

# Identifying and reviewing services of questionable benefit

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# Point of *Identification*

- Evidence (safety, effectiveness, C-E)
- Variation (x3: Geographic, Provider, Temporal)
- Technology Development
- Interest or Controversy
- Consultation
- Nomination
- Assess New-Displace Old
- Leakage (indication creep)
- Legacy - Grandfathering
- Practice in conflict with guidelines

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

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

**ABSTRACT**

In Australia, one projection of total health expenditure (in 2002–03 dollars) envisages an increase from \$71.4 billion in 2002–03 to \$162.3 billion in 2032–33.<sup>1</sup> As a proportion of total gross domestic product (GDP), this represents an increase from 9.4% in 2002–03 to 10.8% in 2032–33<sup>1</sup> — an annual growth of 0.5% above the overall economic growth rate. Coupled with this projected increase in cost are concerns for the sustainability and quality of the Australian health care system.<sup>2</sup> Debate continues on issues such as hospital emergency and surgery waiting lists, models of funding and care, pharmaceutical benefit subsidies, workforce shortages, Indigenous health disadvantage and the role of primary prevention — to name but a few.

To address the problems, federal and state/territory jurisdictions have several options, including accepting the increase in the proportion of GDP allocated to health care expenditure, thereby constraining spending in other portfolios, such as education and defence. However, we propose that potential exists for a cost-saving or cost-neutral agenda of resource reallocation within the existing health budget, aimed at improving the quality of care and health outcomes. In Australia, there is scope to identify ineffective interventions (relative to the cost of their subsidy by the taxpayer) and to assess the potential for reducing their use or removing them from government and insurance funding schedules. This would allow reallocation of funding to interventions and programs that offer more in terms of overall health gain and (cost-) effectiveness. As the resources available for health care are finite, this would reduce the extent of unnecessary suffering and premature death arising from the use of health technologies and practices that deliver less than the best-available value for money.<sup>3,4</sup>

Here, we propose a dedicated program in Australian health policy that explicitly supports this undertaking. Internationally, the process has been referred to as “disinvestment”,<sup>5,7</sup> although it is not necessarily synonymous with the concept of “disinvestment”.

**Potentially ineffective health care practices**

A policy of identifying and assessing ineffective or non-cost-effective practices, reducing their existing use (and redirecting

- 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 multiple comorbidities.
- An opportunity exists for a cost-saving or cost-neutral agenda of reallocation of resources within the existing health budget, through reducing the use of existing health care interventions that offer little or no benefit relative to the cost of their 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

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

# Point of *Prioritisation*

- Cost (per procedure or volume)
- Variation (x3: Geographic, Provider, Temporal)
- Impact (health, disutility, liberation, equity)
- Cost-effective alternative
- Burden (high/low)
- Evidence (sufficient to offer utility, growing consensus)
- Futility
- Precedent
- Amenable to MBS item/pathway refinement!
  - ABIM Choosing Wisely Campaign?

