the urgent need to create healthcare value

It is difficult to determine whether any delivered healthcare services confer value—and if so, by how much—using the traditional definition of value (quality and outcomes divided by cost).

Such was the finding of a systematic review of the literature published this year in the *Annals of Internal Medicine.* Some of the studies included in the literature review showed that low costs were associated with high quality—in other words, that relative value could be obtained. Other studies found that higher costs were associated with lower or equivalent quality so that value creation was elusive.

**The Challenge of Determining Healthcare Value**

So on a fundamental level, how should health care be valued? Theoretically, performance measures designed to assess services deemed to offer low value could drive value creation. *Low-value services are defined as those for which the harms outweigh the benefits or which have undesirable trade-offs between health benefits and expenditures.* An editorial published in the January 2013 issue of *Annals of Internal Medicine* lamented the current reality that physicians can’t respond rationally to incentives designed to discourage use of low-value services. *We concur. Based on our own research, we believe that, unless patients are involved in the decision-making process,*

**Balancing Societal and Individual Benefit**

Moving forward, how ought we to determine how to create healthcare value? As Glinda the Good Witch says in *The Wizard of Oz,* “It’s always best to start at the beginning.” At the beginning, healthcare professionals consider it their ethical responsibility to help, and *not harm,* their patients; in that way, they create value. This is good, because patients who are being helped without being harmed probably represent a pretty good numerator for a value equation. However, that definition ignores value’s denominator. To properly incorporate the denominator, the value equation requires an object: For whom is value being created? It is important to keep in mind that society as a whole and patients as individuals should concurrently obtain value from the provision of health care.

Societal value is achieved by applying evidence about trade-offs between benefits and expenditures. The ethical principle of nonmaleficence (i.e., “do no harm”) suggests that if an intervention does not have a benefit, it should not be offered because it constitutes absolute waste. The principle of social justice suggests that healthcare providers also should not offer costly interventions that produce only modest benefits because such interventions represent relative waste. It is incumbent on professionals to determine which interventions are which bundling payments may actually encourage unnecessary interventions.

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and to use processes that best allocate scarce resources and prevent wasteful expenditures. Here, some paternalism is warranted: Everything should not be offered to everyone. From a societal perspective, one area that is clearly in need of improvement is end-of-life care, where costs are high and variable and opportunities for improvement abound.\(^6\)

From a patient perspective, value can be created only when the patient is well informed about the clinical need for a particular intervention and has requested it. Performing an intervention when a patient neither needs nor wants it only exposes the patient to risk of harm without any opportunity for benefit. As a case in point, several years ago, physicians in Redding, Calif., were found to have been performing unnecessary cardiac interventions.\(^4\) Many were high-risk, high-value procedures that might have appeared to create societal value: Most procedures were performed correctly, process measures were generally achieved, and recovery was uneventful in most cases. But clearly, no real value was created: Patients were exposed to unnecessary harm without the opportunity for achieving benefit because no benefit was likely—and some interventions resulted in poor outcomes.

**The 'Silent Misdiagnosis'**

The Redding story may seem like an egregious example, but is it? Knee arthroplasty is clearly a high-value intervention from a social perspective, given its clear potential for improving quality of life. Yet evidence suggests that the procedure is considerably overused. University of Toronto researchers found that, in an area where there was high use of joint arthroplasty, only about 15 percent of 21,925 patients who had a potential need for the procedure said they were definitely willing to undergo surgery.\(^8\) In other studies, University of Toronto researchers found that enthusiasm among orthopedic surgeons may explain some of the geographic variation in knee arthroplasty rates, and that physicians themselves are inconsistent in their opinions about indications for the intervention.\(^h\)

When Group Health, a large health system in Washington, introduced shared decision making, already low knee arthroplasty utilization rates fell by 38 percent.\(^l\)

Spine surgery offers another example. In the Spine Patient Outcomes Research Trial, 30 percent of 743 patients who were ideal surgical candidates with at least six weeks of lumbar radiculopathy and imaging-confirmed lumbar intervertebral disk herniation chose not to receive discectomy.\(^j\)

**The Way Forward**

It seems clear that the only way healthcare providers can create value for society and patients concurrently is by offering patients interventions only if the benefits are likely to outweigh the risks and if the patients are well informed and want the interventions. Any other approach results in what The Dartmouth Center for Health Care Delivery Science researchers provocatively label "the silent mis-diagnosis."

Analysis of "big data" collected from electronic health records and claims data should help providers determine which interventions are most likely to benefit which populations; these findings should be used to limit the menu of interventions that are offered to patients. Shared decision making should be implemented to ensure that patients who may need surgery are properly informed and their preferences respected.

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Heathcare Reform

qualify for an intervention really want it. Instead of modestly penalizing institutions that do not provide a shared decision-making process, as recommended in a perspective published in The New England Journal of Medicine earlier this year, insurers should decline to pay for such a procedure if it cannot be shown that the patient made an informed choice to undergo it.

The growth of healthcare expenditures represents a profligate economic extravagance that has hijacked growth in family income. Such unrestrained growth leads to global noncompetitiveness, needless impoverishment of future generations, social bankruptcy, and declining healthcare value. Instead of tepid measures that use modest penalties as incentives for compliance, we need bold leadership that relies on analytics and evidence to define options for patient care, enlists patients in their care management and decision making, and refuses to harm patients in the interest of corporate profitability.

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