

IN REPLY: In this issue of the Journal, several correspondents weigh in on our recent article in which we flagged services of potentially low value within Australia's Medicare Benefits Schedule (MBS).¹ Their letters highlight informative and unique reactions to such work.

I would like to begin by clarifying that we are not the party suggesting items are of low value. Rather, we have flagged items that others have asserted — with evidence — are of potentially low value in certain contexts. This small but important point has consequences for how some have perceived and responded to our project. It would be improper to see our contribution as an end point in an evidence-based medicine process; it is but one starting point.

Medicare funds dozens of individual and combined surgical procedures for obstructive sleep apnoea (OSA) because these procedures became entrenched on the MBS before strong evidence was required (many countries do not fund them at all²). In trials, most perform poorly and with significant side effects.²⁻⁴ Upper airway surgery for adult OSA has been prosecuted at length elsewhere, and in that discussion (including rapid responses) many of the points in its defence are rebutted.² Do some patients benefit from surgery? Yes, but as a fifth-line salvage procedure;^{2,4} few applications are of high value and there can be no arguing they are over-used.

Hocking and colleagues are eager to ensure that decisions are not rushed and that more information is brought to the fore. This is a valuable contribution to the process of flagging potentially low-value health care practices. Nowhere is the role of chlamydia as a cause of pelvic inflammatory disease (PID) being questioned; the pooled evidence we cited¹ relates to the value of screening

by age. We are excited to hear of the ACCEPt trial, and hope it is sufficiently powered to determine whether repeated annual screening in general practice for those aged under 30 years will lead to a reduction in the prevalence of chlamydia and incidence of PID.

Chan and colleagues raise concern about evidence omitted from and competing with that cited in our article, with the important goal of achieving balance. Omission of the articles they identify points to lack of sensitivity in our search. Further scoping would obviously reveal these papers. Both points were discussed.^{1,5} More evidence has surfaced since we conducted our search, and shows that 22.5% of cardiac defibrillator implantations (in the United States) represent waste.⁶

Haines enthusiastically and constructively furthers the discussion with his specialty knowledge of oncology. Although our project didn't include considering pharmaceuticals, and "did not also address the vast costs associated with treating the subsequent complications of the radical treatment interventions", I would encourage the clinical and broader communities to follow the lead provided here by Haines to raise critical awareness of these issues.

Readers should view our list as a starting point in a quality improvement agenda, not as an end point. Be reassured that Australia's world-class health technology assessment processes include, for example, the construction of PICO (population/s, indication/s, comparator/s, outcome/s) criteria if and when services of potential low value face formal review. Also, clinical stakeholders (generally a panel of up to 10 clinicians) are involved to give expert guidance. Regarding the downstream considerations mentioned by Haines, in an earlier but related article,⁷ criteria were proposed covering many such "disutilities", including cost considerations, equity in care and health impact, all of which might add weight when prioritising certain candidate services. Further, Australia's policy and research processes increasingly provide avenues for broader stakeholder engagement.⁸

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Established health care practices will always have a great deal of support from many sources, including from clinical champions and publication bias favouring established practices. There is also a broad literature exploring the role cognitive dissonance and psychological reactance play in clinical decision making. How these interrelate with the perpetuation of low-value care is explored in a new article.⁹ Finally, too few groups critically evaluate established practices. Those groups that do face a difficult task because they must overcome a higher burden of evidence to reverse established beliefs.^{9,10}

It is easy to call an established health care practice high value, even in the face of uncertainty. The greater challenge is the road less travelled; accepting new evidence contrary to conventional wisdom. Join the campaign against waste: write to the Department of Health and Ageing (Medical Benefits Division), your hospital board, state health department or the Australian Health Insurance Association, and nominate areas of low-value health care. By helping identify low-value practices for formal review, you will contribute to freeing resources for higher-quality, higher-value applications.

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