

# What is value in health care?

*Some thoughts from a European and health systems perspective*

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LONDON  
SCHOOL of  
HYGIENE  
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MEDICINE





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# Perspective FREE PREVIEW

## What Is Value in Health Care?

Michael E. Porter, Ph.D.



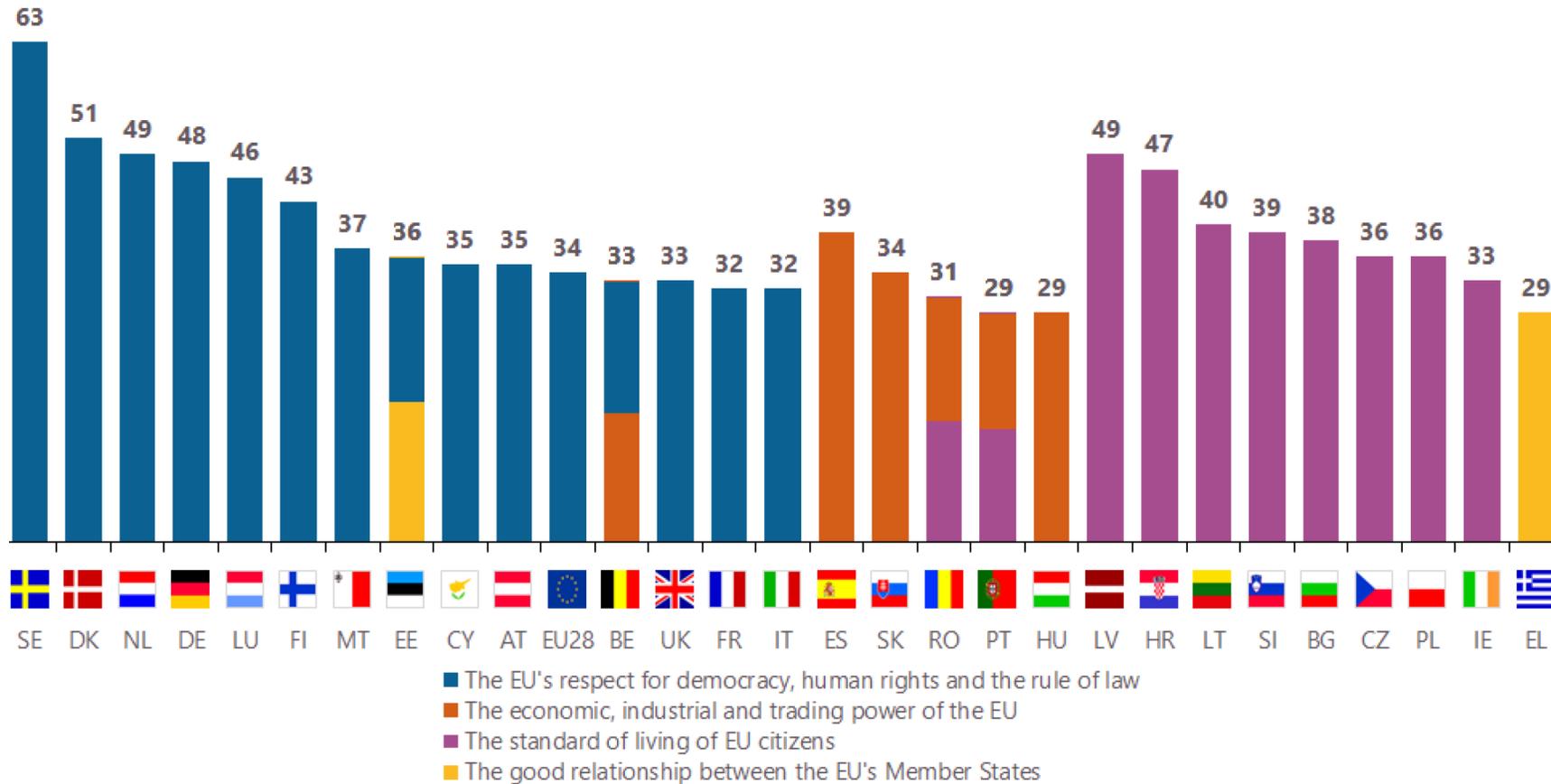
This article has no abstract; the first 100 words appear below.

In any field, improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders. In health care, however, stakeholders have myriad, often conflicting goals, including access to services, profitability, high quality, cost containment, safety, convenience, patient-centeredness, and satisfaction. Lack of clarity about goals has led to divergent approaches, gaming of the system, and slow progress in performance improvement. Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.<sup>1</sup> This goal is what matters for patients and unites . . .

# Thinking about 'value' in the context of the European Union

- The European Union's fundamental values
  - Respect for human dignity and human rights
  - Freedom
  - Democracy
  - Equality
  - The rule of law
- These values unite all EU Member States – countries not recognising these values cannot be members of the EU
- The main goal of the European Union is to defend these values in Europe and promote peace and wellbeing of its citizens
- The EU works towards social equality, develops social security and seeks to protect the weakest, prevent social exclusion and discrimination

## Main assets of the European Union (1)



# The European social model

- Health care coverage is almost universal
- Principle of solidarity
- Social protection as a means of promoting social cohesion and economic growth
- Health care is not a normally traded good

# Values and principles of health systems in Europe

- 2006 European Council conclusions on *common values and principles* in EU health systems
  - Universality
  - Access to good quality care
  - Equity
  - Solidarity
  
- 2008 Tallinn Charter 'Health Systems for Health and Wealth': Member States of the WHO European region commit to
  - Promote *shared values of solidarity, equity and participation*
  - Invest in health systems and foster investment across sectors influencing health
  - Promote transparency and be accountable
  - Make health systems more responsive to people's needs, preferences and expectations
  - Engage stakeholders
  - Foster cross-country learning and cooperation
  - Ensure that health systems are prepared and able to respond to crises

European **Observatory** on Health Systems and Policies Series

## Economic Crisis, Health Systems and Health in Europe

Impact and implications for policy

Health Systems and Economic Crisis

Health Systems and  
Health Systems and

Sarah Thomson  
Josep Figueras  
Tamás Evetovits  
Matthew Jowett  
Philipa Mladovsky  
Anna Maresso  
Jonathan Cylus  
Marina Karanikolos  
Hans Kluge

Health Systems and  
Health Systems and

# Economic crisis, health systems and health in Europe

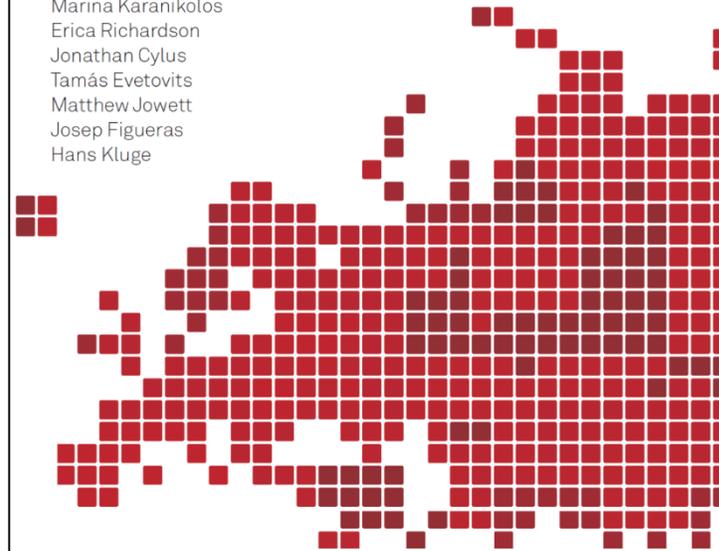
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Observatory  
Studies Series

