Reconciling disinvestment and adoption decisions: new proposals for technology decisions

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Outline of Session

Don
• Current approach for technology decisions = recipe for expenditure growth
• Why not just disinvest?

Chris
• Identifying low value services for disinvestment
• Some potential models for reconciling disinvestment and adoption
• But will they work?
Objectives

1. Understand shortcomings of current approaches
2. Understand what opportunities might exist and advantages disadvantages of each
3. There is no third objective
Current Approach to Decision Making

Meeting 1
- Drug A
- Decision A
- Revisit A
- Drug B
- Decision B
- Revisit B
- Drug C
- Decision C
- Revisit C

Meeting 2
- Drug A
- Decision A
- Revisit A
- Drug B
- Decision B
- Revisit B
- Drug C
- Decision C
- Revisit C

Meeting 3
- etc.
- Decision A
- Revisit A
Current Approach to Decision Making

- The use of health technology assessment (HTA) to support decision making is largely focused on adoption (or investment) decisions.

- This “add-on” approach will inevitably result in *expenditure growth*.

- Why?
  - There is a natural flow of HTA-informed adoption decisions – push from companies and pull from payers – few candidates referred to disinvestment.
  - Misconceptions about disinvestment.
  - Decision-makers are still faced with separate disinvestment and technology management decisions which are difficult to implement in hindsight.
Current Approach to Decision Making

Example 1, Two drugs for same population:

Meeting 1: Drug B, Positive recommendation

Meeting 5: Drug C, Negative recommendation

BUT INCREASED KNOWLEDGE AND ALTERNATIVE IS GENERIC – DISINVESTMENT OPPORTUNITY?
Opportunity Cost?

The >$150 million spent annually on blood glucose test strips among patients with type 2 diabetes who are not using insulin could be used to pay for.............

OR

2,200 nurses

2,800 dieticians/nutritionists

Universal coverage of insulin for all patients with type 1 diabetes in Canada.. and then some....

OR

All oral Diabetes medication
Why not just disinvest?

- Clinical heterogeneity
  - May be cost-effective for someone

- Loss aversion
  - a $5 cash discount, or avoid a $5 credit card surcharge

- Political, clinical and social challenges

- Requires resources

Solution – bargaining

- Solution is to support decision makers by making simultaneous adoption and disinvestment recommendations.

- Example – generic price cuts
  - 35% to 65%
  - Increased dispensing fees in some jurisdictions
  - Opportunity costs?

  “Additionally, these price reductions will result in savings to our government that will help enhance patient care for seniors and families.”

  “…price cuts will generate enough savings to raise social assistance and disability payments by 1 per cent each.”
Disinvestment

Systematic, transparent, HTA-based approaches to identify feasible ways to release funds from low-value services/technologies to fund high-value services/technologies
Disinvestment – Not just taking things away

- Price negotiation
- Restricting use
- Reducing frequency of use
- Incentives – copays, reference pricing?
- Increasing use of drug reviews to revisit decisions
- Delist??(!)
### How do we identify ways to release funds from low-value services/technologies?

<table>
<thead>
<tr>
<th>Identifying adverse events of drugs/technologies</th>
<th>Identifying ways to release funds from low-value services/technologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers and health professionals submit reports voluntarily</td>
<td>Consumers, health professionals submit disinvestment topics voluntarily</td>
</tr>
<tr>
<td>Manufacturers are required to submit reports</td>
<td>Manufacturers are required to submit disinvestment topics as part of CDR Process</td>
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<tr>
<td>Data mining spontaneous reports</td>
<td>Data mining formulary and hospital budgets to identify potential disinvestment topics</td>
</tr>
<tr>
<td>CADTH, drug plans and Health Canada submit topics to <strong>CIHR Drug Safety and Effectiveness Network</strong></td>
<td>HTA groups, drug plans, hospital-based HTA units submit topic to <strong>Coordinating HTA Group/Funded research network</strong></td>
</tr>
<tr>
<td>Researchers/collaborators of <strong>CIHR Drug Safety and Effectiveness Network</strong> submit topics</td>
<td>Researchers/collaborators of <strong>Coordinating HTA Group/Funded research network</strong> submit topics; other sources (e.g., Choosing Widely)</td>
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</tbody>
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**Passive Surveillance**

