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What is This?
Health Technology Assessment in the Canadian Health Policy Arena
Examining Relationships between Evaluators and Stakeholders

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This article uses a sociopolitical perspective to analyse the results of a case study of six Canadian Health Technology Assessment (HTA) agencies and their stakeholders: health care administrators, provider associations, patient associations and the biomedical industry. A total of 40 HTA agency representatives and 46 stakeholders were interviewed. A self-administered survey was also filled out by a larger number of respondents belonging to the four groups (n = 405). Our study indicates that the concept of HTA has gained acceptance and that several groups want their concerns and priorities to be included in the agencies’ agendas. Nevertheless, stakeholders question the political autonomy of HTA agencies and their ability to bring about concrete change. This article proposes strategies that may help improve relationships and exchanges between evaluators and their stakeholders. Evaluators must not be afraid to ask for more accountability in the way health technology policies are drafted.

KEYWORDS: health technology assessment; HTA utilization; knowledge transfer; research-centred collaboration
Introduction: Positioning HTA in the Health Policy Arena

Health Technology Assessment (HTA) is a field of evaluation that seeks to contribute to policy-making by providing evidence about the efficacy, safety and cost-effectiveness of health technology. HTA also informs decision-makers, clinicians, patients and the public about broader issues such as the ethical, legal and social implications of introducing, using and disseminating health technologies (Banta et al., 1995; Battista et al., 1999). This kind of evaluation has found the publicly funded Canadian health care system to be particularly fertile ground in which to grow and expand. More than 10 HTA groups have been established in Canada since 1988.

Has this remarkable increase in the production of HTAs been accompanied by a parallel transformation in uptake and utilization of HTAs? Now would seem to be a good time to explore this question, especially since the expectations of HTA stakeholders have rarely been examined (Davies and Littlejohns, 2002; Farmer and Chesson, 2001). How do stakeholders perceive the usefulness and credibility of HTA agencies? How do they use, implement, ignore or challenge their findings? In what ways would they like to collaborate with evaluators?

This article aims to shed light on such questions by examining stakeholder expectations and concerns and by contrasting these with the views of evaluators. To understand more fully how the health policy arena is being transformed by six Canadian HTA agencies, four influential groups were targeted: health care administrators, provider associations, patient associations and the biomedical industry. Adopting a sociopolitical perspective, our mixed-methods study explores the tensions inherent in the process of institutionalizing the production, dissemination and use of policy-oriented evaluation. More specifically, the article examines: 1) stakeholders’ understanding and interpretations of HTA; 2) the process through which scientific credibility and political autonomy intermingle, thereby influencing stakeholder perceptions and practices; and 3) the institutional dynamics that affect the implementation of HTA findings. The article concludes with recommendations that may help improve relationships and exchanges between evaluators and their stakeholders.

What is HTA? And what should its Role be in the Health Policy Arena?

Since the end of the 1980s, the field of HTA has grown considerably in Europe, North America, Australia and emerging countries (INAHTA, 2008). According to Perleth et al.:

HTA is not defined by a set of methods, but rather by its intention, i.e. to provide evidence-based information ensuring value for money in health care. [HTA’s] purpose is to provide input into a policy decision, while taking different perspectives ideally in combination (e.g. clinical, societal, economic, etc.). (2001: 240)

Because of its intended link to policy, HTA has taken on different organizational forms. HTA in Central Europe (Germany, Austria, Luxembourg, Switzerland and
the Netherlands) ‘has taken a different course than in taxed-based or private health care systems (such as the United States)’ where it is performed by multiple individuals and groups often located in sickness funds, coverage-related bodies or universities (Wild and Gibis, 2003: 188). By contrast, ‘in countries like Sweden, Canada, Norway, the United Kingdom, and Spain, where the health systems are largely publicly funded (tax-based), public agencies devoted to HTA have been created’ (Wild and Gibis, 2003: 188). In Canada, since health care is a provincial responsibility and the provinces vary greatly in size and resources, provincial- and national-level HTA agencies have been structured in a variety of ways (university-based research groups, arm’s length government agencies and independent not-for-profit agencies).

According to Sassi, HTA activities have been growing steadily in the past decades ‘but often without reaching the critical mass required to make a significant impact on health policies. Lack of communication and lack of coordination between HTA agencies and programs were at least in part to blame for this failure’ (2000: 282). The EUR-ASSESS project was developed because of this shared recognition and aimed, among other things, to increase coordination of HTA in Europe. Closely connected to such initiatives was the need to better understand how to disseminate results to decision-makers (Battista et al., 1994; Cookson and Maynard, 2000). As Sassi notes:

Agencies/programs seem to have been stimulated to develop innovative methods for the dissemination of their products. Examples are the use of new means of communication, such as the Internet, a better collaboration with opinion leaders in the relevant fields, production of briefings or summaries of HTA reports, and development of bulletins or newsletters. (2000: 286)

During this period, HTA researchers started to examine, adapt and apply some of the principles and tools stemming from research on knowledge transfer (Battista et al., 1999; Bero et al., 1998; Grilli and Lomas, 1994; Grimshaw et al., 2002; Lavis et al., 2002). Conceptually, this literature has generally focused on studying the factors and characteristics of individual pieces of research that may explain uptake by individual targets (Grilli and Lomas, 1994). In recent years, however, knowledge-transfer scholars have expanded this framework and examined the types of relationships or exchanges that should be established between knowledge producers and various users in order to facilitate the uptake of research evidence (Lavis et al., 2002).

This concern with dissemination forces policy-oriented evaluators to reflect on and become more familiar with the interests and interplay between the various stakeholders in the health policy arena. Because the regulation of health technology directly affects several groups (patients, industry, providers, taxpayers, etc.), each of whom may lose or gain clinical, economic and symbolic resources through the process (Giacomini et al., 2000; Lehoux and Blume, 2000), it is important to understand the expectations of different stakeholders (Sassi, 2000: 289). For instance, Wild and Gibis underscore that HTA ‘can be seen as an alternative to interest-driven or otherwise biased expertise’ (2003: 188). However, because HTA can limit the influence of physicians, it remains ‘a somewhat unappreciated tool amongst the profession’ (2003: 188).
Furthermore, many have called for patients and/or members of the public to be included in HTA activities (Bastian, 1998; Royle and Oliver, 2004), mainly because ‘citizen participation in health decision-making has been considered an important feature of responsive and equitable health systems’ (Pivik et al., 2004: 254). In Canada, for instance, ‘many consider that patients/consumers have both a moral and ethical right to participate in health care decisions, particularly within the context of a publicly funded health system’ (Pivik et al., 2004: 254). Thus, there are no doubts that HTA researchers would like their work to be widely disseminated and integrated into policy-making and clinical practice. What remains unclear is which audiences should be targeted and how HTA agencies can or should interact with these audiences.

