International Journal of Technology Assessment in Health Care, 30:1 (2014), 1–2.

doi:10.1017/S0266462313000743

Editorial

ART OF THE POSSIBLE?

Sarah Garner
National Institute for Health and Care Excellence London, UK

It is very fitting that the strap line for the article on reassessment (1) is derived from the quote "politics is the art of the possible" attributed to Otto von Bismarck. Bismarck was the first chancellor of the unified German Empire that preserved peace in Europe until 1914. Politically deft, he persuaded the southern German states to join with his North German Confederation by provoking hostilities with France.

The article in a similar vein attempts to find a politically acceptable way to move forward with the "disinvestment" agenda. The need for disinvestment is pretty uncontroversial (2); demand is outstripping supply, and we need to ensure that healthcare resources are spent on interventions that are of clinical value. In some jurisdictions, they also need to be cost-effective. Arguably we also have a moral duty not to use things that are of no value, particularly when they expose patients to the risk of harm. If we are requiring new technologies to undergo stringent assessment then we need to apply those same rules to established technologies. But given this is all common sense, why has disinvestment proven so difficult in practice?

The first thing you learn as a researcher in this area is that any discussion on disinvestment starts, and invariably finishes, with lengthy objections to the terminology. As the authors point out the term "disinvestment" is considered by some to be unpalatable and divisive. Sponsors are concerned that their intervention is even potentially considered to be of questionable value, pre-empting subsequent review. Clinicians do not like the implication that their practice could be potentially substandard and there is always the counter-argument that it could be useful for somebody. The rule of rescue is always emotive but viewed from another perspective "Pleading from subgroups and "judicious selection" is always the last refuge of a failing intervention" (3). Researchers and policy makers have, therefore, turned to terms such as optimal practice reviews, low-value health care, reinvestment, and my particular favorite, reducing ineffective practice (RIP).

The authors of the article have proposed a new "value-neutral" framework for disinvestment that they have termed "health technology re-assessment." The stated differentiating factors between assessment and reassessment are type of technology under review and their greater focus on implementation; stopping something is always more difficult that starting. The authors have not identified any differences in the actual technical methodology that will be required. However, beyond the known issues to deal with a lack of evidence, there has never been a suggestion that new HTA techniques would be required. One barrier to the adoption of "re-assessment" is that the term suggests that an initial assessment has been done, which for legacy technologies is invariably not the case.

A very real consequence of the plethora of terminology is that it is very difficult to share experience and target technologies. Discussions with the NELM, the U.S. organization in charge of the MESH headings that are used to index the medical literature, have failed to get a separate sub-heading created. This, coupled with publication bias, makes it nearly impossible to proactively identify candidates through the medical literature. Indeed the concept has proven difficult to convey to U.S. audiences where there is an apparent political paranoia that even stopping technologies of no proven value could be portrayed as rationing. Researchers have, therefore, established their own network under the auspices of Health Technology Assessment International (4). The network is agreeing to a set of author-provided keywords to be submitted to journals to enable indexing.

As many similar articles have done, the authors have identified the need for political support. Even between the two examples provided the contrast is quite marked. In Australia the government has provided full support and strategy with parallel academic work incorporating deliberative stakeholder engagement (5). The structure of the payment system is such that payment codes can simply be removed as one extreme or have their indications refined in a nuanced manner so that technologies are better targeted toward high-value uses. In contrast, in the United Kingdom, the only enforceable aspect of NICE's guidance is that the NHS has to provide funding for cost-effective technologies through the appraisals program within 3 months. All other recommendations are merely guidance (6). This, coupled with the lack of a reimbursement system in secondary care, means that any controls have to be put in at a local level.

A call to action is presented which will resonate with the HTA community. Many of the identified needs also apply to HTA and the interplay between the two similar agenda's needs careful management. HTA bodies are already struggling to manage the new entrants, which have a very visible potential budget impact. The paucity of evidence base for many potential disinvestment candidates presents a quandary. Most research

funders will be unwilling to fund a RCT of an outdated treatment in preference to a more current question. Yet there is a reluctance to make an explicit decision between continue funding or to stop. Real-world evidence of effectiveness, or lack of effectiveness, may provide a potential solution but the development of methods is required.

Ultimately, perhaps the only strategy that may work for disinvestment is to financially or otherwise incentivize people to stop or make it more difficult to do use something without authorization. Following von Bismarck's strategy maybe sponsors and clinicians could be required to suggest disinvestment options to match the budget impact of new technologies they want to introduce? Such "directed displacement" could avoid irrational "slash and burn" techniques that are being implemented to manage budgets; for example, stopping clinically and cost-effective elective surgery.

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https://doi.org/10.1017/S0266462313000743 Published online by Cambridge University Press