Speaker

WHERE IS THE VALUE IN VALUE-BASED HEALTH CARE?

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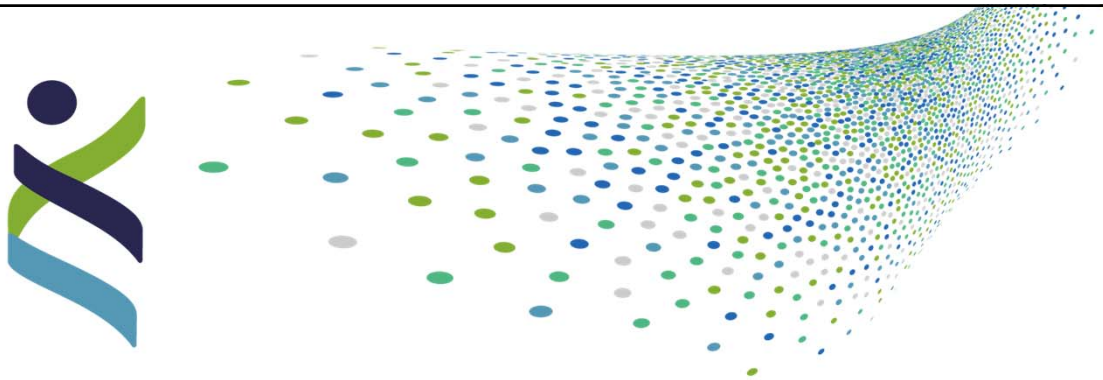


VBHC and sustainable, high-performing health systems

The policy perspective

Luke Slawomirski
ISPOR, Glasgow
November 2017

@LukeSlawomirski

OECD
BETTER POLICIES FOR BETTER LIVES

Value across a system

'Health' – 'Utility' – 'Well-being'

$$\textbf{Value}_{\textbf{(system)}} = \frac{\text{'Outcomes'}}{\text{'Costs'}}$$

Resources are and always will be scarce

Value across a system

INNOVATION

'Health' ~~Effective~~ 'Utility' ~~Timely~~ 'Well-being'

Safe

Equitable

People-centered

$$\textbf{Value}_{\textbf{(system)}} = \frac{\text{'Outcomes'}}{\text{'Costs'}}$$

Efficient

'External' costs

Inputs / expenditure
- *Technical efficiency*

Opportunity cost
- *allocative efficiency*

Patients/community often bear the cost

Value across a system

INNOVATION

Safe Effective Timely Equitable

People-centered

‘External’ costs

think climate change

Value = (system)

Quality

‘Costs’

Efficient

Inputs / expenditure

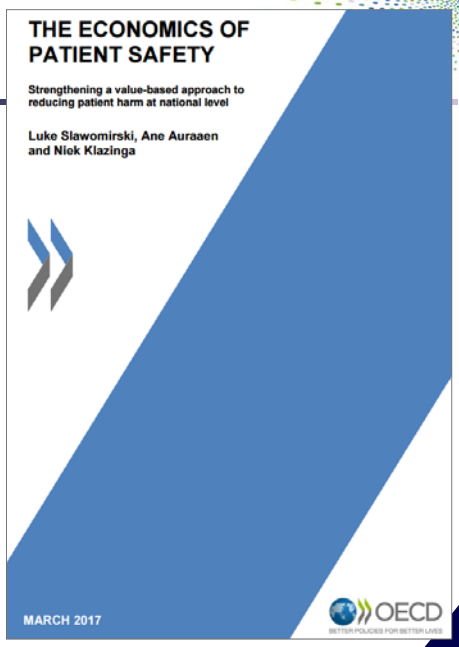
- Technical efficiency

Opportunity cost

- allocative efficiency

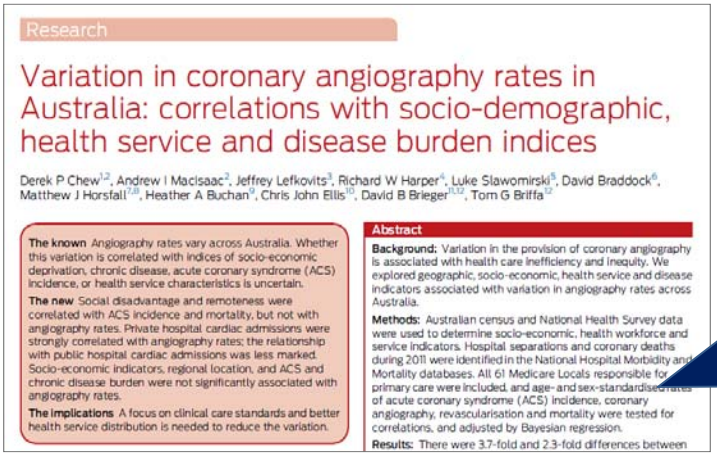
First, do no harm!

- Global BOD ~ TB or malaria
- Consumes 15% of acute care resources
- External costs: trillions
- Highly preventable (cheap)!



Source: www.oecd-ilibrary.org/social-issues-migration-health/the-economics-of-patient-safety_5a9858cd-en

More care where it's needed (and vice versa)



Research

Variation in coronary angiography rates in Australia: correlations with socio-demographic, health service and disease burden indices

Derek P Chew[1,2], Andrew I Macisaac[2], Jeffrey Lefkovits[3], Richard W Harper[4], Luke Slawomirski[5], David Braddock[6], Matthew J Horsfall[7,8], Heather A Buchan[9], Chris John Ellis[10], David B Brieger[11,12], Tom G Briffa[12]

The known Angiography rates vary across Australia. Whether this variation is correlated with indices of socio-economic deprivation, chronic disease, acute coronary syndrome (ACS) incidence, or health service characteristics is uncertain.

