

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-07)
Strategies to Address Rising Health Care Costs
(Reference Committee G)

EXECUTIVE SUMMARY

Despite a recent slowdown in growth, US health care spending continues to rise faster than the overall economy, wages, and inflation. In 2005, National Health Expenditures (NHE) reached almost \$2 trillion, representing \$6,697 per person or 16% of gross domestic product. As rising health care costs drive up health insurance premiums and the number of the uninsured, there has been mounting public pressure for action to contain health care costs. In this report, the Council on Medical Service identifies strategies to contain health care costs and achieve greater value for health spending, paying particular attention to the role that physicians play in addressing health care costs.

It is critical to recognize that the ultimate public policy goal is not cost-reduction *per se*, but achieving better value for health care spending. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. The goal is not necessarily to reduce utilization but to “rightsize” use of services in accordance with their relative costs and benefits. The likely, but not guaranteed, net result would be lower per capita spending, with slower (or negative) cost growth over time. Accordingly, policymakers should not be deterred from simultaneously addressing the issues of rising costs, quality improvement, the uninsured, and health disparities, particularly given that solving these problems often go hand-in-hand.

Physicians play a central role in efforts to contain costs and improve value, both because of the impact of their behavior on costs and outcomes, and because their involvement is essential to the development of successful initiatives. While physicians play a central role, confronting endemic problems like obesity, tobacco use, and violence will require coalitions of stakeholders from within and outside the health care system, as well as major societal change.

Together, the body of clinical and cost evidence on the US health care system points to significant opportunities to reduce health care spending and improve value. Rising health care costs have been fueled by increased prevalence of preventable chronic disease, clinical risk factors, and unhealthy behaviors. There are also major inefficiencies in health care system, including overuse and underuse of services, and excessive non-clinical costs.

Based on analysis of this body of evidence, the Council proposes the following four broad strategies to manage costs and improve value:

- Reduce the burden of preventable disease;
- Make health care delivery more efficient;
- Reduce non-clinical health system costs that do not contribute to patient care; and
- Promote “value-based decision-making” at all levels.

From these broad strategies follow a number of specific, cross-cutting, synergistic policy interventions. The most promising interventions identified by the Council include promotion of patient lifestyle counseling, comparative cost-effectiveness research, continued development of health information technology, use of clinical performance measures that promote efficient use of services, targeted insurance benefit design, and investigation of opportunities to reduce non-clinical activities that do not add value to patient care.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8 - A-07

Subject: Strategies to Address Rising Health Care Costs

Presented by: William A. Dolan, MD, Chair

Referred to: Reference Committee G
(Steve Kanig, MD, Chair)

1 Despite a recent slowdown in growth, US health care spending continues to rise faster than the
2 overall economy, wages, and inflation. In 2005, National Health Expenditures (NHE) reached
3 almost \$2 trillion, representing \$6,697 per person or 16% of gross domestic product (Catlin et al.,
4 *Health Affairs*, January 2007). As rising health care costs drive up health insurance premiums and
5 the number of uninsured, there has been mounting public pressure for action to contain health care
6 costs. A variety of evidence documents avoidable or inefficient health care spending, including: a
7 rise in chronic medical conditions associated with modifiable risk factors; international
8 comparisons of spending and epidemiological outcomes; geographic variations in treatment
9 patterns; fragmentation of care; and widespread use of unwarranted or redundant services.

10
11 In this report, the Council on Medical Service identifies strategies to contain health care costs and
12 achieve greater value for health spending. This report pays particular attention to the role that
13 physicians play in addressing health care costs, and focuses on strategies to: (a) reduce the burden
14 of preventable disease; (b) improve the efficiency of health care delivery; (c) reduce non-clinical
15 health system costs that do not contribute value to patient care; and (d) improve health-related
16 decision-making processes.

17 INCREASED VALUE FOR HEALTH CARE SPENDING

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20 Although much of this report concentrates on strategies to reduce health care costs, it is critical to
21 recognize that the ultimate public policy goal is not cost-reduction *per se*, but achieving better
22 value for health care spending. Value can be thought of as the best balance between benefits and
23 costs (i.e., efficiency, in economic terms), and better value as improved clinical outcomes, quality,
24 and/or patient satisfaction per dollar spent. Opportunities exist to improve outcomes and quality
25 while also reducing costs and, clearly, such opportunities should be pursued aggressively.
26 However, strategies involving cost-quality tradeoffs are warranted when the value of improved
27 outcomes outweighs the additional cost, or substantial savings accrue without significant
28 compromise in quality. Thus, the goal is not necessarily to reduce utilization but to “rightsize” use
29 of services in accordance with their relative costs and benefits. The likely, but not guaranteed, net
30 result of “rightsizing” use of services would be lower per capita spending, with slower (or even
31 negative) cost growth over time.

32 THE CENTRAL ROLE OF PHYSICIANS

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35 Physicians play a central role in efforts to contain costs and improve value, both because of the
36 impact of their behavior on costs and outcomes, and because their involvement is essential to the
37 development of successful initiatives. Although physician services are only a fifth of NHE

1 spending, physicians impact spending on other services, for example, by ordering lab tests,
2 prescribing medications, and admitting patients to the hospital. A portion of these services
3 represent defensive medicine, provided in response to the threat of professional medical liability
4 rather than on the basis of clinical necessity. Physicians also come into contact with most members
5 of the public each year, putting them in a unique position to reduce and prevent risk factors for
6 disease and injury. In public opinion polls, many people cite their physician as the person with the
7 greatest influence in supporting behavioral changes such as smoking cessation, improved diet or
8 increased physical activity. Smoking cessation counseling by physicians has been identified as one
9 of the most cost-effective ways to prevent disease. In addition, the design and implementation of
10 clinically sound, feasible strategies to address health care costs depends on the clinical expertise,
11 intimate knowledge of the health care system, and buy-in of physicians. Members of the growing
12 cadre of physicians assuming management positions in hospitals, integrated delivery systems, and
13 insurance companies are uniquely positioned to institute policies and procedures that address costs
14 and improve value. Finally, while physicians play a central role, confronting endemic problems
15 like obesity, tobacco use, and violence will require coalitions of stakeholders from within and
16 outside the health care system, as well as major societal change.

