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Can We Lower Low-Value Care? Policy Measures and Lessons in Australia, Canada, England, France, and Germany

Reinhard Busse, Prof. Dr. med. MPH FFPH

Dept. Health Care Management, Technische Universität Berlin, Germany

with

Verena Vogt, Adam Elshaug, Tai M Huynh, Wendy Levinson, Hugh Alderwick, Kalipso Chalkidou & Isabelle Durand-Zaleski

What is the problem?

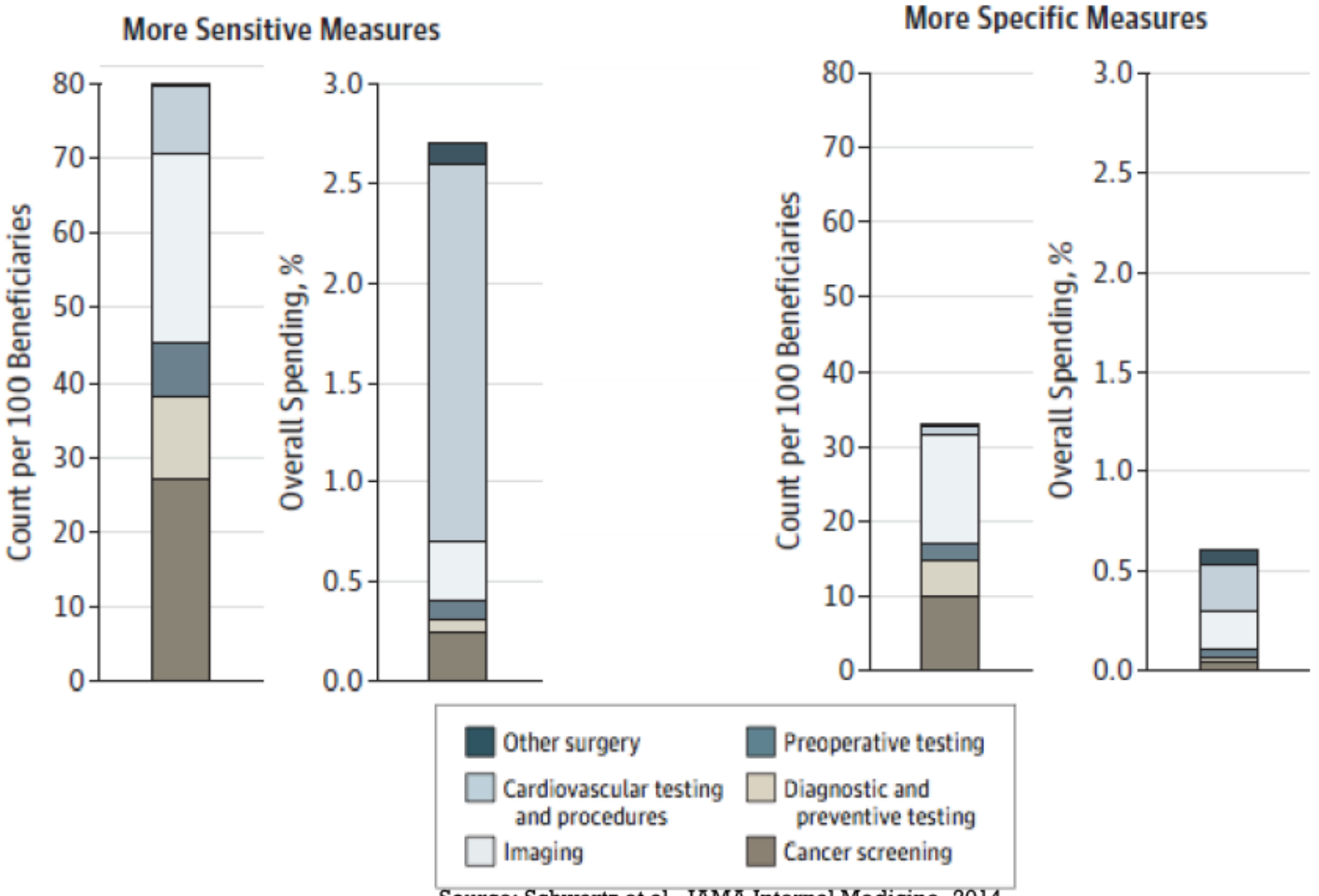
Health care of unknown benefit,
of no benefit,
superseded by better alternatives or
with more harm than benefit

provides low (or no) medical value

but consumes health care resources (both human and financial resources) which could be saved or used otherwise producing more value

