Interview, Cost, and the Quality of Care

John H. Krouse, MD, PhD, MBA

In this present issue, we are going to explore the issue of variation in otolaryngology practice, its inherent effects on cost of care, and the subsequent consequences of these factors on healthcare quality. This issue is of increasing importance in US healthcare and will continue to frame important discussions on healthcare utilization and delivery.

The Institute for Healthcare Improvement has proposed an initiative known as the “Triple Aim” that will facilitate new designs in US healthcare systems. In this Triple Aim, healthcare delivery will focus on 3 interrelated factors: (1) improving the patient experience of care, (2) improving the health of populations, and (3) reducing the per capita cost of healthcare. To operationalize these principles, new models for healthcare delivery are proposed, and they include a variety of approaches to innovative financing as well as a strong focus on quality in healthcare as demonstrated by measurable, objective outcomes.

As argued by Michael Porter, “achieving high value for patients must become the overarching goal of healthcare delivery, with value defined as the health outcomes achieved per dollar spent [italics added].” Stated in another way, value in healthcare is seen as a function of the quality of care and the cost at which it is delivered: \[ \text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}. \]

Value of care therefore increases when the quality of that care increases, the cost of care declines, or some combination of these 2 outcomes occurs. While, intuitively, many physicians believe that there is a strong positive relationship with utilization of expensive healthcare services and improved outcomes, research does not support that assumption. In fact, there is little association between the quality of care delivered and the cost at which care is delivered. Moreover, in many cases, increased cost is associated with decreased quality. Value to the consumer, therefore, is generally not optimized by simply undergoing more expensive or more intensive medical services.

One method that can be used to lower the cost of care and, at the same time, improve quality and value is to decrease the variation in care that is delivered. A series of studies from the MD Anderson Cancer Center illustrates that interventions targeted to evaluate and modify individual surgeon behavior and to address differences among surgeons can decrease adverse patient-level outcomes such as wound infections and need for transfusion, as well as reduce economic indicators such as hospital length of stay. Careful attention to variation in physician practice and a sharp focus on quality can achieve improved outcomes such as those noted at MD Anderson; it can also drive a reduction in cost to the patient and to the healthcare system.

In this month’s issue of the journal, we will examine some of these important healthcare issues. The current discussion is sparked by an article written by Cracchiolo et al., in which the authors examine the variation of care among similar otolaryngology practices in academic institutions in a single geographic area. In their article, the authors review Medicare payment data released in 2014 and examine reimbursement and billing patterns among 4 separate, academically affiliated otolaryngology practices. Adjusting for case mix index of patients at those institutions, Cracchiolo et al note a two-fold difference in Medicare payments across these 4 groups. They conclude that practice patterns among these groups differed widely, resulting in significant variation in charges and payments.

We have invited several commentaries to examine issues that are raised by the Cracchiolo et al article. While 1 invitation was declined, 2 commentaries appear as companion pieces in this issue and frame the discussion around variation, quality, and value of care. In the first of these commentaries, Sun discusses the history of variation in otolaryngology—head and neck surgery, tracing the conversation back to Glover’s classic 1938 paper on differences in tonsillectomy rates in adjacent regions in the United Kingdom. In that paper, Glover documented differences up to eightfold in the number of tonsillectomies performed in similar geographic regions, with at least part of that variability being reflected in differential household income among patients’ families. Sun explores this type of variation over the next 75 years, citing examples of differences in care and examining various contributing factors.

In our second commentary, Gourin examines geographic variation in delivery of care and notes that increased cost and utilization are not necessarily associated with improved quality of or satisfaction with that care. Both Gourin and Sun cite Gawande’s 2009 landmark examination of differences in utilization of Medicare services in adjoining El Paso and McAllen.
Texas.\textsuperscript{10} In this insightful paper, Gawande noted that the overall per capita Medicare expenditure in McAllen was twice as high as that in neighboring El Paso, despite similar patient populations and without demonstrable benefits in quality and outcome. He attributed these differences to a fee-for-service system that rewarded volume rather than value or quality. Gourin discusses similar examples and offers a discussion about the implications of variation in care and overutilization of medical resources.

As Porter states, “shifting focus from volume to value is a central challenge” in American medicine.\textsuperscript{2} It is this fundamental change in the operating model that drives a decrease in the variability of healthcare delivery. As the healthcare system focuses away from simply increasing volume of care, it can begin to achieve cost reductions and improvements in quality that will be accomplished through a decrease in variability (Figure 1). There are certainly no easy answers in the future of American healthcare delivery, and we wanted to stimulate discussion among otolaryngologists as they anticipate practicing in a climate of healthcare reform. The journal will continue to engage our readers in that discussion and will provide a forum for the exchange of ideas and evidence that will guide otolaryngologists into the coming decades. Thank you again for reading.

John H. Krouse, MD, PhD, MBA
Editor in Chief,
Department of Otolaryngology/Head and Neck Surgery,
Temple University, Philadelphia, Pennsylvania, USA

References
5. Lewis CM, Monroe MM, Roberts DB, et al. An audit and feedback system for effective quality improvement in head and neck surgery: can we become better surgeons [published online January 13, 2015]? Cancer.