EDITORIAL

Eliminating Wasteful Health Care Spending—Is the United States Simply Spinning Its Wheels?

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The United States is the most expensive health care system in the world,[1] with broad consensus among experts that a considerable portion of that health care spending is wasteful. In 2012, Berwick and Hackbarth[2] estimated that, at minimum, wasteful spending accounted for 21% of total expenditures in the United States. Since its publication, the United States has experimented with several new payment models, hoping to spur innovations that will curb unnecessary and wasteful health care spending. In a study in a recent issue of *JAMA*, Shrank and colleagues[3] took another look at how much progress we have made. Overall, the results are disappointing.

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Shrank and colleagues[3] estimated that now as much as 25% of total health care spending in the United States is wasteful, amounting to approximately $760 billion to $935 billion wasted annually. That is more than the country spends on primary and secondary education for all of its children.[4] Similar to the Berwick and Hackbert study,[2] the study by Shrank and colleagues[3] estimated waste across 6 categories, using a framework from the Institute of Medicine: failures of care delivery, failures of care coordination, overtreatment, administrative complexity, pricing failures, and fraud and abuse. Beyond just identifying waste, the authors estimated that $191 billion to $282 billion per year could potentially be saved with the systemwide adoption of interventions that reduce waste. For their study, they examined 54 unique articles or reports from peer-reviewed literature, government agency documentation, and the gray literature that were available January 2012 to May 2017.

The study by Shrank et al[3] offers an important moment to reflect on the progress or lack thereof in eliminating waste from the US system. Why has it been so hard? One reason may be that the national strategy is placing too much emphasis on initiatives that do not work. Since the passage of the Affordable Care Act, the federal government has implemented several value-based programs to target improvements of quality of care, reduce adverse events, and emphasize care coordination as a means to reduce unnecessary spending. The goal of value-based programs is primarily to address inefficiencies in 3 of 6 areas: failure of care delivery, failure of care coordination, and overtreatment or low-value care. Shrank and colleagues[3] estimate that these areas collectively account for 27% to 37% of total waste. Unfortunately, most value-based programs have had little to no meaningful association with changes in cost, quality, or wasteful spending.

Hospital pay-for-performance programs, for example, including the Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program, have not improved patient outcomes or reduced complications,[5,6] and there is scant evidence that they have reduced waste. Another key program, the Hospital Readmissions Reduction Program, was touted as initially successful, but newer evidence suggests that little if any change in hospital revisit rates resulted, and it is possible that modest unintended harm occurred.[7,8] Other national alternative payment models, which are increasingly being used as a tool to encourage better integration and coordination of care between inpatient and outpatient clinicians, have had some modest effects. For instance, bundled payments for episodes of care have reduced expenditures for a few conditions (primarily low-risk surgeries)[9,10] but not for others, such as medical conditions.[7] Federal patient-centered medical-home demonstrations have also failed to generate any meaningful savings.[11] The one bright spot has been accountable care organizations, which appear to have achieved modest savings, largely by avoiding hospitalizations and post-acute care and primarily in physician-led organizations.[12] The degree to which this represents integrated care is unclear, and at least 1 study[13] has raised questions about the degree to which the savings are associated with better risk selection (that is, accountable care organizations save money by avoiding patients at high risk). Either way, even the most optimistic reading of accountable care organizations suggest their savings are just a small fraction of the estimate of waste by Shrank et al[3] across these 3 domains. In addition, other studies have found that targeting care coordination and care management produces little to no savings at all.[14] Taken together, although these value-based programs may improve population health, the evidence that they are taking waste out of the system is lacking. In fact, they may simply be adding to the quality reporting and administrative complexities that characterize so much of the US health care system.[15]

Does this mean targeting waste is ill advised? It does not mean that at all. In fact, we believe that we have spent too little time tackling the bigger drivers of wasteful spending: pricing failures and administrative complexity. Shrank and colleagues[3] have shown that, collectively, these factors account for 54% to 65% of wasteful spending. As health care systems have intensified efforts to consolidate, prices for health care services have increased. Prescription drug spending per capita in the United States is also almost double that of other countries,[1] in part because of a regulatory system that fails to support adequate competition among generic medications and constrains payer negotiation among brand-name drugs. But high prices go far beyond pharmaceuticals and extend to tests, procedures, and even the salaries of clinicians. Increasing administrative complexity of the US system is also creating burden,

burnout, and additional waste. If the United States actually wants to reduce wasteful spending, it is time to focus in earnest on interventions that address pricing failures and reduce administrative complexity.

