

**HTAi 2018**

ANNUAL MEETING

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CANADA

# Identification Of Technologies Of No Or Low Added Value

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# The toolkit on disinvestment

A jointly effort performed by HTAi IG on DEA, IG on ethics, EuroScan network and INAHTA is aiming to elaborate a toolkit that could aid organizations and individuals on the steps to be developed when considering disinvestment activities.

This presentation refers to one of the chapters of that book on identification activities and disinvestment.

# Introduction

Health technology has no or low added value when it is harmful and/or is deemed to deliver limited health gain relative to its cost, representing inefficient health resource allocation\*.

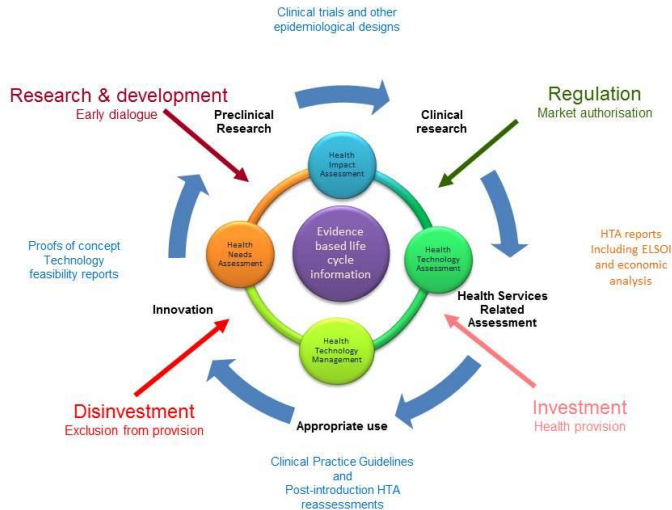
Adam Elshaug

# Introduction (I)



- Here, we synthesized state of the art methods for identifying candidate technologies for disinvestment, and propose a framework for executing this task.

# Introduction (II)



- The traditional linear concept of health technologies life cycle assumes that once decisions on reimbursement were taken, health technologies remained unassessed up to their disuse by health professionals: under this conception, technologies follow a linear path, involving sequential steps from inception to obsolescence.
- The life cycle of a technology is multi-faceted and multi-dimensional, depending on the nature and number of uses

# Methods

We searched systematic reviews on disinvestment and compared the methods used for identifying potential candidates.

A descriptive analysis was performed including sources of evidence used and methods for selection / filtration.

# Results

Ten reviews on disinvestment initiatives worldwide were identified.

One of them was specifically focused on methodologies for identifying and prioritizing candidate technologies for disinvestment (REDETS, Lain Entralgo, 2012)



# Results

Criteria for identifying existing, potentially non-cost-effective practices as candidates for assessment



## New Evidence

New evidence on safety, effectiveness and/or cost-effectiveness may come to light that changes previously held conclusions and is sufficiently useful for decision making



## Geographic variations in care

Geographic variations after adjusting for demographics and location of centres of excellence, suggest differences in clinical opinion about the value of the interventions



## Provider variations in care

Clinical heterogeneity of procedure, where the choice of intervention varies for the same class of disease or condition.



## Temporal variations in volume

A trend in item volume between time-points of a substantial percentage. Most often this is a decrease. An increase after adjusting for trends in incidence may flag "leakage" (usage beyond the restriction/indication) or indication "creep".



## Technology development

When an intervention has evolved to the point that it differs markedly from the initial or prototype intervention that was originally assessed or funded, then the initial intervention should be reviewed.

## Assess new intervention — displace old

When a new intervention is presented to the relevant committee(s) for regulatory assessment, and is considered a potential replacement for (an) established comparator(s) for that indication, then that comparator for that patient indication is automatically considered and assessed for disinvestment



## Consultation

Consultation with clinical, nursing, allied health and technical staff, health care administrators and funders (including both public and private health insurance).



## Nomination

A process (potentially anonymous) established where individuals, associations and colleges (from medical, nursing, research, allied health or the general public) could nominate interventions and justify their choice. To be substantiated by evidence.



## Public interest or controversy

Expressions (to media, letters to editors, enquiry submissions) from patients, consumer advocacy and support groups, and community groups, highlighting negative (or ineffective) experiences following treatment.



## Leakage

Technology use (with reimbursement) outside the evidence-based indications.



## Legacy items

Long-established technologies that have never had their cost-effectiveness assessed — look for coupling with other identification items.



