Value for Money in Health Care: Why It's Hard to Achieve and What We Might Do About It

Menzies Centre for Health Policy
Australian National University
November 10, 2010

Steven Lewis, President
Access Consulting Ltd., Saskatoon, Canada &
Adjunct Professor of Health Policy
Univ. of Calgary & Simon Fraser University

Part 1

Value for Money (VFM): The Not-So-Simple Concept

What Is Value For Money?

- The benefit realized for a particular level of expenditure
- The ratio of outputs to inputs
- The ratio of outcomes to inputs
- In comparative terms, the benefit resulting from spending on A vs. Spending on B,C,D,...

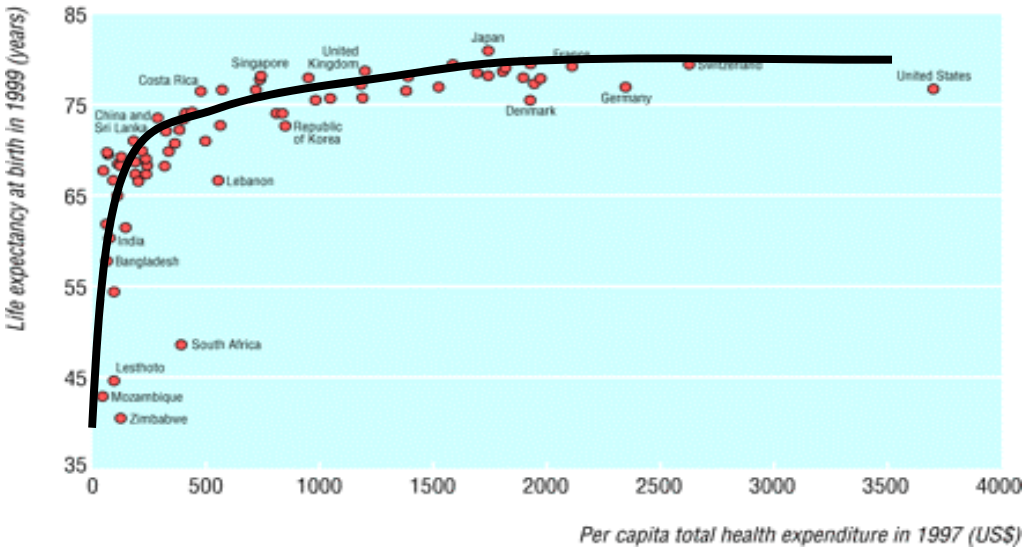
The Key Term is “Value”

- **Value is not a straightforward proposition in health care**
  - **Not all health care is able to produce tangible health status benefits**
  - **Different groups value different aspects of health care**
  - **It is hard to calculate the value of care whose effects play out over the long term**
  - **Attributing outcomes to interventions is often difficult (other factors are at work)**

