

Identifying existing health care services that do not provide value for money

Adam Elshaug, MPH, PhD

Hanson Fellow, Adelaide Health Technology Assessment (AHTA)
Senior Lecturer, Department of Public Health

School of Population Health and Clinical Practice
The University of Adelaide, Australia

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Background documents

- **Elshaug AG***, Bessen T* (* equal 1st author), Moss JR and Hiller JE. Addressing 'waste' in diagnostic imaging: Some implications of comparative effectiveness research. *Journal of the American College of Radiology*, (Accepted 17 March, 2010).
- **Elshaug AG**, Moss JR, Littlejohns P, Karnon J, Merlin TL and Hiller JE. Identifying excess health care services that do not provide value for money. *Medical Journal of Australia* 2009; 190(5): 269-273.
- **Elshaug AG**, Hiller JE and Moss JR. Exploring Policymakers' Perspectives on Disinvestment from Ineffective Health Care Practices. *International Journal of Technology Assessment in Health Care*, 2008; 24(1): 1-9.
- **Elshaug AG**, Hiller JE, Tunis SR and Moss JR. Challenges in Australian policy processes for disinvestment from existing, ineffective health care practices. *Australia and New Zealand Health Policy*, 2007; 4: 23 (31 October 2007).
<http://www.anzhealthpolicy.com/content/4/1/23>
- **Elshaug AG** and Hiller JE (as acknowledgements). Health Technology Disinvestment: tests, drugs and clinical practice. Report on a national disinvestment workshop. (2009) Centre for Clinical Effectiveness, Melbourne, Australia
http://www.southernhealth.org.au/page/Health_Professionals/CCE/Projects/SHARE/
- **Elshaug AG**, Watt AM, Moss JR, and Hiller JE. *Policy perspectives on the obsolescence of health technologies in Canada* [internal manuscript – HTS Policy Forum discussion paper]. Ottawa: Canadian Agency for Drugs and Technologies in Health (CADTH); 2009.

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Comparative effectiveness, comparative value

“ There is substantial overuse, under use, and misuse of medical care in the United States. Interventions that are of little value are commonly overused; care that is effective is commonly underused; and care that is of unproved value is frequently misused. Spending on medical interventions continues to increase without evidence that doing more results in better outcomes or better patient satisfaction”

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Wennberg as quoted in Daniels S. *The leader's guide to hospital case management* (2005), p.187

And the community is noticing

“In the last 2 years, doctors recommended treatment you thought had little or no benefit?”

Country	Aust	Can	Ger	Neth	NZ	UK	US
Sample (N)	1009	3003	1407	1557	1000	1434	2500
Response	17%	12%	20%	13%	15%	10%	20%

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Cathy Schoen et al. Toward higher performance... Health Affairs. 2007, 26(6); 717-734.
Adapted from Exhibit 2, page. 721
Original Source: Commonwealth Fund International Health Policy Survey, 2007.

“So much is expected, by the public and by politicians. But resources are finite and choices have to be made about where and how to invest – and disinvest – to make the most out of the nation’s funding for health” (NICE, 2006)

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- Economic imperative (sustainability)
- Ethical imperative (quality of care)
- Best practice imperative (excellence)

What should we call it?

Disinvestment:

- Withdrawal (partial or complete) of resources
- From practices/procedures/pharmaceuticals /technologies/ programs that deliver no or low health gain + are thereby
- Not efficient use of health resources thereby
- Freeing resources for more effective, safe, cost effective and prioritised health services

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What should we call it?

Disinvestment - lukewarm reception

"*dis-*" infers a negative or reversing force;
undo (an investment)

- Displacement + reallocation
- Reassessment for Reinvestment
- Comparative effectiveness/value
- Retrenchment
- Obsolescence

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Disinvestment \neq obsolescence

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Disinvestment + opportunity cost

- Does not entail an all or nothing approach
 - can occur in degrees
- Re-focuses on the positive
 - Reallocation of funding
 - To safe + effective interventions
 - To patient groups most likely to benefit
- For health gain resulting from the better deployment of health resources