17

18 AMA POLICY AND ANALYSES

19

20 Previous AMA analyses of health care spending, cost-containment initiatives, and modifiable risk
21 factors linked to the rise in costly chronic illness are included in the following reports:

22

- 23 • Council on Medical Service Report 1 (A-06), “Health System Expenditures”
- 24 • Joint report by the Council on Medical Service and the Council on Science and Public Health,
25 “Reward-Based Incentive Programs for Healthy Lifestyles” (A-06)
- 26 • AMA Financial Trends Report, “Health Insurance Costs and Coverage” (August 2005)
- 27 • Council on Medical Service Report 5 (A-05), “Containing Catastrophic Care Costs”
- 28 • Council on Medical Service Report 13 (A-02), “Growth in Health Care Costs and Health
29 Insurance Premiums.”

30

31 In summary, these analyses concluded that: (a) a multi-pronged approach to cost-containment is
32 needed, involving greater reliance on private markets as well as government action; (b) because
33 increased use of third-party payment has been a major historic driver of cost growth, successful
34 cost-containment efforts must engage patients as allies in managing costs; and (c) it is critical to
35 continue the development of specific cost-containment and quality initiatives, such as evidence-
36 based medicine, clinical treatment guidelines, disease management, and reduction of modifiable
37 risk factors for chronic disease.

38

39 Long-standing policy calls for the AMA to study projections of future health care costs and assist
40 society in prioritizing services (Policies H-155.979, D-155.996, H-155.963, H-155.978, and H-
41 155.980, AMA Policy Database). Cost-containment strategies are supported so long as they do not
42 jeopardize patient health, quality of care or the patient-physician relationship; are evidence-based
43 and developed with physician involvement; recognize cost containment as a legitimate but
44 secondary objective to improving patient outcomes; and make patient participation voluntary
45 (Policies H-155.970, H-285.998[4,5], H-285.944, H-185.988, H-380.996, H-155.998, and H-
46 155.985). AMA policy recognizes the central role that physicians play in cost-containment efforts,
47 including development and implementation of initiatives such as disease management and clinical
48 practice guidelines (Policies D-155.995, H-160.938, H-425.989, H-155.966, and H-285.931). The
49 AMA has adopted extensive policy regarding clinical practice guidelines and quality measures,

1 including the position that such guidelines are not a substitute for the experience and judgment of a
 2 physician (Policies H-410.961, H-410.968, H-320.949, H-410.965, D-450.983, D-450.978, D-
 3 410.998, H-410.960, H-450.988, H-450.995, H-410.970, and H-410.968).

4
 5 Several policies advocate federal support for activities to improve the efficiency of health care
 6 delivery. Policies H-335.964 and H-285.926 support the activities of the Agency for Healthcare
 7 Research and Quality (AHRQ) and research on the clinical impacts of cost containment efforts.
 8 Numerous policies support development of health information technology, including Policies H-
 9 405.982, H-478.995, H-478.994, and H-480.971. Policy H-155.994 encourages physicians and
 10 hospitals to share information in order to avoid the need for duplicative diagnostic tests, and Policy
 11 H-185.996 promotes utilization of care in the most appropriate settings.

12
 13 AMA policy opposes government price controls (Policies H-395.997, H-270.995, and H-395.995).
 14 Extensive policy on physician payment addresses pay-for-performance programs and tiered
 15 physician networks (Policies H-140.872, H-450.947, H-450.944, D-285.972, and H-400.996). In
 16 particular, Policy H-450.947 sets forth pay-for-performance principles and guidelines.

17
 18 The extensive body of AMA policy on preventive medicine and public health includes several
 19 policies recognizing the impact of chronic illness and lifestyle behaviors on health care costs
 20 (Policies H-155.988, H-425.993, H-425.994, H-425.999, H-425.998, and H-440.902). Many
 21 policies on prevention and public health aim to reduce the burden of disease, although most were
 22 adopted without an explicit cost-containment goal. Numerous policies promote use of
 23 recommended preventive services (Policies H-425.997, H-425.987, H-425.984, H-425.986, H-
 24 185.954, H-425.991, and H-425.992). A number of policies promote healthy lifestyle behaviors
 25 through: patient and consumer education; reward-based incentive programs; and coordination
 26 among physicians, other health care providers, insurers, employers, unions, and government
 27 (Policies H-150.953, H-170.963, H-170.995, H-170.984, H-170.986, H-170.999, H-425.982, H-
 28 440.917, H-440.969, H-490.916 and H-490.917). Policy H-440.911 supports a series of public
 29 health initiative recommendations, and other AMA policy supports legislative and organizational
 30 action designed to reduce disease burden associated with public health threats (Policies H-440.912,
 31 H-440.944, H-440.960, and H-440.965).

32
 33 Hundreds of AMA policies address specific public health issues such as obesity, substance abuse,
 34 accidents, and violence. These can be found in the following sections of the AMA Policy
 35 Database: H-10.000 Accident Prevention/Unintentional Injuries, H-15.000 Accident Prevention:
 36 Motor Vehicles, H-30.000 Alcohol and Alcoholism, H-80.000 Crime, H-95.000 Drug Abuse, H-
 37 145.000 Firearms: Safety and Regulation, H-150.000 Foods and Nutrition, H-345.000 Mental
 38 Health, H-440.000 Public Health, H-470.000 Sports and Physician Fitness, H-490.000 Tobacco
 39 Use, Prevention and Cessation, H-495.000 Tobacco Products, and H-515.000 Violence and Abuse.