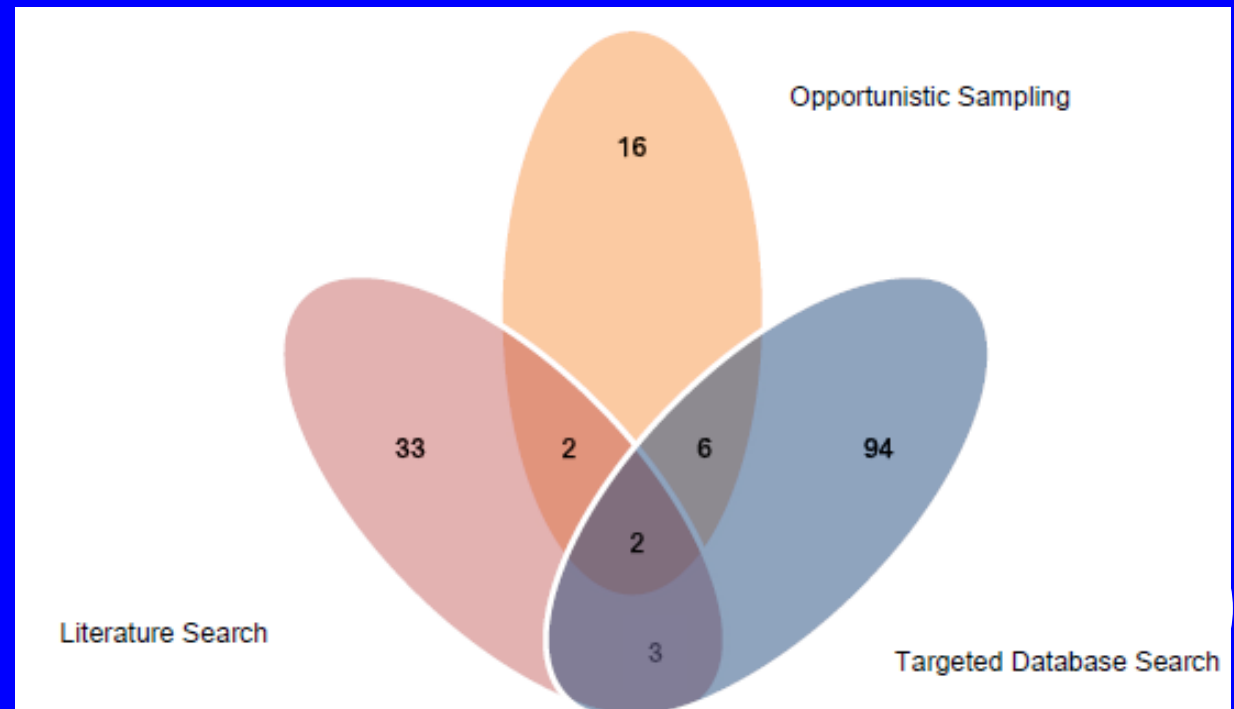
# Scanning & Prioritisation Project

(Elshaug, et al., *Med J Aust*, 2012)

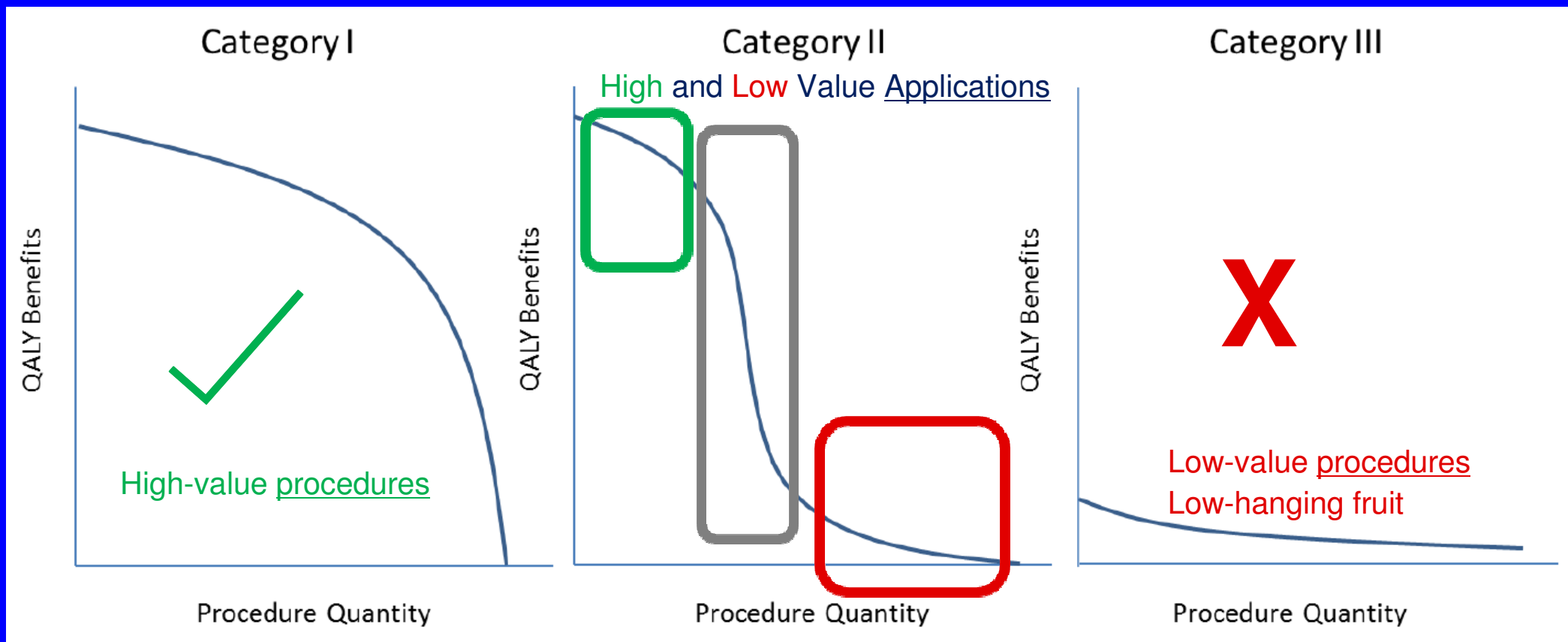
- Multi-platform approach
  - Broad Literature search;
  - Targeted database analysis (e.g. NICE, CADTH);
  - Opportunistic Sampling (e.g. clinical input)

