What is low-value care?

- Clinically
  - Evidence of lack of clinical value
  - Evidence of harm
  - Poor risk-benefit profile in mild cases
  - Effective only for sub-groups
  - Less likely to work than alternatives
- Economically
  - Less cost-effective compared to alternatives
- Societal values: ‘cosmetic’ interventions
- Uncertainty
  - No evidence
  - Weak evidence
- Variation in practice
How do we remove it?  
Disinvestment

• …relates to the processes of withdrawing (partially or completely) health resources from any existing health care practices, procedures, technologies and pharmaceuticals that are deemed to deliver no or low health gain for their cost, and are thus not efficient health resource allocations.

• …view to re-allocation/re-investment towards technologies, practices and programs with greater demonstrated (cost-) effectiveness


Fixed budget and opportunity cost
NHS chief tells trusts to make £20bn savings

The head of the NHS has told senior managers to plan for spending cuts even more drastic than those already thought to be on the way.

By James Ball and Patrick Sawyer
9:00PM BST 13 Jun 2009

NHS trusts will have to deliver between £15 billion and £20 billion in efficiency savings over three years from 2011 to 2014, David Nicholson, the NHS chief executive, told health service finance directors in a speech delivered behind closed doors.

The steep cuts would be equivalent to up to six per cent of the current
“Many of the most significant opportunities to improve productivity will come from focusing on clinical decision-making and reducing variations in clinical practice.”

“For commissioners there are critical decisions about the allocation of resources that have to be addressed …… The key areas of focus should be reducing spend on low-value interventions and re-designing pathways (especially for people with long-term conditions) to avoid unnecessary hospital admissions. Integrating care across health and social boundaries is an important element of pathway design.”

---

**Figure 1: National spending on low clinical value treatments on the Croydon list**

<table>
<thead>
<tr>
<th></th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective interventions with a close benefit/risk balance in mild cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially cosmetic interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective interventions where cost-effective procedures should be tried first</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatively ineffective procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancelled procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

£ millions

1,400
1,200
1,000
800
600
400
200
0
Disinvestment from low value clinical interventions: NICEly done?

Over the past 10 years NICE has identified over 800 clinical interventions for potential disinvestment. But Sarah Garner and Peter Littlejohns report that although disinvestment will increase efficiency and quality, the opportunity for cash saving is unlikely to meet the necessary targets.
The NICE ‘Do Not Do’ Database

NICE ‘do not do’ recommendations

What are the NICE ‘do not do’ recommendations?

During the process of guidance development NICE’s independent advisory bodies often identify NICE clinical guidelines where certain interventions, or treatments should be avoided. These recommendations are identified by the label ‘do not do’ or ‘do not use’. They may be due to evidence that the practice is not recommended or is considered unsafe. This may be due to evidence that the practice is not considered effective or cost effective. If evidence to support the clinical effectiveness of an intervention or treatment is lacking, then an expert judgement has been used. This list of recommendations has been published as part of the NICE ‘do not do’ recommendations database.

What is the NICE ‘do not do’ recommendations database?

The NICE ‘do not do’ recommendations database contains all the ‘do not do’ recommendations that have been made since 2000. These have been extracted from NICE’s various guideline documents, clinical guidelines, technology appraisal guidelines, and other clinical guidance. They will be updated and replaced as new guidelines are published.

Each record contains the ‘do not do’ recommendation and includes additional information, including the recommendations, health topic, the guidance it comes from (with a link to the relevant paragraph in the guidance) and the other ‘do not do’ recommendations from the same guidance. Each record also includes the health care setting that describes the main clinical context in which the intervention or investigation may be undertaken. The health care setting is subject to vary according to local arrangements.

Search the NICE ‘do not do’ recommendations database.

What about ‘do not do’ recommendations before 2007?

NICE introduced optimal practice review recommendation reminders in December 2006, as part of a set of NICE clinical guidelines.

URL: http://www.nice.org.uk/usingguidance/donotdorecommendations/index.jsp

• Clicking on an individual ‘do not do’ recommendation, opens up a full record with further details about the recommendation with its context from the guideline.
Summary Results (1)

Since 2003 NICE has produced 797 recommendations for either complete disinvestment of interventions or restricting from routine use.

The overwhelming majority of the collection (over 95%) are recommendations from clinical guidelines.

