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• Funded by NHS R&D, Department of Health, and ESRC InT Programme

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Service integration and evaluation in HTA: the case of telemedicine and telecare

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This presentation….

- Reflects on what happens to ‘evaluation’ and ‘evidence’ when it is interpreted and evaluated by managers and policy makers
- Problem: longstanding difficulties for proponents of telemedicine and telecare systems in getting these devices into practice

Practical problem

- Conflict between policies of ‘modernisation’ and ‘evidence-based practice’
- Struggles around appropriate evaluation designs, integration of systems in NHS services
- ‘Failure to adopt’

HTA

- Formal methods, clinical trials, systematic reviews, meta-analysis
- Managers and policy makers struggled with this:
  - ‘Trials can go on for ever, and at the end, even if you’ve achieved your confidence intervals, the moment has passed,’ K1
  - ‘trials are vital, they give us the evidence, but the evidence is always arguable and it doesn’t influence policy makers as much as we would like. They suffer from *evidence fatigue.’ K2*

Formal methods….

Trials are a problem for proponents of telemedicine

‘Our study can’t succeed, we’re failing to recruit because the GPs can basically see that all we’re doing is adding on work to them and not taking it away, which - you know - is the whole point of telemedicine’. K3

‘I wouldn’t place too much reliance on [name of trial] it’s a fantastic trial design but it’s nothing like what would really happen in normal general practice’. K3 Three years later….

– ‘you know they’ve published that trial in [name of journal], but when I talk to people at the NHS it means nothing to them because it was so divorced from reality in its conception. It may have set back telemedicine not advanced it’.

Evidence across boundaries

- ‘Really, we need to identify *who* needs evidence, and *what* sort of evidence they need. It’s important because telecare is a link between different policy areas and evidence is the glue that can hold them together. We need to draw on a range of evidence - and there’s a lot of frustration about the definition of proper evidence. We need to work on what you might call qualitative evidence because that’s much more suited to this task.’ K8

TECHNOLOGY, POLICY AND THE PROBLEM OF KNOWLEDGE

- ‘Several witnesses suggested that there is a need for the development of methodologies that can provide for much longer-term review of the net benefits of new systems or devices. Much of the evaluation depends on clinical trials to provide evidence upon which to make a cost-benefit analysis. These can take considerable time, quite legitimately so, to determine this. Firms complain about the delays this can cause in relation to the introduction of their products, a point also made by some patient advocacy groups.’ House of Commons Health Committee, 2005

INTERPRETIVE FLEXIBILITY DENIED AND CELEBRATED

- Complex systems for medical diagnosis, monitoring and management were displaced by simple systems aimed at producing routine surveillance data and ensuring safety at home.
- Homogeneous trial samples recruited through rigorous application of inclusion and exclusion criteria were displaced by normal populations with complex and heterogeneous problems.
- Mechanisms for knowledge production that employed standardised procedures designed into the provision of care were displaced by the flexible reworking of everyday health and social care practice.
- Generalisable statistical data about proof of outcomes were displaced by a mix of site specific quantitative and qualitative data about processes.
- Generalisable economic modelling and cost-effectiveness research were displaced by local cost accounting estimates of spending and saving across specific budgets.
- Academic or research ‘elites’ were displaced by local managers, professionals, and service suppliers in cross-sectoral collaborations.