Health technology assessment in primary and community care

NEARLY 20 years ago, Howie pointed out that '25 000 GPs and their aggregate of unanswered questions and untested impressions remain one of the most significant sources of research potential available to contemporary medicine'.[1] The 1997 National Health Service (NHS) Executive report *R&D in Primary Care*[2] and the 1997 Medical Research Council topic review *Primary Health Care*[3] raise the importance of further investment in the development of research infrastructure in primary care. While the academic general practice community is growing and produces increasingly high quality work, concerns have been expressed that the research community does not always answer the questions that cause clinicians most concern. The NHS Research and Development Strategy, which includes the Health Technology Assessment (HTA) Programme, was established to enable those who put research findings into practice to have a greater influence on the agenda of health service research and thus to contribute more fully to the development of a knowledge-based health service.

The HTA programme is based on the recognition that many clinical decisions are made more on belief than knowledge. Health technology includes all the methods that are used to promote health, prevent and treat disease, and improve rehabilitation or long-term care. It therefore covers the activities of all healthcare professionals and embraces pharmaceuticals, healthcare procedures, and care settings. HTA aims to answer four questions for clinical and policy decision makers:

1. Does the intervention work?
2. How does it compare with alternatives?
3. For which patient group is it appropriate?
4. What is the cost?

The development of new technologies does not fall within the remit of HTA, although newer technologies clearly require careful assessment. New technologies may enter clinical practice without adequate evaluation (e.g. lithotripsy, endoscopic surgery) and the cost of such services ultimately falls on the NHS. Because of the difficulties of withdrawing services of even limited benefit, pressure to continue funding may be overwhelming. Conversely, other effective and cost-effective technologies may be underused (e.g. anti-platelet therapy in cardiovascular disease and glyceryl trinitrate (GTN) for anal fissure) and relevant HTA can demonstrate and promote valuable benefits. Furthermore, improved outcomes may only apply to specific patient sub-groups and HTA can guide more precise application of a technology (e.g. the use of cholesterol-lowering drugs in high-risk patients, as opposed to all patients with raised cholesterol levels).

Since 1994, the HTA programme on primary and community care has commissioned research to the tune of over £7.5 million. The topics are eclectic, ranging, for instance, from the organisation and impact of primary care emergency centres to near-patient testing in general practice. But they are focused on questions that have been submitted by people who work in or use the NHS. As a needs-led enterprise, the HTA programme depends on practitioners, users, and managers to identify the areas where research is required to help make more informed decisions. Suggestions can be sent in to the National Coordinating Centre for Health Technology Assessment (NCCHTA), where they are recorded and allocated to one of six multidisciplinary expert panels of which the Primary and Community Care Panel (PCCP) is one. The submission of questions that concern people who work in and use the NHS is invited through advertisements in professional journals and input is sought from national bodies, consumer organisations, and research departments. The research recommendations of reviews from the Cochrane library, or from reviews carried out in the HTA programme itself, are scanned as an important source of genuine areas of uncertainty. Finally, there is a re-examination of topics that did not become prioritised the previous year.

The PCCP prioritise many hundreds of research questions that come to it by considering the scale of the problem, how many people the health technology will affect, how much difference it will make, how much is known about the technology already, and the current and likely future pattern of use. The provision of the in-depth information that is required for the final decision on the selected topics across the six expert panels is provided by the NCCHTA research team in consultation with relevant specialists. A definitive list of priorities is decided at the end of each year by the Standing Group for Health Technology.

The team then prepares commissioning briefs to help prospective researchers focus on the prioritised questions. The research topics are widely advertised and applications are invited to undertake the projects. There are two types of research that are relevant to HTA: primary research in which new data is collected, and secondary research where the findings of existing research are reviewed. Sometimes a combination of both elements is appropriate in modelling studies, as in the HTA assessment of beta interferon for multiple sclerosis.[4] The time taken to complete research projects is an important potential limiting factor in the ability of the programme to appear responsive. This is particularly so in primary research projects when there may be a need to recruit large numbers of patients so as to achieve a significant answer. The role of rapid appraisals of health technologies is the subject of ongoing research within the programme and is of increasing importance with the establishment of the National Institute of Clinical Excellence,[5] part of whose role will be to issue guidance on the use of technologies.

Publication of reports of the research projects is a vital part of the procedure, as there is no point in getting an answer to a question perceived to be of importance to the NHS and then not getting the message to the people who want to use it in practice. One of the conditions on which the research is commissioned is that the research team should prepare a paper for publication in a peer reviewed journal. Additionally, the HTA programme publishes a monograph of the research as a detailed account of the study and its findings. These monographs are available from the NCCHTA free to those working in the public sector and can be downloaded from the Internet.

The following topics are examples of some of the 33 research projects now underway in primary and community care, which the HTA programme has commissioned:

- Long-term outcome of cognitive behaviour therapy.
- A randomised controlled trial of the management of venous leg ulcers in the community.
- A randomised trial comparing leisure-based exercise on prescription, home-based walking, and usual advice in primary

care.
- The management of patients on long-term benzodiazepine medication.
- Effectiveness of diabetes education interventions for adolescents.
- Acupuncture for migraine and headache in primary care: a pragmatic randomised trial.

