

## What is the Scope of HTA?

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### PERSPECTIVE

#### ABSTRACT

The appropriate scope of HTA is not a given, nor is it to be determined in the abstract. Like the “perspective” of a study, it is determined by the problem it is being harnessed to solve, the identity of the decision makers who “own” that problem, and the context in which the decision is to be made [1-3]. At its most general, HTA is a method of assisting decision makers (public or private; profit or non-profit) to define the objectives of a possible investment and to explore alternative means of realising those objectives. Decision makers are “principals”, on whose behalf HTA analysts are “agents”. The objectives are set by the principals in this agency relationship, not the agents.

#### KEYWORDS

HTA, Decision makers, Public

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## INTRODUCTION

### Context is key

There is a context for all decisions, defined by the culture, history, and traditions of a community [4]. It is also defined by the identity of the person doing the deciding, their level of seniority, their degree of discretion, their accountability, the nature of the technologies available, the budget for health care, the interests of multiple stakeholders, and the length of time over which the consequences of the decision will pan out in a real world. The values and professional abilities of decision makers are two further factors out of a multitude of others, which affect outcomes, costs, expectations and achievements. Changing any one of these contextual features is likely to change the decisions that are reached, whoever is making them, and their consequences.

### What's in and what's out?

The context may also dictate specifically what may be considered when a decision is being made and what is not to be considered, which will usually include effectiveness and/or efficiency, fairness [5], and it may impose a specific concept of either: efficiency and fairness. The discretion allowed and the constraints imposed are thus critically important determinants of how issues of efficiency and fairness can be handled. The HTA analyst has the job both of eliciting the values to be respected in any analysis and of judging the feasibility of various options, given the policy objectives of whomever is commissioning the work (typically a department of government, a health service operational manager, or a senior manager in a public or private insurance company).

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What is socially right and ethical is not, therefore, to be decided a priori but in the light of the specific context. If the HTA is being commissioned by, say, a manufacturers' association, to facilitate a judgment of who gains and who loses from a proposed workplace health and safety intervention, with a view to negotiating compensating deals with those affected (management and workers), the scope of the study will be designed to reflect the concerns of each of the two broadly defined affected parties. Or, to take another example, if the focus of an HTA is to be on the outcomes of an intervention only for a specific sub-group of the population (say, rural or urban), then information about other groups, large or small, is irrelevant save, perhaps, for purposes of comparison. What's in and what's out effectively defines what is commonly referred to as the "perspective" of a study [6].

### Whose values count?

Many of the elements of an HTA are rich in social value judgments [7]. This is inevitable since an HTA typically seeks to infer what is in the public interest and how that public interest is defined and measured. All the following require explicit or implicit value judgments of the public interest. The healthcare budget itself will depend upon priorities established at a relatively high level between alternative uses for resources inside and outside healthcare or within a general health care envelope. The measures of outcome (like lives saved, quality-adjusted life-years and disability-adjusted life-years) are deeply imbued with social values that give meaning to some concept of "health", which may vary according to whose life is likely to be affected (like babies, children, adults, the elderly, the mentally ill, informal family carers, people with multiple morbidities); the likely consequences of a decision for the distribution of the burdens of sickness and of healthcare expenditures; and the acceptability of degrees of risk under conditions of uncertainty [8].

There are also other kinds of judgment that are often required: how good or complete the research evidence is; what the balance should be between quantitative and qualitative evidence; how transferable the results obtained in one study in another are to another political context; how competently the systematic reviews, research summaries and all other supporting analyses have been done; how acceptable the necessary changes are in affected persons' political and financial interests; how cooperative the professional groups are who are essential to implementation [9].

