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IS YOUR DOCTOR WASTING YOUR MONEY?

THE SCIENCE BEHIND ANALYZING HEALTHCARE WASTE

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With four years' worth of data, the Washington Health Alliance's (WHA - www.wahealthalliance.org) Community Checkup (www.wacommunitycheckup.org) has confirmed again that, across 47 measures, 51% of the healthcare received *and paid for* in Washington state was determined to be wasteful. Read that sentence twice, it's a mouthful.

Background

In 2004, when healthcare costs for public employees were rising at an alarming rate, the King County Executive Director pushed to form an organization to reduce misuse of healthcare and improve quality. Created initially to enable the county benefits committee to prevent cutting benefits, the Alliance was successful in bringing together the integral pieces of the puzzle - doctors, hospitals, insurance companies, employers, and consumer organizations. Now, the Alliance is in its 16th year and continues to push for quality and cost improvements to the system at large.

With several successful projects under its belt, the Alliance sat down in 2014 and examined 47 procedures that were widely known to be overused.

Examples included:

- Opioids prescribed for acute low back pain in the first four weeks
- Annual cardiac screenings or other tests for low-risk and asymptomatic individuals
- Antibiotics prescribed for upper respiratory or ear infections
- Screening for vitamin D deficiency

The Alliance then asked Washington state, major employers, and health insurers to share their claims data to evaluate the use of these 47 services. After assessing the data and estimating conservatively, the Community Checkup found the extraordinary number of 51%. Over half of these services delivered were unnecessary.

Interpreting the results

It's not just the percentage that hits home, the scale is immense too. Over the four-year period, 9.5 million claims were reviewed and the total cost of wasteful care totaled $703 million. To put these numbers in context, a group of over 4 million Washington residents, insured both commercially and through Medicaid, comprised the data set. Doing the math, this equates to two services and $175 per person.

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Let's talk about who paid for it. All health plans have cost sharing in the form of copays, deductibles, and coinsurance, so a portion of these services were paid for by employees straight out of their pockets. The portion that was paid for by an insurance company or employer came out of these same employees' pockets indirectly, in the form of payroll deductions or reduced wages. Simply put, we all paid for it.

As you can imagine, healthcare providers are becoming aware of this. As Stewart Gandolf, a healthcare marketing expert, wrote in his blog,

> "Previously 'passive patients' have become empowered consumers, due in large measure to the swing of the financial burden to their personal pocketbook. And, with that money-shift, consumers search for and expect greater value and quality of service, timely and convenient care, transparent information, and a positive (if not outstanding) patient experience."

But even as doctors know their patients have increasingly higher payroll deductions and cost sharing in their health plans, and that certain services are not appropriate in over half the cases reviewed, practices are not changing.

What to do with the numbers?

So what is the next course of action, now that we have this information? There are multiple steps that need to be taken.

1. The Alliance and other organizations that publish this research across the country need to broaden the data set past the original 47 measures and account for more complicated and expensive procedures.
2. Barriers (e.g. technology, and lack of vendors and integration) to quick and easy access about high performing doctors need to be addressed and removed, enabling consumers to:
   a. Pick a clinic based on how the clinic performs in these measures.
   b. Go to office visits with the right questions to ask.
3. Health plans need to include data on care quality when creating PPO networks, pricing, and physician-incentive compensation. Health plans should pay for quality of care, not volume of care.

Given that the US healthcare economy was $3.6 trillion in 2018 according to the National Health Expenditure Accounts, a large amount of money is at stake. In fact, the US spends more on healthcare than other comparable high-income countries, with out-of-pocket and private expenses representing a disproportionately large portion.

What if the 51% number does transcend all healthcare services? What if healthcare premiums could be cut in half, just by taking some small steps to eliminate wasteful care? It is not pie in the sky and the analytics are clear now; we just need to get the results in the hands of the consumers and enable them to do what they do best.

Employers working with their consultants must clearly communicate the importance of this to their employees. Then they need to create incentives and push consumers to take advantage of them. It is just a matter of will; everyone wins when consumers receive the right care.