Deprescribing Policies: Time for a Fresh Approach

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One of the most difficult clinical tasks is deprescribing a medicine that was previously prescribed—a significant challenge when patients have too many medications, some of which no longer benefit the patient but continue to have adverse effects. Health policy suffers from the same problem, and the same factors that make deprescribing so difficult in clinical medicine also make deprescribing a health policy intervention a challenge.

The same harms we see in patients exposed to polypharmacy are likely in the health care delivery system. It’s time to take a different approach. One place to begin is the Hospital Value-Based Purchasing (VBP) program, which is ripe for policy deprescribing.

Like medicines that should be deprescribed, policies like VBP were initially created with good intentions. We know that incentives matter in health policy and that part of the reason that our health care system fails to deliver consistently high-quality care is the lack of clear incentives for quality. In an attempt to address this issue, the US Congress incorporated Hospital Value-Based Purchasing into the Affordable Care Act in 2010. Value-based purchasing is designed to reward quality, leveraging financial incentives to encourage hospitals to adhere to a broad set of metrics, including ones measuring clinical processes, patient experience, costs, and health outcomes. This well-intentioned policy, however, has failed to live up to even the most modest of goals and the best evidence suggests that it is likely causing more harm than good. In an era where we have added so many other policies into the health care markets (readmissions penalties, penalties for hospital-acquired conditions, and bundled payments, to name a few), it is high time we deprescribe hospital VBP.

Evidence on VBP’s Effects
One principle (though not the only) for assessing a medicine’s eligibility for deprescribing is whether the medicine is still clinically useful. Evidence on the benefit of VBP has been clear for some time: it has had no positive effect on patient care. One early study found no effect on patient outcomes. Other studies followed, finding little effect on patient experience. The most recent data, examining outcomes years after the launch of the program, find little evidence that VBP leaves patients better off. These results were wholly predictable; VBP was modeled after a Centers for Medicare & Medicaid Services (CMS) demonstration program that also failed to improve patient outcomes. Now, with more than half a decade of additional information, there is little reason to believe that this policy intervention will suddenly start working. While many of us have written about how to make the program more effective, there seems to be little appetite for actualizing these changes. This program’s lack of efficacy is a key reason to consider deprescribing.

Beyond the lack of effectiveness, there is also reasonable evidence of harm. First, the failures of VBP represent significant opportunity cost. Hospitals have hired staff and consultants to meet the VBP goals. The CMS has teams of individuals overseeing the program. It is harmful to spend time, effort, and resources on a program that isn’t helpful, just as it is harmful to ask a patient to take a medicine that we know is not effective.

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But the issues with VBP go beyond these harms. There is clear evidence that safety-net hospitals and those that disproportionately care for sick patients are more likely to get penalties, whereas hospitals that care for healthier, wealthier patients are more likely to get bonuses. That inequality is clear harm to the health care system.

Welcome to the Global Village
When experts classify a variant, they consider not only its biological consequences, but also its prevalence in the general population and the phenotypic characteristics of any disease associated with it.

“These things are really important, especially in underrepresented minorities who are tested less and have a different spectrum of what is ‘normal’ in genetics,” Domchek said. Clinicians have to be careful not to assume that these patients’ VUS are pathogenic just because they’re not seen in the general population.

That’s why having an expansive international database with information from people of varying ethnic backgrounds from around the world is valuable. “The more the variants the times seen, the more precise the classification can be because you’ll have personal and family history to guide you.”
The CMS has been down this road before with its Hospital Readmission Reduction Program, which also disproportionately harmed safety-net hospitals. Congress eventually had to step in and demand that the agency take a different approach. It's time for Congress to intercede and take action on VBP as well.

**Why Is Deprescribing so Hard?**

We know that deprescribing medicines can be difficult. Clinicians often feel that deprescribing suggests that their initial decision was wrong (though it may not have been) and of course, there is simply clinical inertia— with so many other things to do, finding time to explain why a medicine is no longer needed is difficult. These challenges apply to health care policy as well. Policy makers feel invested in the programs that often took months or years to craft and implement. People overseeing these programs want to believe strongly that the program is working.

Hospitals, likewise, often invest substantial resources into programs and are loath to admit that their efforts have not borne fruit. Entire industries and consulting organizations are created to help hospitals meet the goals of programs like VBP and these vested parties are also resistant to changes. While these “stakeholders” are usually well intentioned, they make deprescribing policies very difficult. The inertia keeps federal programs in place well after they have been found to be ineffective.

**How to Move Forward?**

Unlike clinical medicine, where our treatments have been rigorously tested in clinical trials, most policies are implemented based on little evidence that their benefits outweigh their harms. It would be useful to test out our policy efforts more rigorously, possibly rolling them out in certain regions and communities before a large-scale national implementation (an approach the CMS proposed for their mandatory bundled payment programs).

In addition, and every bit as important, Congress should demand rigorous, independent evaluations. Right now, the CMS chooses its own evaluators, and although these evaluations are meant to be independent, the truth is that evaluators know that in order to get future contracts from the agency, their current assessments have to satisfy their funder. This arrangement means these evaluations are far less useful. Congress could easily shift the evaluation money it already allocates over to the National Institutes of Health and set up an independent mechanism through which evaluators are selected.

Finally, every health policy intervention should have a sunset clause stipulating that it will have an end date (with a timeline varying from a few years in some instances to longer in others). If the policy has been demonstrated to be working, Congress can then renew it. The current default of policies lasting forever makes little sense.

The failure to learn from ineffective policies and to prune policies that are not succeeding has become a major impediment to improving our health care system. It leads to wasted time, potential harm, and loss of faith in the policy making process.

We can do better. We know that deprescribing is hard, whether in clinical medicine or health policy. But like a physician in practice who takes time during his or her busy day to examine a patient’s medications and choose which ones to discontinue, Congress and the CMS both need mechanisms in place that allow them to pause and consider which of its policies are working and which ones need deprescribing. Without such an approach, we will continue to have policies that cause more harm than good and make it more difficult to improve the care of patients.

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