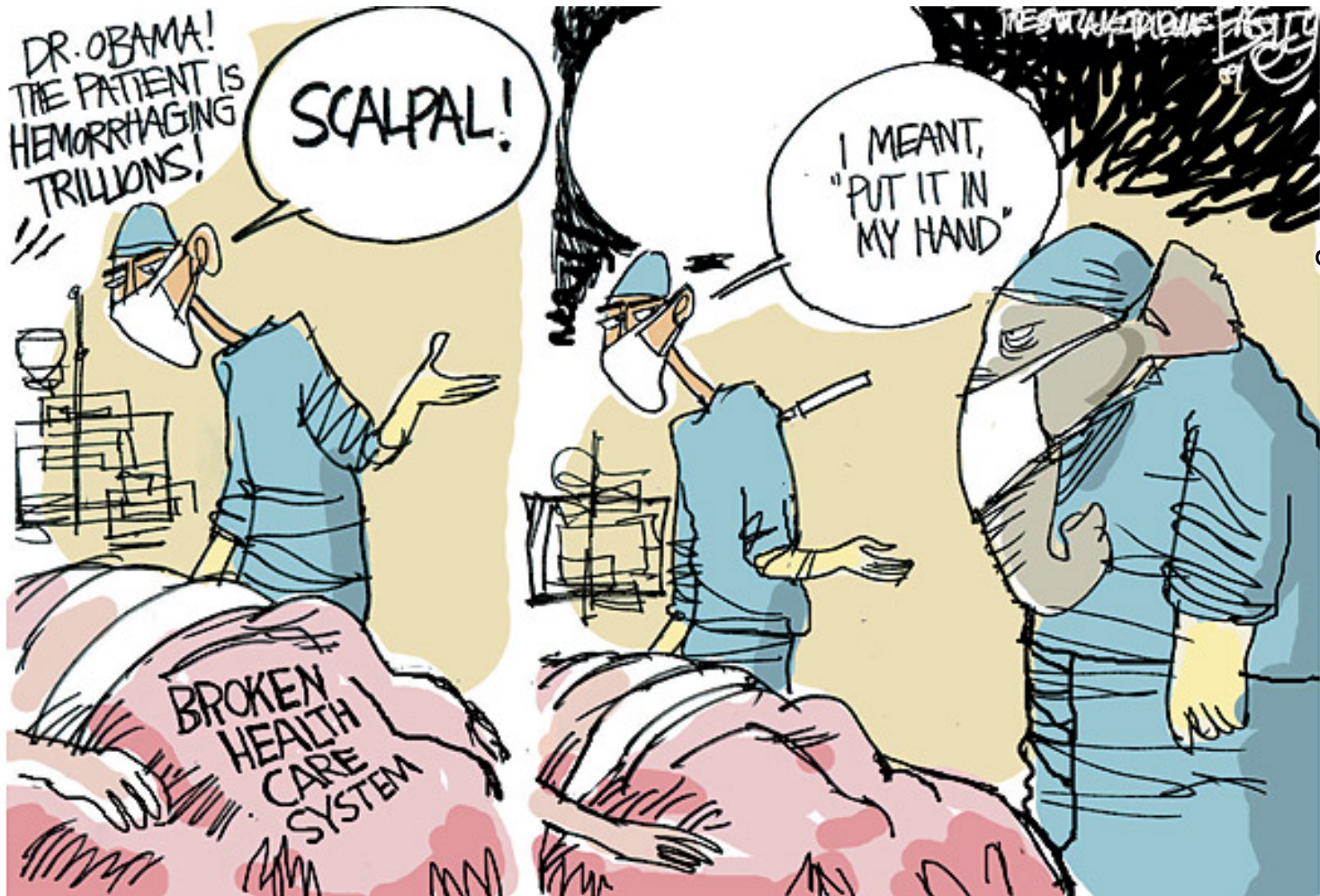
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Disinvestment \neq rationing



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Disinvestment = controversy (one person's waste...)



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Brief history: USA

1976: Blue Cross Blue Shield Medical Necessity Project

- 76 "outmoded and useless procedures"

1978: National Center for Health Care Technology

- \$4mill budget, 20 staff
- 'multifaceted assessments'
- disbanded in 1982 - opposition from interest groups (eg AMA) + Republican administration

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Brief history: Canada

1990s: 'De-listing' activities at provincial level

- 46 procedures/tests removed
- selection varied in specificity with no criteria
- interest groups pressured for items to escape review/consideration
- highly variable adoption across provinces

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Brief history: UK - 2005

- *Disinvestment* coined by NHS as formal policy
- Fourth stream of system reform: *clinical waste*
 - underuse, overuse and misuse of services
- Disinvestment an explicit part of NICE's guideline remit to Primary Care Trusts
 - NICE 'Optimal Practice Reviews'
 - Disinvestment is optional
 - Variability of uptake across PCTs
 - New debate around the need for regulation

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Brief history: Spain (inc Basque) - 2009



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- Basque office for HTA (Osteba)
 - Guideline for Not Funding Technologies (GuNFT)
 - Principally for hospital-based disinvestment initiatives
 - Ibarгойen-Roteta N, et al. Scanning the horizon of obsolete technologies: possible sources for their identification. *Int J Technol Assess Health Care*. 2009 25(3):249-54.
- Galician HTA Agency (avalia-t)
 - PriTec web based tool – available in English
 - Prioritisation of technologies susceptible to post-introduction observation and;
 - The prioritisation of potentially obsolete health technologies
 - <http://www.pritectools.com/>

2009 - A federal government agenda..

- DoHA Health Technology Assessment Review
 - Discussion paper 5 – Enhanced Post Market Surveillance

REVIEW OF HEALTH TECHNOLOGY ASSESSMENT IN AUSTRALIA

PROPOSAL 16 – A REVIEW PROCESS WITH CAPACITY TO RECOMMEND DISINVESTMENT

The discipline of HTA could play a larger role in making recommendations around the disinvestment of health technologies including the:

- identification of ineffective technologies;
- provision of advice recommending reducing or refining the use of technologies; and
- provision of advice recommending the removal of technologies from government and insurance funding schedules altogether¹².

This would allow reallocation (or reinvestment) of funding to interventions and programs that offer overall health gains more efficiently and could encourage more robust and efficient processes around all health care decision making, not just disinvestment.

