Adding value in what we do: the future vision

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The value proposition in New Zealand healthcare

Value in healthcare

About 50 years ago, Paul McCartney and John Lennon complained that “money can’t buy me love”; based on the Commonwealth Fund’s 2014 review, it would appear that money can’t buy a credible health system either.

The ranking of 11 countries' health systems by the Commonwealth Fund

	Australia	UK	US	NZ
Rank 2004 (5)	2	3	5	1
Rank 2006 (6)	4	3	6	2
Rank 2007 (6)	3	1	6	3
Rank 2010 (7)	3	2	7	5
Rank 2014 (11)	4	1	11	7 =
Per capita USD 2011	3,800	3,405	8,508	3,182

But, the NHS is well over budget and core reforms have failed

	Australia	UK	US	NZ
Rank 2004 (5)	2	**3**	5	1
Rank 2006 (6)	4	**3**	6	2
Rank 2007 (6)	3	**1**	6	3
Rank 2010 (7)	3	**2**	7	5
Rank 2014 (11)	4	**1**	11	7 =
Per capita USD 2011	3,800	**3,405**	8,508	3,182

What about the New Zealand capitated spend?

	Australia	UK	US	NZ
Rank 2004 (5)	2	3	5	1
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Per capita USD 2011	**3,800**	**3,405**	**8,508**	**3,182**

The New Zealand capitated spend looks low

NZD to USD exchange rate.

Low capitated GDP in NZ, such that the spend as a percentage of GDP is closer to the norm.

Relatively low private spend (only 17% of total).

- About 20% of total Government expenditure is on health.

Personnel are the major cost and are paid in NZD.

- (disposable income and job vacancy susceptibility to the Australian healthcare labour-market).

Susceptibility to the Australian healthcare labour-market

Medical graduate loss to Australia fallen from historical mean levels of 25% to negligible outflow (net inflow) – similar for nursing.

- Over-supply of Australian medical graduates.
- Australian nursing workforce outflow fallen from 6% p.a. to 2% p.a. consistent with economic distress.

Increasing perception that NZ is a preferable place to study and work.

Top personal tax rates of 0.49 in Australia and 0.33 in NZ mitigates gross wage differences.

This does not look good

	Canada	UK	US	NZ
Rank 2004 (5)	4	3	5	**1**
Rank 2006 (6)	5	3	6	**2**
Rank 2007 (6)	5	1	6	**3**
Rank 2010 (7)	6	2	7	**5**
Rank 2014 (11)	10	1	11	**7 =**
Per capita USD 2011	4,522	3,405	8,508	3,182

