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

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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,...

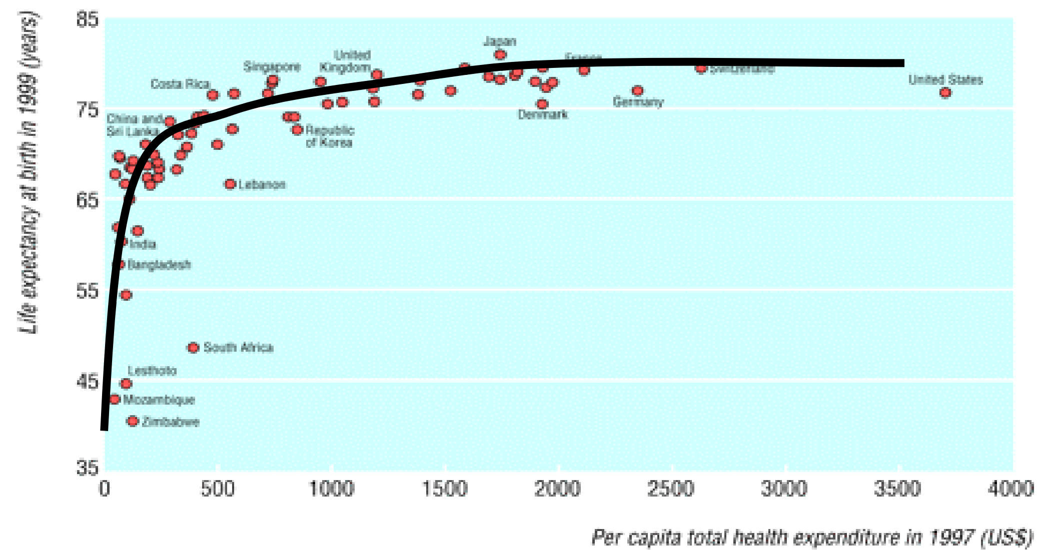
The Key Term is "Value"

- 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

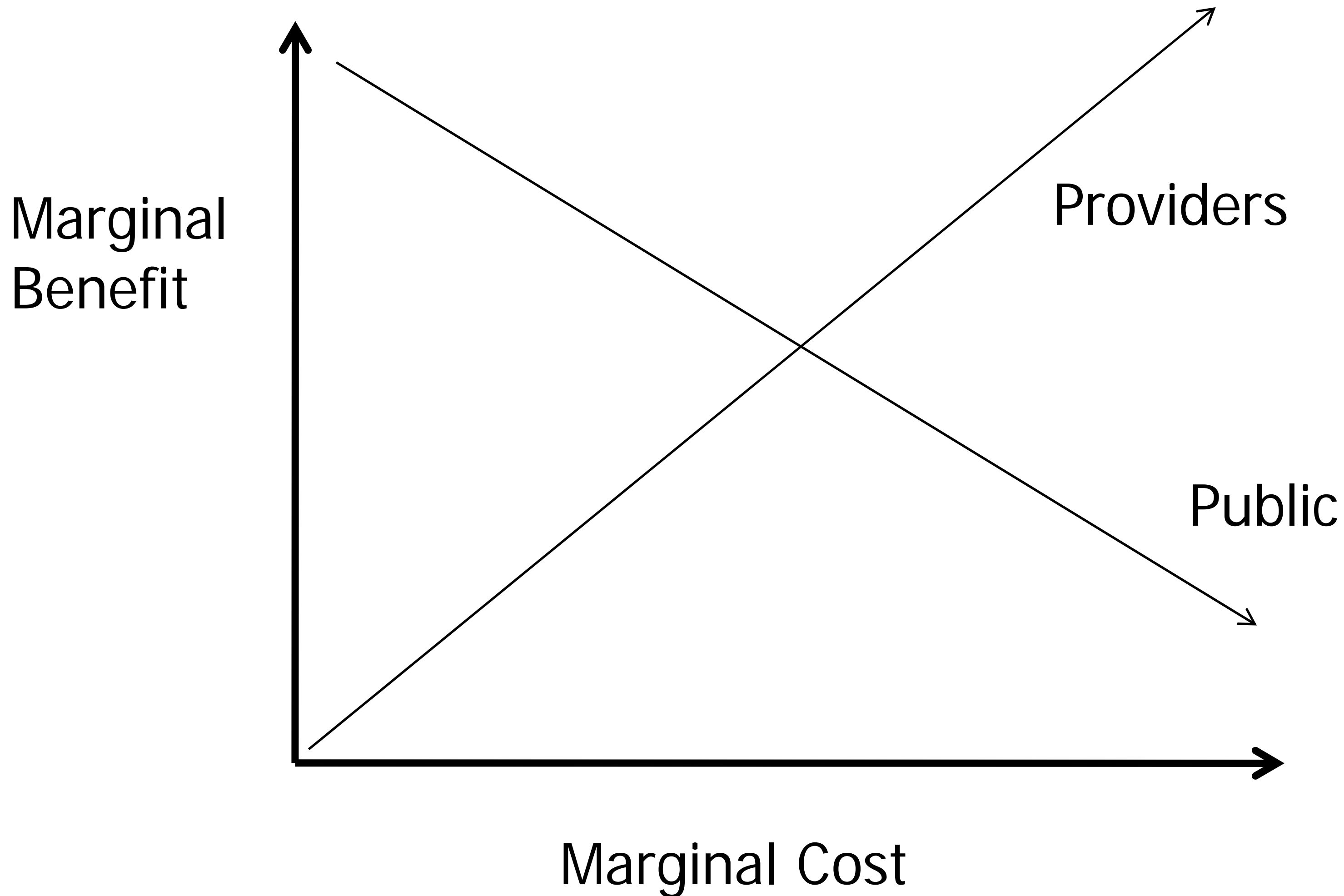
- Health care accounts for roughly 20% of population health status
- Some disorders can be addressed cheaply and some cannot
- Ethical norms preclude utility-driven decisions (e.g., rule of rescue, NICU heroics, aged care)
- Some needs count for more than others (even in universal, publicly financed 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

