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## Preface

The rising cost of health care in the United States and most developed countries is creating increasing pressure to control medical care expenditures. This is true regardless of whether the payer is a government agency or a private sector insurance company. In the United States, millions of citizens lack health insurance altogether. These “self-pay” patients face financial ruin if they become seriously ill, and many must forgo even basic medical services including preventative care. The Affordable Care Act (ACA) of 2010 was intended to expand coverage for the uninsured and to reduce projected health-care expenditures by restructuring the way in which medical care was reimbursed. Previously the American health-care system was largely based on a fee-for-service arrangement wherein providers were paid for each unit of service. This encouraged hospitals and physicians to provide more care than was sometimes necessary and resulted in a misalignment of incentives between payers and the providers. As described in Chap. 1, the ACA includes provisions to shift reimbursement from the traditional fee-for-service system that encourages increasing the volume of care to value-based contracts utilizing bundled payments for episodes of care (or even entire populations). The ACA also includes quality metrics and risk sharing arrangements to better align the incentives between payers and providers. Whether the intended outcomes of the ACA are eventually realized or not will take some years to be determined. Regardless of the eventual fate of the ACA, the pressure to contain health-care costs will continue to increase. Similar pressures will be experienced in other developed countries including those with largely government-financed health-care systems.

Ancillary services including the clinical laboratory, radiology, and pharmacy are common targets of utilization management programs. This is because these services are frequently perceived to be overutilized and because they can be easily quantified in terms of the units of service provided and their attendant costs. The available menu of laboratory tests continues to expand including the rapid introduction of high-cost genetic and molecular diagnostic assays. As well, the number of pharmaceuticals and radiological procedures is also steadily expanding with many new high-cost drugs and scans becoming available. The growth in technologies available to medical providers will continue to drive increases in health-care costs. When this is combined with the aging populations in most developed countries and increasing life spans, the prospects for relentless and potentially ruinous increases in the cost of medical care are drawing increasing concern.

There are a number of approaches that can be employed to reduce health-care expenditures including:

1. Reducing reimbursements to providers for individual units of service
2. Arbitrarily reducing (or delaying) the amount of care that is provided
3. Improving the efficiency of the health-care system such that units of care can be provided at a lower unit cost
4. Implementing evidence-based utilization management programs to reduce or eliminate unnecessary care

There is an extensive literature on utilization management of ancillary services as is illustrated by the bibliographies accompanying many of the chapters in this book. However, the literature has been spread across multiple journals and other published sources spanning several decades. It is therefore difficult for individuals who are exploring utilization management initiatives to compile and assimilate what has been previously published as a starting point for implementing a utilization management program. We realized the need for a textbook dedicated to providing medical professionals with a concise but comprehensive review of utilization management in the clinical laboratory. We also chose to include chapters on utilization management in the pharmacy and in radiology. One chapter provides an international perspective Canada. In an effort to achieve as broad a representation of the topic as possible, we asked a number of colleagues to contribute chapters reflecting their own expertise and personal experiences. The chapters included in the book are as follows:

- “Health-Care Reform and Its Impact on Medical Reimbursement”
- “Utilization Management in the Clinical Laboratory: An Introduction and Overview”
- “Effective Governance Structure and Management of Utilization Programs”
- “Informatics and Decision Support in Utilization Management”
- “Utilization Management Employing Test Interpretations and Algorithms”
- “Calculating Costs and Savings in Utilization Management”
- “Benchmarking and Management Metrics in Utilization Management”
- “Laboratory Formularies”
- “Utilization and Other Resource Management in Clinical Chemistry”
- “Utilization Management in Routine Hematology”
- “Patient Blood Management”
- “Utilization Management of Blood Derivatives”
- “Utilization Management in the Clinical Microbiology Laboratory”
- “Utilization Management in a Large Community Hospital”
- “Utilization Management: The Role of Reference Laboratories”
- “Utilization Management in Anatomic Pathology”
- “Utilization Analysis in Hematopathology”
- “Test Utilization: Controlling Cost in Reference Laboratory Testing”
- “Utilization Management of Genetic Testing”
- “The Use of Physician Profiling and Prior Approval (Gatekeeping) in Utilization Management in the Clinical Laboratory”
- “Test Utilization: The Essential Role of the Clinical Consultant”
- “The Role of the Genetic Counselor in Utilization Management”
- “Utilization Management in Radiology”
- “Strategies for the Clinical and Financial Management of Drug Utilization”
- “Laboratory Utilization Management in Canada”
- “Utilization Management Initiatives That Can Be Imported into Healthcare Systems”

We wish to thank the authors for their willingness to contribute to this special edition and hope that the information contained in the articles is both educational and of practical use to those who are engaged in utilization management activities.

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