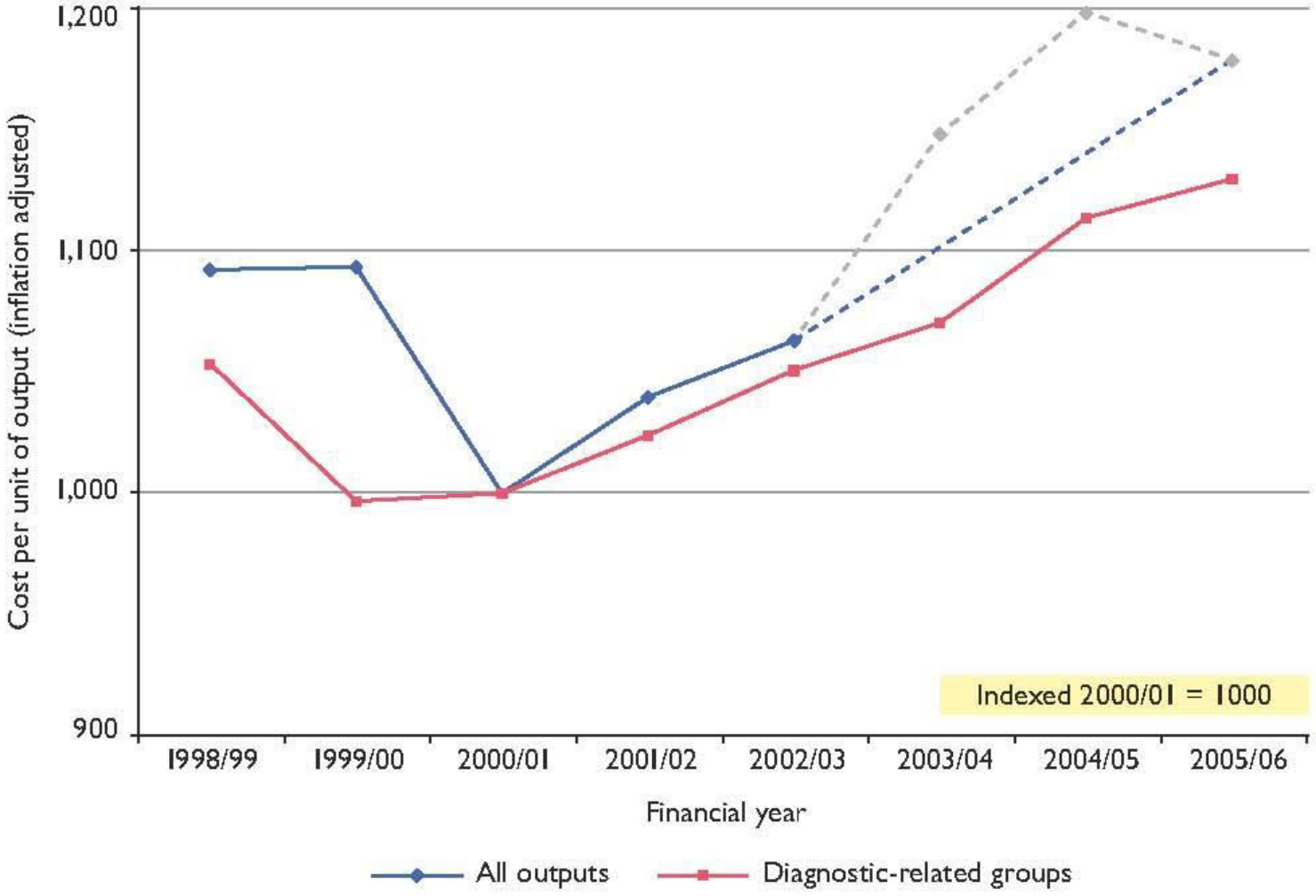
New Zealand post-2001

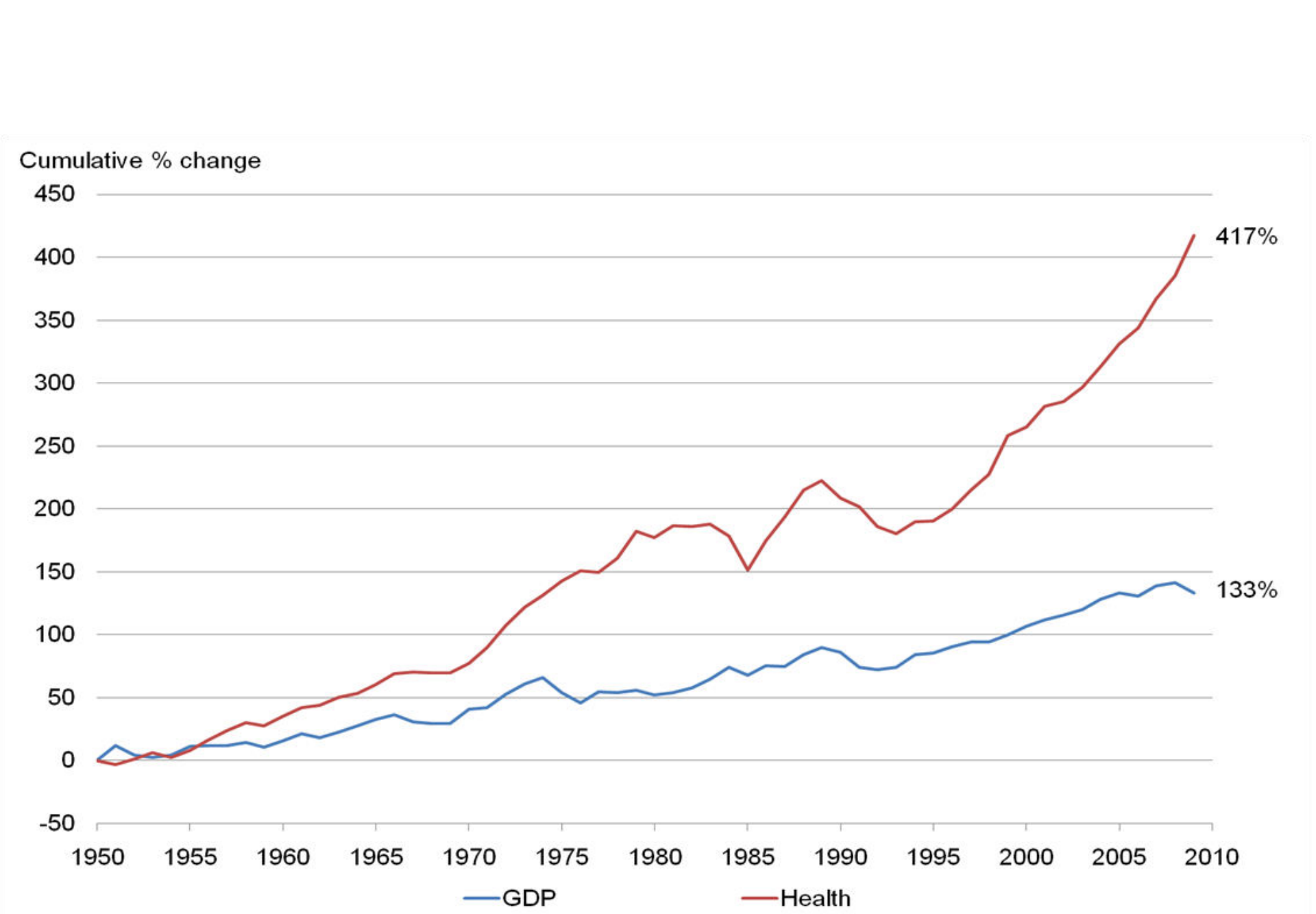
Between 2001 and 2010, productivity was lost in most domains of the health system.

In the same period, health costs grew substantively.

In 2013, health cost growth was estimated as 8.5% p.a. compared to nominal GDP growth of about 6% p.a.

Figure 2: Inflation-adjusted cost per unit of output (indexed 2000/01 = 1000), 1998/99 to 2005/06




Cumulative % change
450
400
350
300
250
200
150
100
50
0
-50
1950
1955
1960
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
417%
133%
GDP
Health

Value in healthcare

In the context of increasingly unaffordable healthcare, there are two key issues. The first is **health funding** and the second is healthcare **purchasing and commissioning**.

Health funding

Health funding is increasingly challenged by an ageing demographic and an increasing chronic disease burden.

There is increasing attention to social insurance, employment-based, group and not-for-profit mutual schemes, such as those operated in Germany, the Netherlands, Singapore, South Korea and Switzerland.

Health funding

There are putative models of health insurance that should promote compliance in people with chronic disease and consequently reduce the consumption of healthcare.

Smart purchasing

The balance of this presentation is on the second issue, which is how health services are purchased, and in particular, how purchasing can address unmet health need and result in better, innovative and integrated services.

The question you need to address is how will such a future milieu affect you and what value will/can you and your colleagues add?

Health need and unmet need

How is unmet health need identified and how are any discovered service gaps related to how services are purchased and or commissioned?

How robust are the surveys and analyses of unmet need?

Contributors to unmet need

- Acceptability factors.
- Accessibility factors.
- Affordability factors.
- Availability factors.

How are these highly inter-dependent drivers of healthcare uptake analysed with respect to purchasing and commissioning factors?

