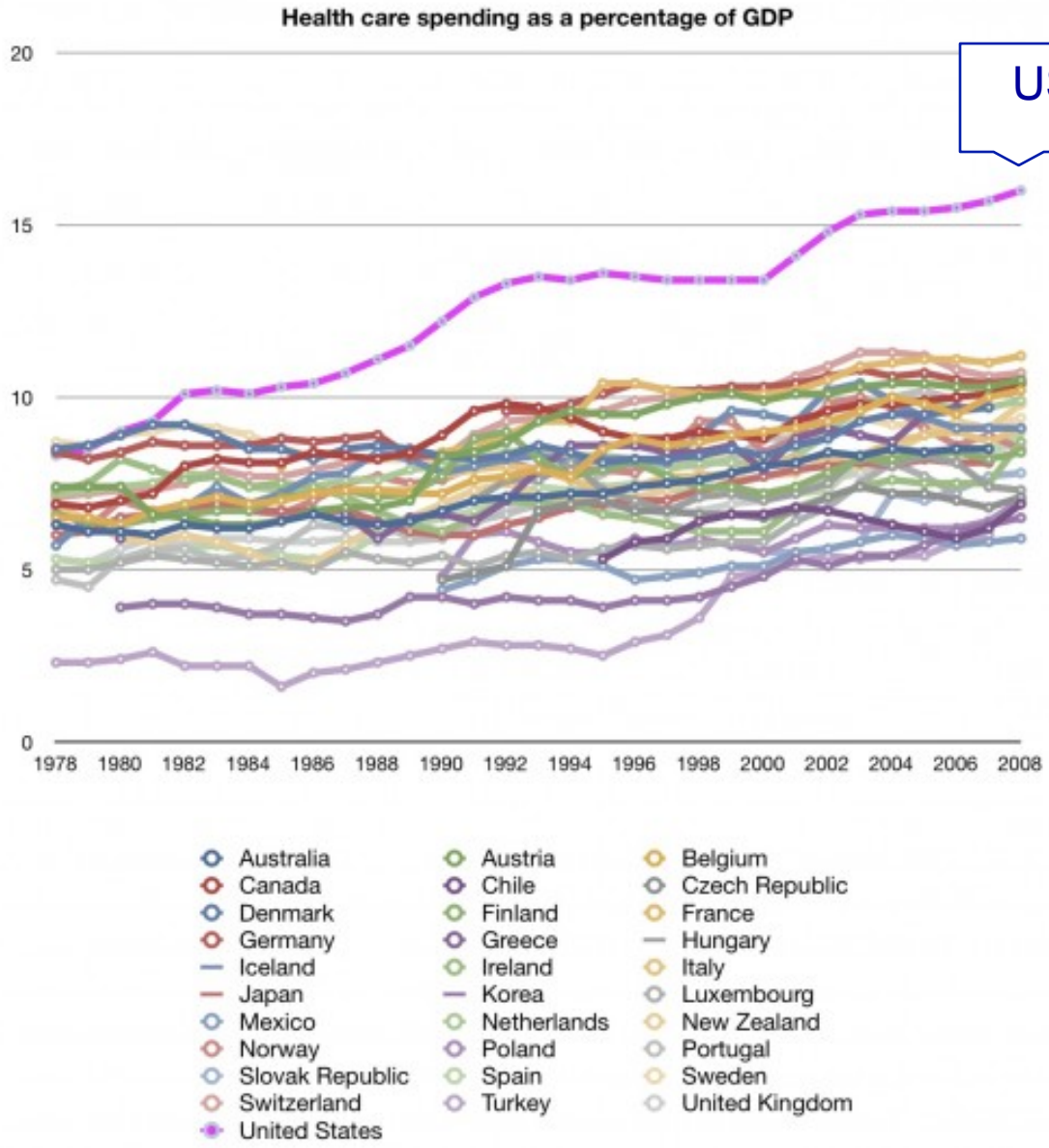
The Ethics of Reducing "Waste" in Healthcare:

