Role of the hospitals in a Changing Healthcare Paradigm and Ecosystem

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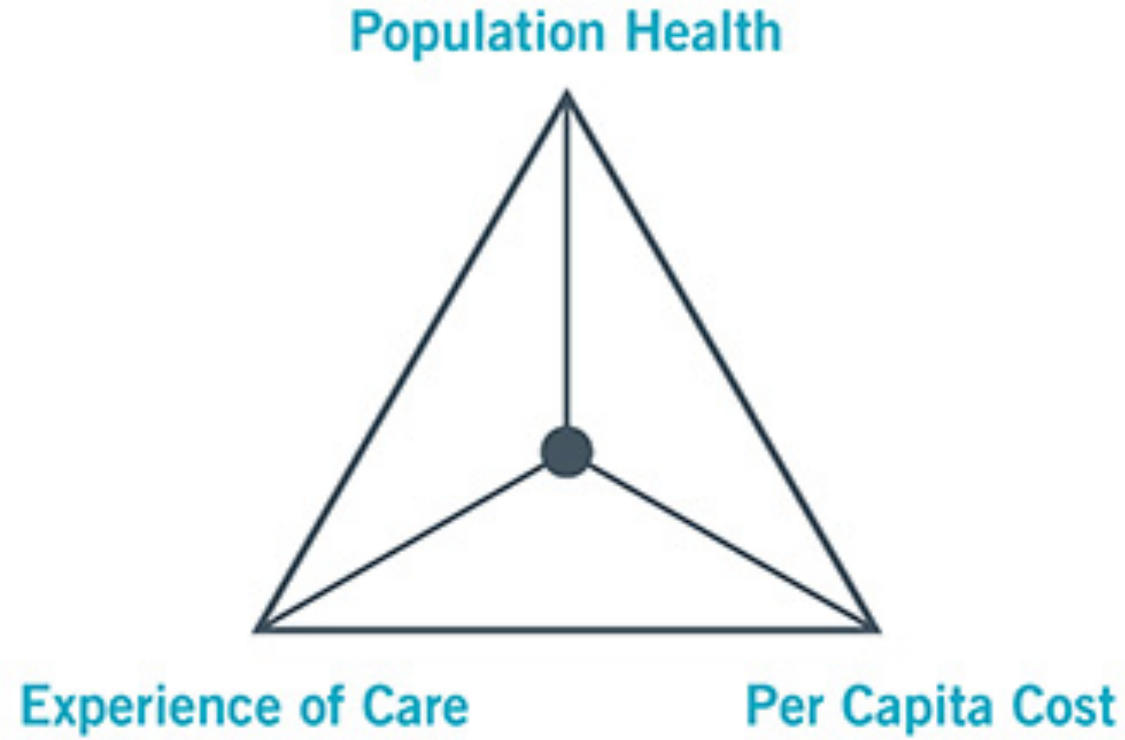
Global challenges faced by Health Care

- Drivers
  - → Globalisation
    - 10% of the cost of a GM car produced in Belgium = HCcoverage for US GM worker
  - → Consumerism
    - More knowledgeable, demanding citizens
  - → Changing Demographics & Lifestyle
    - Age, BMI,…
  - → Diseases expensive to treat
    - Chronicity
  - → New technologies and treatments
    - Personalized medicine,...

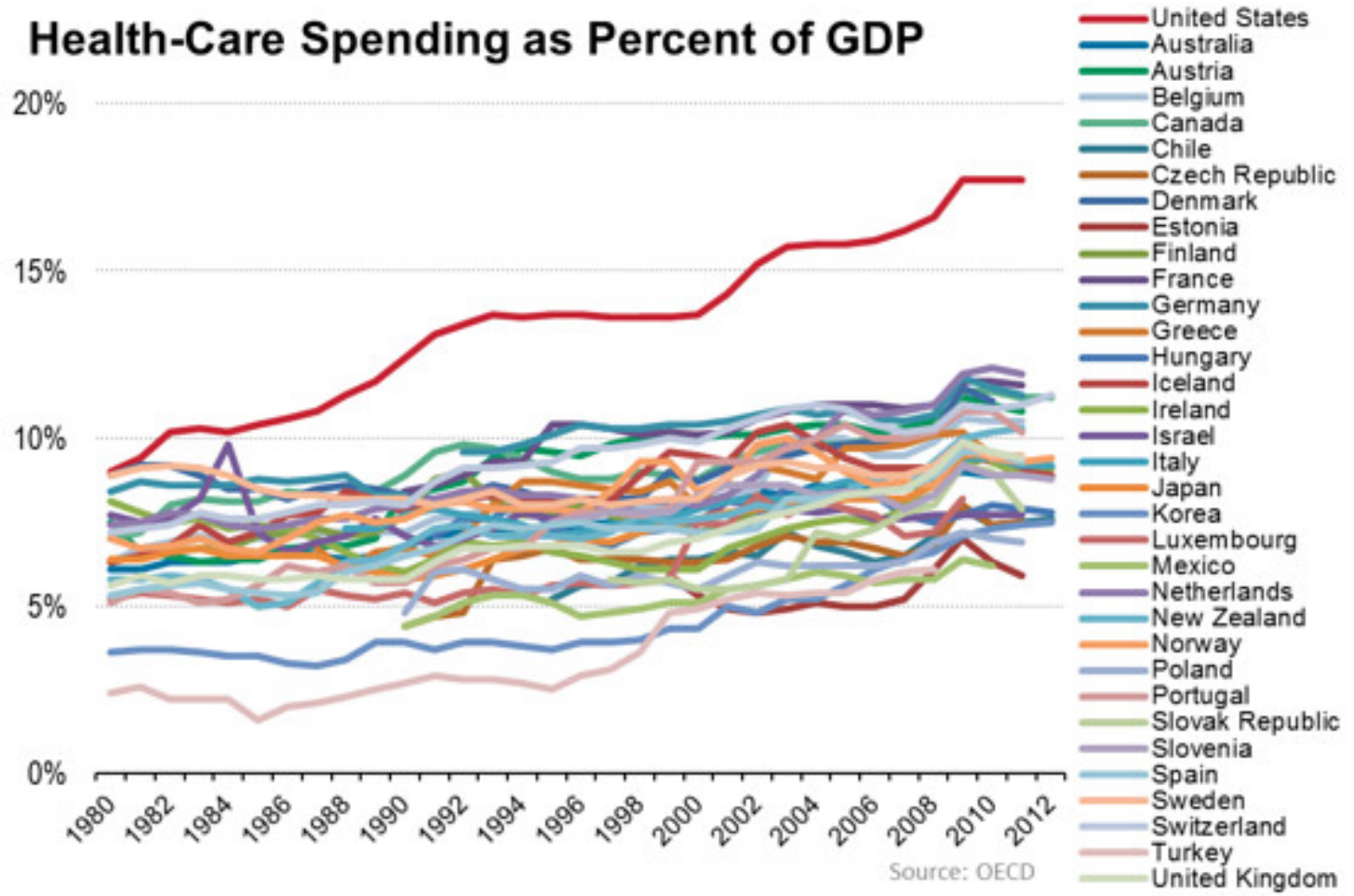
- Inhibitors
  - → Budget constraints
    - Priorities?
  - → Societal expectations
    - Healthcare as a public social right vs a pure market service
  - → Lack of aligned incentives
    - Few incentives for collaboration, service transformation,…
  - → Inability to balance ST/LT perspectives
    - Focus predominantly on ST
  - → Inability to access and share information
    - There is a lot of data outthere, but…