Unmet health need in whole-of-Europe surveys

Eurostat 2013	Cost barriers	Travel barriers	Waiting time barriers	Non health system factors	Total unmet need (% of total pop.)
Sweden	0.5	0.2	1.2	11.7	**13.6**
France	2.1	0.1	0.5	3.5	**6.2**
Germany	0.6	0.1	0.8	4.5	**6**
UK	0.1	0.1	1.4	1.5	**3.1**
Switz'land	1	0	0.1	1.2	**2.3**
Neth'lands	0.1	0.1	0.3	1.1	**1.6**

Non health system factors seem to be the dominant cause of unmet need!

Eurostat 2013	Cost barriers	Travel barriers	Waiting time barriers	Non health system factors	Total unmet need (% of total pop.)
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Any clues here?

Eurostat 2013 Common. Fund 2014 OECD 2008	Cost barriers	Travel barriers	Waiting time barriers	Health spend USD per capita	Total unmet need (% of total pop.)
Sweden	0.5	0.2	1.2	**3,925**	**13.6**
France	2.1	0.1	0.5	**4,118**	**6.2**
Germany	0.6	0.1	0.8	**4,495**	**6**
UK	0.1	0.1	1.4	**3,905**	**3.1**
Switz'land	1	0	0.1	**5,643**	**2.3**
Neth'lands	0.1	0.1	0.3	**5,099**	**1.6**

But relevant US spend is now about $9,000 per capita!!

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Any clues here?

Eurostat 2013 Common. Fund 2014 OECD 2008	Cost barriers	Travel barriers	Waiting time barriers	Doctors per 1,000 pop (ratio of OECD mean)	Total unmet need (% of total pop.)
Sweden	0.5	0.2	1.2	**1.1**	**13.6**
France	2.1	0.1	0.5	**1.1**	**6.2**
Germany	0.6	0.1	0.8	**1.1**	**6**
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So what to do?

Some overarching strategies.

Some overarching philosophies.

Some overarching strategies

The IHI Triple Aim as a cornerstone principle.

The systematic reduction of waste.

- An ethical prerequisite to any healthcare rationing.

The systematic reduction of treatment injury.

The systematic reduction of treatment injury

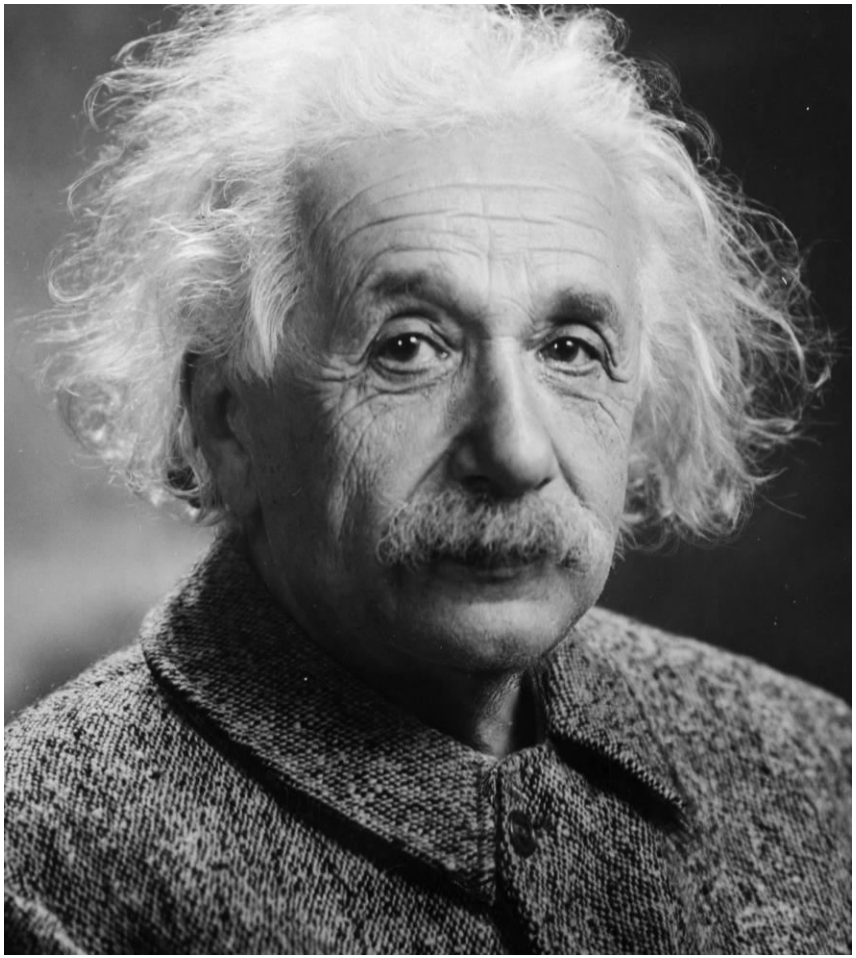
In the US, medical error is the third most common cause of death, exceeded only by heart disease and cancer.