Not as Easy as it Seems

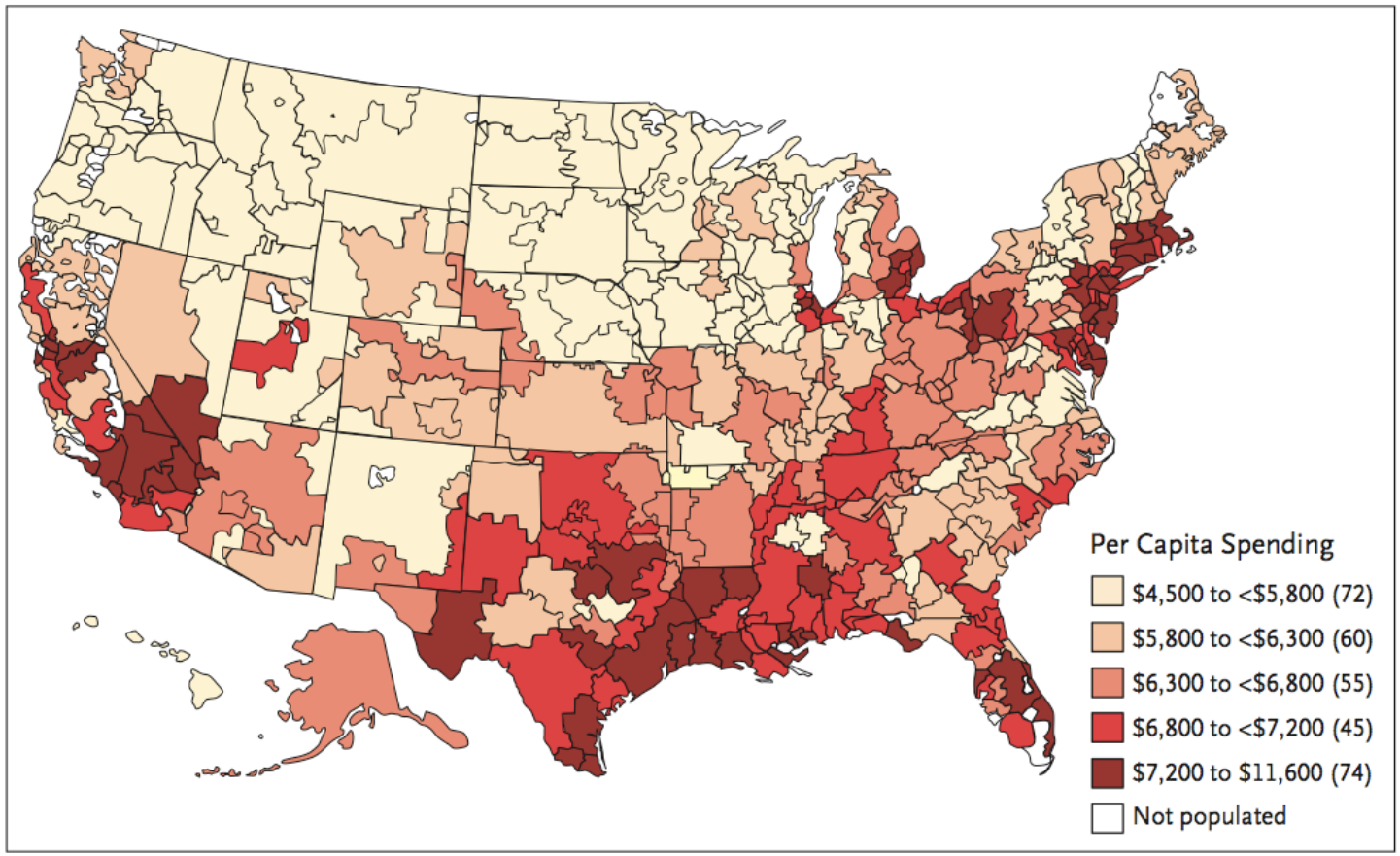

Health care spending as a percentage of GDP
USA
20
15
10
5
0
1978 1980 1982 1984 1986 1988 1990 1992 1994 1996 1998 2000 2002 2004 2006 2008
Australia
Canada
Denmark
Germany
Iceland
Japan
Mexico
Norway
Slovak Republic
Switzerland
United States
Austria
Chile
Finland
Greece
Ireland
Korea
Netherlands
Poland
Spain
Turkey
Belgium
Czech Republic
France
Hungary
Italy
Luxembourg
New Zealand
Portugal
Sweden
United Kingdom

What are the sources of "waste" in the health care system?

- Failure to use public health measures and clinical prevention to avoid poor outcomes
- System inefficiencies
- Materiel inefficiencies
- Administrative waste
- Clinical waste

"It is thornlike in appearance, but I need to order a battery of tests."