12. Elshaug A, *et al.* *MJA* 2009;190(5):269-73.

Brief history: Recent Australian events

PAIN WE HAVE TO HAVE

Health reform will hurt a lot — but there is no avoiding it

HEALTH accounts for 9 per cent of GDP, a figure that will rise to 12.4 per cent in a little over 20 years. But not all of the money is well spent now and many billions will be wasted in the future without reform. Kevin Rudd made the point in a speech last week when he referred to research that found a common treatment for fractures to the spinal cord had the same benefit as doing nothing. But imagine the howls from doctors who provide the procedure and what they would tell their patients if funding for it were

patterns. And more money is not the only answer. As Mr Rudd points out, 15 per cent-plus of patients wait too long for elective surgery — a figure that has not improved over time.

But while there is no single solution, the first step is to accept that health needs the equivalent of the 1990s reforms, which ended uncompetitive work practices and industry subsidies in state-regulated industries. For a start, Canberra could suggest to NSW, firmly, that it follow states that fund hospitals according to the average cost

‘Useless’ treatments to be culled

Sid Maher

will be a battleground. The old will want ever more spent on treatment, the young will resent the increased costs. And the medical workforce will oppose changes to preferred work

across the country. Canberra \$1.3 billion a year. This would upset supporters of the status quo, but the sooner the squealing starts the sooner the reforms will begin.



The Australian

17/8/09

Genuine support from the highest level...

"a fairer more sustainable health system"

Nicola Roxon, MP. [Australian] Federal Health Minister, 2009

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Challenges (1)

- Lack of resources to build and support policy mechanisms

Current assessment structures are overwhelmed with applications for new and emerging technologies and hence have limited capacity to address existing services.

(MSAC: 700 pages of documentation at recent meeting – all for new and emerging)

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Challenges (2)

- Lack of reliable administrative mechanisms to identify and prioritize technologies/practices
- And to develop the evidence needed to underpin decisions around legacy items
 - Motivation?
 - Directive?
 - Resources?
 - Data availability and interpretation?

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Challenges (3)

- Political, clinical and social challenges of removing an established technology or practice (entrenchment)
- Resistance to change due to established clinical training and practice paradigms
- Clinical and consumer influence and preferences
- Political sensitivities, interests, and resistance
- Supplier-induced demand
- Incentive and disincentive mechanisms
- The sunk costs of human and physical capital which would thereby become obsolete

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Senator Nick Xenophon on 20 Aug 2009:

<http://www.thepunch.com.au/articles/ivf-for-the-rich-and-infertility-for-the-rest/desc>

"Science can deliver this opportunity to thousands of Australians every year who would otherwise be left infertile. Government must not stand in the way"



The Federal Government has cut your Medicare rebate on cataract surgery by 10%.

Cataract Surgery

by 10%

Are they blind to the facts?

Cataract Surgery:

- ✓ Allows seniors to keep their drivers' licences
- ✓ Reduces social isolation and depression in the elderly
- ✓ Reduces falls and hip fractures in the elderly

Slashing the rebate will only:

- ✗ Increase costs for pensioners
- ✗ Force patients to pay bigger gaps
- ✗ Blow out public hospital waiting lists.

"Grandma's not happy!"

Find out more - www.grandmasnothappy.com.au

Have this dangerous rebate cut reversed. Write to your local MP or phone your local radio station today! Or contact Council on the Ageing (COTA) (02) 9286 3860, email info@cotansw.com.au

This Government needs to start listening.

ASCO Australian Society of Ophthalmologists

COTA Council on the Ageing

ION Independent Ophthalmic Network

Authorized by Mr. Kerry Gallagher for the Australian Society of Ophthalmologists (ASCO)

Challenges (4)

- Lack of published studies with clear evidence showing existing technologies provide little/no benefit
 - ~ Structured processes for decision-making with degrees of uncertainty
- Accepting different levels of evidence!

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Proposed Approaches

- Identifying and prioritizing practices/technologies for evaluation
 - Expanded Horizon Scanning Model
 - Explicit, a-priori, transparent, inclusive, (but) removed from vested interests

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Identifying services for 'disinvestment'

- Evidence (safety, effectiveness, C-E)
- Variation (x3: Geographic, Provider, Temporal)
- Technology Development
- Interest or Controversy
- Consultation
- Nomination
- Assess New-Displace Old
- Leakage
- Legacy - Grandfathering
- Conflict

Elshaug A, et al. *Medical Journal of Australia*.

2009 Mar 2;190(5):269-73.

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FOR DEBATE

Identifying existing health care services that do not provide value for money

Adam G Elshaug, John R Moss, Peter Littlejohns, Jonathan Karon, Tracy L Merlin and Janet E Hill

ABSTRACT

- Health systems can be improved appreciably by making them more efficient and accountable, and enhancing the quality of care, without necessarily requiring additional resources.
- Australia, like other nations, cannot escape making difficult health care choices in the context of resource scarcity and the challenge of delivering quality care, informed by best available evidence, to an ageing population with many comorbidities.
- An opportunity exists for a cost-saving or cost-neutral agenda of reallocation of resources within the existing health system through reducing the use of existing health care interventions that offer little or no benefit relative to the cost of those public subsidy. This would allow reallocation of funding towards interventions that are more cost-effective, maximising health gain.
- Criteria based on those developed for health technology assessment (HTA) might facilitate the systematic and transparent identification of existing, potentially ineffective practices on which to prioritise candidates for assessment as to their cost-effectiveness.
- The process could be jointly funded by all relevant stakeholders but centrally administered, with HTA groups resourced to undertake identification and assessment and to liaise with clinicians, consumers and funding stakeholders.

