



From an Ethics of Rationing to an Ethics of Waste Avoidance

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Bioethics has long approached cost containment under the heading of “allocation of scarce resources.” Having thus named the nail, bioethics has whacked away at it with the theoretical hammer of

distributive justice. But in the United States, ethical debate is now shifting from rationing to the avoidance of waste. This little-noticed shift has important policy implications.

Whereas the “R word” is a proverbial third rail in politics, ethicists rush in where politicians fear to tread. The ethics of rationing begins with two considerations. First, rationing occurs simply because resources are finite and someone must decide who gets what. Second, rationing is therefore inevitable; if we avoid explicit rationing, we will resort to implicit and perhaps unfair rationing methods.

The main ethical objection to rationing is that physicians owe


an absolute duty of fidelity to each individual patient, regardless of cost. This objection fails, however, because when resources are exhausted, the patients who are deprived of care are real people and not statistics. Physicians collectively owe loyalty to those patients too. The ethical argument about rationing then shifts to the question of the fairest means for allocating scarce resources — whether through the use of a quasi-objective measure such as quality-adjusted life-years or through a procedural approach such as increased democratic engagement of the community.¹

Ethicists arguing for fair rationing have had to contend with claims that the cost problem would be solved if we eliminated

waste, fraud, and abuse. They have replied with statistics suggesting that waste, defined as the cost of deliberate fraud, accounts for less than 10% of health care costs. Moreover, eliminating all waste would result in one-time savings; the primary drivers of cost escalation — technological advances and the aging of the population — would proceed unchecked.

The facts that have recently overtaken this ethical discussion show that waste in U.S. health care, defined more broadly as spending on interventions that do not benefit patients, actually amounts to a much larger sum — at least 30% of the budget — and that this waste is a major driver of cost increases.²

A case study for the shift in ethical focus is the treatment of advanced, metastatic breast cancer with high-dose chemotherapy followed by autologous bone marrow transplantation. This treatment was initially thought to of-

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fer perhaps a 10% chance of a significant extension of life for patients who would otherwise be fated to die very soon. Insurers' refusal to pay the high costs of this last-chance treatment did much to torpedo public trust in managed care during the 1990s. Data now suggest that the actual chance of meaningful benefit from this treatment is zero and that the only effect of the treatment was to make patients' remaining months of life miserable. In this case, the ethical debate over rationing was misplaced.

As in the breast-cancer case, waste in health care goes far beyond deliberate fraud. We have for too long ignored how much money is spent in the United States on diagnostic tests and treatments that offer no measureable benefit.³ Redirecting even a fraction of that wasted money could expand coverage for useful therapy to all Americans, while reducing the rate of overall cost increases.²

The ethical question therefore shifts to waste avoidance. Even though the concept of medical futility has had a vexed history, this new ethical question is a subcategory of the futility debate.⁴ We used to think that the issue of futility arose only when physicians, in keeping with their professional integrity, refused to offer useless treatment even when patients or families demanded it. We now realize that futile interventions may be administered not solely because of patients' demands but also by physicians acting out of habit or financial self-interest or on the basis of flawed evidence. The ethics of waste avoidance is thus in part a component of the ethics of professionalism.⁵

The two principal ethical arguments for waste avoidance are

first, that we should not deprive any patient of useful medical services, even if they're expensive, so long as money is being wasted on useless interventions, and second, that useless tests and treatments cause harm. Treatments that won't help patients can cause complications. Diagnostic tests that won't help patients produce false positive results that in turn lead to more tests and complications. *Primum non nocere* becomes the strongest argument for eliminating non-beneficial medicine.³

Since elimination of wasteful, nonbeneficial interventions is ethically mandated (as has recently been emphasized in the Choosing Wisely campaign led by the American Board of Internal Medicine Foundation), the question then shifts to implementation. Here, I believe, we must consider the limitations of evidence. Data from randomized clinical trials represent population averages that may apply poorly to any individual patient. An ethical system for eliminating waste will include a robust appeals process. Physicians, as loyal patient advocates, must invoke the process when (according to their best clinical judgment) a particular patient would benefit from an intervention even if the average patient won't. Few tests and treatments are futile across the board; most help a few patients and become wasteful when applied beyond that population. But the boundary between wise and wasteful application will often be fuzzy.

