

Eliminating waste in healthcare spending (Editorial)

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Eliminating waste in healthcare spending

There is no silver bullet—just incremental change based on good data

Kalipso Chalkidou and John Appleby

Health systems in all countries—no matter how they are organised, funded, and regulated—should strive to maximise benefits to patients for every pound, dollar, or euro they spend. The cost of not doing so can be measured in money terms—but, more importantly, in death, pain, and disability that could have been averted. But, as the Organisation for Economic Cooperation and Development (OECD) pointed out recently, a considerable chunk of the world's health spending is probably wasted, and the key determinants of the level of wasteful spending are the organisation, funding, and regulation of countries' healthcare systems.

Characterising waste

The organisation suggests that about one fifth of healthcare spending across OECD countries is wasted. This is equivalent to \$1.2tr (£950bn; €1.1tr) and equal to five times the annual spending on the UK NHS.¹ This figure is consistent with a 2010 analysis by the World Health Organization which concluded that 20-40% of healthcare spending globally is wasted.² A Lancet commission on right care also recently highlighted huge variations in care across and within countries, rich and poor, that are not justifiable by the needs of patients and pose a serious challenge to healthcare systems as they try to attain or sustain universal healthcare coverage.³

The 300 page OECD report—a joint effort by leading academics and policy makers from OECD countries, the European Commission, WHO, and non-governmental organisations—proposes a framework for characterising waste, ranging from clinical (for example, adverse events and overprescribing of antibiotics) to operational (such as low levels of generic drug substitution and variation in procurement prices for same products) to governance related waste (for example, corrupt practices or ineffective management and administration, such as time consuming reporting practices).

For each type of waste, the report points to behavioural, financial, organisational, and regulatory policy levers to change practice and identifies key players and country specific vignettes of best practice. The “Who, why, and what to do?” summary tables nicely set out the problems and potential solutions, although evidence that suggested policies are effective is limited and context sensitive most of the time, pointing to the need for more systematic evaluation of policy interventions for improving the value of care.

How the UK compares

There are no country specific estimates of waste, but on many of the example measures that the OECD uses, the UK seems to be doing rather well. It ranks top for generic prescribing, equal second with Estonia, Finland, and the Netherlands for day case cataract treatment, below average for diabetes related admissions and length of stay generally, average for the rate of visits to emergency departments, and third lowest on administration costs for a publicly run health system (just above Ireland and Portugal).

On the other hand, unexplained variations in treatment (as in other countries) are prevalent, wasteful delays in discharging patients are common and increasing, and data on patient reported outcomes suggest that we’re not getting good value from some interventions, such as hernia operations.⁴

No quick fix

As the OECD and others have pointed out,⁵ there’s no quick way to eliminate waste, make better use of scarce resources, and improve the value of care for patients. Examples of improvements from the UK (and applicable worldwide) show that switching eligible patients from inpatient care to day care, or from branded to generic drugs, or reducing lengths of stay in hospital can take a generation.⁵ Even so, some problems remain difficult to deal with—such as unexplained and unwarranted variations.

The other lesson from experience is that there’s no silver bullet to fix the waste problem. Improving value and reducing waste require health systems to generate the right data—on their activities, health impact, and costings, among others—to quantify and analyse the problem. They also need

ways to encourage and disseminate clinical innovations—the source of so many improvements in healthcare productivity.⁵ Although the professionalism of healthcare professionals is important, experience also shows that the right financial and non-financial incentives—through payment mechanisms and other approaches—can help nudge individuals and organisations to focus on more efficient ways of delivering healthcare.⁶

Most importantly, to maximise value in healthcare we need better information about what works in reducing waste and what doesn't, and under what institutional arrangements and regulatory frameworks.

Paradoxically, asking health systems to be more innovative in finding ways to eliminate waste sometimes requires a bit of organisational “slack,” such as investing in better facilities that may help attract and retain staff or having the capacity to innovate or to train for, say, emergency situations hence improving the system's reliability. Such slack is much harder to find at time of financial pressures. Perhaps this is a type of useful “waste” that the report does not go into.⁷

References

1. Organisation for Economic Cooperation and Development. Tackling wasteful spending on health. OECD, 2017.
2. World Health Organization. World health report: health systems financing: the path to universal coverage. WHO, 2010.
3. Brownlee S, Chalkidou K, Doust J, et al. Evidence for overuse of medical services around the world. *Lancet* 2017 Jan 6 [Epub ahead of print.] doi:10.1016/S0140-6736(16)32585-5. pmid:28077234.
4. Appleby J, Devlin N, Parkin D. Using patient reported outcomes to improve health care. Wiley-Blackwell, 2015.
5. Alderwick H, Robertson R, Appleby J, Dunn P, Maguire D. Better value in the NHS: The role of changes in clinical practice. King's Fund, 2015.
6. Farrar S, Chalkley M, Yi D, Ma A. Payment by results: consequences for key outcomes measures and variations across HRGs, providers and patients. 2010. www.abdn.ac.uk/heru/uploads/files/pbr-report-2011.pdf
7. Zinn J, Flood AB. Commentary: slack resources in health care organizations—fat to be trimmed or muscle to be exercised? *Health Serv Res* 2009;356:812-20. doi:10.1111/j. 1475-6773.2009.00970.x pmid:19674426.