# Emphasis on 'value' in health care reform sends mixed messages, physician says

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The wide consensus that health care spending poses a threat to the nation's fiscal solvency has led to the championing of "value" as a goal of health care reform efforts. But the divergence of opinions between patients and physicians on the meaning of value presents an obstacle to progress in achieving genuine reform, says Lisa Rosenbaum, MD, a Robert Wood Johnson Foundation Clinical Scholar and cardiologist at the Perelman School of Medicine at the University of Pennsylvania.

In a Medicine and Society article published this week the New England Journal of Medicine, "The Whole Ballgame—Overcoming the Blind Spots in Health Care Reform," Rosenbaum writes that rather than facing the big-picture reality that spending less will mean sometimes having less, a more hopeful—but misleading—emphasis on pursuing high-value health care has emerged as the dominant paradigm. But, notes Rosenbaum, "Value in health care depends on who is looking, where they look, and what they expect to see."

The emphasis on value effectively splits patients and physicians into separate groups. When the focus is on physicians, creating value means reducing overuse, increasing efficiency, and providing incentives to deliver evidence-based care. But when the focus is on patients, creating value means enhancing patients' experience and paying attention to processes and outcomes that matter to them.

The problem, says Rosenbaum is that both concepts of value sound promising in isolation and, to their respective adherents, reinforce the

illusion that each can improve health care. But when viewed together, contradictions can arise. For example, Rosenbaum cites patients who ask their physicians for batteries of tests to achieve peace of mind about an illness—even if there is little or no evidence that doing so delivers better care or produces better results. A patient-centered approach would acknowledge the psychological benefit that patients derive from undergoing such tests; but a physician-centered approach would caution against administering costly tests that have little or no data to support their efficacy. Further complicating this dichotomy are studies showing that, for instance, patients who receive medical imaging, regardless of whether it is truly indicated, are generally more satisfied with their care.

Likening the present-day situation to a psychological phenomenon called inattentional blindness—the tendency to become immersed in specific stimuli at the cost of missing other things that are right before one's eyes—Rosenbaum calls for a view that encompasses the perspectives of both patients and physicians. "Patients and physicians are on the same team and the patient–physician dynamic remains central to medical care, decisions about resource use, and our evolving definition of quality," she said. "If we focus on physicians and patients separately, we lose sense of how their goals may or may not match up."

Offering a solution, Rosenbaum offers an example from her own training experience. "A cardiac patient I was seeing had had a number of tests already. But he was still concerned about his condition and asked, 'Isn't there some other test you could do?' My preceptor spent a long time explaining to the patient and his wife the implications of his previous tests, why all the tests he had found on the Internet would probably be of no further value, why he needed to take an additional blood-pressure medication and begin exercising, and how he should change his diet. At the end of the conversation, he and his wife exchanged a look of relief. 'No one has ever explained any of this to me before,' he said."

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