Bending the Value Curve

In health care policy circles, "bending the cost curve down" may qualify as the phrase of the decade. More than 1 million web search references are testament to its widespread use, intended to express a focus on reducing health care costs. Yet it should not surprise anyone familiar with technocratic vocabulary that there is no clear agreement on what the phrase means.[1] Nonetheless, with health care spending nearing one-fifth of the nation's gross domestic product,[2] the nationwide clamor to "bend the cost curve down" is understandable. In this commentary, however, we discuss the shortfalls of focusing on costs alone and instead propose a national commitment to "bending the value curve up."

Although finding ways to control health care spending is certainly important, focusing on cost alone is neither sufficient nor appropriate. Calling out costs in isolation may be disconcerting to many stakeholders, including those whose health care services or livelihoods rely on this important sector of the economy. For example, patients might associate cutting costs with decreased access or hastily provided care, and clinicians may fear lower salaries or undue administrative pressures. Moreover, slicing away at high-quality and lifesaving programs for the poor, the young, the disabled, or the elderly or increasing the financial burden for disadvantaged populations is shortsighted and unfair.[3,4] Beyond this, focusing on cost alone ignores the benefits to life and well-being that result from high-quality health care spending, even if it is associated with a high price tag. Rather than simply asking whether we are spending too much, we should also ask whether we are achieving the kind of care experiences and outcomes we would expect for the price we are paying.

Value is the quality of an output divided by the cost to achieve it. The numerator of the value ratio can be defined by using the 6 Institute of Medicine domains of quality: safety, effectiveness, efficiency, timeliness, patient-centeredness, and equity.[5] The denominator would be the resources consumed in terms of money, time, and labor. Applying the value ratio includes determining which outcomes should be targeted for quality and cost measures. For example, Michael Porter's value framework organizes outcomes for any given medical condition into 3 successive tiers: health status achieved or retained, process of recovery, and sustainability of health.[6] Although relevant metrics and outcomes will vary immensely across medical conditions and patient populations, it seems far more sensible to place these value-based measures at the center of the discussion about improving health care rather than a blunt attempt to cut costs regardless of outcomes.

Despite $2.8 trillion spent on health care, health outcomes in the United States are not consistently good. Research has demonstrated that evidence-based care

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is delivered only half the time,[7] and Americans face far more threats to their safety in the health care system than any patient, family member, or provider should deem acceptable.[8–10] Imagine that you went to a restaurant and were told you had a 50/50 chance of getting the meal you ordered and paid for.[7] Even worse, imagine that you had an estimated 1 in 10 chance of being harmed.[9] The United States spends far more than any other country on medical care, yet Americans have life spans shorter than people in countries spending less. Although many pockets of excellence exist, inconsistencies in care and gaps in population-level experiences and outcomes demonstrate that platinum-level spending has tarnished areas throughout the system. Reducing costs alone will not solve this "paradox of excess and deprivation"[11]; we need to address quality and cost simultaneously.

By considering the ratio of quality to cost instead of aggregate costs alone, we shift our focus to addressing spending (whether large or small) that does not provide high-quality results. In this framework, low-cost services that deliver no benefit or may even cause harm are assigned low value, and high-cost services that provide high-quality results are assigned high value. Rather than developing new interventions in a vacuum, we must focus on avoiding "pseudo-innovation": technologies that cost more but do not lead to demonstrably better outcomes.[12,13] Moreover, the value framework emphasizes the need to innovate how we deliver health care services to improve value.[12–14]

For the health care professional, focusing on value should be a better way to balance duties to individual patients and system-level concerns. Health care professionals have a unique stewardship role, the careful and responsible management of finite resources, that complements their Hippocratic Oath.[8] In fact, efforts to maximize care for an individual patient must consider access to services today and in the future, and providing low-value care today increases the chances that patients will be priced out or restricted from access to services in the future. Bending the value curve up emphasizes stewardship[15] of precious resources by consistently delivering the right care to the right patient at the right time in the right way by the right provider at the right price. By improving the quality domains and striving for consistency and reliability, we gain more than what can be achieved by a single-minded effort to cut costs. In addition, this focus aligns professional and system goals with those of patients in the "jobs to be done" framework of innovation[16]: Patients want health and well-being, not visits to doctors' offices or hospitals. As we seek to improve efficiency of care delivery, we must remember that patients ultimately see value in achieving and maintaining health, not in their interaction with the health care system.[17] By relentlessly pursuing value across multiple dimensions, we center ourselves on the jobs of diagnosing patients, treating patients, and keeping them well.

No doubt, there are many opportunities to reduce costs by addressing various forms of waste, including failures of care delivery and care coordination, overtreatment, administrative complexity, pricing failures, and fraud.[18] However, it is important to implement cost-cutting initiatives from the vantage point of increasing value. In many ways, value in health care will be in the eyes of the beholder, the patient–customer, and although we should be unwavering in delivering safe, effective, and equitable care, individuals may differ in how they balance the domains of quality based on their own needs and values. Certainly, compromises in resource allocation cannot be avoided, and as in any transformation, there will be those who gain and those who lose. Although the value proposition is a more holistic one, it is important to remember that activities we label as having low value represent income to someone. Thus, we should not be surprised that even using this framework will not alleviate all concerns and objections, but we can at least feel more comfortable that the results of improving value will be more in line with our values as a society.

The idea of improving value in health care is inherently more optimistic and palatable than the one-sided version of bending the cost curve down. Shifting to a more balanced mantra of "bending the value curve up" should unify us all in pursuing what the Institute for Healthcare Improvement calls the Triple Aim: improved patient experience, lower per capita costs, and better health for populations.[19]

So what curve do you want to bend?

With this theme in mind, "Bending the Value Curve" is a new commentary series in *Hospital Pediatrics* that will highlight the professional duty of stewardship in the care we provide to patients and families. Echoing the definition of value (quality over cost), we are interested in pieces that discuss the provision of high- or low-value care in pediatrics or its costs. We are calling

for pieces written by trainees that discuss the safety, effectiveness, efficiency, timeliness, patient-centeredness, equity, and costs of care. These may be illustrative examples of how stewardship could have been improved, how clinical care could have been improved with greater attention to value, or how clinical decisions or costs affected patients and families. Commentaries should be 1000 to 1500 words. They should include exploration of key literature relevant to the topic. The first author must be a clinical trainee: professional student, graduate student, postdoctoral student, resident, or fellow. Commentaries may have 1 to 4 authors, and a faculty member is encouraged to serve as senior author. Submissions should follow the instructions for authors for *Hospital Pediatrics,* listed at http://www.hospitalpediatrics.org/site/misc/Author_Guidelines-MASTER.pdf

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