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Editorial article

The time for high value practices☆

La oportunidad de promover las prácticas de alto valor

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Providing the patient with the health care he/she needs, at the right time and in the right way, is an essential objective of clinical practice. Decisions and interventions are expected to be evidence-based in terms of their benefits to the patient. When this is not possible, the benefit is expected to outweigh the harm that could be caused. Finally, when their costs are compared with other alternatives, they are expected to provide greater benefit[1]. However, some practices deviate from these premises, generating underuse[2] or overuse[3] at the time of diagnosis, referral or treatment.

Both are due to multifactorial causes that include, among others, budget constraints, organizational decisions, practice styles, professional accountability framework, lack of resources, knowledge or skills, misguided health beliefs, etc. Both coexist over time and, although they are common to all countries and health systems, there is significant variability in their numbers between interventions, countries and between regions within the same country[2,3].

Examples of underuse are found in the difficulties of access to health resources, both due to budgetary limitations (in developing countries or among people with fewer resources in developed countries), and due to organizational decisions (extension of cancer screening programs or access to certain treatments). Also, when patients do not receive the treatments they require or when they decide not to adhere to them[2]. Figures on underuse are difficult to specify, but in developed countries it has been reported that up to 45% of decisions may not be based on practice guidelines[4].

Underuse during the most critical phases of the COVID-19 pandemic has come to the fore in the chain of interruptions and cancellations in access to healthcare[5]. People's fear of becoming infected when visiting the centres has also played a role. Some estimates suggest that, in the first 12 weeks of the pandemic, more than 28 million surgeries (37% oncological surgeries) were cancelled worldwide[6]. Other data suggest that referrals from primary care were reduced by up to 60% in the first five months[7] and hospital admissions for non-COVID-19 pathologies by up to 69%[8].

The available data on overuse force us to reflect on their risk to patients and the inefficiency they generate in health systems. The volume of patients undergoing low-value practices in developed countries is as high as 80%, depending on the type of indication[3]. In Spain, 36% of family doctors[9] surveyed about their practice in the last five years acknowledged that they were recommending low-value practices to their patients quite frequently. In another recent study in our country, surgeons reported that unnecessary preoperative chest X-rays were still being performed in 15% of surgeries[10].

In our healthcare model, the family doctor and paediatrician are the gateway, and their decisions determine the likelihood of overuse. In this case, we have found that up to 55% of adult patients and 39% of paediatric patients have received at least one indication classified as Do Not Do by scientific societies[11]. Furthermore, this overuse causes insecurity. Up to 15% of those admitted to hospitals suffer an adverse event associated with low-value practices[12] and, in primary care, this incidence is around 5% in family medicine and 6% in paediatrics[11].

At the macro level, a few years ago, action began to reduce this overuse in our setting and in our country, although with varying degrees of success. With the *Less is More, Slow Medicine, Too Much Medicine, Do Not Harm,* or *Choosing Wisely* strategies, the best known and most widespread worldwide, the aim has been to raise awareness among physicians (and sometimes also among patients) of the impact of low-value practices[13]. The campaign Ċommitment to the Quality of Scientific Societies in Spain,; led by the Ministry of Healthcare, with the scientific coordination of Guía Salud[14], specified a set of Do Not Do's with the idea of modifying medical practice for the benefit of the patient and the sustainability of our healthcare model. Other initiatives are added to this campaign, such as DianaSalud led by the Center for Biomedical Research in the Epidemiology and Public Health Network (CIBERESP) or proposals for regional health services, such as the "Essencial" project in Catalonia, or the Andalusia, Aragon, Castilla-León or Navarra strategies, to name the best known. But one thing is to identify what should not be done, another is to measure what is being done that should not have been done, another is to disseminate what should not be done, another is to stop doing what should not be done, and yet another is to do what should be done. The *Right Care Alliance*[15] movement promotes cost-effective healthcare, tailored to each patient's circumstances and based on the best available evidence. It shares the objective of reducing overuse, but does so from a positive approach, promoting High Value Practices.

