Editorial

Lights, Camera, Action: How to Make Arthroscopy a Star in Value-Based Health Care

In an era of increasingly greater analysis of health care expenditure, orthopaedic surgery is often pointed to as a major driver in escalating health care costs. This assertion is despite evidence that orthopaedics as a specialty contributes less toward creating spending excess when compared with specialties such as internal medicine, cardiology, ophthalmology, radiology, and even family medicine.[1] To avoid the dull blade of indiscriminate pay cuts, a new paradigm of value-based reimbursement has gained traction. As value-based health care increases in popularity, arthroscopists must take action to prove and defend the value of arthroscopic procedures. Failure to do so may result in across-the-board cuts resulting in stifled innovation and unfulfilled promise within sports medicine.

Value in health care is generally defined as health outcomes per dollar spent. Thus, in order to maximize value, an intervention could either maximize outcomes or decrease costs. Black and Warner[2] recently published an elegant review of basic health care business principles and their influence on the future of orthopaedic surgery. Based on their principles and the seminal work of Harvard Business School Professor Michael Porter, we believe arthroscopy is well positioned in a value-based health care system to flourish because of superior outcomes achieved with reasonable costs.

With regard to cost, arthroscopic procedures are often performed in ambulatory surgical centers that provide ample opportunity for cost savings through improved operational efficiencies, more efficient staffing, better capacity utilization, and lower overhead expenses. Arthroscopy additionally provides value to payers and patients beyond mere cost savings and operational optimization. High-quality studies have shown that patients can achieve significantly improved health outcomes at long-term follow-up after arthroscopic procedures. A growing body of literature is relating these outcomes to cost metrics so as to provide evidence for the value of arthroscopic surgery. Notably, Shearer et al.[3] have recently shown that for patients with femoroacetabular impingement, hip arthroscopy could be highly cost-effective as a salvage procedure to stave off total hip arthroplasty. Further, the authors suggest that hip arthroscopy has an incremental cost-effectiveness ratio comparable to other procedures considered to be highly cost-effective by health systems.

The future script of arthroscopy in a value-based model is yet to be written, and physicians can play a pivotal role in helping payers, hospitals, and policymakers understand the importance of reimbursement to surgeons for these inherently valuable procedures. One study from the subspecialty area of total joint reconstruction provides a cautionary tale about the recent trend for decreasing orthopaedic surgeon compensation. Bernstein and Derman[4] analyzed the relationship between reimbursement and procedural volume and found that as reimbursements to surgeons declined, the volume of procedures increased (with concomitant increase in steep payments to hospitals) so that, in the long term, it actually cost the government *more* to pay surgeons *less*. Although it has its limitations, the study does illustrate the dangers of physician compensation cuts while also highlighting the need to transition from a volume-centric to a value-centric mode of incentives.

Transition to a value-based model of care delivery and reimbursement is inevitable and is already well under way. Arthroscopists must embrace the future as present and begin work to ensure that the value of arthroscopy is highlighted for key stakeholders. But how can we quickly transform such a nebulous call to arms into meaningful fact-on-the-ground change? There are several areas where orthopaedic leadership can guide our efforts: editors of journals should encourage and actively solicit studies that link outcomes and cost in order to aggressively create a modern body of literature supporting value in arthroscopy; research grant committees can invest in the development of high-quality value-based multicenter and national registries dedicated to disease-care cycles involving shoulder, elbow, wrist, hip, knee, and ankle arthroscopy; physicians should take an active interest in understanding direct and indirect costs at the patient level so as to target cost containment in a systematic value-adding manner; and industry research should be required to measure standard value metrics to foster value-based competition and stimulate cost-conscious innovation.

There are many actors in health care and even within orthopaedics who will be vying for the attention of payers and policymakers in the imminent future of value-based

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reimbursement. Perhaps no surgical procedure is better suited for the role of star than arthroscopy—it is now up to us to put on a good show.

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