What is a scoping report?

This scoping report was undertaken to ascertain the quantity and quality of the published evidence on this topic and to clarify the research question. Scoping reports are undertaken in an approximately 1-month period. They are based upon a high-level literature search and selection of the best evidence that Healthcare Improvement Scotland could identify within the time available. The reports are subject to peer review. Scoping reports do not make recommendations for NHSScotland. Further information on scoping reports is available at www.healthcareimprovementscotland.org

Background

Health budgets are increasingly constrained by many factors including funding new technologies and developments in clinical practice. As a result, healthcare organisations, including the National Health Service (NHS), are constantly forced to make decisions about which services will be funded or not. Most health organisations have responded to this demand by exploring opportunities that can release funds by ceasing to provide certain healthcare services that offer less than satisfactory health outcomes compared with known alternatives.

The term ‘disinvestment’ has been most commonly used to describe this process. However, because ‘disinvestment’ can sometimes be perceived as having a negative connotation, other terms such as ‘decommissioning’, ‘defunding’, ‘delisting’, ‘resource release’ and ‘removing ineffective services’ have also been used to refer to disinvestment-type practices.

The process of detecting and eliminating services that provide less than satisfactory health benefits is complex and challenging. It requires high-level decision making, commitment and partnership from all relevant stakeholders in order to make the process explicit, transparent, standardised and effective. When making decisions that affect healthcare activities, it is important to elicit the views and opinions of all relevant stakeholders, including the public, and ensure that areas they regard as important have been adequately considered.

Despite the increasing attention and focus on the concept of disinvestment, no internationally accepted definition of the term was found within the health policy literature. Elshaug et al. put forward a definition which is most widely used. They define disinvestment as the “process of (partially or completely) withdrawing health resources from any existing health care practices, procedures, technologies, or pharmaceuticals that are deemed to deliver little or no health gain for their cost and thus are not efficient health resource allocation”.

The following question was scoped:

1. What approaches have been taken and efforts made to ensure public involvement in decision making relating to potential disinvestment in healthcare interventions and technologies?

Thus, this review is focused on strategies that have been used to identify, consider and possibly include the public perspective, when making decisions relating to disinvestment-type activities.

Literature search

A search was carried out in the Cochrane library, NHS Economic Evaluation Database and Medline to identify relevant publications, in English, including journal articles, technical reports, policy documents, conference abstracts and posters, published up to July 2012. This was supplemented by general web searching, and backward and forward citation searching from included references.
Due to the broad approach to the literature search, 186 potentially relevant items were identified. Articles discussing or assessing approaches used to obtain or incorporate public opinion when making any decisions relating to disinvestment were selected. Articles exploring the issue of disinvestment specific to the policy context or the rationale for disinvestment were not considered relevant.

Evidence base

Table 1. Included evidence sources

<table>
<thead>
<tr>
<th>Publication type</th>
<th>Number of publications</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health technology assessment (HTA)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Report</td>
<td>2</td>
<td>11,12</td>
</tr>
<tr>
<td>Local policy document</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Primary study</td>
<td>3</td>
<td>7,8,9</td>
</tr>
</tbody>
</table>

Findings

The majority of the articles did not meet the inclusion criteria. Only five articles discussed frameworks, policies, processes or methods that have been developed and used to obtain, consider or incorporate the views of the public during the disinvestment process. Two additional articles were identified during peer review.

Disinvestment framework

A comprehensive review of the disinvestment agenda in selected countries was undertaken by an Austrian HTA\(^2\). The HTA assessed disinvestment activities and practices, in different organisations and committees, in four countries — England (National Institute for Health and Care Excellence (NICE)); Spain (Basque Office for Health Technology Assessment and Galician Agency for Health Technology Assessment); Australia (Adelaide Health Technology Assessment, Pharmaceutical Benefits Advisory Committee and Medical Services Advisory Committee); and Canada (Canadian Agency for Drugs and Technologies in Health).

