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

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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.
“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”

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?”

<table>
<thead>
<tr>
<th>Country</th>
<th>Aust</th>
<th>Can</th>
<th>Ger</th>
<th>Neth</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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<td>3003</td>
<td>1407</td>
<td>1557</td>
<td>1000</td>
<td>1434</td>
<td>2500</td>
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<td>Response</td>
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<td>12%</td>
<td>20%</td>
<td>13%</td>
<td>15%</td>
<td>10%</td>
<td>20%</td>
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</table>

Cathy Schoen et al. Toward higher performance... Health Affairs. 2007, 26(6); 717-734. Adapted from Exhibit 2, page. 721
“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)

- 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
- Not efficient use of health resources thereby
- Freeing resources for more effective, safe, cost effective and prioritised health services
What should we call it?

Disinvestment - lukewarm reception
“dis-” infers a negative or reversing force; to undo (an investment)

- Displacement + reallocation
- Reassessment for Reinvestment
- Comparative effectiveness/value
- Retrenchment
- Obsolescence
Disinvestment ≠ obsolescence
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
Disinvestment ≠ rationing
Disinvestment = controversy
(one person’s waste...)

DR. OBAMA! THE PATIENT IS HEMORRHAGING TRILLIONS!

SCALPAL!

I MEANT, "PUT IT IN MY HAND"

BROKEN HEALTH CARE SYSTEM
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
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
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
Brief history: Spain (inc Basque) - 2009

- Basque office for HTA (Osteba)
  - Guideline for Not Funding Technologies (GuNFT)
  - Principally for hospital-based disinvestment initiatives

- 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/
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 altogether.

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.

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

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
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)
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?
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
Recent Australian events

Senator Nick Xenophon on 20 Aug 2009:

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

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

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

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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- Legacy - Grandfathering
- Conflict

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)


Diagram: Average cost of domiciliary oxygen therapy (DOT) per patient prescribed per year in Australian states and territories, by source of funding (2005).

- **DVA** - Department of Veterans' Affairs
- **DoHA** - Department of Health and Ageing

NSW state data exclude capital equipment purchases and administrative costs.
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)

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<th>State</th>
<th>Total services per 100,000 population</th>
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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)

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Vitamin B$_{12}$ & folate testing

MBS Service provision

10 year trend in service
<table>
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<tr>
<th>Year</th>
<th>Organization</th>
<th>Main conclusions</th>
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<tbody>
<tr>
<td>2004</td>
<td>AHTA</td>
<td>Therapeutic knee arthroscopy generally offered no significant advantage compared to blinded placebo treatment in terms of pain, mobility and quality of life</td>
</tr>
<tr>
<td>2007</td>
<td>Blue Cross Blue Shield</td>
<td>“the best available evidence does not clearly demonstrate clinical benefit” Uncertainty regarding clinical benefit can be resolved only by rigorous, multicenter RCTs</td>
</tr>
<tr>
<td>Year</td>
<td>Organization</td>
<td>Main conclusions</td>
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<tr>
<td>------</td>
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<tr>
<td>2008</td>
<td>Cochrane Collaboration</td>
<td>No evidence .. to support the beneficial effect of arthroscopic debridement for osteoarthritis of the knee.</td>
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<tr>
<td>2008</td>
<td>UK – NICE National Institute Clinical Excellence</td>
<td>“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.”</td>
</tr>
</tbody>
</table>
Three most common arthroscopies (Australia): services per 100,000 pop (1999 – 2008)

VARIATION BY TIME
International research, recommendations +
Australian practice (1999 – 2008)
CONFLICT

AHTA Report, 2004
Blue Cross Blue Report, 2007
Cochrane, 2008
NICE, 2008

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and reference given
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 a wider range of methodologies:
  - Broader levels of evidence
  - Explicit factoring of ethical/social issues etc.
Models under consideration internationally

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

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

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