The group leading the European Collaboration for Health Technology Assessment/Assessment of Health Interventions (ECHTA/ECAHI) formally suggested targeting a broad range of audiences: ‘policy makers, clinicians, industry, patients, and the general public’ (Jonsson et al., 2002: 216). This is an ambitious goal given the particular position HTA bodies occupy in the health policy arena. What differentiates HTA agencies from other knowledge producers is the pursuit of a societal mission that requires resilient interfaces with the policy environment – supporting the rational use and regulation of health technology for the benefits of society as a whole (Jasanoff, 1990). But this position necessarily implies that other stakeholder groups may feel threatened or excluded from the process. In previous work, the authors observed that the media, the public and industry were rarely explicitly targeted as audiences by HTA agencies (Lehoux et al., 2005). We also found that the agencies’ products (types and scope of reports) were partly shaped by the audiences they were targeting; some agencies clearly had a user-driven research portfolio while others were mainly operating under a research-driven model (Lehoux et al., 2004). These observations suggest that: 1) HTA researchers may not direct their work to all types of audiences and probably cannot collaborate extensively with all types of audiences; and 2) HTA researchers should, therefore, more explicitly formalize how exchanges and collaboration with various categories of stakeholders should take place (or not).

Conceptualizing the Relationships between Knowledge Producers and Stakeholders

The literature on collaborative research represents an excellent starting point for exploring these issues. According to Golden-Biddle et al. (2003: 21), four key elements come into play: 1) the relational stance that researchers and users assume toward each other; 2) the purpose at hand, which situates occasions for developing and using knowledge; 3) the knowledge-sharing practices for translating knowledge; and 4) the forums in which researchers and users access knowledge. These authors suggest adopting ‘a communicative perspective on research collaborations that emphasizes the members and the communicative elements called upon in knowledge-making and -using efforts’ (2003: 21). Misunderstandings due to cultural differences between researchers and decision-makers and/or practitioners often arise because they ‘do not share the same norms regarding scholarship and
practice, and they often do not know well enough how to work with each other in a way that takes these different norms into account’ (Bartunek et al., 2003: 65).

Socialization through regular exchange may facilitate the emergence, over time, of convergent values and norms. One key phase when exchange between researchers and users of knowledge may play such a bonding role is when preliminary results are presented and debated. The need for researchers ‘to process and interpret research findings together with practitioners, preferably in face-to-face interactions’, was stressed (Golden-Biddle et al., 2003: 20).

Scholars have also flagged a number of issues and potential pitfalls in collaborative research, leading Denis and Lomas to stress that it ‘is a journey without a clear destination’ (2003: 5). The necessity to preserve the autonomy of scientific practices is often raised while ‘the spectre of too close a relationship between the researchers and the government funders can become an issue’ (Goering et al., 2003: 17). This issue does in fact point to the need to be clear about who the partners are and what their stakes are in the research process. Furthermore, one needs to more closely examine what happens during collaborative research since scientific autonomy may not be limited so much by the particular partners that are present in the research process, but rather by the relative weight exercised by each partner. Golden-Biddle et al. recommend focusing on the ‘situated purposes at hand’ in order to enrich the partnership and facilitate the development and use of research (2003: 23). Although this strategy may facilitate the collaborative process with established partners, it may underplay the broader sociopolitical tensions inherent in translating research findings into policy or practices where several stakeholders may be pursuing competing objectives (government, patients, industry, insurance companies, etc.).

The need to manage potential conflicts of interest and to have ‘clear, mutual expectations about the respective roles of each’ (Goering et al., 2003: 18) may be conceptualized in two different ways. First, the focus could be on the collaborative process itself – for example, ‘treating others as equals’, learning as much as possible from each other (Golden-Biddle et al., 2003: 22). This would be consistent with the precepts of collaborative research, which tend to highlight approaches for effective collaboration. Alternatively, the focus could be on exploring the sociopolitical dynamics that structure how the interests, knowledge and responsibilities of various partners are expressed through research-centred collaboration and how they influence the outcomes of this collaboration. This emphasis would be consistent with a critical analysis of what participation involves in terms of power relationships (Cooke and Kothari, 2001).

Our article adopts this second conceptualization in an attempt to make more explicit how different types of stakeholders – with conflicting stakes in health technology and with varying levels of resources – perceive the value and usefulness of scientific evidence about health technology. As has been highlighted, collaborative research often involves a fairly explicit contractual agreement between users and producers. In the case of HTA agencies, knowledge producers cannot expect to please all stakeholders and they do not commit to formal agreements with all of them (Battista et al., 1999). In fact, their recommendations may involve either increasing or decreasing access to certain technologies, which may translate into
actions that are compatible with either cost-control initiatives or the easier adoption of innovations. Therefore, this article focuses on three questions:

1) How do stakeholders understand and interpret the role of HTA in policy-making?
2) How does perceived scientific credibility and political autonomy influence stakeholder attitudes toward HTA?
3) What institutional dynamics affect how HTA findings are used, implemented, ignored or challenged?

Methods: Multiple Case Study Combining Quantitative and Qualitative Data

Our study relies primarily on qualitative data, supplemented with quantitative data (Datta, 1997; Yin, 1994). The study was designed around six Canadian HTA agencies that formally agreed to participate. Our study timeframe (2001–3) represents a noteworthy period in the process of HTA institutionalization in Canada. These agencies had been in existence from eight to thirteen years and had therefore built established organizational patterns in terms of knowledge production and relationships with stakeholders.

This article draws from three main sources: 1) semi-directed interviews with HTA researchers, 2) a sample of their stakeholders and 3) a self-administered survey of a larger number of stakeholders. The agencies and their respondents were located in the provinces of British Columbia, Alberta, Saskatchewan, Ontario and Quebec. Stakeholder respondents were selected from the most influential formal organizations and reflected a range of viewpoints: health administrators, health care providers, patients and the biomedical industry (see Box 1).

