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Smarter Spending on Health Care: How can we Achieve more Health by Reducing Waste?

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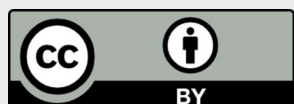
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This work is part of initiatives led by the **CRITERIA Network** of the Health, Nutrition, and Population Division (HNP) of the Inter-American Development Bank. For more information, please visit the CRITERIA Network website: <https://www.iadb.org/en/who-we-are/topics/health/health-initiatives/criteria-network>

Background information

Health care costs in Latin American and the Caribbean are soaring just as demand for more and better health services is growing. Reducing or eliminating funding for health technologies or technology uses (HTUs) that generate little or no health benefits—and may even cause harm—would save millions of dollars. Redirecting those resources toward smarter interventions would save lives and improve the quality of life.



→ What is the challenge?

The share of GDP allocated to health care is much smaller in Latin America and the Caribbean (6.9 percent) than in the OECD (8.5 percent). This smaller allocation makes it especially critical that countries in the region spend smarter—by reducing redundancies, wasted resources, and inefficiencies that consume the very scarce resources the region needs to improve health (Savedoff et al, 2023).

Several factors make it critical to make wiser use of health care budgets:

- Pressures on health spending are increasing as countries develop; adopt new, often costly technologies; and face the growing demands associated with aging and the rising prevalence of chronic diseases. By 2030, spending on health care in most countries in Latin American and the Caribbean will grow more rapidly than those countries' national income, a pattern that is not sustainable (Rao et al. 2024).
- Globally, an estimated 20–40 percent of health spending is wasted (Mbaw et al., 2023; OECD 2017). Redirecting the millions of dollars spent on treatments that do not efficiently improve health toward interventions that do could vastly improve health without increasing health care spending.
- Increasing the efficiency of health spending is key to advancing toward universal coverage. By improving the efficiency of healthcare spending, countries in Latin America and the Caribbean could increase life expectancy by 3.2 years, reduce child mortality by 7.1 deaths per 1,000 children under five years of age, and expand the coverage of skilled birth attendance by another 7.6 percentage points (Castelli et al. 2020; Moreno-Serra et al. 2019; Savedoff et al, 2023).
- Part of the technological pressure comes from new technologies that lack value, but also another part of it comes from the low value use of current technologies.
- Clinical practice takes place in a very decentralized, dispersed way, which makes it difficult to control costs at an aggregate level.

→ How can “strategic disinvestment” help policy makers address it?

By improving the efficiency of health systems, “strategic disinvestment”—reducing or eliminating funding for low-value or no-benefit HTUs, including those that may even cause harm, and redirecting the freed-up resources to interventions that yield greater health benefits—can improve the lives of millions of people in the region and help increase fiscal sustainability. To help policy makers do so, the Inter-American Development (IDB) developed a framework to guide disinvestment decisions by identifying HTUs that are candidates for disinvestment, prioritizing them, and estimating the potential impact on population health of redirecting the resources devoted to them elsewhere. The approach focuses exclusively on wasteful and ineffective HTUs. Disinvesting from such technologies therefore does not compromise patient care.

The proposed framework consists of three phases:

1. Identify potential candidates for disinvestment.
2. Prioritize candidates for disinvestment and identify the data needed to analyze healthcare spending.
3. Estimating the level of waste for each technology (or its wasteful use) and the resources that would be freed up by reducing it. Then, calculate the opportunity cost associated with the freed-up resources to provide a comprehensive assessment of the impact of disinvestment.

→ Identifying potential candidates for disinvestment

Identifying candidates for disinvestment from wasteful HTUs involves three steps:

- i. Holding preliminary discussions with country experts—asking them, for example, to cite the clinical decisions that cause the most waste in their organizations in terms of overuse, overdiagnosis, or overtreatment. These discussions can identify the main sources of waste and help explain the dynamics underlying them.
- ii. Reviewing key academic publications and grey literature (e.g., government lists) that shed light on the main sources of waste.
- iii. Conducting an anonymous, online survey of stakeholders, in order to compile a detailed list of disinvestment candidates.

A variety of stakeholders can help identify candidate HTUs for disinvestment. Payers have a strong incentives to eliminate waste. Health care professionals have first-hand experience with sources of waste. Clinical auditing companies are experts at identifying unnecessary services through billing and diagnostic audits. Pharmacy benefits managers have detailed knowledge of waste in prescription drugs. Health technology assessment agencies and government actors are familiar with new technologies and aware of potential candidates for disinvestment.