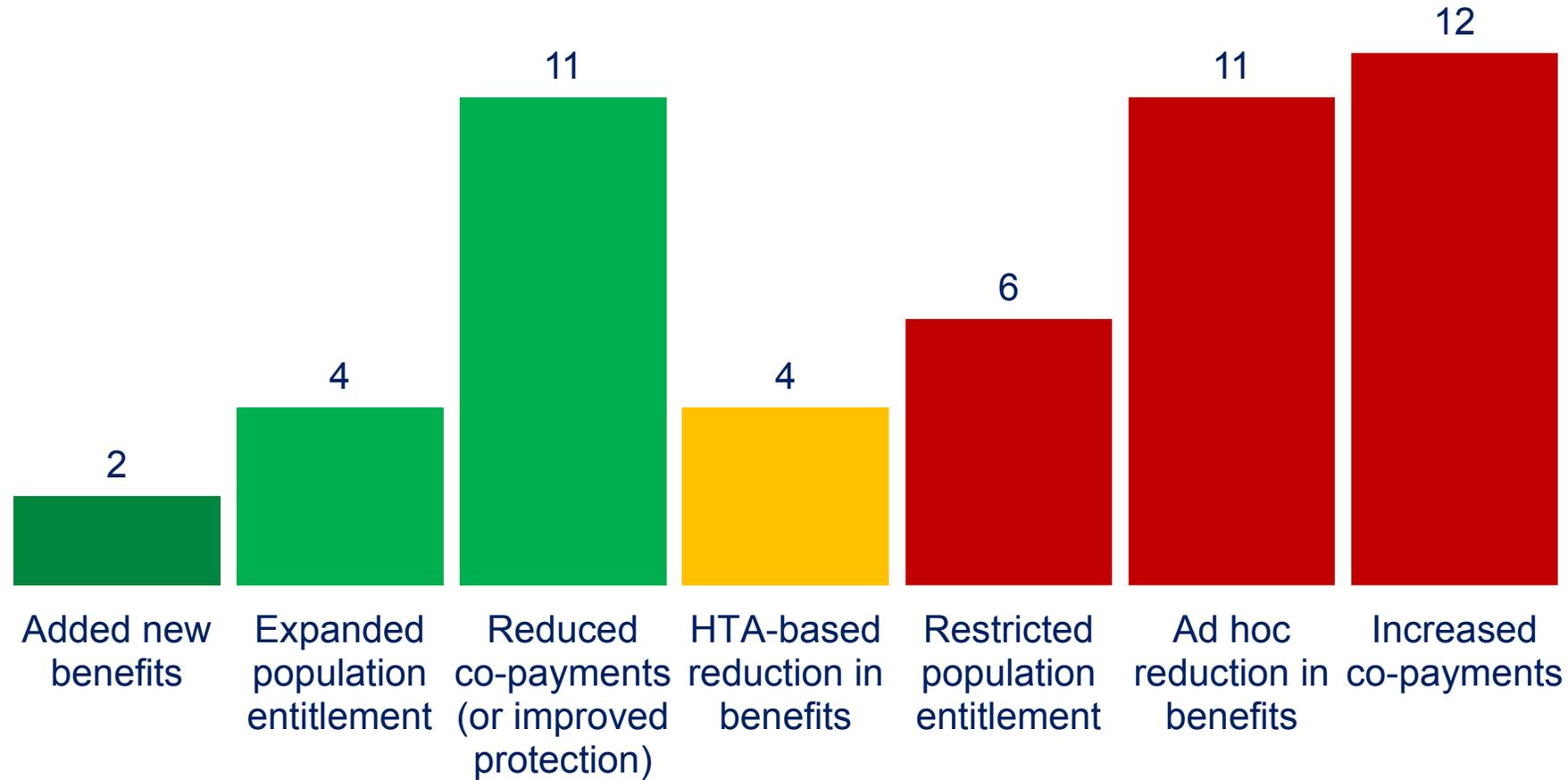
## Country experience

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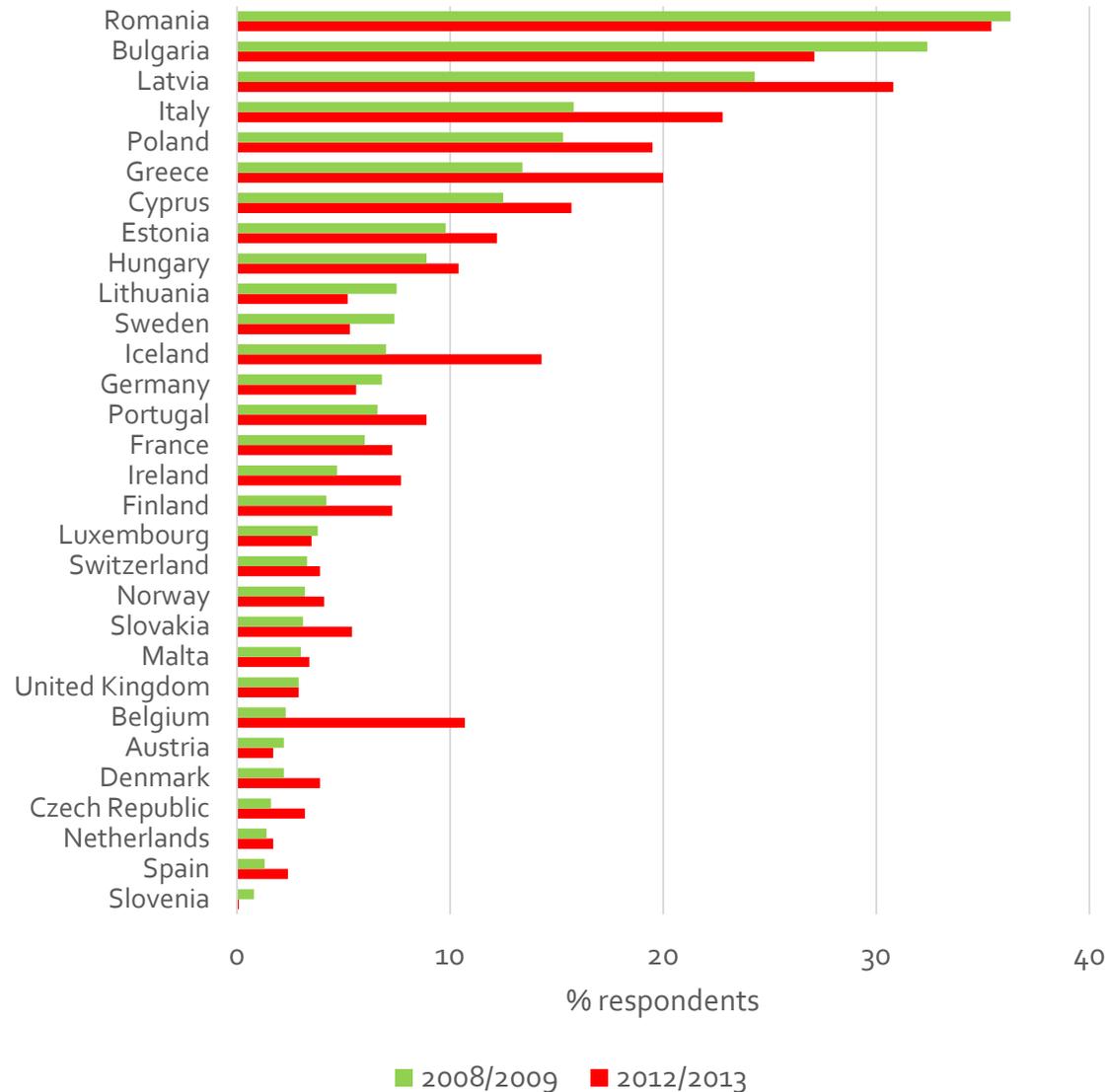
# Changes to benefits packages in the EU in response to the financial crisis



Source: Thomson et al 2015

# Impacts on health inequalities and inequities in access to health care

Foregone medical care (%) among disadvantaged populations in 30 countries



# From re-affirming common values and principles of health systems in the EU...



Brussels, 4.4.2014  
COM(2014) 215 final

COMMUNICATION FROM THE COMMISSION

On effective, accessible and resilient health systems

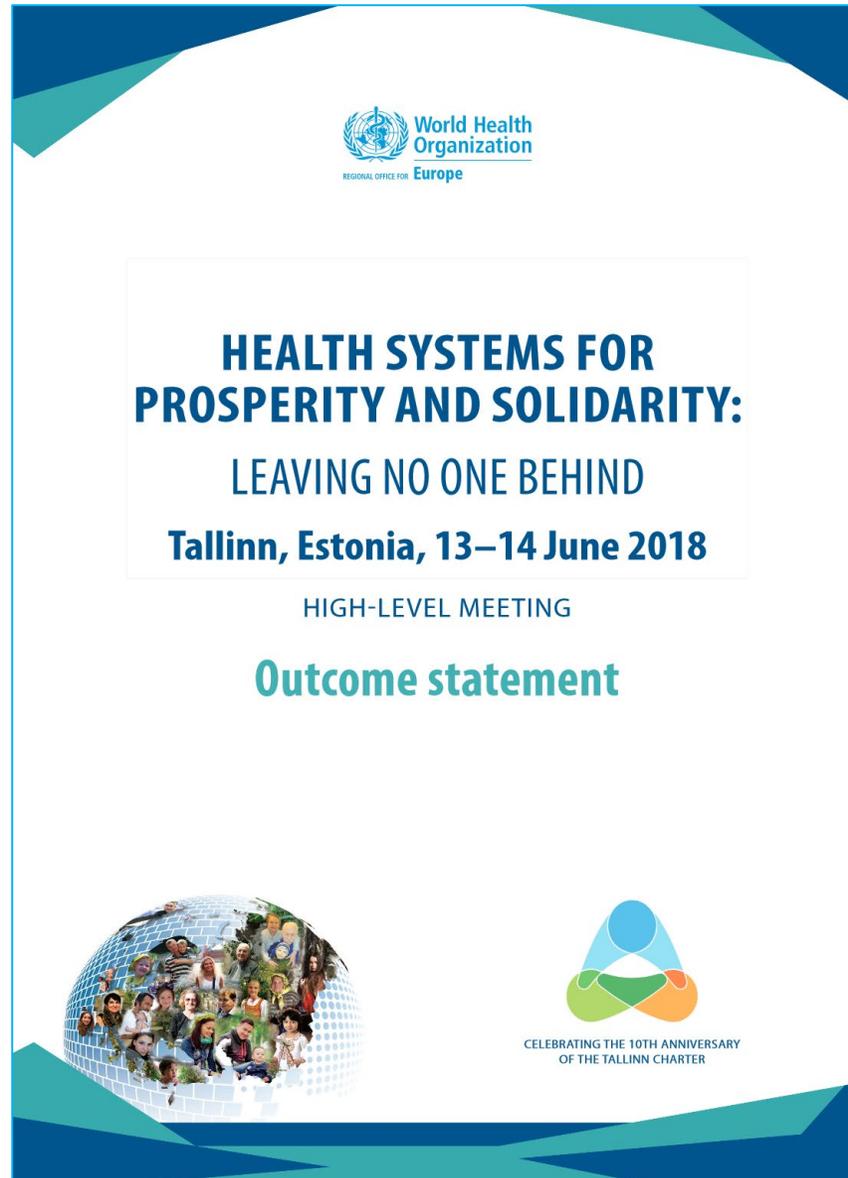
*Health systems need to be resilient: they must be able to adapt effectively to changing environments, tackling significant challenges with limited resources*

*Health is a precondition for economic prosperity*

Need to:

- Strengthen the **effectiveness** of health systems
- Increase the **accessibility** of health care
- Improve the **resilience** of health systems

# ... to Tallinn 2018 'Health Systems for Prosperity and Solidarity: Leaving no-one behind'...



## *Include*

- Recognising importance of moving towards universal health coverage for a Europe free of impoverishing payments for health, specifying ways of improving coverage, access and financial protection for everyone.