## Conflict with guidelines

Where practice is inconsistent with clinical practice guidelines, clinical college position statements, Cochrane Review recommendations (and where there is no Cochrane Review on that technology).

Elshaug A. et al 2009.

The framework consisted in twelve items ("triggers") (Table 1), Application of these triggers through "horizon scanning" techniques facilitated the systematic and transparent identification of existing potentially ineffective technologies and medical practices.



# Results

## Doing PBMA

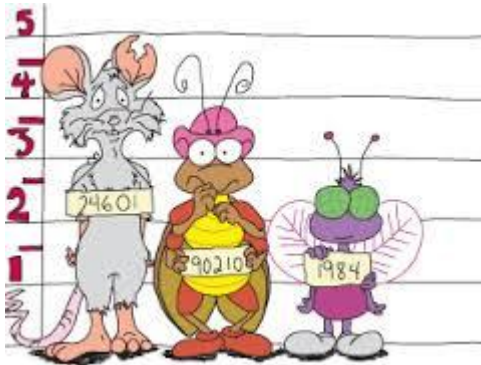
PBMA approaches needs assessment by asking five questions about resources:

1. What resources are available in total?
2. In what ways are these resources currently spent?
3. What are the main candidates for more resources and what would be their effectiveness and cost?
4. Are there any areas of care which could be provided to the same level of effectiveness but with less resources, so releasing those resources to fund candidates from (3)?
5. Are there areas of care which, despite being effective, should have less resources because a proposal from 3. is more effective (for £s spent)?

Questions 1 and 2 pertain to the *PROGRAMME BUDGET*  
Questions 3-5 are addressed in *MARGINAL ANALYSIS*

- Gallego G et al, 2010. authors proposed other *strategies* by which appraisal of existing technologies might be triggered like the *comparative effectiveness research, research into clinical practice variations and Program Budget and Marginal Analysis (PBMA)*







# Results



- Ludwig Boltzman Institute, 2011. Describe that there were consensus on the methods of identification and prioritisation but not methodological guidelines

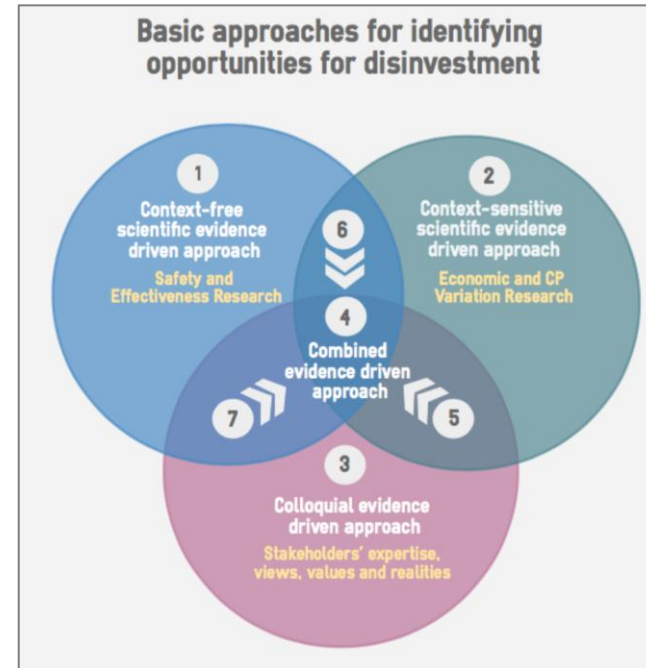
# Results

- Health Technology Assessment International (HTAi) Policy Forum met in San Francisco, USA, 2012 to explore the use and role of HTA in the reduction of lower value or ineffective uses of Health Technology.
- Members of the Forum proposed different *approaches* for the identification of technologies for reassessment

	<b>Ongoing consultation with clinical specialty groups</b> Stakeholders are consulted with the purpose of identifying and prioritizing technologies they believe to be misused and/or of no or little value
	<b>Using routine data to identify technologies associated with high budget impact</b>
	<b>Using routine data to identify variations in use of technologies and/or associated outcomes</b>
	<b>Routine identification of technology candidates for optimization</b> All new HTAs for technology introduction include identification of candidates for optimization/reassessment; All technologies are identified as candidates for reassessment x years after initial introduction or assessment.
	<b>Monitoring published studies and systematic reviews</b> Identification of new evidence on existing technologies and/or evidence that new technologies outperform existing technologies and/or relevant evidence gaps
	<b>Feasibility assessment to support prioritization</b> Identification of barriers and opportunities in order to select reassessment candidates with most potential for change and impact

