Challenges and Opportunities for Disinvestment in Australia

A need to evaluate the implementation and impact of Choosing Wisely in Australia

Rebecca Trowman Day[1], Richard Norman[1] and Suzanne Robinson[1]
1 School of Public Health, Curtin University, Perth, Australia.

Abstract

Purpose – Worldwide, there is significant growth in the cost of (and demand for) healthcare, which often clashes with a requirement to contain expenditure. This duality leads to an increasing need for a systematic approach to disinvestment in health technologies. The purpose of this paper is to consider the challenges and opportunities for disinvestment policy decisions in Australia. It discusses the implementation of the Choosing Wisely campaign and the need for rigorous evaluation of such campaigns in the Australian healthcare system.

Design/methodology/approach – The authors highlight characteristics of disinvestment: what it is and what it is not, and discuss international examples of identifying low value care, including the recent Choosing Wisely initiative. The authors discuss the barriers to implementing initiatives such as Choosing Wisely and the complexities in evaluating their effectiveness.

Findings – While the primary purpose of the Choosing Wisely campaign is improved decision making through clinical engagement, it is expected that implementation could lead to resource savings alongside improvements in patient safety and service quality. While there is research looking to understand the barriers and facilitators to the implementation of initiatives such as Choosing Wisely, little is known about broader patient impacts, and more attention on the quantification of their effect on both patient outcomes and resource use is needed.

Originality/value – This work highlights the limited knowledge around implementation of disinvestment strategies and the paucity of research around the impact of strategies such as Choosing Wisely in the Australian public hospital system. This is important as future research in this area will give greater certainty about the benefits and consequences of Choosing Wisely leading to improved opportunities for resource savings and patient safety and quality.

Keywords – Australia, Disinvestment, Choosing Wisely, Policy, Public Health
Paper type – viewpoint
The authors do not have interests to declare

Background

Internationally, there is a pattern of significant growth in both the cost of, and demand for, healthcare. Conversely, healthcare budgets, which had once enjoyed a reasonably protected proportion of Gross Domestic Product (GDP) that increased year on year, are now strongly constrained. The increase in costs and demand are in part due to the success of health systems across the world. People are living longer and require increased care over time. Equally, many diseases which were once associated with short life expectancy are now considered as chronic, requiring ongoing provision of care. On the demand side, patients and their families are also increasingly well-informed, and are more demanding of what is perceived to be the best (and often the newest) in health care technologies. The combined impact of these factors, namely changing epidemiology and disease diagnosis, technological advances and demand for access to the latest technologies from empowered patients is generally positive in terms of patient outcomes, but poses a challenge to the healthcare system. It requires considerable effort to balance these factors against the constraints on total expenditure that exist everywhere (Jackson and Hambleton, 2016).

As we are globally experiencing a period of slow economic growth, the desire to do more with fewer resources is seen across many healthcare systems throughout the world. This is likely to require the use of disinvestment. Elshaug et al., (2007: 2) described the ways of doing this as *'…the processes of (partially or completely) 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 are not*

efficient health resource allocations'(Elshaug et al., 2007). Use of the term disinvestment is becoming more common over time, and it is important to define both what it is, and what it is not.

Defining disinvestment

Disinvestment is not the cutting of clinically appropriate services for which a clinical need exists. Equally, it is not based solely on costs, and is not about cost shifting from health services to the patient or between hospital and community sectors. Disinvestment decisions should be driven by evidence on the safety, clinical and cost-effectiveness of practices and technologies with a focus on patient safety and quality of care. It also should be linked with resource reinvestment and reallocation; disinvestment from inefficient health care in one area can provide the opportunity to use funds to achieve larger improvements in patient health in another (Hollingworth et al., 2015). In identifying topics for disinvestment, the concept of value and the distinction between cost and value is important to consider: high-cost interventions may be of value if the benefits are large enough to justify the costs (Qaseem et al., 2012).

Various forms of disinvestment exist. These range from decommissioning or full withdrawal of services (for example closure of an emergency department) to restriction of services (for example treatment only for specified population subgroups) to retraction of services (for example reduction in funded IVF cycles) to substitution of services (for example replacement of acute beds with nurse led beds) (Daniels et al., 2013) Disinvestment can be described as passive or active. An example of passive disinvestment would be the natural attrition of interventions that were once common that have become outdated as new evidence emerges. Active disinvestment is the use of approaches to reduce the practice of unnecessary, inefficient or harmful interventions (Hollingworth et al., 2015). The use of active disinvestment is likely to pose more challenges for healthcare decision makers, but may also yield greater opportunities for redistribution of resources to higher value services. Given the current fiscal climate and rising healthcare costs and demands, health services are seeking opportunities to redirect funds to effective and efficient practices with an increasing focus towards active, rather than passive, disinvestment (Parkinson et al., 2015).

