

# Imagining a World Without Low-Value Services: Progress, Barriers, and the Path Forward

Dhruv Khullar, MD, MPP; Carrie H. Colla, PhD; and Kevin G. Volpp, MD, PhD

**L**ow-value services—services that provide insufficient clinical benefit relative to cost—are increasingly recognized as a major problem in the US health care system. By some estimates, nearly half of Medicare beneficiaries receive a low-value service each year, and low-value care accounts for more than \$100 billion in health care spending annually.<sup>1,2</sup> The costs are likely much larger if downstream effects, such as psychological and financial harm to patients, additional unnecessary testing, and other complications, are included.<sup>3</sup>

During the coronavirus disease 2019 pandemic, the delivery of most services—both low- and high-value—is likely to be reduced. The pandemic's unprecedented impact on the US health care system, and society writ large, offers an opportunity to reshape the conversation and incentives around low-value services after the immediate crisis subsides. But without dedicated attention, it is likely that low-value services will return to prepandemic levels, if not higher, given disruptions in care and incentives to recoup lost revenue.

In the past decade, initiatives such as the ABIM Foundation's Choosing Wisely campaign and *JAMA Internal Medicine's* Less Is More series have helped raise awareness of the issue. But low-value care has remained pervasive, and significant reductions in the provision of low-value services have proven difficult to achieve.<sup>4</sup> Although progress on a problem as complex as low-value care will require time and sustained effort, it is worth examining current barriers to and opportunities for accelerating progress, especially at a time of abrupt and extensive changes within the health care system ([Table](#)).

## Barriers

Efforts to reduce the delivery of low-value care face 3 main challenges. First, the incentives within most health care organizations continue to encourage the delivery of more care. Fee-for-service payment still dominates in most organizations, which effectively penalizes clinicians for reducing utilization, including of low-value services. For many clinicians faced with productivity pressures and time constraints, the path of least resistance may be ordering a requested diagnostic test or medication instead of having a longer,

## ABSTRACT

Low-value services are a major problem in the US health care system. We believe that the coronavirus disease 2019 pandemic's unprecedented impact on the health system, and society writ large, offers an opportunity to reshape the conversation and incentives around low-value services. This article explores current barriers to and opportunities for accelerating progress toward high-value care delivery. We examine how financial and nonfinancial incentives, uncertainty in clinical decision-making, and insufficient partnering with patients and families contribute to the delivery of low-value care. We then explore potential solutions, including making it easier for clinicians to forgo low-value services and providing them with actionable information to make those decisions, expanding payer efforts to develop "value report cards," developing measures that map the adverse health and economic effects of low-value services, and training clinicians and health care leaders to engage in conversations with patients about the personal medical, financial, and psychological harms of low-value services.

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**TABLE.** Barriers to and Opportunities for Reducing Low-Value Services

Major barriers	Possible solutions
Financial and nonfinancial incentives favor delivery of more services	<ul style="list-style-type: none"> <li>• Design systems that encourage and make it easier for clinicians to weigh value in clinical decisions</li> <li>• Change electronic health record defaults to encourage high-value services and make it harder to practice low-value care</li> <li>• Provide peer comparison feedback and low-value service utilization reports to clinicians</li> <li>• Consider “appropriateness modifiers” to clinician payment</li> <li>• Implement “value report cards” from payers and state agencies</li> <li>• Integrate efforts to reduce low-value services into the National Quality Strategy</li> <li>• Create national awards to recognize organizations that have significantly reduced low-value care utilization</li> <li>• Create patient materials for clinicians to rely on, potentially saving time at the bedside</li> </ul>
Lack of accurate and robust measurement	<ul style="list-style-type: none"> <li>• Measure the downstream harm and economic consequences from low-value services</li> <li>• Include routinely collected patient-reported outcomes in assessments of value</li> <li>• Develop new measures that target overuse (in addition to underuse) of clinical services</li> <li>• Provide more funding to develop new measures capturing low-value services and interventions that aim to reduce them</li> </ul>
Poor communication to patients regarding the consequences and harms of low-value services	<ul style="list-style-type: none"> <li>• Train clinicians to communicate clearly and concretely about low-value services</li> <li>• Emphasize personal medical and financial harms</li> <li>• Build partnerships with advocacy groups and community organizations, particularly for marginalized populations</li> <li>• Employ traditional and social media to raise awareness of the issue</li> </ul>

more difficult conversation about why it is unwarranted. These conversations are further challenged by care models that threaten longitudinal clinician-patient relationships, such as urgent care clinics, direct-to-consumer telemedicine services, and clinical shift work, which may also interfere with the trust needed between clinicians and patients to collaborate to reduce low-value care.

Uncertainty in clinical decision-making also plays a major role. Clinicians are trained to be thorough, and they may order tests or perform procedures because common cognitive heuristics in medicine favor doing more, not less. Clinicians and patients alike fear missing a rare diagnosis (risk aversion) or may vividly recall illnesses befalling others (availability bias), prompting further testing and treatment, even when risks and costs outweigh potential benefits.

A second barrier to progress is gaps in accurate and robust measurement of low-value services. Measurement is complicated by technical and philosophical debates about what “value” in health care means. Waste for one patient may be peace of mind, or even high-value care, for another. The most widely available data sources, such as administrative claims, lack the clinical detail necessary to measure delivery of many potentially low-value services. In some cases, there also remains a resistance to forthrightly contend with value in health care, as reflected by congressionally mandated

stipulations that Medicare not consider cost in coverage decisions.