Interviews

We interviewed all of the HTA agencies’ executives (n = 10) and communication officers (n = 10) and selected evaluators (n = 20) with a minimum of three years’ experience (Marshall and Rossman, 1989). We conducted a total of 46 interviews with stakeholders whose mission and activities were most relevant to our study. This included representatives from health administrations (n = 17), health care provider associations (n = 11), patient associations (n = 14) and industry (n = 4) (interview questionnaires are available upon request). Interviews were conducted between May 2001 and October 2002, either in person or by telephone, and lasted from 45 to 90 minutes. All interviews were tape-recorded and transcribed to electronic format (Marshall and Rossman, 1989). We used a qualitative analytical approach called symbolic interactionism, which focuses on how individuals, through regular interactions, develop shared meanings and conceptualize, perceive and understand the role of evaluation (Murphy et al., 1998: 201). This approach was particularly helpful in identifying how knowledge producers and stakeholders, through their experience in interacting together, anticipated and defined the contributions and responsibilities of each other.
Survey

We developed a self-administered survey to explore the views of a larger number of stakeholders (available upon request). It was developed based on eight exploratory interviews, the literature on knowledge utilization and a survey developed in a study on collaborative research (Denis et al., 2003). Survey data were collected from January 2002 to June 2002. Table 1 indicates an overall response rate of 27 percent ($n = 405$) with the breakdown as follows: health care providers ($n = 223$), administrators ($n = 105$), patients ($n = 60$) and industry ($n = 17$). Variation in response rate across groups and/or jurisdictions can be explained by our decision to not exclude any groups who were, in principle, relevant audiences and by the heterogeneity of topics addressed by the agencies (e.g. screening tests, imaging devices, drugs, mental health interventions, etc.). In examining respondents’ profiles, we found that about half of them were top-level managers.$^3$ Most questions were closed and used a five-level Likert scale. Descriptive statistics are presented.

Results: Acceptance, Credibility and Challenges

Has the Concept of HTA Gained Acceptance in Canada?

Table 2 shows the importance that the four groups of stakeholders attribute to nine issues pertaining to health technologies and services. Across groups, access to health services was the prime issue, followed by evaluation of health services
Table 1. Survey Response Rates by Group and Jurisdiction

<table>
<thead>
<tr>
<th></th>
<th>Providers associations</th>
<th>Administrators</th>
<th>Patient associations</th>
<th>Industry</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>National</td>
<td>48/95</td>
<td>51</td>
<td>28/111</td>
<td>25</td>
<td>19/35</td>
</tr>
<tr>
<td>BC</td>
<td>24/107</td>
<td>22</td>
<td>11/76</td>
<td>14</td>
<td>9/42</td>
</tr>
<tr>
<td>Alberta</td>
<td>14/52</td>
<td>27</td>
<td>8/40</td>
<td>20</td>
<td>3/23</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>8/32</td>
<td>25</td>
<td>14/42</td>
<td>33</td>
<td>4/16</td>
</tr>
<tr>
<td>Ontario</td>
<td>77/304</td>
<td>25</td>
<td>21/120</td>
<td>18</td>
<td>6/54</td>
</tr>
<tr>
<td>Quebec</td>
<td>52/196</td>
<td>27</td>
<td>23/47</td>
<td>49</td>
<td>19/57</td>
</tr>
<tr>
<td>Total</td>
<td>223/786</td>
<td>28</td>
<td>105/436</td>
<td>24</td>
<td>60/227</td>
</tr>
</tbody>
</table>
Table 2. Importance of Issues Related to Health Technology and Services

<table>
<thead>
<tr>
<th>Issue</th>
<th>Provider associations (1)</th>
<th>Administrators (2)</th>
<th>Patient associations (3)</th>
<th>Industry (4)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>n</strong></td>
<td><strong>Mean</strong></td>
<td><strong>SD</strong></td>
<td><strong>n</strong></td>
<td><strong>Mean</strong></td>
</tr>
<tr>
<td>Access to health services by the population</td>
<td>218</td>
<td>4.53</td>
<td>0.72</td>
<td>105</td>
<td>4.52</td>
</tr>
<tr>
<td>Evaluation of health services and technology</td>
<td>217</td>
<td>4.00</td>
<td>0.85</td>
<td>104</td>
<td>4.09</td>
</tr>
<tr>
<td>Controlling the cost of health services*</td>
<td>221</td>
<td>3.90 (2)</td>
<td>1.10</td>
<td>105</td>
<td>4.42</td>
</tr>
<tr>
<td>Development of new health services</td>
<td>219</td>
<td>3.84</td>
<td>0.93</td>
<td>105</td>
<td>3.72</td>
</tr>
<tr>
<td>Controlling the cost of health technology*</td>
<td>219</td>
<td>3.79 (2)</td>
<td>1.14</td>
<td>105</td>
<td>4.20 (1,3)</td>
</tr>
<tr>
<td>Introducing new health technology into the health care system*</td>
<td>220</td>
<td>3.63 (4)</td>
<td>1.10</td>
<td>105</td>
<td>3.69 (4)</td>
</tr>
<tr>
<td>Renewal of existing technology</td>
<td>218</td>
<td>3.59</td>
<td>1.13</td>
<td>105</td>
<td>3.59</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Provider associations (1)</th>
<th>Administrators (2)</th>
<th>Patient associations (3)</th>
<th>Industry (4)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td><strong>Mean</strong></td>
<td><strong>SD</strong></td>
<td><strong>n</strong></td>
<td><strong>Mean</strong></td>
</tr>
<tr>
<td>Purchase of new technology by hospitals</td>
<td>222</td>
<td>3.35</td>
<td>1.29</td>
<td>105</td>
</tr>
<tr>
<td>Supporting R&amp;D activities in the biomedical industry*</td>
<td>218</td>
<td>2.83</td>
<td>1.23</td>
<td>(3,4)</td>
</tr>
</tbody>
</table>

Notes: Scores were based on a five-level Likert scale: 1 – Not important; 2 – Somewhat important; 3 – Important; 4 – Very important; 5 – Extremely important. Mean scores are presented.

* There are statistically significant differences between mean scores (Tamhane’s T2 is a conservative pairwise comparison based on the t-test; \( p < 0.05 \)). If a mean score for a group is significantly different from that of one or more other groups, the number codes of these other groups are given in brackets.
and technology, control of costs of both services and technology, and development of new services. Not surprisingly, administrators were more concerned about costs than were providers, patients and industry. Industry is very interested in the introduction of new technology and R&D. The fact that providers and administrators do not consider R&D critical is somewhat perplexing given the initiatives of HTA researchers around emerging technologies (e.g. early warning and horizon scanning).

Table 3 shows how stakeholders evaluated seven features of HTA agencies. According to all groups except industry, scientific rigour and credibility are strong assets of the agencies. Interestingly, the agencies’ political autonomy raises fewer concerns for administrators and patients than it does for providers and industry. The ability to make changes in health care systems was the weakest feature. The following sections will now examine some of these features in light of our interviews with HTA agency representatives and stakeholders.

