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The "Show Me the Value" Health Care Revolution

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There are three, and only three, ways to reduce the total cost of any good or service: pay less per unit; use fewer units; or improve efficiency and effectiveness so that less money and/or fewer units are needed to achieve the desired result. With trembling hands, the U.S. health care system is preparing to give the third method a serious try.

Government-controlled systems excel at the first two options. They set global budgets, prescribe prices and proscribe pricy new technologies until there's tangible proof of need. The decisions about each individual's care may ultimately lie with clinicians, but government or government-funded intermediaries can place a heavy thumb on the scale. In this country, Medicare and Medicaid offer less-comprehensive versions of price and utilization controls through a kind of single-payer "light."

The effectiveness of these strategies, however, is now facing unprecedented challenge. Were the draconian 24.4 percent cut to physician pay mandated by the Medicare Sustainable Growth Rate (SGR) formula for 2014 to go into effect, the program would be thrown into chaos. On the demand side, meanwhile, as many as 32 million Americans could enter the health-care system because of the Patient Protection and Affordable Care Act (ACA), upping national use of medical services at the same time aging Baby Boomers are doing the same.

With "pay less" and "do less" of dwindling utility, that leaves "do things better." Since today's health care system is hamstrung by the kind of piecework methods Hippocrates would instantly recognize, pushing into a 21st century world of sophisticated measurement and management represents an unprecedented paradigm shift.

One might assume a U.S. marketplace filled with powerful private payers would long ago have developed ways to ensure providers provide value for the dollar. Alas, the health care market is not like others. In his famous 1963 essay *Uncertainty and the Welfare Economics of Medical Care*, economist Kenneth Arrow wrote: "The social obligation for best practice is part of the commodity the physician sells, even though it is a part that is not subject to thorough inspection by the buyer." (Arrow) A half-century later, "just trust me" medicine is only now starting to fade.

Efforts to purchase health care using criteria related to efficiency and effectiveness go back a hundred years, starting with efforts to apply Taylorism to hospitals. (Millenson) However, deference to clinician judgment and the firm belief by many Americans that "more is better" when it comes to medical care have posed powerful barriers to change. One prominent example occurred in the early 1990s when managed care companies acting on behalf of employers tried to limit new mothers to a one-night hospital stay, a practice common in Europe with no ill consequences. Although the new policy was being applied in a non-governmental setting, a public backlash quickly prompted a near-unanimous Congress to ban the practice.

"Pay less," unless it's reimbursement to those treating the poor, conjures up similar fears. Back in 1895, an editorial in the *Journal of the American Medical Association* warned darkly that a life insurer trying to reduce by 40 percent the fees it paid doctors to perform physicals risked "a scrutiny 40 percent less thorough" of would-be policyholders. (*JAMA*) Similar worries about the possible dire effects of payers exercising market power led Congress to ban competitive bidding to choose drugs for the Medicare Part D benefit and to annually override SGR cuts even as that action inexorably caused subsequent mandated reductions to soar.

Still, even with a recent lull in health care inflation, health care now accounts for 18 percent of the gross domestic product, or about 50 percent more than the next costly nation, endangering America's global economic competitiveness. Closer to home, workers' median income between 2003 and 2011 increased just 10 percent, while family premiums for employer-based coverage shot up 62 percent. (Schoen et al.) Even with those sharp increases, deductibles doubled, and with the prospects for premium inflation in the decade ahead no better, health insurance premiums are taking an ever-greater chunk out of worker paychecks.

At the same time, local governments have begun linking health care and pension costs to a lack of funding for schools, roads and other civic needs. With the consequences of high health care costs increasingly pinching individual citizens in their pocketbooks, trust in "trust me" medicine has eroded. In its place we see the rise of "show me the value" health care, which seeks to explicitly link cost and quality in benefits design and in provider payment schemes. The arguments and supporting data for this shift aren't new, but some of those making the argument are.

There is, for instance, the Institute of Medicine (IOM) Roundtable on Value and Science-Driven Health Care, whose very name disarms suspicions that penny-pinching payers could be influencing its deliberations. A recent report declared that a stunning 30 percent of total health care spending could be eliminated without harming care quality. (IOM) In the same vein, the National Commission on Physician Payment Reform called for a phase-out of fee-for-service payment within five years and its replacement by payment based on the quality of care provided. (National Commission on Payment Reform) The group's Honorary Co-Chair was former Republican Senate Majority Leader and cardiac surgeon Bill Frist. In a press release, Frist pointedly called "get[ting] the most from our health care dollars" a "bipartisan issue."

