National Institute for Public Health
and the Environment
Ministry of Health, Welfare and Sport

Are we ready to disinvest?

research findings

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Introduction

- Relevant terminology in the field of low-value care and disinvestment

What do you think of when you hear the term low-value care?

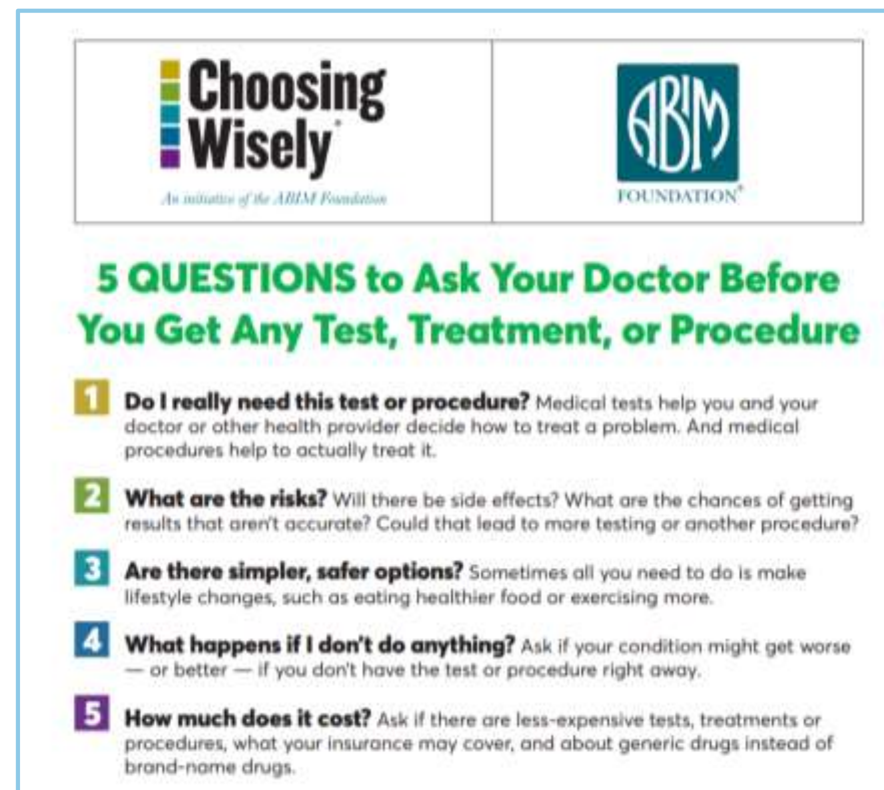
- Woordwolk associaties (mentimeter)

Low-value care

- Definition:
  - Healthcare practices (services and technologies)
  - that have been demonstrated
  - to provide little to no benefit overall
  - or that even cause harm
  - to certain patient groups

Low-value care: often used similar terms

- Choosing wisely
- "Gepast gebruik van zorg"= Appropriate use of healthcare
- "Passende zorg" = Appropriate care



Deimplementation

- Stopping and/or reducing low-value care
- Several types of deimplementation strategies
  - Clinician-focused:
    - Examples: guideline dissemination, clinical decision support, clinician education, alternative payment methods (e.g. pay for performance), behavioural nudges, clinician feedback
  - Patient/client-focused:
    - Patient cost sharing, patient education and shared decision-making, quality reporting to patients
  - System-focused:
    - Example: disinvestment
    - Disinvestment: full withdrawal, retraction, restriction or substitution of resources from healthcare interventions

Disinvestment decisions in the past

Background

- Basic benefit package
- Effectiveness, cost-effectiveness, necessity and feasibility

Previous disinvestment policy processes

Type of disinvestment	Main reason for disinvestment (according to policy documents):			
	Effectiveness	**Cost-effectiveness / budget cuts**	**Necessity**	**Feasibility**
Full disinvestment	NESS handmaster (2007)	Quit smoking interventions (2012)		Diane-35 pill (2014)
	Allergy-free covers (2009)	Medication Fabry disease (2013)	Stand-up-chair (2009)	Non-complicated extractions (2011)
	Acetylcysteine (2010)	Medication Pompe disease (2013)	Rollator, crutches, walker (2013)	Circumcision (2013)
	Psychoanalytic therapy (2010)	Ranibizumab (2015)	Contraceptives (2011)	
	Intravesical sodium chondroitin sulphate/ hyaluronic acid (2014)	Statins (2009)	Helmet therapy (2013)	
	Renal denervation (2017)		Second opinion (2016)	
	Radiofrequent denervation (2016)		Fax machines for auditory impaired (2009)	
	Contralum ultra (2016)		Maternity care assistance (2016)	
	Paracetamol-codeine (2013)		Intracavernous fentolamine /papaverine (2009)	
Restriction		Antacida (2012)	Dentist (2011)	Benzodiazepines (2009)
		Diet advise (2012)		
		Fertility treatment (2013)		
		Anti-depressants (2011)		
		Physiotherapy (2011 & 2012)		
Retraction			Incontinence products (2012)	
		Curative mental healthcare (2012)		
Replacement				