MJA 2009; 190:269-273

Potentially ineffective health care practices

A policy of identifying and assessing ineffective or non-cost-effective practices, reducing their existing use (and redirecting those resources) undoubtedly represents an option for improving sustainability and quality in health care. However, Australia has a poor track record in achieving this, particularly outside the area of pharmaceutical assessment.^{5,6} A significant challenge is the need for, and requisite development of, a fair and systematic method to identify practices for which assessment is appropriate, based on an agreed framework.⁷ Failure to undertake this in a systematic and transparent manner has the potential to entrench stakeholder resistance. Mechanisms already exist to identify interventions that can be demonstrated to be harmful or ineffective before they are adopted in Australia. As well as enhancing and extending these mechanisms to consider interventions in current use, a further step would be to identify interventions that, although safe and effective, are not sufficiently cost-effective to warrant widespread use in routine practice.

Box 1 lists examples from a 2008 report from the Institute of Medicine in the United States of widely adopted health interventions now deemed 'ineffective or harmful',¹⁰ although arguably the list focuses on those that are harmful. Additional items are shown in Box 2 where the concern is less about safety and more about clinical and

[to] ensure better data for evidence-based allocation of resources... [and to use those] data to allocate resources across the system based on hard evidence. Public funding would be added and removed on the basis of clearly demonstrated effectiveness.⁹

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Point of *Prioritisation*

- Cost (per procedure or volume)
- Impact (health; liberation; equity)
- Cost-effective alternative
- Burden (high/low)
- Evidence (sufficient to offer utility; growing consensus)
- Pay for Evidence
- Futility
- Precedent

Elshaug A, *et al. Medical Journal of Australia*. 2009 Mar 2;190(5):269-73.

Method for today's case studies:

- **Evidence** (safety, effectiveness, C-E)
- **Variation** (x3: Geographic, Provider, Temporal)
- Technology Development
- Interest or Controversy
- Consultation
- Nomination
- Assess New-Displace Old
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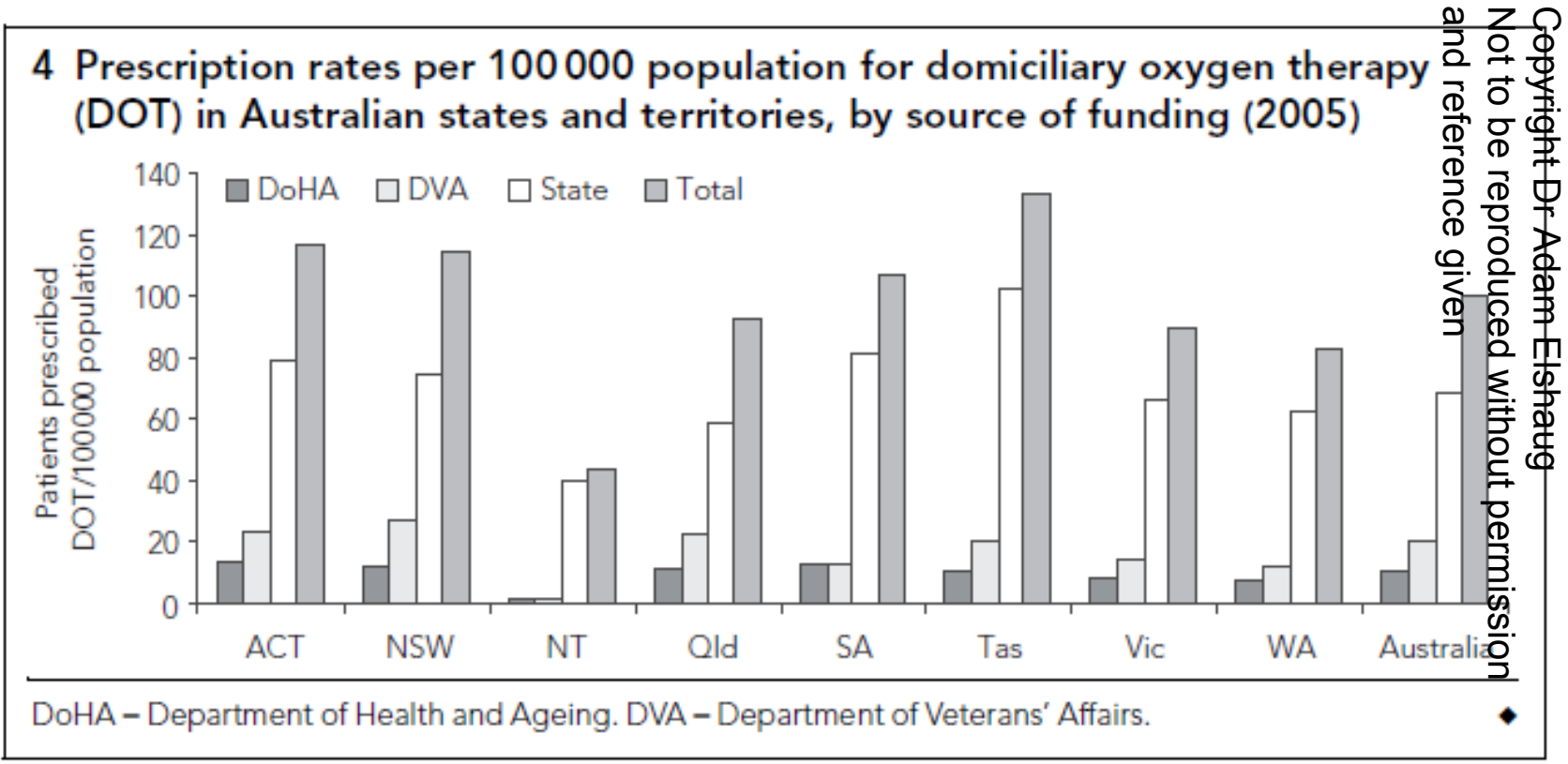
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Domiciliary oxygen therapy prescription rates