Why Achieving "Pure" VFM Is Difficult

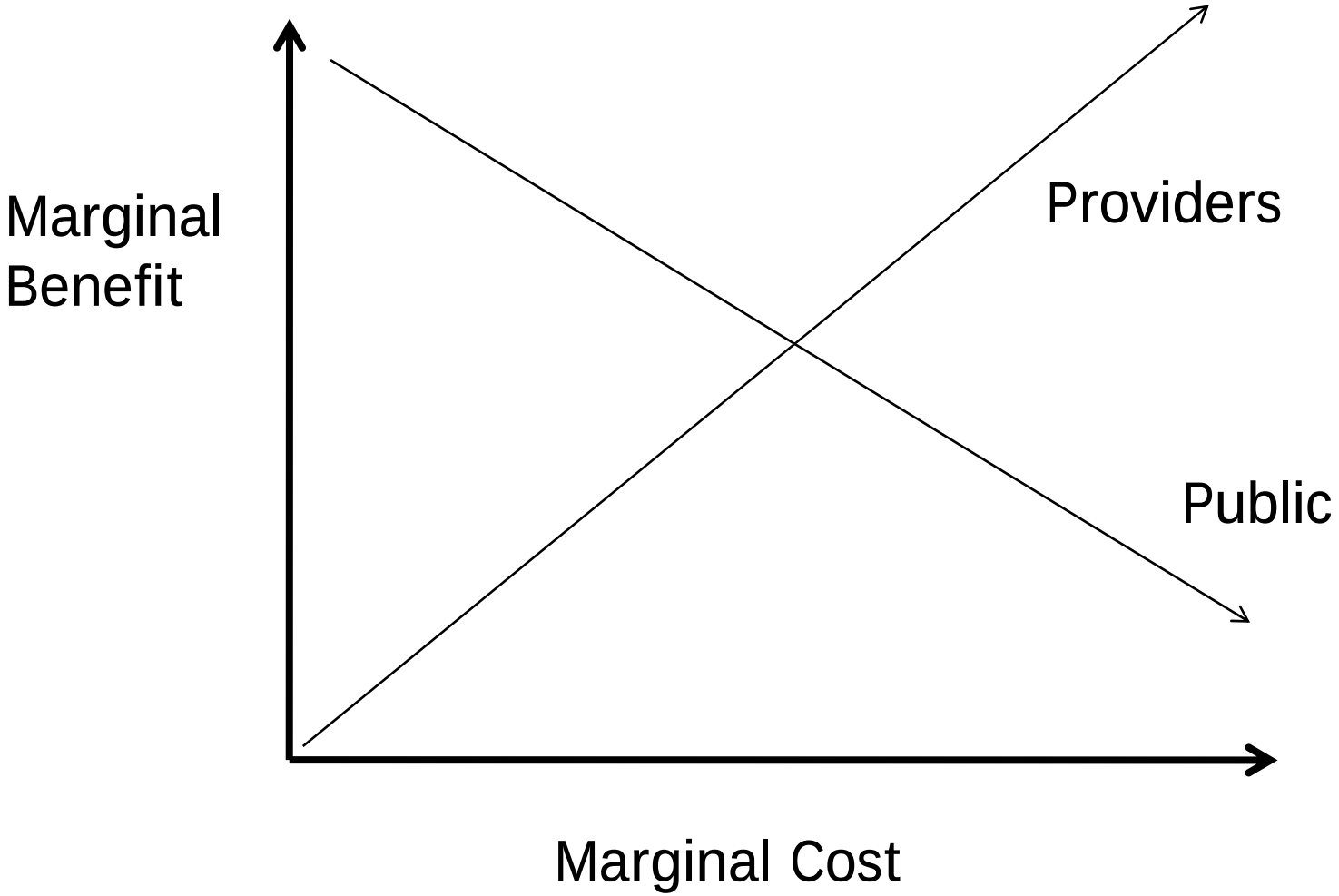
- Health care accounts for roughly 20% of population health status
- Some disorders can be addressed cheaply and some cannot
- Ethical norms preclude utility-driven decisions (e.g., rule of rescue, NICU heroics, aged care)
- Some needs count for more than others (even in universal, publicly financed systems)
- There is no political consensus to maximize population health status

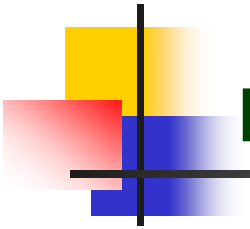
Life expectancy at birth in1999 by per capita total health expenditure in 1997 in 70 countries



Source: Leon, Walt & Gilson, BMJ 2001;322:591-4

Whose Utility Curve Is More Influential?





Part 2

How Do We Get Better Value for Money?

What Does Better VFM Mean?

- Health care gets more *efficient*: more outputs per unit of input
  - Example: multi-channel lab testing
- It gets more *effective*: better outcomes per unit of input
  - Example: CABG procedures in elderly
- It gets more *accessible*: faster/more local service
  - Example: UK wait times reductions
- It gets *cheaper*: the price drops
  - Example: off-patent statins

How Have We Done?

