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# Co-operation is strength: Joint achievements of the Nordic HTA centers

*Michael 2012;9: 137–146*

*The Nordic countries have a long tradition of collaborating in health care, also in the area of health technology assessment (HTA). Over the years, the Nordic HTA agencies have worked together both within wider international networks and through various neighborly projects. Joint reports have revealed major differences in treatment selection and organization of care between the Nordic countries. The agencies have also shared methods for finding essential HTA reports from other countries and distributing new information rapidly. Co-operation has resulted in providing more HTA information to customers than each agency alone could handle.*

*The Nordic HTA directors meet regularly twice a year for informal discussions of policies and strategies, and consider jointly how the impact of HTA could be improved worldwide. These meetings are an important arena for peer support, and new ideas for joint work are often born here. Nordic agencies have been active members in international HTA organizations and projects, participating in the boards as well as methodological working groups. At the European level, wide HTA collaboration now is hoping for permanent funding. Collaboration also widens understanding of HTA needs and ways of communicating results to users.*

## **Nordic HTA centers getting together**

The Nordic countries, Denmark, Finland, Norway and Sweden, share a long democratic tradition and close neighborly relations. Collaboration is also supported by similar language roots for Danish, Norwegian and Swedish; all Finns learn Swedish in school. The countries are all actively engaged in health technology assessment (HTA) and often work jointly. This paper examines how and why.

In the early 1980s, Nordic Hospital Institutes initiated discussions about collaboration in medical technology assessment. Eventually a collaborative body, Nordic Evaluation of Medical Technology (NEMT) started working on issues concerning the diffusion and use of technologies such as MRI, prostate cancer screening, and coronary bypass surgery, publishing a number of reports (1). The starting pace for national HTA was somewhat different in each country: Sweden had an early start, establishing SBU in 1987. Finland followed suit with FINOHTA in 1995. In 1997, Norway established SMM (from 2004, NOKC) and Denmark started DIHTA (from 2001, DACEHTA).

Sweden was also active as one of the founders of the International Network of Agencies for Health Technology Assessment (INAHTA) in 1993, with 12 other HTA institutions representing nine countries. The INAHTA secretariat was located in Sweden from 1996 to 2011, with SBU's director Egon Jonsson at the helm as the first executive secretary. The newly started centers in the other countries soon applied for INAHTA membership too. They thus entered a network that provided a useful forum for developing HTA methods and expertise. All centers have taken very active roles in INAHTA: their experts have held Board positions, managed the working groups and joint projects. Over the years INAHTA has had a chairperson from Denmark, Norway and Finland.

### **An informal meeting place**

The national Nordic HTA agencies learned they had much in common, but some ideas were not so easy to implement through INAHTA. An initial joint meeting of the Nordic HTA directors was held in Copenhagen in December 1998. This resulted in an agreement to meet regularly, the four institutions taking turns to host a meeting, for a briefing on current activities and plans. From then on, the Nordic agency directors have met twice a year.

At the meeting, an important advantage is the possibility to share thoughts on strategic and tactical issues for HTA in each country, knowing that all others know what you are talking about and have had similar experiences. HTA directors face many political and practical challenges in their everyday work. This unique peer support has been especially inspiring and useful during changes in funding and during introduction of new governance structures. All Nordic HTA organizations have experienced major changes over the past 20 years. Another advantage is the opportunity to informally discuss international affairs and to consider how the impact of HTA can be improved worldwide.

The agenda in directors' meetings usually starts with brief country reports, covering the political situation and any new methodological or structural developments in each organization. Lists of ongoing and planned projects are exchanged, originally to avoid duplication of work, but later also providing ideas for mutual collaborative projects. The directors also discuss current developments in INAHTA and other international HTA networks, such as the European network for HTA (EUnetHTA), Health Technology Assessment International (HTAi) and Euroscan, the international network on new and emerging health technologies.

### **Methodological collaboration**

For each get-together, the Nordic HTA directors also agree on a few themes to be discussed in more detail. These can cover joint projects, methodology, or policy issues. We have explored methods for implementing HTA results or collecting topic suggestions; the relationship between HTA, systematic reviews, and guidelines; or links with Cochrane and Campbell collaborations. To support these thematic discussions, the directors usually invite experts from the hosting organization to join.

Methodological questions have also been on the agenda, such as the use of the GRADE instrument as an evaluation tool (2,3). Occasionally the meetings have been preceded or followed by a thematic workshop. The librarians of the Nordic HTA units arranged in 2011 a methodological seminar in Helsinki, and the directors joined in the final session that discussed a more stable cooperation. In the directors' meeting the following day, the draft of the first project plan for Nordic HTA librarians was accepted.