**Active Surveillance**
Prioritizing Disinvestment Topics

- Economic Impact
- Health Impact
- Feasibility

Low value services with smaller budget impact and feasibility issues:

- Time & Effort

High-level HTA-based assessment of disinvestment option:

- Detailed HTA-based assessment of disinvestment options
Reconciling investment and disinvestment

Disinvestment option repository
- Low value service (e.g., ICER>100K)
- Feasible to disinvest

Investment Decision
- High value service (e.g., ICER<20-30K)

Payer
Better accounting of costs and benefits (and timing)

- Costs/cost-savings to payer (e.g., hospital or drug plan)
- Costs/Cost-savings to broader healthcare system
- Costs/Cost-savings to patients/society
Reconciling investment and disinvestment

Disinvestment option repository

- Low value service (e.g., ICER > 100K)
- Feasible to disinvest

Payer 1
- Option 1
- Option 2
- ....
- Option N

Payer 2
- Option 1
- Option 2
- ....
- Option N

High value service (e.g., ICER < 20-30K)
Models for reconciling investment and disinvestment

- Technology compared to other technologies within disease area and budget
- Technology compared to other technologies within disease area
- Technology compared to all other technologies within the budget
- Technology compared to other technologies within health system
Model A

• Technology compared to other technologies within disease area and budget
  • e.g., compare all drugs for diabetes funded by a drug plan

• Advantages
  – Simple, intuitive, easier for producers to supply options, easier for analysts

• Disadvantage
  – May promote health system inefficiency (assumes resources constrained to disease area)
Model A

- Low value service (e.g., ICER > 100K)
- Feasible to disinvest

Disease Area
- Disinvestment Option 1
- Disinvestment Option 2
- ... (omitted)
- Disinvestment Option N

Payer
- High value service (e.g., ICER < 20-30K)
Model B

- Technology compared to other technologies within disease area
  - e.g., compare drug to surgical procedure in same disease area

- Advantage
  - Intuitive, easier for applicants, analysts

- Disadvantage
  - Need system of transfer payments; still only considering one disease area which may be inefficient
Model B

- Low value service (e.g., ICER>100K)
- Feasible to disinvest

Payer 1
Option 1
Option 2
...
Option N

Disease Area

Payer 2
Option 1
Option 2
...
Option N

Transfer of funds

Payer 1

High value service (e.g., ICER<20-30K)

Payer 2

High value service (e.g., ICER<20-30K)
Model C

- Technology compared to all other technologies /services within the budget
  - e.g., compare all drugs to all other drugs in drug plan; all technologies to other technologies within a hospital/region
- Advantage
  - No transfer payments, better for expenditure control
- Disadvantage
  - Less health system efficiency (assumes resources constrained to budget), more reliant on active surveillance, less intuitive if services different

Model C

- Low value service (e.g., ICER>100K)
- Feasible to disinvest
Model D

- Technology compared to other technologies within health system
  - e.g., all technologies compared to all technologies by all payers
- Advantage
  - Greatest system efficiency(?), best for expenditure control
- Disadvantage
  - Requires coordination within health system including transfer payments, complex analysis required, most reliant on active surveillance, less intuitive if services different
Model D

- Low value service (e.g., ICER > 100K)
- Feasible to disinvest

Payer 1
Option 1
Option 2
Option N

Payer 2
Option 1
Option 2
Option N

Payer 1
High value service (e.g., ICER < 20-30K)

Payer 2
Transfer of funds

High value service (e.g., ICER < 20-30K)
Advantages and Impact

Ontario quietly cuts funding for diabetics’ blood-sugar test strips
Ontario reducing funding for blood-glucose test strips after research shows they have limited benefit for diabetes patients not taking insulin.

The move, which takes effect Aug. 1, will save the province up to $25 million annually and will affect mostly non-insulin dependant diabetics who are reimbursed for strips under the Ontario Drug Benefit Program.

CADTH Annual Budget $22 million
Thanks

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