triple. vision

The NHS five-year vision will help the health service rise to the challenges of an ageing population with complex healthcare needs, US health improvement expert Don Berwick told recent HFMA conferences. Seamus Ward reports

The *Five-year forward view* (FYFV) is a 'terrific' strategy that aims to redesign services to meet the changing needs of the population, US healthcare guru Don Berwick told chief executives at the HFMA CEO Forum in January.

He said the strategy would strike a chord across developed and some developing economies. Health systems faced caring for ageing populations living with more complex healthcare needs. But in the US and the UK, as well as places like Singapore, the healthcare architecture – buildings and services offered – were not in the right place to meet the need, particularly for chronic illnesses.

Professor Berwick, who helped found the US Institute for Healthcare Improvement (IHI), said the institute believed healthcare should be designed around the triple aim (see diagram).

The first aim is improving the patient experience of care, through factors such as improved safety, effectiveness, efficiency and equity. The second aim is to react to the causes of ill health through population health-based programmes, such as better nutrition, increased physical activity and tackling poverty and violence. The third element is the reduction of per capita cost – continuously improving the design of systems so there were fewer and fewer processes.

'Many organisations might start from the assumption that there is a tension here; that cost and quality go in the opposite direction; that if you want to save money you have to give up health and care,' he said. 'But in manufacturing they have come to the position where it is legitimate to design and redesign to improve quality. Better care, better health, lower cost.'

The FYFV was a triple aim strategy, he said. 'The document speaks a lot about improving care, but also strongly – and thrillingly – it talks about population health. It's terrific in its interventional scope and especially in terms of prevention, it has tremendous potential.'

He set out 10 design concepts for the triple aim system that could be at the heart of the FYFV. 'The old system is based on the patient coming to see the doctor, but the new system moves knowledge, not people. The old system asks, "What's the matter with you?" but the new system asks, "What matters to you?". While the old system uses professional capacities, the new system uses all the skills and resources in the community.'

Other elements of the new system included more care outside hospitals; individualisation of care; and the value of a team-based approach against the increasing specialisation of the old system. He added: 'The old system is about fixing things that went wrong, but the five-year vision is about putting wellbeing in the core agenda.'

Key questions

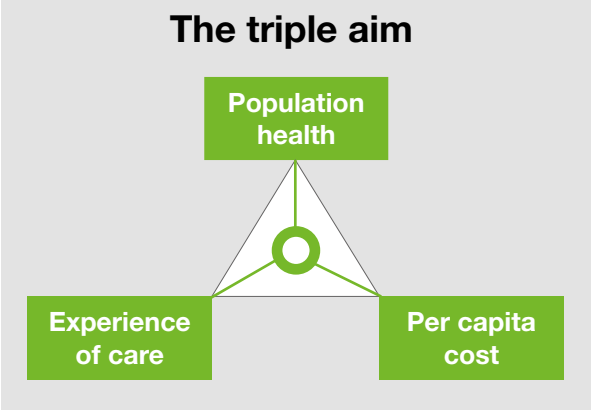
He believed the strategy raised four questions that must be addressed by NHS leaders, including chief executives:

- Do they believe in this aim?
- If so, do they believe it is possible? 'This belief will have to come from the executives and governors. Your workforce will not believe in this any more strongly than you do,' he told the conference.
- How will it be implemented?
- What can they, as leaders, do to contribute to this?

Professor Berwick told *Healthcare Finance* the shift to outcomes-based thinking was crucial. 'I was always amazed that the standards of efficiency were input-based. I don't understand that, as the true standard of efficiency has to include the product. One consideration we need is to make sure we understand the total cost, because if the definition of costs is too narrow, we may miss things that should be included.'

He said healthcare in the US was underperforming compared with the UK system. Professor Berwick, speaking to finance directors at a separate meeting, said its cost base was rising with per capita spending about twice that in England – and rising.