## *Invest*

- Making the case for investing in health by ensuring that money is available to provide inclusive services, and in particular to protect the poorest in society

## *Innovate*

- Acknowledging need for health systems to strategically uptake, roll out and scale up innovation to meet people's needs, both technological and system innovation

# ... to Astana 2018: towards universal health coverage and the Sustainable Development Goals



## Envisions

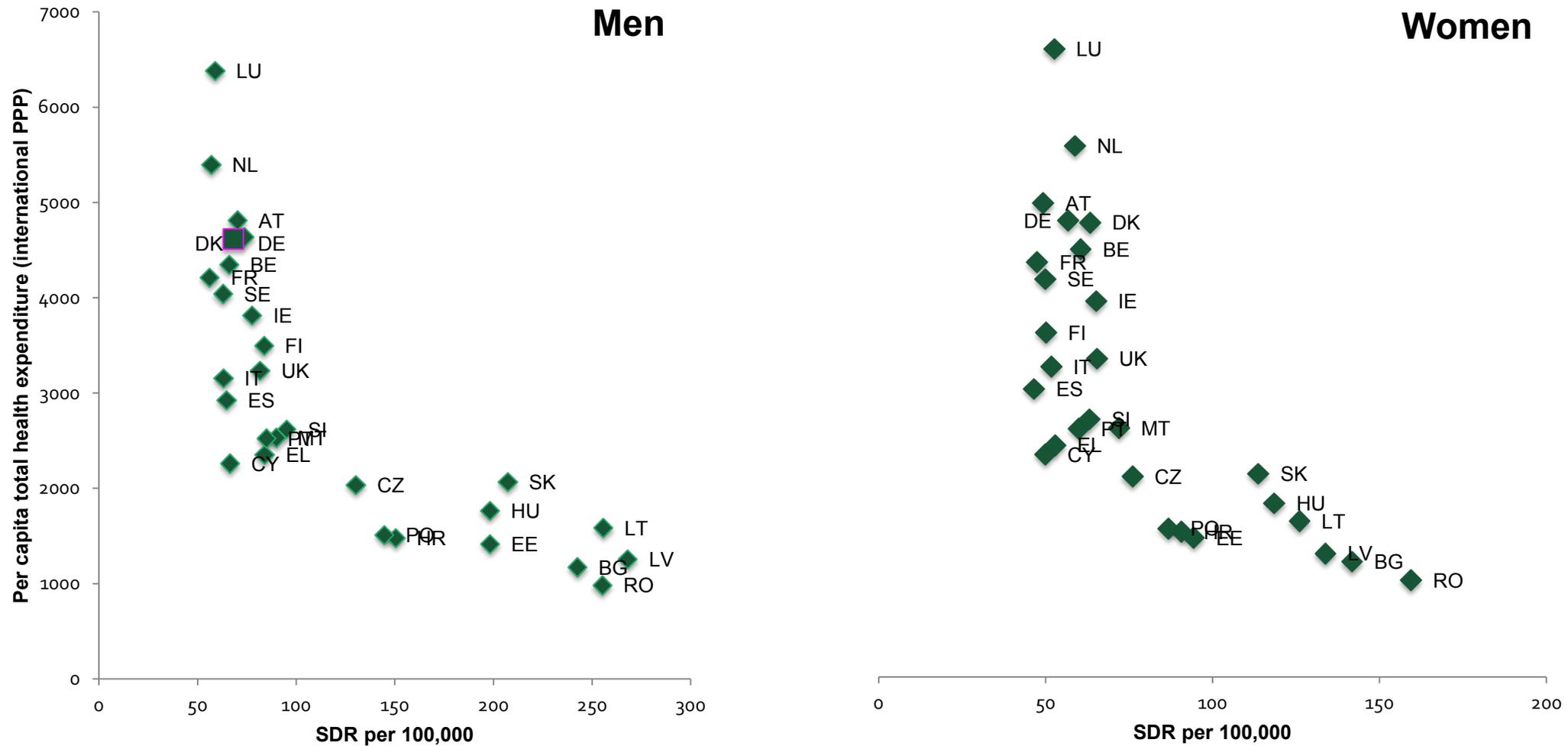
- Governments and societies that prioritize, promote and protect people's health and well-being through *strong health systems*
- Primary health care and health services that are *high quality, safe, comprehensive, integrated, accessible, available and affordable* for everyone and everywhere, provided with by well-trained, skilled, motivated and committed health professionals
- *Enabling and health-conducive environments* in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being
- Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans

# Effectiveness, accessibility and resilience

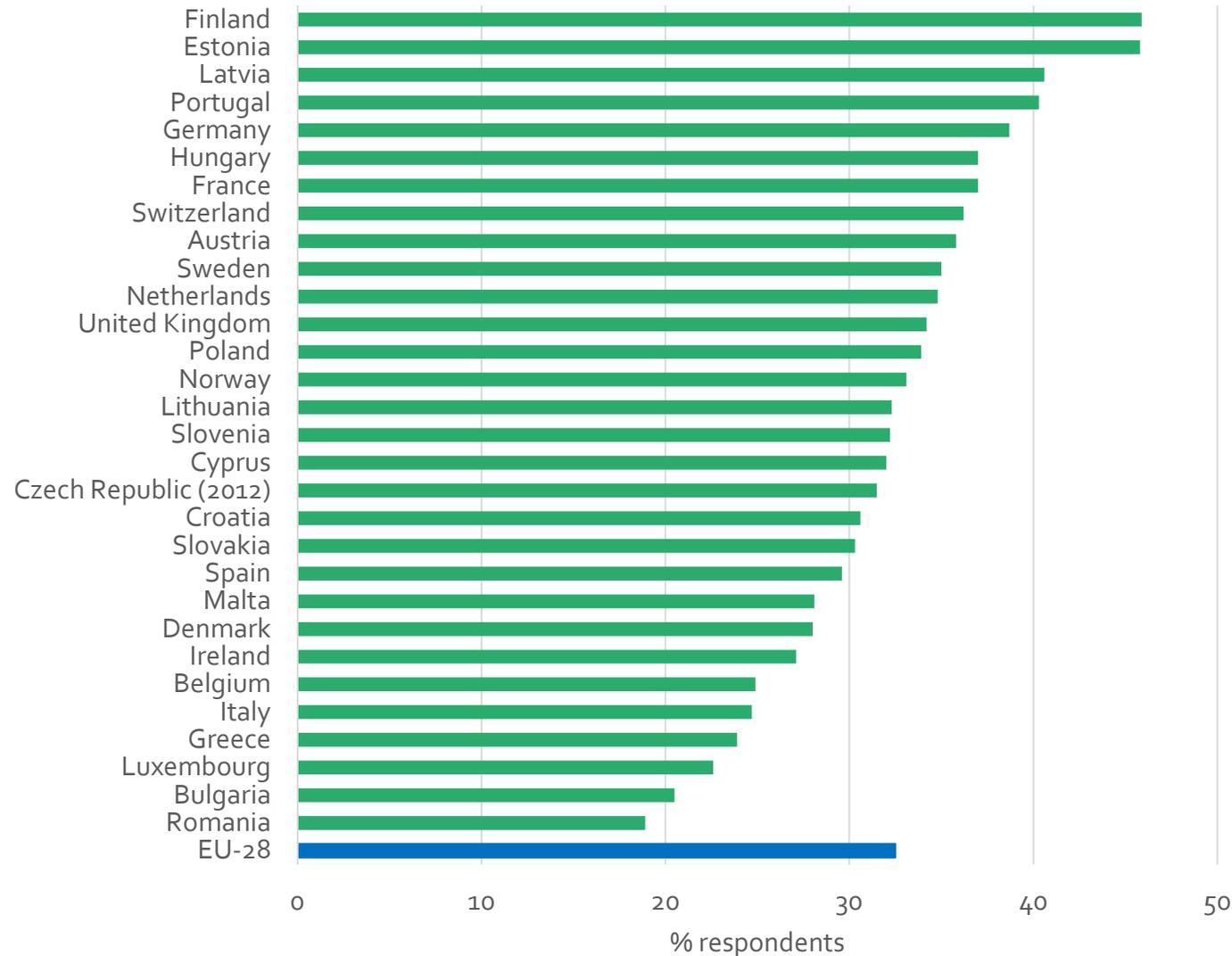
- **Effectiveness:** health systems' ability to produce positive health outcomes, i.e. to improve the health of the population
- **Accessibility:** European Social Charter (1996) emphasises the importance of transparent criteria for access to medical treatment, and the obligation for States to have an adequate health care system which does not exclude parts of the population from receiving health care services
- **Resilience:** Ability to adapt effectively to changing environments and identify and apply innovative solutions to tackle significant challenges with limited resources