40
 41 CLINICAL FACTORS DRIVING HEALTH CARE COSTS

42
 43 Increased prevalence of chronic disease, clinical risk factors, and unhealthy behaviors have fueled
 44 rising health care costs. For example, the prevalence of obesity and diabetes has doubled over the
 45 last 25 years, and more than a quarter of health care spending growth in recent years is attributable
 46 to the rise in obesity and obesity-related growth of diabetes, high cholesterol, and heart disease
 47 (Thorpe et al., *Health Affairs*, October 2004). Today, a small number of disease categories and
 48 related lifestyle behaviors account for a majority of morbidity and mortality, much of it premature
 49 or avoidable. Four conditions and four unhealthy behaviors account for roughly \$800 billion in

1 annual combined medical spending and lost productivity. The four disease categories are:
 2 cardiovascular disease, primarily heart disease and stroke; cancer; chronic obstructive pulmonary
 3 disease (COPD); and diabetes. The four modifiable behaviors are: unhealthy nutrition, physical
 4 inactivity, smoking, and excessive alcohol consumption.

5
 6 Treated prevalence of disease – defined as underlying disease prevalence combined with changing
 7 clinical thresholds for diagnosis and treatment, and technological innovations that allow treatment
 8 to reach more patients – accounts for an estimated two-thirds of cost growth over the past five
 9 years. By comparison, only one-third of the cost growth during this period is due to rising
 10 treatment costs per case (Thorpe, *Health Affairs*, November/December 2005). Similarly, treated
 11 prevalence of disease, not treatment costs per case, drive Medicare cost growth, with virtually all
 12 spending growth attributable to patients with multiple comorbidities (Thorpe and Howard, *Health*
 13 *Affairs*, August 2006). Although a portion of the rise in treated prevalence represents earlier
 14 detection and more aggressive treatment of disease, much is due to an unwelcome rise in disease.
 15 This finding suggests that cost-containment efforts should focus on reducing the need for medical
 16 services (quantity), rather than prices. It also suggests that effective cost-containment efforts will
 17 require better management of chronic illness, and investments in prevention and public health.

18
 19 Violence and accidents represent another major source of avoidable mortality, morbidity, and cost.
 20 Motor vehicle collisions are by far the leading cause of death among children, followed by
 21 homicide and suicide for those aged 15-19 (Centers for Disease Control and Prevention (CDC),
 22 June 2006). Rates of firearm-related deaths and other lethal violence are especially high for
 23 minority males, and are believed to be markedly higher in the US than other industrialized nations.
 24 Women are at higher risk of domestic violence and sexual assault. Alcohol and illegal drugs
 25 contribute to the prevalence and severity of all forms of violence and accidents, including motor
 26 crashes, assault, suicide, drowning, and fire. Most of the health care costs of violence, accidents,
 27 and other trauma arise from treating patients who sustain non-fatal injuries. A single event can
 28 result in multiple injuries and disability, including brain damage, which may require ongoing care
 29 and expense. Trauma-related injury consistently ranks as one of the three most costly disease
 30 categories, accounting for between 5 and 10 percent of aggregate health care expenditures (Machlin
 31 and Adams, MEPS/AHRQ, 2003 and Thorpe et al., *Health Affairs*, October 2004). Key
 32 opportunities for prevention include counseling patients on seat belt use and gun safety, and
 33 screening for depression and substance abuse.

34
 35 The fact that minorities experience markedly worse health, and higher rates of chronic illness and
 36 injury has several additional policy implications. During the past century, mortality rates have
 37 declined steadily, but those of blacks have persistently been 30% higher than those of whites
 38 (Woolf, *JAMA*, February 7, 2007). This suggests that medical care and public health initiatives
 39 could have a greater impact on health and outcomes if they were targeted toward minorities and
 40 other underserved populations. However, the ability of the health care system, in isolation, to
 41 improve health in underserved populations is limited by the fact that the social factors underlying
 42 health disparities lie largely outside the health care system. Such factors include fewer educational
 43 opportunities, worse living conditions, and greater exposure to violence. Studies suggest that
 44 investments in education, for example, could do as much or more to reduce health disparities than
 45 investments in health care and public health (Woolf, *JAMA*, February 7, 2007 and Kindig, *JAMA*,
 46 December 6, 2006).

1 INEFFICIENCIES IN HEALTH CARE DELIVERY

2

3 In addition to reducing the need for medical attention, improving the efficiency with which services
4 are provided can also lower health care costs and improve value.

5

6 Definition of Efficiency

7

8 Broadly defined, efficiency is the optimal balance between benefits and costs, involving both the
9 production process and what is produced – minimizing resource use for given output (or
10 maximizing output with given resources) and producing the most valued mix of outputs. Thus,
11 health care efficiency can be improved by providing the same level (amount and quality) of care at
12 lower cost, providing more care at the same cost, reducing overuse of services, and increasing
13 underused services. “Efficiency” should not be equated with “cost reduction.” Cutting back on the
14 number of organ transplants or shortening patient primary care visits might reduce costs, but would
15 also diminish efficiency insofar as the value of care sacrificed exceeds the savings. Similarly,
16 improving “productivity” need not increase value (i.e., be efficient), if it simply increases output of
17 services that confer little benefit or even cause harm (e.g., ineffective treatments, treatment of
18 trivial conditions, over treatment). These examples highlight the importance of considering costs
19 to the entire health care system or society, not just particular stakeholders. Denial of certain
20 benefits could yield immediate savings to insurers but increase future costs elsewhere in the
21 system. To the extent that more efficient provision of care extends longevity, there could be an
22 increase in individual lifetime costs and/or aggregate costs in future periods. Finally, the question
23 of who receives services must be considered. The likely immediate effect of extending health
24 insurance coverage to the uninsured and eliminating disparities in medical care based on race and
25 ethnicity would be to increase aggregate US health care spending, but such increased spending
26 would not be classified as inefficient. Thus, policymakers should not be deterred from
27 simultaneously addressing the issues of rising costs, quality improvement, the uninsured, and
28 health disparities, particularly given that solutions to these problems often go hand-in-hand.

