JAMA Dermatology

EDITORIAL

The Value of Our Care

Emmy M. Graber, MD, MBA; Lawton Robert Burns, PhD, MBA

The significance of the study by Kirby et al[1] is its attention to costs. As physicians, we are often so preoccupied with treating patients and focusing on diseases that we do not consider the costs that we are incurring and therefore the value of our care. Health care spending in the United States was approximately 17.9% of the gross domestic product (GDP) in 2012 and has been on the rise for many years.[2] The per-capita health expenditures grew 3.2% in 2012.[3] Although health care expenditures have slowed in recent years owing to the recession, health care spending in the most recent quarter (the first quarter of 2014) hit its highest rate of growth (5.6%) in 10 years, boosting the nation's GDP by 1.1% in the first quarter of 2014.[4,5] Moreover, over the past decades, health care spending has continued to outpace increases in our GDP. Continued spending increases that exceed GDP growth means that the US health care system will be increasingly funded by debt. Continuing on this path will lead to economic instability in the United States, making the role of cost containment a critical part of health care reform.

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Improving the health care system depends on 3 interdependent factors: cost containment, access to care, and quality care. Economists used to refer to this as the "iron triangle" of health care owing to difficulties in accomplishing all 3 goals simultaneously. Policy experts now refer to this tripartite agenda as the "triple aim," in the belief that the 3 goals are more compatible. Current health care reform efforts focus on extending health insurance coverage and thus the access goal. Over time, however, the more intractable goals have been cost containment and quality improvement. These are now the topic *du jour*.

The "value" of a health care system is defined by quality of care divided by cost. Employers and third-party insurers (both public and private sector) are beginning to ask clinicians to document the value of the care they deliver to determine reimbursement. High costs will diminish the value of our care, and we need to be cognizant of this factor, which may have a negative impact on our value. However, patients have paid a premium for their health care through a third-party payer and do not view the value of individual health care encounters as being dependent on costs. After paying a lump sum for health insurance and meeting their deductible, patients feel entitled to all services. Patients have no sensitivity to cost or volume of care sought because they are paying through a third party. When there are third-party payers, patients expect a lot from health care services. Consumers have no incentive not to spend wildly.

As exemplified in this study, patients with hidradenitis suppurativa (HS) often utilize the emergency department. Is this the result of consumer ignorance of costs and desire for quick, easily accessible care? Or is this really the result of inability to access dermatologists on an outpatient basis when needed?

One objective of health care reform is containing costs. To do so, we have to prevent patients from spending unnecessarily. Patients with HS need to discriminatively utilize costly services, such as the emergency department, and instead focus on maintaining a regular outpatient follow-up for optimal disease control. Dermatologists can facilitate this by routinely scheduling follow-up appointments for those with chronic diseases rather than have them follow up as needed. As discussed in the study by Kirby et al,[1] there is a high demand for dermatologists. Patients experiencing disease flares may have difficulty accessing their dermatologist on an outpatient basis when urgent issues arise.

A major flaw with the study by Kirby et al[1] is the authors' failure to determine costs based on an individual's overall health status. The level of an individual's overall health status (eg, as measured by the number of chronic diseases) is the biggest indicator of costs that the individual will incur. The top 1% of the population with the most chronic diseases accounts for 21% of health care spending.[5] Following the Pareto principle, the top 20% of the population accounts for nearly 80% of all health care spending; this finding holds across different categories of the insured (eg, Medicare, Medicaid). Patients in this top 20% have 5 or more chronic conditions. Kirby et al[1] mention that it would have been helpful to determine the disease-specific costs of HS. However, the value of health care is not determined by disease-specific costs but instead by the overall quality of care per costs of an individual, not a specific disease. It would have been helpful to know the average number of chronic diseases affecting each cohort to help assess their comparative cost contribution based on each cohort's overall health status.

Knowing that costs are highly correlated with overall health status, we should focus not only on caring for patients' skin but also on ensuring that patients get care for their other comorbid chronic conditions. It is not enough to tell a patient with HS and with the comorbid condition of obesity to lose weight; it is critical for us to refer patients to nutritionists as well as behavioral change experts who can help the patient with an exercise program. Acts such as these may improve value because they improve a patient's overall health status, thereby significantly reducing costs.

The authors discuss the high costs of inpatient and emergency department care that contributed to the costs of treating patients with HS. However, the largest driver of health care costs beyond health care status is expensive technology. Treatments for HS do not typically require utilization of high-cost technology, such as devices or state-of-the-art procedures.

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