Current “paradigm” of Healthcare Delivery

The IHI Triple Aim

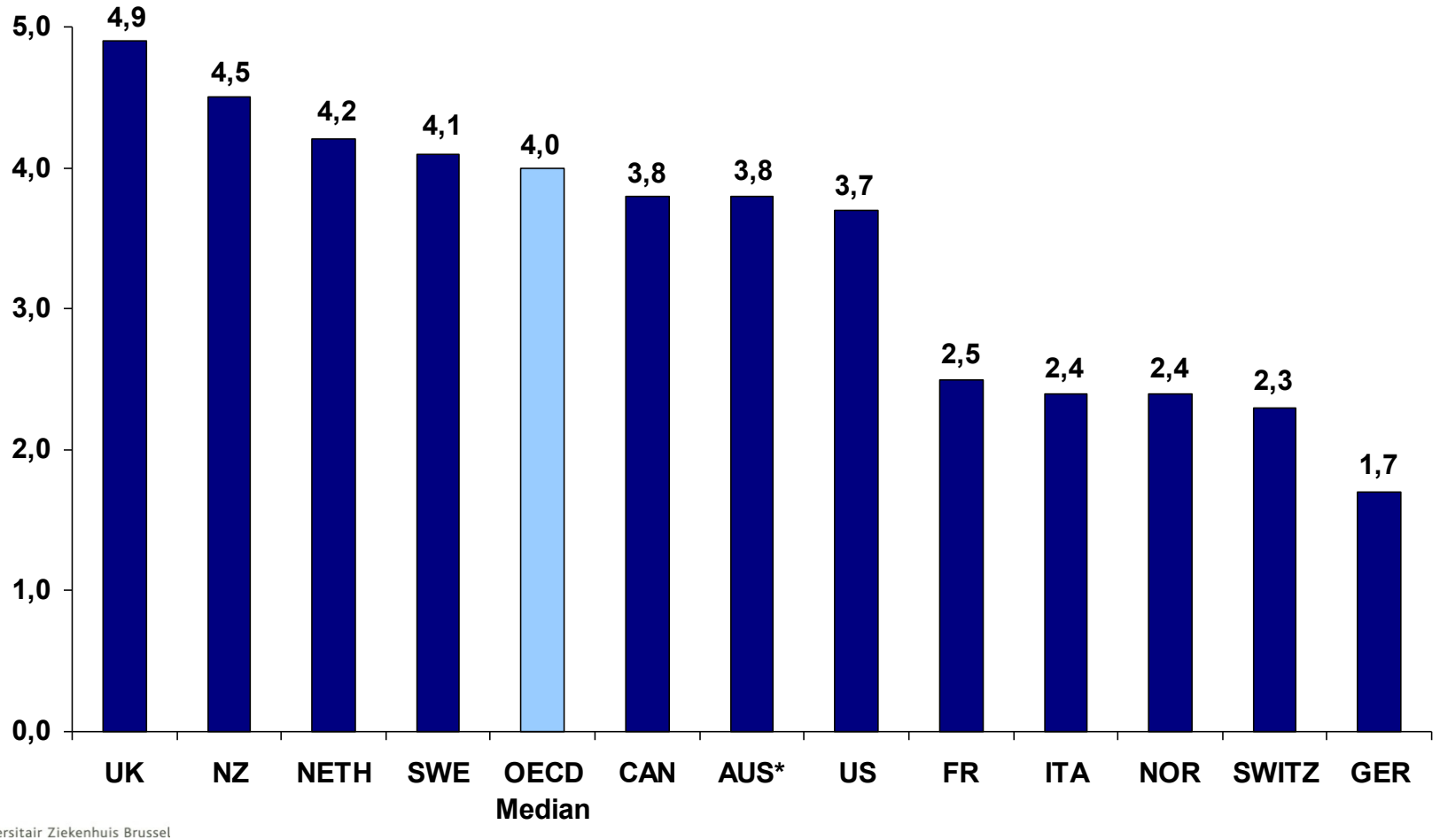


Health Care expenditure follows GDP (in the western world)



Is there a limit on HCE growth?

Average annual growth rate of real Health Care Expenditure, per capita, 1997-2007



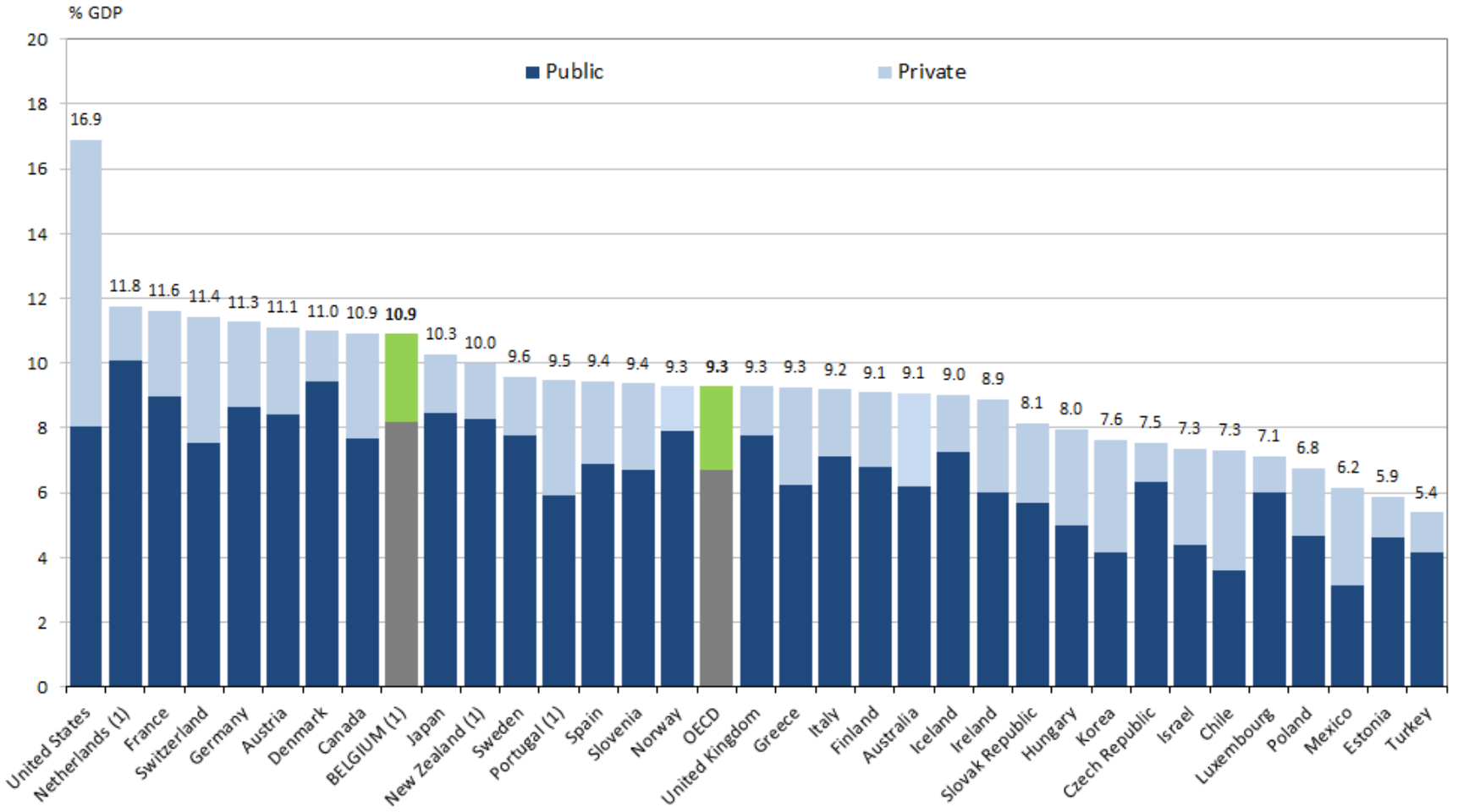
YES, there is a limit on growth…!

