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LETTERS TO THE EDITOR

HTA in the United Kingdom

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To the Editor:

I was dismayed to find that the article on HTA in the United Kingdom in the recent Special Issus of IJTAHC on the History of HTA (1) makes so little mention of the main component of HTA in England and Wales, namely the NHS HTA Programme. That seems a puzzling oversight for a program that, since its inception in 1993, has spent 138 million GBP on commissioning nearly 850 in-depth HTA studies, sifted and prioritized from some 15,000 suggestions drawn from all quarters of UK health service, policy, and research worlds. From these, it has published nearly 500 full-length HTA monographs (with over 125 more currently in editorial review) in the series *Health Technology Assessment*, which has attracted over 15 million downloads as well as being distributed in hard copy to just over 128,000 recipients. Around 120 of these monographs resulted from research commissioned explicitly to advance the methodology of HTA—a contribution that is unique among the world's HTA agencies. This stream of HTA publications, which has also spawned countless summaries, local adaptations, translations, academic papers, and other spinoffs, has had an acknowledged impact throughout the world of HTA.

Such a large undertaking surely merited more than the few lines that it was afforded in the article. The program's under-representation would both surprise and disappoint the thousands of academics, clinicians, policy makers, managers, and health service users—not to mention the 8,000 patients enrolled into UK HTA trials—who have been involved in some way or another in identifying and prioritizing the HTA topics, commissioning and carrying out the scientific work, and publishing, disseminating and implementing the results. Perhaps the journal should at some stage seek to rectify this astonishing omission, if only to acknowledge their efforts and those of the hardworking staff past and present of the National Institute of Health Research National Evaluation, Trials and Studies Coordinating Centre (NETSCC, formerly known as NCCHTA).

Moreover, any authoritative and balanced history of UK HTA would also feature the pioneering work in the 1990s of the Scottish and regional HTA programs (respectively, the Scottish Health Purchasing Information Centre led by Norman Waugh and the regional Development and Evaluation Committees run by Andrew Stevens and others) that were the precursors of the NHS HTA Programme.

REFERENCE

1. Drummond M, Banta D. Health technology assessment in the United Kingdom. *Int J Technol Assess Health Care.* 2009;25(Suppl 1):178-181.

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HTA in the United Kingdom: Response

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To the Editor:

Professor Gabbay says he is dismayed that our article on the history of HTA in a recent special issue makes so little mention of the NHS HTA Programme, He calls this "a puzzling oversight," which "would both surprise and disappoint the thousands . . . . who have been involved in some way or

another." It was not our intention to underplay the role of the program, nor to disappoint the thousands of participants. Rather, there was a considerable amount of material to cover and a limited amount of space to do it in. Any history of HTA in the United Kingdom is inevitably a personal reflection, and it is understandable that Professor Gabbay's own account would put the program more center-stage, given his role as former director.

We did acknowledge the central role of the NCCHTA in coordinating HTA efforts in the United Kingdom in recent years and its support for the work of NICE. The number and quality of HTA reports produced by the NHS HTA Programme is indeed impressive and probably surpasses the performance of most, if not all, comparable programs in other jurisdictions. However, the production of reports does not, of itself, guarantee impact. It was our judgment that, in commenting on the past 10 years in the United Kingdom, we should emphasize the role of NICE in *using* HTAs to issue guidance on the use of health technologies in the NHS. Of course, this is merely our judgment, but one which we believe is consistent with the international view of the recent developments in HTA in the United Kingdom.

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Harmonizing HTA

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To the Editor:

Paul Trueman and colleagues (3) have reported on an important issue. Several HTAs on the same topic have been published recently. They have examined four recent HTA reports on drug-eluting stents (DES), demonstrating varying methods and conclusions. All four HTAs included local registry data and economic evaluations in addition to analyses of published research. The authors concluded that the published evidence considered by most of the agencies had "only limited influence on the resulting recommendations."

Although the study by Trueman et al. represents only a small sample of HTA reports—and ought not to lead to broad assumptions as to inconsistency in international HTA—we consider it useful to comment on the methods used in this study, its conclusions, and, in particular, the following statement presented in the discussion section: "this conclusion challenges the EUnetHTA approach."

PROBLEMS IN WORKING METHODS

The article contains inaccuracies. The HTAs produced by Austrian (LBI) and Belgian (KCE) HTA entities are said to "have no direct link to reimbursement and coverage" (1;2). However, the main KCE mission is to advise policy makers in obtaining an efficient allocation of healthcare resources, and the LBI report had a direct and measurable impact on coverage. Conclusions are sometimes oversimplified. The KCE report, which was incorrectly cited, was interpreted as "advocat[ing] clearly that DES should not be reimbursed," whereas the report actually recommends the consideration of a readjustment of the reimbursement price of DES toward the levels of bare metal stent reimbursement.

Furthermore, the article states that "KCE and LBI considered published evidence on DES but made no attempt to generate primary research." In fact, a Belgian percutaneous coronary intervention registry was analyzed, and primary research on cost-effectiveness was performed. It was also stated that "these local registry data were used to supplement the published evidence," whereas actually the local data were not applicable and relative risk improvements were based on published meta-analyses.

The summary table of economic evaluations also contains several mistakes such as the omission of countries (Japan and Brazil) and incorrect ranges of outcomes.

APPRAISING A COOKBOOK BY TASTING FOUR MEALS PREPARED WITHOUT USING THE BOOK

The fundamental problem with the article is that it questions the feasibility of the HTA Core Model approach, even though none of the four HTAs actually used this specific approach.

The article stated that "the core data set was criticized by the HTA bodies and appeared to have had limited influence on the resulting recommendations." As authors of two of the included DES reports, we would like to stress that we did not criticize the idea of a Core Model. Rather, we would see it as a benefit to have a clear structure, accessible guidance, and a common pool of HTA information at hand when preparing local HTAs.

HTA CORE MODEL: WHAT IS IT?

There were some inaccurate assumptions about the HTA Core Model in the article that probably led to the authors' pessimistic views.