.
- Objective-linked education and programmes of organisation.
- Problems of accreditation.

Evaluation proposal of the educational activities arranged by the organisation itself: Osakidetza and the Department of Health.

1. Detection of needs
2. Comparison of the needs and priorities of the professionals to those of the organisation.

Factors to take into account :

- Irregular postgraduate education.
- Personal motivation.
- The non-existence of reference standards.
- The percentage of resources dedicated to education in hospitals is not clear. The traditional educational activities such as clinical sessions have not yet been evaluated.
- Much less is done at other levels (primary care).

Out-patient surgery

- Great boom in out-patient surgery over the last five years.
- There is controversy over the the types of processes used in out-patient treatment due to the need to put into operation a monitoring system (resources).
- The need to appraise the individual clinical criteria of inclusion and exclusion (age, previous pathology), resource organisation and care, differentiating the processes and the type of anaesthesia (nursing care, pre-operative tests, postoperative controls, etc.).

In-patient and out-patient protocols for AIDS patients

The need to establish admittance criteria and primary care and home treatment monitoring and control for AIDS patients.

Commentary:

- Home treatment for terminally-ill AIDS patients improves the quality of death but does not reduce costs.
- The costs increase radically (five times more than in the less severe periods) in the last six months of life.
- There are clinical practice guidelines such as those published by AHCPR on Evaluation and management of the HIV infection and protocols for primary care.

Preanaesthetic information

- The problems derived from the coordination of the services. Justification of analysis requests and diagnostic techniques before anaesthesia. There is no monitoring by the same anaesthetist. The person who produces the report may be different from the one who administers the anaesthetic.
- It is not considered to be an indispensable practice.
- The contents of the information to be handled. Is it necessary to have unification of surgical and anaesthetic information? Or can they remain separate?
- Legal responsibility. Tendency towards bureaucracy and defensive medicine.
- Variables such as age and previous pathology are the determinant elements in a protocol.
- The need to produce protocols using a consensus method. Osteba produced a protocol of pre-operative evaluation for healthy patients.

APPENDIX 6

CALCULATION OF PRIORITY SCORES

CRITERIA	Score Criteria (P)	Health care of the terminally-ill		Efficiency of periodic control of the chronically-ill. Protocol evaluation		Laboratory and radiology tests in hospital emergency services	
		Number (V)	P (Ln V)	Number (V)	P (Ln V)	Number (V)	P (Ln V)
Prevalence	2.66	5	4.28	3.77	3.53	2.88	2.19
Importance of the illness	2.80	5	4.51	3	3.08	2.44	2.50
Cost	1	3.22	1.17	3.33	1.20	3.66	1.30
Variation in the rates of use	2.94	3.11	3.34	3	3.23	2.77	3.00
Possibility that an evaluation changes health results	2.55	3.44	3.15	5	4.10	2.66	2.49
Possibility that an evaluation changes costs	1.83	2.7	1.82	3.22	2.14	3.22	2.14
Possibility that an evaluation changes ethical and legal aspects	2.22	5	3.57	3.11	2.52	2.55	2.08
Priority Score			21.83		19.80		15.70

CRITERIA	Score Criteria (P)	Menopausal care		Utilisation protocol of magnetic resonance		Analysis of routines in primary care health examinations	
		Number (V)	P (Ln V)	Number (V)	P (Ln V)	Number (V)	P (Ln V)
Prevalence	2.66	2.66	2.60	2	1.84	3.44	3.29
Importance of the illness	2.80	2.77	2.85	1	0	2.44	2.50
Cost	1	2.88	1.06	3.66	1.30	2.88	1.06
Variation in the rates of use	2.94	2.77	3.00	3	3.23	3.55	3.72
Possibility that an evaluation changes health results	2.55	2.33	2.16	2.11	1.90	1	0
Possibility that an evaluation changes costs	1.83	2.88	1.94	3.55	2.32	2.88	1.94
Possibility that an evaluation changes ethical and legal aspects	2.22	2.77	2.26	1	0	2.44	1.98
Priority Score			15.87		10.59		14.49

CRITERIA	Score Criteria (P)	Use of antibiotics in primary care		Home treatment		Personel health education	
		Number (V)	P (Ln V)	Number (V)	P (Ln V)	Number (V)	P (Ln V)
Prevalence	2.66	3.22	3.11	1.88	1.68	1	0
Importance of the illness	2.80	2.77	2.85	2.88	2.96	2.33	2.37
Cost	1	5	1.61	2.44	0.89	2.33	0.85
Variation in the rates of use	2.94	5	4.73	2.44	2.69	1	0
Possibility that an evaluation changes health results	2.55	3.22	2.98	3.22	2.98	2.88	2.70
Possibility that an evaluation changes costs	1.83	5	2.95	2.44	1.63	2.22	1.46
Possibility that an evaluation changes ethical and legal aspects	2.22	2.55	2.08	2.55	2.08	3.11	2.52
Priority Score			20.30		14.84		9.89

CRITERIA	Score Criteria (P)	Out-patient surgery		In-patient or out-patient care protocol for patients with AIDS		Preanaesthesia information	
		Number (V)	P (Ln V)	Number (V)	P (Ln V)	Number (V)	P (Ln V)
Prevalence	2.66	2.44	2.37	2.66	2.60	2.33	2.25
Importance of the illness	2.80	2.77	2.85	3.33	3.37	2.33	2.37
Cost	1	2.11	0.75	2.77	1.02	1	0
Variation in the rates of use	2.94	3	3.23	2.33	2.49	2.66	2.88
Possibility that an evaluation changes health results	2.55	3	2.80	3.33	2.98	2.55	2.39
Possibility that an evaluation changes costs	1.83	3.22	2.14	2.77	1.86	1.83	0
Possibility that an evaluation changes ethical and legal aspects	2.22	2.44	1.98	3.33	2.67	3.33	2.67
Priority Score			16.12		16.99		12.55

APPENDIX 7

EUSKO JAURLARITZA



GOBIERNO VASCO

OSASUN SAILA
Osasun Sailordetza
*Osasun Antolamendu
eta Ebaluaziorako Zuzendaritza*

DEPARTAMENTO DE SANIDAD
Viceconsejería de Sanidad
*Dirección de Ordenación
y Evaluación Sanitaria*

Servicio de Evaluación de Tecnologías Sanitarias. Osteba SOLICITUD DE EVALUACIÓN O INFORMACIÓN

TEMA:

DESCRIPCIÓN DE LA SITUACIÓN ACTUAL:

El TEMA planteado está RELACIONADO fundamentalmente con el ámbito de:

Técnicas Diagnósticas

Estrategias Preventivas

Alternativas Terapéuticas

Aspectos organizacionales

COMENTAR de las siguientes CARACTERÍSTICAS aquellas que tengan relación con el tema:

- Procedimiento Novedoso/Anticuado

Aspectos epidemiológicos (Incidencia, Prevalencia, etc.)

- Efectividad (demostrada o desconocida)

Seguridad del procedimiento y aceptación por los pacientes

Eficiencia (costes)

Frecuencia de uso y variabilidad. Grado de utilización apropiada. Controversia o Incertidumbre

Aspectos organizativos

Implicaciones éticas y sociales (accesibilidad, demanda de los usuarios)

Potencial impacto de la evaluación o de la información solicitada

Alternativas a las que sustituye o complementa el tema solicitado

PROPUESTA DE CAMBIO

JUSTIFICACIÓN PARA EL CAMBIO

Se ruega APORTAR BIBLIOGRAFÍA Y/O DATOS que apoyen los aspectos argumentados

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