- HCE spending in Europe in 2010 fell for the first time in decades!

Country	2000-9	2009-10	Country	2000-9	2009-10
Ireland	6,5	-7,9	Portugal	1,8	0,5
Greece	7,2	-7,3	France	2,1	0,8
Czech Rep	6,0	-4,4	Italy	1,3	1,0
Denmark	3,2	-2,1	Sweden	3,4	1,2
Slovenia	3,9	-2,0	Netherlands	5,5	2,0
Spain	4,1	-0,9	Hungary	3,1	2,2
EU 24	**4,6**	**-0,6**	Slovak Rep	10,9	2,4
UK	4,9	-0,5	Germany	2,0	2,7
Cyprus	2,7	-0,2	Malta	3,5	3,6
Austria	2,2	0,1	Romania	5,6	4,2
Belgium	3,8	0,2			
Finland	3,9	0,4	Norway	2,9	-2,0
Poland	7,1	0,5	Switzerland	2,0	1,4

www.oecd.org/health/healthataglanceeurope.htm

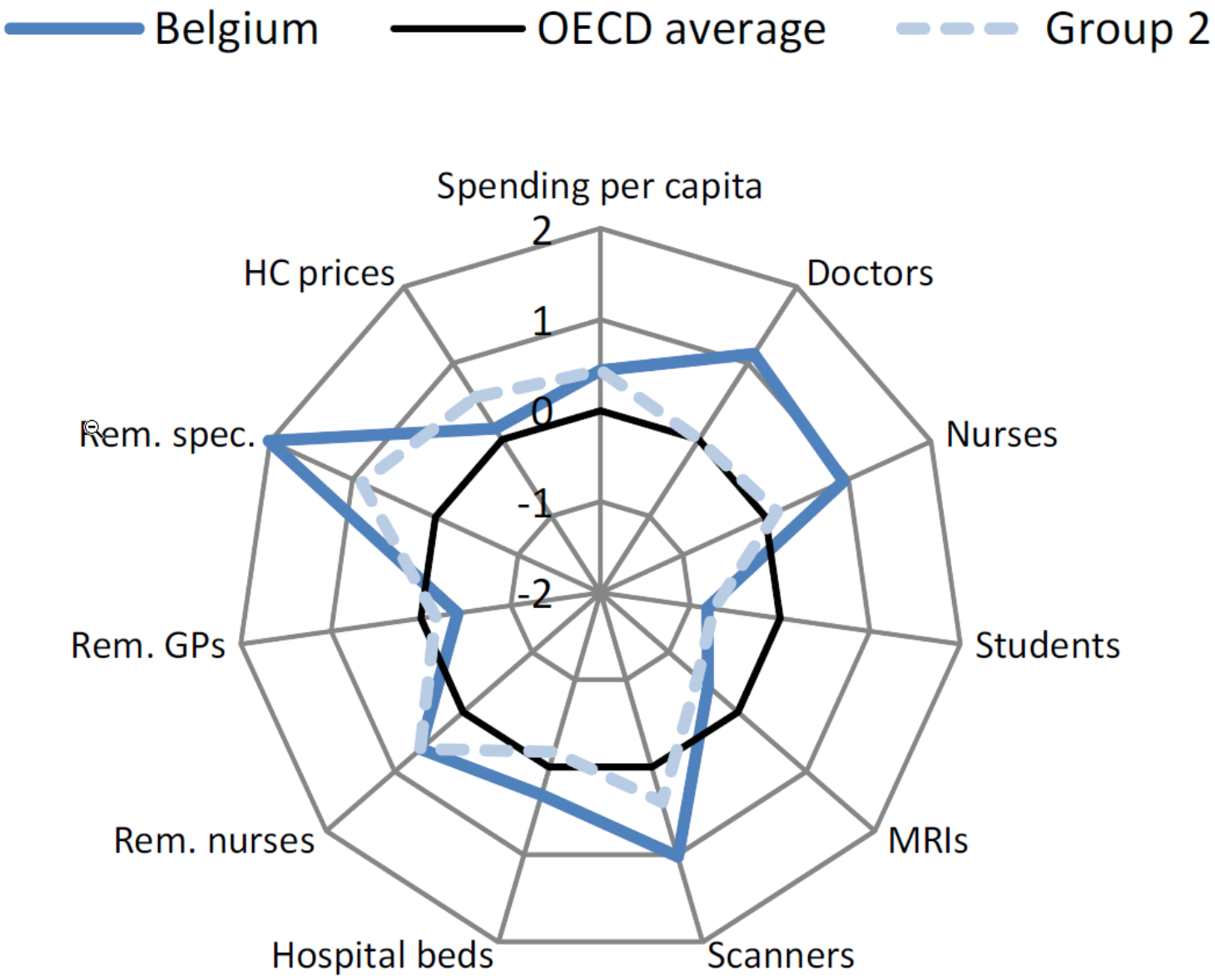
Belgium : not cheap



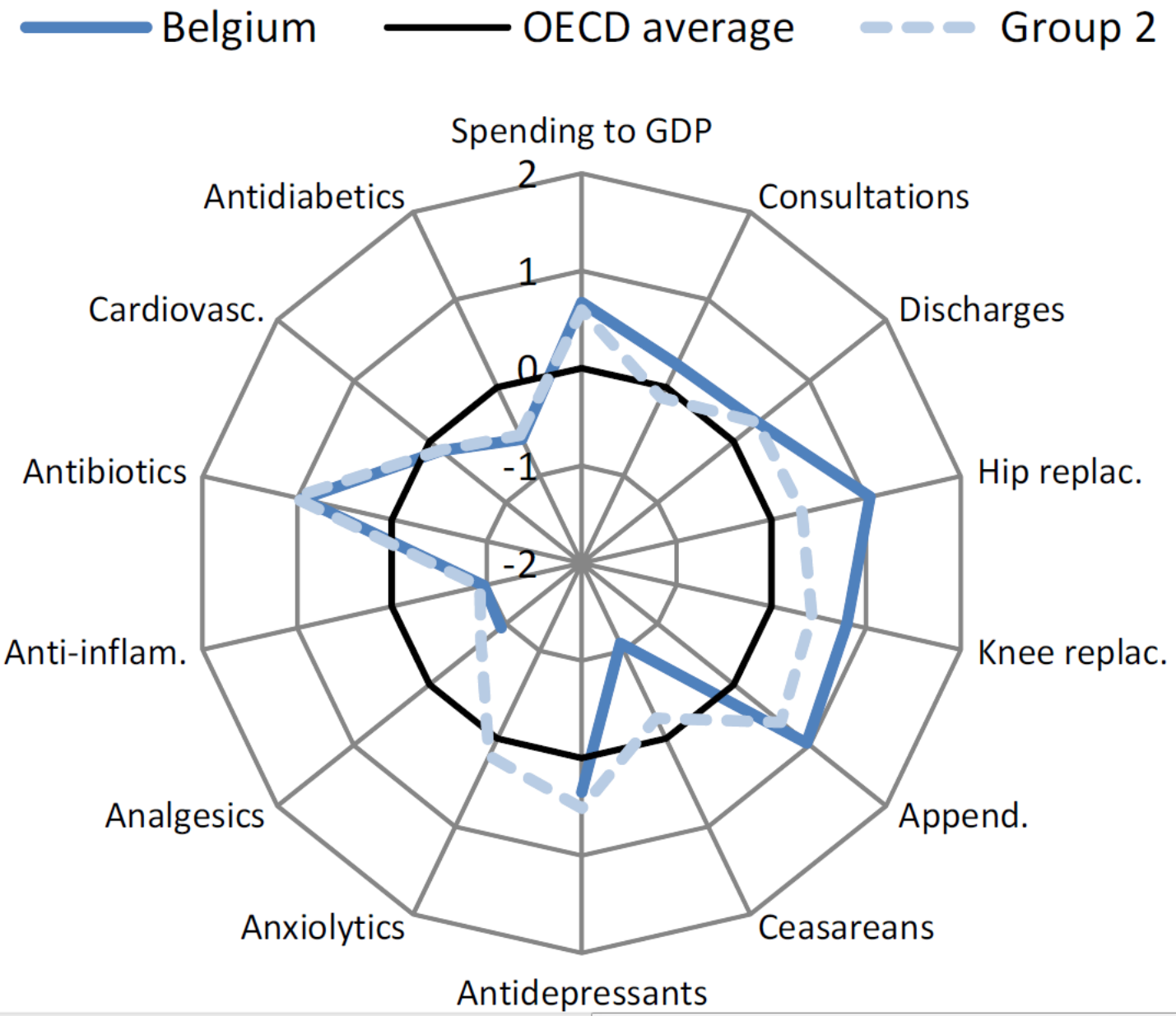
1. Total expenditure excluding capital expenditure.