Findings from these efforts can be refined by conducting informal discussions with stakeholders. Although not part of formal data collection, these exchanges can help validate and contextualize the findings of steps i–iii, providing additional insights into the specific conditions under which HTUs can be classified as wasteful.

→ Prioritizing disinvestment

Not all wasteful HTUs can be discontinued at once. To maximize the impact of disinvestment efforts, it is essential to prioritize which candidates to address first.

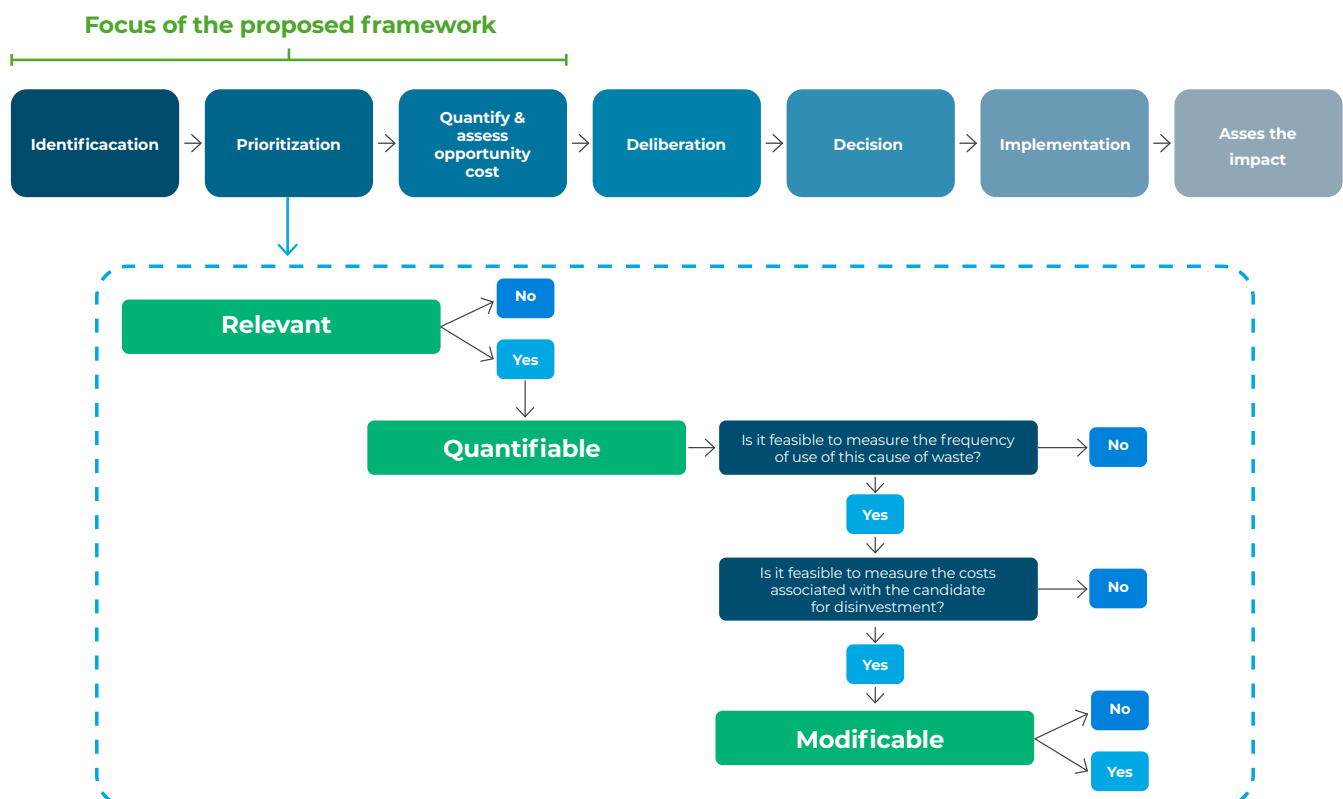
The first step in doing so is to order the list of candidate HTUs, based on how frequently each is mentioned in steps 1–3 above. This ordering provides an initial set of priorities for disinvestment.

The second step is to assess which HTU candidates meet the overarching prioritization criterion of maximizing allocative efficiency by reducing waste. Candidates that do not help achieve this goal are eliminated.