Over the next two years, the results of studies that were commissioned in the first years of the HTA programme will become available. From this example it can be seen that the results of these projects could have important messages for health care staff, indicating more effective approaches in these areas of care.

It is very important if the primary and community care research resource is to be used effectively that there is input by general practitioners (GPs) to the HTA programme, both by the submitting of questions that need to be answered and, when there is a capability, of applications to undertake research. If the findings of HTA programmes are to be widely applicable then the research must be carried out in settings that reflect everyday practice. This will require more GPs to become involved in research as leaders and collaborators in research teams. It is also important for them to give support to HTA studies by engaging their patients in projects that are addressing relevant uncertainties in practice.

Suggestion forms for research topics and further information about the HTA Programme and the research topics that the programme wishes to commission are available on the Programme website (http://www.hta.nhsweb.nhs.uk).

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Supporting doctors, or the beginning of the end for self-regulation?

THE failings of self-regulation have been familiar, long before the recent high profile cases. At some stage in their professional lives, most doctors will have come across others whose failings have been tolerated and covered up by their colleagues. *Supporting doctors, protecting patients*, the consultation document from the Department of Health (DoH) for England, summarises the damning evidence on under-performing doctors. Appreciable numbers of both hospital doctors and general practitioners (GPs) are believed to be under-performing, and much larger numbers are reported to be suffering from psychological disturbance. Twenty-nine hospital doctors have been suspended from duty for more than six months under disciplinary procedures that take far too long and are therefore hugely expensive. The DoH document analyses the weaknesses of the current system: problems are acknowledged too late, so that the possibility for remedial educational intervention is lost in favour of the cumbersome disciplinary procedures; problem doctors can move from one employer to another without any steps being taken to deal with the problem; and there is confusion about the overlap of responsibilities between the National Health Service (NHS) and the General Medical Council (GMC).

In order to streamline the current procedures, the DoH will create two Assessment and Support Centres to be run jointly by the NHS and the profession. Doctors will be able to refer themselves, or will be referred when a problem has been identified that cannot be resolved informally. So far, so good (and so uncontroversial). Nobody would dispute that the NHS has a duty of care to patients.

The difficulty arises in assigning responsibility to the new Centres, not only for contractual and disciplinary matters but also for matters of professional competence. It purports to support the principle of professional self-regulation and sets out how the new Centres will work in partnership with the GMC, particularly where rapid referral to the GMC's professional conduct committee is indicated. Nevertheless, it presents obvious difficulties. First, there is considerable scope for disputes between different bodies, where doctors who have been thought by the Centres to be in need of retraining are deemed competent by the GMC (or vice versa). Secondly, in some cases where there has been an unacceptable standard of care, there will be disagreement as to whether it has arisen through individuals under-performing or through under-investment in the service as a whole. It will be difficult for an agency of the NHS, as both employer and part of government, to act impartially in such cases. Thirdly, despite the

emphasis on early identification of problems, it is hard to see that a change in procedures will bring this about. The line that divides honest and acceptable human error from consistent under-performance will always be a difficult one to define until the performance has fallen a long way from what is acceptable.

Before we rush to preserve professional self-regulation, it is important to remember that the profession implicitly abandoned the idea of doctors being the only ones who can exercise such judgement a long time ago. The GMC has had lay members for many years and they are now involved in its performance procedures. The RCGP has a long history of working in partnership with lay people and includes lay assessors in their Fellowship by Assessment visits. We no longer think that doctors can or would want to have sole responsibility for professional standards; it is the prospect of passing responsibility to governments motivated partly by trying to save money and partly by wanting to win the next election that is unacceptable. Besides, attitudes to maintaining competence are set to change beyond all recognition with the implementation of the arrangements for clinical governance and revalidation. It would surely have been sensible to wait and see how these systems work before imposing yet another major change on the profession. In any case, systems to deal with these problems already exist and have never worked properly. What is needed is not the creation of another system, but a change of climate that would enable existing systems to work properly.

Of course, as the document acknowledges, most English GPs are likely to be performing to a high standard and should have nothing to fear from the proposed changes. The document is entitled '*Supporting doctors...*' and talks about a system free of stigma, but it is hard to see how this can be achieved when so much is at stake. Even if the Centres work supportively, it is likely that many doctors will feel threatened by the implication that their performance is being watched all the time. GPs feel vulnerable to increasing demands from the public and the NHS alike, and these proposals are unlikely to allay their sense of insecurity. This is hardly the action of a responsible employer anxious to look after its workforce and ensure future recruitment that would be recommended by management consultants.

In the end, the changes may also have substantial unintended effects. In order to prevent under-performance by a few, a climate of fear could be created in which a much larger number of GPs will be encouraged to practise a more expensive, defensive style of medicine that will benefit neither ourselves, nor the NHS, nor our patients.

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Further reading

Supporting doctors, protecting patients is available at www.doh.gov.uk/pub/docs/doh/consultation.pdf. Comments should be sent to cmoconsult@doh.gov.uk

A draft response from the College is available on the RCGP website at www.rcgp.org.uk

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