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LETTER TO THE EDITOR

DO WE NEED 'CARE' IN TECHNOLOGY ASSESSMENT IN HEALTH CARE?

At the 1995 ISTAHC Board meeting in Stockholm, there was a proposal to change the name of the Society. The main concern seemed to be that the term "technology" very often, and mistakenly, alludes to machines, and it is so interpreted by many decision makers. We are now informed by the ISTAHC Newsletter (1) that Seymour Perry was asked to conduct a survey, for which, happily, he just reported the results. In short, the verdict is that it is best to "let sleeping dogs lie."

With the occasion of a similar effort, carried out in the framework of the EUR-ASSESS Project, to define health care technology assessment, I would like to offer some thoughts that may reopen the debate. Only, this time the argument is not with "technology," which I also believe we have to live with, but with "care." I will try to be explicit and brief.

In the literature dealing with health technology assessment we come across a variety of terms, the most often used being:

- Health technology assessment;
- Health care technology assessment;
- Medical technology assessment; and
- Biomedical technology assessment.

In order to choose the one which best represents the issues at hand, I suggest that we turn to the contextual definition of health (care) technologies offered by the Executive Committee of the EUR-ASSESS Project:

> Health care technologies are the drugs, devices, procedures, and the organizational and support systems within which health care is delivered.(2)

We must notice that this definition considers "health care" as the "endpoint" in a process that, however, has, or should have, an even broader final outcome, namely, the production of "health" itself. If we accept this, we should modify the definition above to read as:

> Health technologies are the drugs, devices, procedures, and the organizational and support systems within which *health* is *produced*.

In this context we can discuss the four phrases mentioned above, which are often used interchangeably to express the same concept when, in fact, they express quite

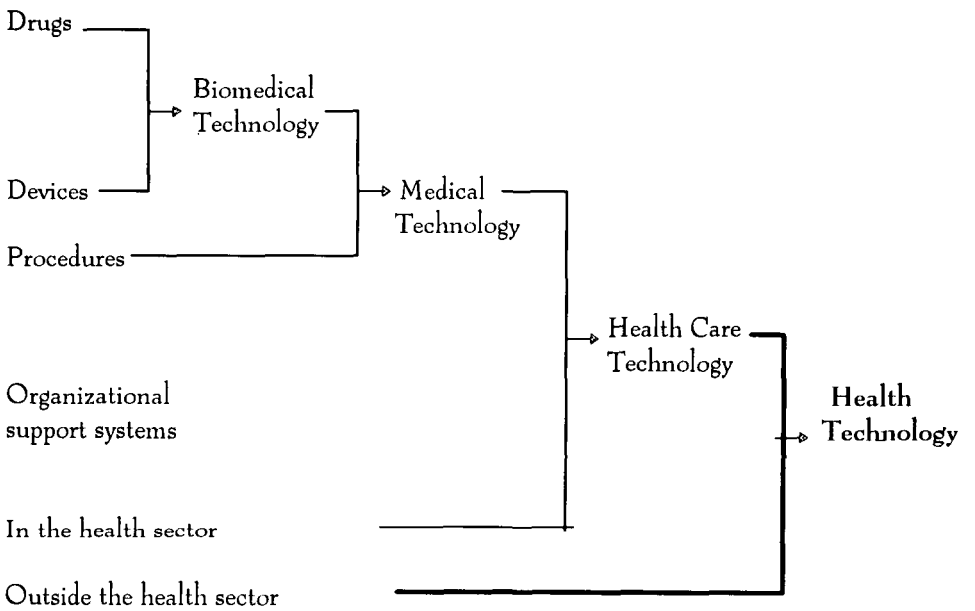

Figure 1. Alternative definitions of technology in health.

different things. Starting from the bottom of the list, we could offer the following thoughts, which are also summarized in Figure 1.

Drugs and devices are technologies dealing primarily with the biological parameters or characteristics of the process under which health is produced. As they are used mostly by the medical profession, we can probably assign them to the category of *biomedical technologies*.

The addition of *procedures* refers us to the main domain of the medical art, or the practice of medicine. In this sense, we could say that drugs, devices, and procedures constitute what we might call *medical technology*.

When we add organizational and support systems, we have to be a little careful. Organizational and, especially, support systems may originate and operate within the health care system, but they also may not. For example, primary health care, which the SBU correctly lists among the health technologies in need of assessment (3), and home care, are health technologies heavily dependent on organizational and support systems, the main features of which are determined by forces and attitudes outside the health system. They are mainly societal variables or organizational and system parameters, which, nevertheless, decisively determine *the final health outcome*.

I propose, therefore, that the organizational and support systems be distinguished into:

- Systems originating and operating within the broader health care system; and
- Systems originating and operating within the social sector or even society as a whole.

With this distinction in mind, we can probably agree that *health care technology is a subject of health technology,* just as health care is only an input into the production of health. Health care technology may be seen as the product of drugs, devices, procedures, and organizational and support systems originating and operating within

the broader health care system. Health technology, on the other hand, may be seen as to encompass all of the above as well as the societal organizational and system parameters that determine the final health outcome.

If we follow this train of thought, the term "*health technology assessment*" is more appropriate. In fact, this view seems to be supported by most of the arguments very aptly developed in the EUR-ASSESS Executive Committee's two-page note. It is mentioned, very correctly, that "*HCTA is not defined by a set of methods, but by its intention.*" Obviously, the final intent of technology used in the health sector is not to produce health care, but rather, health itself. It also mentions that "*The field includes studies of ethical and social consequences of technology.*" Again, this makes it quite obvious that we are concerned with health and not only health care. Finally, the interdisciplinary nature of HCTA is probably another argument in favor of the view that *what we mean is HTA and not HCTA*. If, however, we decide to stick with HCTA, we might want to make more explicit that we are dealing with a somewhat narrower concept than the one developed in the Executive Committee's proposed draft definition.

Incidentally, this might be a token, albeit belated, contribution to the survey conducted by ISTAHC. If we take the view outlined above, we must all be members of . . . ISTAH, and this letter published in the *International Journal of Technology Assessment in Health*.

I do hope all this has not been tedious or an excersise in "hair splitting." I do, however, think that we should always try to make our concepts quite clear, and this has been an attempt to contribute in this effort.

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