University of Glasgow | Institute of Health & Wellbeing

What (HTA) methods have been used in disinvestment in health care?

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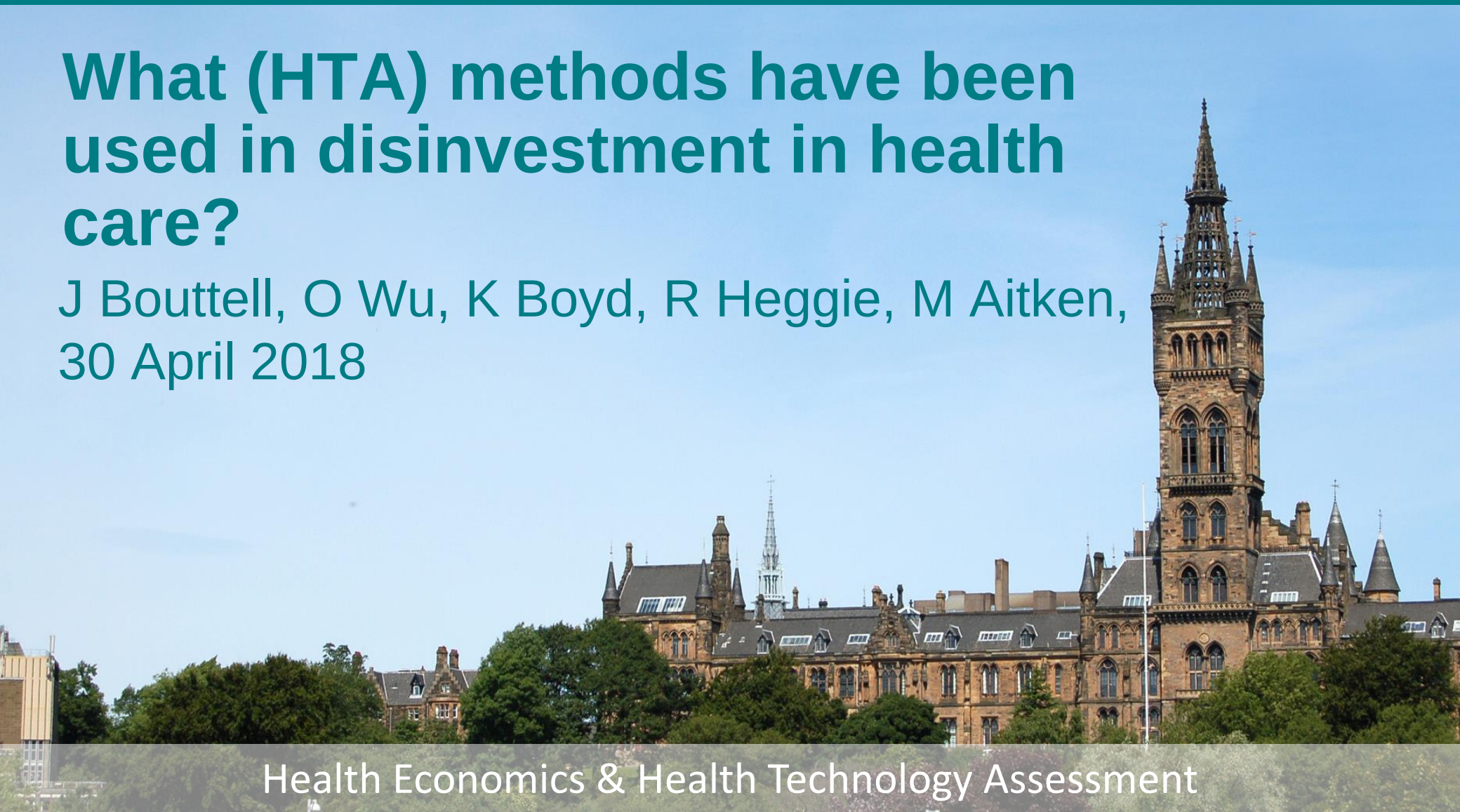


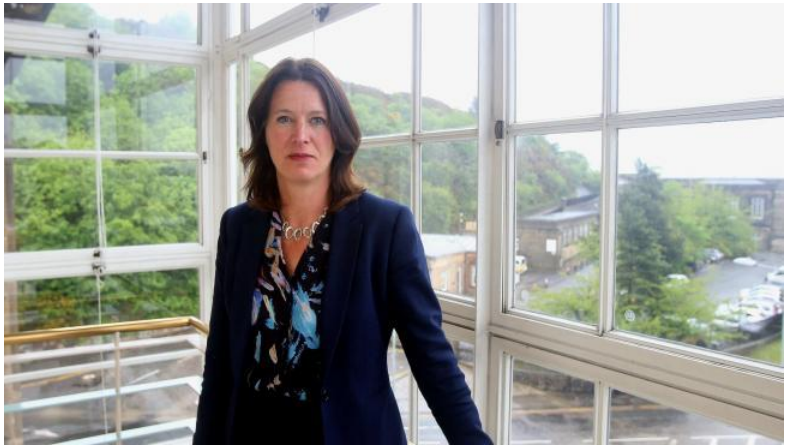
Health Economics & Health Technology Assessment

Importance

Karl Claxton's findings on the NICE threshold:

£20,000 - £30,000 (or more) vs £13,000

Catherine Calderwood (Chief Medical Officer's "Realistic Medicine" agenda



Definition

"the process of withdrawing (partially or completely) health resources from any existing healthcare practices, procedures, technologies and pharmaceuticals that are deemed to deliver no or low health gain for their cost and thus [do] not [represent] efficient health resource allocation"