Identifying low-value care

There is an increasing body of activity seeking to identify and reduce the use of low-value healthcare that may deliver marginal or no benefits or even cause harm (Elshaug et al., 2012). Well-established examples that are reviewed and evidence-based include 'do-not-do' recommendation lists, which focus on ineffective, harmful or cost-*in*effective health care practices. The National Institute for Health and Care Excellence in England and Wales has been producing 'do-not-do' recommendations over the past ten years, and have identified over 800 interventions for potential disinvestment (Garner and Littlejohns, 2011). The Grattan Institute's 2015 report 'Questionable care: Avoiding ineffective treatment', is an Australian example of this approach and focused on five procedures delivered in Australian health services that could be potential topics for disinvestment with an emphasis on appropriate patient selection (Duckett et al., 2015). The current Medicare Benefits Schedule (MBS) Review has a key objective to eliminate the funding of low-value or inappropriate health services provided through the MBS. The Review identifies low-value care as being treatments of low or no clinical benefit provided to particular patient groups; as instances of extreme variation in the provision of care across different settings (not explained by patient characteristics); and when an (otherwise effective) test or procedure is performed at an inappropriate interval or frequency. The Australian Atlas in Healthcare Variation also identifies variation in healthcare use across Australia. However it does not indicate the degree to which the variation identified may be warranted or make any recommendations about the use of technologies or practices (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority, 2015).

The Choosing Wisely campaign

The Choosing Wisely campaign (which originated in the United States) is now attracting worldwide attention and is being implemented in many countries. The Choosing Wisely initiative aims to engage physicians and patients in conversations to identify tests, treatments and procedures that provide either no or limited benefit and in some cases may lead to harm (Levinson et al., 2014). The campaign encourages collaboration between medical colleges and societies and consumer groups to develop lists of practices to

be questioned. The lists are based on practices that are: frequently done or costly; evidence-based; within the control of the specialty and created using a transparent process (Wolfson et al., 2014). A possible reason for the high level of international interest in this campaign has been cited as the focus on value with regards to patient safety and quality of care rather than on costs (Levinson et al., 2014). In Australia, the Choosing Wisely campaign was launched in 2015 and is being facilitated by NPS MedicineWise, an "*independent, not-for-profit, evidence-based organisation*" that is funded by the Australian Government Department of Health and aims to promote the quality use of medicines and tests (NPS Medicine Wise, 2016). To date, over 20 colleges and national specialty societies are participating in the Choosing Wisely Australia campaign with an Advisory Group that inform the strategic development, implementation and evaluation of the campaign.

Creating lists and recommendations, as exemplified by the Choosing Wisely campaign, is part of the initial phase of identifying low value care. The bigger challenge now is prioritising and implementing disinvestments from these lists leading to a change in practice (Paprica et al., 2015). As the "*need for change is undeniable*" (Jackson and Hambleton, 2016), a campaign such as Choosing Wisely could, in principle, lead to the evidence-based 'de-implementation' of a range of practices. The term 'de-implementation' is defined as "*stopping practices that are not evidence-based*" (Prasad and Ioannidis, 2014) and is an emerging theme in implementation science. In order for Choosing Wisely to lead to practice change in a health system, Levinson et al (2014) have identified the principles of a successful Choosing Wisely campaign as being:

- clinician led (as opposed to payer/government or health system led; important for trust)
- patient focused (communication is key and should be used to facilitate a process of shared decision making appropriate for the individual patient)
- evidence-based (use of up-to-date evidence is important for clinician and patient trust)
- multi-professional (including also nurses and pharmacists for example)
- transparent (the processes used to create lists should be available and all conflicts declared).

Issues for, and criticisms of, the Choosing Wisely campaign include that, in creating lists of low value interventions, participating societies generally name practices conducted by other specialties as being of low-value (Morden et al., 2014). Morden *et al.* also note that revenue generating practices also tend to be omitted from the lists. Levinson et al (2014) stated that portraying the Choosing Wisely campaign as cost cutting or a 'rationing' exercise is likely to undermine both clinician engagement and patient/public trust in the whole campaign. An additional challenge will be appropriate provision of the patient and public education that will be critical to the success of Choosing Wisely. In order to reduce the use of practices listed in the recommendations, patient expectations (that have been shaped and reinforced by habitual overuse of health care) will have to be tempered (Morden et al., 2014). Another criticism leveled at campaigns such as Choosing Wisely, typically by clinicians, is that it is simply extrapolating generalised lists to individual patients, with the removal of the nuance of clinical judgment in individual circumstances. However the Choosing Wisely campaign states that the recommendations are a starting point for a conversation pertaining to most appropriate care for an individual patient (Wolfson et al., 2014).