In New Zealand, within a decade, the cost of treatment injury will be greater than that for road traffic accidents, and domestic and industrial injuries.

- Identify and analyse, publish and partner.

Some overarching philosophies

The definition of insanity is doing the same thing over and over and expecting it to come out differently.



Some overarching philosophies

You are a product of the decisions you make – you can not choose to not make a choice, as to not choose is to choose the status quo.

Some overarching philosophies

In his writings, a wise Italian says that the best is the enemy of the good.

What can be learnt and what is recommended?

First, funding and accountability arrangements can be characterised according to the specificity (i.e. tight or loose) with which:

a. desired outcomes are defined *ex ante*;

b. funders define how those outcomes should be achieved; and,

c. providers are held accountable for delivery.

Funding and accountability arrangements

Loose-Loose-Loose (LLL)

- Most population based funding in place today.

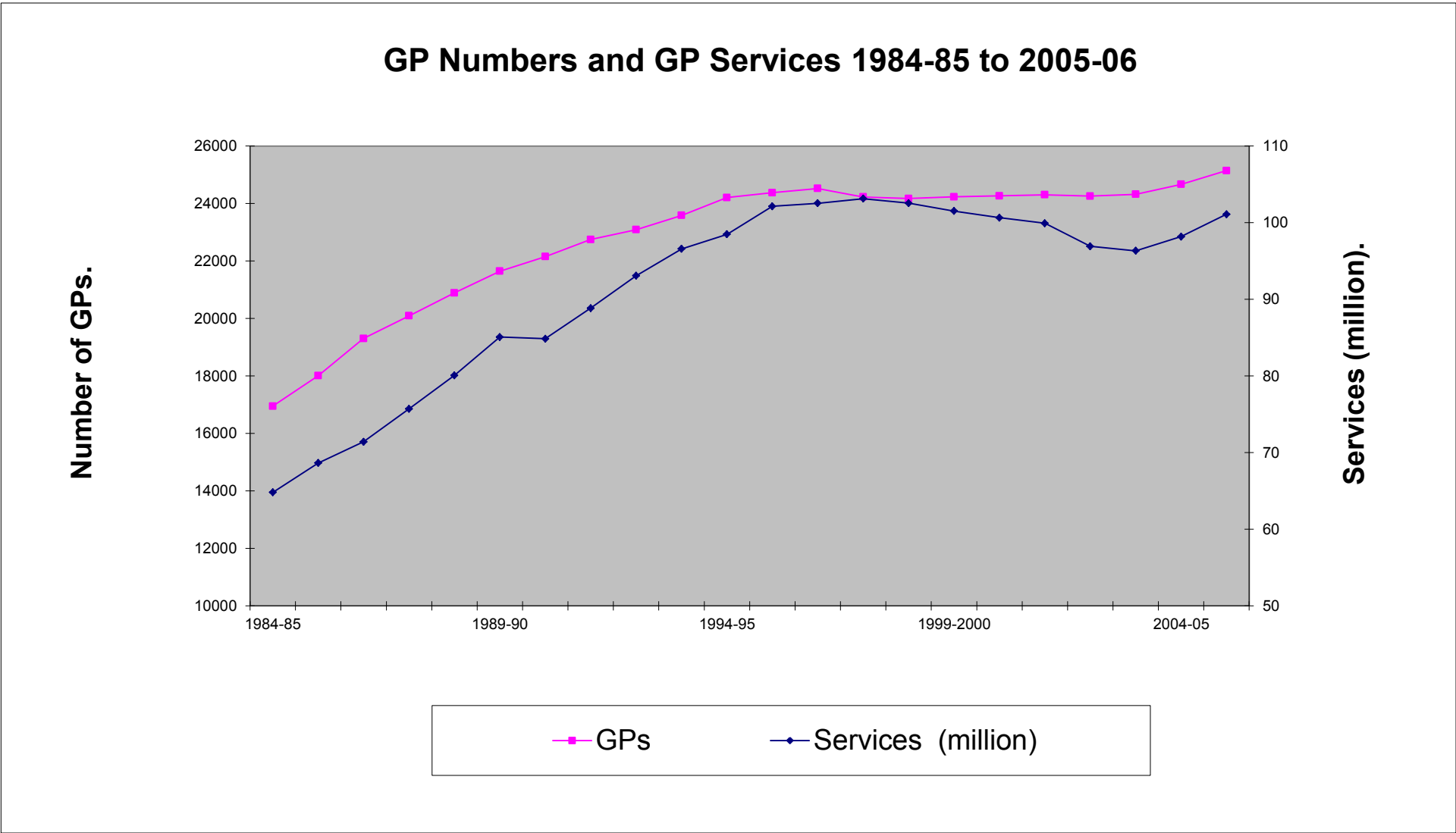
Loose-Tight-Loose (LTL)

