Mark Britnell: A global perspective on the transformation of health care

The theme today will be the battle, or the dichotomy, between transacting and transforming, and just so you know what I mean when I use those words, transacting is doing things better and transforming is doing better things.

Last year we asked 3,000 chief executives across the world what was front-of-mind in terms of their thinking. Most chief executives are thinking very short term about cost efficiencies and bottom or top lines, and the second thing you can see here is that only one in four chief executives is seriously paying any attention to their business for us re: care models of the future.

Last year I convened 45 chief executives and clinical leaders from 22 countries across six continents and what we thought we would do is play a little test and a game with them about their balance between their mindset on transacting their way out of trouble and their mindset about transforming their way out of trouble. And before we did that, of course, we had a theory. I call this theory ‘the paradox’, and it goes like this: that any leader of any organisation tends to think their organisation is fine, it’s just the rest of the health system that’s a problem. So basically the cliché, if you like, is I believe that we have to change, but that change starts with somebody else. Now, if everybody thinks that way then we’re in trouble.

Across 45 leaders from different countries their responses are pretty tactical or transactional: cost reductions, lean and improvement - that’s good - focus and specialisation, IT, with some thinking about new workforce models. You know when you ask them what was going on in their health systems and their payment mechanisms, whether it was in Korea or Japan, South Africa or Brazil - there’s a big push on three tectonic changes. The first one is that payment systems or reforms are trying to actually make people integrate and collaborate more, secondly that quality is figuring more prominently in terms of payment, both rewards, incentives and, indeed, sanctions and thirdly this quest now (this emerging theory, if you like) on patient value.

Now, you don’t need to have read Porter’s work on value to understand what it is. Crudely it’s patient outcomes divided by the cost of securing those outcomes. The second most important point I’d like you to take away from this discussion today is that there is a massive global thirst and desire for integration, and the people that we invited in terms of Rome and our survey work before that conference suggests that three-quarters of them still think that cost can be reduced and 90 per cent, perhaps more importantly, believe that outcomes can be improved. But the five global things that we debated are the rise of the activist payer, the desire for hospitals to not be defined by their fortification of bricks and mortar but to become health systems, that patients should become active partners, that there are three things to learn at least from high-growth, emerging markets in South America, Africa and Asia, and fifthly in terms of the means to achieve these ends that authentic innovation and also integration (innovative integration) are the techniques that we think are mostly likely to have success in the next period of time.

So I’m not going to go through each of these points, but let me just touch on three issues here which I think are important. Some payers are now focussing on value, so they’re placing longer term contracts, they’re specifying outcomes, they’re moving away from a fee for service or finished consultant episode payment system, and they’re allowing providers to get together and work out how best to deliver services. Point two is that unless you’ve got...
great information, preferably of a personalised nature, to patients with long term conditions or several co-morbidities, typically over the age of 75, unless you segment and stratify that population group, you have no chance of producing value in a system. And thirdly, delivery must be integrated.

There are four dominant emerging models of providers... hospitals in this case, primarily... seeking to reorganise and transform. The first one is pretty straightforward about getting bigger, so whether it’s global players, or indeed regional players, merging and acquiring, there are strong tendencies now both in the USA but of course as we know with the 40 or 50 or 60 hospitals that will be in trouble over the next two to three years, there will be probably another round of merger and acquisition.

The second thing which I think is important, and it’s a challenge when I go round the world, that I give to all chief executives of big hospitals is: are you absolutely sure you’re doing everything you can to optimise your effectiveness and your efficiency? The holy trilogy or trinity of three things, having great process control, professionals holding themselves to account, and information technology systems that’s giving near as real time clinical and financial information as possible starting to think about focussing on the patients and transforming care processes both within and across organisations in a fundamentally different way.

Now you can’t fake this. You need leadership to hang around, there are good examples like Virginia Mason or Inter Mountain, but you need to stick at this for 10 years. It is possible to reduce cost by 15-20 per cent and exponentially improve quality. The third thing to say is - and I think this personally is an ex-foundation trust, the First Way Foundation Trust, 10 years ago - is allowing our hospitals to become health systems. Now some people are merging or rearranging vertically and horizontally, and you can see in some of the examples, Guy Zinger and Apollo, are even becoming, in the case of Apollo, that now obviously offers 32 million lives insurance so they’re becoming a different form of system. And then finally, and I think we still play about with this in England, there are, of course, organisations. You know about Eyes and Hearts from India, but I don’t know how much you know about Coxa in Finland that just looks at joint replacements... people are dramatically reducing the cost of care often by a quarter, massively improving productivity and quality is as good as any you’ll have seen in the world.

What surprised me from a group of alpha males and alpha females in Rome was the absolute desire to start thinking about patients as partners. Now there is a lot of evidence, emerging still I grant you, from the BMJ, from the New England Journal, from the Lancet, that suggests if you practice some of these techniques between co-production, co-creation, co-design and self-supported that we do know from NESTA (the National Endowment for Society Technology and the Arts) for their people-powered healthcare pilots that have been running for the last two or three years, the evidence base suggests that costs fall by about 7%, that actually people feel much happier and in more control of their care, and quality is improved.

So, in summary, if you don’t remember anything else about my presentation, just remember that all of the developed health care world believe that their own organisations are fine, it’s just their health systems need changing. And to end with a quote which I’m sure you all you know, that great Gandhi quote, ‘Let’s be the change we want to see’.

Thank you very much indeed.