# Countries vary in terms of 'value for money' regarding health care outcomes



# One-third of adult population in the EU have a long-standing illness/health problem (2014)



# Developing primary care further is a key priority in most countries

## PRIMARY CARE

By Dionne S. Kringos, Wienke Boerma, Jouke van der Zee, and Peter Groenewegen

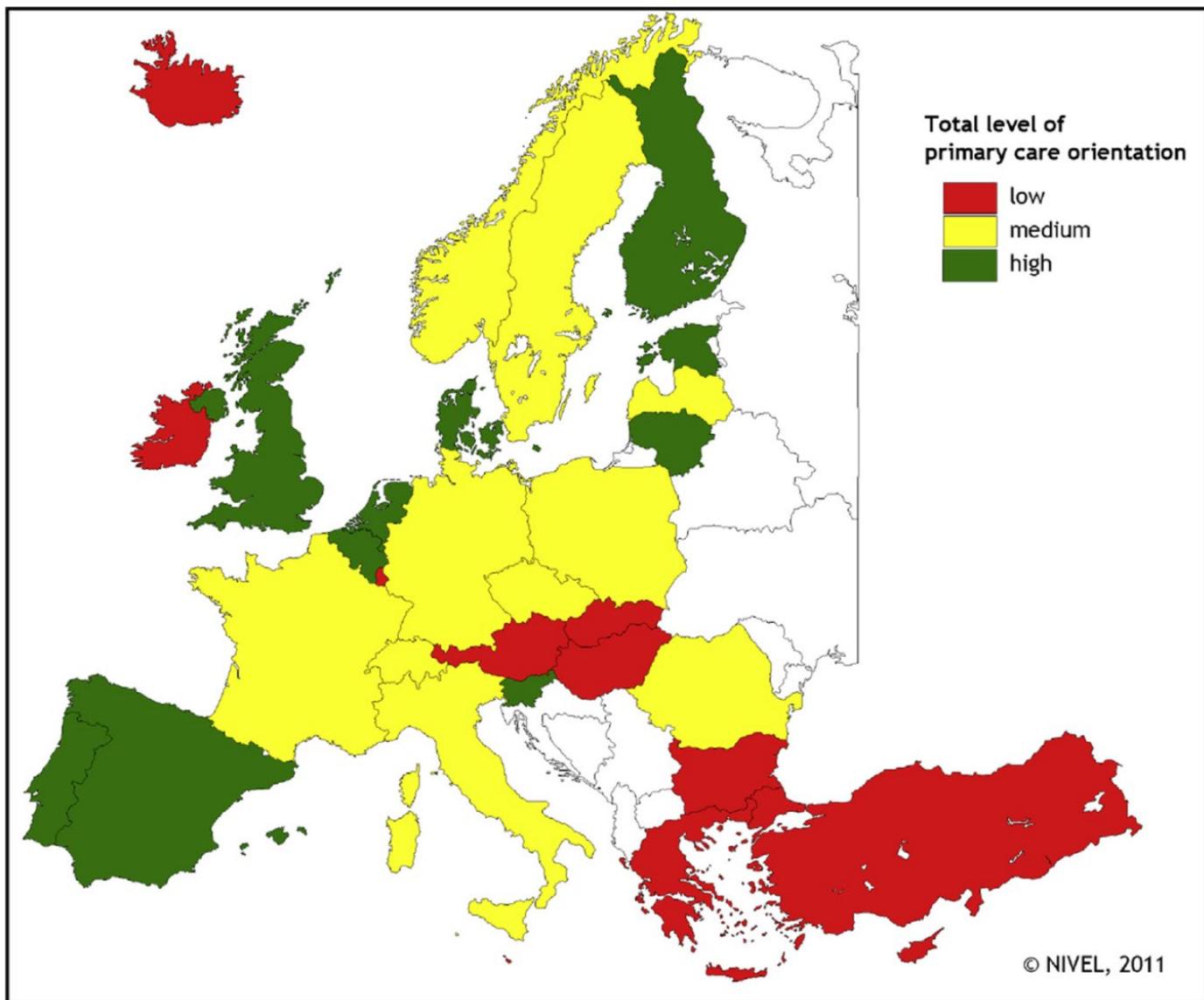
## Europe's Strong Primary Care Systems Are Linked To Better Population Health But Also To Higher Health Spending

**ABSTRACT** Strong primary care systems are often viewed as the bedrock of health care systems that provide high-quality care, but the evidence supporting this view is somewhat limited. We analyzed comparative primary care data collected in 2009–10 as part of a European Union–funded project, the Primary Health Care Activity Monitor for Europe. Our analysis showed that strong primary care was associated with better population health; lower rates of unnecessary hospitalizations; and relatively lower socioeconomic inequality, as measured by an indicator linking education levels to self-rated health. Overall health expenditures were higher in countries with stronger primary care structures, perhaps because maintaining strong primary care structures is costly and promotes developments such as decentralization of services delivery. Comprehensive primary care was also associated with slower growth in health care spending. More research is needed to explore these associations further, even as the evidence grows that strong primary care in Europe is conducive to reaching important health system goals.

*"Countries with stronger primary care structures were associated with fewer potential deaths [from] ischemic heart disease [...], from cerebrovascular disease among men, [...] and from chronic asthma, bronchitis, and emphysema" but not from diabetes.*

*"From 2000 to 2009 countries with more comprehensive primary care had a slower increase in health care spending" – at the same time countries with stronger primary care structures had higher health spending*

# Variation in primary care strength across Europe



Strength Of Key Primary Care Aspects In Thirty-One European Countries, 2009-10

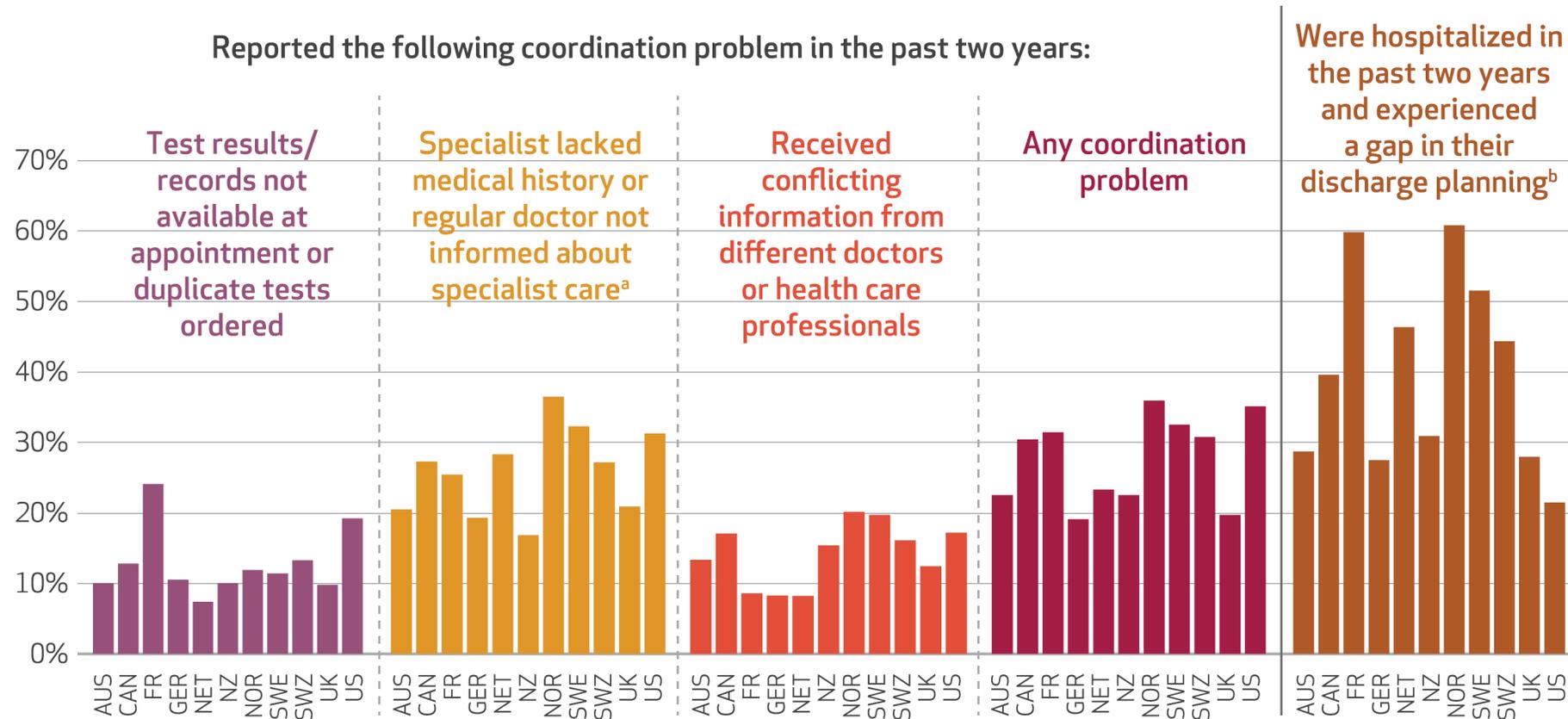
Country	Structure	Accessibility	Continuity	Coordination	Comprehensiveness
Austria	2.22	2.27	2.19	1.38	2.33
Belgium	2.21	2.13	2.38	1.70	2.53
Bulgaria	2.14	2.15	2.33	1.44	2.54
Cyprus	1.91	2.11	2.32	1.49	2.19
Czech Rep.	2.14	2.35	2.41	1.64	2.33
Denmark	2.38	2.46	2.43	1.96	2.40
Estonia	2.29	2.21	2.42	1.71	2.41
Finland	2.31	2.20	2.32	1.74	2.51
France	2.16	2.06	2.33	1.63	2.47
Germany	2.20	2.25	2.38	1.38	2.34
Greece	2.10	2.08	2.25	1.96	2.17
Hungary	2.08	2.34	2.33	1.46	2.29
Iceland	1.77	2.28	2.40	1.60	2.42
Ireland	2.20	1.96	2.38	1.57	2.36
Italy	2.33	2.27	2.31	1.73	2.13
Latvia	2.14	2.15	2.38	1.65	2.41
Lithuania	2.27	2.29	2.30	1.98	2.56
Luxembourg	1.90	2.03	2.31	1.63	2.42
Malta	2.12	2.17	2.17	1.82	2.38
Netherlands	2.50	2.38	2.26	2.20	2.32
Norway	2.27	2.25	2.36	1.56	2.55
Poland	2.12	2.35	2.33	1.92	2.29
Portugal	2.41	2.34	2.35	1.62	2.47
Romania	2.31	2.26	2.33	1.55	2.20
Slovak Rep.	2.02	2.27	2.39	1.39	1.98
Slovenia	2.36	2.47	2.30	1.84	2.32
Spain	2.43	2.44	2.43	1.84	2.51
Sweden	2.23	2.17	2.25	2.32	2.49
Switzerland	2.04	2.17	2.37	1.63	2.42
Turkey	2.27	2.05	2.15	1.61	2.36
UK	2.52	2.40	2.37	1.88	2.52