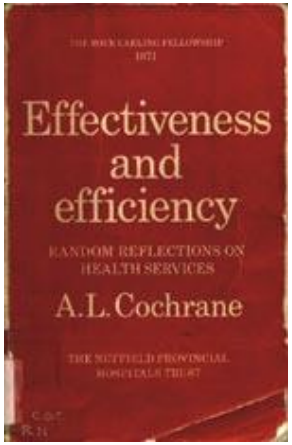
How big is the problem? For the U.S., large - but cited figures are an underestimation of the size

(26 selected services only; Berwick calculates $ 192 bn/ 7% spending on overtreatment)



Source: Schwartz et al., JAMA Internal Medicine, 2014

Have we only just discovered the issue?



No – we have known about it as a component of other terms for a long time:

- Cochrane's *Effectiveness and Efficiency* (1972) → evidence-based medicine, clinical guidelines, Cochrane Collaboration

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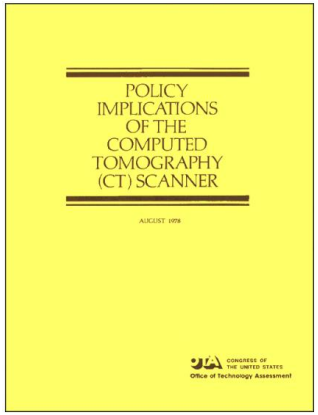
- Wennberg's *Small Area Variations in Health Care Delivery* (1973)

Table 3. Variation in number of surgical procedures performed per 10,000 persons for the 13 Vermont hospital service areas and comparison populations, Vermont, 1969. (Rates adjusted to Vermont age composition.)

Surgical procedure	Lowest two areas		Entire state	Highest two areas	
Tonsillectomy	13	32	43	85	151
Appendectomy	10	15	18	27	32
Hemorrhoidectomy	2	4	6	9	10



- U.S. Office for Technology Assessment → Health Technology Assessment (1975)

Have we only just discovered the issue?

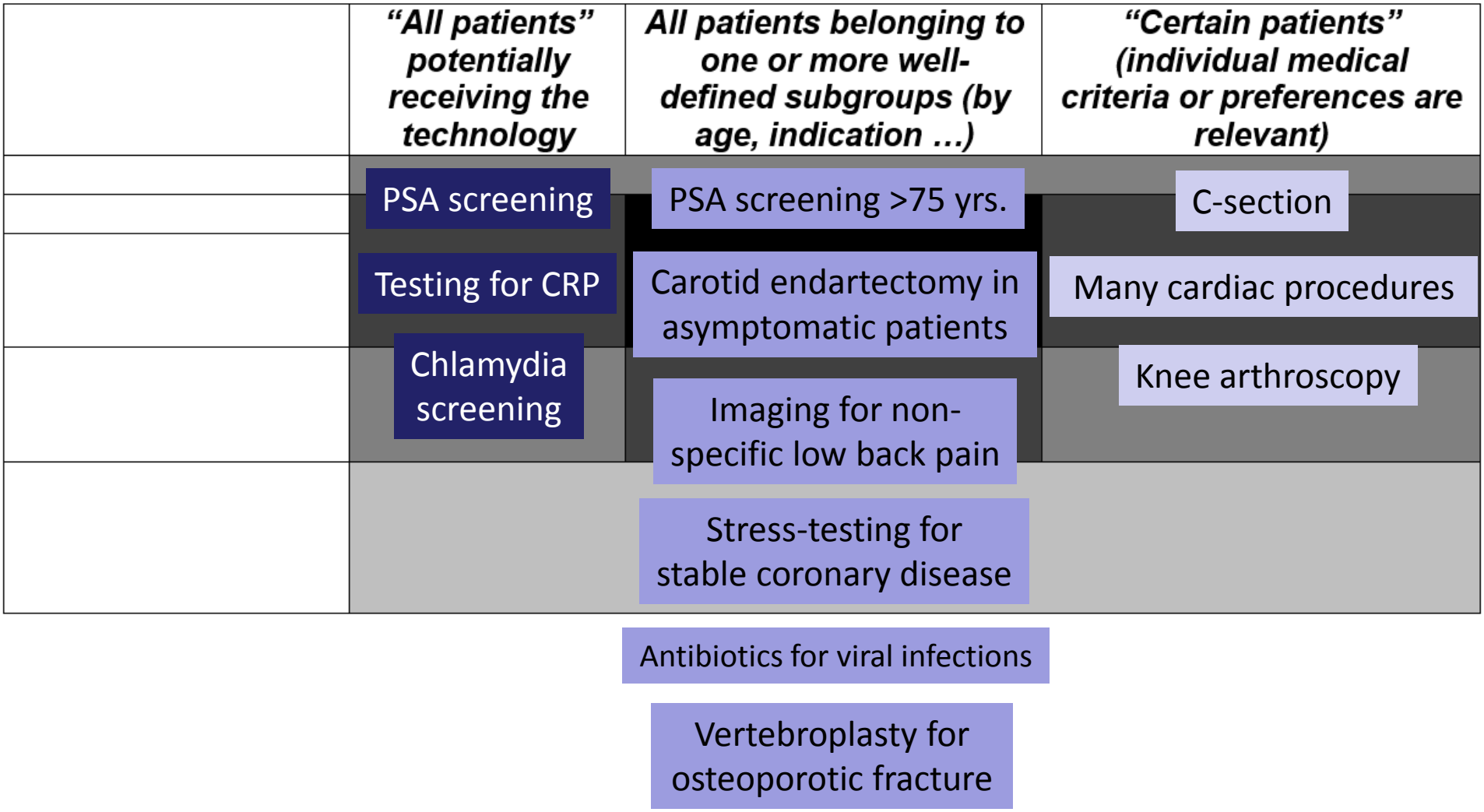
- Brook's assessment of the appropriateness of medical technologies (1986)
- IOM's *To Err is Human: Building a Safer Health System* (2000) → Patient safety
- "Waste" (Fuchs 2009, Berwick 2012)
- "Disinvestment" …

