



Waste, We Know You Are Out There

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Both presidential candidates have put forward proposals for curtailing waste in the U.S. health care system. Behind these claims are estimates that various medical procedures are used

inappropriately as much as one third of the time in the United States. The director of the Congressional Budget Office, Peter Orszag, stated in August 2008 that “a variety of credible evidence suggests that health care contains the largest inefficiencies in our economy. As much as \$700 billion a year in health care services are delivered in the United States that do not improve health outcomes.”¹ Reports abound of needless or low-benefit procedures, some performed for fear of litigation, some out of venality, some demanded by importunate patients, and some representing the mindless repetition of established routine: “That’s the way we do things here.” As is often noted, other countries spend

less per person than we do and achieve equal or superior outcomes. That a first-class health system can be run for less than the United States spends — or a better system for what we actually spend — is undeniable. But what, really, do we mean by waste? Do we have the means to curtail it? How fast can savings be realized?

Increased health care spending has not been wasteful on the average. The gains from improved health outcomes have equaled or exceeded the total value of all measured economic growth.² Although not all these improvements can be attributed to health care, the combination of improvements in longevity that can be traced to medical care, combined with ben-

efits from reduced pain and anxiety and increased personal functioning, can justify spending growth.³ Of course, no waste “on the average” in no way excludes considerable waste on the margin. And high historical returns do not guarantee high future returns.

What, exactly, is wasteful health care spending? Everyone would agree that a costly intervention that is always useless or that harms patients is wasteful. Even care that is expected to help but turns out to be ineffective may be judged to be wasteful — but only in the trivial sense that fire insurance on a house that never burns down is *ex post facto* wasteful, when one disregards the peace of mind fostered by protection against risk.

To be meaningful, however, a definition of waste must rest on an *ex ante* perspective: What is the expected value of outcomes for definable classes of patients? And,

Probability of Benefit or Harm from Three Hypothetical Medical Interventions.				
Intervention	Probability of Extending Life		Probability of Death	Expected Years of Extended Life
	By 1 Yr	By 5 Yr		
1	0.5	0	0	0.5
2	0.25	0.05	0.7	0.5
3	0	0.1	0.9	0.5

as a practical matter, the definition must be supported by credible evidence. A given intervention typically affects individual patients differently. Analysts sometimes summarize these outcomes — including harms as well as benefits — in a single number for each intervention, such as the cost per added life-year, quality-adjusted life-year, or disability-adjusted life-year. The resulting averages conceal information that may be important to patients and providers. The three hypothetical cases in the table, for example, produce the same expected increase in survival but may well be viewed differently by a patient.

The costs per unit of health improvement from medical interventions typically form a smooth continuum. Waste could be defined as care that costs more than some threshold per unit of health care improvement. But what threshold? The cost of extending life by 1 year or improving its quality ranges from a few dollars to millions of dollars; and studies of the same intervention sometimes produce quite different results.⁴ Judgments will vary as to where along this continuum waste begins. Furthermore, such estimates incorporate analysts' weightings of various outcomes and risks, which may differ from the values that patients would place on them. Most of the care that analysts label as waste is not uniformly useless but pro-

duces average benefits that are judged to be small relative to cost — and typically that cost is widely diffused among payers other than the patient. Even those interventions deemed excessively costly actually help some patients. So it is easy to understand why — apart from self-interest — physicians may provide their patients with wasteful care. Thus, the very definition of waste is unclear, and the term is fraught with ethical ambiguity.

Assuming a socially accepted definition, curtailing waste in order to slow the growth of spending is a goal worth pursuing aggressively. Unfortunately, the U.S. health care system could not be better structured to frustrate the elimination of waste than if it had been designed to do just that. Payers, with one exception, lack sufficient leverage to materially influence the practice of medicine. The exception, Medicare, operates under authorizing legislation that states: "Nothing in this title shall be constituted to authorize any Federal Officer or employee to exercise any supervision or control over the practice of medicine."