29

30 Overuse of Services

31

32 Research suggests that unnecessary health care services account for a substantial share of health
33 care spending. One study found that non-evidence-based diagnostic tests were ordered frequently
34 during routine preventive health exams, with the estimated annual costs of unwarranted use of just
35 three low-cost tests alone – urinalysis, electrocardiograms, and x-rays – in the range of \$50 to \$200
36 million (Merenstein et al., *American Journal of Preventive Medicine*, June 2006). The Medicare
37 program recently established coverage of a “Welcome to Medicare” visit for new Medicare
38 beneficiaries, which must include numerous, costly tests and procedures not supported by
39 evidence-based guidelines. Fragmentation of care also contributes to overuse and overspending,
40 including inefficiencies related to site of service such as emergency department visits that could
41 have been provided at lower cost in a physician’s office. Current payment systems reinforce
42 fragmentation by providing little or no reimbursement for coordination activities, and by
43 reimbursing on the basis of individual services, tests, and procedures, rather than for meeting a
44 patient’s overall health care needs. Lack of availability of patient records also results in excessive
45 cost, for example, for repetitive medical histories and duplicative diagnostic tests.

46

47 Wide geographic variations in clinical treatment practices are also cited as evidence of inefficient
48 overuse of care. A pair of studies examining regional variations in Medicare spending not due to
49 differences in illness conclude that patients in higher-spending regions receive more services but no

1 better quality, access, health outcomes or patient satisfaction (Fisher et al., *Annals of Internal*
2 *Medicine*, February 2003). Related research finds striking variations across academic medical
3 centers in end-of-life care for chronically ill Medicare patients, with large differences in the
4 likelihood of being admitted to an intensive care unit (ICU) (Wennberg, et al., *Health Affairs*,
5 October 2004). Some studies suggest that high-cost, high-intensity practice patterns can be
6 associated with worse quality and outcomes, perhaps because more “handoffs” among specialists
7 make information sharing and coordination of care more difficult (MedPAC Report to Congress,
8 June 2003). While there is general agreement that regional variations reflect inefficient overuse of
9 care, there is dispute over the extent to which this is true and, especially, over the underlying
10 causes and implications of overuse. Some studies imply that in areas where the supply of
11 physicians and hospitals is high relative to demand for care, providers induce patients to utilize
12 more care, and that strong financial incentives are needed to hold providers more directly
13 accountable for providing efficient care. Other analyses show that physicians are highly responsive
14 to outcomes evidence, adapting practice patterns to improve patient care, suggesting a need for
15 wider dissemination of usable information on outcomes, costs, and best practices. Additional
16 research is needed to determine the extent to which regional variations in clinical practice patterns
17 reflect inefficiency, and the best ways to reduce inefficient variation.

18
19 End-of-life care is often cited as a specific source of overuse. A quarter of the cost of Medicare
20 services is for patients in the last year of life, but reducing these costs presents several challenges
21 (Hogan et al., MedPAC Report 00-1, May 2000). One difficulty with shifting patients to lower-
22 cost settings is predicting who can be saved by treatment. A study of ICU patients showed that
23 among the most expensive 10%, two-thirds survived (Welton, *American Journal of Critical Care*,
24 2002). Even when meaningful odds of benefit have diminished, cultural expectations often make
25 patients, family members, and medical professionals reluctant to discontinue lifesaving treatment.
26 Another difficulty is that the evidence on cost savings from shifting terminal patients to lower-cost
27 settings such as hospice has generally been disappointing or inconclusive, with the notable
28 exception of hospice care for cancer patients (Chernew et al., *Health Affairs*, 2004; Luce and
29 Rubenfeld, *American Journal of Respiratory and Critical Care Medicine*, 2002; Buntin and
30 Huskamp, *Gerontologist*, 2002; and Emanuel et al., *Archives of Internal Medicine*, 2002). Hospice
31 care, advance directives, and related measures have been found to enhance palliative care, provide
32 better coordination of care, reduce the likelihood of dying in the hospital, and increase patient
33 autonomy (Luce and Rubenfeld, *AJRCCM*, 2002 and Emanuel, *JAMA*, June 26, 1996). Thus,
34 despite a lack of demonstrated cost-savings, better management of end-of-life care would improve
35 quality, yielding greater value.

36
37 Defensive medicine represents another source of inefficient health care spending. Although the
38 existence of defensive medicine is well-documented (Kessler and McClellan, *Quarterly Journal of*
39 *Economics*, 1996, Kessler and McClellan, *Law and Contemporary Problems*, 1997, and Studdert
40 et. al., *JAMA*, June 1, 2005), quantifying its cost is much more difficult. A government report
41 approximated the national cost of defensive medicine as between \$70 and \$126 billion for 2001
42 (US Department of Health and Human Services, March 2003).

43 44 Underuse of Services

45
46 Other research suggests inefficient underutilization of services that are known to yield savings.
47 One study found that patients receive only 55% of services recommended by clinical guidelines,
48 including preventive services and care for common chronic conditions such as hypertension, high
49 cholesterol, and diabetes (McGlynn et al., *New England Journal of Medicine*, June 26, 2003).

1 Patient non-compliance with recommended treatment regimes, particularly chronic care
2 medication, also contributes to underutilization and avoidable illness and cost. A systematic
3 ranking of the cost-effectiveness of clinical preventive services shows substantial clinical and
4 financial benefit from increasing services such as aspirin prophylaxis in high-risk adults and
5 childhood immunizations (Maciosek et al., *American Journal of Preventive Medicine*, July 2006).
6 Missed opportunities to counsel patients on lifestyle behaviors, exacerbated by fragmented health
7 care delivery, represents a common example of inefficient under-use of services.

