Do Health-Care Decision Makers Find Economic Evaluations Useful? The Findings of Focus Group Research in UK Health Authorities

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ABSTRACT

Objectives: The impact of economic evaluation studies on health-care decision makers has been shown to be rather limited. However, there is an increasing requirement for the cost-effectiveness of health-care interventions to be considered in formulating and implementing guidelines for clinical practice. This paper reports the findings of recent focus group research among UK health authorities, which examined the usefulness of published economic evaluations within the decision-making processes. The findings are presented and discussed in light of other studies that have addressed this issue.

Methods: Focus group research was conducted with decision makers from a sample of two UK health authorities using the National Health Service Economic Evaluation Database (NHS EED) as a research vehicle to locate and report the findings of relevant economic studies. The study sample was initially invited to respond to questionnaires exploring the usefulness of published economic evaluations in the decision-making process and to outline particular topics that it felt would benefit from similar economic evidence. Following this, a detailed search was undertaken to retrieve structured NHS EED abstracts on these topics such that the usefulness and limitations of economic evaluations to decision making could be determined.

Results: Decision makers generally recognized the usefulness and necessity of published economic evaluations in informing their decision-making processes. However, the value of studies was often limited because of the poor generalizability of results, the narrowness of research questions, and the lack of methodological rigor common to many published studies. A total of 237 NHS EED full abstracts were retrieved in the specified areas of interest, which, within specified caveats, were generally found to be useful as decision-making tools. There was a general consensus among decision makers in favor of developing a quality-scoring system for studies, thereby going beyond the critical summaries given in NHS EED.

Conclusions: Decision makers value information on cost-effectiveness as well as effectiveness alone, but methodological improvements are necessary to increase the reliability of economic studies. A quality-scoring system for published studies would be a useful development as a filtering mechanism for decision makers but would raise a number of challenges for health economists.

Keywords: cost-effectiveness, decision making, economic evaluation, health policy, UK NHS.

Introduction

Although previous investigations have shown that economic evaluation studies of health-care inter-
ventions are of limited use, decision makers generally recognize that economic considerations must be taken into account when making decisions about health-care resource allocation [1,2].

The recent move to include cost-effectiveness findings in reviews commissioned by national regulatory bodies such as the newly formed National Institute for Clinical Excellence (NICE) in the United Kingdom not only acknowledges the importance of economic evaluations at the national policy level but also raises the question of how economic evaluations are to be integrated into healthcare
decision making, both at the local level and within the formulation of guidelines.

Despite this increasing awareness of the need for economic evaluations, it is also generally accepted that the quality of published studies is variable. Moreover, researchers adopt a wide range of methodological approaches that may not be familiar to those making decisions about competing health technologies. The interpretation of economic studies may also be limited by the reader’s knowledge of what constitutes good research in health economics, and as such, the relative strengths and weaknesses of particular studies may not be immediately obvious.

Several surveys concerning the use of economic evaluation by decision makers in the UK National Health Service (NHS) have been conducted. Drummond et al. [3] surveyed almost 800 individuals (283 prescribing advisers, 400 directors of pharmacy, 101 directors of public health) in the United Kingdom by mail questionnaire. The following areas were considered: 1) the decision makers’ knowledge of economics; 2) the importance of efficiency as a decision-making criterion; 3) sources of information on costs and outcomes used by decision makers; 4) barriers to the use of economic evaluation; and 5) actual application of the results of economic evaluations. The authors concluded that the use of economic evaluation at the local level was not extensive. The main obstacles to the use of study results related either to the inflexibility of budgets, which limited the movement of resources from secondary to primary care, or the inability to free resources to adopt new therapies. In addition there were concerns about the studies themselves, such as the large number of assumptions and the credibility of industry-funded studies.

In another survey by Duthie et al. [4], 17 pairs of UK NHS decision makers (a mixture of managers and clinicians) were interviewed about the usefulness of economic studies and presented with a variety of health-economics outcomes in order to determine the relevance and appeal of diverse health economic measures to different decision makers. The principal finding of this study was that a high proportion of statements conveying traditional health-economics outcomes, including incremental cost-effectiveness ratios, quality-adjusted life years (QALYs) and willingness to pay, were either not understood or were considered irrelevant by those surveyed.