Berwick and Hackbarth note a relatively minor ethical point, but a serious policy concern²: a substantial reduction in health care spending would seriously disrupt a \$2.5 trillion industry,

and thus the U.S. economy as a whole, and would require careful planning and gradual implementation. A stepwise strategy also makes good ethical sense in the face of the current limitations of evidence-based medicine. Given our patient-advocacy duties, it is better first to eliminate interventions for which we have the most solid and indisputable evidence of a lack of benefit. We can then extend the policy gradually as comparative-effectiveness research identifies other sources of waste with reasonable confidence.

In the end, the ethics of rationing and of waste avoidance are complementary, not competing. Perhaps at present, waste avoidance could save enough money to permit both universal coverage and future cost control. As medical technology advances, especially with personalized genomic medicine, we will almost certainly arrive at the day when we cannot afford all potentially beneficial therapies for everyone. The ethical challenge of rationing care will have to be faced sooner or later, particularly when we confront inequitable distribution of health care resources globally.

An ethical mandate to prioritize waste avoidance doesn't address the political hurdles, of course. Given that one person's health care expense is another person's income, we can anticipate pitched battles, accompanied by demagoguery such as talk of "death panels." Medicine's role in this campaign will pose a serious challenge to physician professionalism. Will U.S. physicians rise to the occasion, committing ourselves to protecting our patients from harm while ensuring affordable care for the near future?

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Beyond the “R Word”? Medicine’s New Frugality

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Quietly, Washington policymakers have begun to concede the need to weigh health care’s benefits against its costs if our country is to avert fiscal ruin. That costs must be counted against benefits is common sense in other domains — and among health policy professionals. But it’s anathema in public discussion of medical care. To silence talk of tradeoffs, politicians invoke the “R word” — rationing.

The R word’s power to stop conversation reflects the popular belief that cost should be no object at the bedside. This belief has circumscribed elected officials’ efforts to control medical spending. Both Democrats and Republicans have stuck to variants on a standard story: cutting services that yield no value will do enough. Proposals from both parties have thus emphasized care coordination, administrative efficiency, and the elimination of useless interventions.

And much can be done along these lines. State-of-the-art management methods, research on comparative effectiveness, and incentives for providers to apply this know-how can make care cheaper and better.¹ It has become common wisdom that 30% of health care spending, or \$800 billion a year, is wasted on ineffective mea-

asures. But cutting this 30% (an estimate from the Dartmouth Institute for Health Policy and Clinical Practice²) is a distant hope. Useless care, critics note, is easy to spot after the fact; it’s much more difficult to recognize at the moment of clinical decision.³

The Patient-Centered Outcomes Research Institute created by the Affordable Care Act (ACA) will move us forward on this front. So will initiatives like the American Board of Internal Medicine Foundation’s new “Choosing Wisely” campaign, which has enlisted 17 medical specialty societies in an effort to discourage overuse of tests and treatments. But high-quality studies of clinical effectiveness can cost tens of millions of dollars and take many years; they’re unlikely to identify much of the wasted 30% in the near term.

Even if we could eventually eliminate that waste, we would merely postpone the reckoning. Medical costs typically increase by a few to several percent per year (after adjustment for inflation). So shaving, say, 3 percentage points each year from the 30% could hold spending steady for a decade or so. But once we cut the entire 30%, costs will resume their rise — unless we start saying no to some beneficial care. Eliminating only ineffective care

would shift the cost curve down but wouldn’t change its slope.

Grudgingly, policymakers have begun to recognize this reality. Their actions, though not their words, move beyond the standard story. Some controversial ACA provisions discourage the development and use of technologies that deliver therapeutic benefits. The Independent Payment Advisory Board (IPAB) will have the power to nudge providers toward more frugal practice by changing Medicare payment policies — and clinicians’ incentives — when spending exceeds target levels. Accountable care organizations may achieve efficiencies and encourage quality, but their financial rewards for thrift will disincline doctors to order some tests and treatments that yield benefits.

Beyond Medicare, the “luxury tax” on employment-based health plans looms as a powerful constraint on the adoption of new therapies. Initially, the effect will be minimal: family coverage won’t trigger the tax unless it’s priced above \$23,000. But the number of Americans affected will grow rapidly, since the liability threshold will rise more slowly than will per capita health spending. (For decades, medical costs have risen 2 to several percentage points faster than the Consumer