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Disinvestment in Western Canada: from principles to practice to lessons learned

Craig Mitton, PhD and Arden Krystal, MHA

Centre for Clinical Epidemiology and Evaluation, Vancouver Coastal Health Research Institute
School of Population and Public Health, University of British Columbia

Provincial Health Services Authority

craig.mitton@ubc.ca and arden.krystal@phsa.ca

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Resource scarcity

- Allocation of health care funds according to defined populations is a global phenomenon
- Basic notion within health authorities is that of a limited funding envelope
  - **Not enough resources to meet all needs**
- Surveys have reported uncertainty amongst decision makers on how best to set priorities and allocate resources

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Historical vs. formal process

	Poor or very Poor	Fair	Good or very Good
Historical or Political Process	18%	50%	32%
Formal/Rational Process	2%	25%	73%

Only about 50% of health care organizations in Canada identify as having a "formal" process in place.

Those who use a formal/rational process tend to be more satisfied with the priority setting process than those without.

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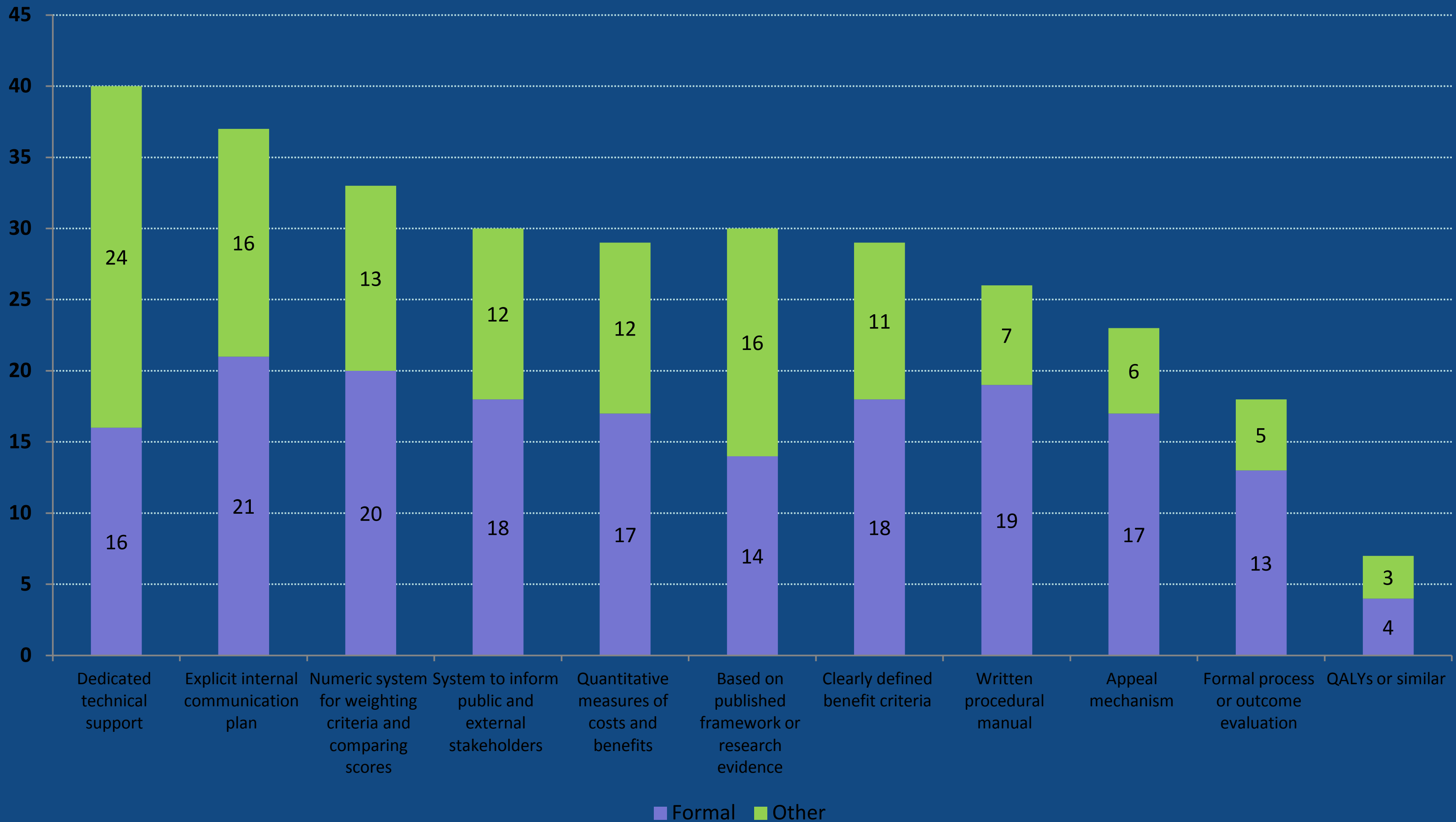
Landscape in Canada



