One way to reduce health care costs is to end unnecessary testing and procedures. There are multiple national and local campaigns, targeting prescribers with guidelines for services that have no health value. Choosing Wisely and Get with the Guidelines are two examples. Turns out that re-educating prescribers does not automatically result in them changing their evil ways. A review of Washington state’s all-payer database provides the evidence.

The Study and Its Findings

1.52 million “services” provided to patients with commercial insurance (not Medicare, Medicaid or workmen’s compensation) were analyzed using a commercially available algorithm and tool. [1]

- 54% were necessary services
- 1% were services that were ambiguous in their indication – judgment calls
- 44% were unnecessary representing a third of health care spending

That is a lot of waste and as might be expected 11 "services" out of 47 were the drivers of waste. There were the usual suspects, antibiotics for upper respiratory and ear problem, screening patients for prostate cancer, Vitamin D deficiency or coronary disease and imaging for headaches and back pain. But one group caught my surgical eye - the testing performed before surgery, part of the "entrance exam" designed to identify problems before they resulted in complications or deaths. These included preoperative electrocardiograms, chest x-rays, pulmonary function tests and baseline laboratory testing for low-risk surgery.

Pre-operative testing

The why of low-value preoperative testing is, to my mind, due to both “an abundance of caution”
and a “failure to communicate.” Surgeons and anesthesiologists are busy doing; they rarely have time to communicate outside of the patient in front of them.

It is appropriate that an anesthesiologist assess a patient before surgery, after all, they are responsible for keeping them both anesthetized and safe. And they developed the first risk stratification system that is universally used, the American Society of Anesthesia Physical Status classification or ASA. The scoring works very well, but the anesthesiologist only makes that determination when the patient has completed their “preoperative testing;” in other words, all of those tests are frequently done irrespective of a patient’s health status. After all, those tests at worst involve drawing blood (and with surgery in their future, a needle stick should not be a big concern), have minimal cost (although the aggregate is quite significant as the paper points out) and who knows you might find something wrong. Requiring everyone to have the same basic testing, irrespective of their health reduces physician work. Without a rote approach, the anesthesiologist would either have to know about the patient first, or the surgeon would have to communicate their concerns, but as I said, we are busy doing – routine testing saves time, our time, not necessarily yours.

The authors point out that most educational efforts have failed with established physicians and that now the emphasis must be directed towards medical students – it is a nice way of saying that these wasteful practices will not be addressed until the current physician-dinosaurs die out and are replaced with a newer generation. I would suggest that while this may be, in sad fact, the best approach we could try and insist that surgeons and anesthesiologists talk more.

It should be possible that they can come together long enough to determine what testing is necessary and sufficient, based on the ASA classification. Integrated health system would do this creation and promulgation of best-practices if they, in turn, were not so busy billing. This is one of those times when skin in the game might make a profound change. What if 50% of the savings went back to the physicians in the few years it might take to learn new habits and develop different work patterns? In a carrot and stick world, education is nice, but for my money, the carrot works better. As to the stick, I am not an advocate of “spare the rod, spoil the child.”

[1] The tool is the MedInsight Waste Calculator commercialized by Millman, a company deeply involved in promulgating criteria used to determine the appropriateness of health care. Despite their long-standing role, how the algorithm works, its magic formula is proprietary, so we have to take their word that everything is appropriately characterized and what those categories genuinely mean.

Source: Calculating Health Care Waste in Washington State: First, Do No Harm JAMA Internal Medicine DOI: 10.1001/jamainternmed.2018.3516

The full report on Health Care Waste in Washington State