A third survey by Crump et al. [5] involved 12 medical decision makers from the Leicestershire Health Authority in the United Kingdom (four medical directors of hospitals and eight local general practitioners) who were interviewed individually and also participated in a focus group discussion. The interviewees were first asked what information they would require to make decisions regarding the use of a hypothetical new drug for obesity, and were then asked more general questions about their use of economic information, the relevance of economic considerations to particular types of decisions, and barriers and incentives to the use of economic evidence. This was part of the European Network on Methodology and Application of Economic Evaluation Techniques (EUROMET) project [6], which investigated the impact of health-economic studies on decision making in nine European countries and surveyed 1022 decision makers by postal questionnaire, semi-structured interviews, or through focus groups.

The results of this study [5] largely confirmed the findings of the earlier work by Drummond et al. [3]. However, when asked which factors might encourage decision makers to make more use of economic evaluations, the interviewees placed particular emphasis on the appraisal of studies by a trusted source, the need for more flexibility in health-care budgets and more detailed explanations of the practical relevance of study results.

Whereas surveys of the kind carried out in the United Kingdom and other European countries have well-known limitations, these findings are comparable with the results of similar studies carried out in the United States. Several surveys have been conducted to explore how managed care organizations and hospitals establish formulary policies and the relevance of cost-effectiveness analyses to this process [7–9]. Despite increasing awareness and use of economic evaluations, cost-effectiveness information was found to be of secondary concern. US decision makers were also found to lack expertise in health economics and tended to prefer timely information targeted at the decisions they had to make.

Whereas some of the concerns of decision makers, such as those about rigidities in healthcare budgets, could only be met by changes in the management and organization of healthcare systems, others could be alleviated by changes in the ways economic evaluation studies are accessed and presented. In particular, it would be possible to provide busy decision makers with critical reviews of published studies in a readily accessible form.

Several databases of economic evaluations now exist. For example, the Collège des Economistes de
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la Santé (CODECS) Database, the NHS Economic Evaluation Database (NHS EED), and the office and the Office of Health Economics Health Economic Evaluation Database (HEED) contain structured abstracts of published studies. In principle, these should help overcome some of the barriers to the use of economic evaluations identified by decision makers and can assist in assessing the usefulness and limitations of economic evaluations within the decision-making process at the local level.

As a vehicle for this research we chose the NHS EED [10] because in addition to being familiar with this particular database, we deemed it the most suitable for the task given that one of its stated aims is to be a decision-making tool for the NHS. To this end, and in contrast to certain other databases, it provides critical assessments of published studies and comments on their usefulness to the NHS.

Objectives

The overall aim of this study is to explore whether economic evaluations are widely used by healthcare professionals working in the UK NHS and whether greater access to results of economic evaluations would be beneficial. The detailed study objectives are:

1. to determine current awareness of economic studies and their use in the health care decision-making process;
2. to identify topics of concern to decision makers that may potentially benefit from economic evidence;
3. to retrieve structured NHS EED abstracts dealing with topics identified in (2) and to determine their usefulness to decision makers; and
4. to identify, through discussion with decision makers, recommendations for improving the usefulness, quality, and reporting of economic evaluations in the future.

Questionnaires addressing these issues were developed and sent to participants prior to each stage of the study as outlined in the following section.

Methods

The study was facilitated as a result of the cooperation of a convenience sample of decision makers working for two different UK health authorities. The two particular health authorities (Leicestershire and North Yorkshire) were chosen because they had demonstrated an interest in economic evaluation and were interested in participating in the study. Therefore, the results obtained are likely to represent a “best case” scenario regarding the usefulness of economic evaluations. We return to this point in the discussion.

Initially, letters of invitation outlining the objectives and potential usefulness of the research were sent to a senior official at each of the two health authorities. Consent to conduct the study was obtained and a number of health-care professionals from each authority were subsequently identified to participate in the study.