# Basic approaches for identification

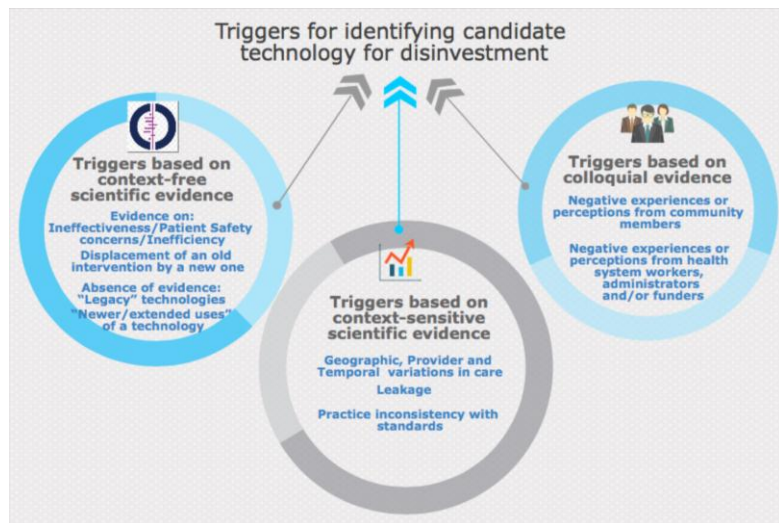
- **“Context-free scientific evidence driven approach”** (*Approach 1*) provided by systematic reviews, evidence-based clinical practice guidelines, effectiveness and safety assessment included in HTA reports.
- **“Context-sensitive scientific evidence driven approach”** (*Approach 2*): analysis of the implementation, organizational capacity, economics, legal and ethical issues related to the use of a specific technology in a certain context. PBMA or cost-effectiveness analysis.
- **“Colloquial evidence driven approach”** (*Approach 3*): evidence that comes from the expertise, views and realities of stakeholders.
- **“Combined-evidence driven approaches”** (*Approach 4, 5, 6 and 7*): four different options, depending on the amount and types of evidence that are combined.



# Triggers for identifying candidates (I)

- Triggers based on **context-free scientific evidence**
  - Evidence on Ineffectiveness/Patient Safety concerns/Inefficiency
  - Displacement of an old intervention by a new one
  - Uncertainties related to “Legacy” technologies
  - Uncertainties related to “newer/extended uses” of a technologies
- Triggers based on **context-sensitive scientific evidence**
  - Geographic variations in care
  - Provider variations in care
  - Practice inconsistency with evidence-based standards
  - Temporal variations in volume
  - Leakage

# Triggers for identifying candidates (III)



- Triggers based on **colloquial evidence**
  - Negative experiences or perceptions from community members
  - Negative experiences or perceptions from health system workers, administrators and/or funders

# Methods for identifying candidate technologies for disinvestment

- **Embedded methodologies**

- Horizon Scanning of existing technologies
- Inclusion of triggers for identifying candidate technologies for disinvestment in purchasing and procurement processes
- Inclusion of triggers for identifying candidate technologies for disinvestment in the guideline development process
- Inclusion of triggers for identifying candidate technologies for disinvestment in system redesign processes related to resource allocation
- Routine use of local data

- **Ad Hoc Methods**

- Horizon or Environmental Scanning
- Identification of opportunities for disinvestment from evidence-based guidelines and/or HTA reports
- Identification of potential candidates for disinvestment from systematic reviews (SR)
- Adaptation of existing list of no-value technologies
- Comparative Effectiveness Research (CER)
- Research into clinical variation practices
- Program Budgeting and Marginal Analysis (PBMA)
- Nomination and consultation methods



# Final remarks

# Conclusions

- There was overlapping among the terms used for describing the different approaches.
- Our proposal differentiating **basic approaches**, **triggers** for identifying potential technologies and **methods** that can be used.
- Scientific and/or colloquial evidence should guide the identification of opportunities for disinvestment.
- Context-free scientific evidence allows the identification of ineffective and/or harmful technologies on the basis of valid and reliable methods.
- Needs to be contextualized. Context-sensitive scientific evidence establishes, which technology or practice is relevant in a certain area or institution due to its variability, burden and/or budget impact.
- Stakeholders involvement is crucial, at least for legitimacy and acceptability

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**Q&A**

*You have*  
**Questions**

*We have*  
**Answers**

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