- Many technical efficiency gains (same-day surgery, non-invasive diagnostics)
- Some improvements in effectiveness (modest gains in cancer survival, improved hip replacements, occasional blockbuster drug)
- Some major accessibility triumphs – advanced access scheduling, telehealth, clinical pathways
- Occasional price reductions (mainly generic drugs and/or effective negotiation)

But On the Other Hand...

- Volume increases offset unit price gains – CT, MRI, cataracts
- Continuous relaxation of appropriateness criteria – prophylactic statins, mood-modifying drugs, knee arthroscopy
- Relentless medicalization of life by pharma, technology makers, media
- Entry price of new technologies unrelated to anticipated health benefit

No Consensus on Opportunity Costs

- Reallocation from health care to other economic and social programs would likely improve aggregate health status (Wilkinson & Pickett)
- Consequences for middle class & above:
  - Some reduction in access to health care
  - No impact on non-medical determinants of health (theirs are already fine)
- Therefore, maximizing total population health status is a vicarious rather than a direct “good” for the middle class and up

Or Put Differently....

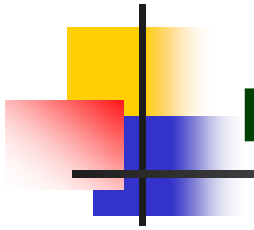
- The advantaged classes have little to gain directly from other forms of social spending
- They may perceive the opportunity cost of ineffectively high health care spending as quite low
- Their VFM calculus may therefore support low-yielding health care spending
- And – huge numbers of the advantaged classes are health care providers

Accountability Is Elusive

- In large and complex systems, it is easy to evade accountability
- Physicians have by and large resisted the role of stewardship over public resources
- Health care's relationship to physicians and employees is fundamentally different from other industries
- Autonomy is a core value, and there is high tolerance for practice variations

Fundamental Unsolved Problems

- Clinical autonomy with little accountability plagues most systems
- Supply-driven utilization is the norm – e.g., diagnostic imaging
- Little sense of stewardship among providers
- Inability to define productivity in terms other than volumes
- Public fixated on access and indifferent to serious and widespread quality issues
- Unjustifiable and wide variations in practice