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2012 Canadian survey, n=91

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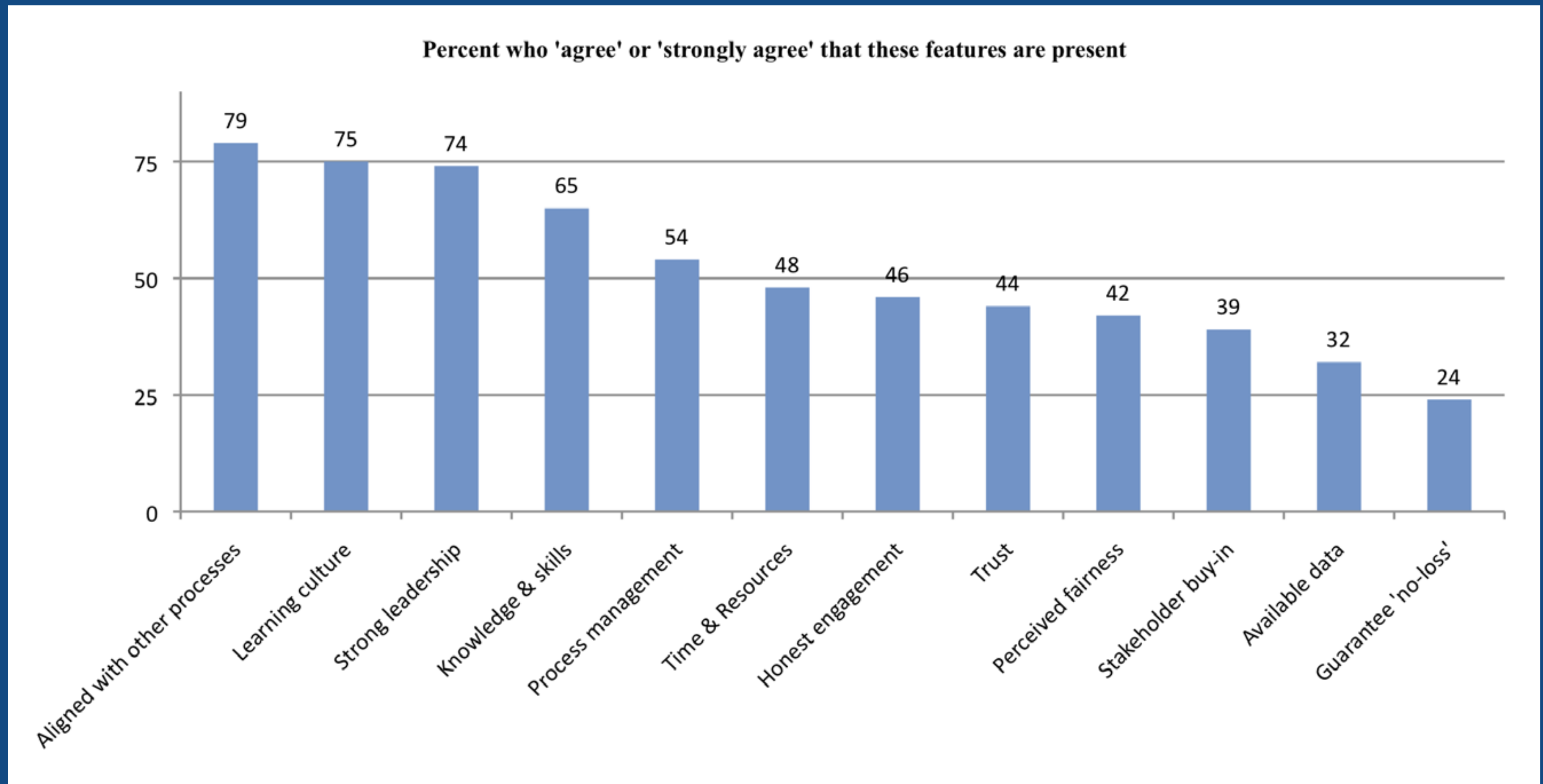
Enablers of Effective Resource Allocation



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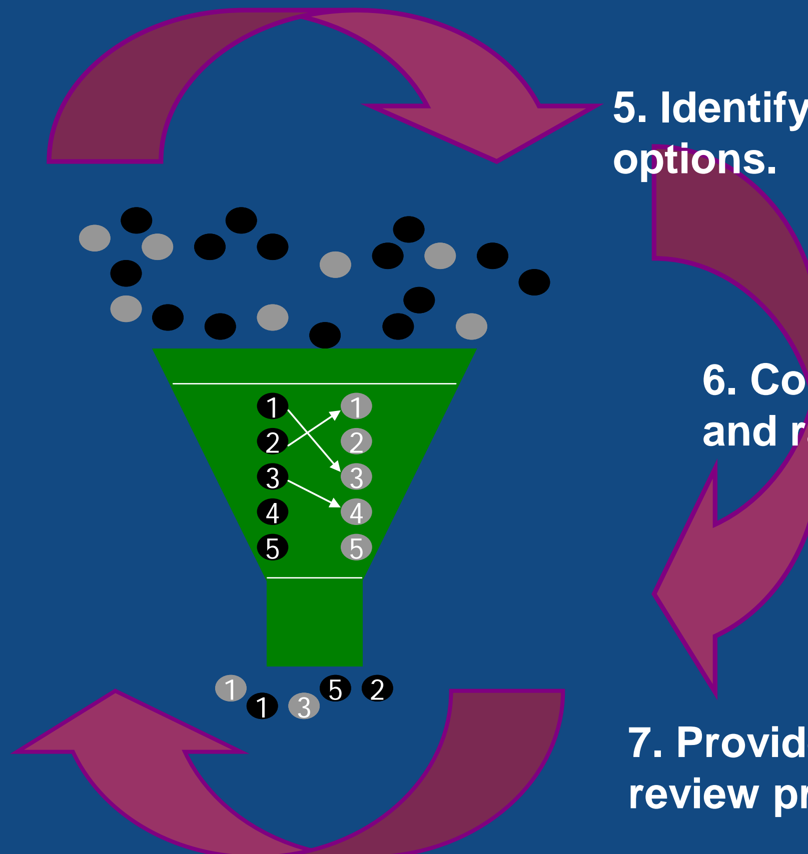
Resource Allocation - PBMA