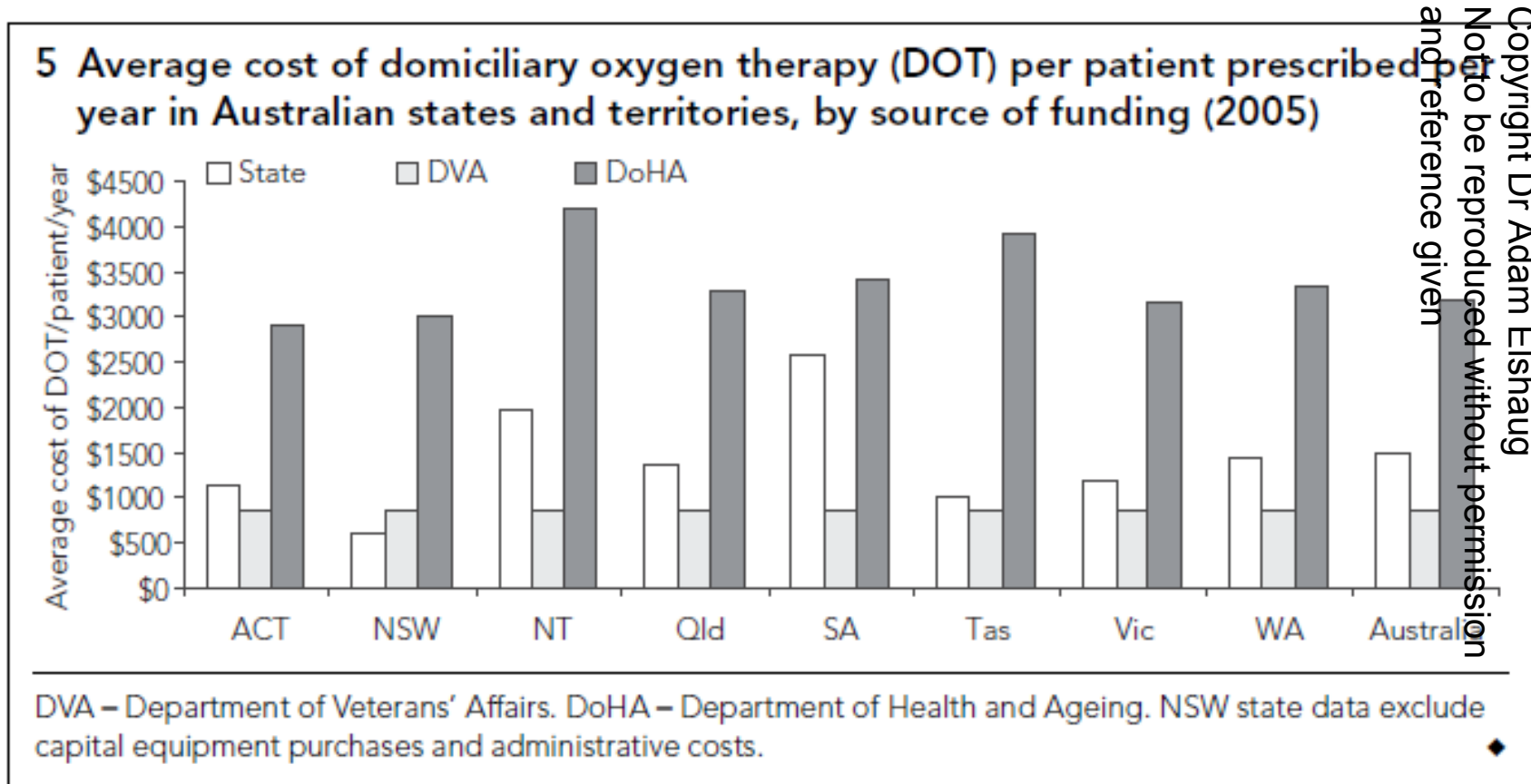
VARIATION by state



Source: Serginson JG et al. *Med J Aust* 2009; 191(10); 549-553

Domiciliary oxygen therapy by state

VARIATION (\$ per patient)



Source: Serginson JG et al. *Med J Aust* 2009; 191(10); 549-553

Surgery for OSA: VARIATION BY STATE

- Uvulopalatopharyngoplasty (UPPP) – scalpel/laser (41786)
- Medicare services in 2008: 1,296 (\$585,792.00)