There are some post-pandemic proposals and reflections that we should consider. The impact of underuse during the pandemic

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is still unknown. Further studies on its consequences on patients' health are foreseeable. Some issues are more direct (increase in hospitalisations due to untreated complexity) and others will be exceedingly difficult to assess (the impact on the training of residents affected by organisational measures for almost a year of their training). Scientific societies, management teams and health authorities must specify as soon as possible what structural and organizational measures should be adopted to face this second pandemic as a result of the consequences of SARS-COV-2 in non-COVID-19 pathologies. Correcting the effects on people, with the focus on equity, should come to the fore.

The need to increase efficiency has been prioritised with the idea of recovering health systems from the impact of the pandemic within a framework that pursues comprehensive, person-centred care. Necessary improvement could come from promoting a high-value practice[16]. There seems to be no better opportunity and no greater need than our immediate horizon.

In Spain (other countries report similar figures)[17] less than 50% of family doctors and hospitals are aware of strategies to reduce overuse[18,19]. The role of scientific societies in pointing out Do Not Do's, which are still common and have a greater capacity to cause harm to the patient, is key. The Quality Commitment strategy that has been launched cannot be reduced to a list of 5 proposals. In the same vein, it is important to consider that without measuring what is happening, little progress will be made. So far, only some recommendations have indicators that allow verifying their compliance. The Health Strategy is echoing the need to measure overuse, but the system would probably appreciate (the patients as well) extending the advances that have been made.

Discouraging certain low-value practices and encouraging high-value practices should be simple, but we do not always succeed, sometimes because of the professionals, sometimes because of the patients, and sometimes because of the system. There is no doubt about the need and usefulness of clinical practice guidelines. However, future professionals must be taught that they are not the solution for all cases. We need to be aware that they do not always cover the whole caseload[20], that they do not cover the whole comorbidity[21] (unlike in everyday practice) and that they occasionally clash with the decisions that are taken after an appropriate clinical reasoning process for a given patient. Moreover, it has long been pointed out that they teach what to do but rarely advise how to stop doing what we used to do and know not to do[22]. A recommendation on low-value practices may need to be considered in the development/revision of practice guidelines to help raise awareness of their impact.

During undergraduate and postgraduate training much is learned about what to do, but less about what not to do. Unlearning is more complex than learning, and the data on the evolution of the Do Not Do's, whose practice refuses to be reduced, is clear to see. Rotating interns could benefit if tutors spread the culture of high-value practices among residents. In this regard, identifying the cognitive heuristics that modulate clinical decisions would improve the training of future physicians and the safety of patients.

Given that management agreements are one of the tools that is proving most successful in changing daily practice (albeit sometimes without benefit to patients), these agreements could include measures to correct the impact of underuse due to the pandemic and overuse due to low-value practices, preventing a return to the old normality in daily practice.

The model of professional responsibility, the fear of being immersed in a complaint procedure or litigation, have an impact on the rise of defensive medicine. Promoting high-value practices requires a broad consensus on what regulatory framework promotes quality and safety for patients and what elements of the current framework put patients at risk.

Clinical leadership, which has been key during the pandemic, should be promoted more decisively than before. At this level, clinicians need new tools to facilitate their decision-making and to enable them to fully benefit from the information stored in electronic clinical records. The current investment under the Recovery and Resilience Plan does not have this as a priority.

The commitment of health professionals to achieve a correct and rational use of resources is essential. But patients also need to be actively involved. So far, the campaigns launched have failed to engage them, sometimes not being sought because policy makers fear that the population will associate it with ¨cutbacks¨. However, without the involvement of all stakeholders, it is not possible to achieve sustainable change over time.

The COVID-19 pandemic has brought the capacity of health systems to the brink of collapse. But the post-pandemic requires different solutions to what has been done in the past in order to provide adequate care for the higher volume of patients now expected, to inspire the professional and to maintain the viability of the system. If we end up doing the same thing, the result will be no different, and if we have to go through something similar again, we may not be able to recover.

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