

# Right Care

A series of papers for the NHS  
by Sir Muir Gray

*1. How to get better value by doing the right things*

## **HOW TO GET BETTER VALUE BY DOING THE RIGHT THINGS**

The value derived from a health service is assessed subjectively. Clinicians may assess value differently from commissioners or managers or patients, and individual patients assess value differently and make different treatment choices on the same evidence.

Common to all assessments of value is the balance between benefit, harm, or the probability of benefit and the probability of harm, and cost.

Value may be increased in two ways. One way is by improving the quality of care, by increasing productivity, safety and patient experience. However, doing things better, safer and cheaper is only one means of increasing value; the other is by making decisions to choose the options that maximise value, and this too is relevant to patients, clinicians, managers and commissioners. Quality improvement requires better actions; value improvement requires both quality improvement and better decisions.

### **Types of low value healthcare**

A number of different types of low value healthcare can be identified:

- interventions where there is proof of ineffectiveness or harm, for example prostate cancer screening;
- interventions where there is no evidence of effectiveness, except when these interventions are being offered in the context of high quality research, for example transcatheter aortic valve implantation;
- interventions which the patient would not have accepted had they been given clear and unbiased information about the probabilities of benefit and harm, for example cataract operation for people with minimal visual loss, or knee replacement surgery for people with loss of function and levels of pain which are not severe, or over-prescribing for very elderly people with Alzheimer's disease (the mean number of drugs for people in old people's homes is eight);
- interventions which produce less value than another intervention that could be offered to a patient with the same condition, for example the inappropriate prescription of domiciliary oxygen for patients compared with the use of the same amount of resources to provide rehabilitation therapy for people with chronic obstructive pulmonary disease;
- interventions which produce less value than the same amount of resources would produce if used to provide a service to patients with another disease within the same programme budget, for example cataract operations for people with minimal visual impairment when the same resources could be used to treat people with diabetic retinopathy or macular degeneration.

It is important to emphasise that, with the exception of the first type of problem, the clinicians may be unaware that they are using resources in a way that does not produce

high value, and it is only when the performance of a clinician or a service is compared with the performance of others, or when some objective measure of need is employed such as the Oxford Hip Score when assessing the probability that a person will benefit from hip replacement, that the situation becomes clear.

## **Increasing value**

Increasing value means that the resources available for healthcare, whether measured in terms of pounds or tonnes of carbon or hours of clinician and patient time, achieve more health benefit and less harm. In a time in which resources are limited, increasing value also offers the opportunity of releasing cash without adversely affecting the health of the population. Indeed, it has been argued that value can be increased and cash released while improving the health of the population at the same time.

## **Three routes to value improvement**

In addition to the contribution that quality improvement makes to increasing value, there are three types of decision that increase value:

- evidence-based decision-making by commissioners;
- clinical decisions by patients and clinicians that ensure that individuals received appropriate and personalised care;
- programme management decisions by professional groups and patients' representatives that ensure all the resources available within a system, for example the rheumatoid arthritis system or programme, the long-term conditions programme or children's health programme, are used for high value activities and not for lower value activities.

## ***Evidence-based decision-making***

Best current evidence is now well summarised and clearly presented through NHS Evidence. However, the availability of evidence does not ensure its use and steps need to be taken to ensure that all decision-makers, particularly commissioners:

- stop low value interventions from starting; this may include a drift into use of an intervention shown to be of high value for one group of patients which then becomes applied to another group of patients for which there is no strong evidence of added value;
- stop or decommission interventions of low or negative value, for example hernia repair operations in people with symptomless inguinal hernia performed with the objective of preventing bowel obstruction but with no evidence of beneficial effects and strong evidence of harmful effects;
- start high value interventions quickly and consistently across the NHS, for example interventions to reduce the risk of venous thrombosis or interventions to identify and treat people with familial hypercholesterolaemia.

There is one other aspect of evidence-based decision-making which requires separate attention and that is the way in which evidence is managed within the NHS. The work of the Public Health Commissioning Network has revealed two serious problems in the management of evidence:

- massive unknowing duplication of effort with inconsistent results; all over the country Primary Care Trusts are unknowingly carrying out assessments of the same piece of evidence or the same piece of technology;
- failure of any single PCT to get to grips with the evidence, both research evidence and evidence from experience, for common serious problems such as epilepsy or rheumatoid arthritis or thyroid disease or headache.

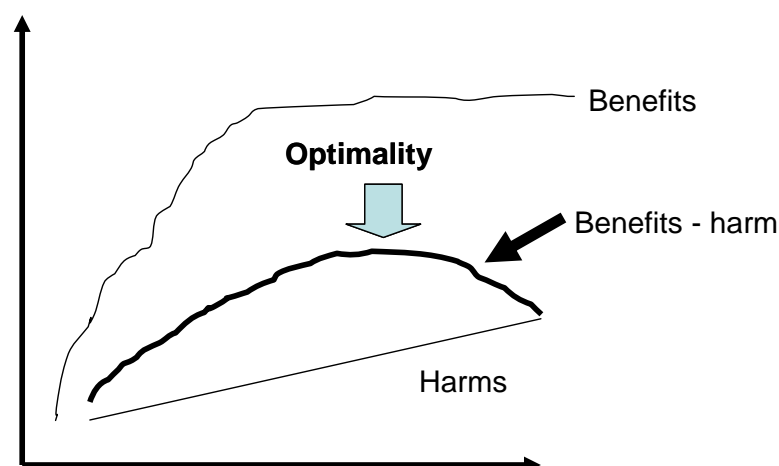
### ***Personalised appropriate care***

The demand for healthcare is often said to be limitless. What is clear now is that informed demand for healthcare is not without limits. By giving people full information about the appropriate contribution that modern healthcare can make to their health and wellbeing, patients are able to make decisions about whether or not to have an intervention, based not only on evidence but also on their unique clinical condition and values.