But [v]ery few health systems, even those that rate high on primary care, achieve high coordination of care

(Starfield et al. 2005)

# Deficiencies in care coordination are commonly reported by patients

Percentages of adults in eleven countries who reported having care coordination problems, 2016



# An initial focus on enhancing coordination for certain (priority) conditions...

Country	Name	Year implemented	Aim/general description	Target	Principal coordinator	Distribution
Austria	'Therapie Aktiv' diabetes disease management programme	2006	To improve the quality of life and	Diabetes type 2	DMP physician (General practitioner /family physician)	Implemented in 6 of 9 states; 2 states operate separate programmes, one of which is to be integrated into 'Therapie Aktiv'
Denmark	Regional disease management programmes	Ongoing since 2009	An interdisciplinary, intersectoral and coordinated effort using evidence-	Diabetes type 2, COPD, Depression, Asthma/COPD	DMP General practitioner	DMPs for most conditions implemented in several regions (Central Region, Southern Region, Zealand); anticipated that programmes will cover all targeted patients in the country
France	Sophia diabetes care programme	2008	To improve the quality of care and	Diabetes type 1 and 2, Diabetes type 2	General practitioner, in collaboration with nurse	Experimental phase targeted patients of 6,000 GPs (6.4% of all GPs) in 10 departments; expanded further in 2010 and nationwide in early 2013, has to date provided services to 226,000 patients (12.5% of the eligible population)
Germany	Disease management programmes	2003	Organisational approach to medical care that involves the coordinated	Diabetes type 1, Diabetes type 2, IHD, Heart failure	Physician	Offered by SHI funds across Germany; in 2010 there were ~2,000 DMPs for each condition; number of participants varies from 126,000 for breast cancer to 3.75 million for diabetes type II (2012)
Netherlands	Bundled payment contract ('care group')	2007	To facilitate multidisciplinary	Diabetes type 2, COPD, Vascular risk	General practitioner / care giver (defined by programme)	There were 97 care groups in March 2010 with bundled payment contract with a health insurer, mostly for diabetes care; there were relatively few care groups for the provision of vascular risk management



# ... giving way to broader primary care reforms seeking to enhance coordination and move care into the community

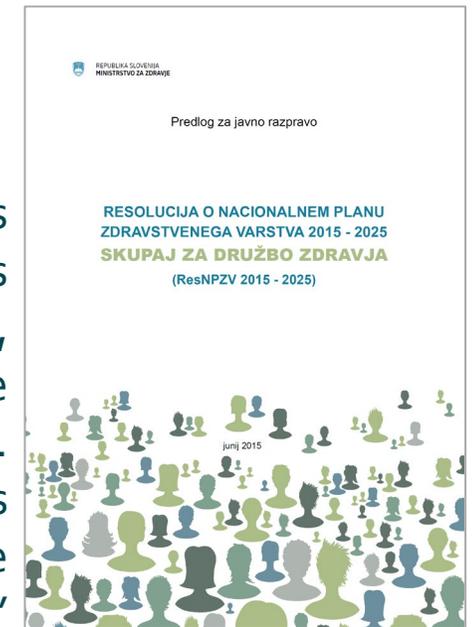


➤ **Austria:** Introducing multiprofessional and – disciplinary teams in a system that has no tradition of team working in the ambulatory care sector

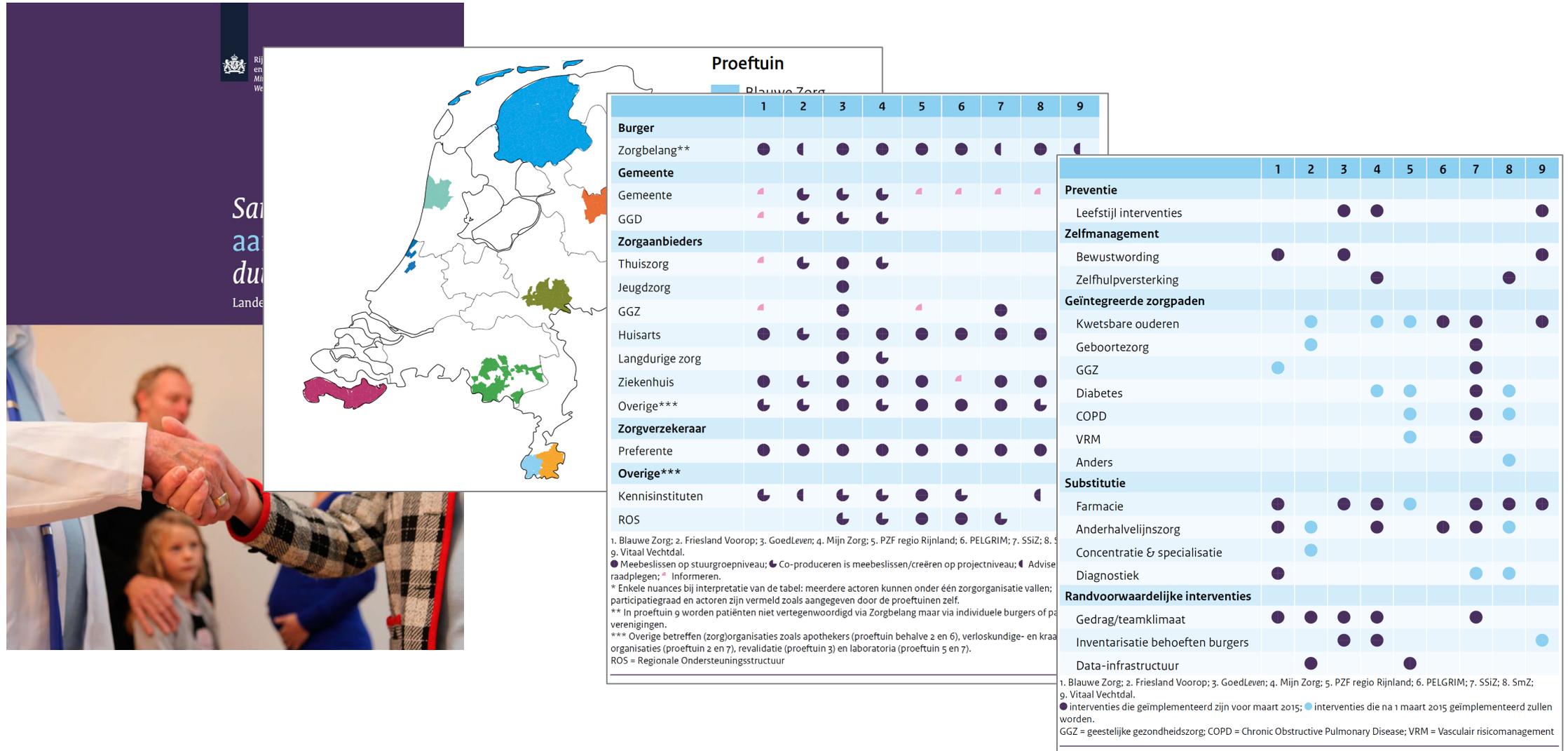


➤ **England:** “Our initial focus .. is on the people with the most complex needs... with GPs developing a proactive and personalised programme of care and support tailored to their needs and views – the Proactive Care Programme.”

