Reviewer’s report

Title: Reorienting PBMA towards disinvestment

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Reviewer: Adam Elshaug

Reviewer’s report:

This review was carried out by Dr Adam Elshaug (invited by journal editor) and Dr Cameron Willis (invited by Dr Elshaug to act as co-reviewer).

We thank the author/editor/s for allowing us the opportunity to review this paper, titled Reorienting PBMA towards disinvestment by Dr Duncan Mortimer. Dr Mortimer outlines what he sees as recent successes/failures in achieving disinvestment and resource release via PBMA, and in doing so he identifies four barriers/enablers to disinvestment via PBMA. He goes on to propose a number of modifications to the PBMA process with the aim of reorienting PBMA towards disinvestment, with his vision for a reoriented PBMA model that is differentiated by four features. We feel that the major comments are of importance and hope these will be taken into serious consideration by editor/s and the author. The minor comments might be considered at the discretion of the editor/s.

Major Compulsory Revisions:

1. The reorientation components of the PBMA model have considerable strengths, and in general are well articulated in this paper (their articulation is a strength of the paper). However, I feel it is inappropriate that this model be referred to as “our reoriented model” because, I would argue most, if not all of the components, have been recognised and implemented, as discrete model/s in the UK under the NICE disinvestment programme since 2005, and more recently in Spain, as applied by the Osteba AND Avalia-t Health Technology Assessment agencies on behalf of their respective government health authorities (and see point 3/d below). It could be said that these operate within a health technology assessment (HTA) model of disinvestment.

2. Given point 1, above, I strongly recommend that this paper be sent to Dr Sarah Garner (Associate Director of Research & Development, NICE: sarah.garner@nice.org.uk) and/or Prof Peter Littlejohns (Clinical and Public Health Director, NICE: peter.littlejohns@nice.org.uk) for additional comment and review.

3. Pg 14: Para commencing “It is also possible to conceive...”: Along a similar vein, the notion of moving to a ‘two-step process’ of first identifying a ‘hit list’ prior to (and perhaps independent of) a wish list is the current, preferred approach (and practice) in numerous jurisdictions. This has already been conceived and applied. I think the audience of this paper should be introduced to the following work:
a. NICE – refer to Dr Garner and Prof Littlejohns. For e.g. Department of Health. Selection criteria for referral of topics to NICE. 2006. www.nice.org.uk/media/43A/49/DH_selection_criteria_July_06.pdf.


c. Avalia-t, Spain: http://www.pritectools.com/


4. Pg. 9 last para: "...stakeholders might seek to influence selection and weighting of benefit attributes... and evidence regarding costs and effects...". The author is correct to point this out, including that the failure to compile/enact hit-lists has, in part, been due to vested interests and advisory group composition etc. However, the jurisdictions listed above (and elsewhere) are increasingly implementing this work within Health Technology Assessment (HTA) frameworks (principles and processes). For example, the framework described in the Med J Aust paper above, includes numerous criteria to overcome these barriers and ensure the process is more systematic, transparent and removed from vested interests. For example:

a. The framework contains a ‘nomination’ component but any subsequent review and decision is distanced from vested interests. Nomination is a promising tool, as this recent editorial indicates: Cook S. Experts’ guide to saving money in health. BMJ 2010;340: c1281

b. It also contains a ‘concurrent specification’ item which expands on the last paragraph on page 14 – prior to the summary. Again, this is a tool well utilised internationally, including at NICE.

5. Overall, the flavour of this paper could be construed as one of cost saving/rationing rather than seeking concomitant quality improvements – i.e. a drive for safety, effectiveness and cost-effectiveness by eliminating waste through disinvesting... Two points have been selected to highlight this....

a. Pg. 14: “Where released resources are required to meet budget deficits, guarantees might specify a minimum share of resources released from each budget area that would be available for re-deployment within that budget area.” The implication here is that stakeholders (physicians) have a say in this reallocation. Should it be explicitly noted that these should be to safe, effective
and cost-effective ends. To do otherwise would undermine the process.

b. Pg. 9: “The incentive for members to contribute to a hit list is much less clear-cut; and would require members to either advocate in favour of disinvestments from their own budget (and perhaps against the interests of their own patients)…” Ideally, effective disinvestment should not work against the interest/s of clinicians or their patients, as it should aim to reduce or eliminate services that are unsafe or of low added value. Again, refer to the BMJ paper cited above. That members might find themselves nominating a needed and valuable service to a hit list surely points to a flawed process that works against the intended goal of disinvestment/reoriented PBMA. I wonder if the comment in parentheses (from the quote above) is required. (a similar paragraph is repeated on pg 12 under the heading ‘Advisory Group’).

Discretionary Revisions:

6. ‘We’ is applied throughout this paper – is this appropriate given it has a sole author?

7. Pg. 4, second line of text: “...assist in identifying features of PBMA [which/that?] may have...”

8. Pg. 8: “anything we do costs money, even if it looks like it should save some. If you try to stop people doing something that does not work they will go and do something more expensive [20].” This reference is 15 years old and the quote is presented without any conversation about the improvements in clinical governance that exist today that might minimise/circumvent this.

9. We think that some clarity is required under the ‘Scope’ section. The example of Canmore is provided on page 8 with reference to surgery. Under this proposed ‘reoriented’ model, can the author clarify where the scope of the programme budget should start and end – how should this be defined and by whom? Also, does placing hard limits on the scope risk hampering a comprehensive identification and prioritisation process?

10. Using terms such as ‘hit list’ risks polarizing stakeholders. Should the focus be centred upon identifying and prioritising candidates for disinvestment – HTA - assessment using evidence-based processes?

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
We declare that we have no competing interests