## Introduction

At the annual meeting of the International Network of Agencies for Health Technology Assessment (INAHTA) in 2002, members discussed the need for a list of standard definitions of terms used in health technology assessment (HTA). The purpose was to give the HTA community – both producers and users of assessment information – a common vocabulary for work in this field. Dr Karen Facey kindly volunteered to compile the list, under the direction of Dr Finn Børlum Kristensen and the INAHTA Education and Training Working Group.

Later in 2002 HTA agencies were asked to send in their glossaries for review and compilation. These submissions formed the basis for a draft glossary. In March 2004, the draft was circulated to all INAHTA members and other colleagues with an invitation to review the list and provide suggestions for changes and additional terms. Many further terms and refinements were submitted and subsequently incorporated into the glossary. But a glossary is never really a finished product, and additions and revisions are needed as HTA continues to evolve. The next challenge will be to translate the glossary into other languages and make it accessible to all through the INAHTA web site.

We would like to express our appreciation to Karen Facey for undertaking this work. This first edition of the INAHTA HTA glossary gives us a common reference point for key terms in HTA. Moreover, it will help us to effectively communicate HTA information to others. Any suggestions for additions, changes or deletions to the glossary should be directed to the Chair of the INAHTA Education and Training Working Group.

Don Juzwishin
Chair, Education and Training Working Group
July 5, 2006

## Acknowledgements

Many of the definitions in this glossary have been reproduced with permission from Dr. Clifford Goodman's guide *HTA 101: introduction to health care technology assessment*. He also reviewed the draft of this glossary and provided advice. We thank Dr. Goodman for his generous contribution to this glossary.

Other entries in this glossary have been created by selecting terms from existing glossaries and from terms and sources suggested by many individuals working in the field of health technology assessment. Special thanks are due to the many individuals from the following agencies who provided lists of terms and comments on the first draft of this glossary:

- Agency for Healthcare Research & Quality (AHRQ)
- Alberta Heritage Foundation for Medical Research (AHFMR)
- Australian Government. Department of Health & Ageing
- Canadian Coordinating Office for Health Technology Assessment (CCOHTA)
- Centre for Health Economics and Policy Analysis (CHEPA)
- Cochrane Collaboration
- Comité d'Evaluation de Diffusion des Innovations Technologiques (CEDIT)
- Danish Centre for Evaluation & Health Technology Assessment (DACEHTA)
- Innovus Research Inc.
- Institute of Applied Health Sciences (IAHS), University of Aberdeen
- NHS Quality Improvement Scotland (QIS)
- Swedish Council on Technology Assessment in Health Care (SBU)
- UK Centre for Reviews & Dissemination (CRD)
- UK National Coordinating Centre for Health Technology Assessment (NCCHTA)
- VA Technology Assessment Program (VATAP)

## Sources

The sources used to compile this glossary include:

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## Additional sources for further information

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# INAHTA HTA Glossary

| Term | Definition/Description |
|---|---|
| **Absolute risk reduction** | A measure of treatment effect that compares the probability (or mean) of a type of outcome in the control group with that of a treatment group, [i.e.: Pc - Pt (or μc - μt)]. For instance, if the results of a trial were that the probability of death in a control group was 25% and the probability of death in a treatment group was 10%, the absolute risk reduction would be (0.25 - 0.10) = 0.15. (See also Number needed to treat, Odds ratio, and Relative risk reduction) |
| **Access** | The degree to which the health care system aids or inhibits an individual or group in gaining entry and receiving necessary services due to constraints in the financing and delivery of care. |
| **Accuracy** | The degree to which a measurement (e.g. the mean estimate of a treatment effect) is true or correct. An estimate can be accurate, yet not be precise, if it is based upon an unbiased method that provides observations having great variation (i.e. not close in magnitude to each other). (See also Precision) |
| **Acquisition cost** | The purchase cost of a drug to an institution, agency or person. |
| **Action research (or participatory action research)** | Where a problem is identified, investigated and changes are made; then reassessed and further changes made, until the problem is satisfactorily resolved. |
| **Additive model** | A model in which the combined effect of several factors is the sum of the effects produced by each of the factors. For example, if one factor multiplies risk by a and a second factor by b, the combined effect of the two factors is a + b. (See also Multiplicative model) |
| **Adverse effect** | An undesirable or unintended effect of an intervention. (See also Adverse event and Side effect) |
| **Adverse event** | Any noxious, pathological or unintended change in anatomical, physical or metabolic functions as indicated by physical signs, symptoms and/or laboratory changes occurring in any phase of a clinical study whether or not considered treatment related. It includes exacerbation of pre-existing conditions or events, intercurrent illnesses, accidents, drug interaction or the significant worsening of disease. |
| **Adverse reaction** | Any undesirable or unwanted consequence of a preventive, diagnostic, or therapeutic procedure in a standard clinical setting. |
| **Allocative efficiency** | An allocation of the mix of resources for maximal benefit (i.e. such that no change in spending priorities could improve the overall welfare). |