Item 41786, services per 100,000 population by state (2008)

State								Total services per 100,000 population
NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
4	6	5	9	11	7	13	6	6

Source: https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml

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Osteotomies of Mandible and/or Maxilla

MA: 1,035; MMA: 456 (\$1,635,613.00)

VARIATION BY STATE

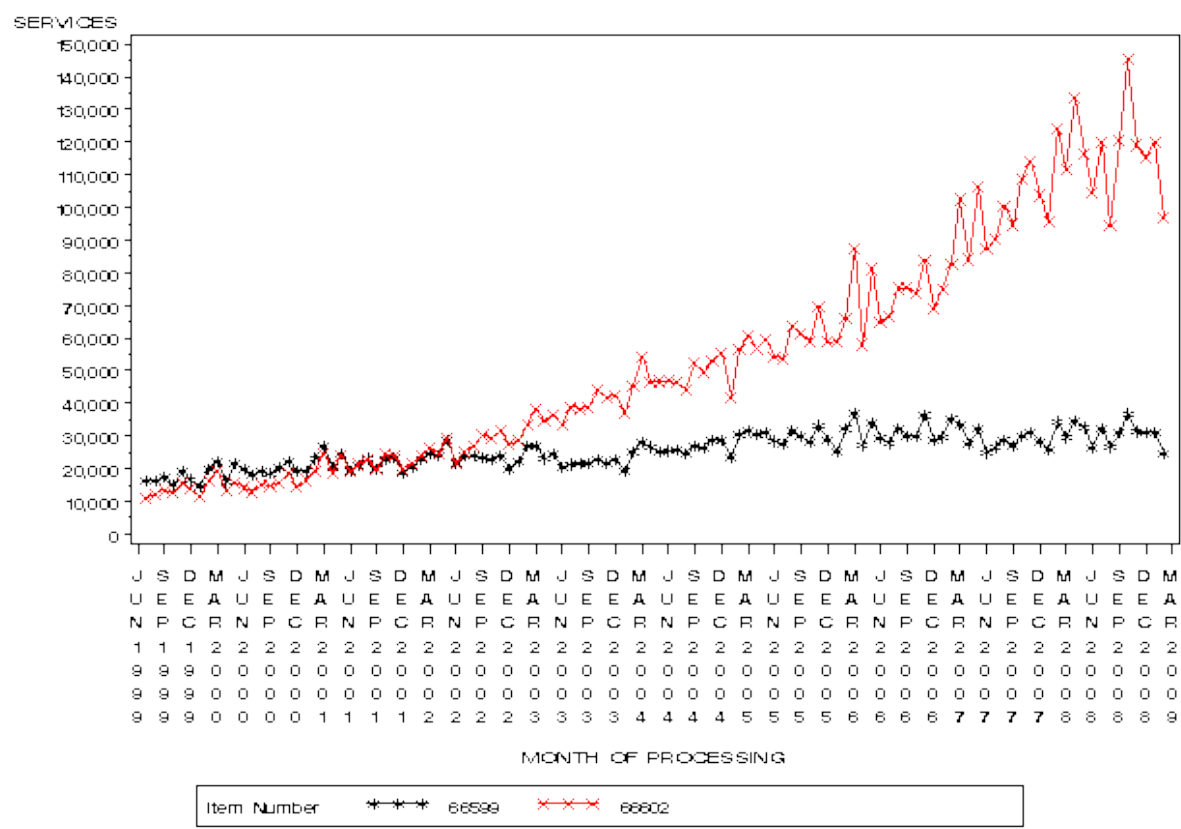
Items 52342-52375, services per 100,000 population by state (2008)

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
52342	1	0	0	0	0	0	4	0	1
52345	0	0	0	0	0	0	1	0	0
52348	1	1	0	0	0	0	1	0	1
52351	1	4	0	1	1	5	1	0	2
52354	0	2	0	0	2	0	0	0	1
52357	1	3	0	0	2	0	2	1	1
52360	0	0	0	0	0	0	0	0	0
52363	0	2	0	1	0	1	0	1	1
52366	0	0	0	0	0	0	0	0	0
52369	0	2	0	0	0	1	0	0	1
52372	0	0	0	0	0	0	0	0	0
52375	1	0	0	0	3	0	4	0	1

Source: https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Vitamin B₁₂ & folate testing

MBS Service provision 10 year trend in service



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Arthroscopy of the knee for osteoarthritis:

EVIDENCE (1)

Year	Organization	Main conclusions
2004	AHTA	Therapeutic knee arthroscopy generally offered no significant advantage compared to blinded placebo treatment in terms of pain, mobility and quality of life
2007	Blue Cross Blue Shield	<p>"the best available evidence does not clearly demonstrate clinical benefit"</p> <p>Uncertainty regarding clinical benefit can be resolved only by rigorous, multicenter RCTs</p>