- 156 Candidates

- 15 selected for rapid review

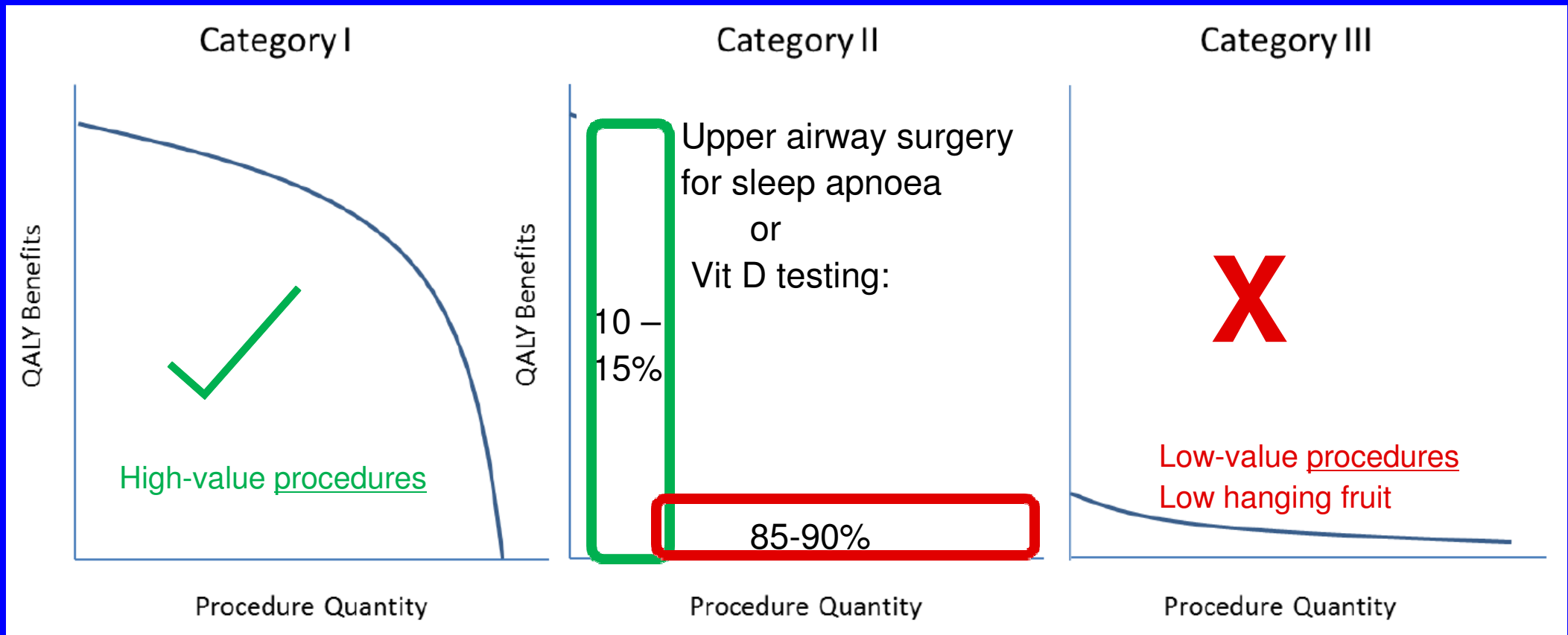


# Defining 'low-value' – for whom, when, with what confidence?



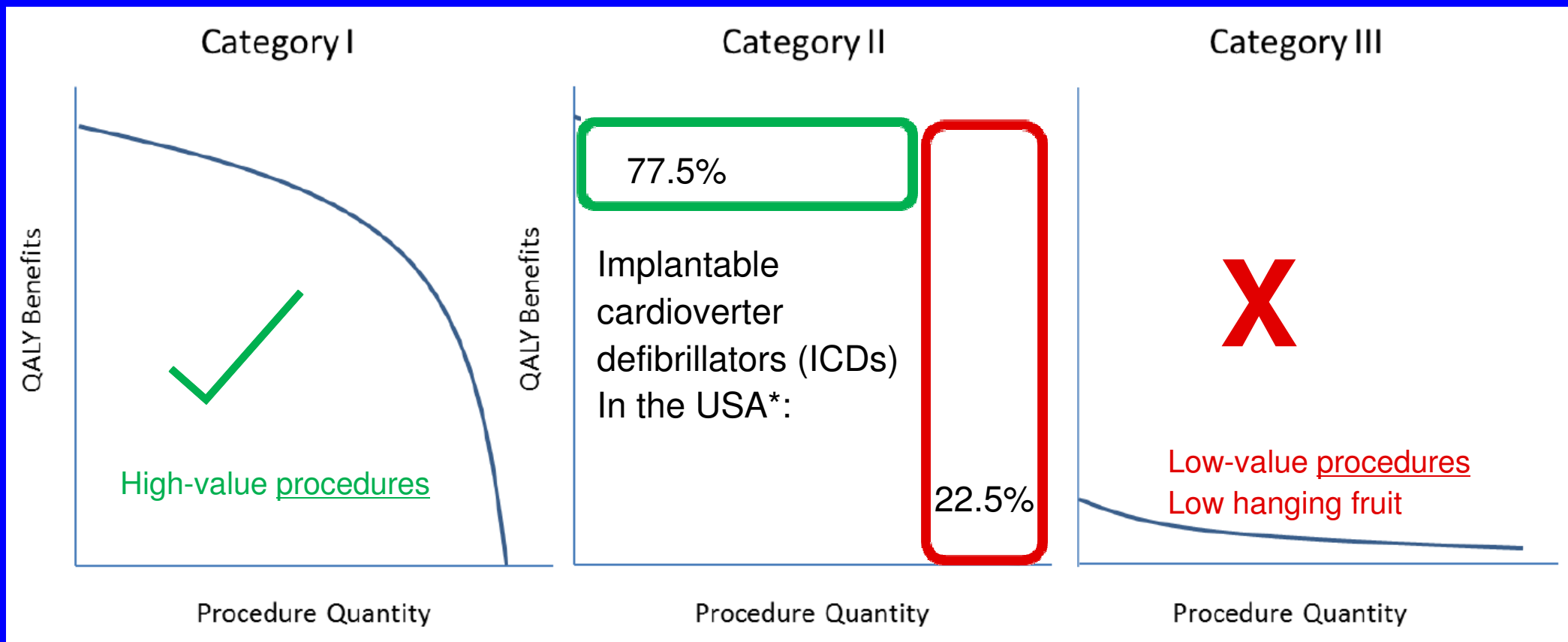
Skinner and Chandra typology of medical technologies with heterogeneous benefits. Costs of treatment are assumed to be constant across and within categories.

# High and Low Value Applications



Skinner and Chandra typology of medical technologies with heterogeneous benefits. Costs of treatment are assumed to be constant across and within categories.

# High and Low Value Applications



\*Al-Khatib et al. *JAMA*. 2011.

# Vertebroplasty: a case study



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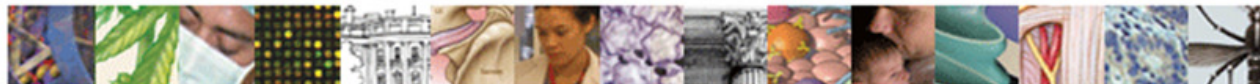
ISSUES ▾

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## Perspective

### How CER Could Pay for Itself — Insights from Vertebral Fracture Treatments

Adam G. Elshaug, M.P.H., Ph.D., and Alan M. Garber, M.D., Ph.D.  
N Engl J Med 2011; 364:1390-1393 | April 14, 2011

Article

References

The pain and disability caused by osteoporotic vertebral fractures have long motivated the search for effective therapy. Two procedures designed to restore vertebral body height and function have been widely adopted: percutaneous vertebroplasty, in which cement is injected into the vertebral body to support the fractured bone; and kyphoplasty, a variant of vertebroplasty in which a balloon is inserted and inflated in a collapsed vertebral body, restoring the bone's height before the cement injection. Initial studies suggested that these procedures were superior to conventional symptomatic treatment. But when later studies cast doubt on those favorable findings, health care funding agencies sought to curb their use. The story of these procedures offers a glimpse of the ways in which comparative-effectiveness research (CER) may influence medical practice and health care expenditures.



# Implementation Considerations:

- 1: High-level decision; formal policy agenda
- 2: Regulatory frame; transparent, independent
- 3: Resourcing of committees; existing or new
- 4: *a priori decision* goal posts (~uncertainty);
  - restrict use, reduce reimbursement, remove
- 5: Candidate selection; protocol driven
  - pre-specified, transparent criteria
- 6: Agreement on mechanisms/models
  - Guidelines / \$ levers / PBMA

# thank you

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