→ confusion (not only) among policy-makers about "low-value" vs. "ineffective", "inappropriate", "unnecessary" or "inefficient" care, "misuse", "overuse, -diagnosis, -treatment", "waste" etc.

Aims of the paper/ presentation/ panel

- To develop a policy-oriented framework of low-value care and strategies to reduce it
- to present—and categorize—strategies applied by policymakers and purchasers, both implemented and/or discussed, in five countries (Australia, Canada, England, France, and Germany), and
- to discuss these strategies in relation to their results and transferability.

The framework to classify “low-value care”



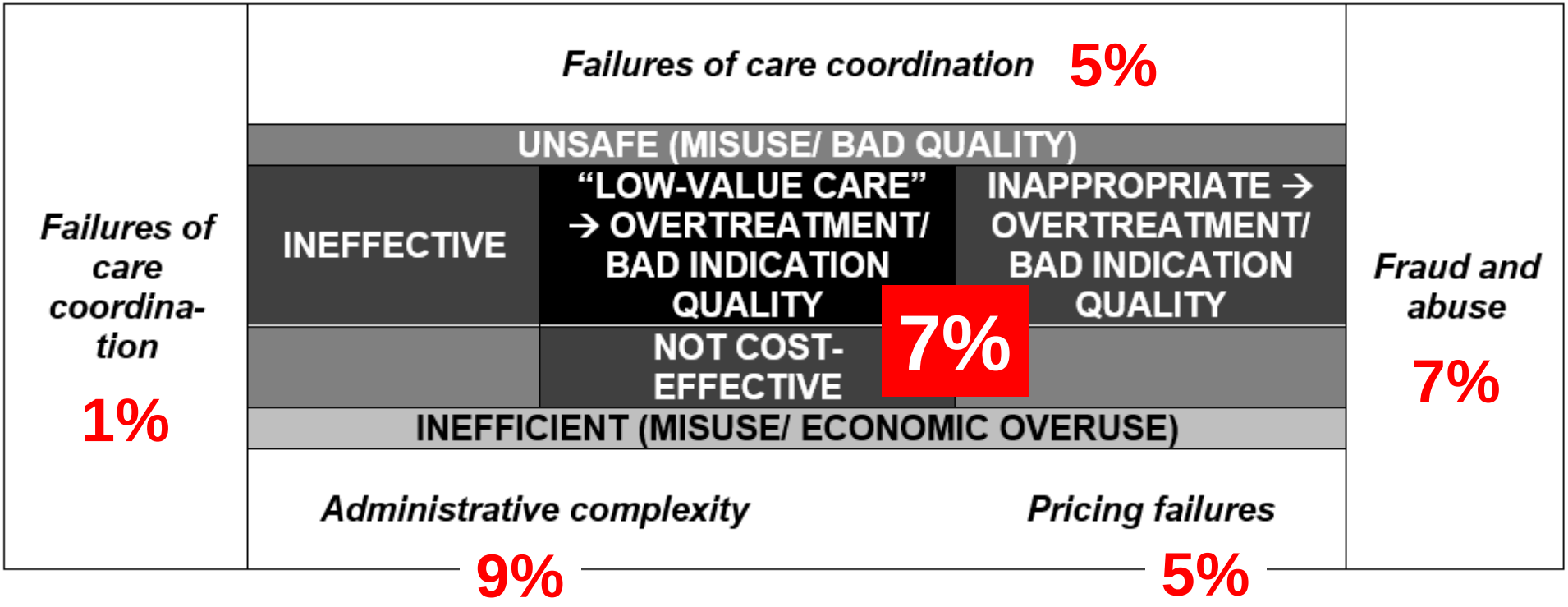
The framework to classify “low-value care”

