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

J Bouttell, O Wu, K Boyd, R Heggie, M Aitken, 30 April 2018
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
Specific guidelines on how to do disinvestment or tools to assist:

- Spain – GuNFT/Pritec (Mayer, 2015)
2. Medicine optimisation programmes

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

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

NICE Do not Do prompts

I n a n i t i a t i v e o f t h e A B I M F o u n d a t i o n

Ideas around over-diagnosis, over-treatment

Health Economics & Health Technology Assessment
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

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

Eg within set budget without PBMA (Roosenhaus, 2012)
No explicit programme

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

Eg within set budget without PBMA (Roosenhaus, 2012)

Eg restrict procedures to certain subgroups – indication creep (Roosenhaus, 2012)
No explicit programme

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

Eg within set budget without PBMA (Roosenhaus, 2012)
Eg restrict procedures to certain subgroups – indication creep (Roosenhaus, 2012)
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

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misaligned incentives</td>
<td>Budget ownership/pay for performance</td>
</tr>
<tr>
<td>Negative terminology/perception</td>
<td>Embed in efficiency/quality improvement</td>
</tr>
<tr>
<td>Resource requirement</td>
<td>Embed in existing processes</td>
</tr>
<tr>
<td>Evidence requirements</td>
<td>Consensus process/new evidence generation</td>
</tr>
<tr>
<td>Lack of stakeholder involvement</td>
<td>Embed stakeholder involvement</td>
</tr>
<tr>
<td>Lack of implementation</td>
<td>Embed in clinical guideline/service pathway review process</td>
</tr>
<tr>
<td>Political will/media/public perception</td>
<td>Wide stakeholder consultation/marginal changes</td>
</tr>
</tbody>
</table>
## Barriers to and facilitators of disinvestment

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misaligned incentives</td>
<td>Budget ownership/pay for performance</td>
</tr>
<tr>
<td>Negative terminology/perception</td>
<td>Embed in efficiency/quality improvement</td>
</tr>
<tr>
<td>Resource requirement</td>
<td>Embed in existing processes</td>
</tr>
<tr>
<td>Evidence requirements</td>
<td>Consensus process/new evidence generation</td>
</tr>
<tr>
<td>Lack of stakeholder involvement</td>
<td>Embed stakeholder involvement</td>
</tr>
<tr>
<td>Lack of implementation</td>
<td>Embed in clinical guideline/service pathway review process</td>
</tr>
<tr>
<td>Political will/media/public perception</td>
<td>Wide stakeholder consultation/marginal changes</td>
</tr>
<tr>
<td>Barriers</td>
<td>Facilitators</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Misaligned incentives</td>
<td><strong>Budget ownership</strong>, pay for performance</td>
</tr>
<tr>
<td>Negative terminology/perception</td>
<td>Embed in efficiency/quality improvement</td>
</tr>
<tr>
<td>Resource requirement</td>
<td>Embed in existing processes</td>
</tr>
<tr>
<td>Evidence requirements</td>
<td>Consensus process/new evidence generation</td>
</tr>
<tr>
<td>Lack of stakeholder involvement</td>
<td>Embed stakeholder involvement</td>
</tr>
<tr>
<td>Lack of implementation</td>
<td>Embed in clinical guideline/service pathway review process</td>
</tr>
<tr>
<td>Political will/media/public perception</td>
<td>Wide stakeholder consultation/marginal changes</td>
</tr>
</tbody>
</table>
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
References


Elshaug AG, McWilliams J and Landon BE. The Value Of Low-Value Lists. JAMA 309.8 (2013): 775

Haas M, Hall J, Viney R, Gallego G. Breaking up is hard to do: why disinvestment in medical technology is harder than investment (2012)

Harris Sustainability in Health care by Allocating Resources Effectively (SHARE) 6: investigating methods to identify, prioritise, implement and evaluate disinvestment projects in a local healthcare setting BMC Health Services Research 2017: 17:370
https://doi.org/10.1186/s12913-017-2269-1


Scotland G and Bryan S. Why do health economists promote technology adoption rather than the search for efficiency? A proposal for a change in our approach to economic evaluation in health care Medical Decision Making 37.2 (2017): 139-147.

Ruta D, Donaldson C, Gilray I. Economics, public health and health care purchasing: the Tayside experience of programme budgeting and marginal analysis J Health Serv Res Policy Vol 1 Number 4 October 1996