Because the survey approach common to some of the previous studies has a number of limitations with respect to the reliability of data collection and possible gaps in participants’ knowledge, a focus group method was adopted [11]. This qualitative method offers the advantage of allowing researchers to obtain in-depth comments and feedback from participants in a more proactive, semi-structured and interactive manner. The advantages associated with the focus group [12] approach are:

• It stresses information exchange and the spontaneous and open manifestation of the respondents’ knowledge, beliefs, and values.
• It is based on small groups (generally between 5 and 10 members) and tape recorded discussions.
• The discussions are led by an experienced moderator assisted by a rapporteur who documents the sessions’ main conclusions.
• Individuals are selected according to particular professional categories.
• Participants are told to reproduce their basic ideas, wishes and perceptions about a specific issue or social reality.
• Discussions are transcribed and ordered systematically such that the results can be analyzed and grouped into the main relevant categories.

This approach was particularly useful because ultimately decision makers were invited to engage in a process of assessment and feedback regarding the methodology involved in conducting and reporting economic evaluations. In practice, this could only have been achieved effectively if face-to-face meetings with both researchers and members of the study sample had been conducted. This was especially pertinent to the explanation of the methodology for economic evaluations and the layout and rationale of the structured abstracts, which were also used in the later stages of the research.
The health-care professionals making up the sample of decision makers were closely associated with day-to-day decision-making processes affecting the delivery and implementation of medical services in their area of responsibility. The Leicestershire sample consisted of eight individuals responsible for emergency care and mental health. Emergency care was represented by one consultant in public-health medicine, two commissioning managers, one specialist registrar in public-health medicine, one professor of orthopedic trauma surgery, one associate clinical director in medicine, and one access service manager from a social services department in Leicestershire. The project director and director of finance for mental health were also present.

Four participants from the North Yorkshire health authority with the following backgrounds took part: one professor and assistant director of clinical effectiveness; one consultant in public-health medicine; one evidence-based quality development manager; and one general practitioner responsible for clinical governance for primary care groups (PCGs).

The research was conducted over the course of four meetings, two at each authority, and was coordinated by two health economists from each group with the appointed chairperson from each health authority ensuring that all people had an opportunity to participate. By ensuring that health authorities chaired the meetings, the effects of the researchers’ bias on the outcomes of the study were minimized. The meetings took place between February and April 2000, with a period of approximately 1 month between each pair of meetings.

To enable subsequent assessment of retrieved study abstracts, the first meeting included a brief description of NHS EED in general terms and a description of the reporting of economic evaluations within that database. Participants were asked to discuss their responses to the first questionnaire, which they had received beforehand. The questionnaire inquired about participants’ current use of economic evaluations and asked them to suggest a list of topics related to current or recent decisions in their health authority that economic evaluations could usefully inform.

Following the first meeting, a systematic search of the NHS EED was undertaken using keywords describing the intervention, illness or patient group of interest in addition to Medical Subject Headings (MeSH) and other keywords relevant to the topic of interest. Because the nature of this search was extensive and related to all areas that members of the focus groups had identified, it was not feasible to report every subsearch in detail.

Copies of the retrieved abstracts, as well as details of cost, reviews and methodology papers found, were sent to the participants at each health authority along with a second questionnaire that dealt with the usefulness of the economic evidence and the readability of the abstracts. At the second meeting, the NHS EED research teams presented the results of the searches and explained how they were conducted to provide clarification on how members of the group could retrieve economic evidence in an area they could be involved with in the future.

A final consolidated version of the results was forwarded to both health authorities prior to publication to limit the potential for adverse influences and biases that could have been introduced by the researchers.

**Results**

Overall, all participants considered the economic evaluations and the results of the first pair of meetings to be useful in helping to inform health-care decision making. The general consensus was that economic considerations are essential to support the decisions taken by managers and clinicians responsible for ensuring that the health services provided offer good value for money.

Most of the participants had previously used published economic evaluations, although to varying degrees. In both groups it was emphasized that some decisions cannot be based purely on economic considerations because other quality issues, such as the psychological well-being of the patient, or equity considerations, may override economic factors. Despite this caveat, all these issues should in fact be taken into account in a comprehensive economic evaluation. Representatives from both health authorities expressed concerns regarding the lack of generalizability of economic evaluations. In general, it was thought that economic evaluation studies were focused on very narrow and specific questions that did not allow for the complexity of decision-making processes in the real world, where issues were much broader. Thus, as most published health-economic studies explore the cost-effectiveness of particular health technologies rather than more general health programs, they were viewed as being of limited use to decision makers employed by health authorities.