Decision-making processes in disinvestment

There has been significant effort to develop criteria and processes that utilise the best available evidence to assess the safety, clinical and cost-effectiveness of the introduction of new health technologies. However, in contrast and reflecting the relative novelty of formal inclusion of disinvestment in public decision making, similar efforts have not been directed towards disinvestment of technologies that are ineffective or inefficient, or practices that have never been adequately assessed and are embedded in practice (Haas et al., 2012). There is also an inadequately broad literature detailing the de-implementation of established practices and knowledge about the barriers and facilitators to this. Specifically, with regards to de-implementation, Harvey and McInnes (2015: 312) state that "*…there is a need for more locally focused studies examining how de-implementation actually happens in practice and whether it really does mirror investment and implementation in reverse*" (Harvey and McInnes, 2015). In the current fiscal climate it is

imperative that optimal use is made of available healthcare resources to deliver quality care and improve patient outcomes, and disinvestment is likely to form a major part of achieving this goal.

The success of any health policy is dependent on a number of barriers and enablers. Many interventions considered effective at a research level fail to translate into meaningful patient outcomes in practice (Damschroder et al., 2009). Particularly if a policy seeks to "disinvest" it will require sensitive implementation for the full benefits to be realised (Dickinson et al., 2011). A challenge for disinvestment is that ceasing (or not recommending) a service is a greater challenge than introducing one. It is essential that the process of making such decisions is collaborative, involving health-care providers and policy-makers (Rooshenas et al., 2015). In 2013, the Health Policy Advisory Committee on Technology (HealthPACT) held a workshop titled 'Disinvestment in Australia and New Zealand' (HealthPACT, 2013). Key messages from this workshop were that the engagement and timing of consultation with the clinical community (with quality and safety being key levers to engagement) is critical to ensuring appropriate consideration, prioritisation and de-implementation of a technology or clinical practice.

The success of a campaign such as Choosing Wisely could be defined as change in practice and outcomes associated with the individual recommendations; at the highest level, the aim of Choosing Wisely is to reduce unnecessary care, to avoid harm and to decrease waste. In order to achieve this, it will be necessary for the system itself to be influenced and clinician attitudes and behaviour will need to change, and patients will have to accept that more is not always better. However, the campaign aims to be more than "*the sum of the individual recommendations*"; it has been developed to effect change in medical practice on a much broader scale and to set the stage for a cultural shift and reform (Wolfson et al., 2014). In order for this to happen, the campaign has created minimal rules and principles and provided maximum flexibility and needs to instill a sense of trust in both clinicians and patients, and most importantly will require "*skill and time*" to demonstrate success (Morden et al., 2014). While some research has examined the implementation of the Choosing Wisely campaign across the world, little data exist regarding the impact of the Choosing Wisely campaign on healthcare resources and patient outcomes at the hospital level (Colla et al., 2016). Successful implementation of an intervention such as Choosing Wisely may have a wide range of effects on patient outcomes and clinical processes. This is challenging, as measurement of total impact will have to reflect the complexity (Levinson et al., 2014) and an integrative approach will be required (Bhatia et al., 2015). A mixed method approach that evaluates the process, barriers and facilitators of implementation of Choosing Wisely at the hospital level is needed. This could draw on recent advances in implementation science that could help with exploration of sustainable uptake, adoption and implementation of evidence-based approaches. Additionally, a detailed analysis of the impacts of Choosing Wisely, such as on the patient experience and outcomes and on healthcare resource utilisation is needed.

Thus, future research is required to answer many questions pertaining to the process, impact and outcomes of the Choosing Wisely campaign. This will be best addressed with a collaborative approach that allows for exchange and sharing of national and international approaches to research and knowledge transfer. The agenda should include detailing the change management processes and actual change in use and possible disinvestment in technologies resulting from the implementation of a Choosing Wisely campaign at the hospital level; that is, how efficient and effective is Choosing Wisely in practice? The effects on the patient experience, outcomes, safety and quality must be examined and understood: including whether there are any negative or unintended consequences for patients (for example any negative effects on the patient-doctor relationship or negative patient experiences of not being offered an intervention). Resource use resulting from the Choosing Wisely campaign must also be evaluated to ascertain whether resources are freed up as a result of the campaign, and importantly whether any saved resources are effectively fed back to that service, and whether other areas (such as allied health) suffer any consequences. In addition, *"measurement and evaluation of the campaign's impact on attitudinal and behavioural change is needed"*(Wolfson et al., 2014). Research such as this, focusing on the evaluation, will inform clinicians and patients as to the incentives for participating in the Choosing Wisely campaign. This will subsequently decide its future success; that is a shared dialogue leading to improvements in patient safety and quality of care with the possibility to address the resource challenge faced by all.

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