**Can Science with Limited Political Autonomy be Credible?**

Although most interviewees felt HTA agencies were credible organizations producing rigorous studies, industry respondents were more sceptical about the credibility and usefulness of HTA and their opinion was sometimes influenced by rumours or general impressions.

At one point I’ve heard comments from people in the health care system, high-level managers, saying that what the agency had said wasn’t very important, that they didn’t care about the results of the study. . . . I was a bit shocked because it lessens the agency’s credibility. If the results aren’t credible, it’s a waste of money. (Industry 1, Jurisdiction 5)

However, assuming that scientific credibility would be a sufficient cause for uptake tends to oversimplify the dynamics between stakeholders and evaluators. A significant tension surfaces between scientific credibility and political autonomy, which is more acute in the case of HTA agencies because they must produce *independent* and *usable* science. As interviewees explained, agencies’ political autonomy can be challenged in two ways. First, agencies could give too much credit to clinical experts in their assessments, although assessment requires knowledge that can hardly be entirely independent from expertise.

It’s very important to have independent bodies that validate. Now the problem is . . . by choosing experts, you’re already biased . . . because experts already have a vested interest in the application of the technology. And if you pick non-experts, while they may not be biased, the problem is they may not grasp the subtleties of the field. (Provider 1, Jurisdiction 5)

It then becomes a matter of balance, wherein agencies have to actively protect their political autonomy and produce irreplaceable science. It calls for accessing specialized expertise that is not seen as blinded by, or overly enthusiastic about, specific technological advances. Second, as stressed by a representative of a patient association, agencies must not give the impression of being ‘too cosy’ with government and of supporting its streamlining policies.

There’s a bit of an arm’s length relationship – the agencies receive their funding but they’re not controlled by the government and most people are sort of okay with that.
<table>
<thead>
<tr>
<th>Perception of HTA Agencies</th>
<th>Provider associations (1)</th>
<th>Administrators (2)</th>
<th>Patient associations (3)</th>
<th>Industry (4)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n Seidenifc rigour*</td>
<td>121 4.17 0.71</td>
<td>78 4.29 0.67</td>
<td>17 4.35 0.61</td>
<td>14 3.29 0.91</td>
<td>230 4.17 0.74</td>
</tr>
<tr>
<td>Credibility*</td>
<td>126 4.17 0.75</td>
<td>79 4.22 0.75</td>
<td>16 4.44 0.63</td>
<td>15 3.20 1.01</td>
<td>236 4.14 0.80</td>
</tr>
<tr>
<td>Accessibility of its reports*</td>
<td>126 3.90 0.84</td>
<td>77 4.26 0.82</td>
<td>15 4.07 1.03</td>
<td>16 3.88 0.81</td>
<td>234 4.03 0.86</td>
</tr>
<tr>
<td>Dissemination of its work</td>
<td>121 3.54 0.96</td>
<td>75 3.87 0.92</td>
<td>14 3.64 0.84</td>
<td>16 3.75 0.77</td>
<td>226 3.67 0.93</td>
</tr>
<tr>
<td>Political autonomy*</td>
<td>98 3.49 0.89</td>
<td>68 3.93 0.82</td>
<td>15 3.87 0.64</td>
<td>14 3.00 0.88</td>
<td>195 3.64 0.88</td>
</tr>
<tr>
<td>Ability to formulate clear recommendations</td>
<td>116 3.53 0.86</td>
<td>72 3.67 0.79</td>
<td>14 3.79 0.58</td>
<td>13 3.15 0.99</td>
<td>215 3.57 0.83</td>
</tr>
<tr>
<td>Ability to introduce concrete changes into the health care system</td>
<td>104 2.89 0.88</td>
<td>65 3.15 0.89</td>
<td>10 3.20 0.63</td>
<td>12 2.58 0.79</td>
<td>191 2.98 0.88</td>
</tr>
</tbody>
</table>

Notes: Scores were based on a five-level Likert scale: 1 – Very poorly; 2 – Poorly; 3 – Moderately; 4 – Highly; 5 – Very highly. Mean scores are presented. Only respondents who knew about the work of the agencies answered this question.

* There are statistically significant differences between mean scores (Tamhane’s T2 is a conservative pairwise comparison based on the t-test; \( p < 0.05 \)). If a mean score for a group is significantly different from that of one or more other groups, the number codes of these other groups are given in brackets.
What wouldn’t be okay is . . . if it looked like they were too close and the government was using their research to make very controversial decisions that were in favour of the government, to either save money or whatever. I think this would rear its ugly head pretty fast. But I think that, generally speaking, that’s not the case. (Patient 1, Jurisdiction 6)

Such tension associated with ‘who your client is’ is recognized by evaluators themselves. Showing autonomy requires maintaining a certain distance from government decision-makers, while at the same time knowing how to meet their informational needs. Otherwise, HTA may well embody an independent science but one that is not used.

Because some of the results of what we produce may not be what the health districts like to hear, it can result in people thinking this is exactly what the government would like to hear . . . some rationalization for these massive cuts they’ve just made. This would compromise the agency’s credibility. (HTA Producers 1, Jurisdiction 6)

In our interviews, evaluators did not agree with the cost-containment objective and argued that stakeholders need to be educated about HTA’s mission:

I think we are still perceived as a cost-cutting agency. But, those [stakeholders] who have an opportunity to work either on working groups or through the data collection processes . . . receive an education that goes far beyond that. We are looking at enhancing patient care or the quality of the system versus cost containment. (HTA Producers 2, Jurisdiction 6)

Several interviewees suggested that increased exchange with stakeholders would reduce doubts regarding their autonomy: ‘We have worked on an ongoing basis with a number of people and committees, so the work we do is given credibility within that committee’ (HTA Producer 1, Jurisdiction 2). Evaluators also stressed that receiving funding from the government does not tie their hands or force them to pursue only research that fits the government’s agenda.

And that’s probably an issue that we need to deal with, in the sense that we need to make it very clear that we’re separate and we need to work with these groups [of users] to dispel that sort of idea. . . . When somebody is funded by a government agency, you automatically think there is a close tie but, in actual fact, there isn’t. (HTA Producer 1, Jurisdiction 1)

Along the same lines, HTA producers regarded themselves as (and deployed efforts to be perceived as) scientifically autonomous and providers of rigorous, unbiased information.