4. Develop decision criteria with stakeholder input.

3. Clarify existing resource mix.

5. Identify & rank funding options.

2. Identify priority setting committee.



6. Communicate decisions and rationale.

1. Determine aim & scope of decision making.

7. Provide formal decision review process.

8. Evaluate & improve.

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Key Concepts

- Shifting or re-allocating resources based on comparison against pre-defined criteria (i.e., MCDA)
- Clinicians and managers working together
- Ethical conditions built in, especially transparency
- Tool to improve decision making regardless of fiscal imperative
- Link to Health Technology Assessment agencies

Managing evidence

- Education on process and expectations on using evidentiary base
- Standard business case template
- Targets on investments and disinvestments
- Process guidelines and formal, explicit submission process
- www.prioritizesoftware.com

Expected Outcomes

- Primary benefits of explicit approach
  - Achieving real resource shifts consistent with strategic decision making objectives
  - Bending the cost curve and investing in areas where marginal gains are greatest
  - Clinical engagement and opportunity for public involvement
  - Greater transparency and accountability

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Disinvestment – the Challenge

- Disinvestment poses a clear challenge in any context
- Canadian ‘success’: over 30 organizations with disinvestments ranging from $200K to $45M
  - That said, it is not at all easy and investment options tend to overshadow disinvestment options
- So, what are some practical lessons learned?
- And in the end what’s the alternative?

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Disinvestment – the Challenge

- Healthcare historically has been all about investment
- Most very nervous about disinvestment
- Can be politically charged
- Culture change for administrators and clinicians who think every service is valuable – aren't used to assessing the relative value of all the services provided
- PBMA provides a much more evidence-based and reasoned approach to budget reductions

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Common Steps to Manage Resources

1. Generate revenue
2. Cost reduction activities
3. Outsource services
4. Re-engineering, process efficiency – e.g., LEAN
5. Non-clinical integration, consolidation, standardization
6. Clinical integration, consolidation, standardization

→ **Common steps to meet fiscal constraints**

7. Disinvestment

→ **Removal of ineffective services**

→ **Reduction of lower value services**

Steps 1-6 are done all the time; step 7 is much harder but is absolutely necessary

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Disinvestment – example #1

- Some disinvestments represent a complete elimination of a program or service, while others involve restructuring the same service
  - Elimination example: PBMA methodology supported disinvestment of several NGO grants and programs on the basis of duplication and lack of alignment with strategic direction
  - Savings in the millions of dollars
  - Evaluation indicated only minor impact

Disinvestment – example #2

- Some disinvestments are particularly emotionally and/or politically charged
- PBMA assists in supporting change through strong rationale
- Elimination Example #2 – disinvested in acute care spiritual care services on the basis of duplication, low uptake in the service
- Savings of approximately $1.2M
- Evaluation – 1 patient complaint in 3 years

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Disinvestment – example #3

- Restructuring example – PBMA supported closure of a 20 bed in-patient sub-acute rehabilitation unit on the basis of poor utilization for purpose and high cost vs. benefit
- Reinvested in a full outpatient program
- Savings of $800k
- 50% more patients served; ALOS in tertiary rehabilitation units decreased by several days

Lessons learned

- Using PBMA requires that you do your homework
- Cannot be done quickly, so always have disinvestments and investments ready in the pipeline
- Engagement of physicians and middle managers essential for buy-in
- Socialize politically as early as possible

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Based on experience

- Disinvestment is not only possible but can be done in an evidence informed manner
- Disinvestment options must be subject to the same criteria as for investment options
- Helpful to start with disinvestment options, cover a projected budget gap then move to re-investment
- Formal approach enables engagement and better decisions --- **contrast with across the board cuts**

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Summary

- Disinvestment is a challenge but real-world experience available to draw on for transferable lessons

- Primary purpose of disinvestment is to allocate released resources to the bottom line or re-investment

  - May be ineffective services but typically we are talking about services that are providing some benefit at present

- Recommend that this type of process be conducted on an ongoing basis; should be part of "doing business"