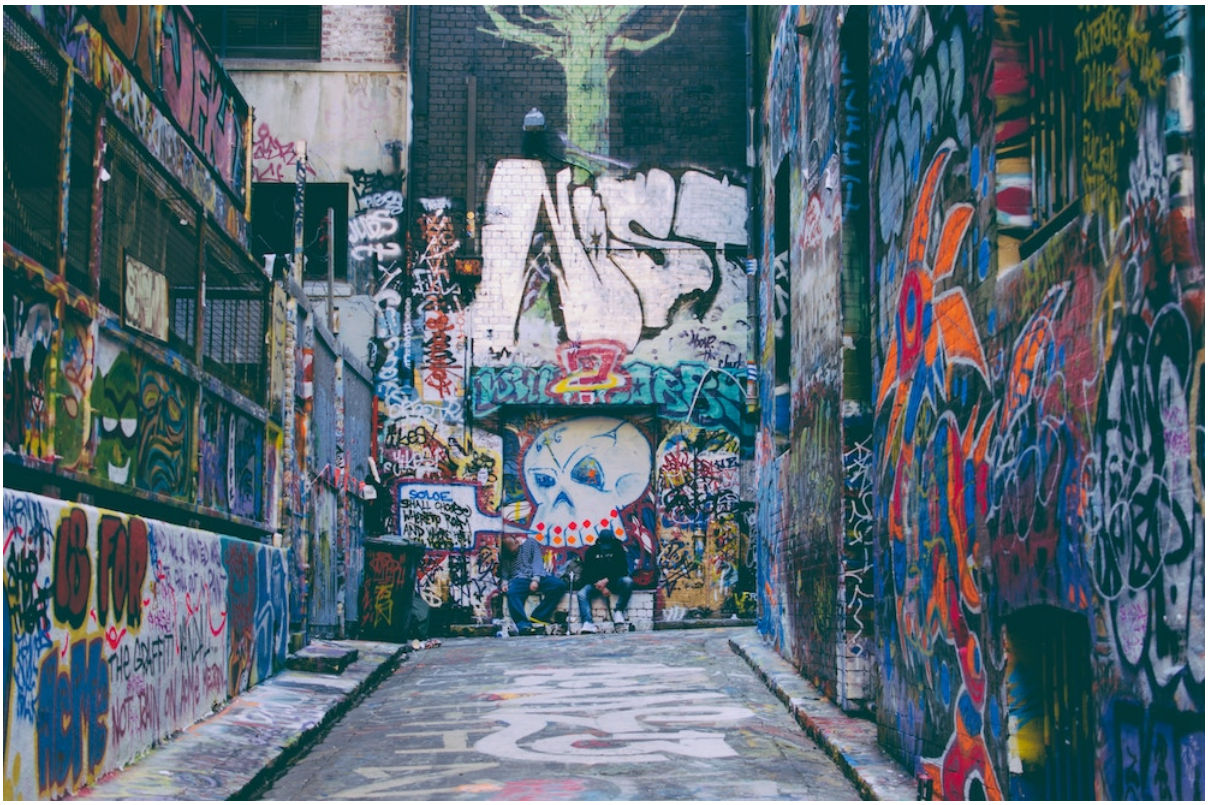
Should Value-Based Health Care Help Improve Life Expectancy?

written by Theresa Hush | December 6, 2018



As Americans in a highly developed and prosperous economy, we have ascribed a value to our highly sophisticated, expensive health care system—that it should enable us to achieve better health. If we didn't believe in the value of our health care system, we would not support health coverage, most people would not visit health care providers, and the public health system would not get be funded.

This may sound all too obvious, but it isn't. Whether our health care system actually achieves that ascribed value of improving health status is now in question. Given last week's release of Center for Disease Control (CDC) statistics on life expectancy in the U.S., American health care gets a C-, at best. For the third year in a row, life expectancy in the U.S. has declined—a trend not recorded since World War I and the 1918 influenza pandemic.

This raises an interesting question about all the resources we are pouring into Value-Based Health Care (VBHC). How can we create VBHC solutions that really do achieve the value we want in health care?

One Test of Value: Our Collective Health Status

The CDC reported that an American born in 2017 could expect to live 78.6 years, a tenth of a year less than a 2016 estimate. Men's life expectancy declined by the same amount, to 76.1 years; life span for women remained the same at 81.1 years. This alarmed public health experts, in part because increased death rates among younger adults are reducing average life expectancy for the population as a whole. Since a society's health is associated with a nation's economic development status, the downturn raises the concern that Americans are not faring as well as they should.