Our scientific autonomy is one of our strongest assets. We make a concerted effort to ensure that the problem is defined and the question bounded in an extremely objective context. And so we seek advice from many, many different vantage points . . . Our unit is very highly regarded because of this sense of autonomy. . . . We make sure we are objective by selecting the external reviewers of our work to be representative of different points of view on the particular problem. . . . This is how we make sure we leave no stone unturned in terms of objectivity. (HTA Producer 1, Jurisdiction 4)

Hence, HTA’s mandate embodies a paradox: to increase HTA use, HTA must fit with the stakeholders’ agenda, but to protect HTA credibility, HTA must appear to be entirely independent.
Is it Possible to Introduce Concrete Changes within the Canadian Health Care System through HTA?

Table 4 presents what stakeholders believed should be the HTA objectives of the agencies, and contrasts this with what stakeholders judged were the objectives actually being pursued. Assessing effectiveness was seen as a relevant objective and respondents believed that agencies were fulfilling this aim. Respondents rated the goals of contributing to a rational use of technology and to improving clinical practice as just slightly less important and, again, felt agencies were not doing enough work in these areas. Along the same lines, respondents valued the two goals of contributing to health care management and contributing to policy-making, but reported that agencies were falling short in their efforts to achieve these goals. Our qualitative analysis fleshes out these data, presenting the thoughts of several of our interviewees on how the agencies’ role as an agent of change in their jurisdiction was limited.

Table 4. Objectives that Should be Pursued by the Agencies versus Those that Actually Are

<table>
<thead>
<tr>
<th>Objective</th>
<th>Should be pursued</th>
<th>Are actually being pursued</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate the effectiveness of technology and health services</td>
<td>281 4.11 0.80</td>
<td>230 3.67 0.86</td>
<td>0.44</td>
</tr>
<tr>
<td>Contribute to the reduction of public spending in health care</td>
<td>268 3.03 1.16</td>
<td>191 2.71 1.05</td>
<td>0.32</td>
</tr>
<tr>
<td>Contribute to a rational use of technology and health services</td>
<td>277 3.94 0.89</td>
<td>213 3.19 0.95</td>
<td>0.75</td>
</tr>
<tr>
<td>Contribute to the improvement of clinical practices</td>
<td>283 3.99 0.84</td>
<td>219 3.26 0.94</td>
<td>0.73</td>
</tr>
<tr>
<td>Contribute to the improvement of health care management</td>
<td>282 3.73 0.88</td>
<td>207 2.86 1.01</td>
<td>0.87</td>
</tr>
<tr>
<td>Contribute to the improvement of health policies</td>
<td>284 3.74 0.89</td>
<td>206 2.89 1.00</td>
<td>0.85</td>
</tr>
</tbody>
</table>

Notes: Scores were based on a five-level Likert scale: 1 – Not at all; 2 – Somewhat; 3 – An average amount; 4 – A great deal; 5 – Entirely. Mean scores are presented. Only respondents who knew about the work of the agencies answered this question. The smaller sample size in the second column is explained by the exclusion of those who answered ‘do not know’. Some respondents may be more comfortable being prescriptive about the importance of the objectives than they are making a judgment about the performance of the agencies.
Research Agenda and Mandate

Evaluators have developed a variety of ways of deciding on their research priorities (Lehoux et al., 2005). At one end of the spectrum, the Department of Health may ‘inform’ the agency’s agenda but most projects remain investigator-initiated, while at the other end the agency’s portfolio is oriented by a public service ‘pull’ rather than by a scientific ‘push’. Under the ‘public service pull’ model, the research agenda consists of answering requests from its various user groups, e.g. from decision-makers to members of the public. While it is believed that requests formulated by the Department of Health or officials from the health care system should not be declined, the depth of the response will be based on available resources and the extent to which the request fits the agency’s priorities.

Not surprisingly, the ‘public services pull’ model, where evaluators’ agendas are closely aligned to users’ requests, is far more attractive than the ‘scientific push’ model, at least from a stakeholders’ perspective. As one administrator bluntly put it: ‘My position would be that HTA agencies should really be more closely aligned to government in order to help government translate technology assessment into policy development’ (Administrator 1, Jurisdiction 3). By contrast, the ‘scientific push’ model is seen as both unpredictable and uncontrollable.

Most of their research agenda . . . is driven by their research scientists. If someone comes on board and has an interest in heart disease, then they’ll do more projects on heart disease. Although it’s high quality research, the problem is that it may or may not fit with the government’s policy agenda. And so if one of the goals of health research is to influence health policy, you need to somehow keep checking to see if your research agenda fits with the government’s policy agenda. (Administrator 1, Jurisdiction 1)

A respondent from a patient association recognized the strengths of the ‘scientific push’ model, but was equally concerned about the significant autonomy granted to researchers in this model.

[The agency] is one of the most reputable and highly regarded research organizations in the country . . . The research gets done by excellent researchers and it is published in peer review journals, but the added value should be that this information is available to [the ministry of health]. . . . [HTA researchers] get the money, they go away, they do their thing . . . but the grant they’re getting is to do work that has applicability to the nation. . . . Work needs to be made available. This is not just academic work that academic researchers just present at conferences or publish in peer-reviewed journals. (Patient 1, Jurisdiction 1)

The lack of control over the scientific programs of HTA agencies is further reflected in the fact that many stakeholders would like to see agencies embrace a broader agenda than the prominently biomedical one traditionally applied. Several stakeholders believed that the issues that matter go beyond medical practice. As one interviewee pointed out: ‘Unfortunately, the information the agency provides is heavily focused on medical practice rather than on other areas, and that’s probably limiting for the system in some sense’ (Provider 1, Jurisdiction 1). Respondents from patient associations expressed doubts about the clinical focus of HTAs: ‘Some of their information is helpful, but I find most of it is clinical, but
I guess that’s what they do. I think they’re more helpful in bringing about systemic improvement in health care, as opposed to providing information that we as a lay organization can take advantage of” (Patient 2, Jurisdiction 1). Similarly, a respondent from industry stressed that HTA should be conducted in a practice setting as opposed to a research office: ‘To assess technologies, they need an environment that is relevant – i.e., where it’s going to be used. It can’t be disembodied from reality’ (Industry 1, Jurisdiction 5). Finally, one interviewee observed that assessments are most often limited to publicly funded technologies while important areas of services and equipment are paid for privately. ‘There’s a whole other array of services that are not insured under Medicare that need to be studied’ (Provider 1, Jurisdiction 6).

**Types of Recommendations and Conclusions**

For a respondent from a patient association, generic information about a particular device or procedure, including effectiveness, safety and costs, is not sufficiently helpful for the patient.