8 9 Excessive Non-Clinical Spending

10
11 Inefficient health system spending includes non-clinical spending that does not add value to patient
12 care, such as excessive costs associated with administration, insurer profits, executive
13 compensation, direct-to-consumer advertising by the pharmaceutical industry, and other marketing.
14 Excessive insurer profits can arise from factors such as lack of market competition among a small
15 number of carriers and excessive government payments health plans enrolling Medicare and
16 Medicaid patients. Recently, a host of new “cottage industries” has cropped up around the
17 insurance industry. These vendors provide third-party payers with services such as claims
18 processing, billing, “repricing” of payments to providers, determination of medical necessity,
19 regulatory compliance, and physician profiling. Non-clinical activities should be subject to cost-
20 effectiveness analysis to determine whether they ultimately add value to patient care.

21 22 BROAD STRATEGIES

23
24 Together, the body of clinical and cost evidence on the US health care system points to significant
25 opportunities to reduce health care spending and improve value. In simple mathematical terms,
26 spending can be brought down by reducing the price of health care services, the quantity of
27 services provided, or both. The preceding analysis suggests that meaningful reductions in health
28 care spending will ultimately be accomplished by reducing growth in the overall quantity of
29 services used. At the same time, improving the value of health care spending will also entail
30 increased use of certain services. Accordingly, rising health care costs should be addressed
31 through the following four broad strategies:

- 32
- 33 • Reduce the burden of preventable disease. This includes reducing risk factors for disease and
34 preventing the onset of chronic illness; improving patient compliance with medications and
35 preventive service recommendations; encouraging improved nutrition and physical activity;
36 preventing injury due to accidents and violence; and conducting public health campaigns.
37
 - 38 • Make health care delivery more efficient. This includes the use of cost-effective sites of
39 service; better coordination of care; reducing unnecessary services; increasing use of services
40 with positive return on investment in terms of reducing future disease and cost burden; greater
41 availability of cost-effectiveness information; improving management of chronic conditions;
42 and reduction of medical errors.
43
 - 44 • Reduce non-clinical health system costs that do not contribute to patient care. This involves
45 reducing non-clinical activities that do not meet the cost-effectiveness criteria of adding value
46 to patient care, such as excessive spending on administration, profits, and marketing.

- 1 • Promote “value-based decision-making” at all levels. This involves improving the processes
 2 by which decisions are made, so that they take into consideration both cost and benefit –
 3 particularly clinical outcomes. Value-based decision-making can be thought of as an extension
 4 of evidence-based medicine, in which a host of private and public decisions are improved
 5 through greater availability of information and through incentives. Examples include
 6 physicians and patients choosing among drug therapies, insurers designing health plan cost-
 7 sharing features, legislators determining public health budgets, and legislators considering
 8 mandated insurance coverage of particular benefits. Bridging the disconnect between costs and
 9 benefits is an overarching theme in numerous recent commentaries on the US health care
 10 system (Porter and Teisberg, *JAMA*, March 14, 2007; Woolf, *JAMA*, February 7, 2007;
 11 Chernew et al., *Health Affairs*, January 2007; and Kindig, *JAMA*, December 6, 2006). In some
 12 way, each of these analyses seeks to improve health outcomes relative to spending by
 13 improving the basis on which decisions are made and resources allocated.

14
 15 Each of these strategies will require changes in both patient and physician behavior, as well as
 16 targeted increases in medical and non-medical spending. The first strategy focuses on reducing
 17 overall demand for health care services, whereas the others focus on reducing the provision of low-
 18 value or harmful services, as well as increasing provision of high-value services. In practice, the
 19 strategies overlap. For example, more efficient management of chronic illness may reduce future
 20 disease burden by averting acute episodes of illness.

21
 22 SPECIFIC INTERVENTIONS

23
 24 The following specific interventions cut across the four broad strategies to manage costs and
 25 improve value. Again, there is overlap and synergy among the specific measures. For example,
 26 health information technology can be used to integrate the findings of cost-effectiveness research
 27 into clinical practice.

28
 29 Investments in Public Health and Prevention

30
 31 Preventing and halting the progression of disease, particularly stemming the rise in obesity, has the
 32 potential to dramatically reduce health care spending and improve health outcomes. Anti-smoking
 33 campaigns have succeeded in reducing the rate of smoking in the US since the 1960s, providing
 34 lessons for obesity control and other public health efforts. Key elements of effective tobacco
 35 control include clinical intervention, education, legislative regulation, tax and other financial
 36 incentives, and combining all elements into a comprehensive program (Mercer et al., *American*
 37 *Journal of Clinical Nutrition*, 2003). Research demonstrates the synergistic impact of influencing
 38 behavior through multiple channels and reaching people in a variety of settings, with medical care
 39 playing an important but limited role. Accordingly, the CDC has identified the following strategies
 40 to reduce obesity in children: increased physical activity, increased breastfeeding, reduced
 41 television viewing, reduced intake of sugar-sweetened beverages, and increased consumption of
 42 fruits and vegetables (Dietz et al., *Health Affairs*, March/April 2007). Achieving public health
 43 goals will require coordinated efforts involving schools, parents, legislators, employers, physicians,
 44 and insurers. For example, a growing number of employers offer employee wellness programs
 45 with services such as personal health assessments, on-site medical screenings, lifestyle counseling,
 46 exercise and nutrition classes, smoking cessation programs, aggressive monitoring of chronic
 47 conditions, and financial incentives for healthy behaviors. The federal government plays an
 48 ongoing role in tobacco control, providing data surveillance, evidence-based funding guidelines
 49 and best practice recommendations for states, program evaluation, legislative analyses, and

1 dissemination of clinical practice information (CDC State Tobacco Activities Tracking and
 2 Evaluation System; and CDC Office of Smoking and Health, August 1999). Public health
 3 advocates also point to the role of government regulation, for example, citing the fact that
 4 standardized nutrition labeling was brought about through legislation rather than voluntary action
 5 by the food industry.