Twenty specific areas that could benefit from economic evidence to support decision making were...
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Initially, decision makers reacted positively to the pertinence of NHS EED abstracts summarizing the findings of retrieved studies. In general, they considered the abstracts to be a useful source of information that could contribute to the decision-making process and to the identification of related research.

A total of 164 abstracts were retrieved for the Leicestershire Health Authority, of which 109 were studies in emergency care and 55 were studies in the area of mental health. A total of 73 full abstracts were found for the North Yorkshire Health Authority. Overall, 237 abstracts were retrieved through the search of the NHS EED. Details pertaining to each clinical area identified are summarized in Table 1.

That the retrieved abstracts contained information that could be helpful to varying degrees was highlighted during the discussion. A comment from one of the participants from the Leicestershire Health Authority indicated that one abstract on assertive community treatment (ACT) was highly relevant and proved to be useful for decisions regarding the future implementation of ACT for those with severe mental illnesses in Leicestershire.

Although a broad range of studies were retrieved, not all of them were regarded as being useful in the decision-making process. Participants did emphasize that these were nonetheless helpful in identifying areas in which economic evaluations remain to be conducted and in bringing other studies of potential interest to their attention. Some abstracts allowed decision makers to identify areas in which they lacked specific knowledge, such as the statistical and methodological aspects of economic evaluation.

Participants also identified certain factors that could limit the use of economic evaluations reported in NHS EED abstracts to support healthcare decision making. First, decision makers underlined problems in generalizing the results of health-economic studies to the UK setting given that a high percentage of the studies were carried out abroad, particularly in the United States. In fact, 65% of the economic evaluations on the NHS EED are derived from studies conducted in the United States [13]. Decision makers questioned the transferability of these findings to the UK NHS model for delivery of health care.

Second, in some cases participants questioned the quality of the clinical evidence used in economic evaluations. They were of the general view that critical (NHS EED) study summaries in some cases were too brief and that it would be unwise to base decisions on such flawed papers. Third, they re-emphasized their view, expressed at the first meeting, that some economic evaluation studies deal with very specific diseases or interventions and consequently they cannot reflect the more complex real-world conditions under which decision makers have to act.

In particular, health authority representatives found the abstracts supplied to be satisfactory in terms of readability. Consistent with the findings of similar studies, some of the participants experienced problems with the economic terminology used. A recurring suggestion was that the commentary and conclusions should be at the beginning of structured abstracts so that the principal findings and limitations of the study would be evident at first glance.

Regarding the doubts surrounding the quality of clinical evidence, it was also suggested that NHS EED abstracts should be more explicit in criticizing, where appropriate, the original paper. Decision makers also thought that details about the study interventions were often too brief. They pointed out that these details provide important background

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### Table 1 Clinical areas identified and search results

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of NHS EED abstracts</th>
</tr>
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<tbody>
<tr>
<td>1. Telemdecine</td>
<td>6</td>
</tr>
<tr>
<td>2. Acute/emergency admission</td>
<td>1</td>
</tr>
<tr>
<td>3. Nurse practitioners vs. doctors in minor injuries units</td>
<td>8</td>
</tr>
<tr>
<td>4. Ambulance/first responders/paramedics/skill levels</td>
<td>14</td>
</tr>
<tr>
<td>5. Trauma assessment—home vs. hospital</td>
<td>24</td>
</tr>
<tr>
<td>6. Trauma/home</td>
<td>4</td>
</tr>
<tr>
<td>7. Chest pain and chest pain clinics</td>
<td>19</td>
</tr>
<tr>
<td>8. DVT—home vs. hospital care</td>
<td>22</td>
</tr>
<tr>
<td>9. DVTs (home)</td>
<td>6</td>
</tr>
<tr>
<td>10. Home hospital</td>
<td>5</td>
</tr>
<tr>
<td>11. Mental health—long-term side effects of treatment</td>
<td>41</td>
</tr>
<tr>
<td>12. Mental health—self-harm</td>
<td>1</td>
</tr>
<tr>
<td>13. Mental health—compliance with treatment</td>
<td>10</td>
</tr>
<tr>
<td>14. Mental health—ACT</td>
<td>2</td>
</tr>
<tr>
<td>15. Use of statins in the primary prevention of ischaemic heart disease</td>
<td>11</td>
</tr>
<tr>
<td>16. Management of back pain and the use of acupuncture</td>
<td>0</td>
</tr>
<tr>
<td>17. Hip replacement revision—but or after the symptomatic phase</td>
<td>6</td>
</tr>
<tr>
<td>18. Management of COPD</td>
<td>12</td>
</tr>
<tr>
<td>19. Stents and angioplasty and how they relate to CABG</td>
<td>12</td>
</tr>
<tr>
<td>20. Hip and knee replacement</td>
<td>32</td>
</tr>
<tr>
<td>TOTAL</td>
<td>237</td>
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Abbreviations: ACT, assertive outreach/assertive community treatment; CABG, coronary artery bypass graft; COPD, chronic obstructive pulmonary disease; DVT, deep vein thrombosis.
information, which should be described more thoroughly. Participants also provided recommendations as to how to improve the layout, such as clearer headings and a more distinct separation of sections. Furthermore, they favored a more interactive interface offering links to relevant sites, i.e., to glossaries and sources of health-economic information such as the effectiveness bulletins provided to the NHS Centre for Reviews and Dissemination. Another useful improvement would be to provide a filter for searching that would be based on varying levels of evidence and could also limit a search to specific years. This could eventually include some form of quality-scoring system that would classify studies according to different levels of quality of evidence.