One of the limitations of HTA and clinical practice guidelines is that they’re based on primary research. . . . The problem is that most primary research doesn’t actually identify results for the end points that you or I care about. . . . Most people want to know whether if I choose A versus B, am I going to get back on my feet sooner, am I going to feel better, is it going to cost less, am I going to have fewer side effects? (Patient 1, Jurisdiction 4)

Although economic aspects are almost always part of the public debate around health care, providers believe that HTAs should focus more on clinical effectiveness.

Often the conclusion is that there is insufficient evidence to warrant public expenditure on this technology. But that’s not usually what we’re interested in. We’re interested in knowing whether or not it’s developed enough that a physician can use it regardless of how it might get funded. (Provider 1, Jurisdiction 4)

Administrators did not share this view and discussed at length the types of recommendations they wish HTA would provide. They call for clear recommendations and for agencies to provide not only information, but also guidance.

They’re all doing a reasonably good job in providing information but I think all of them could do a lot more in terms of providing ‘intelligence’. . . . For instance, [a particular agency] is compiling health indicators, rating communities and districts right across Canada. If there is an elevated rate in a particular area, this information could help local people take action on potential problem areas . . . Can you answer the ‘so what?’ question, like is the rate significantly higher? That to me falls within the realm of providing ‘intelligence’ as opposed to just information. (Administrator 1, Jurisdiction 1)

This need for assessments to be more incisive – and actually normative – is echoed by another administrator: ‘We’re looking for real commitment to help us move things along’ (Administrator 2, Jurisdiction 3). In contrast, one provider clearly recognized the need for a distinction between the evaluation process and the
decision-making process, stressing that, while such a tension is sometimes frustrating, it also highlights the fact that it is individuals and organizations that are ultimately responsible for making decisions.

The conclusion of the report doesn’t go far enough in terms of decision-making. It’s both a strength and a weakness. . . . It provides some independence and a good analysis, but it’s useless if it doesn’t have any impact. Thus, the agency should probably keep its mandate as it is but there needs to be someone at the other end who does something with it and doesn’t wait too long. (Provider 1, Jurisdiction 5)

Indeed, several knowledge producers found it very tricky to achieve a balance between drawing conclusions about the strength of the evidence and defining what should be done with these findings. While the former is definitely part of the evaluator’s task, the latter is seen as the responsibility of decision-makers and clinicians.

We’re aware that a lot of decisions made by government departments have political overtones and that there’s a limit to what they can manage, but I think we need to feel that at least they have the best advice they can get. We don’t make recommendations. We don’t say you should cover this drug or you should buy this many machines. We just say the evidence shows that this isn’t worth buying or that this technology is beneficial or whatever. And then the people and the policy-makers make the decisions. (HTA Producer 1, Jurisdiction 3)

Similarly, one evaluator stressed that separating evaluation from implementation is what makes the whole endeavour credible: ‘Sometimes we find this frustrating but I guess it is an appropriate distinction. We need to be objective and credible, do the research, and then leave it to the policy makers’ (HTA Producer 2, Jurisdiction 6). In addition, changing the health care system requires power and authority, something not granted to any of the Canadian agencies. Therefore, the necessary articulation between science and policy-making may fall between the cracks of evaluation and implementation.

The other limitation is probably that we don’t have a strong focus or ability to implement findings or to make change happen. It’s not part of our mandate and we’re not the decision-makers. We can come up with recommendations, but then somebody else has to say yes, they should be implemented, and somebody has to provide the funding to implement them. So we can put out information, but sometimes it stops there. (HTA Producer 1, Jurisdiction 1)

Applicability to Local Contexts

One aspect of HTA that was deemed to be fairly important for stakeholders and that was provided by most agencies is the contextualization of findings (e.g. information about current levels of service utilization, surgical rates and prescription patterns). Such information may be particularly helpful for stakeholders as it identifies more clearly if there is a gap between evidence and practice, and what type of actions may be required to reduce it. The following comment emphasizes stakeholders’ needs for such contextualized inputs.⁴
For example, the recent closure of some hospitals here was compared to [other province], but what we really needed to know was what were the sizes of the hospitals, what were the sizes of the communities. It appears that, in fact, they weren’t directly comparable. So that’s when it becomes problematic – when we don’t have enough information about specifics. (Provider 1, Jurisdiction 2)

Findings that are contextualized can also reduce the concern, noted earlier, about the perceived lack of clear recommendations since it provides a ‘local take’ on concrete issues that stakeholders can use to lay the groundwork for their policy-making process.

**Timeliness and Turnaround Time**

The issue of assessment timeliness is one of the most recurrent concerns about the usefulness of research in policy-making. However, is this a real issue or more of a red herring, as suggested by one administrator? ‘Timeliness is an overrated argument. It reflects the difficulty administrators have in managing their own timelines’ (Administrator 1, Jurisdiction 5). In general, both evaluators and stakeholders recognize the paradoxical tension between the time required to produce a full HTA report and the urgency of decision-makers’ needs for information when they are in the process of making decisions. Perhaps not surprisingly, some stakeholders asserted that the causes of and solutions to the problem lay with HTA producers, while some producers judged that it lay with stakeholders. Indeed, for many stakeholders, the time it takes to produce a full HTA report is not only hard to justify but also unrealistic (on average one year). In order to solve this problem, they call for ‘rapid tech assessments’ followed by a full report when necessary. Pressure is put on policymakers when an innovation is actively and publicly promoted and/or contested.5

We need to be able to respond to the substance, we need to be able to respond to the hype, and we need to be able to respond to the legal issues. And it’s coming at us really fast and furious and when we’re actually in the trenches and trying to make decisions, we need more help than an 18–24 month technology assessment. . . . We may need to change the methodology to reflect the reality of the very rapid development of technology and the way it’s being promoted to the public. (Administrator 2, Jurisdiction 3)

One administrator similarly defined the timing problem as a tension between providers, who want to quickly adopt innovations, and evaluators, who cannot fully assess the technology before it has been used and researched in clinical settings.