| Term | Definition/Description |
|---|---|
| **Causal pathway** | Also known as an "analytical framework," a depiction (e.g. in a schematic) of direct and indirect linkages between interventions and outcomes. For a clinical problem, a causal pathway typically includes a patient population, one or more alternative interventions (e.g. screening, diagnosis, and/or treatment), intermediate outcomes (e.g. biological markers), and health outcomes. Causal pathways are intended to provide clarity and explicitness in defining the questions to be addressed in an assessment; they are useful in identifying pivotal linkages for which evidence may be lacking. |
| **Causality** | The relating of causes to the effects they produce. The Bradford Hill criteria for causal association are: consistency; strength; specificity; dose–response relationship; temporal relationship (exposure always precedes the outcome; it is the only essential criterion); biological plausibility; coherence; and experiment. |
| **CINAHL (Cumulative Index to Nursing and Allied Health Literature)** | Electronic database covering the literature in nursing and allied health. Years of coverage: 1982 - present. |
| **Citation** | The record of an article, book, or other report in a bibliographic database that includes summary descriptive information, e.g. authors, title, abstract, source, and indexing terms. |
| **Clinical effectiveness (effectiveness)** | The extent to which a specific intervention, procedure, regimen, or service does what it is intended to do under ordinary circumstances, rather than controlled conditions. Or more specifically, the evaluation of benefit to risk of an intervention, in a standard clinical setting, using outcomes measuring issues of importance to patients (e.g. ability to do daily activities, longer life, etc.). |
| **Clinical (practice) guideline** | A systematically developed statement to assist practitioner and patient decisions about appropriate health care for one or more specific clinical circumstances. The development of clinical practice guidelines can be considered to be a particular type of HTA; or, it can be considered to be one of the types of policymaking that is informed or supported by HTA |
| **Clinical outcome** | An outcome of major clinical importance that is defined on the basis of the disease being studied (e.g. fracture in osteoporosis, peptic ulcer healing and relapse rates). |
| **Clinical pathway** | A multidisciplinary set of daily prescriptions and outcome targets for managing the overall care of a specific type of patient, e.g. from pre-admission to post-discharge for patients receiving inpatient care. Clinical pathways often are intended to maintain or improve quality of care and decrease costs for patients in particular diagnosis-related groups. |

| Term | Definition/Description |
|---|---|
| **Clinical prediction** | A clinical prediction rule is a tool for assisting clinical decision making, which consists of variables obtained from the patient's history, physical exam, or testing that provide the probability of an outcome or suggest a diagnostic or therapeutic course of action. |
| **Clinical significance** | A conclusion that an intervention has an effect that is of practical meaning to patients and health care providers. Even though an intervention is found to have a statistically significant effect, this effect might not be clinically significant. In a trial with a large number of patients, a small difference between treatment and control groups may be statistically significant but clinically unimportant. In a trial with few patients, an important clinical difference may be observed that does not achieve statistical significance. (A larger trial may be needed to confirm that this is a statistically significant difference.) |
| **Clinical trial** | A carefully controlled and monitored research study on human subjects or patients evaluating one or more health interventions (including diagnostic methods and prophylactic interventions). Each trial is designed to answer specific scientific questions. |
| **Cochrane Central Register of Controlled Trials (CENTRAL)** | A database of references to controlled trials in health care compiled from the specialised registers of the Cochrane groups and other organisations, searches of MEDLINE, EMBASE and other databases. |
| **Cochrane Database of Methodology Reviews (CDMR)** | The CDMR contains two parts: *Cochrane Methodology Reviews* (complete systematic reviews of methodological studies) and Protocols for reviews that are currently in progress. |
| **Cochrane Methodology Register (CMR)** | A database of articles and books about methods for conducting systematic reviews of the effects of health care interventions. It is published in The Cochrane Library. |
| **Cochrane Database of Systematic Reviews (CDSR)** | This database includes the full text of all available Cochrane Collaboration systematic reviews, and the procotols for reviews that are currently underway. (See also The Cochrane Library) |
| **The Cochrane Library** | A collection of databases published on CD-ROM and the Internet and updated quarterly, designed to provide information and evidence to support decision making in health care. The databases are as follows: the Cochrane Database of Systematic Reviews, the Cochrane Database of Methodology Reviews, the Cochrane Central Register of Controlled Trials, the Database of Abstracts of Reviews of Effects, the Cochrane Methodology Register, the Health Technology Assessment database and the NHS Economic Evaluation database. |
| **Cochrane Methodology Register (CMR)** | A bibliography of publications which report on the methods used in the conduct of controlled trials. It is published in The Cochrane Library. |