Source: *OECD Health Statistics 2014.*

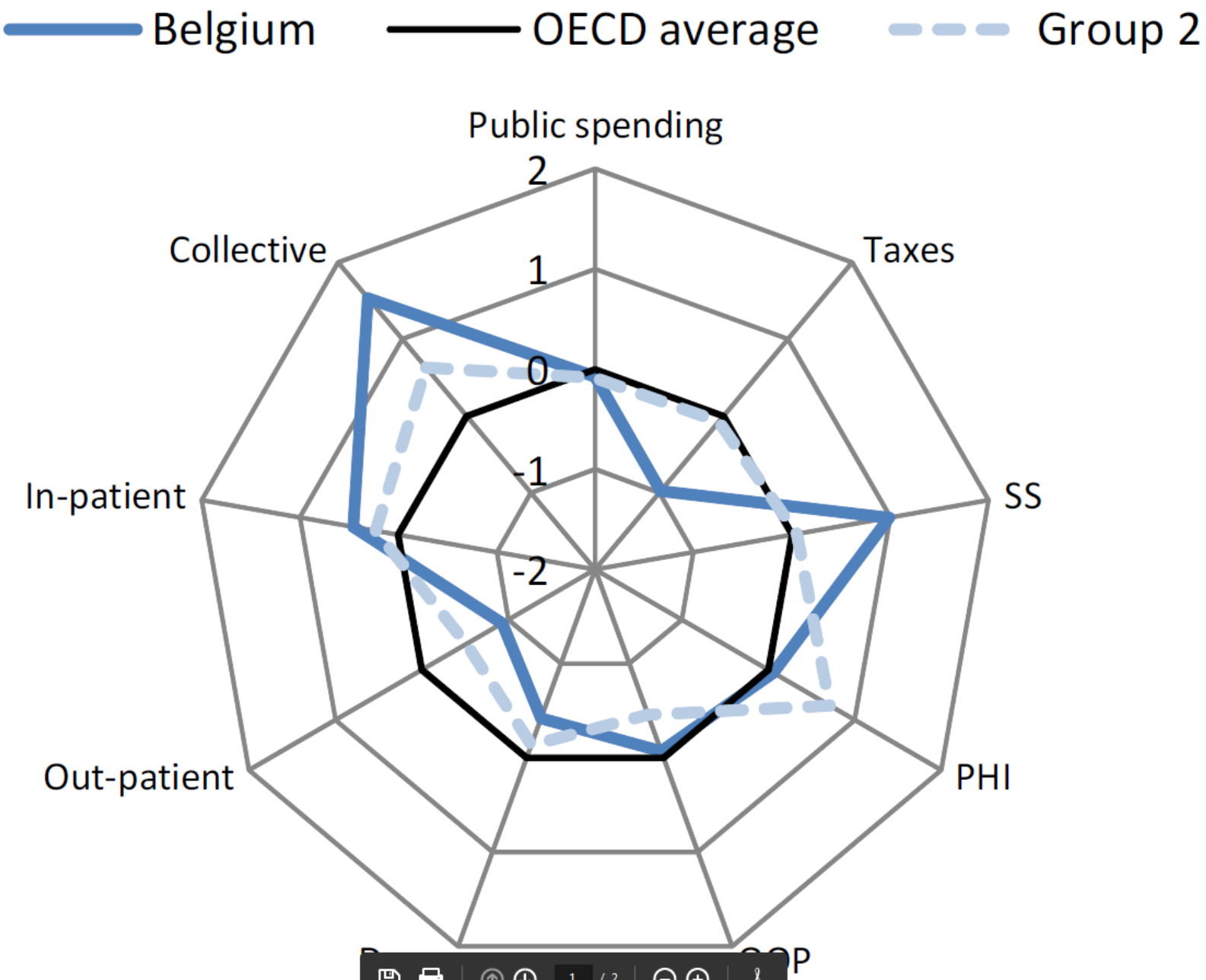
C. Prices and physical resources

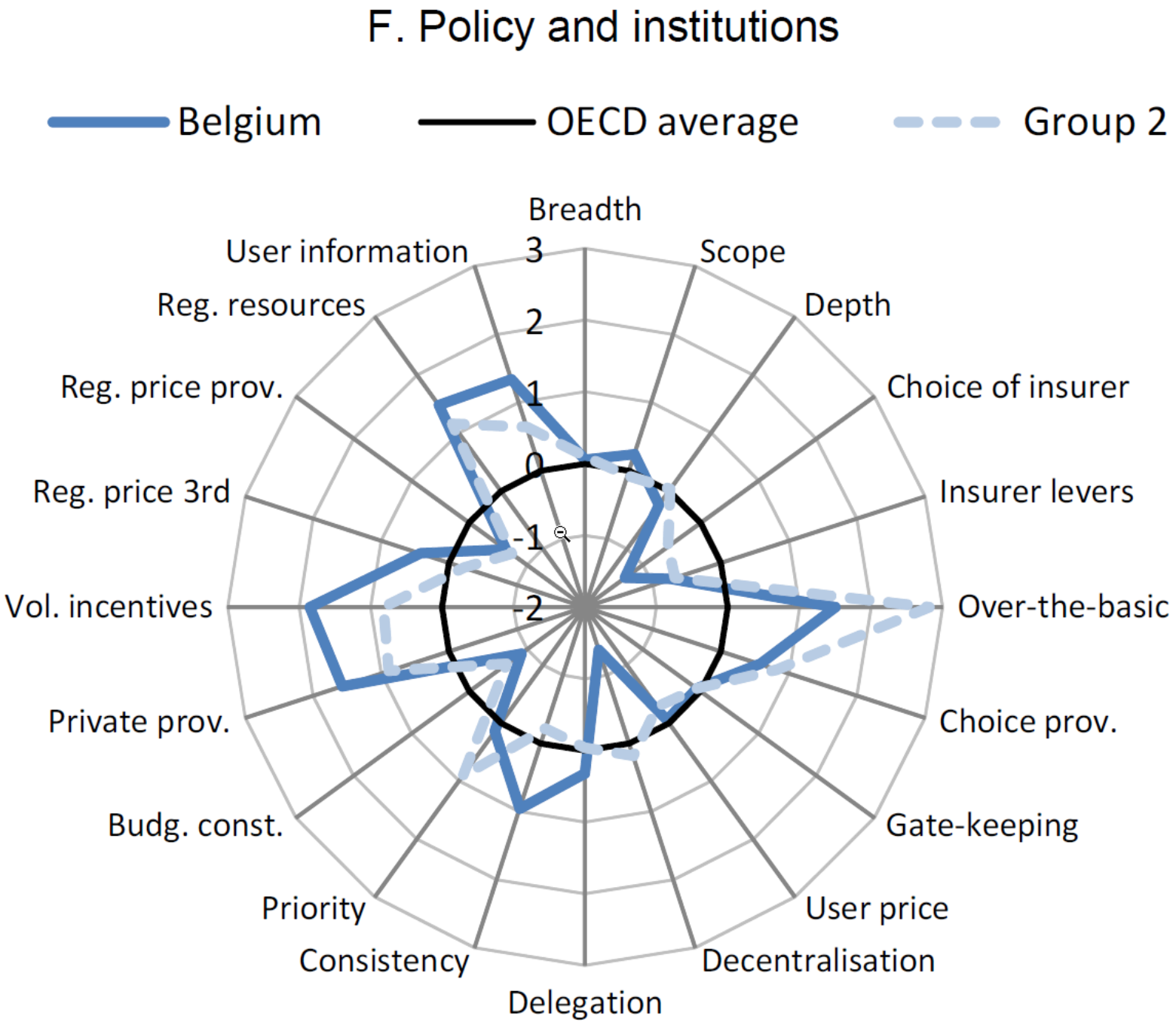


D. Activity and consumption



E. Financing and spending mix




F. Policy and institutions
Belgium
OECD average
Group 2
Breadth
Scope
Depth
Choice of insurer
Insurer levers
Over-the-basic
Choice prov.
Gate-keeping
User price
Decentralisation
Delegation
Consistency
Priority
Budg. const.
Private prov.
Vol. incentives
Reg. price 3rd
Reg. price prov.
Reg. resources
User information
3
2
1
0
-1
-2

OECD Economics Department Working Papers

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Belgium: Enhancing the Cost Efficiency and Flexibility of the Health Sector to Adjust to Population Ageing

English

Stéphane Sorbe[1]
1: OECD, France

25 June 2013
No.: 1066
Pages 36
DOI 10.1787/5k44ssnfdnr7-en

Belgium has a good record in delivering accessible care, but adaptation to population ageing will be complicated by the fragmentation of responsibilities in the healthcare system and a strong reliance on government regulations. The organisation of the system could be rationalised by giving sickness funds a more active role as promoters of cost-efficiency, better aligning the incentives of the different levels of government and focussing on medium-term budgeting. At the level of care providers, better information flows and