



Beyond Microsystem Fixes: Targeting National Drivers of Low-Value Care

Comment on “Key Factors that Promote Low-Value Care: Views of Experts From the United States, Canada, and the Netherlands”



Adina Weinerman¹, Christine Soong^{2,3,4*} 

Abstract

Low-value care drivers and interventions are often focused on a microsystem (eg, clinic or inpatient ward) or within a health system. Identification of national drivers such as payment structure and medical culture of overuse can help identify regional approaches to reducing low-value care. However, these approaches in isolation are insufficient and require additional strategies. These can include policy and payment changes and adopting shared decision-making (SDM). SDM has the potential to move medical culture away from the ‘more is better’ paternalistic and physician-centric culture to one that actively engages patients as full partners in managing their care.

Keywords: Low-Value Care, Overuse, Shared Decision-Making

Copyright: © 2022 The Author(s); Published by Kerman University of Medical Sciences. This is an open-access article distributed under the terms of the Creative Commons Attribution License (<https://creativecommons.org/licenses/by/4.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Citation: Weinerman A, Soong C. Beyond microsystem fixes: targeting national drivers of low-value care: Comment on “Key factors that promote low-value care: views of experts from the United States, Canada, and the Netherlands.” *Int J Health Policy Manag.* 2022;11(9):1971–1973. doi:10.34172/ijhpm.2022.7077

Article History:

Received: 12 January 2022

Accepted: 19 July 2022

ePublished: 6 August 2022

*Correspondence to:

Christine Soong

Email:

christine.soong2@sinahealth.ca

Much of the research on low-value care focused on describing the magnitude of the problem with little in the way of effective, large-scale solutions. Many local, often single-centered context-specific solutions have been described, making it challenging to scale and spread. A regional or national approach to understanding drivers of low-value care and their associated solutions holds great appeal to quality improvement researchers and policy-makers.

In the International Journal of Health Policy and Management, Verkerk and colleagues aimed to identify the key factors that impact low-value care on a national level. This was done by conducting semi-structured interviews with 18 experts on low-value care, from three countries (the United States, Canada, and the Netherlands) that are actively reducing low-value care.¹ They described 7 distinct factors that promote low-value care across three different categories (system, knowledge and social). The system category included (1) payment structure, (2) pharmaceutical and medical device industry, and (3) fear of malpractice litigation. The knowledge category included (4) biased evidence of knowledge and (5) medical education. And the ‘more is better’ social category included (6) public culture and (7) medical culture. The authors concluded that interdependent factors regarding the healthcare system and culture lead to the provision of low-value care and that better awareness and understanding of these factors can help support policy changes that promote high-value care.

The reason for focusing on national factors was based on prior evidence that reductions in low-value care is better achieved by changing systems and policies rather than trying to change clinician behaviour.^{2,3} However, several of the examples of promising strategies described to counter low-value care (eg, education, information campaigns and increasing awareness) do not target policy. On the contrary, these low-impact tools have a track-record of inefficacy.⁴ The other listed strategies of funding and reimbursement reform, compensating physicians for value rather than volume, are far more likely to be impactful and should be seriously considered by policy-makers.

Included in the payment structure section, the authors suggest “moving away from pay for performance” in apparent reference to volume-based physician reimbursement. Interestingly, there was no exploration of pay-for-performance (“P4P” or “pay-for-results”) programs implemented across many countries, including those whose perspectives were highlighted in this study. The introduction of hospital P4Ps has generated numerous debates over its impact on clinical outcomes.^{5,6} Often criticized for incentivizing (or disincentivizing through penalties) narrow targets of quality such as process measures, P4Ps have at times spurred low-value care in their focus on timeliness measures at the expense of other domains of quality such as cost.^{7,8} For example, early P4Ps in the United States focusing on emergency department response times to early initiation of pneumonia treatment

resulted in overuse of antimicrobials and inappropriate blood culture testing.⁹ Fortunately, recent evolution of reimbursement schemes toward incentivizing value appears to be a promising pivot towards achieving a more balanced quality agenda.¹⁰ As such, national healthcare payment and incentive programs remain a powerful influence on utilization and early P4P experiences provide an important lesson on the unintended consequence of achieving select quality targets at the expense of value.