The new Social disadvantage and remoteness were correlated with ACS incidence and mortality, but not with angiography rates. Private hospital cardiac admissions were strongly correlated with angiography rates; the relationship with public hospital cardiac admissions was less marked. Socio-economic indicators, regional location, and ACS and chronic disease burden were not significantly associated with angiography rates.

The implications A focus on clinical care standards and better health service distribution is needed to reduce the variation.

Abstract

Background: Variation in the provision of coronary angiography is associated with health care inefficiency and inequity. We explored geographic, socio-economic, health service and disease indicators associated with variation in angiography rates across Australia.

Methods: Australian census and National Health Survey data were used to determine socio-economic, health workforce and service indicators. Hospital separations and coronary deaths during 2011 were identified in the National Hospital Morbidity and Mortality databases. All 61 Medicare Locals responsible for primary care were included, and age- and sex-standardised rates of acute coronary syndrome (ACS) incidence, coronary angiography, revascularisation and mortality were tested for correlations, and adjusted by Bayesian regression.

Results: There were 3.7-fold and 2.3-fold differences between

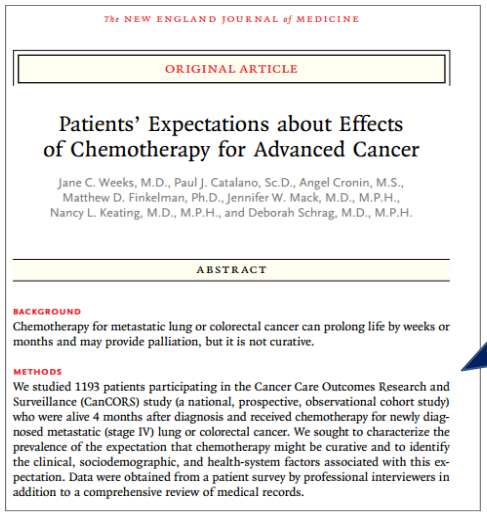
- **Social disadvantage** and **remoteness** correlated with health need **but not with angiography rates.**
- **Private health insurance** status strongly correlated with angiography rates.

Source : www.mja.com.au/journal/2016/205/3/variation-coronary-angiography-rates-australia-correlations-socio-demographic

Effects on populations, over time

What is the system value of curing hep-c in a patient?

Better communication



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Patients' Expectations about Effects of Chemotherapy for Advanced Cancer

Jane C. Weeks, M.D., Paul J. Catalano, Sc.D., Angel Cronin, M.S., Matthew D. Finkelman, Ph.D., Jennifer W. Mack, M.D., M.P.H., Nancy L. Keating, M.D., M.P.H., and Deborah Schrag, M.D., M.P.H.

ABSTRACT

BACKGROUND
Chemotherapy for metastatic lung or colorectal cancer can prolong life by weeks or months and may provide palliation, but it is not curative.

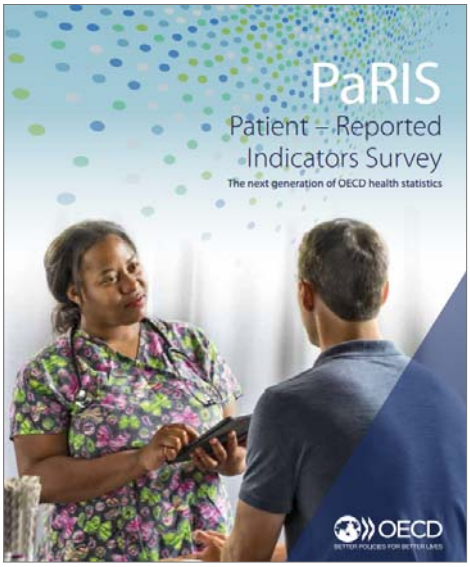
METHODS
We studied 1193 patients participating in the Cancer Care Outcomes Research and Surveillance (CanCORS) study (a national, prospective, observational cohort study) who were alive 4 months after diagnosis and received chemotherapy for newly diagnosed metastatic (stage IV) lung or colorectal cancer. We sought to characterize the prevalence of the expectation that chemotherapy might be curative and to identify the clinical, sociodemographic, and health-system factors associated with this expectation. Data were obtained from a patient survey by professional interviewers in addition to a comprehensive review of medical records.

"…**69%** lung cancer and **81%** colorectal cancer patients thought that chemotherapy could cure them.

….. compromise their ability to make informed treatment decisions aligned with their preferences."

Source : www.nejm.org/doi/full/10.1056/NEJMoa1204410#t=abstract

Measure what matters



- Outcomes valued by patients (generic, condition- and domain-specific PROMs)
- Experience of care (PREMs)
- Potentially, safety incidents (PRIMs)

http://www.oecd.org/health/paris.htm

Are we ready?

- Value is a way of **thinking**
- Care delivery ⇔ Research ⇔ HTA / pricing
- More information on **what matters to patients**.
- Upskilling, education, socialisation of **care teams**.
- **Incentives /signals** (embed value across institutions).
- Involve **patients** plus **citizens** and **communities.**

Thank you

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