incentive structures could facilitate addressing practice and efficiency variations and supplier-induced demand. This notably involves completing the shift to pathology-based budgets in hospitals, more capitation in the remuneration of doctors and measures to tackle the high spending on drugs. Once incentives for cost-efficiency are in place, a shift towards a more demand-driven system could be encouraged by phasing out over-prescriptive hospital regulations. In addition, relative remunerations of doctors should be revised regularly to ensure an adequate supply per specialty. In long-term care, home care, which is generally cost-efficient, could be further encouraged by giving more autonomy to patients to organise their care. This Working Paper relates to the 2013 OECD Economic Survey of Belgium (www.oecd.org/eco/surveys/belgium).

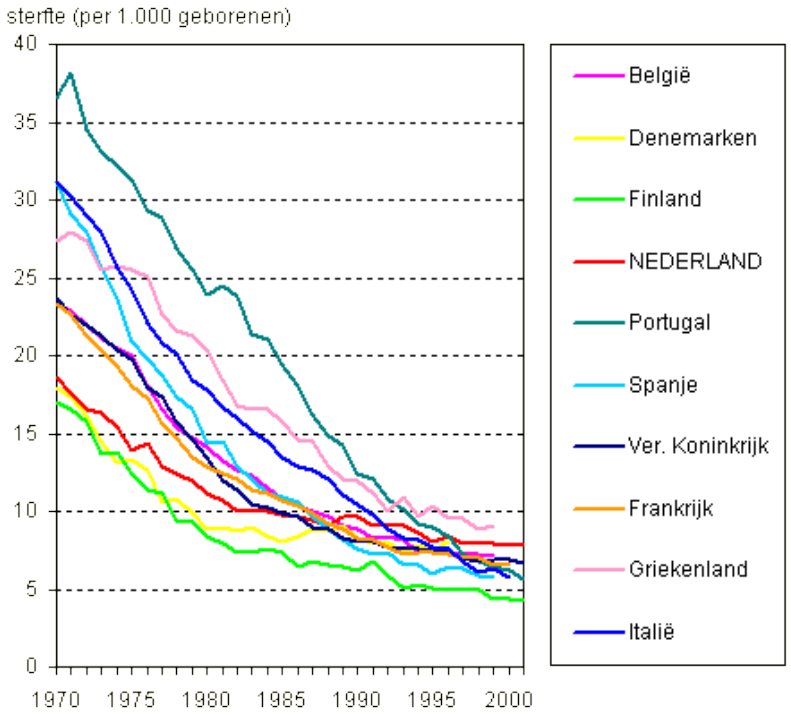
Keywords: health, long-term care, pharmaceuticals, Belgium, hospital, sickness funds, population ageing

JEL Classification:

- H51: Public Economics / National Government Expenditures and Related Policies / Government Expenditures and Health
- I11: Health, Education, and Welfare / Health / Analysis of Health Care Markets
- I13: Health, Education, and Welfare / Health / Health Insurance, Public and Private
- I18: Health, Education, and Welfare / Health / Government Policy; Regulation; Public Health