Aspects affecting the outcome of disinvestment policy processes

- Support
- Institutional role
- Financial interests
- The ability of patient groups to organize themselves
- Effect on current patients
- No consistent role of package criteria

Public preferences regarding disinvestment

- Views on disinvestment
- Preferences for disinvestment

Q-methodology

Viewpoints

Maintain reimbursement of necessary healthcare, even if it is expensive or only results in small health gains

Disinvest unnecessary, ineffective and inefficient healthcare

Transparent and consistent disinvestment decision-making processes

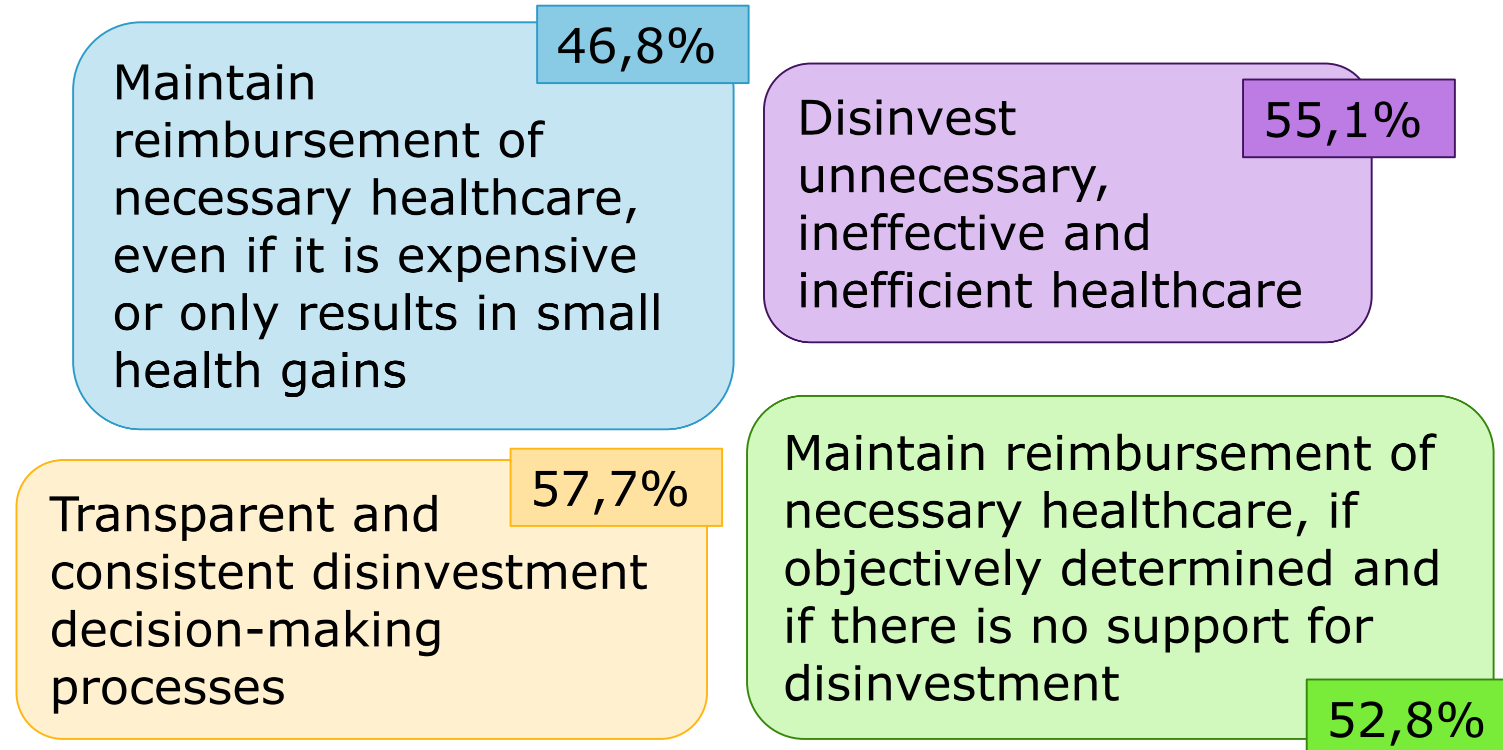
Maintain reimbursement of necessary healthcare, if objectively determined and if there is no support for disinvestment

Support for the viewpoints

Treatments that are necessary must continue to be reimbursed. Necessary treatments are treatments for critically ill patients, treatments that are listed in the medical guidelines and treatments that doctors believe to be necessary. If a treatment exists, it is morally unacceptable to deny it to a patient. Even if treatment has little effect, is very expensive, or if the quality of life is still poor after treatment, the reimbursement may not be discontinued.

- ❑ Completely agree
- ❑ Agree
- ❑ Agree a little
- ❑ Don’t agree, don’t disagree
- ❑ Disagree a little
- ❑ Disagree
- ❑ Completely disagree

Public support for the viewpoints



How would the general public make disinvestment decisions?

