Words can spearhead social transformation. Let’s hope that’s true for “value” in health care. Where other mantras – such as quality or managed care – have failed to galvanize the system’s diverse stakeholders, value may have a chance.

What seems special about the term is that, seemingly simple, it is actually complex and subtle. Under its umbrella, a wide range of interested parties can find the things they hold most dear, from improved patient outcomes to coordination of care to efficiency to patient-centeredness. And it is intuitively appealing. As Lee noted in the Journal, “no one can oppose this goal and expect long-term success.”

The question, of course, is whether the term will help spur the fundamental changes that our health care sector so desperately needs. In this regard, a closer examination of the value concept confirms its appeal but also exposes the daunting challenges facing health system reformers.

Michael Porter has defined value as “health outcomes achieved per dollar spent.” Any survivor of introductory microeconomics will hear echoes in this phrase of one basic measure of economic efficiency: output per unit of input. An efficient business gets the most output possible, given current technology, from every dollar spent.

Porter and colleagues adapt microeconomics to health care through their definition of output: patient-centered health outcomes. These are results that individual patients desire: survival, speedy and uncomplicated recovery, and maintenance of well-being over the long term. These are also things that clinicians, payers, and purchasers should seek for their patients, employees, and customers. The value movement’s definition of outcomes treats the patient as a whole person, insists that measures of outcome transcend disease-specific indicators to account for all of the patient’s conditions, and include data collected over time and space to produce comprehensive measures of patient well-being. Value proponents further insist that inputs be measured comprehensively to include all the costs of producing desired outcomes.

Widely adopted, the concept of value would provide a north star toward which health care providers could navigate. Its emphasis on the whole patient and comprehensively measured costs would encourage teamwork among clinicians and coordination of care across specialties, clinical units, and health care organizations. The focus on patient-centered outcomes would support increased effort to measure patient-reported outcomes of care, such as their level of function and perceived health status over time.

Promising as it is, the emphasis on value also raises illuminating and challenging questions. The first is: why all the fuss with defining it? In most markets consumers define...
value by purchasing and using things. In the 1990s, personal computers had considerable value. We know that because consumers bought lots of them. Now, with the arrival of tablets, personal computers seem to be losing value. And so it goes for untold numbers of goods and services in our market-oriented economy. Eminent professors don’t wrack their brains defining the intrinsic value of electric shavers, overcoats, or roast beef.

We need to define the value of health care, however, for a simple but profound reason explained in 1963 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585909/) by Nobel-prize-winning economist Kenneth Arrow. Arrow showed that health care markets don’t work as others do, because consumers lack the information to make good purchasing decisions. Health care is simply too complex for most people to understand. And health care decisions can be enormously consequential, with irreversible effects that make them qualitatively different from bad purchases in other markets. Americans are therefore reluctant to let the principle of caveat emptor prevail. One reason to define value carefully and systematically is to enable consumers to understand what they are getting, an essential condition for functioning health care markets.

The compelling need for a good definition of health care value highlights another fundamental challenge. We have not yet developed scientifically sound or accepted approaches to defining or measuring either patient-centered outcomes of care, or – surprisingly – the costs of producing those outcomes. The scientific hurdles to defining patient-centered outcomes are numerous. Outcomes can be subtle and multidimensional, involving not only physiological and functional results, but also patients’ perceptions and valuations of their care and health status. The ability of health care organizations to measure costs is primitive at best and doesn’t meet the standards used in many other advanced industries. Equally challenging is the lack of data systems to support outcome measurement. Producing the holistic assessments needed requires the aggregation over time and space of data from multiple clinicians and health care organizations, as well as patients themselves. The health care system’s electronic data systems are just now entering the modern age.

Given the value of measuring value, and the current obstacles to doing so, still another urgent question arises: what should we do now? Despite recent moderation in health care costs, our health care system is burning through the nation’s cash at an extraordinary rate and producing results that, by almost every currently available measure, are disappointing.

To turn the promise of value measurement into the reality of better care at lower cost, a few short-term actions seem prudent. First, the nation needs a plan to turn the concept of value into practical indicators. Since government, the private sector, consumers and voters all have a vital stake in health system improvement, they should all participate in a process of perfecting and implementing value measures, preferably under the leadership of a respected, disinterested institution. The Institute of Medicine comes to mind, but others could be imagined. This process should produce an evolving set of measures that will be imperfect initially but improve over time.

Second, both government and the private sector need to invest in the science and electronic data systems that support value measurement. Investments in systems should focus on speeding the refinement of standards for defining and transporting critical data elements that must be shared by patients, providers, and insurers to create patient-centered outcome measures.

Third, in consultation with consumers and providers, governments need to develop privacy and security policies that will assure consumers that their health care data will be protected when shared for the purpose of value measurement.

Last, and perhaps most important, the trend toward paying providers on the basis of the best available value measurements needs to continue. These payment policies motivate providers to use value measures to their fullest extent for the purpose of improving processes of care and meeting patients’ needs and expectation.

To some observers, putting value at the forefront of health care reform may seem obvious, noncontroversial, and, potentially, meaningless. As Lee notes, who can be against it? To use an American cliché, it seems a little like motherhood and apple pie: widely endorsed, comfortable, and signifying little. But the value movement could be much more than that. When value does become as well defined and accepted as motherhood and apple pie, we’ll be much closer to making health care better for all Americans.