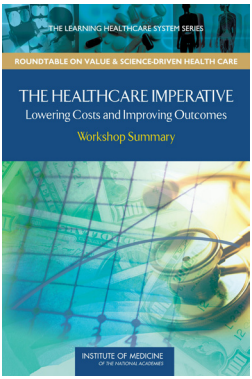
The Healthcare Imperative

Lowering Costs and Improving Outcomes



To address concerns about escalating healthcare costs and the need for effective solutions, the Institute of Medicine, with support from the Peter G. Peterson Foundation, hosted a series of meetings with providers patients, hospital administrators, health economists, employers, insurers, and others to discuss the sources of waste and inefficiency in health care.

Highlighted below are key discussion elements, sumarrized in the report from the meetings. The full report can be viewed or downloaded at www.iom.edu/vsrt.

The Imperative for Action

Challenges for health costs and outcomes

Health cost excesses with personal, institutional, and national consequences. In the past decade, U.S. health costs have increased by 92%, representing approximately four times the inflation rate for the economy as a whole. Out-of-pocket costs for individuals have increased by 40%. Overall, Medicaid now takes almost 20% of state budgets, crowding out other state priorities such as education.

Health outcomes far short of expectations. Despite health spending double the average for other developed nations, U.S. health outcomes rank below two to three dozen other countries on indices such as life expectancy, care for chronic disease, and persistent disparities in the access and outcomes of care.

Fragmented decision points, inconsistent principles, and political distortions. Barriers to appropriate care include poor care coordination, lack of consistent evidence-based guidelines, payment systems that encourage volume over value, and political influences that sometimes overturn scientific determinations.

Accounting for Waste

Six Domains of Excess Spending

EXCESS COST DOMAIN ESTIMATES:
Lower bound totals from workshop discussions*

UNNECESSARY SERVICES — **Total excess = $210 B***
- Overuse: services beyond evidence-established levels
- Discretionary use beyond benchmarks
  – Defensive medicine
- Unnecessary choice of higher cost services

INEFFICIENTLY DELIVERED SERVICES — **Total excess = $130 B***
- Mistakes—medical errors, preventable complications
- Care fragmentation
- Unnecessary use of higher cost providers
- Operational inefficiencies at care delivery sites

EXCESS ADMINISTRATIVE COSTS — **Total excess = $190 B***
- Insurance-related administrative costs beyond benchmarks
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

PRICES THAT ARE TOO HIGH — **Total excess = $105 B***
- Service prices beyond competitive benchmarks
- Product prices beyond competitive benchmarks

MISSED PREVENTION OPPORTUNITIES — **Total excess = $ 55 B***
- Primary prevention
- Secondary prevention
- Tertiary prevention

FRAUD — **Total excess = $ 75 B***
- All sources—payer, clinician, patient fraud

****Lower bound totals of various estimates, adjusted to 2009 total expenditure level***

Drivers of the Problem

Systemic factors driving excess costs

Scientific uncertainty. Clinical evidence development is not keeping pace with the emergence of new diagnostics, treatments, and insights into individual variation.

Perverse economic and practice incentives. The fee-for-service reimbursement system creates perverse incentives, rewarding service volume rather than value.

System fragmentation. Multiple, disconnected, and uncoordinated decision points in healthcare delivery and finance are fundamental challenges to efficient and effective care.

Opacity as to cost, quality, and outcomes. Without meaningful and trustworthy sources of information on costs and outcomes of care, neither patients nor their clinicians can make fully informed decisions.

Changes in health status. An aging population, the growing prevalence of obesity, and increaases in multiple co-occurring, complex chronic diseases are accelerating the need for health services.

Lack of patient involvement. The culture of care is not yet conducive to active patient participation in care decisions, despite growing use of web-accessible information and evidence of the positive effect of shared decisions-making on health outcomes.

Under-investment in population health. Because health status is importantly influences by behavioral, social, and environmental factors, progress depends on a stronger commitment to population-wide health programs.

Corrective Levers

Strategies to lower cost and improve outcomes

Streamlined and harmonized health insurance regulation. Reduce complexities and inconsistencies in coverage standards and requirements.

Administrative simplification and consistency. Streamline and harmonize inconsistent payment and reporting requirements.

Payment redesign to focus incentives on results and value. Focus payments on episodes, outcomes and value, and increase targeting those at highest risk of poor outcomes.

Quality and consistency in treatment. Establish treatment guidelines as the starting point for effective care, tailoring as indicated, and capturing the care experience for continuous improvement.

Evidence that is timely, independent and understandable. Foster effective care through a dedicated, unified program provides reliable guidance, keeps pace with changes, and improves practice reliability and consistency.

Clinical records that are reliable, sharable and secure. Use health IT to enhance the effectiveness and efficiency of care, facilitate patient handoffs, provide clinical decision guidance, and foster patient involvement.

Data that are protected, but accessible for continuous learning. Create a digital utility, with clinical data as a resource for real-time monitoring of the results of treatment, ongoing generation of new evidence for effective care, and continuous care improvement.

Transparency requirements on cost, quality and outcomes. Build an accessible information resource, with transparency as to cost, outcomes, and value serving as a critical element of system change.

Culture and activities framed by patient perspective. Position patient perspectives and needs as primary—and convenience and interest as secondary—for the design and execution of healthcare organization and delivery.

Medical liability reform. Diminish defensive medicine as a driver of unnecessary services and procedures—e.g. through harbors for best evidence practices, caps on non-economic damages, specialized tribunals.

Prevention at the personal and population levels. Elevate the focus on prevention, ranging from clinical preventive services to community health and wellness.

Opportunities to Get to 10 Percent

Lowering costs by 10% in 10 yrs without sacrificing quality

ESTIMATED HEALTH COST SAVINGS
Selected approaches: individual perspectives

	Estimated Savings in Year Ten Low	High
CARE-RELATED COSTS		
• Prevent medical errors	$8 B	$12 B
• Prevent avoidable hospital admissions	$44 B	$48 B
• Prevent avoidable hospital readmissions	$16 B	$20 B
• Improve hospital efficiency	$38 B	$80 B
• Decrease costs of episodes of care	$32 B	$53 B
• Improve targeting of costly services	$9 B	$20 B
• Increase shared decision-making	$6 B	$9 B
ADMINISTRATIVE COSTS		
• Use common billing and claims forms	$181 B	
RELATED REFORMS		
• Medical liability reform	$20 B	$30 B
• Prevent fraud and abuse	$5 B	$10 B

STAFF CONTACT: Robert Saunders, Ph.D, Program Officer
202-334-2747 / rsaunders@nas.edu