Causes of Wasteful Spending in the U.S. Healthcare System

The first article of this three-part Health Capital Topics series on the decreasing marginal utility in healthcare, discussed the exponential increase of U.S. healthcare expenditures in recent years, which has not necessarily resulted in better health outcomes for the U.S. population. Healthcare costs accounted for over 17% of the U.S. gross domestic product (GDP) in 2011, and continues to grow at much higher rates than other comparable industrialized nations, indicating that the U.S. may not be receiving sufficient “value per dollar” spent on the population’s healthcare. One approach to increasing the “value per dollar” spent on healthcare is to reduce wasteful spending in the healthcare system. Reducing this wasteful spending necessitates the identification of the various types of waste in the U.S. healthcare system. The second installment of this three-part series will examine the different sources of waste that have allowed such inefficient and unsustainable healthcare spending to thrive in the U.S. despite the declining yield on investment.

In the context of healthcare spending, waste is defined as spending that could be eliminated without harming consumers or reducing the quality of care. A 2013 study by the Institute of Medicine estimated that approximately 30% of healthcare spending, or roughly $750 billion, was squandered on unnecessary or poorly delivered services, excessive administrative costs, fraudulent claims, and other needless costs in 2009. An April 2012 study published in the Journal of the American Medical Association (JAMA) estimated that six categories of wasteful spending (described below) annually consumed between $558 billion and $1.26 trillion, amounting to approximately 21% to 47% of total healthcare expenditures in the U.S.

**Failures of Care Delivery**

The April 2012 JAMA study categorized the first type of waste as failures of care delivery. This type of waste can be attributed to poor execution of effective preventive care and patient safety practices resulting in worse clinical outcomes and higher costs, such as preventable adverse events, which is defined as injuries to a patient caused by the medical intervention (rather than the underlying medical condition). A U.S. Department of Health and Human Services (HHS) report estimated that these preventable adverse events led to roughly $4.4 billion in additional Medicare spending in 2009. Overall, the April 2012 JAMA study estimated that waste resulting from failures of care delivery consumed between $102 and $154 billion in 2011.

**Failures of Care Coordination**

Failures of care coordination account for the second category of waste, which results from fragmented care due to a lack of communication and coordination between providers, and may lead to unnecessary hospital readmissions and preventable health complications. A 2013 JAMA study on readmission rates of common hospital conditions found that from 2007 to 2009, the 30-day readmission rate was: (1) 24.8% after hospitalizations for heart failure; (2) 19.9% after hospitalizations for acute myocardial infarction; and, (3) 18.3% after hospitalizations for pneumonia. Overall, the April 2012 JAMA study estimated that the waste resulting from failures of care coordination accounted for approximately $25 billion to $45 billion in 2011.

**Overtreatment**

A third category of waste is attributed to overtreatment, which occurs when patients are subjected to medical services at a higher volume or cost than necessary. One significant source of overtreatment is the practice of defensive medicine, when healthcare providers order unnecessary tests or services to protect themselves against malpractice liability. In 2011, waste due to overtreatment was estimated by the April 2012 JAMA study to represent between $158 billion and $226 billion of wasteful healthcare spending.

**Administrative Complexity**

Administrative complexity, a fourth category of waste, results from the inefficient and overly bureaucratic procedures of public and private health insurers, as well as accreditation agencies. For example, physicians spend an average of approximately three hours per week interacting with health plans rather than on patient care. When the amount of time devoted to such interactions by nursing and clerical staffs was included, the total time spent interacting with health insurers cost physician practices approximately $23 billion to $31 billion annually. Overall, the April 2012 JAMA study estimated that waste due to administrative complexity accounted for approximately $107 billion to $389 billion in 2011.

(Continued on next page)


### Pricing Failures

A fifth category of wasteful healthcare spending may be attributed to *pricing failures*, which occurs when prices for healthcare services grossly deviate from those in well-functioning markets. This pattern of pricing failures, totaling between $82 billion and $272 billion in 2011,22 may well lie, in great part, in the cost of pricing failures, which occurs when prices for healthcare services grossly deviate from those in well-functioning markets. For example, the 30 most commonly prescribed drugs in the U.S. are 33% more expensive than those same drugs in Canada and Germany, and more than double the prices of those sold in Australia, France, and the United Kingdom.20 Additionally, U.S. primary care physicians receive higher fees for office visits, and orthopedic physicians receive higher fees for hip replacements, than in Australia, Canada, France, Germany and the United Kingdom.21

In 2011, the amount spent on fraudulent claims, as well as the additional enforcement activities to catch the wrongdoers, totaled between $82 billion and $272 billion.26 Although *fraud and abuse* continues to be a major source of waste in healthcare spending, substantial progress has been made in recent years. Since the enactment of the Affordable Care Act (ACA), the Department of Justice (DOJ) and Office of Inspector General (OIG) have increased both enforcement efforts and willingness to prosecute fraud and abuse violations. The DOJ recently announced a record-breaking recovery of $4.3 billion in fiscal year 2013 from individuals and entities who attempted to defraud federal healthcare programs.27 This pattern of increased enforcement could significantly reduce waste in the U.S. healthcare system in the coming years.

Despite the recent flattening of U.S. healthcare expenditures per capita, policy makers are debating how to best combat wasteful spending. The key to reducing expenditures may well lie, in great part, in understanding these underlying causes of waste in the U.S. healthcare system. The third and final installment of this three-part series will examine various aspects of the latest iteration of healthcare reform which are designed to reduce wasteful spending and make healthcare more affordable.

---

3 “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,” Institute of Medicine, 2013.
5 Ibid, p. 1513.
9 Ibid, p. 1514.
12 Ibid, p. 1514.
13 Health Affairs, December 13, 2012.
16 “What does it cost physician practices to interact with health insurance plans?” Lawrence P. Casalino, et al., Health Affairs, Vol. 28, No. 4, August 2009.
17 Ibid.
19 Ibid.
21 Ibid, p. 5-7.
23 Ibid.
25 Ibid.
Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of Health Capital Consultants (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: “Accountable Care Organizations: Value Metrics and Capital Formation” [2013 - Taylor & Francis, a division of CRC Press], “The Adviser’s Guide to Healthcare” – Vols. I, II & III [2010 – AICPA], and “The U.S. Healthcare Certificate of Need Sourcebook” [2005 - Beard Books]. His most recent book, entitled “Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services” was published by John Wiley & Sons in March 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Shannon Pratt Award in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of Health Capital Consultants (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the valuation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored “Research and Financial Benchmarking in the Healthcare Industry” (STP Financial Management) and “Healthcare Industry Research and its Application in Financial Consulting” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser’s Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.