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LETTER TO EDITOR

# The Ethical Challenge in the Provision of Health Services: Unnecessary Services

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**A B S T R A C T**

Most health systems in developing countries are confronted with the major challenge of providing unnecessary healthcare services. Unnecessary healthcare services can be defined as a spectrum of overused, low-value, or inappropriate interventions that lack a clear clinical indication, provide minimal or no benefit to the patient, and may cause harm. This issue not only depletes limited resources across the broader health system—including hospitals, insurers, and out-of-pocket payers—but also directly jeopardizes patient safety through adverse effects, preventable complications, and misdiagnoses. Patient safety is a core value of all hospitals and stands as one of the most critical indicators of healthcare service quality. The available evidence points to the severity of this problem and underscores the urgent need for systematic interventions.

**Keywords**: Defensive Medicine; Fee-for-Service Plans; Health Services Misuse; Low-Value Care; Medical Overuse; Patient Safety; Unnecessary Procedures

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Studies in Iran have reported a substantial financial burden associated with unnecessary healthcare services. In particular, inappropriate hospitalizations and excessive laboratory testing can impose considerable costs on patients and health insurers (1-4). It appears that this challenge extends far beyond mere financial costs; indeed, tracing its roots reveals three structural, complex, hard-to-address, and deeply intertwined factors.

1. Defensive medicine: In all likelihood, most physicians cite the fear of litigation and legal repercussions as the primary motive for ordering unnecessary services—an issue that has been documented in several studies (5-7).

2. Fee-for-Service Payment System: In Iran, physician reimbursement is not purely fee-for-service; rather, it reflects a hybrid structure combining fixed salaries, fee-for-service tariffs, and performance-based components (1). However, the fee-for-service component—which links payment to the volume of services delivered—remains a dominant mechanism in many clinical settings. This structure creates an inherent financial incentive for providers to increase service volume, a phenomenon known as supplier-induced demand (SID). Iranian evidence supports this concern: a recent dynamic panel analysis of cataract surgeries found that a 10% increase in ophthalmologist density was associated with a 4.9% – 6.2% increase in surgery counts and a 7.3% – 7.9% increase in service volume, consistent with supply-sensitive utilization patterns. Similarly, qualitative health systems research in Iran identifies fee-for-service payment and dependence on service volume as key drivers of unnecessary utilization. International systematic reviews have also demonstrated that fee-for-service reimbursement is associated with a higher quantity of services compared with alternative payment models such as capitation. This

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factor therefore plays a significant role in the ordering of unnecessary services (8-10).

3. Patient Expectations and Limited Health Literacy: Limited health literacy and patient expectations are prevalent in a subset of the population, leading many to perceive receiving intravenous fluids, antibiotics, or even repeated CT scans as a sign of "good treatment" (11). This strong patient insistence places physicians in a difficult position, often compelling them to comply with requests for services that are clinically unnecessary to maintain the therapeutic relationship or meet patient expectations.

Given that the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD) emphasize the transition toward value-based healthcare systems, there is a pressing need for a cohesive national initiative to develop a list of unnecessary and "Do Not Do" services and laboratory tests within Iranian hospitals (12, 13). Beyond the financial and patient-level drivers mentioned above, system-level governance failures play a critical role in sustaining this issue. Specifically, the lack of effective clinical oversight and the absence of continuous feedback to service providers have further deepened the gap between evidence-based clinical standards and actual practice. To address these systemic issues, some of the most important strategies available to health system policymakers include the following:

1. Reforming the payment structure: Transitioning away from the traditional fee-for-service model towards value-based payment systems—such as capitation, Diagnosis-Related Groups (DRGs), bundled payments, and Pay-for-Performance (P4P) tied to evidence-based clinical quality metrics rather than merely patient satisfaction. these models can align financial incentives with clinical value and care coordination, making the provision of unnecessary services financially unappealing for physicians.

2. Establishing a utilization review system: Forming clinical committees in hospitals to review patient records —either through sampling or targeted selection— to ensuring that medical orders are consistent with the most recent evidence-based clinical guidelines and national protocols.

3. Empowering the public and raising awareness: Leveraging mass media and social networks for educational and cultural interventions to rectify common misconceptions regarding diagnostic and therapeutic services. This would encourage patients to demand necessary services from their physicians rather than insisting on unnecessary ones.

4. Analyzing and reporting: Providing monthly performance reports (scorecards) to physicians regarding their service provision patterns. This would allow each physician to compare their own service profile with the average of their peers in the same specialty and subspecialty, and enable them to implement the necessary corrective adjustments.

5. Supporting evidence-based medicine and reforming complaint/litigation pathways: Establishing an appropriate legal framework that supports physicians who practice evidence-based medicine and adhere to clinical guidelines to protect them from frivolous lawsuits. In addition, reforming the patient complaint process can reduce the fear of legal repercussions, which drives the provision of unnecessary services.

Evidence-based policy-making and evidence-based practice represent an effective pathway for addressing challenges of this nature (14, 15).

Addressing this issue requires a fundamental, multidimensional revision of the current system. While the five strategies outlined above provide a comprehensive framework, their successful implementation depends on a phased approach that carefully evaluates cost, feasibility, and prioritization. Without such revision, the efficiency of the health system will face serious threats, and financial resources will continue to be wasted. Furthermore, the erosion of public trust in the medical staff and the entrenchment of limited health

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literacy and expectations of over medicalization within society will worsen. Therefore, health system managers must take immediate measures to contain the silent epidemic of over medicalization and system inefficiency. This can be achieved by designing operational programs and drawing inspiration from successful international experiences, such as the implementation of evidence-based clinical guidelines by the UK's National Institute for Health and Care Excellence (NICE) and the Choosing Wisely campaign in the United States and Canada, both of which have demonstrated measurable reductions in low-value care and unnecessary medical interventions.

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R.A Drafting the work, Substantial contributions to the conception, Final approval of the version to be published; K.K Drafting the work, Substantial contributions to the conception, Final approval of the version to be published.

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The authors declare no competing interests.

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