### The first tasks

The very first tasks in any HTA are therefore to be clear about the "owner" of the study, in the sense of the decision-making group on whose behalf the work will be done, and to establish as precisely as one can what the question is that an HTA might help answer [10-12]. This normally entails identifying one or more interventions that can affect health for the better; settling what is meant by "health"; deciding the criteria for choosing between the interventions (cost-effectiveness, fairness, sustainability, religious proscriptions,...); selecting speeds of implementation; identifying potential gainers and losers; evaluating what other services will necessarily be forgone as a consequence of a decision to spend; making interpersonal comparisons between ethical claims to benefit; deciding who will be consulted and otherwise involved in the decision-making process; identifying any training needs required for conducting the analysis and for implementing its results; and conveying the recommendations to "board level" authorities, clinical professionals, managers, organised patient groups, insured individuals and families, and the general public.

### In essence...

The basic requirement is always simple: an HTA needs to address the issues considered to be significant by the decision-makers (the principals) and their expert advisers (agents). Regarding the agents, one requires sufficient competence and integrity to commission and evaluate analyses that meet conventional professional standards and that have political credibility [13]. It can never involve the HTA analysts determining the scope. A qualification: the analysts may on occasion be commissioned to specify a study's scope. When such is the case, HTA analysts would be well-advised to elicit from decision makers as best they can their principal interests and values. Failure to do this with due diligence, like arrogantly presuming from the start a right to dictate scope themselves, will surely produce a report whose only deserved future is to gather dust on a shelf.

## REFERENCES

- 1) Mira C, Montalvão P, Fonseca I, Borges A. Localised laryngotracheal amyloidosis: a differential diagnosis not to forget. *BMJ Case Rep.* 2021, 14:e237954.
- 2) Phillips NM, Matthews E, Altmann C, Agnew J, Burns H. Laryngeal amyloidosis: diagnosis, pathophysiology and management. *J Laryngol Otol.* 2017, 131:S41-417.
- 3) Edmund P, Oren F, Brian O, Mary FC, David L, et al. Amyloidosis of the upper aerodigestive tract. *Laryngoscope.* 2003, 113:2095-101.
- 4) Mitrani M, Biller HF. Laryngeal amyloidosis. *Laryngoscope.* 1985, 95:1346-1347.

- 5) Lewis JE, Olsen KD, Kurtin PJ, Kyle RA. Laryngeal amyloidosis: a clinicopathologic and immunohistochemical review. *Otolaryng Head Neck Surg.* 1992, 106:372-377.
- 6) Graamans K, Lubsen H. Clinical implications of laryngeal amyloidosis. *J Laryngol Otol.* 1985, 99:617-623.
- 7) Aydin Ö, Üstündag E, Iseri M, Özkarakas, H, Oguz A. Laryngeal amyloidosis with laryngocele. *J Laryngol Otol.* 1999, 113:361-363.
- 8) Czeyda-Pommersheim F, Hwang M, Chen SS, Strollo D, Fuhrman C, et al. Amyloidosis: modern cross sectional imaging. *Radiographics.* 2015, 35:1381-392.
- 9) Rosengren S, Mellqvist UH, Nahi H, Forsberg K, Lenhoff S, et al. Outcome of AL amyloidosis after highdose melphalan and autologous stem cell transplantation in Sweden, long-term results from all patients treated in 1994-2009. *Bone Marrow Transplant.* 2016, 51:1569-1572.
- 10) Deviprasad D, Pujary K, Balakrishnan R, Nayak DR. KTP laser in laryngeal amyloidosis: five cases with review of literature. *Ind J Otolaryngol Head Neck Surg.* 2013, 65:36-41.
- 11) Yiotakis I, Georgolios A, Charalabopoulos A, Hatzipantelis P, Golias C, et al. Primary localized laryngeal amyloidosis presenting with hoarseness and dysphagia: a case report. *J Med Case Rep.* 2009, 3:9049.
- 12) Bartels H, Dikkers FG, van der Wal JE, Lokhorst HM, Hazenberg BP. Laryngeal amyloidosis: localized versus systemic disease and update on diagnosis and therapy. *Ann Otol Rhinol Laryngol.* 2004, 113:741-748.
- 13) Ma L, Bandarchi B, Sasaki C, Levine S, Choi Y. Primary localized laryngeal amyloidosis: report of 3 cases with long-term follow-up and review of the literature. *Arch Pathol Lab Med.* 2005, 129:215-218.