I think there’s a tension between providers wanting to provide the most recent and best services, and the time that’s needed to do good research. As you know, systematic reviews or technology assessments can take a long time because it’s very difficult to assess the evidence. On the other hand, we’ve got clinicians who believe they’ve come to a conclusion and are anxious to start doing something. (Administrator 1, Jurisdiction 2)

This issue was also addressed by an industry respondent who stressed that such a problem might never be solved:

Knowledge users tend to need the information when the product comes to market and these HTA groups often have a difficult time doing this because they haven’t got the
However, this pressure for rapid delivery of findings did not impress evaluators to the same extent. For some of them, one key aspect underlying the ‘timeliness’ argument is the lack of continuity in their discussions with administrators. Perhaps senior evaluators hold a longer term vision about policy-making and they become, over time, more critical observers of the policy-making world. One CEO of an HTA agency noted: ‘The Department has this sort of “hurry up and wait attitude”; in other words, hurry up we need this report, we need this report . . . so we give them the report and then we hear back from them a year or so later’ (HTA Producer 2, Jurisdiction 1). Thus, the timeliness argument has a counterpart – the lengthy process through which decision-makers deliberate and implement changes. Several HTA producers were critical of the rapid turnover in government staff, which means having to continually re-establish mutual trust and understanding. HTA producers were also sometimes critical of the lack of scientific literacy and mastery of health care issues on the part of newly appointed officials who had previously been managing non-health-related portfolios. Finally, a few denounced the ‘political hot potato’ strategy that administrators adopt instead of investing in long-term planning efforts.

The requests become part of a crisis management strategy rather than part of an overall plan by a forward-looking group of people at the Ministry. Ideally, I would have thought there would be a group of people from our agency and a group from the Ministry working together and thinking ahead – not about the political hot potatoes for the government this year, but about strategies for the next ten years, such as what sort of evaluation research would help us plan the system. (HTA Producer 3, Jurisdiction 1)

The timeliness argument may reflect a more profound divide between stakeholders and evaluators. These two groups may hold conflicting views about how health care systems should be governed. Overall, our results suggest that cross-fertilization of evaluators’ and stakeholders’ worldviews, which scholars believe is the strong point of collaborative research, has not yet fully occurred.

**Discussion: Improving Relationships between Evaluators and Stakeholders**

This study shows that: 1) the concept of HTA has gained strong acceptance across Canada, although its ability to introduce change is debatable; 2) preserving the autonomy of HTA agencies is seen as very important, although stakeholders also want their concerns and priorities to be included in the agencies’ agendas; and 3) for concrete changes to be implemented, both evaluators and stakeholders will have to define more clearly their respective roles, purposes and worldviews. The article now considers three policy implications arising from our study that we believe may help other publicly funded policy-oriented evaluators refine their collaboration and exchanges with stakeholders.
Managing Stakeholder Expectations by Clarifying the Purposes and Boundaries of Exchanges

Any bridging of the gap between evaluators and stakeholders, who sometimes pursue conflicting objectives, requires a careful analysis and definition of the purposes and mutual expectations structuring such interaction (Ross et al., 2003). Stakeholders must be clearly informed that evaluators are committed to the production of independent and usable science, which means that the input of stakeholders is necessary to increase the relevance and uptake of assessments, but that input does not in any way bind the assessment process or the research agenda. By claiming to provide policy-oriented research that can help ensure better decision-making in a context of scarce resources, HTA producers may have unintentionally created expectations that are at times unrealistic. Farmer and Chesson (2001: 232) observed that even when it took from 3 to 6 months to produce and release HTA reports, timeliness was still an issue for decision-makers who ‘wanted information as quickly as possible’. The authors therefore concluded: ‘Agencies need to match users’ expectations by producing what they have promised’ (Farmer and Chesson, 2001: 232).

Another way of looking at the issue is to review what outputs and deadlines can be reasonably promised, and to examine more closely what knowledge is lacking and how the HTA report can constructively affect the policy-making process given its current stage of development (Giacomini, 2005). This would be more consistent with our findings suggesting that timeliness is not in fact the sole issue and that it may be diverting the attention of evaluators exclusively toward the swiftness of the assessment process while the salient issue is the ability to produce knowledge that can make a difference given the various competing claims in the policy arena (Jasanoff, 1990). Producing this type of knowledge requires, at the outset, an analysis of the policy problem at hand to which policy-makers as well as other stakeholders can contribute. Such an early contribution must make its goals explicit but not unduly affect the assessment process.

Managing stakeholder expectations not only entails clarifying the mandates and methods of evaluators but also, later in the assessment process, discussing how and in what ways policy recommendations can be drawn from existing evidence. Although stakeholders express ‘a desire for information to end uncertainty’ (Farmer and Chesson, 2001: 232), the reality is that both evaluators and stakeholders often have to deal with uncertainty. This can be managed at two stages: during the interpretation of the evidence, or when drawing recommendations. For instance, collaboration seeking to increase the contextualization of HTA is seen by McGregor and Brophy (2005) as one factor explaining the high impact of HTA reports produced at the hospital level. These reports were developed ‘in collaboration with the hospital’s administration, health-care professionals, and patients, all of whom would be affected by decisions’ (McGregor and Brophy, 2005: 266). In this case, having a broad spectrum of stakeholders, but with a strong focus on what technologies the hospital should acquire, may be one way of facilitating constructive exchanges. For McGregor and Brophy, this represents one of the greatest benefits of an HTA unit at the hospital level because ‘a policy decision on what should be done requires far more than an objective analysis of the evidence’ (2005: 266).
For example, a decision to adopt a safety device to protect health personnel from needle stick injuries depends, in addition to the cost, on a knowledge of the local rates of HIV, hepatitis C and hepatitis B, the local institution’s budget status, the potential for additional funding, the potential effects of the decision on local nursing morale and on the value judgements of the community. Such issues are best estimated locally (McGregor and Brophy, 2005: 266).

However, for a national- or provincial-level agency, engaging with a broad range of stakeholders becomes more complex. For instance, while there seems to be a consensus across the four stakeholder groups about the need for technology to be used rationally, the question remains: ‘Rational from whose perspective?’ From a macro-policy perspective, it may prove perfectly rational to authorize access to a given innovation on the basis that it creates economic opportunities and helps please powerful providers and media-cherished patients. In order to critically analyse the power struggles and find appropriate ways of dealing with them, evaluators would greatly benefit from borrowing and adapting concepts and analytical tools from the social and political sciences. For instance, Sassi observed that EUR-ASSESS participants were pursuing different agendas ‘with some being more interested in the policy side of the HTA process while others were more interested in the scientific development of methodologies’ (2000: 287). As these two aspects should go hand in hand in the development of policy-oriented evaluation, we need further research on concepts and tools that can explicitly flesh out the policy implications of assessments (Berg et al., 2004). While the efforts of HTA producers have already paid off, as evidenced by the fact that several stakeholders now value the assessment of health technology and have taken concrete actions to access and use HTA, we still need explicit ways for deriving policy recommendations from evidence, especially when either the evidence or the decision is ‘grey’ (Giacomini et al., 2003).

