



Understanding the stakeholders' intention to use economic decision-support tools: A cross-sectional study with the tobacco return on investment tool

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ABSTRACT

Background: Despite an increased number of economic evaluations of tobacco control interventions, the uptake by stakeholders continues to be limited. Understanding the underlying mechanism in adopting such economic decision-support tools by stakeholders is therefore important. By applying the I-Change Model, this study aims to identify which factors determine potential uptake of an economic decision-support tool, i.e., the Return on Investment tool.

Methods: Stakeholders (decision-makers, purchasers of services/pharma products, professionals/service providers, evidence generators and advocates of health promotion) were interviewed in five countries, using an I-Change based questionnaire. MANOVA's were conducted to assess differences between intenders and non-intenders regarding beliefs. A multiple regression analysis was conducted to identify the main explanatory variables of intention to use an economic decision-support tool.

Findings: Ninety-three stakeholders participated. Significant differences in beliefs were found between non-intenders and intenders: risk perception, attitude, social support, and self-efficacy towards using the tool. Regression showed that demographics, pre-motivational, and motivational factors explained 69% of the variation in intention.

Discussion: This study is the first to provide a theoretical framework to understand differences in beliefs between stakeholders who do or do not intend to use economic decision-support tools, and empirically corroborating the framework. This contributes to our understanding of the facilitators and barriers to the uptake of these studies.

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1. Introduction

Tobacco smoking is a worldwide health and economic problem. In Europe estimated costs of smoking tobacco are just above 1% of the EU Gross Domestic Product in 2000 [1]. Tobacco continues to adversely influence global health, accounting for 6.9% of life years lost, and 5.5% of disability-adjusted life-years in 2010 [2,3]. The WHO Framework Convention on Tobacco Control [4] has been ratified by EU member states [5], suggesting that more effort needs to be directed towards tackling tobacco smoking in the European Community at all levels, including public health research [6]. Due to limited resources available for tobacco control, health-care budget holders may have a need to set priorities regarding choices for smoking cessation methods, making it relevant to know whether the societal benefits of these methods are worth the investments that have to be made [7]. The information of cost-effectiveness studies may provide value to the policy process. As many health consequences of tobacco smoking manifest in the long-term, model-based economic evaluations may provide particular valuable information for stakeholders of tobacco control. To give an overview in costs and benefits, several (model-based) economic evaluations of tobacco control methods have already been conducted, including pharmacological and psychological interventions [8–15].

Using an earlier model-based economic evaluation tool [16], Brunel University London, the National Institute of Health and Clinical Excellence [NICE], and regional tobacco control organisations in England developed and tested the Tobacco Return on Investment Tool (hereafter 'ROI tool') in 2012. This tool aims to help decision-makers understand the return on investment of their chosen package of tobacco control interventions, which may include a mix of pharmacological and behavioural support components. The tool includes an interface to select the geographical area of interest, resulting in estimates of smoking prevalence in particular countries and regions within a country. Additionally, the impact of smoking on relevant outcomes is modelled taking into account several time horizons. EQUIPT (European-study on the Quantifying Utility of Investment in Protection from Tobacco) has the ambition of developing and disseminating a new version of the ROI tool across Europe [17].

Disseminating economic decision-support tools, such as the ROI tool, may be a challenge. Despite the fact that the amount of cost-effectiveness information has increased over the last decades, the uptake by stakeholders of these economic evaluations to aid their decision-making continues to be limited [11,18,19]. For instance, limited uptake of economic evaluation information was reported in research into policy decision-making in the UK [20], and in a number of European health care systems [21,22]. The availability of cost-effectiveness information does not automatically translate into the adoption of the most cost-effective intervention. For instance, in the Netherlands internet-based computer tailoring for smoking cessation has been shown to be highly cost-effective [14], and yet these interventions have currently not been adopted by national agencies.

Explanations for the limited impact on health policy of economic evidence have been explored [23]. Multiple

barriers to the use of cost-effectiveness information have been identified [11,18,24], including uncertainty in the quality of the studies [19], limited applicability of the economic evaluation studies for the setting of the stakeholders [18], limited economic evaluation knowledge of several stakeholders [18,19], negative attitude towards scientific evidence, lack of tools and skills to interpret scientific evidence, no perception of relevance of research, lack of support for management and front-line staff, and difficulty of applying evidence in the local context [11]. Moreover, it is important to consider timeliness and relevance of research as well as stakeholders' trust in the source of evidence [11].

Whilst the above studies identify key barriers for stakeholders to use available economic evidence, literature does not provide a framework of the underlying mechanism by which potential facilitators and barriers to the uptake of evidence in decision-making processes come into play. Previous studies identified important factors related to the uptake (or non-uptake) of cost effectiveness information in health policy decisions [23,25]. However, these theories focused less on the motives of stakeholders for uptake or non-uptake, which is the focus of the current study that uses an integration of social cognitive models to understand these motives. This approach also allows us to identify potential strategies to increase levels of motivation of the stakeholders.

The goal of the study is therefore twofold: (1) to explore beliefs about an economic decision-support tool of tobacco control that determine stakeholders' intention to use such a tool; and (2) to investigate which theoretical concepts determine stakeholders' intention to adopt such tool.

2. Method

2.1. Theoretical framework

We applied the I-Change Model (see Fig. 1) [14,26–28] to explain behaviour related to the uptake of any innovation like a health economic decision model, by integrating concepts of various health behaviours, – communication, and promotion models [29–33]. The I-Change model has been used widely in identifying the determinants of health behaviour and behaviour related to the uptake of health promoting interventions [34–38]. The model explains uptake of health behaviour and health behaviour promoting policies in (at least) three phases (i.e., awareness, motivation, and action phase), with each phase having phase specific determinants. The model postulates that the specific determinants are: knowledge, awareness, and risk perceptions for understanding awareness (i.e., knowledge and awareness of such evidence-based tools, and perceived risks of not using such tools), and attitude (perception of advantages and disadvantages towards such a tool), social support (perception whether other people support the use of such a tool), and self-efficacy (the perceived ability to use such tool) for understanding motivation. This leads to the intention to adopt certain behaviour (i.e., uptake of such a tool). As the decision-support tool in this study was not yet available at the time of the study, the action phase (i.e., developing and enactment

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