Among candidates that are consistent with the overarching criterion, three other criteria—relevance, quantifiability, and modifiability—are then sequentially assessed:

- **Relevance.** Relevance refers to the size of the savings generated by disinvesting from an HSU. If the savings are not significant, the candidate is eliminated.
- **Quantifiability.** Quantifiability refers to the feasibility of quantifying the frequency of use of an HTU and the feasibility of quantifying the costs associated with it.
- **Modifiability.** Most disinvestment decisions focus on modifying or substantially reducing (rather than eliminating) an HTU. HTUs that can be eliminated are assigned the highest level of modifiability; HTUs requiring behavioral changes that are difficult to implement receive the lowest modifiability rating.

Figure 1. Phases for disinvestment and prioritization criteria



For each criterion, we created practical, step-by-step flowcharts to guide the assessment and prioritization of each HTU candidate for disinvestment.

→ Quantifying wasteful spending and its opportunity cost

To quantify the level of waste, the methodology uses data from payers to calculate the percentage of every technology that comprises waste. For each HTU, with support from clinicians, we first defined a baseline that reflects appropriate or evidence-based use. Once this baseline for evaluation is identified, the unit cost of the HTU under assessment is estimated. We then compared this baseline with the actual number of services or prescriptions delivered to identify the share of use that exceeded what would be considered necessary or effective. This difference represents the level of waste. Given the heterogeneity of information sources, we estimated minimum, average, and maximum values of waste for every HTU assessed.

Once the size of the waste is quantified, it is evaluated based on its opportunity cost—that is, the benefit forgone by devoting resources to a wasteful HTU rather than a higher-impact one¹. Three metrics are calculated:

- The number of additional quality-adjusted life years (QALYs)² based on the countries' cost-effectiveness threshold³.
- Reductions in coverage gaps for “best-buy”⁴ services such as prenatal care or human papilloma virus (HPV) vaccination.
- The number of additional QALYs gained by closing gaps in service provision of certain “best-buy” interventions (such as cervical cancer screening and diabetes management)

Assessing wasteful spending in this way can be very compelling. It can show, for example, how many cervical cancer screenings could be funded with the money saved from no longer performing Caesarean sections (C-sections) when they are not medically indicated. Quantifying the cost of unnecessary treatment in this way clearly highlights the substantial cost of these treatments in terms that decision makers, and the wider public, can easily grasp, helping create public support for smarter spending.

→ Findings from case studies of Colombia and Dominican Republic

We developed a proof of concept in two countries, Colombia and the Dominican Republic. The results were stunning (figure 2). In Colombia, we studied six interventions: computed axial tomography (CT scans), C-sections, chest X-rays, proton pump inhibitors, antibiotics, and antihistamines. We found that the least cost-effective interventions were CT scans performed on patients with common headaches and C-sections conducted without a medical diagnosis indicating their necessity. Unnecessary CT scans alone cost the health system \$9.5 million in 2023. Optimizing—not slashing—the use of CT scans and reallocating the resources to more cost-effective interventions would have yielded huge benefits.

Estimated benefits from using the cost-effectiveness threshold method suggest that Colombia would have gained an additional 1,672 QALYs from reallocating funding for the six HTUs studied. Using the freed-up resources to fund two highly effective interventions (cervical cancer screening and diabetes management) would have yielded an additional

1 This was done using a method similar to that employed in previous IDB work to estimate population health losses and opportunity costs associated with high-cost medicines (Gutierrez et al, 2025).

2 A quality-adjusted life year (QALY) combines both the length and quality of life into a single measure and is used to compare how much health benefit different interventions produce. One QALY represents one year of life in perfect health.