The early studies of Jack Wennberg and colleagues, demonstrating variations in the delivery of health services greater than could be explained by differences in prevalence of disease or excessive capacity, led them to the conclusion that informed medical decision-making was not only a moral imperative, it was also an economic imperative because the promotion of appropriate care reduced healthcare costs.

Unlike many services, healthcare has a significant potential to cause harm, including death, as well as providing benefit. As the amount of service delivered to a population increases, the unit of increase in benefit resulting from the unit of increase in supply diminishes – the law of diminishing returns. The amount of harm done, however, rises in direct proportion to the amount of care provided, and therefore when there has been a significant increase in investment, the balance of benefit to harm changes, and it may pass a point, called the point of optimality by Avedis Donabedian, where further increase in investment reduces the value to the population (Figure 1).

After a certain level of investment the health gain may start to decline



It is on the right-hand side of the curve shown in Figure 1 where personalised decision-making is particularly important because, as the resources increase, people who are less severely affected, and therefore stand a smaller probability of benefit, are offered treatments which were formerly only offered to those severely affected by the condition. The achievement of personalised appropriate care which is beneficial for individual patients and the population requires:

- patient decision aids to give unbiased information and to help the patient reflect on their values;
- clinicians trained not only to communicate risks and benefits clearly but also able to identify the patient's preferred style of decision-making and adapt accordingly;
- objective measures of symptom severity which can help the patient and clinician assess the likelihood and magnitude of benefit;
- standardised procedures to analyse variation in service provision, for example cataract extraction rates.

### ***Better value programmes and systems***

A system is a set of activities with a common set of objectives and a feedback loop. Systems can exist for presentations like pelvic pain or chest pain or the first seizure in a child. They can also exist for conditions such as rheumatoid arthritis or epilepsy. A programme is a set of systems with a common knowledge base and a common budget. A musculoskeletal programme, for example, would have within it systems for joint pain assessment, rheumatoid arthritis, osteoarthritis and osteoporosis. Programmes also focus on population groups such as elderly people with multiple diagnoses.

The management of health services through programmes and their component systems engages those who commit the resources, clinicians and patients and patients' representatives, in decisions about relative value. For any programme or system wishing to introduce a new technology or some innovation to improve quality, the first source of finance in future will be from within the relevant system in the first instance and, if those responsible for the programme budget are assured that the system is working as efficiently as it can, from one of the other systems budgets within that programme. For example, to develop resources for diabetic retinopathy treatment a decision could be made to switch resources from the cataract programme if it were felt that the population of people at risk of visual failure gained more value that way.

Commissioners would need to take a lead in opening up the debate which at present focuses principally on institutional budgets and the relationships between primary, secondary and tertiary care. Value analysis requires:

- the presentation of budgets focused on programmes, not institutions;
- the skill to perform marginal analysis within a single programme budget, the Mental Health Programme budget, for example;
- the skills to carry out marginal analysis between programme budgets, between the budget for children and the budget for older people, for example;

- the commitment and skill to engage the population served in these analyses and debates.

## Organisational and professional development

At present the health service, a complex organisation, is managed in a number of different ways. One way is through choice, and the leverage of the split between commissioning and providing. Consumer voice is also increasingly influential and a third force is the performance management system. All of these have, and will continue to have, a contribution to make but to maximise value a number of changes are needed in style. The principal change is a move away from confrontational relationship between those who invest in health service (the commissioners) and those who provide health services (managers and clinicians) to one that is collaborative. Of particular importance is the involvement of clinicians and patient organisations in programme and systems development.

What is needed are the following developments:

- PCT co-operation, for example co-operation between PCTs and a health economy so that the PCTs and the providing organisations who deliver most of the care to a particular economy, such as Leicestershire or North Central London or Greater Manchester, form networks. SHAs and PCTs also need to specialise and share to a much greater degree, for example with each SHA taking a national lead on two or three programmes and each PCT taking a lead on one particular system with a willingness to share the work done on programmes and systems to all other SHAs and PCTs;
- the primary focus of the health economy should not be on the relationship between primary and secondary care but on the programme budgets for the population served, with the responsibility for analysing variation in the levels of service provided to identify inappropriate care;
- joint development of both provider staff, particularly clinicians responsible for management, and commissioners, so that both sets of professionals understand low value; not only the primary preoccupation of those delivering services, which is with quality, technical efficiency and patient experience, but also the additional focus of those people responsible for allocating resources to populations is on value, allocative efficiency and equity;
- a style of working that uses the powers of the internal market and command and control for implementation but relies on open networks, including citizens and patients as full partners, which create innovative solutions. Such creative networks, sometimes called complex adaptive systems, occupy the space between bureaucratic organisations and professional associations and use both face-to-face and Internet communication to analyse and solve the wicked problems we face.

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