➤ **Slovenia:** “We will improve access to health care ... with an emphasis on primary care, prevention, integrated - comprehensive treatment of the chronically ill ... that takes into account the needs of the population, including the needs of an ageing population.”



# Moving beyond single disease-focus: Population health management models



# Major NHS initiatives to transform and integrate health and social care services, 2009 to 2018

2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
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## Integrated care pilots (2009–2011)

16 pilots were supported by the Department of Health to test integrated care organisations proposed by the **NHS Next Stage Review 2008**. Most pilots tried to integrate services of similar types (for example, GP practices) rather than across services (for example, primary care and secondary care). NHS staff reported improved care processes but patients did not share the sense of improvement. The pilots did not reduce hospital activity.

## Funding transfer to local authorities (2011–2015)

2010 Spending Review transferred £2.7 billion from the NHS to local authorities over the four years to 2014-15, to promote better joined-up working.

## Integrated care pioneers (2013–2017)

25 sites were selected to develop and test new ways of joining health and social care services until 2019. The programme closed early in December 2017. The programme has a national support package with a budget of £3 million per year. Each pioneer proposed and developed its own model for a population of between 100,000 and 3,000,000 and received funding of around £50,000.

## The Better Care Fund (2015 onwards)

Implemented from 2015-16, the Better Care Fund is a pool budgeted from local authorities and clinical commissioning groups to help improve integrated care. In 2015-16, the NHS was required to ring-fence £3.46 billion for the Fund. Total pooled funding for 2015-16 and 2016-17 was £5.3 billion and £5.9 billion respectively. The Fund has incentivised local areas to work together but has not achieved its financial targets.

## Vanguards (2015–2018)

50 vanguards were selected by NHS England and £329 million was spent to develop and test the blueprints of five new models of care for the future of the NHS. The five new models were proposed by the **NHS Five Year Forward View** in 2014, aiming at joining up health and social care services. In 2017, the **Next Steps for NHS Five Year Forward View** proposed the development of **accountable care organisations** as one way of delivering population-based new care models developed through vanguards.

## Sustainability and transformation partnerships (STPs) (2016 onwards)

44 partnerships between NHS organisations and local authorities were created to improve health and care in the areas they serve. STPs focus on health systems and aim to keep the spending across the system within a set limit. They support new care models but do not replace new care models. In 2017, NHS England selected 10 more advanced STPs as integrated care systems.

2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
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## The NHS Long Term Plan

- £20.5 billion for the NHS for the next 5 years
- Integrated care systems to cover all of England by April 2021
- Establishment of new primary care networks aligned with expanded community multidisciplinary teams to lead to fully integrated community-based health care
- ....

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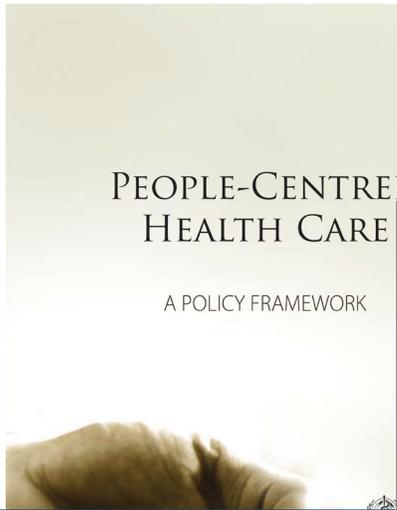
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#NHSLongTermPlan

www.longtermplan.nhs.uk





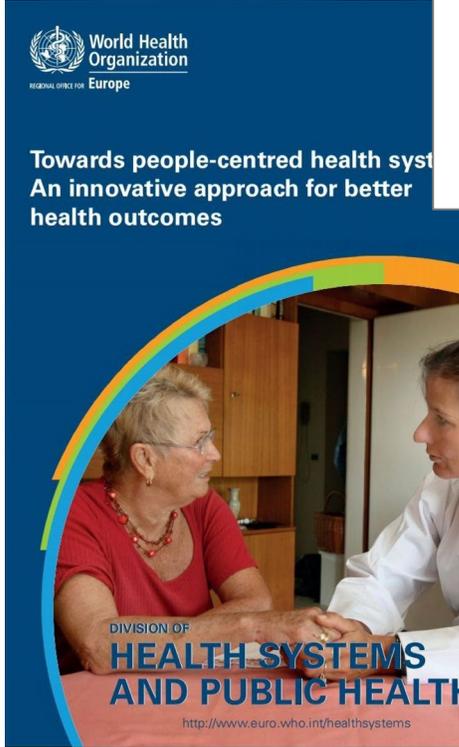
World Health Organization

SIXTY-NINTH WORLD HEALTH ASSEMBLY  
Provisional agenda item 16.1



Report 2012:3 (highlight report)

Patient-centeredness in Sweden's health system – an external assessment and six steps for progress



World Health Organization  
REGIONAL OFFICE FOR Europe

Towards people-centred health systems  
An innovative approach for better health outcomes

DIVISION OF  
HEALTH SYSTEMS  
AND PUBLIC HEALTH

<http://www.euro.who.int/healthsystems>

Framework on integrated, people-centred health services

NHS  
Primary Care



Putting patients and public first

Equity and...  
generating the  
NHS



PEOPLE  
at the  
CENTRE

OECD Policy Forum  
on the Future of Health

Ministerial Statement

THE NEXT GENERATION  
of HEALTH REFORMS

OECD Health Ministerial Meeting

17 January 2017

Reorienting health systems to become more people-centred

16 January 2017

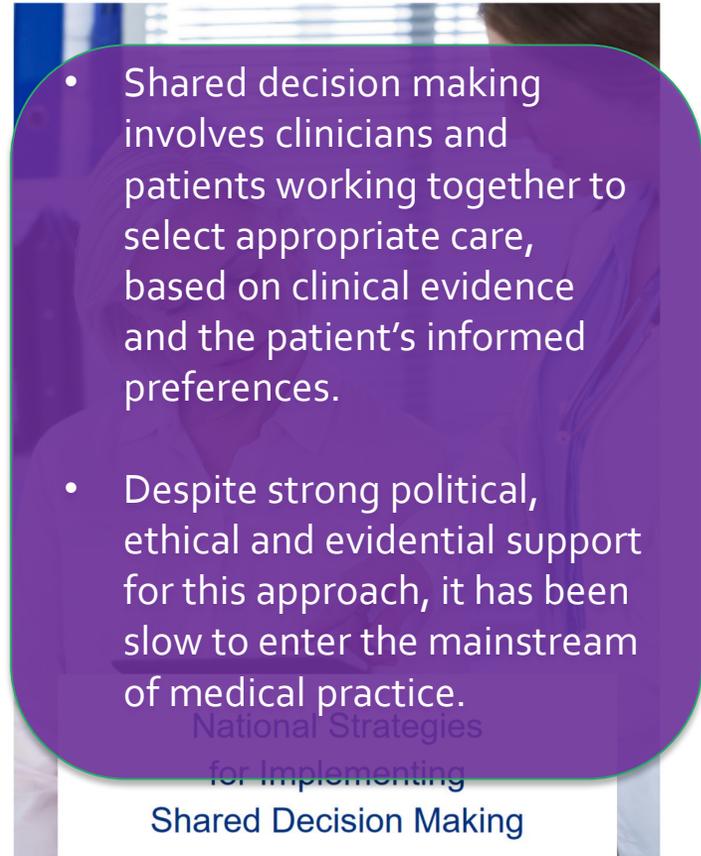


# WHO (2016): A people-centred approach is needed for...

- *Equity in access:* For everyone, everywhere to access the quality health services they need, when and where they need them.
- *Quality:* Safe, effective and timely care that responds to people's comprehensive needs and are of the highest possible standards.
- *Responsiveness and participation:* Care is coordinated around people's needs, respects their preferences, and allows for people's participation in health affairs.
- *Efficiency:* Ensuring that services are provided in the most cost-effective setting with the right balance between health promotion, prevention, and in- and-out patient care, avoiding duplication and waste of resources.
- *Resilience:* Strengthening the capacity of health actors, institutions and populations to prepare for, and effectively respond to, public health crises

# But what precisely is meant by patient-/person- or people-centred services and systems remains unclear

- 'Centredness' is often focused on better access to information
  - E.g. OECD Ministerial Statement on people-centred systems identifies
    - need for a fundamental change in how people interact with health services and health professionals
    - 'Big data' and increased access to more information about health broadens range of possible ways for people to manage their own health
- Tends to focus on the individual level where evidence tends to be stronger such as shared decision-making and self-management support
- Many strategies lack a clear formulation of the theoretical basis that would explain how activities will lead to anticipated outcomes
- Much of the evidence remains dominated by professional, organisational and policy-makers' perspectives