The results with supporting quotations from participants are summarized below in Table 2.

### Discussion

In general, participants from both health authorities had common views about the importance of economic information in health-care policy and the value of structured abstracts such as those provided by the NHS EED, which they considered to be a useful source of input for decision making. However, in only a few instances did an individual economic evaluation answer a specific question.

This study identifies a number of options that could improve the usefulness of the NHS EED, and other similar sources of economic evidence as tools for decision makers. First, in view of the preponderance of studies from abroad and their limited generalizability to the UK NHS, more studies applicable to NHS settings should be undertaken and identified as a priority in literature searches of databases like the NHS EED. This would ensure that more reliable and meaningful results would be available for health-policy decision making in the United Kingdom.

Second, the main limitations identified by participants were that published studies often tackled narrow questions whereas decision makers had to deal with much broader issues. This criticism demonstrates that the type of economic evaluation undertaken may also be a factor in terms of a study’s value to decision makers depending on the level at which it is being considered: clinician-patient, health authority, or policymaker. For example, at the clinician-patient level, cost-consequence studies—a subclassification of cost-effectiveness analyses—may be desirable because they leave the health outcomes disaggregated and explicit to the decision maker, with associated resources and total costs being reported for each. However, in making decisions that affect competing health interventions across a wide range of clinical

<table>
<thead>
<tr>
<th>Topic/area</th>
<th>Positive points</th>
<th>Negative points</th>
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<tbody>
<tr>
<td>Economic evaluations in decision making</td>
<td>Most participants had used economic studies to varying degrees&lt;br&gt;Useful in informing the decision making process&lt;br&gt;Economic considerations are essential if value for money is to be achieved</td>
<td>Economic issues alone should not drive decisions. The quality of care provided must be taken into consideration&lt;br&gt;Not all studies retrieved were useful</td>
</tr>
<tr>
<td>Methodology of economic evaluations</td>
<td>Generalizability of studies—Are studies from the US applicable to a UK context?&lt;br&gt;Focus on narrow questions—Decision makers face broader areas such as how to manage specific patient populations&lt;br&gt;Because of narrow focus, many economic evaluations are of limited value at the HA level&lt;br&gt;Need for a quality scoring systems for studies. This can act as a “filter” and identify high/low quality studies&lt;br&gt;Poor quality of effectiveness evidence used in economic evaluations</td>
<td></td>
</tr>
<tr>
<td>NHS EED abstracts</td>
<td>Useful source of information (to varying degrees) within the decision-making process&lt;br&gt;Can help in identifying other studies or areas of interest&lt;br&gt;Satisfactory in terms of readability&lt;br&gt;Can help in identifying the need for future research&lt;br&gt;Reveal decision makers’ lack of knowledge of health economics</td>
<td>Should be more overtly critical of poor quality studies&lt;br&gt;Need to clarify/explain use of terminology or jargon&lt;br&gt;Call for commentary to be “at the beginning” of the abstracts&lt;br&gt;Descriptions of interventions are too brief&lt;br&gt;Layout needs improving&lt;br&gt;More interactive interface with links to definitions/glossaries relating to health economics&lt;br&gt;Need for search filters that would more accurately identify suitable studies</td>
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specialties, a cost-utility approach such as cost per quality-adjusted life year (QALY) may be preferable because a common and aggregated benefit measure is utilized, thereby making such comparisons possible.