Most of the countries did not have a comprehensive disinvestment framework at a national level. Spain was the only country that had a formal methodological framework. Although NICE issues mandatory disinvestment advice in England, no comprehensive framework for disinvestment had been published as at 2011\(^2\). The literature search for this report did not identify any disinvestment framework produced by NICE.

Disinvestment initiatives were also identified in Scotland, Denmark, France and Italy. However, the HTA reported that these countries did not have any broad scale disinvestment project, and the initiatives identified were not analysed as only minimal and fragmented information was provided in the available literature.

The HTA concluded that there was no strong evidence to suggest that any of the approaches used in the four countries reviewed could be considered a best practice model for other countries. The authors noted that certain groups, like the public, may find it difficult to accept the need for disinvestment in healthcare, as the term (‘disinvestment’) may suggest denial of access or reduced investment in some services. An urgent need to develop a transparent disinvestment framework through a process that would incorporate the views of all relevant stakeholders was a key recommendation that emerged from this HTA report\(^2\).

Disinvestment and the public

As various stakeholders are involved in decisions to introduce and phase out services within the health service, it is essential to ensure that the public perspective is included during the decision-making process. However, no comprehensive systematic evidence synthesis on how to elicit and incorporate the views of the public during decision making as relates to disinvestment practices was identified. Also, this review did not identify any specific formal strategy for disseminating disinvestment guidance, advice or recommendations and communicating them to the public. Only one locally developed decommissioning tool\(^6\) and three primary studies\(^7,8,9\) offered discussions and analysed how the public are implicated in disinvestment-related decisions.

A Primary Care Trust (PCT) in England formalised their decommissioning process to ensure that all stakeholders were involved in decision making, where appropriate\(^6\). The PCT in South-East Essex developed a disinvestment and decommissioning toolkit intended for use when making both clinical and non-clinical disinvestment and decommissioning decisions. The toolkit ensures that an explicitly defined process with clear lines
of accountability and responsibility is followed, when approval has been given to disinvest from a service. The process states that if disinvestment is anticipated due to the introduction of a new service model, the commissioner is required to seek guidance from senior employees in communications and patient and public involvement departments with regards to whether consultation or engagement with the public is required. It was highly recommended that this communication be made at an early stage due to the length of time required for informal engagement and public consultation. The toolkit also recognises feedback from community groups (Local Involvement Networks) as a key mechanism for identifying potential services for disinvestment review. The patient and public involvement team will usually provide expert advice on how to seek views from relevant community groups and previous service users.

One Scottish-based qualitative study, presented as a poster, was also considered relevant to this question. The author interviewed 12 taxpayers, none of whom was under NHS employment or directly involved with making decisions in the NHS. The study assessed the acceptability and issues associated with disinvestment to Scottish taxpayers, and if “loss aversion” (people’s tendency to prefer the NHS not accepting a new treatment than the removal of an existing treatment) was a significant factor to the disinvestment agenda. The criteria (benefits and risks, severity and prevalence of condition and availability of alternative treatment) used to assess these were drawn from a tool developed by the Galician HTA agency to identify and prioritise obsolete technologies.

Although disinvestment was generally viewed as being important within a restricted budgetary environment, the study reported that ‘disinvestment’ was still perceived negatively. Obsolete technologies or technologies perceived as unnecessary such as services provided for cosmetic reasons had the highest priority ranking for services from which to disinvest. Participants were of the opinion that taxpayers and patients should not be heavily involved in decision making at a national level as they lacked the necessary knowledge and may be biased when making such decisions. They suggested instead that the agenda be clinician-led and responsive to local needs. Participants preferred to disinvest in services of no proven benefit as they considered health benefits to patients as paramount. However, they found it difficult to decide whether decisions should be based on prevalence or severity of the condition. The study concluded that the disinvestment agenda is generally acceptable to taxpayers in Scotland. However, it should be noted that these findings are based on a small sample of taxpayers and may not represent the views of the Scottish population.