There are several potential ways policy makers might consider addressing pricing failures, although this would require considerable policy interventions from federal and state governments. First, enhancing cost transparency might help. Addressing payment discrepancies between hospital outpatient facilities and office-based practices is crucial and has begun to happen. Tackling consolidation among physicians and hospitals, which has resulted in high prices without clear improvements in quality or outcomes, is also critical. Third, the Centers for Medicare & Medicaid Services and the US Food and Drug Administration could take a series of steps to reduce drug prices, from opening up more competition to allowing for importation of generic drugs from other countries and potentially even negotiating drug prices directly.

How might policy makers address waste attributable to administrative complexity? Ongoing government initiatives are trying to improve interoperability and facilitate transfer of information across health systems to reduce duplication. In addition, strategies should focus on streamlining processes between clinicians and payers, standardizing quality measures and reporting for value-based contracts, and reducing the complexity of prior authorizations. Collectively, these efforts could potentially generate meaningful savings.

Shrank and colleagues[3] have reminded readers again of the large challenges facing the US health care system in its effort to eliminate waste. Although there is value in value-based care, the evidence to date suggests that the current national approach to addressing wasteful spending is having little effect, largely because it is failing to tackle the largest areas of waste. Efforts to improve care coordination and care fragmentation are important and may improve care. However, to meaningfully tackle costs and waste, it is necessary to address the high prices and administrative complexity that plague the US health care system, because, as the infamous bank robber Willie Sutton said when asked why he robbed banks, that is where the money is.

ARTICLE INFORMATION

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REFERENCES

1. Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. *JAMA*. 2018;319(10):1024-1039. doi:10.1001/jama.2018.1150

2. Berwick DM, Hackbarth AD. Eliminating waste in US health care. *JAMA*. 2012;307(14):1513-1516. doi:10.1001/jama.2012.362

3. Shrank WH, Rogstad TL, Parekh N. Waste in the US health care system: estimated costs and potential for savings [published online October 7, 2019]. *JAMA*. doi:10.1001/jama.2019.13978

4. National Center for Education Statistics. The condition of education 2019. https://nces.ed.gov/pubs2019/2019144.pdf. Published 2019. Accessed September 26, 2019.

5. Figueroa JF, Tsugawa Y, Zheng J, Orav EJ, Jha AK. Association between the value-based purchasing pay for performance program and patient mortality in US hospitals: observational study. *BMJ*. 2016;353:i2214. doi:10.1136/bmj.i2214

6. Sankaran R, Sukul D, Nuliyalu U, et al. Changes in hospital safety following penalties in the US Hospital Acquired Condition Reduction Program: retrospective cohort study. *BMJ*. 2019;366:l4109. doi:10.1136/bmj.l4109

7. Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program with mortality among Medicare beneficiaries hospitalized for heart failure, acute myocardial infarction, and pneumonia. *JAMA*. 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

8. Wadhera RK, Joynt Maddox KE, Kazi DS, Shen C, Yeh RW. Hospital revisits within 30 days after discharge for medical conditions targeted by the Hospital Readmissions Reduction Program in the United States: national retrospective analysis. *BMJ*. 2019;366:l4563. doi:10.1136/bmj.l4563

9. Joynt Maddox KE, Orav EJ, Zheng J, Epstein AM. Evaluation of Medicare's bundled payments initiative for medical conditions. *N Engl J Med*. 2018;379(3):260-269. doi:10.1056/NEJMsa1801569

10. Barnett ML, Wilcock A, McWilliams JM, et al. Two-year evaluation of mandatory bundled payments for joint replacement. *N Engl J Med*. 2019;380(3):252-262. doi:10.1056/NEJMsa1809010

11. Sinaiko AD, Landrum MB, Meyers DJ, et al. Synthesis of research on patient-centered medical homes brings systematic differences into relief. *Health Aff (Millwood)*. 2017;36(3):500-508. doi:10.1377/hlthaff.2016.1235

12. McWilliams JM, Hatfield LA, Landon BE, Hamed P, Chernew ME. Medicare spending after 3 years of the Medicare Shared Savings Program. *N Engl J Med*. 2018;379(12):1139-1149. doi:10.1056/NEJMsa1803388

13. Markovitz AA, Hollingsworth JM, Ayanian JZ, Norton EC, Yan PL, Ryan AM. Performance in the Medicare Shared Savings Program after accounting for nonrandom exit: an instrumental variable analysis. *Ann Intern Med*. 2019;171(1):27-36. doi:10.7326/M18-2539

14. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA*. 2009;301(6):603-618. doi:10.1001/jama.2009.126

15. Casalino LP, Gans D, Weber R, et al. US physician practices spend more than $15.4 billion annually to report quality measures. *Health Aff (Millwood)*. 2016;35(3):401-406. doi:10.1377/hlthaff.2015.1258