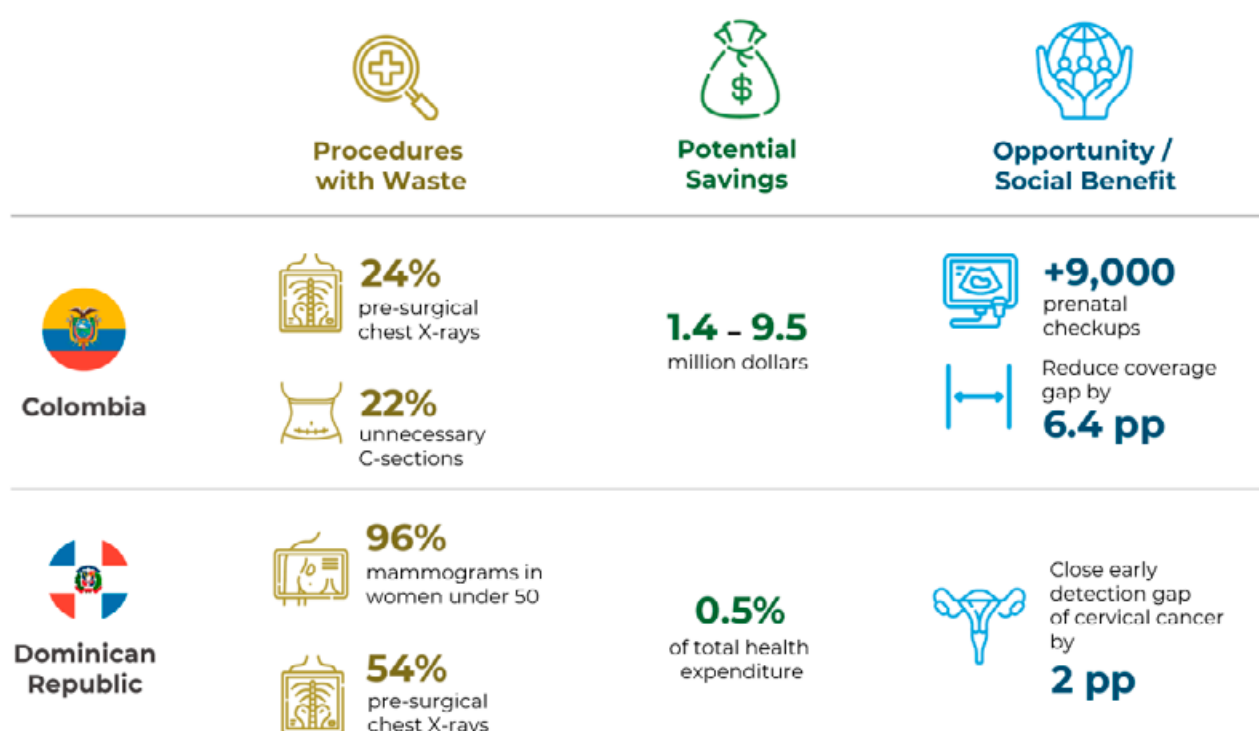
3 The cost-effectiveness threshold reflects how much it costs the health system to generate one unit of health and therefore indicates how much health might be forgone elsewhere when resources are used for a new intervention. For the same reason, it also represents the maximum amount a health system is willing to pay for one additional unit of health gain (such as a quality-adjusted life year or QALY), serving as a benchmark to judge whether an intervention offers good value for money.

4 To identify “best-buy” services, we considered interventions included in essential health service packages designed for low- and middle-income countries by the DCP3 initiative (World Bank, 2017).

573 QALYs. Reallocating resources from unnecessary CT scans could have financed 9,029 additional prenatal checkups or 12,100 HPV vaccination schedules a year. Far greater benefits would have been enjoyed if all HTUs with low efficiency had been considered.

In the Dominican Republic, we found that about 96 percent of mammograms and 54 percent of chest X-rays performed as preoperative tests for low-risk patients were unnecessary. Reducing or eliminating the use of these and the other HTUs studied could have cut total annual health expenditure by 0.5 percent. Reallocating these resources would help close coverage gaps in high-impact interventions, such as the management of diabetes and the early detection of cervical cancer.

Figure 2. Estimates of wasteful interventions and potential savings from reallocating funding to high-impact uses in Colombia and the Dominican Republic



→ How might your country benefit from smarter spending on health care?

Adopting the IDB strategic disinvestment framework to rationalize health care spending has many advantages:

- It provides quantitative evidence to support health policy decisions.
- It allows millions of dollars of unnecessary expenses to be redirected to high-impact interventions, improving population health.
- By estimating opportunity costs in terms of health outcomes—such as QALYs gained or coverage gaps closed—it can enhance the legitimacy, transparency, and political acceptability of disinvestment decisions and help stakeholders realize that rationing and controlling costs can lead to reallocation, value optimization, and better health outcomes.
- It makes health systems—and fiscal balances—more sustainable, efficient, and equitable.

- By focusing exclusively on waste, it increases the political feasibility of disinvestment, as it avoids decremental cost-effectiveness decisions and the complexities inherent in the trade-offs between individual and societal benefits they entail.

→ Would you be interested in applying this tool in your country?

If you would like to explore how this conceptual and methodological framework can guide disinvestment decisions, please contact the IDB health specialist in your country. Together, we can promote evidence-based decisions that expand access, improve efficiency, and ensure more equitable health systems throughout the region.

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