DISINVESTMENT & HTA

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Challenge of health systems: priority-setting

”Society simply cannot meet all medical needs, and certainly not all medical preferences, so it **must decide which needs should be given priority and when resources are better spend elsewhere**”

Source: Norman Daniels & James E. Sabin. Setting limits fairly: can we learn to share medical resources, 2002; p.2

& disinvestment

"withdrawing health resources from any existing health care practices, procedures, technologies or pharmaceuticals that are deemed **to deliver little or no health gain for their cost**, and thus **do not represent efficient health resource allocation"**

Source: Elshaug AG, Hiller, JA. Moss, R. Exploring policy-makers perspectives on disinvestment from ineffective healthcare practices. Int J Technol Assess Health Care, 2008; 24: 1-9

- Includes notions of **ethical obligations of physicians** (do not harm) and of **justice**

Issues to be addressed:

- For what sort of problems might disinvestment be a solution?
- Is there any evidence that disinvestment “works”?
- What factors complicate disinvestment?
- Should we try to facilitate disinvestment? Why (not)? How?
- Implications for HTA

“We will no longer pay for this”

- Who is the “we”?
- What is “this”?
- What *reasons* do or may organizations have for discontinuing funding?
- Who are *affected* by such decisions, and in what way?
- How may consequences vary by *context*?

Disinvestment

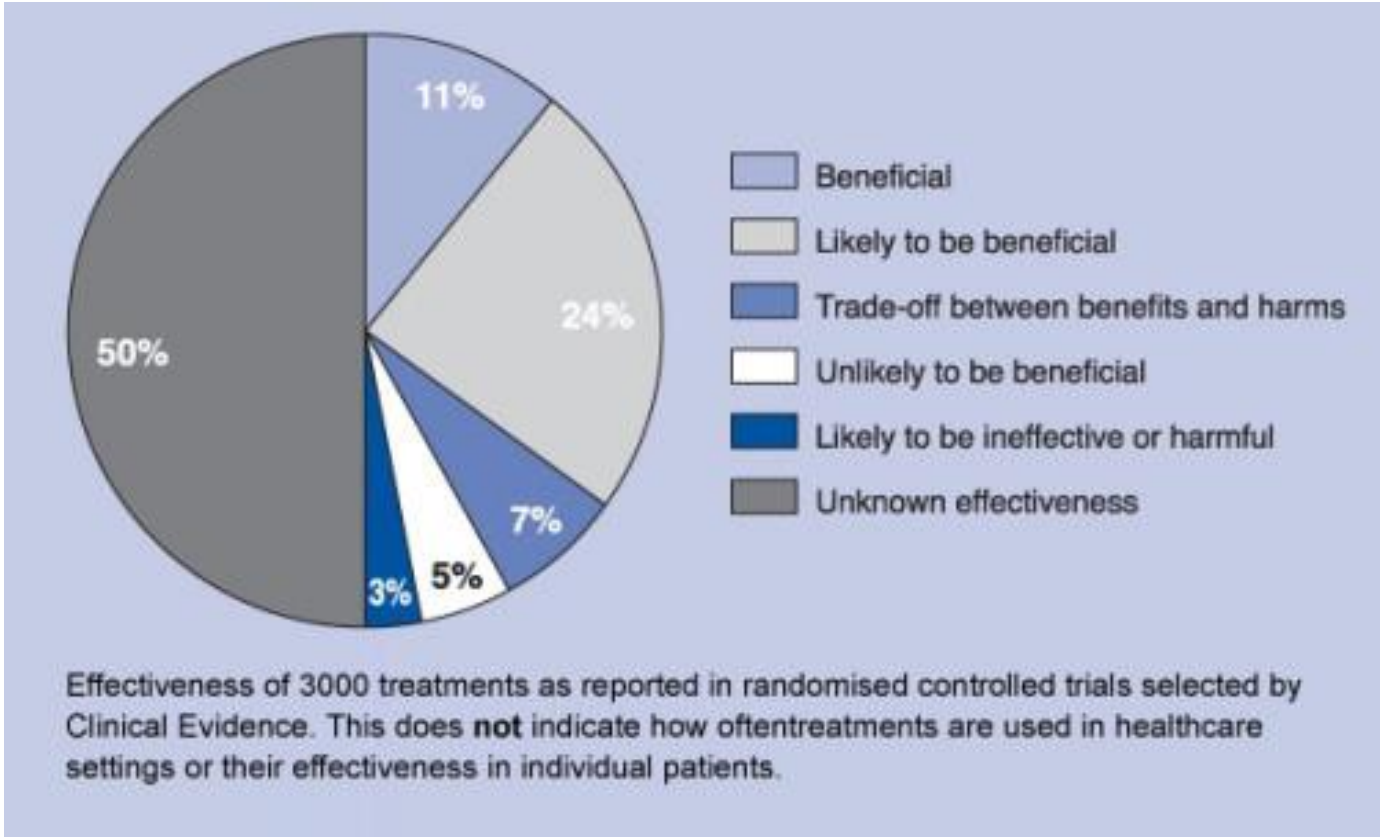
- "We used to cover the costs of this existing/established technology [xxx], but there is accumulating evidence that [xxx] is of no (comparatively little) value." (re-assessment)