Nordic HTA experts participated in providing joint methodological training in HTA winter schools which were held in the early 2000s. This brought the teachers as well as the students closer to their peers, and participants often became key resource persons in joint Nordic HTA projects. A useful result was a Danish HTA handbook (4).

Capacity building has also consisted of opportunities for gaining work experience in sister agencies. Staff exchange has covered different types of expertise, from librarians to database experts and architects. A more generic five-day Nordic Workshop in Evidence-Based Health Care, first offered in 1998, is now a yearly arena to build competence in critical appraisal of scientific literature. It recruits participants also from outside the HTA field: guideline editors, journalists, individual clinicians, and even health policy makers. The workshop is held in late May in Norway (5).

### Joint projects

The decision of a joint Nordic project was an important step toward practical cooperation. The topic selection was crucial: it should be an important policy question in each country. The first project, “Hearing impairment among adults”, focused on diagnostics and the use of relevant hearing aids. Project funding was successfully applied from the Nordic Council of Ministers. A Nordic working group of specialists in audiology and HTA was formed in 1999 and later complemented with an audiology specialist from the United Kingdom. The Nordic directors participated in the steering committee, and the work consisted of a systematic literature review, economic analysis and a survey of practices in the participating countries. The report which was published in 2001, with summaries in five languages, could point out striking differences in practice and use of resources between countries (6).

After this positive experience, the directors wished to continue with a new joint project, including a literature review and a survey of national practices. The choice this time was “Obstructive sleep apnea”, a much more extensive theme than the first one. The project started in 2004 and a detailed report was published in English in 2007. The report contained important clarifications regarding the causes and diagnosis of sleep apnea (7).

This report also revealed major differences between the Nordic countries, both in the organization of treatment (table 1) and in the selection of interventions. The literature review showed good evidence on the effectiveness of continuous positive airway pressure therapy and mandibular reposition-

*Table 1. Number and type of departments offering diagnostic evaluations of sleep apnoea. Source: SBU (2007): 291.*

Clinic / Country	Denmark	Finland	Iceland	Norway	Sweden
Anaesthesiology	16	-	-	-	-
Clinical physiology and neurophysiology	1	13	-	-	21
Ear, nose and throat	3	9	-	14	21
Mouth and teeth	4	-	-	-	-
Neurology	9	4	-	6	-
Pulmonary	-	26	3	16	8
Private	-	3	2	3	1
Total	33	55	5	39	51
Number of clinics doing more than 52 evaluations in 2003	25	43	3	31	45

*Table 2. Patients evaluated in 2003 referred for the following treatments, if any (mean percentages). Clinics performing 100–500 evaluations per year. Source: SBU (2007): 293.*

Treatment /Country	Denmark	Finland	Iceland	Norway	Sweden
CPAP	57	37	37	47	34
Surgery	7	16	2	25	6
Dental/orthodontic treatment	3	6	7	6	26
Other treatments (diet, etc)	16	12	53	23	6

CPAP = Continuous positive airway pressure

ing devices. The effectiveness of surgical treatment on sleep apnea, in contrast, was poorly documented but it did have notable side effects. Norway and Sweden were the extremes in practice variation: Sweden used little surgery but prescribed numerous mandibular devices, while in Norway surgery was common but mandibular devices rarely used (table 2). The debate following the publication showed that Norway had very favorable funding opportunities for this type of surgery, but no reimbursement for mandibular devices. Sweden had offered reimbursement for the night guards. A joint report showed that public attention could be directed at peculiarities of the practice, as well as at funding traditions which were not based on evidence. In Norway, the report led to changes in reimbursement for and guidelines on the treatment of sleep apnea.

The Nordic HTA units have somewhat different mandates and working patterns. This caused for example a proposal to develop common procedures for evaluating medicines for public reimbursement to wither. FINOHTA only evaluates drugs as compared to other types of technologies (e.g. surgery), and in Denmark, assessment of drugs is mostly done by other organizations. The development of a joint overall methodology remains undone, even though the units occasionally share assessments of new drugs.

The current joint project between FINOHTA and NOKC on Hyperbaric Oxygen Therapy aims to pilot test the use of the EUnetHTA Core Model (8) of this topic. SBU is responsible for the health economic part of this pilot.

### **Keeping customers satisfied**

HTA reports are extensive and time consuming to prepare, and many excellent assessments and systematic reviews are published yearly in and outside the Nordic countries. All Nordic agencies have processes for dissemination of international HTA reports in their own language, and we have copied

from each other good methods for finding essential reports and rapid ways of distributing the new information. NOKC and FINOHTA provide brief structured summaries of international reports, while SBU and DACEHTA also invite experts to comment on such reports. This notably increases the availability of HTA information to our customers.