6
 7 Cost-Effectiveness Research and Information Dissemination

8
 9 Policymakers show growing interest in evaluating and comparing the cost-effectiveness of new and
 10 existing pharmaceuticals and medical technologies (Davis et al., Commonwealth Fund, January
 11 2007; Wilensky; Buto and Juhn; Clancy; and Rowe et al., *Health Affairs*, November 2006; and
 12 Thorpe, *Health Affairs*, November/December 2005). A more narrowly focused “Wellness Trust”
 13 to prioritize disease prevention has also been proposed (Lambrew, Brookings Institution, April
 14 2007). Appeals for increased federal support of cost-effectiveness research have been fueled by
 15 growth in preventable illness, health care costs, pressure for price and quality transparency,
 16 scientific advances, and awareness that well-established clinical findings are not always applied in
 17 practice. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
 18 directed the Agency for Healthcare Research and Quality (AHRQ) to conduct comparative
 19 outcomes – but not cost – research on interventions, including prescription drugs, for ten priority
 20 conditions in the Medicare population (Neumann et al., *NEJM*, October 6, 2005).

21
 22 Comparative cost-effectiveness information would enable physicians and patients to make more
 23 informed health care decisions, for example, substituting name brand drugs with less expensive
 24 generic equivalents. Such information could also be used by insurers, employers, government
 25 entities, educators, and others seeking to prioritize which diseases to target, recognize overuse and
 26 underuse of specific services, and identify preventive services and treatments demonstrated to yield
 27 positive “return on investment.” Comparative cost-effectiveness information also can be used to
 28 design incentives for value-based decision-making by patients and physicians, for example,
 29 through health plan benefits, disease management programs, and pay-for-performance initiatives.
 30 Over time, comparative information could slow spending growth by discouraging the innovation
 31 and adoption of high-cost, low-benefit technologies. In order for cost-effectiveness research to
 32 impact clinical practice and outcomes, sufficient resources must be devoted to translating and
 33 disseminating findings in usable form.

34
 35 Health Information Technology

36
 37 Health information technology and cost-effectiveness research have the potential to synergistically
 38 improve the value of health care spending, with information systems facilitating the dissemination
 39 and application of research findings, while also allowing routine data collection to advance cost-
 40 effectiveness research and quality transparency. Evidence from other industrialized nations
 41 suggests that development and adoption of more advanced health information technology in the US
 42 would lower spending and improve clinical outcomes (Anderson et al., *Health Affairs*, May/June
 43 2006). Further development of health information technology could improve physician decision-
 44 making and coordination of care in a number of ways. For example, online access to updated
 45 evidence-based clinical treatment guidelines could avert use of ineffective or non-recommended
 46 services. Making comparative prescription drug information available, perhaps automatically
 47 during electronic prescribing, would promote substitution toward lower-cost, clinically comparable
 48 alternatives. Electronic prescribing also could avert some costs associated with dispensing errors
 49 and dangerous drug interactions. Use of networked, interoperable electronic medical records could

1 reduce the need for duplicative diagnostic tests, lower transcription costs, curb time wasted
2 searching for information, provide lifesaving information in emergencies, and possibly even reduce
3 the costs of defensive medicine and professional liability premiums. Information technology might
4 also foster greater collaboration among providers in devising ways to lower costs and improve
5 quality (Milstein, *Health Affairs*, February 2007).

6
7 An obstacle to adoption of health information technology is the fact that physicians may incur high
8 investment costs without recouping the savings permitted by new information systems. For
9 example, savings from reducing duplication of lab tests generally accrue to insurers. Thus, in order
10 for potential cost-savings and returns on investment in health information technology to be
11 realized, incentives must encourage appropriate adoption and use by various stakeholders.

12 13 Clinical Performance Measurement

14
15 The AMA-convened Physician Consortium for Performance Improvement® (Consortium)
16 coordinates the development of evidence-based clinical performance measures. Although the
17 clinical quality measures do not explicitly incorporate cost data or considerations, some recently
18 developed measures implicitly do so by targeting overuse of clinically unwarranted services. In
19 addition, a newly formed workgroup of the Consortium is addressing the issue of whether and how
20 measures might combine clinical and cost information, and the Consortium issued its *Position*
21 *Statement on the Linkage of Quality of Care Assessment to Cost of Care Assessment* in March
22 2007. The position paper and additional information about performance measurement are available
23 on the Consortium Web site (<http://www.ama-assn.org/ama/pub/category/2946.html>). Quality
24 measurements are used to: provide confidential feedback to physicians or physician groups about
25 performance, sometimes relative to peers or benchmarks; report quality information to the public;
26 and provide financial incentives for quality improvements.

27
28 To impact clinical practice, performance measures should be embedded into the physician office
29 workflow, for example, through information and prompts within information technology systems.
30 To date, clinical performance measures have focused on processes (e.g., ordering of recommended
31 tests) rather than health outcomes (e.g., blood glucose or lipid levels), and some observers believe
32 that it would be more effective to base performance measurement and reimbursement on outcomes
33 (Porter and Teisberg, *JAMA*, March 14, 2007). Physicians and others are concerned that
34 performance measurement could inadvertently divert resources away from the types of care for
35 which performance is not measured (Casalino et al., *Health Affairs*, March/April 2007). Another
36 concern is that payers may selectively choose and apply performance measures simply to reduce
37 insurance claims costs, rather than to improve patient care and health outcomes. Finally, it is
38 important that clinical protocols and performance measures not be regarded as substitutes for
39 professional judgment, and physicians are able to adapt treatment based on the specific needs of the
40 patient.

