Can Value Innovations Save Healthcare?

An aging population and burgeoning public debt mean the healthcare sector faces a huge economic and social challenge serving the public in the 21st century. Can we have it both better and cheaper? A report from the INSEAD Alumni Healthcare Summit in London.

In the wake of the financial crash of 2008 the healthcare sector is struggling more than most to adapt to new business challenges and move from short-term budget balancing to a longer term view. **Jacob West** is the director of strategy at Kings College Hospital in London. Founded in a poor part of London in the 19th century when their main challenge was treating infectious diseases, Kings is now an international centre of excellence. He believes the sector has been slow to adapt to the biggest challenge of the 21st century – the management of long-term chronic conditions in an aging population.

"It requires a very different kind of business model with different treatments. Investment needs to be arguably as much in prevention as in cure and needs a different paradigm than treatment of infectious diseases. Arguably healthcare systems haven't caught up with that long-term trend yet quite yet," West told INSEAD Knowledge in an interview at the INSEAD Alumni Healthcare Summit in London in October.

"Part of the change in the model must be looking at 'what is the role of the patient' and moving away from a model where you have a paternalistic doctor and a supine patient. Instead we must think of the patient as a partner and patients taking some responsibility for their wellbeing. Both doctors and patients need to focus on 'wellness' rather than just treating the symptons of the disease."

System Fatigue

Kings College Hospital has already gone some way towards remodelling itself as a hospital fit for the challenging world of doing more for less. "Kings gets 85 percent of its funding for patient care from the National Health Service (NHS). Historically there has been a limit on how much a hospital can earn through private patients. That restriction has now been relaxed through the new NHS reforms – so that's one real positive. We'll be able to earn more money through private and reinvest that in our core services."

Not all hospitals and local health providers, like general practitioners (GPs) will be able to follow the Kings model under the major overhaul of the health service that the U.K. government is currently pushing through. "I think people have got system fatigue," says West. "The NHS has seen a lot of change in recent years. People find it quite hard frankly to follow what all these changes might mean. To some extent the reforms, on the ground, feel like a bit a sideshow compared to the financial pressures on healthcare systems globally."

For most of the U.K.'s GPs, the impact of the controversial Health and Social Security Bill represents the biggest shake up in the NHS for many years. It will abolish Primary Care Trusts, which currently control 80 percent the NHS budget, and will give nominal control of local budgets to local clinical commissioning groups (CCGs) partly run by GPs. Six thousand NHS services are also up for tender to the private and third sector – such as voluntary and community services – including diabetes education, glaucoma treatment, abortion clinics and minor oral surgery.

Politically-driven change ends in misery and failure

While GPs welcome gaining more control of the primary care pathways and where healthcare budgets are spent, the majority of GPs are against the reform because they believe that the profit motive will replace patient care in the system. According to some GPs, the new contract they will have to sign in March 2013 has not even been agreed.

Even the normally diplomatic head of the NHS, **Sir David Nicholson** has said: "My advice to anyone – and I have been involved in the last five or six years with the national programme for IT, and I have, as they say, the scars on the back around all of that – is that big, high-profile, politically-driven objectives and changes like this almost always end in misery and failure."

Elsewhere in Europe one private company is offering a new model which might be of interest to beleaguered GPs running CCGs. **Ville Öhman** is the CEO of Laastari Lähiklinikka – it means "bandage" in Finnish – and he is rolling out "retail clinics" in Scandinavian shopping centres and pharmacies and now has his sights set on Germany, Holland, France and the U.K.

Retail Clinics – a new way forward?

His seven-day-a-week clinics are run by nurse practitioners, many of whom can prescribe for certain conditions – unlike the U.K. – and patients pay a flat fee of €45 per visit which covers all tests, treatments and prescriptions. They only treat 13 common acute conditions – strep throat, flu, ear infections etc – but this still represent 50 percent of cases presented to local doctors.

"This is the first time we've seen drastic innovation in delivery of primary care paths. We have a video and an IT platform system so that the nurse at the clinic does all the examinations and the tests according to the medical best practice guidelines following a check list built on every illness." Tests records can then be sent to a physician remotely. So a physician gets diagnostic data sets from different clinics. "This is a way to allocate physician time in a very, very efficient way."

While Laastari Lähiklinikka's retail clinics are providing a small scale model for balancing value against cost for individual patients, in the U.K. the National Institute for Health and Clinical Excellence, NICE, has been trying to square the national value/cost circle since 1999. A semi-detached arm of the NHS, NICE, was set up to standardise care across the NHS to avoid the problem of postcode lotteries whereby new drugs were available in certain parts of the country and not in others.

Assessing quality of care

Critics of NICE suggest that the funding mandates they pass down to local providers focus too much on value for money rather value to the patient. NICE deputy CEO, **Gillian Leng**, disagrees. "When we look at anything new and we are doing a cost-effective analysis we look at the outcomes for patients. Generally we apply the QALY assessment which stands for Quality-Adjusted Life Years, we look at quality of life compared with length of life and we assess the amount of money that's required to fund that and compare it with the current treatments."

But NICE is having to adapt to the new, more business-like health landscape, by managing the challenge between new technology and the funding as well as take a more holistic approach to regulating health services. "We're expanding the kind of work that we do. We have focused a lot on healthcare from 2013 onwards when we're also going to use the same kind of approach to look at delivering more supportive care services."

One of the challenges for NICE is an aging population, which is forcing a change in the management of the healthcare business model. "There's a significant proportion of patients in their eighties who have eight conditions or more and the complexity of managing those conditions is a challenge that countries will recognise. NICE is actively looking at that."

Andrea Ponti, who leads the healthcare investment banking practice at JP Morgan, is more bullish on the prospects for the future despite predicting flat growth in health spending globally. "There's a lot of very exciting changes in healthcare. The diagnostic industry is discovering more ways to help the pharmaceutical industry and deliver the right therapies to the right patients. There's a huge amount of change and with that change comes opportunities to make money and improve health provision."

Nurturing new health sectors

He predicts certain sectors like diagnostics and biotechnology will continue to drive innovation. "In the hospitals you see a whole new sector growing in the emerging markets like India, China and the Far East. Hospital chains are going to provide for the local populations in a way that they have never been provided for in the past."

But for Kings College Hospital's Jacob West, demographics is the biggest challenge for healthcare. "On the one hand, we have to balance the pressures of public funding and, on the other hand, balance the increase in demand driven by aging population demographics, epidemiology and inflation-busting rising costs which together create a wicked triangle. And that's the hardest thing for any healthcare system to cope with."

EVENT DETAILS:
The 2012 INSEAD Alumni Healthcare summit took place in London on 4-5 October.

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https://knowledge.insead.edu/responsibility/can-value-innovations-save-healthcare-2355