Health Policy 110 (2013) 180–185

Contents lists available at SciVerse ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Disinvestment in the age of cost-cutting sound and fury. Tools for the Spanish National Health System

Sandra García-Armesto[a,b,d,*], Carlos Campillo-Artero[c], Enrique Bernal-Delgado[a,d]

[a] Health Services and Policy Research Unit, Health Sciences Institute in Aragon (I+CS), Spain
[b] Fundación ARAID, Spain
[c] Balearic Islands' Regional Health Service, Spain
[d] Red de investigación en servicios de salud en enfermedades crónicas (REDISSEC), Spain

ARTICLE INFO

Article history:
Received 15 March 2012
Received in revised form
17 December 2012
Accepted 10 January 2013

Keywords:
Disinvestment
Spanish National Health System
Financial crisis

ABSTRACT

This paper proposes the framing of disinvestment strategies as the "value for money" approach suitable for the current situation of acute budget restrictions. Building on the experiences from other countries, it first reviews the instruments already available for implementing this approach within the Spanish National Health Service (SNS) named

(A) The mandate to do it: regulatory framework
(B) The capacity to identify "low value" interventions and produce guidance on best practice
(C) The capacity to monitor compliance to and effects of "enforced" guidance

These three elements have been in place in the SNS for some years now. However their effective alignment in supporting a disinvestment strategy has met with several hurdles. Components of organisational incentives as well as the "technological fascination" affecting professionals' and public perceptions have played a role in Spain as elsewhere. In addition, some idiosyncratic political factors lead to weak mechanisms for the channelling of available evidence into decision-making and the existing SNS technical bodies capped to issue only non-binding recommendations.

Sadly, the "cuts across the board" strategy adopted in facing the financial crisis might have finally triggered the required political clime to overcome these obstacles to disinvestment. In the current context, the SNS stakeholders (professionals and the public) may regard the disinvestment proposal of informed local decisions about how best to spend the shrinking amount of resources, getting rid of low value care, as a shielding rationale, rather than a thread.

"[. . .] it is a tale
Told by an idiot, full of sound and fury,
Signifying nothing."

Borrowed from Shakespeare's Macbeth, scene V

1. Introduction

One would probably feel inclined to argue that these are no times for playing narratives when the crisis is creeping up the fences of welfare state everywhere in our familiar whereabouts. However, we are currently facing a severe risk of the idiot's tale taking over the legitimate debate about rational policy making and efficient use of public resources (whichever amount of them).

The wealthy times when health expenditure discussions were focused on how to tame the growth slope,

* Corresponding author at: Health Services and Policy Research Unit, Health Sciences Institute in Aragon (I+CS), San Juan Bosco 13, Planta O, 50009 Zaragoza, Spain. Tel.: +34 976716792.
E-mail addresses: sandra_garmesto@yahoo.com, sgarciaarm.iacs@aragon.es (S. García-Armesto).

0168-8510/$ – see front matter © 2013 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.healthpol.2013.01.007

displaying admonitory projections of un-sustainability in 20 years time, are undeniably over. European Governments are challenged by the urgent need to adjust expenditure to the acute public budget contraction, in line with the public deficit threshold enforced in the Eurozone. The reflection of this recoil on health budget may be different in magnitude and chronology depending on the country analysed, but it is already happening.

Listening to mass media debates and looking into the kind of reforms where they have been already announced or implemented, the dominant emotion seems to be the form of panic that pulls the scissors out of the drawer and blindly rip off health structure and coverage to make it fit into the shrinking mould.

"Value for money" has been the fashionable motto for several years now, often excuse for eventually expensive "pay for performance" schemes not fully attaining their expected objectives; it might be now the time to talk seriously about the value of health care activity; let's talk disinvestment and quality of decisions on resources allocation.

The term disinvestment was coined – with debatable fortune – two decades ago. Brought up amidst the struggle against incremental adoption of technology (and its derived escalating costs), the term "disinvestment" conceited favour for its prowess in focusing the discussion on wiser use rather than increase of resources, advocating the removal of superseded technology from the benefits basket. However, in the current context, it seems to evocate budget cutting, resonating negatively as health system's pauperisation. Far from that, disinvestment specifically refers to resource allocation decisions based on withdrawing funding from no or low added-value health interventions, freeing up these resources for reinvestment in other health technologies that meet the criteria of safe and cost-effective care. It is, therefore, a supply-centred strategy of rationalisation.

The first question is what is meant by "low value" interventions. The English Audit Commission [1] proposed four categories of technologies eligible as "low value", broadly used in international literature:

1. Effective procedures where there are alternatives for the same indication that should be tried first because they are more cost-effective – i.e. spinal fusion in discal herniation.
2. Effective interventions used in "ineffective" indications: there are defined types of patients for whom there is no clear evidence of benefit superseding risk – i.e. knee and hip revisions for mild cases.
3. Potentially cosmetic procedures – incisional hernia repairing.
4. (Relatively) ineffective procedures – tonsillectomy.

The list of disinvestment candidates should be produced by assessing the catalogue of procedures included in health care regular activity against existing evidence from cost-effectiveness analysis (incremental or decremental), clinical guidelines or other evidence-based products. Those interventions falling in one of the four categories above can then be identified in each context, pointing out potential efficiency gains. The "lion share" may concentrate in the third category: differences in effectiveness and/or cost-effectiveness for the same technology across patient subgroups, providers, or institutions are likely to be significant. Thus, disinvestment efforts must acknowledge that few technologies will be candidates for complete removal. Partial retraction avoiding ineffective indications might be more often the path. Worldwide research suggests that 20–25% of patients receive unnecessary or potentially harmful treatments and 30–40% of patients do not receive treatments of proven effectiveness [2]. The scope for reducing suboptimal care and inefficient allocation of scarce health resources is therefore wide [1,3].

There are several examples around the world and across traditions as different as Ontario, Tuscany, Australia, New Zealand and commissioning bodies around England such as the Croydon Primary Care Trust [2,4–7]. The lessons learnt from those experiences underline some key steps in enhancing "value for money":

- Identifying those technologies ineffective in their usual indications or less effective than alternatives and:
  - Dropping them from the benefits basket or making them subject to avoidable copayment
  - Restricting indications to certain types of patients (choice guided by evidence of positive benefit/risk balance)
  - Specifying and limiting the types of providers more suitable to offer each service (therefore substantiating the indication becomes a requisite, discouraging irrelevant use)
  - Capping the frequency or length of treatments
- Producing and making available guidance on a regular basis to reduce inappropriate use of procedures:
  - Highlighting and tackling unwarranted variations in elective surgery (naming and "shaming" to prompt query and change)
  - Fostering best practices (diagnostic and pharmacotherapy intensity and indications)
  - Improving coordination of care

Experience has shown that this process is far from straight forward though; this is partly due to the difficulties in articulating administrative mechanisms for identifying and prioritising health technologies and/or practices of uncertain clinical effectiveness or cost-effectiveness.

The objective of this paper is to review the instruments available for implementing this approach within the Spanish National Health Service (SNS), to analyse the hurdles challenging their effective alignment and to build the case for their application.

2. Tools available for the SNS

Health competences in Spain are totally devolved to the regional level, Autonomous Communities (ACs). Thus the SNS is actually made up of 17 regional health services only accountable to their respective regional parliaments. The highest SNS coordination body is a council where the 17 regional ministers seat under the presidency of the national