41 42 Payment Reform

43
44 Private insurers, Medicare, and large multi-specialty integrated delivery systems have
45 experimented with payment systems designed to contain costs and/or improve clinical quality.
46 Physician financial incentives include per-patient capitated payments to physicians or group
47 practices, risk-sharing arrangements between physicians and third-party payers, economic
48 profiling, tiered physician networks, and physician pay-for-performance (PFP) programs. PFP
49 programs generally involve capitated case rates, global fees, and evidence-based guidelines.

1 Physician resistance to initial PFP efforts stemmed largely from the fact that individual physicians
 2 faced penalties for factors beyond their control, including actions of other providers, patient
 3 compliance with recommended treatment, patient case-mix, and faulty risk-adjustment. Some
 4 payment methodologies have increased the challenge of clinical integration of care among multiple
 5 clinicians treating the same patient, or imposed rigid treatment algorithms that do not accommodate
 6 justified deviations based on factors such as professional judgment or patient comorbidities. PFP
 7 programs have also been criticized for rewarding only a few high performers, rather than rewarding
 8 all high-quality care (Rosenthal and Dudley, *JAMA*, February 21, 2007). The AMA Private Sector
 9 Advocacy Web site provides additional information on physician payment methodologies
 10 (<http://www.ama-assn.org/ama/pub/category/14416.html>), including economic profiling, tiered
 11 physician networks, and specific pay-for-performance programs.

12
 13 There is general agreement that physician payment reform should give priority to reducing
 14 excessive hospital costs, preventing disease, and reducing health disparities. Current payment
 15 systems do not reward physicians for providing more cost-effective care to hospital patients.
 16 Significant legal barriers limit the ability of hospitals to share cost-savings with independent
 17 physicians, in part so that hospitals do not pressure physicians to limit care inappropriately. In
 18 addition, it is often difficult to attribute savings to specific parties. Recent payment reform
 19 discussions have examined ways to overcome these challenges, align incentives of hospitals and
 20 physicians, and better integrate delivery of care. A Medicare demonstration project is underway in
 21 which hospitals are permitted to pay physicians a portion of documented cost savings generated by
 22 quality improvements. As noted in Council on Medical Service Report 10, “Strategies to
 23 Strengthen the Medicare Program,” also before the House at this meeting, the Medicare payment
 24 system’s Sustainable Growth Rate (SGR) formula penalizes physicians for preventing
 25 hospitalizations by providing outpatient care.

26
 27 Physicians generally do not receive sufficient resources, support, or reimbursement for lifestyle
 28 counseling or management of care for patients with chronic illness. The choice of performance
 29 measures and incentives in PFP programs should reward physicians for supporting patient
 30 behavioral changes such as smoking cessation, improved diet or increased physical activity, and for
 31 management of chronic illness such as diabetes and hypertension. To maximize effectiveness,
 32 insurers should cover nutrition counseling, prescription drugs to aid smoking cessation, and other
 33 complementary services. Physician PFP programs and patient wellness programs could be
 34 integrated so that patients are offered parallel incentives and assistance such as cash awards or gifts
 35 for healthy behavior, nurse helplines, and education programs (Rosenthal and Dudley, *JAMA*,
 36 February 21, 2007). Finally, PFP can be used in the effort to eliminate health disparities based on
 37 race and ethnicity, for example, by offering larger incremental payments for providing high-quality
 38 care to populations that are disadvantaged or more costly to treat effectively (Rosenthal and
 39 Dudley, *JAMA*, February 21, 2007 and Casalino and Elster, *Health Affairs*, April 2007).

40
 41 Better Coordination of Care

42
 43 A number of “patient-centric” models have been proposed to fundamentally restructure health care
 44 delivery and reimbursement in order to reduce fragmentation, improve outcomes, and reduce health
 45 disparities. Following the development of the Chronic Care Model in the 1990s, efforts to improve
 46 coordination of care have broadened to encompass preventive, chronic, and acute care (Wagner,
 47 *Effective Clinical Practice*, August/September 1998). Four national medical societies recently
 48 issued the *Joint Principles of Patient-Centered Medical Home* (American Academy of Family
 49 Physicians, American Academy of Pediatrics, American College of Physicians, and American

1 Osteopathic Association, March 2007). The medical home approach is based on each patient
 2 having an ongoing relationship with a personal physician trained to provide first contact and ensure
 3 continuous, comprehensive care for all stages of life and across the entire health care system.
 4 Other elements include patient and family involvement in decision-making, health information
 5 technology, evidence-based medicine, clinical decision-support tools, and ongoing quality
 6 improvement efforts. Payment reflects the added value of activities that fall outside of face-to-face
 7 patient visits, including coordination among providers and secure e-mail and telephone
 8 consultation. Medicare and Medicaid demonstration programs are testing the medical home
 9 approach for patients with multiple chronic conditions. Other new models propose reorganizing
 10 delivery and reimbursement around episodes or “cycles” of care, rather than discrete services
 11 (Davis, *NEJM*, March 15, 2007 and Porter and Teisberg, *JAMA*, March 14, 2007), and providing
 12 more effective, personalized prevention and treatment by leveraging advances in genetic medicine
 13 (Snyderman, *Journal of Clinical Investigation*, October 2004). Such new models would reward
 14 greater collaboration among physicians, hospitals, and other stakeholders for innovating cost-
 15 effective approaches to care that meet the patient’s overall health care needs, be they preventive
 16 care, acute treatment, chronic disease management, behavioral change, education, or wellness
 17 promotion.

18
 19 Targeted Benefit Design

20
 21 There is growing interest among health policy researchers and insurers in manipulating out-of-
 22 pocket cost-sharing in order to reward compliance by patients with chronic conditions, thereby
 23 averting costly adverse outcomes (Chernew et al., *Health Affairs*, January 2007; Chouhdry et al.,
 24 *Health Affairs*, January/February 2007; Demchak, State Coverage Initiatives issue brief, November
 25 2006; and Furman, Brookings Institution, April 2007). Several large self-insured employers have
 26 started experimenting with lowering copayments for drugs identified as “clinically valuable” (e.g.,
 27 beta-blockers and ACE inhibitors). Initial experience suggests that such targeted benefit design
 28 can improve clinical outcomes and reduce costs.