An ongoing Australian study was also identified. The Assessing Service and Technology Use To Enhance Health (ASTUTE Health) study aims to implement and evaluate a model to refine the indications for disinvesting from ineffective or inappropriately applied healthcare practices. The study is actively engaging with a range of stakeholders including community members to identify the barriers and facilitators of disinvestment, and to determine whether this engagement will contribute to creating improved and transparent decision making processes within the disinvestment domain. The authors anticipate that decision making will benefit from the knowledge delivered through informed engagement and deliberation with the community. However, they note that although this process offers decision makers a more diverse range of knowledge and experience, it does not guarantee the formulation of a less controversial policy process. Street et al. examined data from a phase of the ongoing ASTUTE Health study to determine whether news and social media offer a better understanding of the community perspective as regards disinvestment. The authors regarded print and online media articles (commercial media output, blogs and discussion forums) as the primary source of public opinion and assumed they were reflective of public views. It should also be noted that patient responses were among those classed as ‘community response’ in this study. Results showed that community discussions reflected broad and different ends of the disinvestment debate, diverging strongly for or against disinvestment from public funding. They concluded that news and social media offer an inexpensive way to capture community perspectives, and recommended additional measures of community engagement for future disinvestment policies.
Other findings from the ASTUTE study when published, focused on public involvement in the disinvestment process, may also be relevant to this policy area.

A decommissioning tool published by the United Kingdom’s Department of Health\(^\text{11}\) and an Australian national workshop report\(^\text{12}\) did not state any particular criteria or process of including the public when making disinvestment decisions. However, both articles emphasised the importance of engaging all relevant stakeholders to build a better understanding of disinvestment related practices and to ensure sufficient ‘buy-in’.

**Summary**

Detecting and eliminating potentially obsolete health technologies is a complex process that requires input from all relevant stakeholders, including the public. In addition to the lack of any standard definition of disinvestment, there are also inconsistencies in the terms used to depict disinvestment-type activities.

This review shows that little research has been done to find the best ways of involving the public in making healthcare decisions as regards to disinvestment. There was no strong evidence to suggest that any of the frameworks identified could be considered a best practice model. Most of the articles reported that more effort is needed to enable the public to develop and express informed views, and consequently to incorporate these views when making disinvestment decisions.

**Further work for Healthcare Improvement Scotland**

There is limited evidence that specifically answers the question on how public views have been integrated into decisions relating to the disinvestment of healthcare services. Thus, it has been difficult to identify any suitable approaches for NHSScotland. A more extensive literature review is unlikely to answer this question at this time.

**Equality and diversity**

Healthcare Improvement Scotland is committed to equality and diversity in respect of the nine equality groups defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, sex, and sexual orientation. As a scoping report summarises information and does not provide recommendations a full EQIA assessment is not deemed necessary.

The scoping report process has been assessed and no adverse impact across any of these groups is expected. The completed equality and diversity checklist is available on www.healthcareimprovementscotland.org

### Acknowledgements

Healthcare Improvement Scotland would like to acknowledge the helpful contribution of the following, who gave advice on the content of this scoping report:

- **Dr Adam Elshaug**  
  Health Services and Policy Researcher  
  Department of Health Care Policy  
  Harvard Medical School  
  United States of America

- **Dr Jacqueline Street**  
  Senior Lecturer  
  School of Population Health  
  University of Adelaide  
  Australia

- **Professor Andrew Thompson**  
  Professor of Public Policy and Citizenship  
  School of Social and Political Science  
  University of Edinburgh

- Healthcare Improvement Scotland development team
  - Hilda Emengo  
    Lead Author/Health Services Researcher
  - Paul Herbert  
    Information Scientist
  - Susan Downie  
    Medical Writer
  - Doreen Pedlar  
    Project Co-ordinator
  - Marina Tudor  
    Team Support Administrator
  - Members of the SHTG evidence review committee

© Healthcare Improvement Scotland 2013  
ISBN 1-84404-953-1
References


NICE has accredited the process used by Healthcare Improvement Scotland to produce its evidence review products. Accreditation is valid for 5 years from January 2013. More information on accreditation can be viewed at www.nice.org.uk/accreditation