The commission was sponsored by the Society of General Internal Medicine, which formally endorsed its detailed recommendations some weeks later. Although this seems to be the first time a medical society has agreed even in theory to an end to fee-for-service payment, the move drew nary a peep of protest from the American Medical Association. One reason is surely that the economic alternatives are not attractive; the ax of the SGR hanging over doctors' heads has concentrated the mind wonderfully. However, an even more compelling reason may be a long list of provisions in the Patient Protection and Affordable Care Act (ACA) designed to push the U.S. health care system in a manage-and-measure direction. These include Accountable Care Organizations, part of a shared savings program for Medicare; value-based purchasing for hospitals; a bundled payments demonstration for hospital and post-acute care; reduced payments due to hospital-acquired conditions; reduced payments for preventable hospital readmissions; and mandatory physician quality reporting.

Practical considerations aside, the profession's new openness to value-based payment may also reflect a growing acknowledgement by many doctors that a systemic "do things better" approach is needed. Asked in a 2012 Harris Interactive survey, "Without sacrificing quality, how much do you think health care costs in your community could be reduced?" one in seven agreed with the same waste assessment endorsed by the IOM (30 percent or more) and one in five said the range was 20 to 29 percent. (UnitedHealth)

Still, the truism that "One man's waste is another man's income" isn't about to disappear. So, for instance, of the $765 billion in waste identified by the IOM Roundtable in 2009, the uncontroversial areas of fraud ($75 billion) and "missed prevention opportunities" ($55 billion) play only a minor role. "Excessive administrative costs" may be what clinicians and health industry executives have in mind as a target for cost-cutting-without-sacrificing-quality, and those are significant: $190 billion. But "prices that are too high" comes to $105 billion (whose prices might that be?) and "unnecessary services" looms largest of all, at $210 billion.

It is a situation that cries out for sophisticated management, for managers comfortable with MDs and MBAs, behavioral economics and Big Data, operational change and human obstinancy. Health care is entering an era of detailed scrutiny of both processes of care and outcomes, and this new era will bring with it new rules.

First, who measures, matters. There will be measures driven by government, private payers, regulators and accreditors, but peer assessment won't vanish from clinical settings. In fact, peer assessment may become even more important as a counterpoint to objective measures with inherent reliability limits.

Although traditional sources will increasingly include patient-centric measures such as functional health status or consumer-centric ones such as cost or service, these same kind of measures will also be available from non-traditional sources. Harmonization and rationalization of measures will emerge as a major issue.

Second, power will shift. A 2012 study finding an equivalent accuracy between the Hospital-Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) measures and the assessments on Yelp is a wake-up call about control of information by

industry insiders. (Bardach et al.) Ditto the inclusion on the IOM Roundtable mentioned above of a founder of PatientsLikeMe, a site providing clinical information to patients based on the experience of others with the same illness.

Power will shift in other ways, as well: value-based payment schemes demand sophisticated information systems, and hospitals have capital that small physicians practices often lack. Value-based payment also demands risk management abilities that insurers have spent decades honing. Analytics will be elevated, and teamwork will increasingly trump individualism. The challenge will be to balance systematization against bureaucratization and appropriate autonomy versus appropriate accountability.

Third, disruptive innovation disrupts. Accountability will become a 360 degree affair, with clinicians, employers, government, provider institutions and individual patients all finding that the pleasure of holding others responsible for changing behavior will be balanced by uncomfortable new scrutiny of their own actions. There will be arguments about roles, about information control and accuracy and, of course, about money. Evidence will be dismissed, motives impugned (note the controversy over comparative effectiveness research) and every possible economic advantage fought over in trench warfare clothed in righteous declarations of protecting patients and improving quality of care.

A Victorian-era British parliament member wrote: “A reform is a correction of abuse. A revolution is a transfer of power.” If, indeed, we are to trim a nearly $3 trillion industry by almost one third, it will require a genuine health care management revolution and an unprecedented transfer of power from those who provide care to those who pay for and use it. Revolutionary rhetoric, however, is not the same as putting a revolution into place, and the opening battles of this one are just beginning.

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