# DISINVESTMENT
## (Breaking up is hard to do)

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# In this presentation

- Why is disinvestment one of the flavours of the month?
  - A popular topic amongst researchers and policy makers – very HTA-centric
- A number of non-HTA approaches directly or indirectly address the issue
- How does the HTA approach work?
- Challenges for disinvestment

# Why disinvestment now?

- Health technology is a major driver of increasing HC costs
  - Much attention paid to getting it right
- Initially assumed that HTA would, over time, increase the efficiency of the HC system by ensuring that technologies provide value for money
  - On balance, technology increases costs

# Why disinvestment now?

- New technologies often additional (not replacement)
  - Pre-existing technologies remain reimbursed
- Many technologies in general use never evaluated
- Reviews of existing technologies very slow
  - Australian Medical Benefits Task Force has reviewed 3%

# Disinvestment does occur

- Cessation or restriction of harmful, ineffective, cost-ineffective practices
  - Many interventions once common are now outmoded

- Passive disinvestment or natural attrition
  - Existing treatments fall into disfavour
  - new interventions replace them
  - reports of harm become public

# What about “active” disinvestment?

- Requires partial or complete withdrawal of resources from technologies that:
  - Deliver low or no health gain for their cost
  - Do not represent efficient allocation of resources (Elshaug, 2007)
- Implies more directed approach
- This active notion is what we are interested in

# Non-HTA approaches

- These approaches are not aimed specifically at disinvestment (only).

- Identify candidates for disinvestment
  - Research into clinical practice variations
  - Clinical guidelines
  - Comparative effectiveness research
  - PBMA

# Clinical practice variations

- Large and long-standing literature
- Driven by perceived need to identify causes of variation amenable to intervention
- Variations in
  - Use, per capita expenditure
  - Across regions, by insurance, SE status
  - By practitioner, organisation
- Evidence of substantial variation not explained by clinical need
- Systematic investigations may identify candidate technologies for disinvestment

# Clinical guidelines

- Designed to improve quality of care
  - reduce the use of unnecessary, ineffective or harmful interventions
  - facilitate treatment which has the maximum chance of befitting patients at minimal risk and acceptable cost

- 313 guidelines produced in Australia 2003-2007 by 80 producers
  - 29% “evidence-documented” ie lit. review + description of search & appraisal process

# Clinical Guidelines (cont)

- Initial assumption: Information alone would change practice
- Methods of encouraging uptake
  - involving users in the development of guidelines
  - identification of barriers to acceptance & implementation
  - improved methods of communication & dissemination
  - “champions”, key clinical groups or influential experts
  - information technology
  - incentives
- Uptake is patchy & likely to be cost-increasing
- May identify candidate technologies for disinvestment

# Comparative effectiveness research

- USA-specific term for HTA approaches already in use in other countries
  - $1.1billion funds as part of the US Recovery and Reinvestment Act
- Systematic appraisal of benefits and risks of alternative treatments and interventions
  - No explicit inclusion of costs
- Development of list of priority topics
  - Nominations from HC professionals, consumer advocates, policy analysts etc
  - 1200 topics reduced to more than 100 by considering BOD, variability,  gaps in knowledge and likelihood of improving health
- No proposal to link CER results to funding decisions
  - Information → better decisions by professionals, consumers etc

# Program Budgeting & Marginal Analysis

- Objective is to re-allocate resources within a context of planning and priority setting
  - Formal assessment of costs & benefits
- Management process which can incorporate results from research, local data and expert opinion
  - How are resources currently being used?
  - How can changes to resource use be made (within current budget constraint) to reflect best practice
    - Redistribution, reduction, expansion of services

# **PBMA** (cont)

- Management tool
  - Encourages review of resources
  - Determine whether another allocation would meet their objectives better
- Many applications around the world
- Resource intensive
  - Commitment & cooperation of managers & clinicians
- Activities for investment more readily identified than those for disinvestment
- Budget control is ideal

# HTA-driven approaches

- Australia
- Europe
  - UK
  - Spain
  - Denmark
  - Italy

# Australia

- Early adopter of HTA processes
  - Evaluation of safety & efficacy of pharmaceuticals in 1970s
  - Facilitated by PBS funding arrangements
- PBAC, MSAC, investment in major screening programs
- PBAC & MSAC may recommend withdrawal of reimbursement
  - PBAC has criteria for removal of drug from PBS
  - Companies have also withdrawn superseded drugs
  - PBAC can implement own reviews – one undertaken so far
  - MSAC cannot implement reviews; no formal de-listing criteria
  - Items granted interim approval are reconsidered; continuation of public funding may not be recommended
- Recent HTA report identified disinvestment as an issue
  - no recommendation as to how it might be addressed

# UK

- NICE explicitly recognises need for disinvestment to be integrated into guidance development
  - Produced technology appraisals & clinical guidelines to reduce ineffective practice
  - Recommendation reminders
  - Commissioning guidelines

- Four disinvestment categories
  - Relatively ineffective interventions
  - Largely cosmetic
  - Effective interventions with close benefit/risk balance in mild cases
  - Effective interventions where more CE alternatives should be tried first

# Spain

- HTA undertaken at provincial level

- Basque region
  - 4 phases: identification of obsolete technologies, selection of aspects for evaluation, case study to test evaluation tool, development of a hospital guide to investment in proven technologies
- Galicia region
  - Developed a prioritisation tool (PriTec)
  - Enables simultaneous comparison of 50 technologies

# Denmark

- Pilot project in 2004
  - Assess improper use or obsolete technology
- Focus on imaging technologies
- Information available is a conference abstract
  - Literature review + questionnaire targeting internal medicine units

# Challenges

- Lots of interest, little progress
  - Passive approaches are slow, will continue
  - Dissemination of information (through research evidence, guidelines, management processes) has had a modest effect
  - Active approaches mirror methods and processes of HTA
    - Number of publications state problem & rationale for disinvestment
    - Some pilot studies, case studies
    - No formal structures developed **and used**

# **Challenges** (cont)

- Barriers identified
  - Lack of resources for research
  - Inadequate resources, lack of will to support processes
- Which technologies?
  - Major exercise
- Lack of clear incentive
  - Option value in having lots of technologies available
  - Will resources freed-up by disinvestment be returned to the relevant service?

# Conclusion

- Active disinvestment creates losses
- Any benefits or savings may not be realised immediately (or ever)
- Losses may outweigh benefits
  - Disincentives exist for disinvestment
  - Process of identifying target technologies complicates this
- Impetus for disinvestment can only come from changing incentives
  - Eg pay for performance
  - Role of consumers in choosing providers
  - Organisational structures eg budget holding, blended payment to enhance purchase and use of appropriate technologies
- Future work should aim to investigate how changing incentives affects the use and disuse of technologies