

ANNUAL MEETING UPDATE: PART III

Creating Value for Patients and Creating Opportunity for Families

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Two years ago the SGIM council, after a long debate, changed the SGIM “tagline” to “Creating Value for Patients.” I want to talk about what that means to us and could mean to our patients, families, and communities. As you know, the highest value care is the best quality or outcome at the lowest cost. For the moment, let’s just focus on cost.

We have heard the numbers so often we can repeat them in our sleep—the US spends almost twice as much per capita as the next most expensive industrial country, now at more than \$9,000 per person. In 2013, total health care expenditures were \$2.9 trillion!¹ It is hard for me to get my head around \$2.9 trillion. How do you put that number in context? For me the distance metaphor really doesn’t help. You know the one: “If dollar bills were placed end to end, they could go 4.6 light years...” or some such.

What is also hard to get my head around is the fact that two dramatically different entities—the Institute of Medicine and the Congressional Budget Office—have estimated that we spend 30% of health care dollars on care that “does not bring value to patients.” Actually, that was the IOM.² The Congressional Budget Office just called it waste—\$2.9 trillion, and almost a third is waste.

It is a little easier for me to understand the numbers when I see data on how those costs impact individuals, families, and communities. For example, between 2000 to 2010, the overall inflation rate was 27%, real wage growth was 36%, insurance premiums went up 114%, and workers’ contribution to premiums went up 147%.³ If you had employer-sponsored coverage, the lower your household income, the

smaller the proportion of costs covered by your plan.⁴

At the state level, a study of health costs’ impact on households showed that in 2003 health care costs were more than 20% of median household incomes in one state: West Virginia. By 2011, health costs were greater than 20% of household income in the majority of states.⁵ One in every five dollars of household income went to health care. There are many equally dismal statistics showing that the huge costs of care directly impact patients and families.

There is another way to view health care costs. We know that care needs and outcomes for many of our patients are driven by social determinants of health. I think we all agree that health and longevity should not be pre-determined by gender, race, ethnicity, and especially zip code. What could we do with a small portion of the hundreds of billions of dollars that are wasted?

Economists use the term *opportunity costs*. This represents the concept that resources consumed in one sector of the economy—such as health care—are not available to be spent in another sector, such as housing, education, or social services. After all, money is money—the money spent on health care comes from personal income (with employer benefits such as health insurance substituting for earned income) and tax dollars from multiple sources. Money is fungible, so we can look at some opportunity costs to help us understand the tradeoffs we make by paying all this money for health care.

- 1 ED visit = one month’s rent
- 2 hospitalizations = one year of child care

- 20 MRIs (\$2.6K) = a social worker
- 60 echocardiograms (\$1K) = a public school teacher
- < 0.5% of an academic health center budget (\$2B) = a new elementary school (\$8M)

We can quibble about the dollar amounts and certainly wonder if those savings could actually be used in another sector, but right now we can’t have that debate because the money is gone—there is no opportunity—and a large proportion of those dollars are wasted.

In 2010, the Affordable Care Act (ACA) was signed, and we all breathed a sigh of relief. Finally, we were going to turn health care around. Access would be expanded and the workforce remodeled. Financial incentives would be realigned to support innovative care models: We would shift to patient-centered care, moving from “volume to value.” Don Berwick eloquently simplified the ACA goals by advancing the concept of “Triple Aim”—better health, lower cost, and a better care experience.⁶

It is now five years later. After legislative roadblocks and countless votes to repeal the ACA in Congress, many court rulings, and even a small computer glitch, there has been a lot of progress. Insurance practices have been reformed, millions of people have gained coverage, and the cost curve is bending. Unfortunately, out of pocket costs are not bending as quickly, so the savings may not yet be accruing to patients and families.

But has health care reform reached a tipping point? I don’t think so. Health care reform is a long-

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term transformation that will only be sustained when costs are controlled. As you know, there are still a few folks and some segments of the health care industry that have not totally embraced health care reform and the ACA. Challenges continue. The upcoming Supreme Court decision on federal exchanges and the election in 18 months will be critical to ACA progress. Keep in mind, 23 states including my state of South Carolina have not expanded Medicaid, and so there are still millions of uninsured.

Nonetheless, the administration is pushing forward with ACA implementation, and earlier this year in the *New England Journal of Medicine*, Secretary Burwell set out very aggressive goals for Medicare beneficiaries to be enrolled in delivery systems that focus on quality, value, and alternative payment strategies.⁷ The recently passed sustainable growth rate fix reinforces the focus on value and payment. (And by the way, another attempt to repeal the ACA was defeated in the process.)

The ACA has set the stage, and progress has been made, but leaders in our field are calling on all of us to take a more active role. We can no longer rely solely on the government to advance the health care reform agenda. Don Berwick and others recently wrote: “It is time to move from change forced from the ‘outside in’ to change led from the ‘inside out.’”⁸ Michael Porter and Tom Lee wrote in the *Harvard Business Review*, “Providers must lead the way in making value the overarching goal.”⁹

So what should we in SGIM do? ACA as policy aligns with our values in SGIM—and specifically our value of “social responsibility and equity in health and health care.” Many mem-

bers of SGIM are leading reform efforts, but we all need to play an active role. It will be difficult work, so I think we in SGIM should do three things.

First, we need to continue to advocate for reform given the ongoing threats to the ACA. More SGIM members need to join SGIM on Capitol Hill. We need to continue to advocate within the executive branch and agencies such as the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Health Resources and Services Administration, and the Patient-Centered Outcomes Research Institute. We need to advocate at the state level and at our institutions. I am sure many of you have had conversations with learners and with patients about health care reform, and those conversations need to continue. Advocacy should become part of our work every day.

Second, we need to embrace the concept of value. We must study, practice, and teach methods to provide the highest value care for our patients. We have the professional knowledge, skills, and values to guide us in accomplishing that goal. SGIM members are training the next generation of internists—clinicians, educators, and researchers—and this will be the new professional world within which they will spend their careers. When we bring our values to our work—every time we see patients with our teams, every time we teach a student or resident, every time we write a grant or a manuscript—we create value for patients.

Finally, as we struggle over the coming years (perhaps decades) to

eliminate hundreds of billions of dollars in non-value added care, we should consider how we will use those now-wasted resources in a different way: perhaps the opportunity to reduce the adverse impact of social determinants on the health of our patients, families, and communities. As we return home, we should consider the opportunities we have to create value. Every time we improve access and avoid sending a patient to the ED, it could save a month’s rent. If our care coordination avoids two hospital admissions, it could fund a year of childcare; if we avoid a few dozen imaging procedures, we could hire another teacher. And every morning as we walk into the palatial facilities we call academic health centers, remember that with just a fraction of a percent less in our budget, we could build a new school.

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