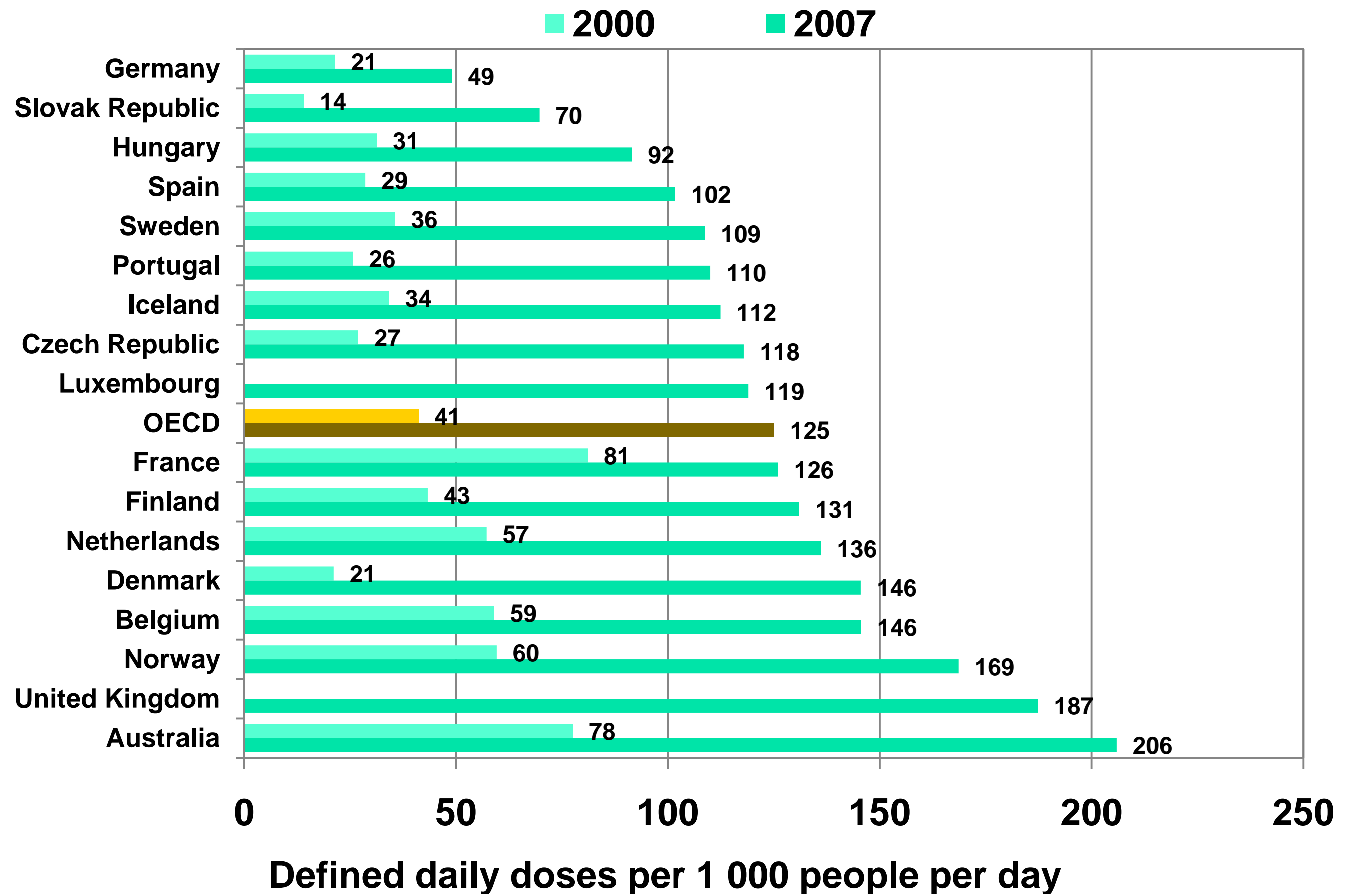
Part 3

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

Policy Mechanisms to Improve VFM

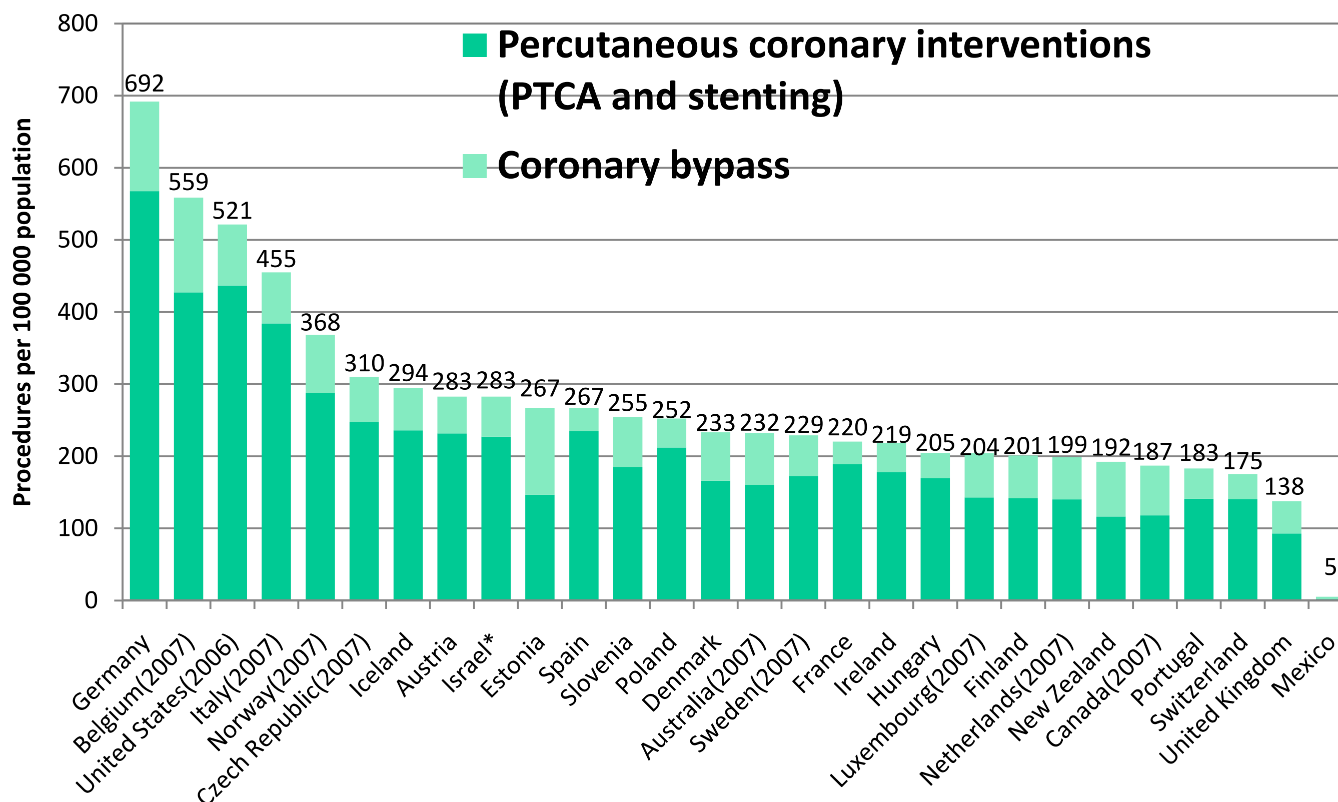
- Evidence-based decision-making – e.g., drug formularies
- Hard bargaining on prices (e.g., NZ)
- Prospective payment systems (DRGs)
- Re-engineer elements of care (Lean, ER flow modeling)
- Pay-for-performance (P4P)
- Some successes on all fronts but results to date are hardly revolutionary

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

- 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

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