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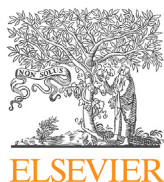

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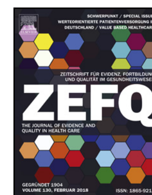

Special Issue / Schwerpunkt

Shifting to triple value healthcare: Reflections from England

Vorschlag zur Neuausrichtung der Gesundheitsversorgung: „TRIPLE VALUE". Reflexionen aus England

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ABSTRACT

Increasing need and demand because of growing and aging populations combined with stagnant or decreasing resources being invested into healthcare globally mean that a radical shift is needed to ensure that healthcare systems can meet current and future challenges. Quality-, safety- and efficiency-improvement approaches have been used as means to address many problems in healthcare and while they are essential and necessary, they are not sufficient to meet our current challenges. To build resilient and sustainable healthcare systems, we need a shift to focus on triple value healthcare, which will help healthcare professionals improve outcomes at the process, patient and population levels while also optimising resource utilisation. Here we present a brief history of the Quality and Evidence-based Healthcare model and then describe how value emerged as a predominant theme in England. We then highlight the four solutions that we, as part of the RightCare programme, designed and refined in the English NHS to turn theory into practice:

- Triple Value Healthcare
- Culture Change, Accountability and Stewardship
- Systems, Networks and Pathways
- Using knowledge and technology as enablers

We end with a description of how triple value is being introduced into Germany and steps that can be taken to facilitate its adoption.

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ZUSAMMENFASSUNG

Die Gesundheitssysteme müssen sich angesichts des demografischen Wandels (steigende Bevölkerungszahlen, immer mehr ältere Menschen) und gleichzeitig knapper werdenden Ressourcen, die in die Systeme investiert werden, radikal neu ausrichten. Bisher wurden Qualitäts-, Sicherheits- und Effizienzsteigerungsansätze als Mittel zur Bewältigung vieler Probleme im Gesundheitswesen eingesetzt. Obwohl diese Ansätze notwendig sind, reichen sie nicht aus, um aktuelle und künftige Herausforderungen zu bewältigen. Um widerstandsfähige und nachhaltige Gesundheitssysteme aufzubauen, braucht es eine Versorgung, die sich auf drei Ebenen werteorientiert ausrichtet: Verteilungs-, Angemessenheits- und persönlicher Wert („Triple Value"). Eine an diesen Werten orientierte Versorgung hilft den im Gesundheitswesen tätigen Fachberufen, die Ergebnisse auf Prozess-, Patienten- und Bevölkerungsebene zu verbessern. Gleichzeitig wird der Ressourceneinsatz optimiert. Im Folgenden beschreiben wir kurz die Entwicklung vom qualitäts- und evidenzbasierten Ansatz hin zum Ansatz der werteorientierten

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Gesundheitsversorgung. Es werden vier Lösungswege aufgezeigt, die den Transfer von der Theorie in die Praxis im Rahmen des englischen „NHS-RightCare-Programmes" skizzieren. Die Lösungsansätze lassen sich mit folgenden Stichworten überschreiben:
- „Triple Value"-Gesundheitsversorgung
- Kulturwandel, Verantwortlichkeit und kluge Führung
- Systeme, Netzwerke, und Pfade
- Wissen und Technologie als Impulsgeber

Introduction: Why value?

Many countries have decided to stop the growth of investment in healthcare or at least slow the growth despite need and demand continuing to increase. These decisions were exacerbated by the 2008 global financial collapse, though Germany has been addressing these issues even before that – take, for example, the Rürup Commission's goal of reducing healthcare expenditure by billions of euros in 2003 [1]. In England, the 2008 global financial collapse drove the then Chief Executive of the English National Health Service (NHS), David Nicholson, to issue the Nicholson Challenge which called for £20 billion in savings by 2014–2015 [2].

Setting aside the financial challenges, even if money were not a problem, growing concern about overdiagnosis and overtreatment is also raising the issue of value. The Choosing Wisely campaign [3] and the BMJ's campaign on Too Much Medicine and Over Diagnosis [4] highlight these issues and raise the importance of thinking of value as well as evidence based decision making and quality.

In response to these challenges, one of the authors, Sir Muir Gray, co-established the NHS England RightCare programme in 2010, which aimed [2,5]:

> *To increase value and address unwarranted variations in spend, activity and outcomes through: using programme budgeting and marginal analysis to improve clinical commissioning; better value commissioning with knowledge, information and coaching; reducing the use of lower value interventions; reducing unwarranted variation in referral rates to elective care; and improving patient satisfaction and reducing the costs of treatment, by involving patients in shared decision-making.*

RightCare represented a shift in the care delivery models used previously, as highlighted in the table below:

Quality & Evidence-based Model	Triple Value Healthcare Model
The Aim is on effectiveness, quality and safety outcomes	The Aim is **triple value** & **greater equity** • Allocative value, determined by how the assets are distributed to different sub groups in the population • Technical value, determined by how well resources are used for all the people in need in the population • Personalised value, determined by how well the decisions relate to the values of each individual
Good service for known patients	**Personalised** service for **all the people affected in the population**
Improvement through competition	Improvement through collaborative **systems and networks** with patients & carers as equal partners
Transformation attempted by reorganisation & more money	Transformation by **culture change** & **digital knowledge services**
Clinicians act as the users of their institution's resources	Clinicians feel they are the **stewards** of the population's resources

The Triple Value Healthcare model has been in use in England since 2010 via the English NHS' RightCare programme, the longest running and most deeply embedded national programme focused on value based healthcare that the authors are aware of, and this new model is also being used in Wales (Prudent Healthcare [6]), Scotland (Realistic medicine [7]) and Saudi Arabia (Model of Care programme).

In this manuscript, we briefly highlight the history of the Quality and Evidence-based Healthcare model and then describe how value emerged as a predominant theme in England. We then highlight the four solutions that we, as part of the RightCare programme, designed and refined in the English NHS to turn theory into practice:

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Quality and Evidence-based Healthcare

The Zeitschrift für Evidenz, Fortbildung und Qualität epitomises the revolution not only of medical journals, but of professions in the last century. Journals started as places for recording scientific research and then they saw their task as contributing to continuing medical education producing material that physicians could use to maintain their knowledge and skills and improve them.

The introduction of quality in healthcare and the development of a new model of care in which doctors had to work within certain constraints and guidelines is fifty years old and this year marks the fiftieth anniversary of Avedis Donabedian's classic article in the Millbank Quarterly [8], generally regarded as the article that launched quality assurance. In many countries, however, little was done until a number of reports were produced that emphasised the importance of quality of healthcare. For example, the Institute of Medicine in Washington came two reports, one called *Causing the Quality Chasm* [9] and the second, focusing primarily on safety, *To Err Is Human* [10]. In the United Kingdom, the stimulus came from a report called *An organisation with a memory* [11] emphasising the need for organisations to become learning organisations.

The development of evidence based decision making is also about twenty years old. This origin can be traced to the development of the McMaster Medical School and the publication in 1986 of the landmark text called *Clinical Epidemiology*, subtitled *A basic science for clinical practice* [12].

In the 1990's the McMaster Faculty decided that although they had got clinical epidemiology on the curriculum it still sounded too academic, and they developed a style of clinical

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