The Beginning: The Dartmouth Atlas

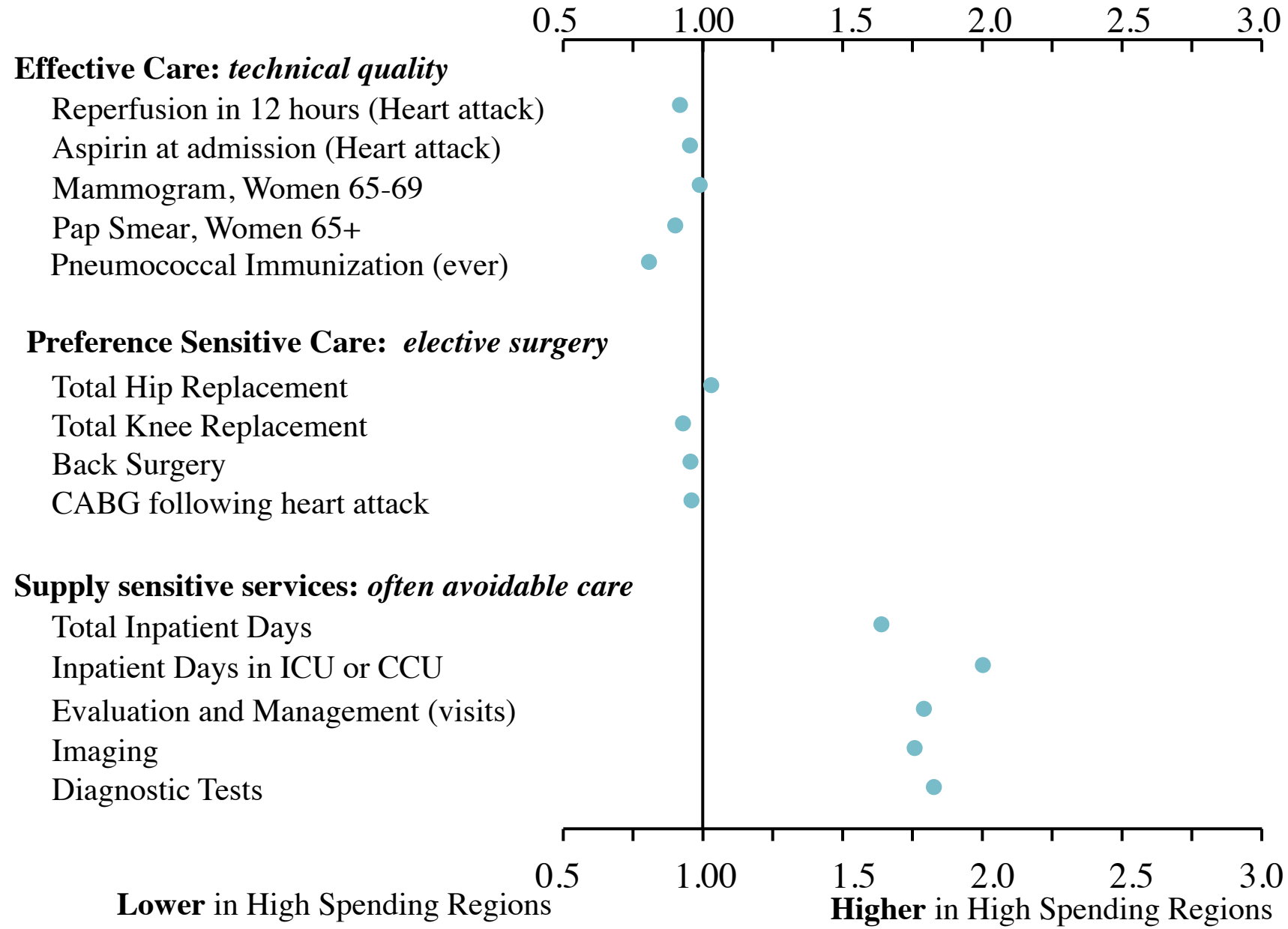


Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

Ratio of Use Rates in High vs Low Spending Regions -- in similar patients

If dot is to right, high spending regions get MORE



Types of "waste" among the variation

- Insufficient evidence to evaluate comparative benefit for any indication
  - Emerging or "experimental" devices, procedures
- Insufficient evidence to evaluate comparative benefit for use beyond established indications, frequency, intensity or dosage
  - Vagus nerve stimulation for depression (approved for treatment of seizures)
- Adequate evidence demonstrating no added benefit with higher risk, higher cost, or both
  - Use of antibiotics in the elderly unless urinary tract symptoms are present
- Adequate evidence demonstrating a small comparative benefit not large enough to justify higher risk to patients, higher cost, or both
  - Chemotherapy for advanced cancer that extends average life span a few weeks