(Elshaug et al quoted in Mayer, 2015)

2. Literature review – identified 23 studies

- Pragmatic, scoping review, not comprehensive
- Quick terminology based review to identify review articles – EMBASE – disinvest$ - 12 studies
- Review of references and citations of one review article – 3 studies
- Update of the database search from review article – 8 studies
- Inclusion criteria – methods or applied, involves disinvestment

Results

- 8 broad groups of methods
- Different levels of application of HTA/CEA
- Much overlap
- Active vs passive
- Explicit vs implicit

1. Guideline/implementation tool

Identify → Prioritise → Decide → Implement

Specific guidelines on how to do disinvestment or tools to assist:

- Spain – GuNFT/Pritec (Mayer, 2015)

2. Medicine optimisation programmes

PBS

Pharmaceutical Benefits Advisory Committee – Australian version of NICE/SMC (Mayer, 2015)

Disinvestment? (Haas, 2012)

- Withdrawal of unsafe medicines
- Replacement of inefficient
- Drugs falling into misuse

NHS England - Medicines value programme

NHS Scotland - Polypharmacy initiative

http://www.polypharmacy.scot.nhs.uk/general-principles/introduction/

3. Elimination of low-value interventions

Choosing Wisely®

An initiative of the ABIM Foundation

NICE Do not Do prompts

smartermedicine

Choosing Wisely Switzerland

Ideas around over-diagnosis, over-treatment

- US - preventative services taskforce “D-lists” (Elshaug, 2013)

ChoosingWisely UK

CLINICIANS RECOMMENDATIONS

PATIENT HEALTH A-Z

About Clinicians Patients & Carers Resources Contact

Recommendations

+ Royal College of Anaesthetists & Royal College of Surgeons England
+ Royal College of Emergency Medicine
+ Royal College of General Practitioners
+ Royal College of Obstetricians and Gynaecologists
+ Royal College of Ophthalmologists
+ Royal College of Paediatrics and Child Health
+ Royal College of Pathologists
+ Royal College of Psychiatrists
+ Royal College of Radiologists
+ Faculty of Intensive Care Medicine

FIVE QUESTIONS TO ASK MY DOCTOR OR NURSE TO MAKE BETTER DECISIONS TOGETHER

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

4. Guideline/treatment pathway revision

- NICE Multiple technology assessment and de novo evidence for guidelines (Drummond, 2016)
- Sweden – "Uncertainties database" (Mayer, 2015)
- Graham Scotland – "search for efficiency" (Scotland, 2016)
- SHARE – Monash Australia – programme of work around allocation of resource (Harris, 2017)

5. Programme Budgeting Marginal Analysis (PBMA)

Fixed budget, marginal, facilitated, implemented?

Lots of examples:

- respiratory health interventions – Wales (Charles et al, 2016)
- child health policy on Tayside (Donaldson and Ruta, 1996)

Rational disinvestment (Donaldson, 2010)

Link with optimisation work (Earnshaw, 2002)

CMO focus on allocative and technical value

No explicit programme

Eg within set budget without PBMA (Roosenhaus, 2012)

6. Local clinical redesign

- Centralisation of services
- Delivery of service by non-clinical staff

7. Cost savings through commissioning

- Restrictive policies imposed in commissioning
- Commissioning guidelines

8. Adherence to existing guidelines

- Systematic benchmarking
- Clinical audit

No explicit programme

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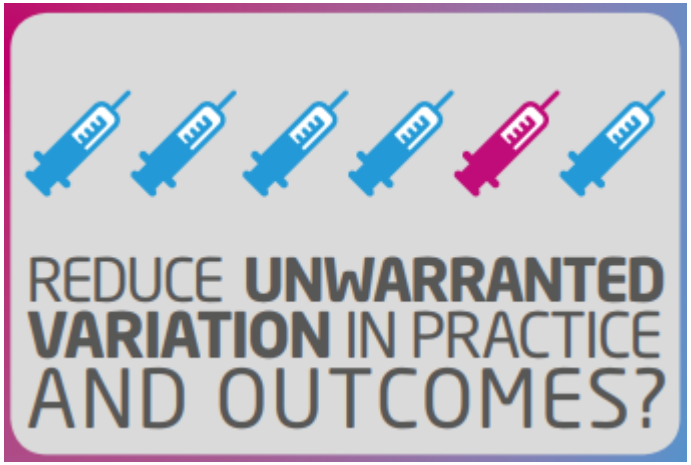
Eg Better Value Healthcare agenda/Realistic medicine

Reducing unwarranted variation – CMO Practising Realistic Medicine

Atlas of Health Variation

- Does the variation matter?
- Are we doing things the same way as in other parts of the country?
- Do we need to change what we are doing?
- Can we learn from successful innovations or best practice guidelines elsewhere?
- Can we share our expertise?



Barriers to and facilitators of disinvestment

Barriers	Facilitators
Misaligned incentives	Budget ownership/pay for performance
Negative terminology/perception	Embed in efficiency/quality improvement
Resource requirement	Embed in existing processes
Evidence requirements	Consensus process/new evidence generation
Lack of stakeholder involvement	Embed stakeholder involvement
Lack of implementation	Embed in clinical guideline/service pathway review process
Political will/media/public perception	Wide stakeholder consultation/marginal changes

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Conclusions

- Disinvestment is not the inverse of investment - it is harder to take something away
- Incentives must be aligned – all key stakeholders/driven by the budget
- Embed processes in routine
- **Evaluate the impact**
- **CMO report timely and relevant**

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