The third health care revolution: A new paradigm for better value health care

Professor Sir Muir Gray, Co-Director NHS QIPP Programme, Right Care Workstream – Department of Health, Director, Better Value Healthcare
All health services worldwide face five major problems:

- patient harm
- unwarranted variation in
  - quality, safety and outcome
  - activity and cost
- inequalities and inequity
- failure to prevent preventable disease
- waste

![Graph showing need and demand, carbon, and € over time with a note for 2011.]
Maximise value by allocating optimally
Musculo-skeletal expenditure per 1000 population by PCT
Weighted by age, sex, and need
2008/09
Mental health £M324-151/Million
Circulation £M174-106
Medically unexplained physical symptoms

Children

Homeless people

Older people with four or more diagnoses
<table>
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<th>Programme</th>
<th>Budget (Million)</th>
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<td>Other</td>
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</table>
PROGRAMME
BUDGETS
2009/2010
MILLION / MILLION
POPULATION

154 GP/PMS
92 SHA
226 Miscellaneous
Maximise value by using resources optimally
Higher value

Lower value

Added value from doing things right (quality improvement + cost improvement)

Higher value

Lower value

Added value from doing the right things) making the right decisions

Higher value
Unwarranted variation in quality, safety & outcome

- patient harm
- health inequalities
- failure to prevent preventable disease
Right Care NHS Atlas of Variation in Healthcare

Percentage of patients admitted to hospital following a stroke who spend 90% of their time on a stroke unit, by PCT, 2009/10
Unwarranted variation in activity and cost

Waste of resources

Higher value  Lower value
Value = Outcomes/Costs

Outcome = Good – Bad
(Outcome = Effectiveness – Harm)

Costs = Money
Costs = Carbon + Opportunity Lost
Examples of lower value activities are those which:

1. Have clear evidence that they are ineffective or that they do more harm than good.

2. Have no evidence of effectiveness but are not being delivered in the context of research that would allow evidence to judge effectiveness to be gathered.

3. Use resources which would produce more value, namely a better balance of benefit to harm, if used for some other group of patients.
Rate of anterior cruciate ligament reconstruction expenditure per 1000 population by PCT Weighted by age, sex and need, 2008/09

The variation among PCTs in the rate of expenditure for anterior cruciate ligament reconstruction per 1000 population is 50-fold.
RESOURCES FOR LEADERSHIP, TRANSFORMATION, AND REVOLUTION

‘Value is the most important concept for healthcare worldwide for the next twenty years’ J.A. MUIR GRAY

We are now in a new era – the era of better value. It is no longer sufficient to provide safe, effective, and high quality care. These characteristics will be taken for granted. Value is the most important term for the next twenty years.

‘Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is the value of health care delivery, or the patient health outcomes relative to the total cost (inputs) of attaining those outcomes.’ Porter, M.E. (2008) What is Value in Health Care? Harvard Business School, Institute for Strategy and Competitiveness.

How To Get Better Value Healthcare provides an understanding of the concept of healthcare value and how it can be increased, and is written primarily for people who pay for or manage health services. The focus for action is on the top ten questions about value:

How much money should we spend on healthcare? Is the money allocated for the infrastructure that supports clinical care at a level which will maximise value? Have we distributed the money for clinical care to different parts of the country by a method that recognises both variation in need and maximises value for the whole population? Has money been distributed to different patient groups by decision-making that is not only equitable but also maximises value for the whole population? Are all the interventions offered likely to confer a good balance of benefit and harm, at an affordable cost, for this group of patients? Are the patients most likely to benefit from the interventions, and least likely to be harmed by them, clearly defined? Is effectiveness being maximised? Are the risks of care being minimised? Can costs be reduced further without increasing harm or reducing benefit? Could each patient’s experience be improved?

Muir Gray qualified in medicine in Glasgow, and has worked for many years in public health for the NHS. He was the founding director of the UK National Screening Programmes, and also of the National Library for Health. He was awarded the CBE, and later a knighthood, for services to the NHS.

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www.bvhc.co.uk

J.A. Muir Gray
Ensuring no patient makes a fateful decision in avoidable ignorance
After a certain level of investment the health gain may start to decline: The point of optimality
As the rate of intervention increases the balance of benefit and harm changes for the individual patient.
The values this patient places on benefits and harms of the options

The clinical condition of this patient, other diagnoses and risk factors, and their social circumstances

Value-based and shared decision-making
Prioritising action
Outcome measures

- Vision: Total sight tests per 10,000 population
LOWER SPEND, BETTER OUTCOME
HIGHER SPEND, BETTER OUTCOME
LOWER SPEND, WORSE OUTCOME
HIGHER SPEND, WORSE OUTCOME
Working in systems and networks
A SYSTEM is a set of activities with a common set of objectives (also known as a service) and an annual report.

A NETWORK is a set of individuals and organisations that deliver the system’s objectives (a team is a set of individuals or departments within one organisation).

A PATHWAY is the route patients usually follow through the network.
A SYSTEM is a set of activities with a common set of objectives (also known as a service) and an annual report; who is responsible for the annual report for asthma care for the population of Dusseldorf.
Practicing population medicine
Dr Jones is a respiratory physician in the Brighton Hospital Trust and last year she saw 346 people with COPD. She hopes to provide evidence-based, patient-centred care, and to improve effectiveness, productivity and safety.
Dr Jones estimated that there are 1000 people with COPD in East Sussex and a population-based audit showed that there were 100 people who were not referred who would benefit: she needs to practise... population medicine.
People who would gain most from the service

People receiving service

People with the condition
Dr Jones, the co-ordinator of the East Sussex COPD Network and Service, has responsibility, authority and resources (one day a week and support) for:
- network development
- localisation of the Map of Medicine
- quality of patient information
- professional development of generalists, and pharmacists
- production of the annual report of the service.

She is keen to improve her performance from being 27 out of the 106 COPD services, and of greater importance, 6 out of the 23 services in the prosperous counties.
Thinking about the individual patient

Thinking about the population
1. Is the service for people with seizures & epilepsy in Manchester better than the service in Liverpool?
2. Who is responsible for the headache service for people in Newcastle?
3. How many liver disease services are there in England and how many should there be?
4. Which service for frail elderly people in the south west provides the best value?
5. Which mental health service in London for children with mental health problems improved most in the last year?
CHANGE: Both the bureaucracy and the market have a part to play but what is needed are complex adaptive systems because health care is too complex to be managed through the market or bureaucracy alone.