- Most transactional funding; results in over-servicing, little innovation and unhelpful competition.

Tight-Loose-Tight (TLT)

- If providers have both financial and outcome risk, then innovation is most likely.

A LTL example



A LLL example

Primary care in New Zealand in 2000

- Fee for service business model.
- GP hours worked per week = 45.
- After-hours and on-call working hours per week = 10.

Primary care in New Zealand in 2013

- Capitated business model.
- GP hours worked per week = 40.
- After-hours and on-call working hours per week = 4.

Recommendations

Where possible healthcare purchasers should use a TLT approach.

- Funders specify a few high-level outcomes and work with providers to cascade those into more specific and clinically determined contributory results (e.g. mental health and diabetes outcomes and claw-back arrangements).

Recommendations

Transactional payments can have utility (e.g. cataract surgery and hip surgery).

Recommendations

Because healthcare is complex and diverse, there is no universally successful purchasing method and the impact of purchasing will be modified by non-financial incentives and instruments.

- Purchasers need to use a process that can evolve and is blended, and that is behaviourally economically sound.

Behavioural economics

For example, regulation and compliance audits of aged care facilities versus the impact of informed consumers and referrers on the provider marketplace.

The power of choice on a provider marketplace

This ‘power of choice’ requires:

a. alternate providers;

b. the publication of outcome data to inform choice; and,

c. that funding follows the choices that consumers and referrers make.

Recommendations

Population-based funding or purchases by way of a capitation are likely to be more effective if they have a TLT basis. In addition, purchasers should :

a. require minimum performance metrics;

b, prefer healthcare **plans** that aim to deliver well-defined improvements and **outcomes** for specific patient segments; and,

c. make some of the payment conditional on success.

Plans and outcomes

Some judgment is required by funders on the likelihood of a **plan** succeeding.

- Based on an assessment of provider capability and capacity (i.e. workforce, IT and facilities) and the proposed operating model.

Outcomes will be determined by the funder's mandate.

- Limited health mandate versus a broader social sector mandate.

Recommendations

For those population segments where earlier health interventions are most likely to result in substantial lifetime benefits, there is utility in taking an investment approach across the social sector.

- This requires the generation and costing of a counterfactual and the sizing of a health investment to obtain better health outcomes, which reduce the long-term financial liability.

Recommendations

There is utility in using well-performing provider alliances.

- In practice this requires careful alliance pre-accreditation.
- Useful measures to promote alliance performance include using rolling contracts (i.e. using increased tenure as a reward and so as to promote investment etc.) and risk-sharing instruments.

How to purchase better, innovative and integrated health services

Healthcare is increasingly unaffordable.

Sophisticated purchasing can help this situation by resulting in better, innovative and integrated healthcare services.