US Choosing Wisely Lists August 2013

- 25 specialty societies identified 135 services

Evidence Category Justification	% of services (n= 135)
Insufficient evidence to evaluate for any indication	1%
Insufficient evidence to evaluate effectiveness beyond established indications, frequency, dosing, intensity	13%
Adequate evidence demonstrating no added benefit with higher risk, cost, or both	76%
Adequate evidence demonstrating small comparative benefit not large enough for cost	6%

Source: Gliwa C, Pearson SD. 2014 Apr 9;311(14):1443-4

The difficult ethics of eliminating "wasteful care"

- Insufficient evidence to evaluate comparative benefit for any indication
  - Emerging or "experimental" devices, procedures
  - The desperate patient with no other options
  - Evolving surgical procedures and other interventions "ahead" of the evidence

The difficult ethics of eliminating "wasteful care"

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  - Patients have unique comorbidities, anatomies, etc. that call for modified use of accepted treatments

The difficult ethics of eliminating "wasteful care"

- Adequate evidence demonstrating no added benefit with higher risk, higher cost, or both
  - Use of antibiotics in the elderly unless urinary tract symptoms are present
  - Patients have unique comorbidities, anatomies, etc. that call for modified use of accepted treatments
  - Evidence of "equivalent" benefit and "higher" risk is based on averages, may not apply to the unique individual patient

The difficult ethics of eliminating "wasteful care"

- Adequate evidence demonstrating a small comparative benefit not large enough to justify higher risk to patients, higher cost, or both
  - Chemotherapy for advanced cancer that extends average life span a few weeks
  - Desperate patient with no other options
  - The patient's individual values regarding the balance of potential benefits and risks should determine use
  - Who is the judge of what is too much cost for the benefit?

Why else do doctors continue to perform “wasteful” care?

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Comparative Effectiveness CEPAC Public Advisory Council

CHOOSING WISELY® SPECIALTY SOCIETY RECOMMENDATION ANALYSIS:
American College of Obstetricians and Gynecologists (ACOG)

Reducing Routine Annual Pap Testing in Women 30 – 65 years of age

Evidence Justification

- Equivalent benefit to testing every 3 years, with higher risks and costs:
  - Annual testing may cause more anxiety for women
  - Increased chance of unnecessary follow-up testing for false positive results, including repeat Pap test and colposcopies (which can cause discomfort and bleeding), and unnecessary costs

