Slouching Toward Value-Based Health Care

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Despite some recent moderation, health care costs continue to grow at rates exceeding those of the larger economy, as documented in the annual assessment by the Centers for Medicare and Medicaid Services (CMS), with which we begin this issue of the journal. Spending growth is not necessarily a problem, assuming the benefits in terms of enhanced health and social well-being grow commensurately. As often noted in these pages and elsewhere, the key is value, measured in terms of the contributions of health care minus the attendant costs, with both contributions and costs conceptualized very broadly.

"Value-based" is the preferred prefix of our era, with manufacturers advocating value-based pricing, employers value-based purchasing, and insurers value-based benefits. The central insight is that services trade in nonhealth markets at prices that consumers and purchasers are willing to pay, taking into account their assessment of the services' features and the prices of competing services, rather than based on the costs of producing those services. In health care, however, the consumer typically is not the purchaser because of being shielded from prices by insurance. Moreover, many clinical choices are made on patients' behalf by physicians, who rarely bear financial responsibility for their clinical decisions. But cost-unconscious demand, one of the defining features of the health care market, is evolving. Managed care sought to increase physicians' price-sensitivity through selective contracting, rate discounting, and utilization management. Consumer-driven initiatives seek to increase patients' price-sensitivity through higher deductibles, tiered drug

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formulas, and other forms of cost sharing. All of these efforts are beset by inadequate information on service quality, a lack of transparency for prices, and misaligned incentives among the many individuals and institutions involved.

This issue of *Health Affairs* explores the evolving concept of value in health care through a range of analyses that maintain a dual focus on cost and appropriateness. Mary Landrum and colleagues disaggregate Medicare data on geographic variations in the use of diagnostic and treatment services for patients with colorectal cancer. Areas with high total spending exhibit higher rates for both recommended and nonrecommended services, which implies that a single-minded focus on cutting spending in high-cost areas would reduce the use of high-value services there without increasing the use of high-value services elsewhere. Shifting to the international arena, Patricia Danzon and Michael Furukawa decompose cross-national differences in per capita pharmaceutical spending. They shed doubt on the conventional wisdom that high U.S. spending is attributable solely to high unit prices, noting that U.S. patients are consuming newer drugs and at stronger doses than are patients in other large economies. Whether this implies that Americans are getting higher benefit for their higher costs, and hence that value does not vary as much as spending does, must wait for assessments of the outcomes of the contrasting drug regimens. Bong-min Yang and colleagues describe the evolution of the national health insurance system in the Republic of Korea, from an initial emphasis on expanding expenditures to the contemporary introduction of economic-effectiveness analysis. They interpret that system as focusing less on cost control per se than on improving value by shifting use from less effective to more effective medications.

We also offer a cluster of papers on "value-based insurance benefits," in which health plans establish copayment requirements based on the expected health benefits of particular services. Richard Hirth and colleagues use cross-national data on patients needing kidney dialysis to document the adverse health consequences of cost sharing that does not consider the special needs of this expensive category of patients. Michael Chernew and colleagues report on a large employer's elimination of copayments and resulting higher adherence for effective chronic disease medications. John Rowe and colleagues evaluate the impact of first-dollar payment for preventive services under Aetna's HealthFund insurance product, in which selective services are excluded from the deductible that heretofore had been the defining feature of "consumer-driven" designs.

These initiatives to promote value in health care are tentative, and they do not address many of the major sources of cost growth, which include intensive services for severely ill patients not managed in a coordinated fashion. But these experiments are important signposts on the long journey toward a health care system that balances the costs and the benefits of particular treatments before recommending them to patients and reimbursing them with social resources.

James C. Robinson, Editor-In-Chief

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