NHS Evidence QIPP Case Studies

- Mainly identified by practitioners in the field
- Quality assured according to a range of criteria: savings, quality of care, evidence of change, ease of implementation
- Over 100 case studies published
- 2-3 new studies each month
- Right care, long term conditions and planned care most topics within QIPP work streams
NICE and Cochrane working together

Significant savings with specific guidance

<table>
<thead>
<tr>
<th>Guideline Number</th>
<th>Short Title</th>
<th>Why does this guidance saves money?</th>
<th>Estimated saving per 100k (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG20</td>
<td>Hypertension (July 2019 update of CG19)</td>
<td>The recommendations update previous guidance on prescribing drugs for hypertension. Follow-up review will ensure recommendations reflect more in drugs, but this is far outweighed by the predicted number of cardiovascular events (heart attacks and strokes) that would otherwise be prevented. Better controlled.</td>
<td>446,627</td>
</tr>
<tr>
<td>CG220</td>
<td>Contraception - non hormonal contraceptives</td>
<td>The recommendations refer to women seeking contraception an informed choice and access to long-acting reversible methods. These methods are more reliable than the pill and do not require daily compliance. The additional cost of providing these methods is more than offset by the costs of unplanned pregnancies (induced terminations or reduced births).</td>
<td>214,051</td>
</tr>
</tbody>
</table>
Difficult to say no

GUIDELINES
Prophylaxis against infective endocarditis: summary of NICE guidance
Roberta Richey,1 David Wray,2 Tim Stokes,1 on behalf of the Guideline Development Group

Commentary: Controversies in NICE guidance on infective endocarditis
Mark Connaughton

The recommendations are undoubtedly flawed in not providing positive indications of when to give antibiotics. However, they are clear and based on the most detailed available review of the admittedly imperfect evidence.

BMJ 2008;336:771
The BCS contributed to the development of the NICE guideline in its capacity as a registered stakeholder and has hosted discussions on the guidance at meetings of its Executive, Board and Council. In all these deliberations there has been broad agreement on a number of points:

a. The available evidence is not conclusive or definitive.
b. The evidence that we do have suggests that, on first principles, antibiotic prophylaxis is likely to be ineffective.
c. It would be very unfortunate if credible authorities produce contradictory guidelines (the new NICE guidance is broadly in agreement with current American Guidelines, forthcoming ESO guidelines, and the existing British Society for Antimicrobial Therapy guidelines).
d. It is essential to monitor the impact of any change in practice by monitoring the incidence of infective endocarditis closely.

In the light of all this the Officers of the BCS have concluded that we should endorse the new NICE guidance whilst recognising that it may create difficulties for some cardiologists and patients. We anticipate that most practising cardiologists will no longer recommend antibiotic prophylaxis to new patients but will not necessarily advise existing patients, some of whom have had the need for antibiotic cover drummed into them over many years, to abandon the practice instantly.

We wish to continue with antibiotic prophylaxis to be allowed to do so. Indeed, in the absence of definitive evidence, the Society views this issue as "a matter of conscience" and will support any member who chooses to recommend antibiotic prophylaxis in selected circumstances.
Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended.

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention.

- Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.
Do not Do….otitis media with effusion

• **Antibiotics**
• **Topical or systemic antihistamines**
• **Topical or systemic decongestants**
• **Topical or systemic steroids.**
• **Homeopathy**
• **Cranial osteopathy**
• **Acupuncture**
• **Dietary modification, including probiotics**
• **Immunostimulants**
• **Massage**

---

**NICE : lessons learnt**

• NICE issues disinvestment guidance
  – Over 800 to date
• Very few candidates for total disinvestment
  – Antibiotics/ Diagnostic tests ?
• New things implicitly replace old things: evaluation required
• Refocus (sub-group targeting)
• Lack of evidence
• Clinicians often want more data to say “No” than to say “Yes”
• Data on usage difficult to obtain.
• “values” vs. “scientific judgements”
How do we stop?

- Identify the interventions and evaluate evidence
- Get agreement amongst stakeholders
- Geographical consensus
- Strong leadership and political support
- Involvement of financial staff
- Monitoring
- Process for ‘exceptional cases’
- Communication
- Incentivise?

Implementation: proposed solutions

- Complete removal from funding schedules
- Tighten or restrict indications associated with coverage/reimbursement:
  - Restrict providers to ‘centres of excellence’
  - Reduction in fee/reimbursement due to technological advancement
- Partial reimbursement/value-based insurance design:
- Risk-sharing / bundled payments / practitioner reimburses payer
- Reimbursement only for guideline adherence:
- Compulsory review of all technology, however introduced
- Sunset clauses
- Concurrent specification of what is to be removed from funding when any new practice or technology is first funded
"Conventional medicine says take aspirin. In the absence of tort reform, defensive medicine says MRI and Cat Scan."