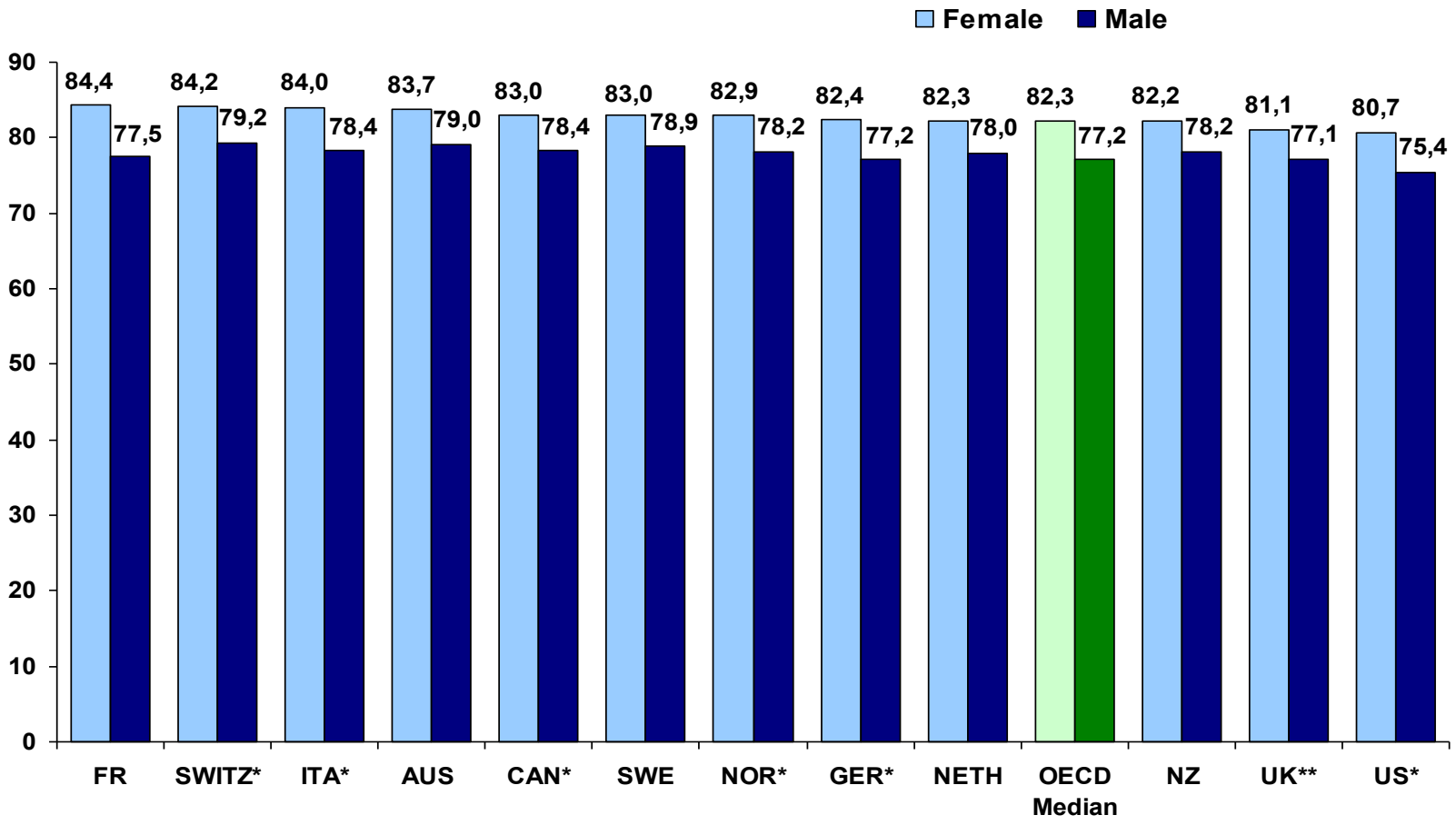
HCE and Outcome

- HCE are very high, and many needs are met…



- Marginal increases will therefore cost more and more….

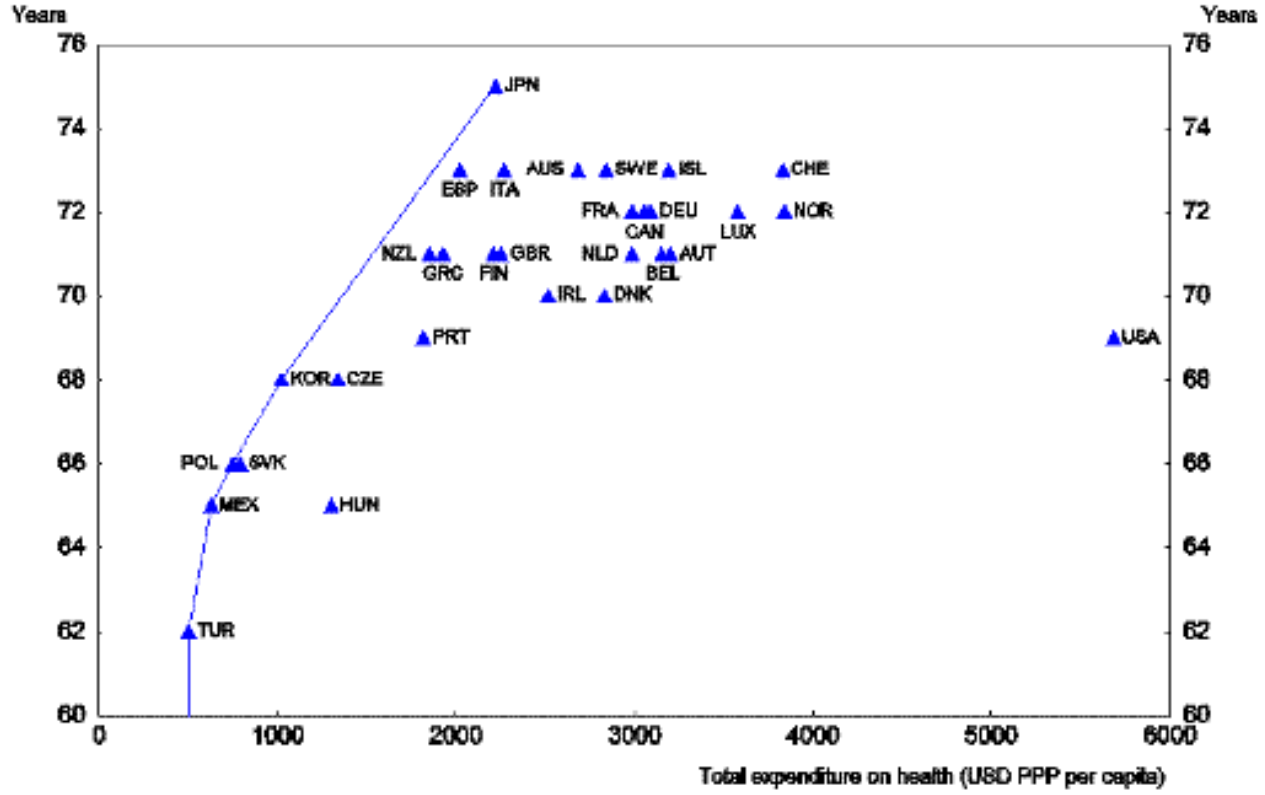
And how on earth will you improve this? (and at what cost, and …do we *want* that?)