The annual statistics released by the CDC highlighted a worrisome trend of higher death rates reported among young people due to unintended injuries—more specifically, death from drug overdoses. OD deaths rose 9.6 percent between 2016 and 2017, according to the CDC, to 70,237. That is many thousands more lives lost to drugs than to federal disaster emergencies during that same time period.

While the opioid crisis may be the biggest explanation for the statistics, particularly due to the increase in fentanyl deaths, it is not the only issue. Sharply increasing suicide rates among both women and men also contribute to concerns about our collective mental health status. Between 1999 and 2017, suicide rates jumped by a third, from 17.8 to 22.4 deaths per 100,000 among men and 4 to 6.1 per 100,000 among women; in addition, the rate of suicides in rural areas is now twice that in cities.

More bad news from other recent studies—escalating death rates in young people from liver cirrhosis due to alcohol abuse—add to the grim picture of our national health.

Individual patients may not be concerned with whether the health care system as a whole improves health status and prevents untimely deaths, given that these are values derived from a social or public health perspective. At the same time, patients may take for granted that the job of health care is to heal and may articulate other values as higher priorities, such as access to coverage or affordability.

Another Test of Value: Value-Based Health Care

Value-Based Health Care responds to the latter concern that Americans are not getting value for their health care dollars by focusing reforms on economics rather than health status. The fact that we spend more on health care than any other developed country has been the driving force for changes in the health care system. VBHC's primary goal is to make our health care system affordable—for Medicare and Medicaid, business and health care consumers.
What about the role of quality measures, such as the five in MIPS that specifically address

processes aimed to stem opioid overprescribing? Quality measures—including episodes that combine both quality and cost—have made positive contributions to VBHC and to better health value. However, many providers remain exempt from reporting, and those who participate need only report one outcome measure out of a total of six quality measures and are therefore effectively exempt.

In short, Value-Based Health Care is mostly about economics, not health status. Value is defined primarily as cost, assuming a general standard of quality delivered by providers.

Any changes taking place under VBHC primarily affect payment models and reimbursements. While there are improvements intended for consumers, such as new Medicare requirements for access to digitalized health records and price transparency, these improvements are designed to help consumers be better *purchasers* of health care, emphasizing economic over medical decisions.

The end result of VBHC will be risk-based reimbursement for providers, starting with Medicare. Providers will be driven by reimbursements to participate in Medicare Advantage or ACOs, and specialists will agree to bundled payments with a fixed price. Without providers, the public health community or government pressing for change, it is unlikely that VBHC will also emphasize values such as protecting consumers from harm or preventing untimely death.

Three Actions that Providers Should Take to Provide Health Care of True Value

This values discrepancy matters, because cost and affordability are intertwined with health status; poor health status will ultimately affect costs. If VBHC maintains its current path, the deficiencies of being too cost-centric will become clear as costs continue to escalate while life expectancy declines further. Then a "new" solution will be suggested to replace VBHC, much the way that narrow PPO networks replaced HMOs—which previously replaced free choice of provider. Each solution had a similar flaw: failure to properly balance the quality product of the system with its cost.

Can we afford more health care failures, economically or societally? Not if we want to avoid the collapse of our current system under financial risk, overstressed providers and costs that exceed the means of most consumers.

The sustainability of the health care system will require that providers take the lead to ensure that health care's real value is defined by health improvement and protection, not just cost cutting. To do so, they should incorporate values of improved health status and prevention of

patient harm into their own VBHC initiatives. Here are three critical areas:

Measure the occurrence of health system failures and establish interventions. This should include:

Infections or illnesses that occur as a result of facility stays, procedures, use of antibiotics or other drugs;
Unexpected mortality of all kinds, including drug overdoses; and
Unintended consequences of treatment that result in secondary illnesses.

Improve provider screening and management of behavioral health issues, including the development of an appropriate referral system if behavioral health or addiction treatment is not internally provided.

Focus VBHC initiatives on gaining improvements in patient health status and outcomes, rather than only patient visits or filling gaps in care. There are a number of preferred approaches to population health that could achieve better value for patients.

The health care system deserves champions who safeguard its real value. While we can't monetize health status, providers can ensure that the system they steward under VBHC creates better results for society. Whether those values are expressed in regulatory policies of Medicare or health plan reimbursements is beside the point, because payment vehicles cannot create good health—only providers and patients can.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.
Image: Linda Xu