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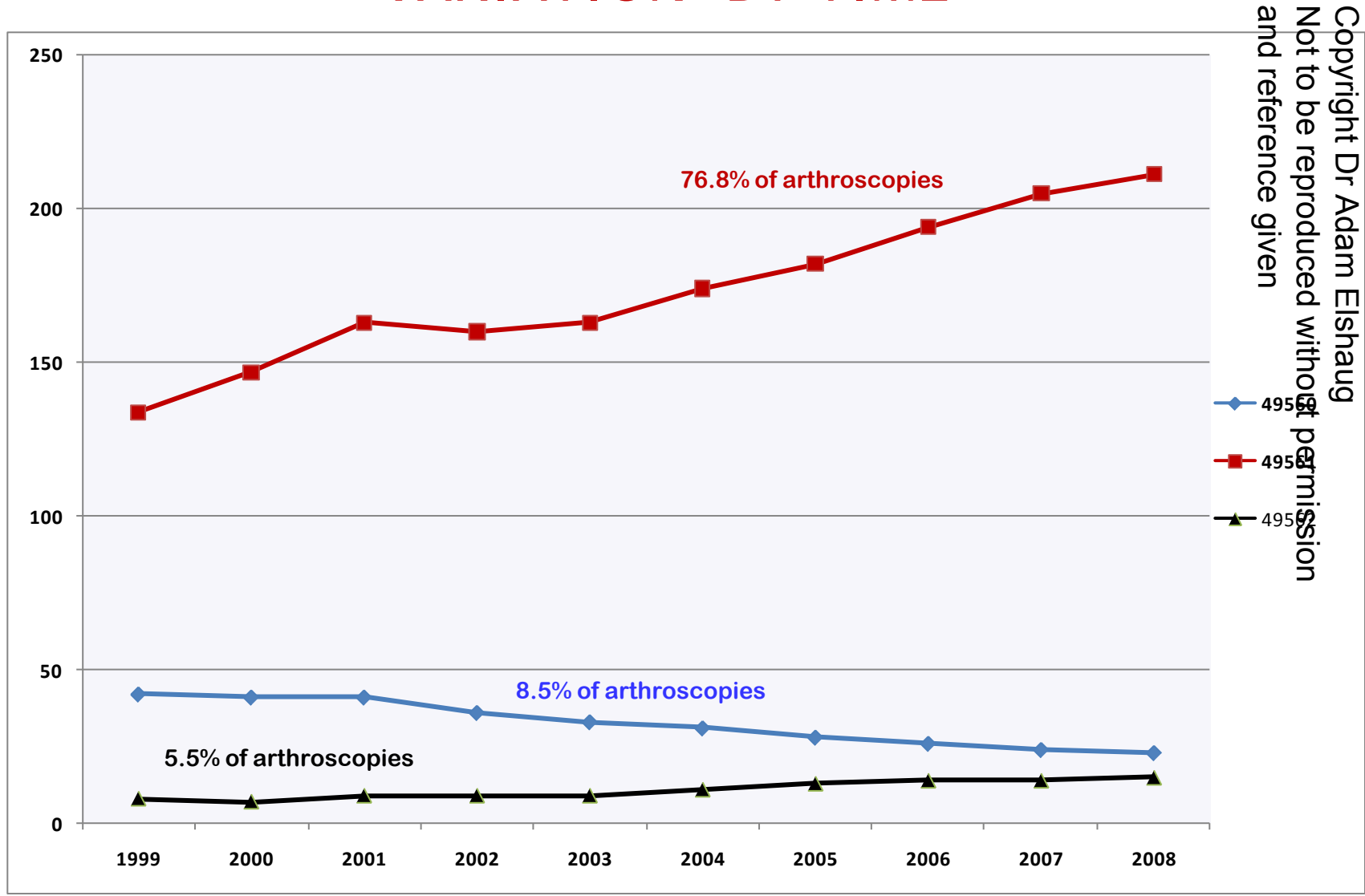
Arthroscopy of the knee for osteoarthritis:

EVIDENCE (2)

Year	Organization	Main conclusions
2008	Cochrane Collaboration	No evidence .. to support the beneficial effect of arthroscopic debridement for osteoarthritis of the knee.
2008	UK – NICE National Institute Clinical Excellence	“Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.”

