Overview of the Workshops

Framing synopsis Healthcare cost increases continue to outpace the price and spending growth rates for the rest of the economy by a considerable margin (Bureau of Labor Statistics, 2009). At $2.5 trillion and 17 percent of the nation's gross domestic product in 2009 (Centers for Medicare and Medicaid Services, 2009), health spending in the United States commanded twice the *per capita* expenditures of the average for other developed nations, and concerns have never been higher on the economic implications for individuals, families, businesses and even the overall capacity and fiscal integrity of critical functions for government at the federal, state and local levels (Peterson and Burton, 2007; Orszag, 2007; National Association of State Budget Officers, 2009; Kaiser Family Foundation, 2009a).

Moreover, there are compelling signals that much of health spending does little to improve health, and, in certain circumstances, may be associated with poorer health outcomes. Between 2000 and 2006, for example, Medicare spending on imaging services more than doubled, with an over 25 percent increase in use of advanced imaging modalities such as nuclear medicine and CT scans compared to an 18 percent increase in readily available standard imaging modalities such as X-rays and ultrasounds, despite the increased risks associated with advanced imaging services (GAO, 2008). Several recent assessments of institutional and regional variation in costs and volume of treatment services indicate that, in many cases, care profiles that are 60 percent more expensive have no quality advantage (Fisher et al., 2003)—Medicare spending per capita by hospital referral region, for example, varied more than threefold—from $5,000 to over $16,000—yet there appeared to be an inverse relationship between healthcare spending by state and quality scores.

In the face of these urgent challenges, the Institute of Medicine (IOM)—with the support and encouragement of the Peter G. Peterson Foundation—convened four meetings throughout 2009, under the umbrella theme *The Healthcare Imperative: Lowering Costs and Improving Outcomes*. These meetings explored in detail the nature of excess health costs, current evidence on the effectiveness of approaches to their control, the primary opportunities for improvement in the near- and long-terms, and the policy levers necessary to engage. The motivating proposition for the series of meetings was *to reduce health care costs by 10 percent within 10 years without compromising patient safety, health outcomes or valued innovation*. Leading experts from throughout the nation presented papers and participated in the discussions reflected in this summary publication. The ideas encapsulated throughout this summary reflect only the presentations, discussions, and suggestions that coursed throughout the workshops and should not be construed as consensus or recommendations on specific numbers or actions.

As defined in the meeting planning and presentations, excess health costs derive from the dynamics at play in 6 overlapping domains of activity.

- Unnecessary services
- Services inefficiently delivered
- Prices that are too high
- Excess administrative costs
- Missed prevention opportunities
- Medical fraud

Because of the overlaps, the difficulty of measurement, and the subjectivity inherent in estimates made under conditions of scientific uncertainty, precision was elusive for estimates of the total amount of excess in the costs of health care. It was, however, notable that estimated totals from three separate approaches

discussed in the workshops—extrapolation from observed geographic variation within the United States, contrasting overall US expenditure levels with those of member countries in the Organisation of Economic Co-operation and Development, and summing the lower bounds of the various estimates for the 6 domains considered in the IOM workshops—amounted to approximately $750 billion, $760 billion, and $785 billion, respectively, for excess US healthcare costs in 2009.

As meeting discussions focused on the factors at play that give rise to patterns of unnecessary costs, certain elements were most commonly discussed as prominent drivers, noted below and generally working in a mutually reinforcing fashion.

Scientific uncertainty
Perverse economic and practice incentives
System fragmentation
Opacity as to cost, quality, and outcomes
Changes in the population's health status
Lack of patient engagement in decisions
Under-investment in population health

Discussions on strategies and policies shown in limited assessments to offer solid prospects for simultaneously lowering costs and improving health outcomes included a number of key levers to address the drivers of excess costs.

Streamlined and harmonized health insurance
Administrative simplification and consistency
Payment redesign to focus incentives on results and value
Quality and consistency in treatment, with a focus on the medically complex
Evidence that is timely, independent and understandable
Transparency requirements as to cost, quality, and outcomes
Clinical records that are reliable, sharable, and secure
Data that are protected, but accessible for continuous learning
Culture and activities framed by patient perspective
Medical liability reform
Prevention at the personal and population levels

These are listed in approximate order of the frequency with which they were discussed and do not necessarily reflect an order of priority. For example, the workshop series focus was primarily on medical treatment, and not on prevention, although the latter was clearly discussed as a major strategy of importance. Similarly, medical fraud was specifically not a focus of these discussions but also clearly important to address. In addition, often mentioned was the fact that, like the drivers, they too are interactive with each other, underscoring the fragility of strategies that are singular in nature.

Certain of the participants, invited to offer insights specific to the challenge of reducing health care costs by 10 percent within 10 years, individually identified the approaches below as prime candidates for strategy and policy attention to lower costs, while improving outcomes, given what is currently known about both the nature of the problems and the availability of potential solutions.

Care-related costs

Prevent medical errors
Prevent avoidable hospital admissions
Prevent avoidable hospital readmissions
Improve hospital efficiency
Decrease costs of episodes of care
Improve targeting of costly services
Increase shared decision-making

Administrative costs

Use common billing and claims forms

Related reforms

Medical liability reform

Prevent fraud and abuse

Finally, meeting participants identified a number of possible issues and activities for follow-up attention of the Institute of Medicine and its Roundtable on Value & Science-Driven Health Care (formerly the Roundtable on Evidence-Based Medicine), including: consideration of what a strategic roadmap might look like for action priorities and cooperative engagement by Roundtable members; improving the methodologies for estimating the nature and implications of unnecessary healthcare costs; assessing the approaches and potential impact of greater transparency as to healthcare costs, outcomes, and value; and strategies and approaches for providing better perspective to the public on the nature and potential impact of measures to lower costs and improve outcomes of health care in the United States.