Another interesting proposed national driver of low-value care is the “more is better” public culture factor, which translates into patients and families requesting low-value care from their clinician. Some of the experts interviewed believe that this culture is a worldwide phenomenon and a significant factor promoting low-value care. This is highlighted in the following quote from the study: “the patient does not want to leave without a prescription with the idea that at least something has been done.” Although this may be true for a proportion of low-value care, there is no evidence to support that this is a *primary* national factor impacting low value care. As the authors acknowledge, there is a dominant, but over-emphasized *perception* that public culture is a significant factor. Inclusion of patients and carers in the study could have provided a more balanced perspective on perceived public culture.

Rather than the public demanding more testing and treatment, it is more likely that healthcare workers underappreciate the harm associated with overtreatment and overestimate the benefits resulting in a failure to fully engaging the patient in an objective risk-benefit analysis. This may represent a form of paternalism in medical culture with a resultant transference of *perceived* desire for more care onto the patient. The clinician assumes that (a) the patient “wants something done”; and (b) the ‘something’ is a prescription for an antibiotic without a fulsome discussion on the appropriate management of a viral illness. In a survey about perceptions about Choosing Wisely recommendations that involved not performing a test or treatment for symptomatic patients (eg, antibiotics for sinusitis and imaging for low back pain), primary care providers anticipated major challenges in getting patients to accept these recommendations.¹¹ This is in direct contradiction to studies demonstrating communication designed to shape patients’ mental models can have substantial effects on risk perception.¹²

While it is true that the quality of information provided to the public likely overestimates benefits and underestimates harm and that society is less willing to accept risks or uncertainty, the literature is clear that in shared decision-making (SDM) utilizing patient-oriented material and decision aids, patient preferences are not drivers of low-value care on a national level.¹³ The authors focused on national rather than microsystem factors (such as lack of SDM) that promote low-value care. However, we would be remiss not to highlight SDM as one of the few patient engagement methods that have been shown to be effective in decreasing the use of low-value care.^{14,15} Decision aids support patients by helping make their decisions more explicit and providing information

about associated benefits/harms of available options. When decision aids are used, they have been shown to increase the number of people choosing more conservative approaches (eg, conservative management over major elective invasive surgery and to avoid medically unnecessary screening tests) and improve patients’ knowledge and more accurate risk perceptions.¹³ Systematic reviews support the concept that when patients actually understand the available treatment options, they do not ask for more care with examples of reductions in antibiotic prescribing by 40% (compared to usual care) for acute respiratory infections in primary care without an increase in repeat consultations for the same illness or decreased satisfaction.¹⁶ Another meta-analysis demonstrated that patient-oriented education reduced the use of low-value care by an average of 31%.¹⁴

An often-cited barrier to SDM is the perception that time constraints limit its utility and feasibility in many busy clinical settings. However, the evidence refutes this claim. In one study, the length of a consultation when decision aids were used increased by only 2.6 minutes compared to usual care.¹³ While we strongly support increasing the use of SDM, we acknowledge that for some patients requesting low-value care, it can be challenging to reassure them and that clinicians should have the skills to navigate these conversations in a time-efficient way. It is also helpful to think of strategies, eg, providing an antibiotic prescription if symptoms do not improve, or booking a follow-up appointment to ensure symptom resolution or providing factual information about “red flag symptoms.”

The impact and importance of SDM has been enshrined in policy in the US where The Centers for Medicare & Medicaid Services made SDM a precondition for payment for a number of conditions and a number of states have passed legislature on decision-making for elective procedures.¹⁷ Other countries have yet to adopt similar policies although there is a call for nations to follow suit.¹⁸ So, in many ways, SDM may be considered a part of a national strategy to counteract the driver of a “more is better” paternalistic medical culture.

In summary, Verkerk and colleagues have furthered our understanding of national drivers of low-value care. Policy-makers interested in national approaches to reduce low-value care should engage patients and carers to carefully craft quality policies and programs that incorporate value as a dimension of quality and consider incentivizing and enabling SDM by clinicians.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors’ contributions

All authors participated in the development of the report, including conception, provision of references, writing of the manuscript, revision of the draft, and approval of the final version.

Authors’ affiliations

¹Division of General Internal Medicine, Sunnybrook Health Sciences Centre, Toronto, ON, Canada. ²Division of General Internal Medicine, Sinai Health,

Toronto, ON, Canada. ³Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, ON, Canada. ⁴Centre for Quality Improvement and Patient Safety, University of Toronto, Toronto, ON, Canada.