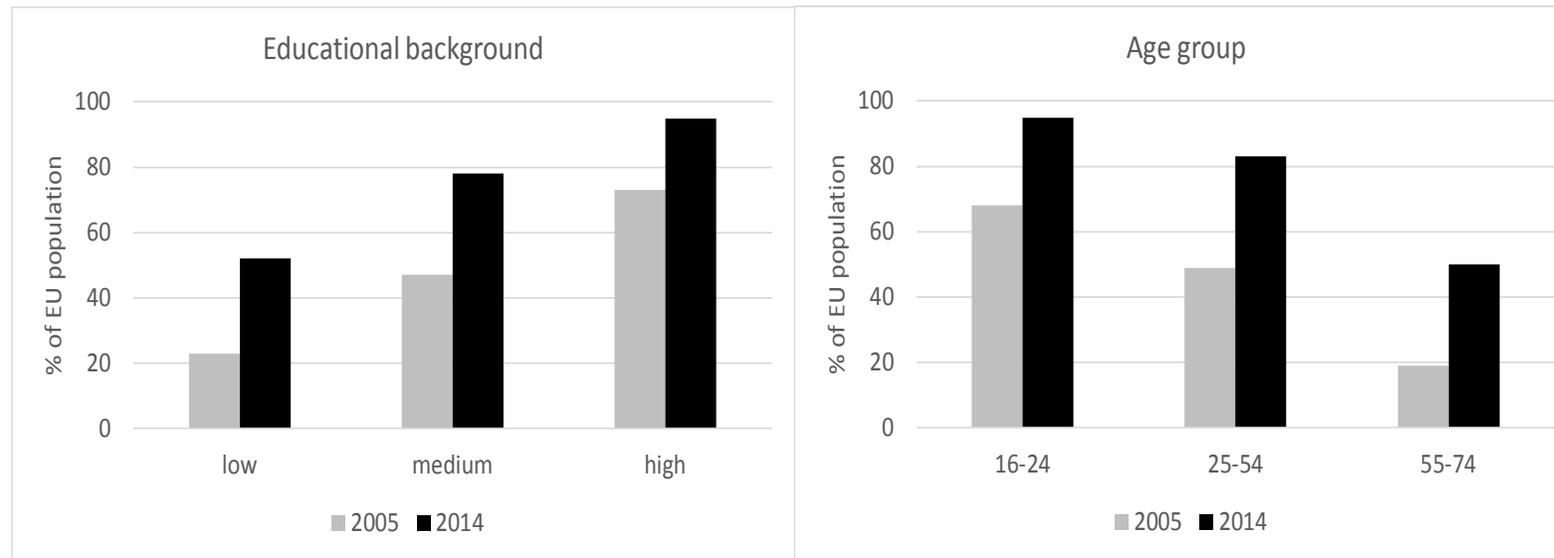
- 
- Shared decision making involves clinicians and patients working together to select appropriate care, based on clinical evidence and the patient's informed preferences.
  - Despite strong political, ethical and evidential support for this approach, it has been slow to enter the mainstream of medical practice.

National Strategies  
for Implementing  
Shared Decision Making

# Digital technologies (too?) often claimed to be the main route into person-centred health systems through strengthening empowerment

- continued digital divide: while principal access to the internet has increased across Europe, use (secondary divide) and comprehension of information on health (tertiary divide) varies across population groups

Regular internet use among EU citizens, 2005 and 2014



*Adapted from European Parliament (2015)*

# Multiple requirements for the workforce...

- Need to manage the transitions of service users between and within services
- Need to shift from a task-oriented approach towards integrated provision
  - necessitates broader range of skills and ability to demonstrate a more reflexive attitude in their work
  - ability to draw linkages and take a whole systems approach
- Need to coordinate among different practitioners
  - ability to work in multiprofessional teams and to communicate with other providers who have roles in managing coexisting conditions
- Shift from hospital-centred paradigm to one that values continuum of care by multiple organisations, including health and social care and community resources
  - ability to work in practice environment where traditional boundaries between organisations or occupational groups are blurred => new forms of working and delivering services

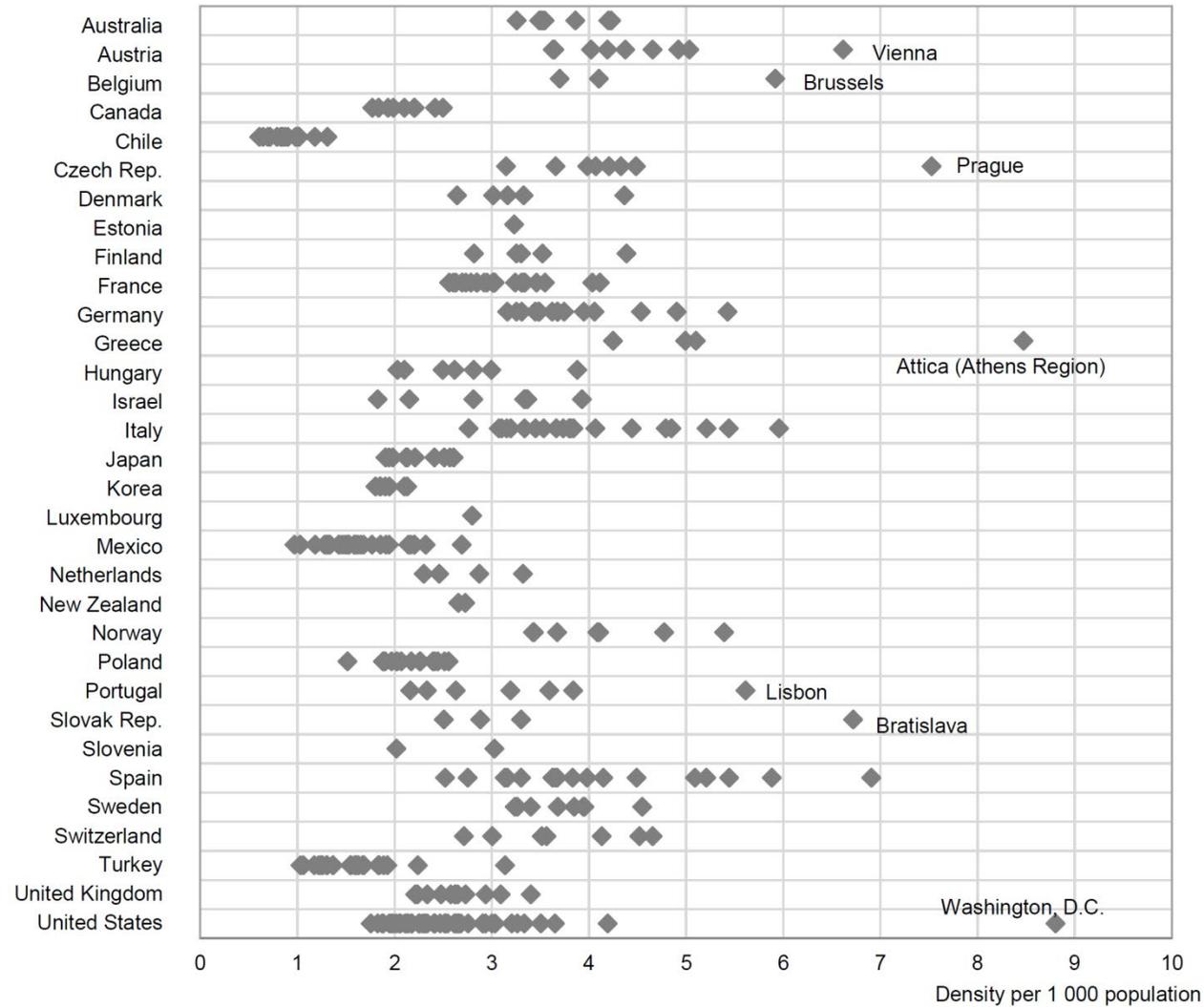
# ... and consideration of the implications

- Vertical (from more specialized highly skilled professionals to less-qualified, lower-cost workers) and horizontal task shifting or delegation (between disciplines, e.g. physiotherapists and occupational therapists)
  - need to consider the potential threats to professional identity and values
  - allow for appropriate training and strategies to alleviate fears
- Shift in decision making from paternalistic patient–provider relationships towards an ideal of a deliberative and partnering model that is more responsive to individual needs
  - need for professionals to develop new skills such as advising service users about recommended treatment, teaching healthcare skills, providing emotional and psychological support, among others
- Shift to population-based approaches
  - ability to manage populations, assess the health needs of wider groups and plan and implement appropriate levels of health and social care interventions
  - ability to work in community settings or in the social care or voluntary sector environments in order to reach the communities of defined populations

# Implementation challenges arising from creating new roles / types of provider

- How to overcome professional resistance?
  - nonmedical practice assistant in Germany
- Who pays for the new role and how?
- What regulatory requirements need to be put in place?
- How does workforce education and training have to be changed to accommodate the new role?
- If a new role is being introduced, what happens to those who previously carried out (some of) these tasks?
- What is the risk of introducing further fragmentation through (unintentionally) creating skills gaps?