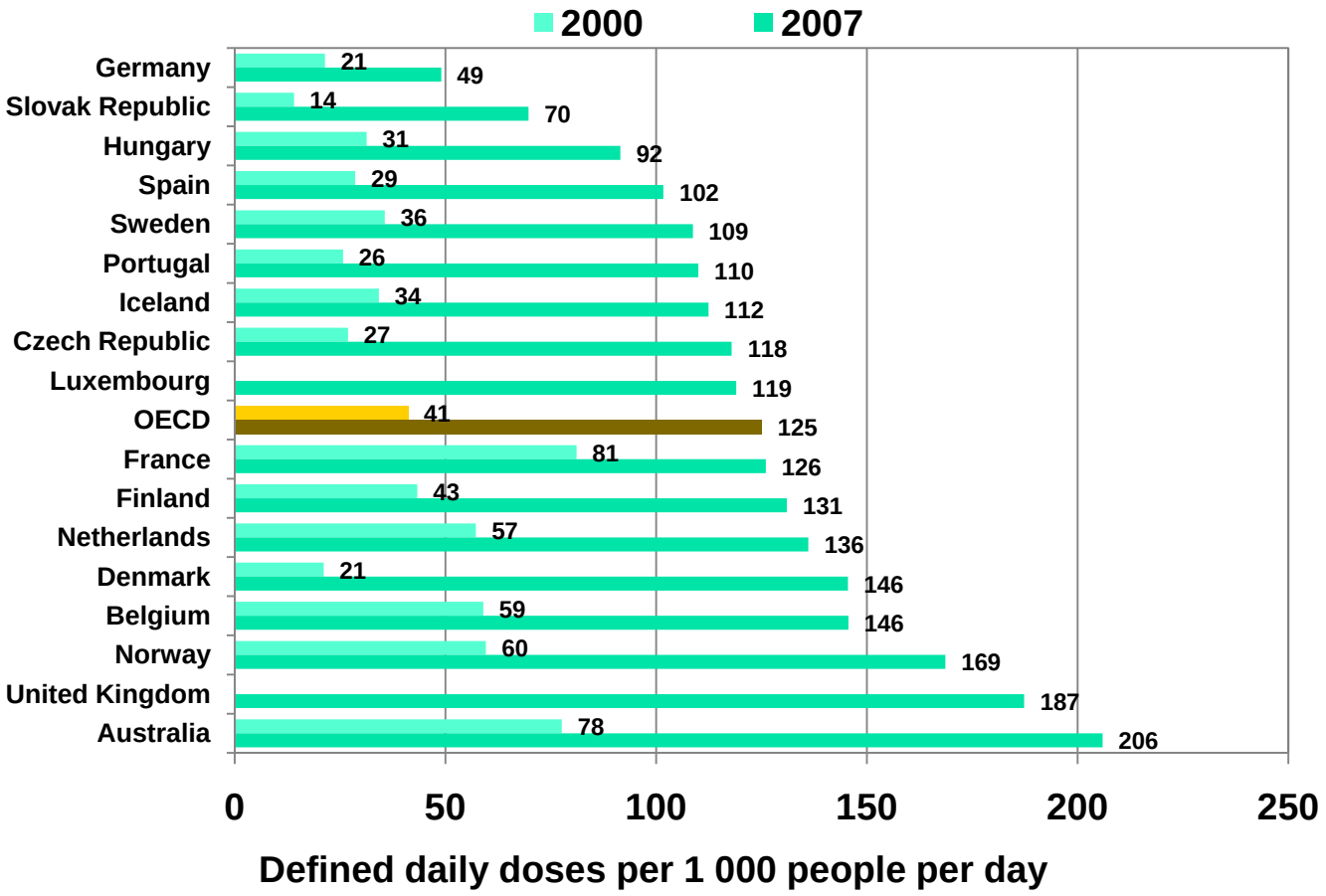
Part 3

What, If Anything, Can Be Done to Improve VFM in Health Care

Policy Mechanisms to Improve VFM

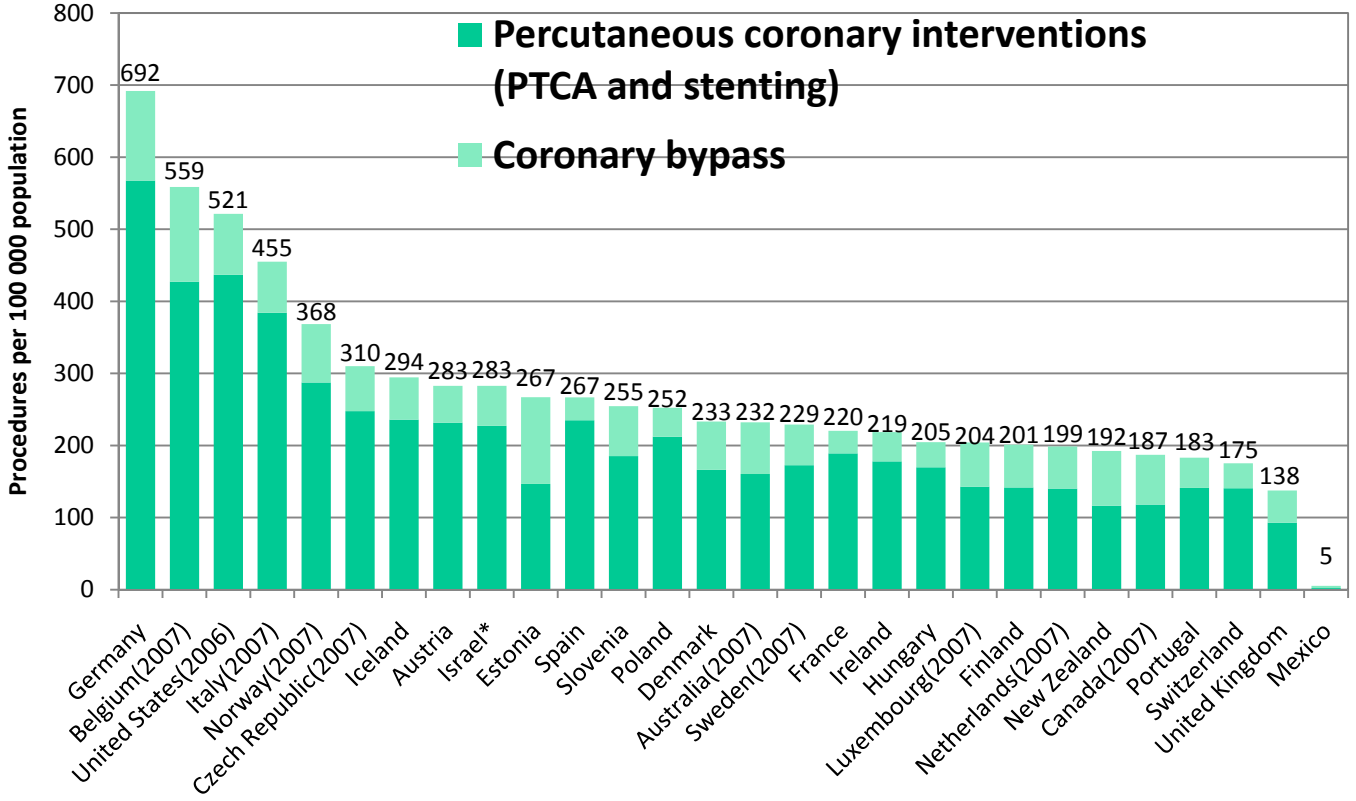
- Evidence-based decision-making – e.g., drug formularies
- Hard bargaining on prices (e.g., NZ)
- Prospective payment systems (DRGs)
- Re-engineer elements of care (Lean, ER flow modeling)
- Pay-for-performance (P4P)
- Some successes on all fronts but results to date are hardly revolutionary

