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IHE SPRING INNOVATION FORUM IV
ECONOMICS & INNOVATION

CROWNE PLAZA – CHATEAU LACOMBE
10111 BELLAMY HILL, EDMONTON

THURDAY APRIL 22, 2010
3:00 – 6:00 P.M.

As part of my preparation for these remarks today I went back to my remarks at the innovation forum held in May of last year (see http://www.albertahealthservices.ca/files/org-2009-05-25-health-economics-speech.pdf). Back then I foreshadowed a concern about allocative and technical efficiency. Since then we have made remarkable progress on the move towards technical efficiency, starting with the work on activity based funding for long-term care facilities. We have also made progress on the allocative efficiency, and have established a health technology assessment and innovation branch within Alberta Health Services.

It is important to recognize though that health technology assessment is not the sole preserve of that branch, to some extent it is part of the everyday work of senior executives, and all the nascent clinical networks. The surgery network for example, is working with the health technology assessment branch on a framework for assessing new surgical technologies.

I'll give a couple of examples of the use of technology assessment in everyday life. There has been recent publicity about the appropriateness of venous imaging and venous angioplasty in multiple sclerosis. Alberta Health Services needed to develop a position on this very quickly. What we essentially did was to produce a two-page paper which characterized our position, developed by the senior physician executive in consultation with experts in the field. The two pager provided a synopsis of the proponent's studies, and a brief evaluation of that (see http://www.albertahealthservices.ca/files/ahs-position-statement-ccsvi-ms.pdf). This was all done very quickly, within days. The Alberta Health Services position was summarized as follows:

> 1. At this time, it is only a hypothesis that CCSVI contributes to, or causes, Multiple Sclerosis, and that venous angioplasty is clinically beneficial.
>
> 2. Further, independent and controlled studies are required to prove, discount, or better understand Dr. Zamboni's study results.
> 3. The nature and frequency of the risks of venous angioplasty are not yet fully understood. Without a clear indication that venous angioplasty carries a clinical benefit that outweighs the risks, it cannot yet be supported as standard practice.
>
> 4. At present, there is no proven indication for venous imaging or venous angioplasty in patients with Multiple Sclerosis. Therefore, unless part of an approved research protocol, these procedures will not be provided by AHS to persons with MS.
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> 5. If, and when, there is independent scientific validation of Dr Zamboni's results, Alberta Health Services will seek approval from Alberta Health and Wellness, under the province's health technology assessment process (described at

http://www.health.alberta.ca/initiatives/AHTDP.html), to introduce the new procedure into practice in Alberta.

So what can be seen here is a quick but careful assessment of the evidence and a reinforcement of the existing provincial health technology assessment processes.

My message here is that health technology assessment is not somehow separate from the day-to-day work of leaders, and is not something that necessarily takes months, years or eons.

We are also in the midst of evaluating what works and what doesn't in community physiotherapy. The literature here was not as good as we wanted but we have undertaken a careful review of what is known and have attempted to map that to what we do. A very complex task raising gaps in our current provision as well as provision of lower priority physiotherapy interventions. We now need to think about how we take this forward.

If we are to build health technology assessment into our everyday practice, we need to have access to good research synthesis, and have the tools and mechanisms to translate how technology assessments into practice. As I intimated last year, I think we have to be much more nuanced in our health technology assessment approach. Here it is my view that the days of seeing everything in black and white are over. Despite the relative sunshine in Alberta this week, much of life is gray. This means that the health technology assessment decision is rarely going to be a go-no go one. Rarely a decision about is this technology all good or all bad. Rather it will be a decision about in what circumstances, in what patient groups, with what comorbidities, with what genetic profile, is this technology appropriate?

I will also put in a plug for tracking implementation of new technologies, has there been indication slip, a technology approved for a particular group now being used more widely? Here our routine data sets can be used to track implementation and outcomes, moving toward what Etheridge (2007) calls a 'rapid learning health system'.

We also need to be better at building evaluation more directly into our practice. In the United Kingdom for example they are now looking at the routine use of patient reported outcome measures, measuring from a patient perspective whether what they got was what they expected. I discussed this issue last year as well.

Finally all of this will be facilitated by having a more integrated relationship with our academic partners, and here the development of an Alberta academic health sciences network should provide important opportunities to build health technology assessment into our everyday work.

Etheredge, L. M. (2007). "A Rapid-Learning Health System." *Health Affairs* **26**(2): w107-118.