- "We used to cover the costs of [xxx], but new interventions have become available that we consider more important / of greater value, and we are unwilling / unable to spend more money. Therefore, we have to reallocate our resources."

- How often do we see this happening? < 50% of 26 disinvestment strategies (from 11 countries) reported that use of low-value services was reduced *Source: Chambers JD, Salem MN, D'Cruz, BN (et al). A review of empirical analyses of disinvestment initiatives. Value in Health, 2017; 20: 909-918*

- What happens instead?

Half of medical treatments of unknown effectiveness



Source: Clinical Evidence, 2012.
https://theincidentaleconomist.com/wordpress/half-of-medical-treatments-of-unknown-effectiveness/

Why does it work that way? (1)

Producing evidence of no effect is difficult, for several reasons:

- **Methodological**
  - No evidence of effect ≠ evidence of no effect
  - Heterogeneity of outcomes: few interventions are completely ineffective for all patients (an issue of appropriate use rather than a coverage decision)

- **Practical**
  - Challenge to clinical practice
  - “We think this intervention might not work: would you be willing to participate in a study to find out whether this is actually true?”

Why does it work that way? (2)

Producing evidence of no effect is difficult, for several reasons:

- **Cultural**
  - Researchers / clinicians / editors / funding organizations consider such research of relatively low interest (albeit this is slowly changing)
  - Disbelief: “this cannot be true” (challenging received wisdom - ASTEC trial; CRASH trial)
  - Conflicting roles of relevant stakeholders

Source: Harris C, Green S, Ramsey W, Allen K, King R. Sustainability in health care by allocating resources effectively (SHARE) 9: conceptualizing disinvestment in the local healthcare setting. BMC Health Services Research, 2017; 17: 633

Disinvestment decisions come in different forms:

- Explicit rationing (priority setting)
- Implicit rationing (bedside rationing)

- Is one type of rationing ‘better’ than the other? If so, in what way?

Differences between explicit and implicit rationing

- Visibility
- Responsibility
- Possibility for appeal
- Explicit rationing requires HTA, implicit rationing does not?

Implications for HTA

- If this is how it works in practice, how can HTA help to improve the quality of decisions?

- Also, how to identify, prioritise and evaluate (potential) obsolete / low value health technologies?
  - Some initiatives exist and in Spain, AVALIA-T developed a framework - https://www.sergas.es/docs/Avalia-t/ObsoleteTechMemFinal.pdf

  - There are also initiatives as Choosing wisely (US), Do-not-do recommendations (NICE, UK), as well as in the Netherlands (ZonMw in collaboration with the medical societies) that may inform HTA agendas

  - Bigger role for the involvement of clinicians

Thank you!