Anticholesterols consumption, defined daily doses per 1000 people per day, 2000 and 2007



Source: OECD, Value for Money in Health Spending, 2010

Coronary revascularisation procedures per 100,000 population, 2008



Source: OECD, Value for Money in Health Spending, 2010

Aggregate Spending vs. Spending Distribution

- How much to spend on health care is a collective, political decision
- How to distribute spending is driven by
  - Interest groups
  - Historical patterns
  - Beliefs
  - Power
- It's not the size of the pie, it's the composition that tells much of the VFM tale

Systems That Do Well

- Kaiser Permanente (famous comparison with NHS in BMJ 2003)
- Veterans Health Care
  - Went from “worst to first” between 1994 and 1998 on quality measures
  - Closed 55% of hospital beds
  - Opened over 300 ambulatory care clinics
  - Huge improvement in screening
- Jonkoping County, Sweden

What High VFM Systems Have In Common

- Active clinical governance (emphasis on quality, reduced variations in practice)
- Big emphasis on upstream end of system (prevention, early intervention)
- Hospital avoidance is high priority (270 patient days/1000 in Kaiser vs. 1000 in NHS in 1990s)
- Committed leadership
- Emphasis on culture more than incentives
- Use of information to improve practice (not just accountability)

Policy Options to Improve VFM

- Decouple funding and payment from volumes where it is clear we want less, not more
- Launch major initiative to identify appropriateness thresholds and ranges
- Set population-based utilization ranges and “tax back” excesses
- Integrate budgets where you want money to flow easily to the lowest cost, effective service (e.g., hospitals and home care)
- Eliminate unjustifiable staffing standards

Policy Options (cont'd)

- Signal to manufacturers that prices will be set commensurate with therapeutic benefit
- Get primary care right – the cascade of cost escalation starts here
- Engage doctors in development of a greater stewardship role over system resources
- Report publicly the variations in VFM from different interventions
- Get auditors-general involved to create pressure for VFM accounting

Contact Information

Steven Lewis
Access Consulting Ltd.
211 – 4th Ave. S.
Saskatoon SK S7K 1N1

Tel. 306-343-1007
Fax 306-343-1071
E-mail Steven.Lewis@shaw.ca