Disinvestment: the disconnected UK view

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NICE resource impact templates

Principles

- Resource impact is the financial change from implementing guidance
- Standard accounting principles apply

- Only direct consequences of implementing guidance – avoiding future admissions is NOT included (para 4.2.5)
- Only services funded by NHS
- Can also report on impact on workforce / infrastructure / training

Emphasise ‘consistent with’ cost-effectiveness But different

The local payer view

In my hospital:

- 15% of costs are medicines
- 70% of costs are staff costs
- 15% are overheads (costs of buildings, admin, etc)

Most staff are on long-term employment contracts, so a fixed cost

If I need to save money fast I freeze staff vacancies and squeeze the medicines budget

My effective financial planning runs to the end of this year. I don't know next year's budget, but already have a list of cost pressures

What does 'disinvestment' mean to me?

Three examples, where new medicine:

- Replaces an existing medicine, so I save money on my 'recurring' costs
- Reduces the additional amount I would otherwise have to have spent, so my planned increase is reduced
- Prevents clinical events so doctor, nurse time etc is freed for other uses (or to be unemployed, or under-employed)

From my budget-holder view these are high, medium, and low value respectively

My definition / assessment of 'disinvestment' also depends on when it will occur and with what degree of certainty

Examples

- Biosimilar for adalimumab at lower cost – high value. Cash-releasing today
- HCV meds that avert liver transplants in 2038 – low/zero value. Distant future, not cash releasing, not my budget
- Oral anticoagulants reduce need for INR monitoring service – low value. Costs to redeploying staff and unclear how much I can reduce capacity
- COPD medicine that reduces ER attendances in my hospital by 400 per year – low/medium value. Could avert pressure to appoint more staff
- Medicine for a rare disease that reduces ER attendance by 1 – zero value

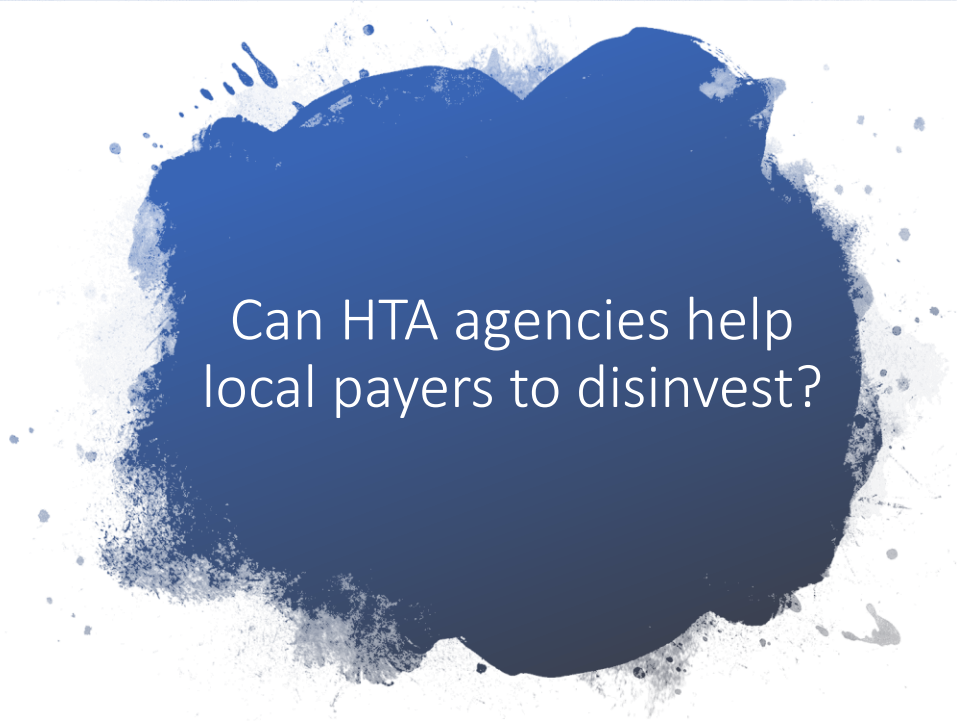
My local payer opinion of HTA agencies?

Some value as a gate-keeper, but do not live in the real world

- Include resources freed at full average cost, not variable cost
- Do not consider scale on which resources are freed
- Do not consider costs of redeploying resources
- Average cost may not reflect true value of resources freed – I do not value freeing up dermatology time but I do value freeing intensive care time

If I was in charge, I would only consider financial costs and cash savings over a 5-year period (and compare to QALYs gained)

I would also set the 'cost per QALY' target at a level that reflects the lost care when we have to strip money from existing services to fund new medicines



Smiling person from NICE arrives

- HTA agency: You want cash savings – I can identify treatments that have no proven clinical value. Does that help?
- Local payer: Hmm. You tell me treatment X should stop. I go to the relevant clinicians and they either say “We agree, that’s why we don’t do it here” or “The agency is wrong, they do have value and we can show evidence to counter that” so at best implementation is costly & controversial and at worst my time is wasted.
- HTA agency: What if we identified things you pay for now that are not cost-effective?
- Local payer: Same problem. If my hospital is doing a lot of the thing you identify, I can start to ‘squeeze’ that through commissioning. //

Local payer in full flow!

- Local payer: However, if I stop doctors doing something that doesn't work then they go and do something more expensive instead, so I try to stop anyone doing anything. I'm just keeping the lid on!
- HTA agency (regretting having ever asked): So what CAN we do?
- Local payer: First, tell the people who set my budget I need a 10% increase each year just to implement everything your HTA agency recommended. Then give me a one-off increase of 50% to replace all the services that have been cut-back over the last 20 years to fund your previous 'advice'. And stop calling it 'advice' when I do not have any choice on implementation. Finally, when you make decisions ignore all pharma claims about savings, because I never see them.

NICE person edges towards door

- HTA agency (defensively): Didn't you get our spreadsheet with the horizon scanning for future cost pressures? We colour coded each one based on the size of impact, into red, yellow or green!
- Local payer: Yes, I got it – you told me your 'advice' would cost me £30 million to implement. My actual uplift (new money) for this year was £10 million and most of that went on the national pay increase for staff. So how did your spreadsheet help me with the £27m gap?
- HTA agency: Well, the colours were pretty, did that cheer you up?
- Local payer: Yes, knowing I was drowning in 50 metres of water rather than 30 metres was very helpful.

Where does this leave pharma companies?

Some thoughts

Read the NICE guidance on resource impact!

Don’t tell local payers your new medicine will pay for itself unless it replaces something more expensive on Day One and releases cash

But you can have discussions with NICE about long-term savings, as usual

Recognise while NICE may not always seem ‘nice’, in relative terms they really are The Nice Guys of the NHS – it could be far worse