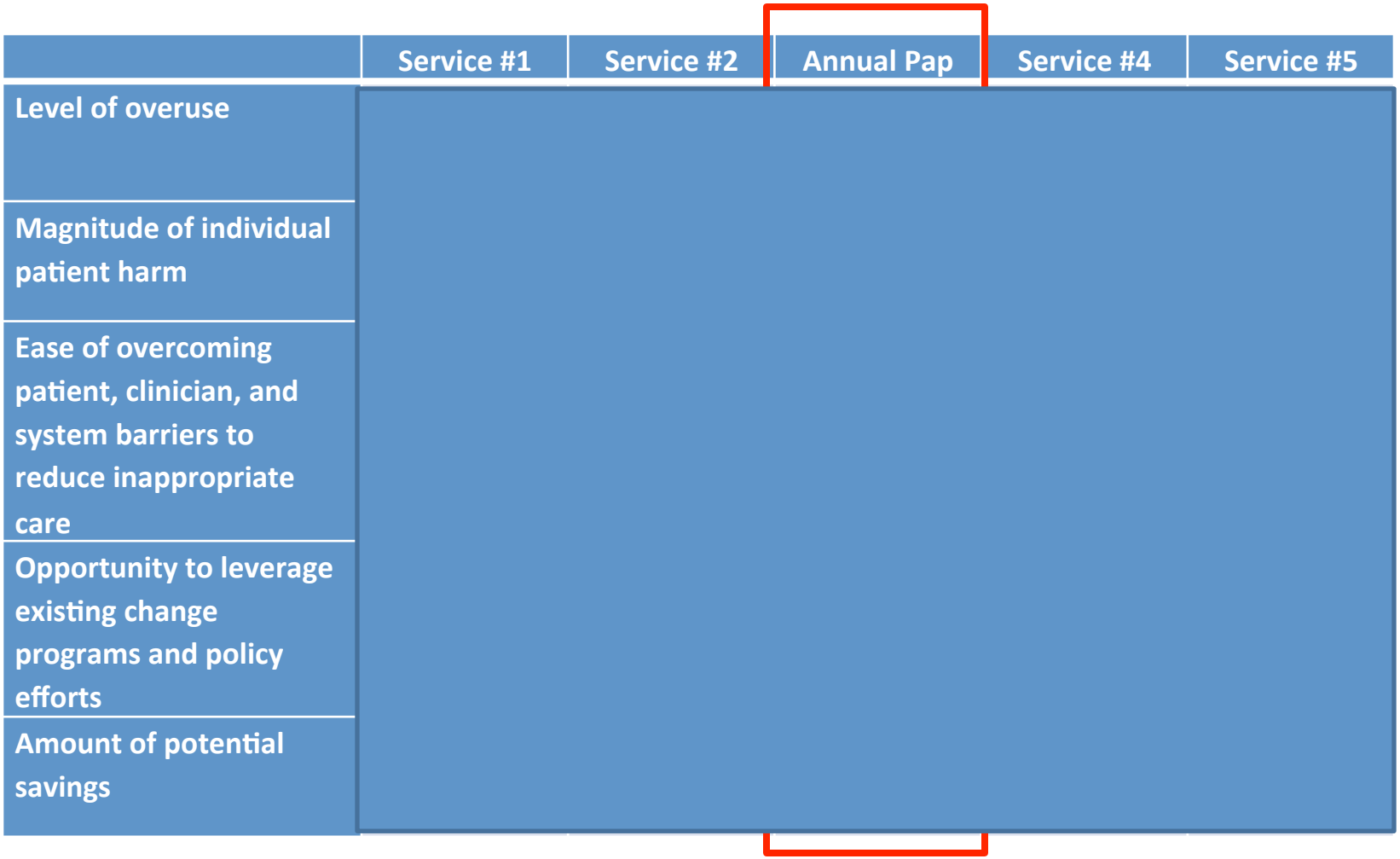
Current Use and Variation in Practice

- **Estimated New England Population Affected: 1.6 – 2.3 million women**
  - 50% of women receive Pap tests at intervals <3 years without clinical indication

- Potential for substantial savings on a region-wide basis due to large number of women affected **($21-$31 million)**

Factors Contributing to Overuse

1. Clinicians are hesitant to change practice due to history of conflicting guidelines
2. Mobile patient populations make it difficult to track the frequency of previous testing; better to test often
3. Financial gain from doing the test
4. Fear of losing patient contact
5. Patient expectation
6. Administrative challenge for payers to identify unnecessary tests in order to give feedback to clinicians


Service #1
Service #2
Annual Pap
Service #4
Service #5
Level of overuse
Magnitude of individual patient harm
Ease of overcoming patient, clinician, and system barriers to reduce inappropriate care
Opportunity to leverage existing change programs and policy efforts
Amount of potential savings

The problematic ethics of reducing waste

- The individual patient is unique and efforts to reduce waste are one-size fits all
  - Almost everything in medicine is helpful for somebody at some time
  - Applied in ways that limit choice and that prioritize "group" values over individual values
- Can't capture rapid innovation, especially in devices and procedures
- The idea of reducing waste may ignore
  - Basic human instincts (e.g. fear of risk, desire for continuity of doctor-patient relationships)
  - Economic realities

The undeniable duty to reduce "waste"

- Beneficence for individual patients
  - Avoiding harm, both physical and economic
- Stewardship
  - Responsibility for using prudently the power given by society to make decisions regarding the use of limited, shared resources
- Grounding our approach in evidence
  - Minimizes the risk of unequal and unfair rationing at the bedside
- Grounding our approach in collaboration with patients and the community
  - Only way to create broadly justifiable boundaries related to uncertainty and cost-effectiveness