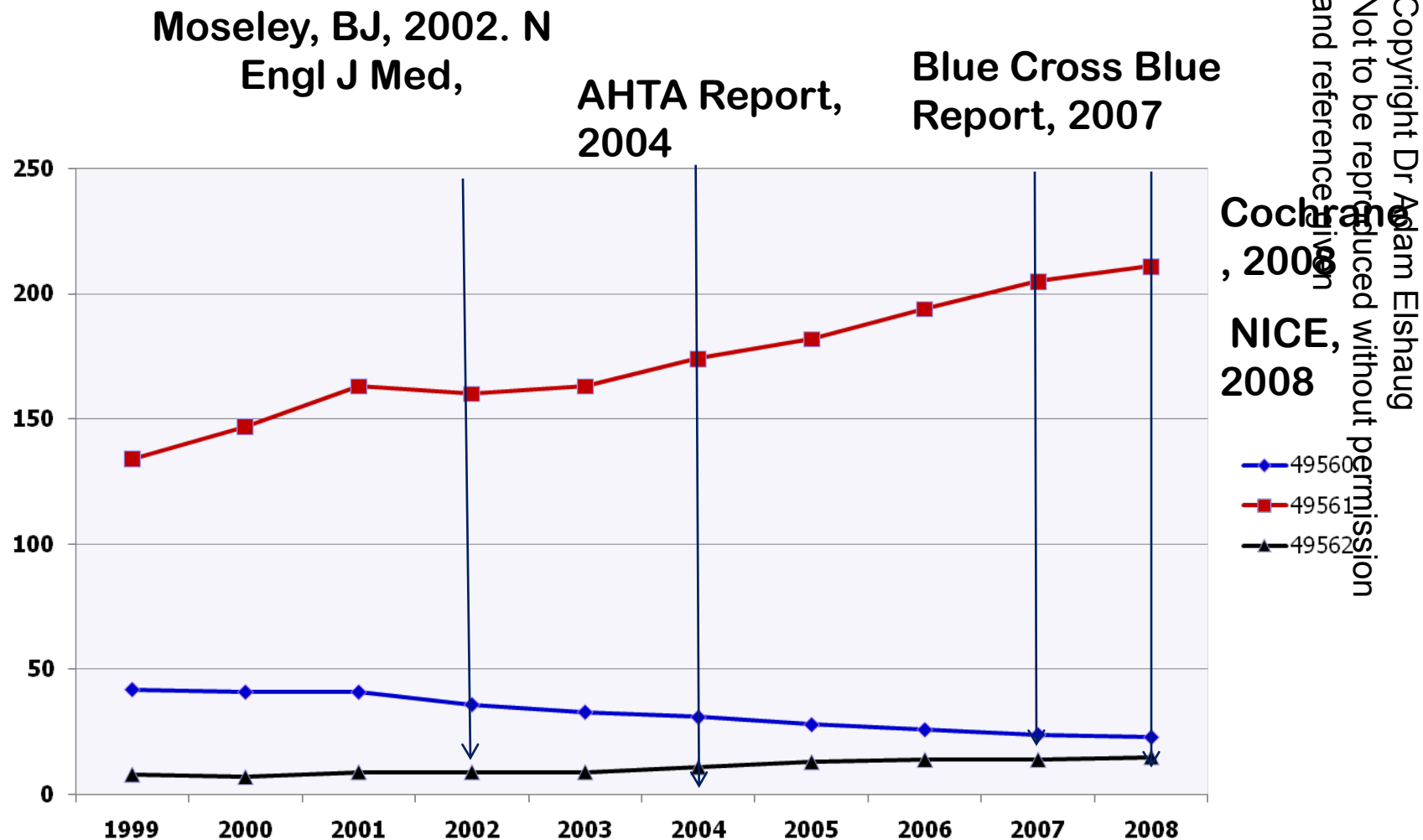
Three most common arthroscopies (Australia): services per 100,000 pop (1999 – 2008)

VARIATION BY TIME



International research, recommendations + Australian practice (1999 – 2008)

CONFLICT



35 candidates identified, and growing

- Ear grommets for otitis media
- Arthroscopic for osteoarthritis of the knee
- Tension-free repair for asymptomatic inguinal hernia
- Exercise ECG for angina
- Blood tests for liver function
- Ultrasound-guided shoulder injections
- Thrombolytic therapy in acute stroke

Developing New Approaches to Assessment

- Existing HTA processes are highly applicable
- *Re-evaluation* requires novel approaches
- Embrace wider range of methodologies
 - Broader levels of evidence
 - Explicit factoring of ethical/social issues etc

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Models under consideration internationally

- Guidelines
- Reimbursement only for guideline adherence
- Remove from funding schedules
- Tighten or restrict indications
- Reduce fee ~ technological development

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Models under consideration internationally

- Partial reimbursement
- Risk-sharing / practitioner reimburses payer
- Restrict providers to 'centres of excellence'
- Compulsory review
- Sunset clauses / time-limited funding (CWED)
- Concurrent specification (1 in 1 out)



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Possible Approaches and Implementation Considerations:

- Element 1: High-level decision and commitment to make this activity an explicit, formal and resourced policy agenda.
- Element 2: Development of a regulatory framework for disinvestment decision-making that is transparent and removed from vested interests (parallel to those in place for new and emerging technologies).

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Possible Approaches and Implementation Considerations:

- Element 3: Consider either:
 - Additional resources and capacity for existing committees to consider existing items in parallel to new/emerging
 - The establishment of new, parallel committee/s to consider existing items
- Element 4: Regulatory support for:
 - Removing, or
 - Reducing reimbursement, or
 - Restricting use - of a comparator technology if a new/existing item has better E/C-E

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Possible Approaches and Implementation Considerations:

- Element 5: The process for selecting candidates for assessment should follow a protocol with pre-specified, transparent selection criteria
- Element 6: Debate among all relevant decision-making stakeholders as to which mechanisms/models, or combinations thereof are most appropriate within a given jurisdiction

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Possible Approaches and Implementation Considerations:

- Element 7: Dedicated stream of funding for capacity building in research and policy development –
 - New and transparent methods to dovetail with existing HTA capacity
 - Stakeholder consultations
 - A working development and implementation plan, and policy reform

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Ms Amber Watt, BMedSci, GDPH

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Prof Janet Hiller, BA, DipSocStudies, MPH, PhD, FPHAA

adam.elshaug@adelaide.edu.au

<http://www.adelaide.edu.au/ahta>



<http://users.skynet.be/J.Beever/pave.htm>



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