He did not have data for England, but based on his experience of working in the UK since 1995, his impression was



"FYFV speaks a lot about improving care, but also strongly – and thrillingly – it talks about population health. I think it's terrific in its interventional scope and especially in terms of prevention, it has tremendous potential"
Don Berwick

that the levels of non-value-added activity was high. In the US, there were six theoretical categories, or wedges, of waste – overtreatment; failure to co-ordinate care; failures in care delivery; excess administration costs; excessive healthcare prices; and fraud and abuse.

Better care co-ordination was one of the main themes of the FYFV. He said that in the US, 34% of health spending was on waste and he estimated it would be 25%-30% in the UK. No health system has got below that level, he added.

There were moral and social justice arguments for reducing costs while maintaining or improving care, Professor Berwick said. In Massachusetts, spending on all budgets was down except for healthcare, which rose 61% between 2001 and 2015. 'What we're thinking about here is confiscation – health is taking resources from everything else we need to do.'

He recently unsuccessfully ran for governor of Massachusetts and described a 20-year-old man he had met while campaigning. The man had been in gangs and had just got out of prison, but was being helped get his life on track by a state-funded support scheme. The scheme's funding had been eroded in recent years and was now under threat. It was schemes such as this – and, he argued, the future of the man he met – that were under threat because of the growing health budget.

'If we don't find a way in the US to counter this, there's going to be a big toll to pay,' he said. 'The social safety net will be unaffordable and workers will have less to take home. The shift in costs to the worker represents a decrease in their standard of living. Business will be less competitive and research and teaching in healthcare will be hit first.'

Rising costs had hit patients in the pocket, he continued. 'American organisations' reaction has been cost-shifting, which I think you've managed to avoid here. To make people more sensitive to the rising spending, they have shifted costs to patients – through higher deductibles and co-payments, for example. The net effect is that take-home pay has fallen as money is going into the healthcare system. That's the confiscation of private resources. Rising spending would be fine if we were getting value for money for it, but we are not. We are nowhere near the top in terms of life expectancy, for example.'

A similar phenomenon was happening in England, with the ring-fencing of the health budget. 'I would be happy with that if it was building value,' he said. 'The question is whether the third part of the triple aim [reducing costs] is achievable.'

The 'confiscation' of resources by healthcare can be reversed. In 2016 the state of Oregon intends to reallocate savings in its Medicaid system – generated by integration similar to that outlined in the FYFV – to education and other social services, he said.

Barriers to overcome

There are barriers. 'The problem is the legacy – the private finance initiative, the workforce, the hospitals trying to stay full. It's a serious battle between good-hearted people with an interest in the status quo and those who want to change to the new system. But what will you do when an empty bed becomes more profitable than a full bed? It's a key question for you and some in the US.'

He called on the assembled leaders to be mindful of the 'first law of improvement'. 'The rubric is that every system is perfectly designed to achieve the results it gets. I have a 14-year-old Subaru with a top speed of, let's say, 96 miles per hour. If I don't like it, I could yell at it or offer it an incentive programme, but it won't go any faster because that's the top speed of the car. If I want to go faster, I need a different car.'

There were examples of systems getting closer the triple aim, he said, such as the Nuka system in Alaska, which is run by and for the native population. Professor Berwick likened it to 'a mini NHS'. It redesigned its service to be team-based, with doctors working alongside advanced nurse practitioners, nutritionists and other healthcare professionals. In its first five years it had produced impressive results, including a 50% reduction in urgent care and ER use, a 53% decrease in hospital admissions and customer and staff satisfaction greater than 90%.

He also cited Project Echo, a telemetry-based system in New Mexico that reduced the need for hepatitis C patients to attend clinics at its academic medical centre. Patients are seen in local clinics, according to a plan set out by specialists. Outcomes – clearance of the virus from the patients' blood – have been good. It has now extended its scope to other services, including diabetes, rheumatology and HIV.

Professor Berwick remains a strong supporter of the NHS and believes the FYFV will help put the service back on track by pursuing the triple aim of better care, better health and lower costs.