

Methods of no value must be abandoned

Health expenditure increases in pace with the development of procedures and medicines that offer new diagnostic and treatment possibilities. In order to maintain a sustainable health service, treatment regimes must be abandoned and replaced when new and better documented methods become available. The health service has a big job to do here.

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Health services are about rights, dignity, egalitarianism – and, of necessity, also prioritization. The latter may seem difficult in a society like ours, where «we should be able to afford» just about everything (1). One of the main factors behind the increase in health budgets in modern societies is the development of new medicines, equipment and procedures which lead to increased diagnostic and treatment possibilities (2). Choices as to how overall health resources should be spent are difficult to make, but at the same time unavoidable. It is 25 years since the initiative for the first report on prioritization in the health service was taken in Norway. The Lønning I Report came in 1987 and was followed ten years later by the Lønning II Report: «Resetting of priorities» (Norwegian text), with new guidelines for priorities in the health services (3). The report singles out three criteria that have to be fulfilled for a measure to be given priority:

- the condition must be serious enough
- the treatment must have expected benefit
- the costs of the treatment must be in proportion to the benefit

The three criteria for prioritization formulated by the Lønning Committee were included in 2000 in the regulations to the Patient Rights Act (4). There is general agreement and understanding for these criteria. But it is also agreed that we have not benefitted enough from the criteria in practice.

Something in – something out?

Treatment regimes should be abandoned if they yield little clinical benefit or adverse

side effects. The primary goal is to redistribute resources in order to achieve a more efficient but still sustainable health service. The challenge, however, is that «old» methods are still in use and demand resources, even though new knowledge and new methods have been established (5). It is simpler to abandon methods with adverse side effects than when patients are «merely» subjected to unnecessary or less effective treatment. Views such as «Some people may still benefit from it» and «It doesn't do any harm» are common. There has been an increasing focus on systematic appraisal of new methods that are wanted in the health system, whereby clinical efficacy, side effects and cost-effectiveness are assessed. Existing methods have not always been subject to an equally systematic appraisal, which also makes it difficult to document and give reasons for why they should no longer be in use. The health administration in a number of countries has the issue of abandoning obsolete or unnecessary methods on its agenda. A systematic (re)appraisal of «old» methods as well appears to be the solution. It has even been proposed making an age-related review of methods in the health service a certain time after introduction, like date-stamping of food products (6).

International experience

A number of projects on phasing out of old methods have been conducted internationally. In the UK, the National Institute for Health and Clinical Excellence (NICE) was requested by the Minister of Health to identify and abandon ineffective procedures. NICE performed a pilot study where clinicians in a number of disciplines were asked to identify unnecessary procedures that cost society more than a specified amount. In particular, unnecessary use of antibiotics and diagnostic tests was identified. The result of the assessments was incorporated in NICE's guidelines. Since 2006 the institute has been instructed that in appraising new methods (NICE guidance) and developing guidelines (NICE guidelines)

what can be replaced must always be identified (7).

The USA has a less unified health service and is striving to improve it. President Barack Obama stated in a speech that abandoning unnecessary methods was essential in order to finance two thirds of the assumed USD 900 billion which an expanded health programme will cost over a ten-year period. He may have been basing himself on a study from 1990 (8). It was being maintained already then that the introduction of new technology and simultaneous (unnecessary) use of existing technology accounted for half of the increase in the health budget (8). A systematic review of disciplines led to the abandonment of old methods in a number of other countries (6). In Sweden, a national model has been developed where a list of high priority proposals is prepared in each discipline on the basis of a cost-benefit analysis and appraisal of ethical and organisational consequences and clinical experience, then these proposals are discussed in a horizontal inter-disciplinary integration (9).

What has been done in Norway?

In Norway we do not have general routines for determining which existing methods should be abandoned by the health service. Various players are involved in decisions to introduce and phase out methods in the health service.

The Norwegian Knowledge Centre for the Health Services is intended to strengthen the knowledge base for professional decisions in the health service, among other things by identifying and summing up documentation on the effectiveness and cost-benefit ratio of new and established methods. The Research Centre and the Western Norway Regional Health Authority have together conducted a pilot study of a decision-support tool to identify what can be replaced and hence phased out in connection with the introduction of new methods in the specialist health service.

The Norwegian Medicines Agency



Illustration Stein Løken

makes regular appraisals of medically equivalent generics for the list of substitutable medicines. This may yield substantial savings when the patent protection for prescription medicines lapses. Whole groups of medicinal products are also appraised in collaboration with the Research Centre to compare efficacy and safety. The purpose is to investigate whether research provides grounds for recommending that one preparation be chosen rather than another (preferred medical product).

The National Council for Quality Improvement and Prioritizing in the Health Service (10) was established as part of the National Health Plan (2007–2010). It was supposed to clarify the role of the players with responsibility in quality and prioritization work. The council's 25 members consist of managers in central health administration, the regional health trusts, the municipal health sector and representatives of professional associations, user organisations and the teaching sector. One of the five points of the council's mandate is to consider issues relating to the introduction of new and costly technology. This point has received most attention up to now. It has given rise to discussion about the need to phase out

existing methods as a means of freeing up resources in both the primary and the secondary health service. In many cases, old methods do not have the cost-benefit documentation that is now expected of new technology. For example, the council has concluded that surgery for sleep apnoea is overuse of a procedure that does not have sufficient documentation for its effectiveness and safety. This led to reduced DRG rates for the procedure and an over 30% reduction in clinical activity in the course of a year (information from Norwegian Patients Register).

In the light of the treatment of many specific cases the council has taken the initiative for a separate national appraisal system in connection with the introduction of new and costly technology in the specialist health service, such as one finds in many other countries.

Conclusion

Systematic appraisal of established methods should be included as a basis for sound prioritization processes in the health service. In principle these appraisals should be based on the same criteria that are used for the introduction of new measures. By increasing awareness of what should be

abandoned, a more balanced flow of technologies can be achieved in the health service. What is medically well founded and what is cost-benefit effective? What are complementary methods and what are substitutes and can be replaced? What is overuse, or directly erroneous use or misuse? Technology can still be relevant, but the indication may have changed.

Such assessments should be made in connection with the introduction of new and costly technology in the specialist health service and when health authorities, enterprises, professional associations and others prepare new or update earlier guidelines or procedures.

Conflicts of interest: None

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