References

1. Verkerk EW, Van Dulmen SA, Born K, Gupta R, Westert GP, Kool RB. Key factors that promote low-value care: views of experts from the United States, Canada, and the Netherlands. *Int J Health Policy Manag.* 11(8):1514-1521. doi:10.34172/ijhpm.2021.53
2. Montini T, Graham ID. "Entrenched practices and other biases": unpacking the historical, economic, professional, and social resistance to de-implementation. *Implement Sci.* 2015;10:24. doi:10.1186/s13012-015-0211-7
3. Colla CH. Swimming against the current--what might work to reduce low-value care? *N Engl J Med.* 2014;371(14):1280-1283. doi:10.1056/NEJMp1404503
4. Cliff BQ, Avanceña ALV, Hirth RA, Lee SD. The impact of Choosing Wisely interventions on low-value medical services: a systematic review. *Milbank Q.* 2021;99(4):1024-1058. doi:10.1111/1468-0009.12531
5. Feng Y, Kristensen SR, Lorgelly P, et al. Pay for performance for specialised care in England: strengths and weaknesses. *Health Policy.* 2019;123(11):1036-1041. doi:10.1016/j.healthpol.2019.07.007
6. Mathes T, Pieper D, Morche J, Polus S, Jaschinski T, Eikermann M. Pay for performance for hospitals. *Cochrane Database Syst Rev.* 2019;7(7):CD011156. doi:10.1002/14651858.CD011156.pub2
7. Petersen LA, Woodard LD, Urech T, Daw C, Sookanan S. Does pay-for-performance improve the quality of health care? *Ann Intern Med.* 2006;145(4):265-272. doi:10.7326/0003-4819-145-4-200608150-00006
8. Soucat A, Dale E, Mathauer I, Kutzin J. Pay-for-performance debate: not seeing the forest for the trees. *Health Syst Reform.* 2017;3(2):74-79. doi:10.1080/23288604.2017.1302902
9. Schuur JD, Hsia RY, Burstin H, Schull MJ, Pines JM. Quality measurement in the emergency department: past and future. *Health Aff (Millwood).* 2013;32(12):2129-2138. doi:10.1377/hlthaff.2013.0730
10. Joynt Maddox KE, Sen AP, Samson LW, Zuckerman RB, DeLew N, Epstein AM. Elements of program design in Medicare's value-based and alternative payment models: a narrative review. *J Gen Intern Med.* 2017;32(11):1249-1254. doi:10.1007/s11606-017-4125-8
11. Zikmund-Fisher BJ, Kullgren JT, Fagerlin A, Klamerus ML, Bernstein SJ, Kerr EA. Perceived barriers to implementing individual Choosing Wisely® recommendations in two national surveys of primary care providers. *J Gen Intern Med.* 2017;32(2):210-217. doi:10.1007/s11606-016-3853-5
12. Rothberg MB, Scherer L, Kashef MA, et al. The effect of information presentation on beliefs about the benefits of elective percutaneous coronary intervention. *JAMA Intern Med.* 2014;174(10):1623-1629. doi:10.1001/jamainternmed.2014.3331
13. Stacey D, Légaré F, Lewis K, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev.* 2017;4(4):CD001431. doi:10.1002/14651858.CD001431.pub5
14. Sypes EE, de Groot C, Whalen-Browne L, et al. Engaging patients in de-implementation interventions to reduce low-value clinical care: a systematic review and meta-analysis. *BMC Med.* 2020;18(1):116. doi:10.1186/s12916-020-01567-0
15. Légaré F, Labrecque M, Cauchon M, Castel J, Turcotte S, Grimshaw J. Training family physicians in shared decision-making to reduce the overuse of antibiotics in acute respiratory infections: a cluster randomized trial. *CMAJ.* 2012;184(13):E726-734. doi:10.1503/cmaj.120568
16. Coxeter P, Del Mar CB, McGregor L, Beller EM, Hoffmann TC. Interventions to facilitate shared decision making to address antibiotic use for acute respiratory infections in primary care. *Cochrane Database Syst Rev.* 2015;2015(11):CD010907. doi:10.1002/14651858.CD010907.pub2
17. Spatz ES, Krumholz HM, Moulton BW. Prime time for shared decision making. *JAMA.* 2017;317(13):1309-1310. doi:10.1001/jama.2017.0616
18. Härter M, van der Weijden T, Elwyn G. Policy and practice developments in the implementation of shared decision making: an international perspective. *Z Evid Fortbild Qual Gesundheitswes.* 2011;105(4):229-233. doi:10.1016/j.zefq.2011.04.018