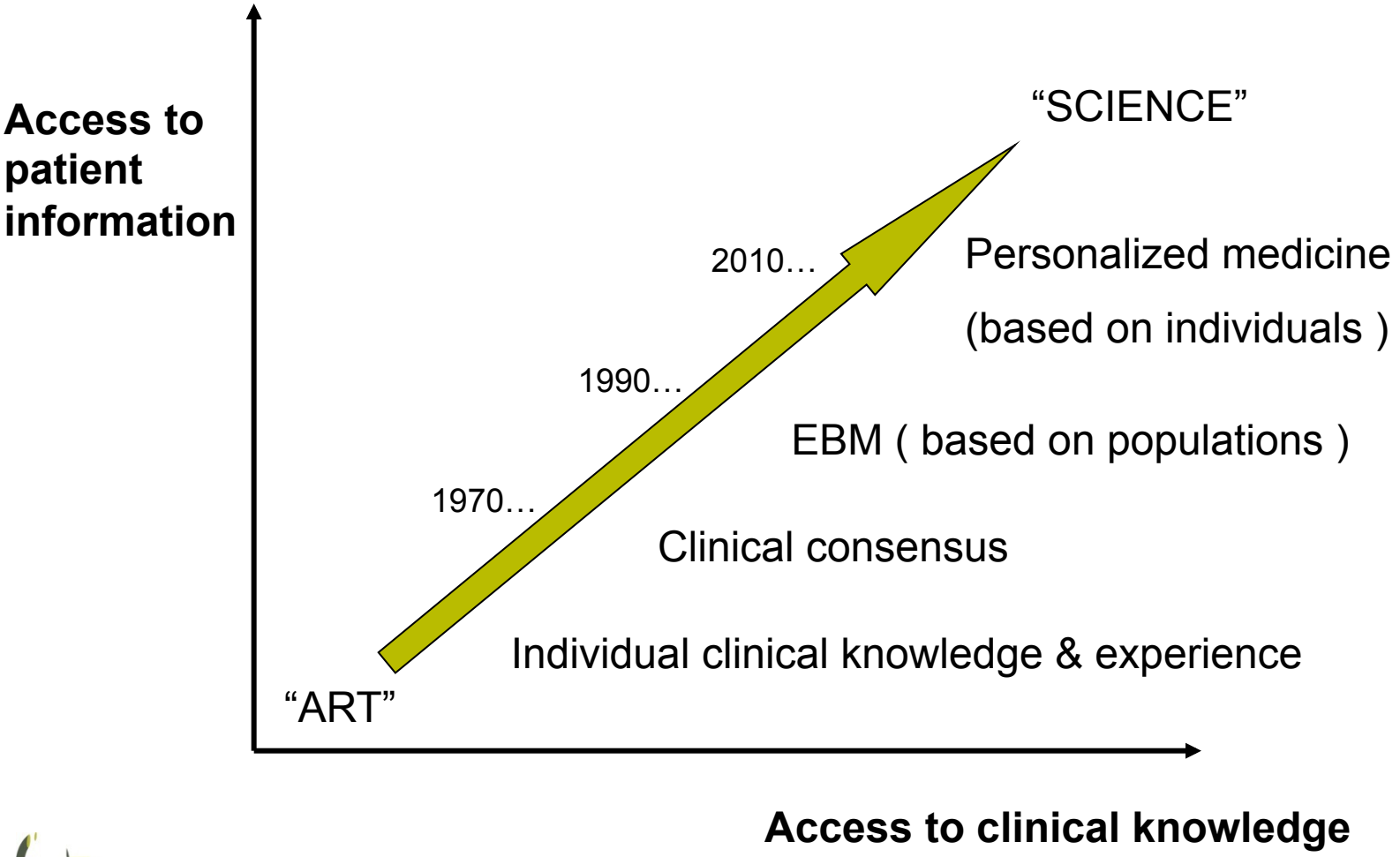
Life expectancy at birth

Exemple : societal expectations

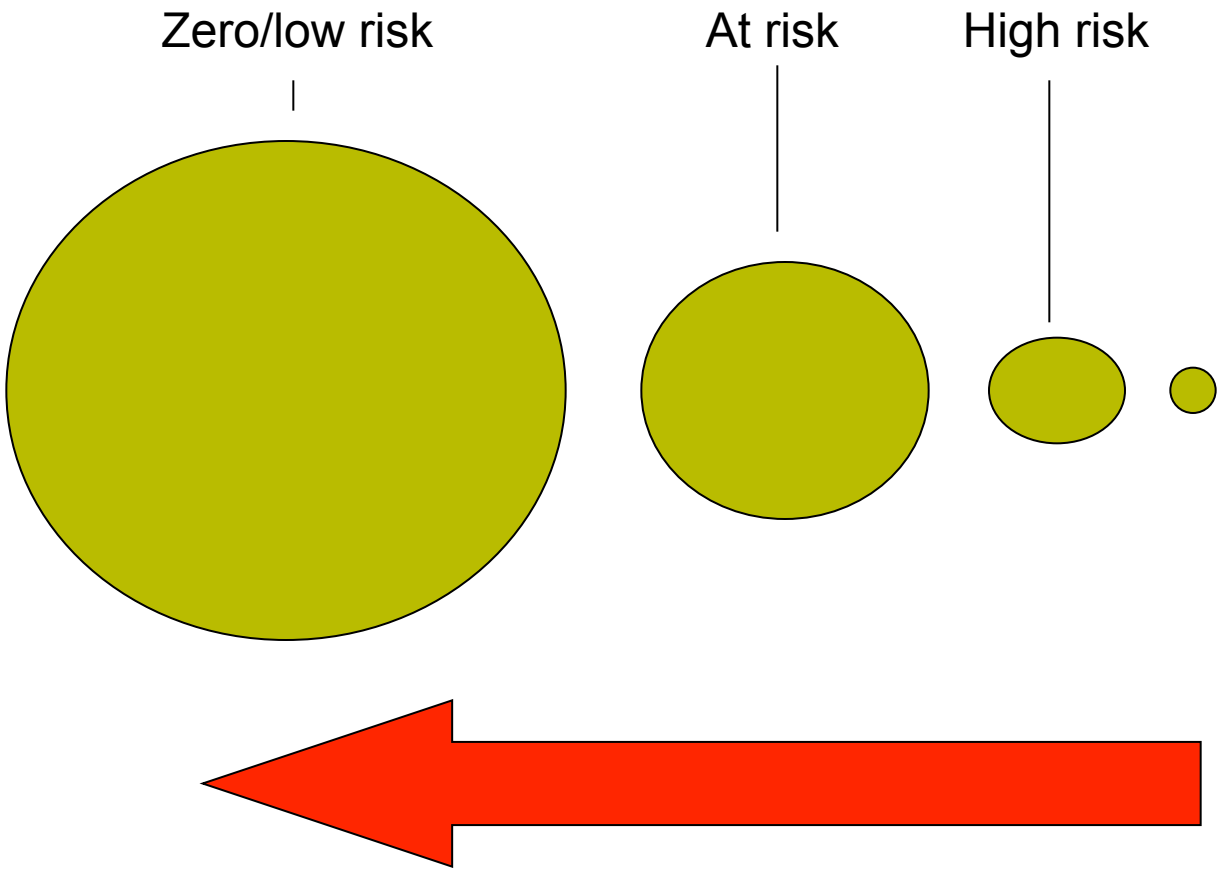
- HC expenditure *vs* max avg age : a buck well spent ???