As publicly funded HTA units, we stand close to our ministries – but we have many other customers too, including health care providers and experts. The agencies have experimented with different methods for collecting suggestions for HTA topics from various customers. Some years ago, FINOHTA successfully translated the Danish form for collecting topic suggestions for hospitals, a Mini-HTA (9, 10, 11). In 2012, the Finnish HTA unit will also test the Norwegian model of collecting HTA topics in one large yearly proposal round from all customers (12). This will facilitate a wider call for topics and allow anyone interested to send suggestions for HTA projects.

In some projects, the customer is interested to have fresh information about practice patterns in Nordic countries. A well-linked Nordic network has contributed to such data being relatively easy to obtain, even for urgent projects.

### **Nordic cooperation at the international level**

Besides working together in INAHTA, the Nordic countries have been active members of Health Technology Assessment International and its predecessor, the International Society for Technology Assessment in Health Care (ISTAHC). Also here, each country has seen its own representatives in the Board, with Berit Mørland chairing HTAi during its decisive early years.

The first ISTAHC scientific conference was organized in Denmark in 1985, and Sweden and Finland have hosted scientific conferences for ISTAHC in the 1990s. At the annual ISTAHC conference in Berlin in 2002, the Nordic directors decided to develop a joint Nordic bid for organizing this conference in Oslo 2004 around the theme of “HTA and Users”. For technical reasons, ISTAHC was unfortunately closed down in 2003, and the joint Nordic conference plans were abandoned. When HTAi was born, the Nordic countries resumed their plans for a joint scientific conference. The application with the theme “Global Efforts in Knowledge Synthesis and Brokering” was aiming at congress in 2010, but Ireland won over the Nordic proposal at the finish line.

All four countries have collaborated on joint proposals for panel sessions at several HTAi conferences, most recently in Rio where the topic was “Us-

ing HTA to inform public safety decisions: The case of sexual offenders”. Ideas for panel sessions can originate in Nordic directors’ meetings or among other peer networks, and proposals often include other countries than the Nordic ones. Several proposals have not been accepted, but this does not discourage the Nordic sister organizations from trying: new bids are again in queue for Bilbao in 2012.

### **Nordic countries and EU**

Nordic HTA agencies were all involved in successive HTA methodology and research projects in Europe in the 1990s, the latest being ECHTA / ECAHI (13). As these were one-time projects, these had only little influence on health policies, as compared to the much more powerful example of British HTA organizations within the National Health Service or the American Agency for Healthcare Research and Quality (AHRQ). When the European Union also solidified its policies, the Nordic leaders unanimously supported plans to aim at more long-term EU collaboration.

All partners in the ECHTA/ECAHI were contacted by DACEHTA (at the Danish National Board of Health) in early 2005 (14). The group of organizations that produced the proposal in early spring 2005 included all the Nordic HTA units but the majority of partners were non-Nordic. Each Nordic agency participated as work package leaders in the project (see Kristensen et al.: Development of European HTA: from vision to EUnetHTA, in this issue). EUnetHTA has succeeded in involving policy makers and convincing them of the need for joint European work in the area, and is currently in its sixth year of funding with reasonable opportunities for establishing permanency.

### **Together we provide more**

International collaboration – the sharing of experience, skill, and methodological developments – is the very lifeline of an HTA organization. In the long run, a national HTA unit cannot survive without international oxygen. Since the Nordic HTA collaboration started, each country has had many positive experiences of working together. Not all ideas have been followed through, and some projects have been more successful than others. Collaboration takes time, resources are limited, and funding is not always easy to find. The number of Nordic collaborative projects has in recent years been smaller, as the units are actively participating in European HTA developments. The new methods will, however, give better possibilities also for new joint Nordic work.

Nordic co-operation has resulted in our customers receiving more HTA information than each agency alone could provide. Not only is there more HTA – the quality is also better when we copy each others' best methods. In our multiprofessional work, solitary experts find colleagues that can share the latest knowledge in their area. Collaboration also widens our understanding of what needs to be done, and how we best can communicate our results to users. The biannual Nordic HTA directors' meetings are an important arena for informal discussions, peer support, and exchange of information; new ideas for joint work are often born here. Internationally, our four agencies that agree on how to support HTA can exert an influence much larger than any of us alone. Between public HTA agencies from small countries, co-operation is strength, indeed.

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*Acknowledgements: The authors wish to thank Prof. Egon Jonsson, Ms. Jaana Isojärvi and Dr. Inger Norderhaug for additional information and useful comments.*

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