These fragmented payers cover most short-term care — 96.5% of the cost of hospital services and 90% of the cost of physician services. Thus, patients don't have much financial incentive to avoid waste. Neither do doctors, whose ethics and training enjoin them

to do what is best for the patients they are treating and whose financial interests may cause them to interpret "what is best" overly broadly. And data to support decisions to curtail particular treatments for groups of patients that can be identified in advance are scarce.

Given these realities, what should be done to cut spending on low-benefit, high-cost care? I believe the first step should be heavy investment in research on what works and what doesn't, and at what cost. Thousands of studies have compared the cost and effectiveness of various interventions, but only a small proportion of what doctors do has been subject to careful cost-effectiveness analysis — particularly analysis that takes into account the vast range of presenting conditions that may influence outcomes. Current estimates of aggregate waste are therefore heroic extrapolations from studies of a small proportion of interventions.

It is scandalous that Congress fails to dedicate, say, 1% of Medicare and Medicaid spending to support research, conducted by an apolitical body, on the effectiveness and relative costs of medical procedures and to require private payers to make a similar contribution.⁵ The results from such research would be years in coming, but the size of the task heightens the need to begin it now.

The second step would be to extend insurance coverage to the uninsured. This step would increase near-term spending. So it may seem odd to include it in a list of measures essential for cost control. But sustained limits on spending, as distinct from voluntary spending reductions arising from cost-effectiveness studies,

will be possible only if nearly everyone is insured. The reason is that if spending limits cause providers to withhold some beneficial care because it costs too much, they will tend to do so selectively, favoring strong payers (the insured) over weak ones (the uninsured). In a world with effective spending limits, being uninsured would take on a whole new and terrifying meaning. Societal revulsion toward the resulting inequalities and deprivation would threaten the entire cost-control effort. Thus, the added near-term spending resulting from extending coverage to the uninsured not only is justifiable in its own right but also is a precondition for sustained cost control.

Other ideas regarding ways to achieve savings abound: increasing patients' cost sharing, unshackling Medicare to allow it to use its spending clout and regulatory influence, changing physicians' norms through education

and financial incentives, implementing delivery reforms such as providing patients with medical homes and improving disease management, increasing use of information technology, instituting reforms of insurance markets, and many others. None of these measures will yield dividends easily or early, and hopes for their payoffs are often greatly exaggerated. Most promise one-time savings only, not a reduction in the long-term rate of spending growth. All would be realized against the background of technological advances and population aging that will continue to increase health care spending at rates well in excess of income growth. Implementation of the measures would not meet the budget challenge posed by the rapid growth of health care spending. But the dividends from repeated one-time savings add up and are well worth pursuing. That all these changes would take decades to become fully effective only adds

to the urgency of initiating them promptly.

No potential conflict of interest relevant to this article was reported.

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ELECTION 2008: THE CANDIDATES' POSITIONS

Reproductive Freedom and the Next President

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In a dramatic speech on the floor of the U.S. Senate in July 2006, Senator Barack Obama (D-IL) described a visit from a constituent whose 2-year-old son, Ryan, had cerebral palsy, which had severely impaired the development of his speech and motor skills. Invoking the many children like Ryan, Obama argued that human embryonic stem-cell research is crucially important and that federal funding for such research is needed. Speaking the following day, Senator John McCain (R-AZ) stat-

ed, by contrast, that human embryonic stem-cell research raises “serious ethical and moral concerns” and that it should receive federal funding only insofar as it relies on embryos that were “originally created for reproductive purposes and [are] now frozen or slated for destruction by in vitro fertilization clinics.”

This disagreement reflects the evolution of the national debate about “reproductive freedom.” Whereas election campaigns once focused on abortion as the pri-

mary element of reproductive freedom, candidates now find themselves addressing a broader array of arguably related issues, including the use of human embryos for stem-cell research and whether such research should receive federal funding; the extension of eligibility for the State Children's Health Insurance Program (SCHIP) to unborn “children” (but not pregnant women), in keeping with a 2002 federal redefinition of “child” as “an individual under age 19, including the period from