29
 30 DISCUSSION

31
 32 Although additional health care spending has yielded substantial clinical, economic, and quality of
 33 life benefits—for example, helping to reduce death rates for cardiovascular disease since the 1960s
 34 (Cutler and Meara, NBER Working Paper, October 2001), health care cost growth has outpaced
 35 general inflation, driven up health insurance premiums, and contributed to the number of the
 36 uninsured. Previous AMA analyses have focused on improving overall function of markets for
 37 health insurance and medical services; and on appropriate development of explicit cost-
 38 containment measures such as disease and case management, pay-for-performance, and end-of-life
 39 care improvements. In addition, the AMA has extensive policy on preventive medicine and public
 40 health, much of which was adopted without an explicit cost-containment goal, but which would
 41 reduce overall, long-term health care costs, improve health outcomes, and increase the value of US
 42 health care spending. The Council on Medical Service reiterates the importance of general market
 43 incentives for health care cost-containment, appropriate cost-containment measures, preventive
 44 medicine, and public health.

45
 46 In this report, the Council asserts that the ultimate public policy goal is not cost reduction *per se*,
 47 but achieving better value for health care spending. Physicians play a central role in improving the
 48 management of health care spending, quality, and health outcomes. Nonetheless, confronting
 49 endemic problems that create needless health care costs, like obesity, tobacco use, and violence

1 will require coalitions of stakeholders from within and outside the health care system, as well as
2 major societal change.

3
4 The Council proposes the following four broad strategies to manage costs and improve value:
5

- 6 • Reduce the burden of preventable disease;
- 7 • Make health care delivery more efficient;
- 8 • Reduce non-clinical health system costs that do not contribute to patient care; and
- 9 • Promote “value-based decision-making” at all levels.

10
11 From these broad strategies follow a number of specific, cross-cutting policy interventions to
12 improve the cost-effectiveness of the US health care system. Together, specific interventions
13 would shift resources toward preventive services and public health interventions, increase the
14 availability of both clinical and cost information needed to make cost-effective decisions, and
15 employ incentives for patients, physicians, and others to make value-based decisions. The
16 proposed interventions emphasize the central role that physicians play in addressing rising costs
17 and improving value for health care spending. Important linkages and synergies exist among the
18 proposed interventions. For example, useful cost-effectiveness information disseminated through
19 health information technology could support physicians in providing personalized lifestyle
20 counseling to patients, particularly if payment reform, performance measurement, and
21 complementary patient support also promote lifestyle counseling. The most promising
22 interventions identified by the Council include promotion of patient lifestyle counseling,
23 comparative cost-effectiveness research, continued development of health information technology,
24 use of clinical performance measures that promote efficient use of services, targeted insurance
25 benefit design, and investigation of opportunities to reduce non-clinical activities that do not add
26 value to patient care.

27
28 RECOMMENDATIONS

29
30 The Council on Medical Service recommends that the following be adopted and the remainder of
31 this report be filed:

- 32
33 1. That our American Medical Association (AMA) recognize that successful cost-
34 containment and quality-improvement initiatives must involve physician leadership, as
35 well as collaboration among physicians, patients, insurers, employers, unions, and
36 government. (New HOD Policy)
37
- 38 2. That our AMA support the following broad strategies for addressing rising health care
39 costs:
40
41 (a) Reduce the burden of preventable disease;
42
43 (b) Make health care delivery more efficient;
44
45 (c) Reduce non-clinical health system costs that do not contribute value to patient care;
46 and
47
48 (d) Promote “value-based decision-making” at all levels. (New HOD Policy)

- 1 3. That our AMA continue to advocate that physicians be supported in routinely providing
2 lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of
3 lifestyle counseling in quality measurement and pay-for-performance incentives; and
4 medical education and training. (Directive to Take Action)
5
- 6 4. That our AMA continue to advocate that sources of medical research funding give priority
7 to studies that collect both clinical and cost data; use evaluation criteria that take into
8 account cost impacts as well as clinical outcomes; translate research findings into useable
9 information on the relative cost-effectiveness of alternative diagnostic services and
10 treatments; and widely disseminate cost-effectiveness information to physicians and other
11 health care decision-makers. (Directive to Take Action)
12
- 13 5. That our AMA continue to advocate that health information systems be designed to
14 provide physicians and other health care decision-makers with relevant, timely, actionable
15 information, automatically at the point of care and without imposing undue administrative
16 burden, including: clinical guidelines and protocols; relative cost-effectiveness of
17 alternative diagnostic services and treatments; quality measurement and pay-for-
18 performance criteria; patient-specific clinical and insurance information; prompts and other
19 functionality to support lifestyle counseling, disease management, and case management;
20 and alerts to flag and avert potential medical errors. (Directive to Take Action)
21
- 22 6. That our AMA encourage the development and adoption of clinical performance and
23 quality measures aimed at reducing overuse of clinically unwarranted services and
24 increasing the use of recommended services known to yield cost savings. (New HOD
25 Policy)
26
- 27 7. That our AMA encourage third-party payers to use targeted benefit design, whereby patient
28 cost-sharing requirements are reduced for maintenance medications used to treat chronic
29 medical conditions, particularly when non-compliance poses a high risk of adverse clinical
30 outcome and/or high medical costs. Consideration should be given to tailoring cost-
31 sharing requirements to patient income and other factors known to impact compliance.
32 (New HOD Policy)
33
- 34 8. That our AMA support ongoing investigation and cost-effectiveness analysis of non-
35 clinical health system spending, to reduce costs that do not add value to patient care. (New
36 HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Advocacy of specific measures to address rising health care costs at an estimated total cost of \$4,890.