Finally, although recent initiatives have raised awareness of low-value care among clinicians, knowledge gaps remain, and researchers and advocates have not effectively communicated the scope or salience of the problem to patients. Research suggests that many patients have difficulty conceptualizing the harm associated with low-value services, often assuming that all care recommended by physicians has value.<sup>5</sup> Helping patients and families understand the adverse consequences of low-value services is important for progress.

### The Path Forward

A number of interventions aimed at reducing low-value services have recently been evaluated, but more research is needed to determine their relative efficacy in various clinical settings.<sup>6</sup> Patient-focused interventions include cost sharing, value-based insurance design, patient education, and clinician or health system report cards. Clinician-focused interventions include initiatives such as pay-for-performance, prior authorization, clinical decision support, and clinician education and feedback. The right intervention likely varies by service type, medical context, and patient population; reducing opioid prescribing for young patients

with migraines, for instance, requires a different set of interventions than reducing early imaging for lower back pain in elderly patients. In general, multicomponent interventions—those that use several modalities and address both patient and clinician roles in low-value care—seem to have the greatest potential.<sup>6</sup>

In addition to further study and expansion of promising interventions, several steps are needed to engender more systemic transformation in our approach to low-value care.

Convenience is important: We should make it easier for clinicians to forgo low-value services. A growing literature from the field of behavioral science suggests that systems can be designed to facilitate better decisions and higher-value care.<sup>7</sup> Many opportunities exist for changing default settings within electronic ordering systems by, for example, adjusting which laboratory tests are included in order sets or the sequence in which medications appear. Changing the defaults in electronic ordering systems has been shown to reduce opioid prescriptions, increase generic drug prescriptions, and lower rates of unnecessary imaging.<sup>7,8</sup> Another study found that behavioral interventions such as peer comparison and accountable justification (ie, prompting clinicians to describe why they are prescribing antibiotics for upper respiratory infections) significantly reduced rates of inappropriate antibiotic prescriptions.<sup>9</sup>

Other promising interventions involve actively providing clinicians with information to make better decisions through clinician education, clinical decision support, and data feedback. For example, giving clinicians routine utilization reports can reduce variation in low-value care, even in the absence of changes in financial incentives.<sup>10</sup> Payers could add an “appropriateness modifier” to clinician payment based on whether a procedure was performed for a high-, medium-, or low-value indication. It may be more effective to modify payment to individual clinicians, as opposed to organizations only, which is less likely to be directly experienced by individuals.<sup>11</sup>

Payers and states might consider evaluating health care organizations using “value report cards” to help patients decide where to seek care and to provide feedback to organizations. At the federal level, efforts to identify and address low-value care should be explicitly integrated into the National Quality Strategy and government-funded research efforts. The Agency for Healthcare Research and Quality could work closely with relevant stakeholders to help develop priority areas for research and action, and organizations that most effectively address overuse might be recognized through awards similar to those bestowed by the Baldrige Performance Excellence Program.

Next, researchers should develop and test measures that more effectively map the adverse health and economic effects of low-value care. Currently, many measures are derived from claims data alone, which may be insufficient for nuanced determinations of low-value care. Moreover, most existing measures focus on encouraging the delivery of underused services, whereas relatively few measures explicitly target overuse or capture the harm precipitated by low-value care. Going forward, performance measures should focus on overuse as well as underuse, include patient-reported outcomes, and more fully capture the downstream harm associated with low-value care. The emerging literature on care cascades following low-value services offers a promising foundation.<sup>3</sup>

Finally, clinicians and health care leaders should help patients more clearly understand low-value care by emphasizing its personal medical, financial, and psychological harms. Conversations about low-value care should focus not on abstractions about lower utilization, resource allocation, or health care costs, but rather on concrete consequences for patients and families. They should be framed not on what is lost but instead on what might be gained. Research has found, for example, that many patients hope that less testing could create time for more interactive and personalized care.<sup>5</sup> Engaging patients will require a multifaceted approach, including training clinicians on how to communicate about low-value care, building partnerships with patient advocacy groups and key stakeholders within local communities, and using traditional and social media to animate the issue for the general public.

Low-value services are now understood to be a major challenge with psychological, financial, and clinical implications. To date, action has been limited by how low-value services have been measured, managed, and communicated to both patients and

clinicians. The large structural health system changes engendered by the current pandemic offer an opportunity to reset how care is delivered. Making progress will require clearer assessment of the economic and health harms of low-value services, as well as making explicit the trade-offs inherent in expending resources on care that does not provide benefits commensurate with its cost. ■

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**Author Affiliations:** Division of Health Policy and Economics and Division of General Internal Medicine, Department of Population Health Sciences, Weill Cornell Medical College (DK), New York, NY; The Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth (CHC), Lebanon, NH; Department of Medical Ethics and Health Policy and Medicine, Perelman School of Medicine, and Center for Health Incentives and Behavioral Economics, University of Pennsylvania (KGV), Philadelphia, PA.

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**Address Correspondence to:** Dhruv Khullar, MD, MPP, Department of Population Health Sciences, Weill Cornell Medical College, 402 E 67th St, New York, NY 10065. Email: kh9010@med.cornell.edu.

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