Third, the findings also suggest that decision makers’ knowledge of underlying health-economic concepts and methodology is often limited. This problem might be overcome by the provision of health-economics support within health authorities which, at present, is only moderate or nonexistent. Consequently, decision makers often feel insecure about interpreting economic results and suggested implementing a quality score or an overall assessment in addition to structured abstracts. This would provide immediate information about the quality and validity of health-economic study findings and could also be used as a filter when searching databases offering structured and critical summaries, such as the NHS EED. By grading health-economic evaluations in this manner, studies of poor quality could be eliminated a priori such that decision makers could focus on relevant studies, which may compensate for limited knowledge and may save time and effort in identifying valid health-economic evaluations.

However, if health economists did recognize the merit of developing an overall quality score, a number of challenges would have to be met. It would be possible to start with one of the existing methodological checklists and to assess the proportion of items that had been handled satisfactorily in a given study. This approach was adopted by Jefferson et al. [14] in their assessment of the impact of the BMJ guidelines for economic submissions on the quality of studies submitted to the BMJ and The Lancet. However, this approach assumes that the criteria included in methodological checklists are: 1) comprehensive; 2) mutually exclusive; and 3) of equal weight. These conditions are unlikely to hold, and considerable work and thought are still required before a reliable quality score is available.

A recent study by Nixon and Pang [15] tackled some of these issues in developing a percentage score for economic evaluations originating in Japan.

Fourth, a potential limitation of economic evaluations highlighted by decision makers was lack of generalizability of results coming from other countries and health-care systems. Much has been written about the problems of generalizing from a given economic evaluation, and various solutions have been proposed [16]. Beyond the rather obvious points of being transparent in one’s analysis and reporting quantities of resources separately from prices (unit costs), general guidance is difficult to give. More research is required to explore ways in which particular study features limit their generalizability and how it can be increased. The development of interactive models to supplement published studies may help, but some analysts have concerns about this. In this respect, however, it is worth emphasizing that the majority of studies abstracted and recorded on the NHS EED and some other databases are derived from US settings. Although this may be considered a limitation for UK decision makers, it may in fact be an advantage for US users of these databases.

In terms of the methodological limitations of the present study, it is possible that a degree of selection bias exists due to the use of a convenience sample made up of health authorities constituted of those willing to work co-operatively with the organizations undertaking the research. Certainly these respondents are much more favorably disposed to economic evaluation than the average. However, to counter this argument, it could also be said that our results are better informed than those derived from a random sample of health authorities because the convenience sample was eager to pursue issues related to improving evidence-based decision making in the NHS. A number of steps were taken to minimize the influence of sponsor bias by ensuring that the meetings were under the control of each health authority and by using NHS EED as a vehicle rather than the principal focus of the research. Consequently, there are no conflicts of interest, given that funding or support for NHS EED is not directly dependent on the outcome of the present study. However, we acknowledge that similar research using a larger, random sample of decision makers would help to validate and extend the present findings.

Conclusions

Although NHS decision makers feel that economic evaluations are useful in principle, in practice their usefulness may be limited. Starting from topics generated by the decision makers themselves, we found that although studies relating to the topics existed, only in a few instances did published economic evaluations provide direct answers to the decision makers’ questions. In particular, decision makers were concerned that the results of published studies may not apply to their settings. Rather, in most instances published studies had more general uses in helping decision makers structure the problem or illuminate related topics.
Structured databases like the NHS EED do fulfill a useful function in that they help potential users quickly identify relevant studies and provide comments on their quality and relevance. However, some of the respondents said they would like to see more details in the structured abstracts and some reformatting, and that an overall quality score might help them to focus on the most important studies.

Many NHS decision makers are still unfamiliar with economic terminology, and it would be useful to launch training courses to educate them in the basics of economic evaluation methodology and searches of structured databases like the NHS EED.

Finally, it would be useful to conduct additional studies of this type, perhaps using a larger random sample of health authorities, to test some of the hypotheses generated in this study.

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