The Role of Physicians in Controlling Medical Care Costs and Reducing Waste

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The looming US budget crisis figures prominently in daily news. The amount of money spent on medical care is increasing faster than the gross domestic product (GDP), and the federal deficit is increasing. Budget experts believe that the deficit cannot be reduced unless medical spending can be controlled. What role will physicians play in controlling health care cost growth? Are physicians even willing to play a role?

Realistically, physicians face 3 scenarios in controlling health care costs. In the first scenario, physicians do nothing. Cost increases continue unabated and the proportion of GDP spent on health care continues to increase. But sooner or later, with or without the help of physicians, the cost crisis will have to be confronted. In a crisis mode, the solution to the spending problem may not be what physicians, or their patients, want.

In the second scenario, health care is rationed. When the “R” word is mentioned, all rational discussion ceases, but the inexorable production of devices, drugs, and procedures that generates both health benefits and higher costs may eventually force the rationing decision. There are multiple ways of implementing rationing, but most individuals would like to prevent it.

In the third scenario, physicians take the lead in identifying and eliminating waste in US health care. Physicians could define waste by assigning all services to 1 of 4 types of care—inappropriate, equivocal, appropriate, or necessary. With inappropriate care, the potential health benefit to the patient is less than the potential harm caused by the procedure, device, or drug. With equivocal care, potential harm and benefit are about equal. With appropriate care, potential benefit to the patient exceeds potential harm. Necessary care is appropriate, represents the only viable option, and produces a large health benefit.

An economist would define waste differently. Waste to an economist is an expenditure that does not produce commensurate value. Many economists believe that the value of a human life is at least $3 million, if not twice that. Therefore, care that provides 1 good year of quality life and costs less than $50 000 to $100 000 is not wasteful, but care that produces a year of good life and costs more than $150 000 is wasteful. Physicians prefer the medical definition. But it is not known how much clinical waste is in the system.

For example, consider the best performing hospitals or health systems in the United States, defined by some measure of quality or efficiency. Based on either metric, how much waste is there in those hospitals or health systems? To answer this question, a tool is needed to measure clinical waste. A comprehensive tool to measure waste across all clinical services does not exist today, but there are many tools that focus on certain aspects of care. After a more complete tool is developed, patients treated in the best performing hospitals or health systems could be sampled after stratifying them based on the total amount of money they spent on health care anywhere in a given year. After the sample is selected, each patient’s medical record could be reviewed and each service received assigned to 1 of the 4 categories (inappropriate, equivocal, appropriate, or necessary).

It would not be very expensive to conduct this review of records for a reasonable sample of patients. The result would be a rough estimate of the potential waste in the system—that is, the proportion of services that were in the inappropriate or equivocal categories. If circumstances demanded, the definition of waste could be expanded to any service that was not in the necessary category.

Once the proportion of care in each category is determined, what portion of health care costs is associated with each category could be determined. In doing this, how eliminating wasteful services affects short-term costs, long-term costs, fixed costs, average costs, and marginal costs could be assessed. In addition, if wasteful services are eliminated, necessary services that the patient did not receive might need to be added (eg, angioplasty is eliminated for a patient with stable angina but additional medical therapy is required). The cost of these additional necessary services would need to be deducted from the previous estimate of savings.

This process would generate an estimate of the proportion of care in top-performing hospitals or health systems that is wasteful and the amount of money that could be saved if clinical methods were improved. If the work is per-
formed correctly, it might even be possible to assign ranges and confidence intervals to the estimates.

Some individuals may be more comfortable sampling care in average hospitals and health care systems. Whatever the sample, if the proportion of care estimated to be wasteful comprises only a small percentage of total costs, then eliminating waste is not a promising policy option for cost containment.

Delivery of health care in the United States is entering troubled waters. There are proposals being considered to roll back government-sponsored health insurance and proposals to limit the benefits individuals have under health insurance. It is unclear whether any of these proposals would have political traction if the US government did not have an enormous budget deficit, driven by uncontrolled Medicaid and Medicare expenditures. The next political window regarding the future of the US health care system is likely to open right after the next presidential election. Before draconian measures are enacted, the waste question needs a scientific answer that physicians agree is valid and reliable.

Physicians should not be taken by surprise. If physicians can help reduce the budget deficit by eliminating waste in the health care system, the profession must agree on what proportion of care is wasteful. Better would be to identify strategies for eliminating waste within a very few years. Such strategies must include teaching all physicians how to recognize and eliminate clinical waste. Board certification examinations and tests in medical school could require physicians to separate waste from necessary care and demonstrate that they use such knowledge in day-to-day practice. Board-certified physicians could represent only those physicians who not only provide high-quality care, but do so with minimal amounts of waste. Hospitals viewed as the country’s best could be those hospitals that reduce clinical waste to a minimum. Without agreement within the medical profession about the magnitude of clinical waste, physicians cannot hope to have a strong influence in the health care cost debate.

In this Commentary, waste has been defined as the use of clinical services that cannot be classified as necessary or necessary and appropriate, but there are other definitions of waste. For example, a service could be defined as wasteful if it is performed by someone with a high salary, when it could be performed with the same outcome by someone who is paid less. Similarly, it is wasteful for a physician to perform a service that a computer could perform at a lower cost with equivalent outcomes, or for a necessary service to be delivered inefficiently. Such considerations have been excluded not because they are unimportant, but because the first step must be to reach agreement on which clinical services, under what circumstances, currently being provided are wasteful and could be eliminated, with resulting cost savings. The upstream implications of reaching consensus are extraordinary.

Because the budget crisis is really a crisis, it behooves physicians to answer the waste question as rapidly as possible. Without an answer, there is no hope that an appropriate policy process for reining in health care costs will be identified. Physicians need to speak with one voice. Is there sufficient clinical waste to help address the federal budget deficit? If the answer is yes, physicians must be prepared to act quickly. If the answer is no, physicians must ensure that society understands the value of increasing health care expenditures more quickly than GDP growth, so that society can decide how much, if any, rationing will be necessary.

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REFERENCES