**Building Reciprocal, Transparent Relationships with Patient Associations and Industry**

The collaborative research literature we examined focuses on how various groups of researchers interact with a number of selected audiences, i.e. groups that either mandated the research or agreed to participate (Ross et al., 2003: 31). This literature proves less helpful when it comes to defining what would be appropriate forms of exchanges with audiences that are not full partners in research but that nonetheless hold a stake in health technology policy and are influential. In the case of HTA, interest-driven groups such as industry and some patient associations have often been left on the sidelines in order to ensure independence. However, implementing a science-based regulation of health technology can hardly be achieved without their participation or, at the very least, their passive approval.

The special nature of HTA – a publicly funded, independent policy-oriented science that should be usable and used – creates a double-bind situation. On the one hand, the societal purpose of HTA, which revolves around promoting a rational use of health technology, does not automatically converge with the interests of every stakeholder. On the other hand, the public funding of HTA and the nature of the policy arena in which decisions are made, forbid, in most jurisdictions, ignoring any
of these stakeholders. Furthermore, each stakeholder seems keen to have the agencies work toward its own particular goal, but not necessarily toward those of other stakeholders. What is seen as distance from one perspective may be seen as ‘too close for comfort’ from another. Hence, it is never possible to fully resolve the tension that exists between the need to maintain a strong link to policy-making and the need to maintain sufficient independence so as not to be perceived as agents of governments (Coburn, 1998) or of any other group. Our interviews with industry respondents and patient associations provide an overview of the range of interests that are at play. More importantly, perhaps, they highlight the need to move beyond previous ways of conceptualizing their potential role in assessments. The literature also suggests that patient groups could share insights about ways of defining the policy problem raised by various health technologies and about barriers and incentives shaping their use in the health care system (Oliver et al., 2004; Royle and Oliver, 2004). Hence, at this stage in the institutionalization of HTA, it would be helpful to establish guidelines defining why, how and when the input of stakeholders should be sought by evaluators. Such guidelines should be informed by an analysis of the sociopolitical dynamics (Cooke and Kothari, 2001) structuring how interests, knowledge and responsibilities of stakeholders are expressed and how they influence the outcomes of HTA-centred collaboration.

**Requesting Feedback from Decision-Makers as an Accountability Mechanism**

The mission, responsibilities, levels of resources and power of HTA agencies vary greatly between countries (Sassi, 2000). However, all evaluators share the belief that they (should) occupy a neutral position in health policy-making at various levels. Stakeholders themselves recognize this as a strong asset. The strength of this independence, we believe, could be used more strategically by evaluators. For instance, by pointing out the differences in the perspectives of HTA producers and stakeholders, our study clearly suggests that decision-makers should reconsider how and to what extent they fulfil their responsibilities toward the health care system and society in general. How much time does it take to act upon HTA evidence? What mechanisms and incentives are put in place to support the implementation of findings? In other words, evaluators should start asking decision-makers questions as well as requesting feedback from them. This would be compatible with the call for evidence-based management, and could be included in the terms of reference that define the methods of collaboration with decision-makers. Although this suggestion may sound a bit presumptuous, Farmer and Chesson observed that ‘health board managers were suffering from information overload and wished that an organization would filter information for them. They also expected relevant, user-friendly information and clear guidance’ (2001: 227). Perhaps it is also time for evaluators to make their expectations toward policy making more explicit so as to make sure their science is used meaningfully.

Before concluding, a number of caveats need to be addressed. Our survey response rate was modest when compared to other types of surveys targeting homogeneous populations. In our case, we judged it reasonable to include four key categories of respondents even though this implied creating a survey instrument...
that perhaps appeared too wide-ranging. We are nonetheless confident that by triangulating the survey data and interviews, this article captures a spectrum of significant opinions from respondents who have an interest and stake in HTA, and sheds light on the interface between the policy arena and HTA.

**Conclusion: The Need for Accountability in Policy-Making?**

Our article suggests that stakeholders, who pursue conflicting objectives and possess varying levels of resources, may not be pushing in the same direction as HTA producers. As indicated in the interviews, the value, usefulness and weight of HTA in decision-making processes are variable and context-dependent. Furthermore, in the absence of strong evidence, dealing with uncertainty involves being able to formulate policy recommendations that are, despite the current grey zones, well informed (by science and other available sources of knowledge), legitimate (by democratic and/or designated authorities), wise (not compromising safety or health of patients) and accountable (transparent and responsive to those affected by the decision). All of these issues call for further research.

This article examined a wide spectrum of interests and explored the views of groups that are influential in the policy environment. Bridging the gap between evaluators and stakeholders will require clearer definition of the respective roles, purposes and worldviews of these two groups. In this process, evaluators must not be afraid to ask for more accountability in the way health technology policies are made.

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**Notes**

1. At the end of 2000, there were eight HTA agencies in existence. In fiscal year 2001–02 the budget of the participating agencies varied from CDN$600,000 to $4.5 million, and human resources from 7.5 FTEs (full-time equivalents) to 27 FTEs.
2. We used NUD*IST software to categorize verbatim extracts (Richards and Richards, 1994; Strauss and Corbin, 1990), and created comparative tables (Miles and Huberman, 1984) to contrast the opinions expressed by different interviewees.
3. Whereas half of the provider and administrator groups relied on more than 500 full-time equivalents (FTEs), close to half of the patient associations employed 10 FTEs or
less. Except for the administrator organizations, up to two-thirds of the organizations had been in existence for more than ten years.

4. One administrator mentioned the difficulty of implementing HTA results in everyday practice: ‘Having more of an implementation focus versus a science focus would be more helpful in getting people’s attention. Because anyone can plan; it’s implementation that’s critical’ (Administrator 1, Jurisdiction 4).

5. Similarly, one respondent from a patients association mentioned the need for HTA to be responsive to the legal context. ‘The problem is [the report] came out a little bit too late . . . it came out at the time of Bill 11! I really needed it then; I needed it before that! And it wasn’t in a language that was easy to understand’ (Patient 1, Jurisdiction 4).

6. Perhaps they have not sufficiently discussed such issues. For instance, a respondent from a patient association suggested that ‘talking’ about the findings of HTAs was important but observed that HTA producers ‘don’t appear to be very comfortable talking to ordinary people’ (Patient 1, Jurisdiction 4).

7. This is because ‘being involved in interpretation processes that take each other’s viewpoints into account should facilitate the ability of each party to translate between, and at least partially integrate, their own and the other’s frameworks’ (Bartunek et al., 2003: 66).

References


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