# Regional variation in physician density in OECD countries, 2011



# Concerns about physician supply in 24 OECD countries

DAILY NEWS

[VIEW ALL NEWS](#)

## EUROPE – DEMAND FOR NURSING STAFF ON THE RISE, UK SEES BIGGEST SHORTAGE OF NURSES

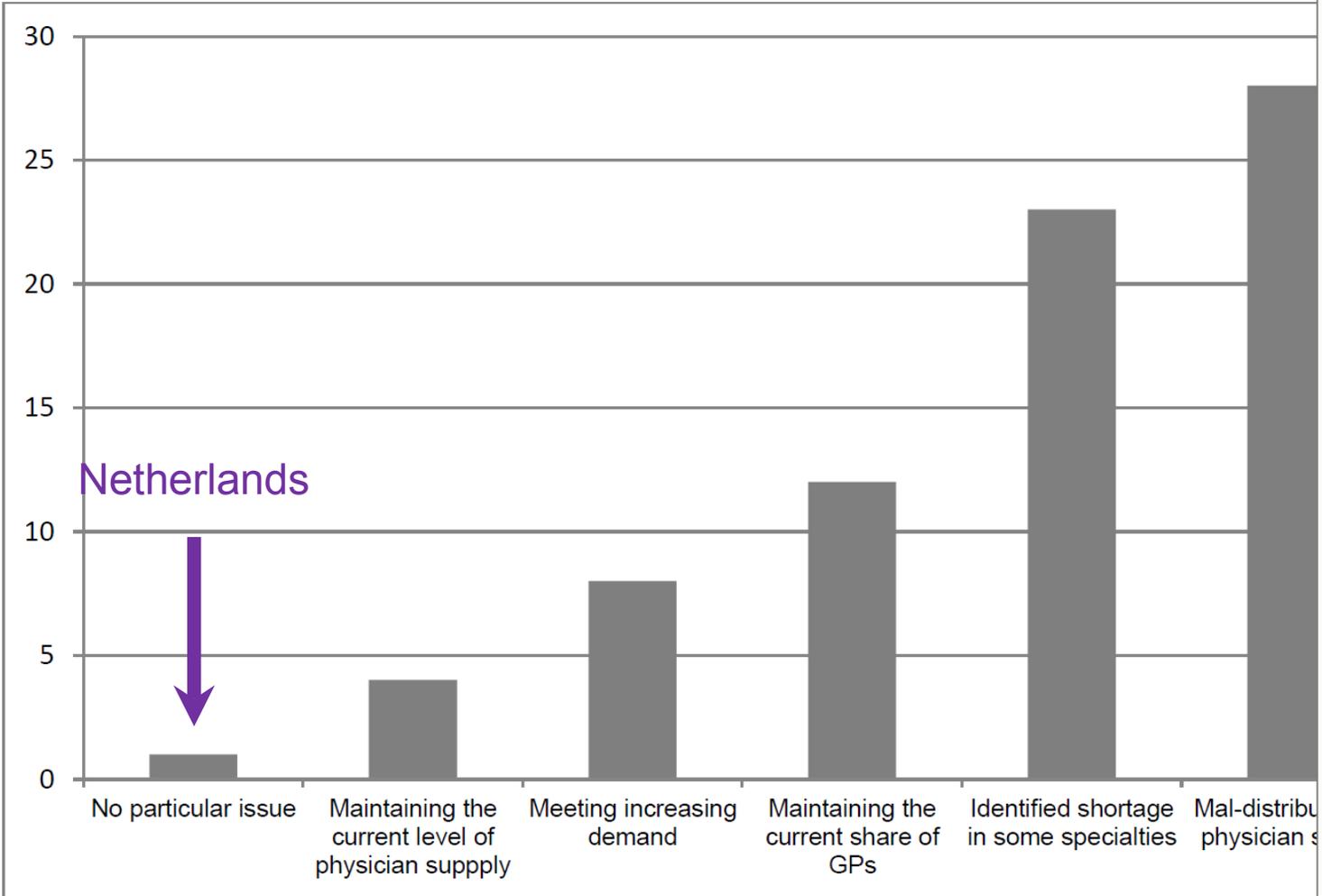
12 January 2018

The demand for nursing staff in European countries remains high with the number of job vacancies increasing for the UK, Netherlands, Germany, France and Belgium, from 2016 to 2017, according to data from Jobfeed.

The data showed that the UK has a shortage of nurses with 790 nurses per 100,000 inhabitants, the lowest number of the five countries surveyed. This is compared to 990 nurses per 100,000 inhabitants in France, 1,050 for the Netherlands, 1,080 for Belgium and 1,330 for Germany.

The UK also has the highest number of vacancies per 100,000 inhabitants with 520.

Further data from Jobfeed showed that the increase in nurse vacancies between 2015 and 2017 has risen for all five countries surveyed. Germany showed the biggest increase at 26.2%, followed by Belgium (18.0%), UK (17.2%), Netherlands (16.9%) and France (2.9%).



# Strengthening and enabling the redesign of services at the different tiers of the system (1)

## ➤ Investing in education and training

- delivery of person-centred care will require a new range of knowledge, skills and competences for professionals, managers and decision-makers
- understanding of how to develop the workforce to put person-centred approaches into practice remains patchy
- managers need to consider approaches of how to best support staff in implementing person-centred approaches
  - making relevant activities a priority
  - (cap)ability of organisations to do implement change against background of demands placed upon them by the wider system context
- wider policy framework needs to be alert to the potential tensions and unintended consequences of policies
- policy environment has to provide the means for those who are asked to implement change to acquire the actual capacity and competence to do so.

# Strengthening and enabling the redesign of services at the different tiers of the system (2)

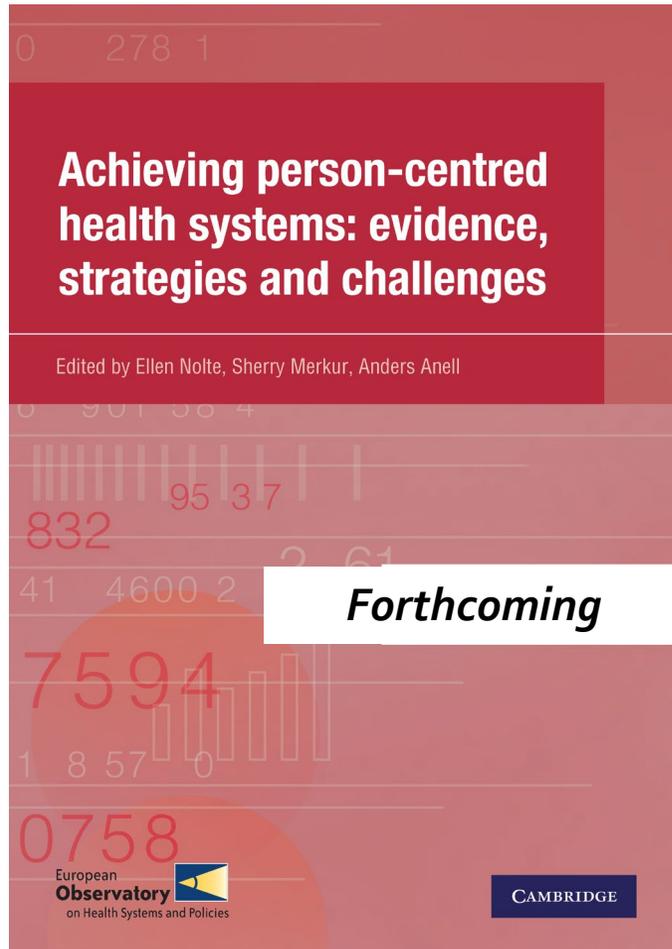
## ➤ **Measuring what matters to people**

- metrics of 'success' continue to be defined by providers and payers
- need for novel or adapted measures that recognise the role of the person at the centre
  - measurement across clinical pathways and service boundaries
  - development of broader indicators that better reflect service users' goals and outcome preferences
  - better measures of concepts such as empowerment, autonomy, care coordination and self-management capabilities
- need for service user and wider public input to ensure that we capture what matters to people

# Strengthening and enabling the redesign of services at the different tiers of the system (3)

## ➤ Health(care) system redesign

- much of the evidence on person-centredness focuses on the interpersonal level between the care provider and the individual service user
- identified levers for the implementation of person-centred care (*Liberati et al. 2015*)
  - committed senior leadership
  - engagement of staff, service users and the wider community at all levels
  - systematic measurement and feedback to continuously monitor people's experiences
  - culture supportive of change and learning
  - adequate policy framework ensuring clear incentives and lines of accountability that are supportive and aligned with the strategic vision of person-centredness
- careful consideration of incentive schemes
  - financial incentives for biomedical or clinical outcomes risk undermining valued aspects of the service user-provider relationship
- adequate resourcing of care delivery redesign is key
- systematic approach of exploration, evaluation and organisational learning an important lever towards real change



- Person-centredness has become a key priority for policy-makers nationally and internationally
- There is a wealth of experience across European countries to become more person-centred, but initiatives that are being undertaken tend to be disjointed and lack an overarching strategic approach
- The 'public' voice still remains pretty much absent in many of the local strategies that are being considered to achieve this
- This is a fundamental shortcoming and should be addressed by leaders at the organisational and system levels as a matter of priority

# Thank you for your attention!



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