	“All patients” potentially receiving the technology	*All patients belonging to one or more well-defined subgroups (by age, indication …)*	*“Certain patients” (individual medical criteria or preferences are relevant)*
Harm > benefit		Antibiotics for viral infections	
Benefit not proven	Low-value pharmaceuticals	FOCUS OF “LOW-VALUE CARE”	
No benefit or not better than alterna-tive (e.g., outdated)			
Benefit better but cost-outcome relation worse		MRI for breast cancer (except after mastectomy)	C-section only as patient/ physician preference
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)	Cataract surgery as inpatient	Inpatient cataract surgery (except if severe co-morbidity)	

The framework to classify “low-value care”

	“All patients” potentially receiving the technology	*All patients belonging to one or more well-defined subgroups (by age, indication …)*	*“Certain patients” (individual medical criteria or preferences are relevant)*
Harm > benefit	SAFETY		
Benefit not proven	EFFECTIVE-NESS	FOCUS OF “LOW-VALUE CARE”	APPROPRIATENESS (“INDICATION QUALITY”)
No benefit or not better than alterna-tive (e.g., outdated)			
Benefit better but cost-outcome relation worse		“COST-EFFECTIVENESS”/ “COST-BENEFIT”	
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)	EFFICIENCY		

Overtreatment vs. other forms of waste



Strategies against “low-value care” – the horizontal view

	“All patients” potentially receiving the technology	*All patients belonging to one or more well-defined subgroups (by age, indication …)*	*“Certain patients” (individual medical criteria or preferences are relevant)*
Harm > benefit	Revoke license		
Benefit not proven	Make HTA mandatory for coverage		
No benefit or not better than alterna-tive (e.g., outdated)	Remove from benefit package/ reimburse equally to alternative		
Benefit better but cost-outcome relation worse	Couple reimbursement to value (rather than effort/ costs of provision)		
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)	Provide equal reimbursement		

Strategies against “low-value care” – the vertical view

	“All patients” potentially receiving the technology	*All patients belonging to one or more well-defined subgroups (by age, indication …)*	*“Certain patients” (individual medical criteria or preferences are relevant)*
Harm > benefit	• *Remove from benefit package*	• *Restrict coverage to certain indications/ subgroups* • *Information campaigns / guidelines to providers* • *Selective non-payment* • *Bundled payment* • *Information campaigns to population/ patients*	• *Quality measurement (outcome)* • *Utilization review* • *Bundled payment* • *Information campaigns/ guidelines*
Benefit not proven			
No benefit or not better than alterna-tive (e.g., outdated)			
Benefit better but cost-outcome relation worse			
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)			

Strategies against “low-value care” – the mixed view

	“All patients” potentially receiving the technology	*All patients belonging to one or more well-defined subgroups (by age, indication …)*	*“Certain patients” (individual medical criteria or preferences are relevant)*
Harm > benefit	Primarily ex-ante and regulatory (license/ HTA/ coverage)		
Benefit not proven			
No benefit or not better than alterna-tive (e.g., outdated)		Ex-ante = steering behaviour, possibly prior authorization & ex-post = utilization review	Ex-post = quality indicators and utilization review & ex-ante = steering behaviour
Benefit better but cost-outcome relation worse			
Equal benefit but provision inefficient (e.g., inpatient instead of day-care)			

Conclusions

- Problem is large and necessitates a broad strategic approach (no country has done that yet)
- Mixture of regulation (license/ coverage), financing and information required, both ex-ante and ex-post
- But measuring the value of care is difficult and achieving consensus on measures often impossible
- Where measures against low-value are implemented, decisions are sometimes successfully challenged → strong political commitment required
- Value is often dependent on the clinical context, not very suited to strong ex-ante strategies → area of information mixed with utilization review