- Preference to disinvest treatments…
  - That do not have a large effect on quality of life and life expectancy
  - That are targeted at older patient groups
- Less savings > more savings
- Alternative treatment not relevant

RIVM onderzoek vergoeding van zorg

HELP | VERGELIJKEN | BEVESTIGEN

Rangschik op:

Te bezuinigen: 100M
Gerealiseerde bezuiniging:
Resterende bezuiniging: 100M

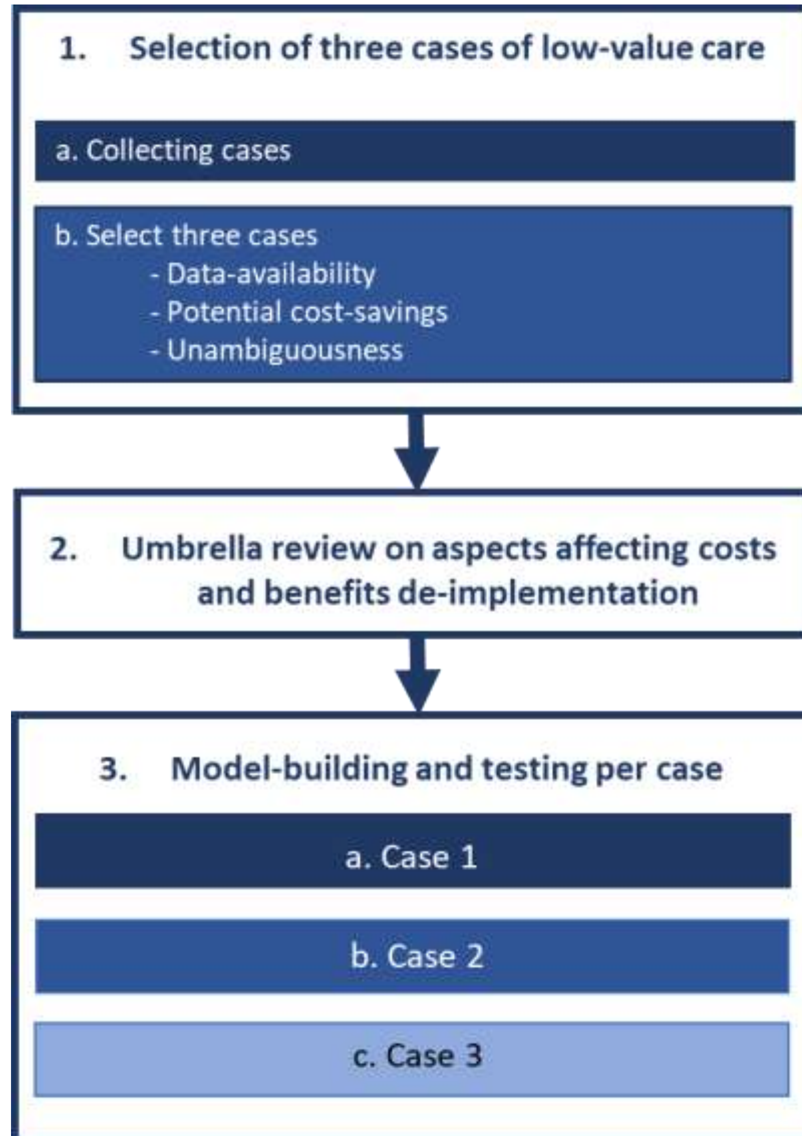
Bezuiniging	Naam	Vergelijken	Selectie	
75M	Behandeling 1			INFO
80M	Behandeling 2			INFO

Cost-savings of deimplementation

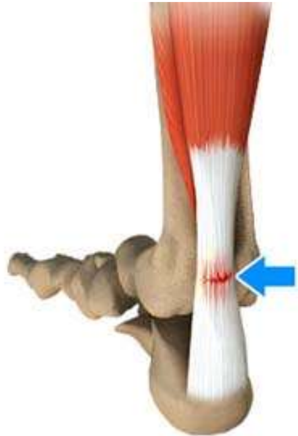
Background

- High expectations of the cost-savings that can be obtained from deimplementation
- Estimates of cost-savings of deimplementation
  - Simplistic modelling approaches
  - Do not take into account: substitution, subgroups and specificity of patient group
  - Focus on specific types of care
  - Calculated for other countries

Approach



Cases



Surgery for achilles tendon ruptures

Mammography for women <30 years with focal breast complaints

Imaging for non-specific low back-pain without alarm symptoms/red flags

Findings

- Feasible to develop a modelling approach
- However:
  - Collecting model input = time consuming
  - Interviews with stakeholders are essential
  - Many assumptions needed
- Societal benefits limited
  - Small number of patients
  - Low costs of the procedure
  - Need for substitution

Are we ready to disinvest?

- If it concerns ineffective and non-necessary care
- Decisions are made transparently and consistently
- Be aware of substitution
- Use multiple deimplementation strategies

Thank you for your attention!

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- For more information on the presented research:
  - See my PhD dissertation ‘Disinvestment decisions in healthcare: an exploration of mechanisms and considerations’.
  - Contact me