Example : changing paradigms // cost



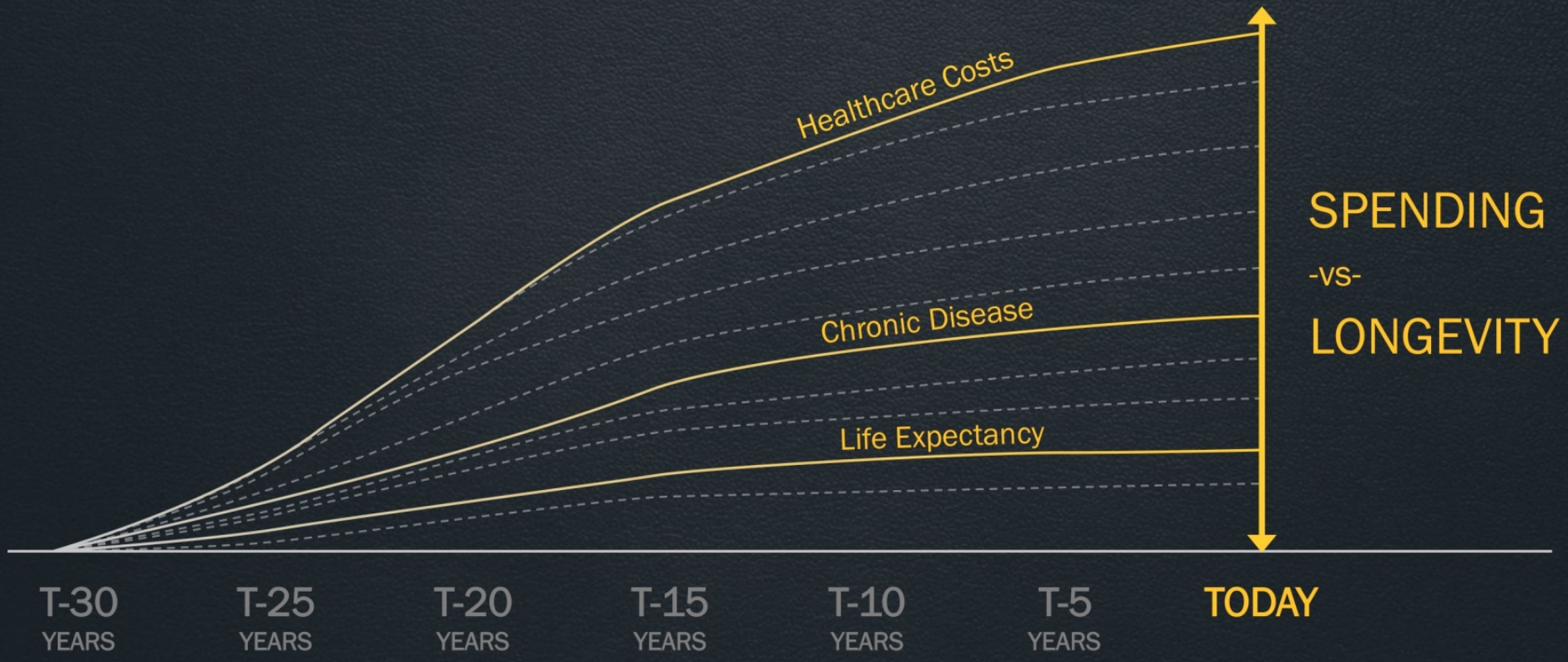
“Strange business model”…: Health-care or Sick-care ?



Active disease : < 20 % of pop, > 80% of cost

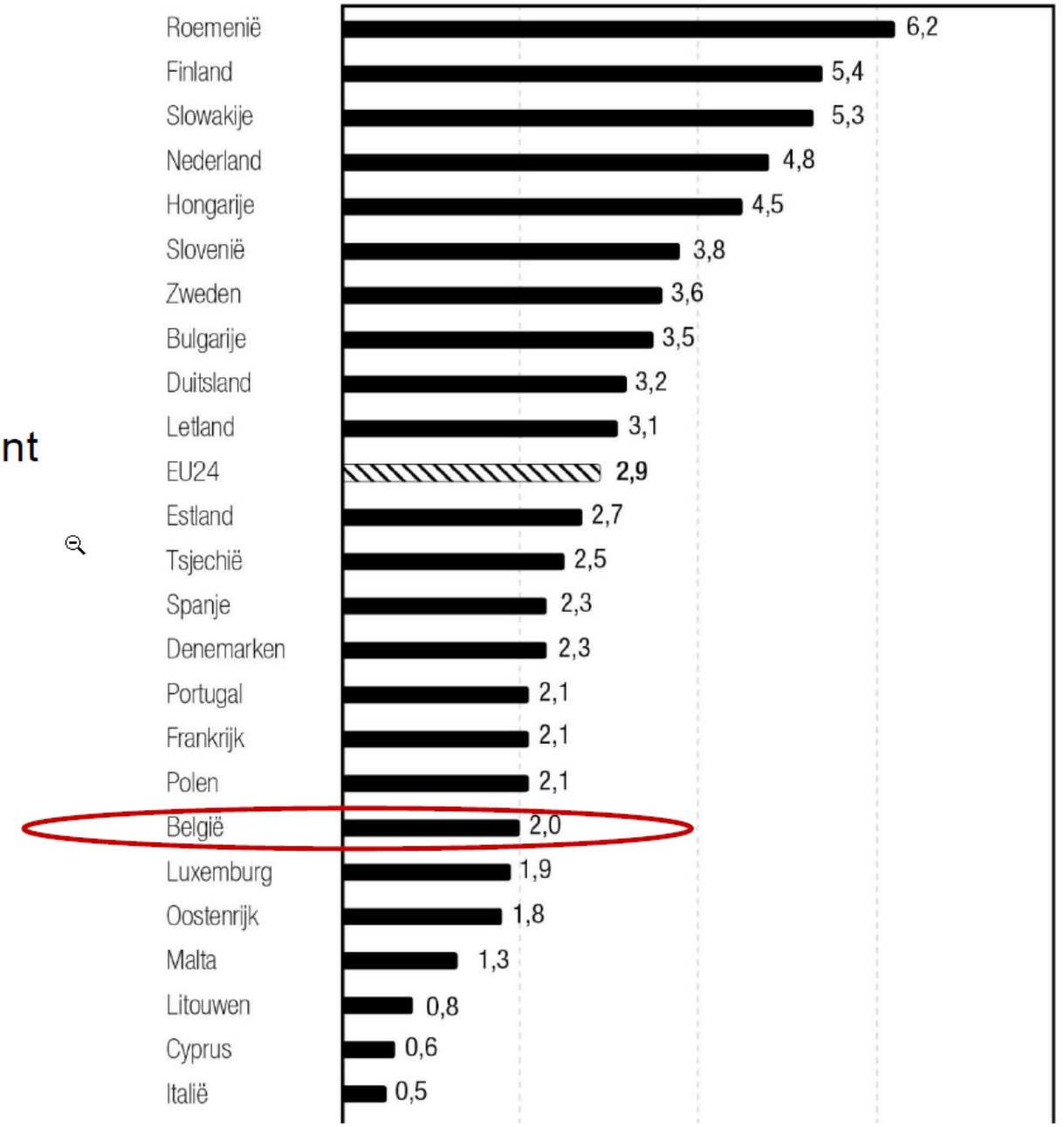
(and >80% of this is spent during the last 12 months of life)

The Healthcare Reality



te weinig geld voor preventie!

% of the total healthcare expenditure spent on prevention (EU 27)



Life expectancy USA

- An average American reaches the age of 80, if…
  - → He weares his seatbelt
  - → Doesn't have guns at home
  - → Doesn't smoke
  - → Eats fresh veggies and fruits on a daily basis
  - → Moves for 30 minutes three times a week

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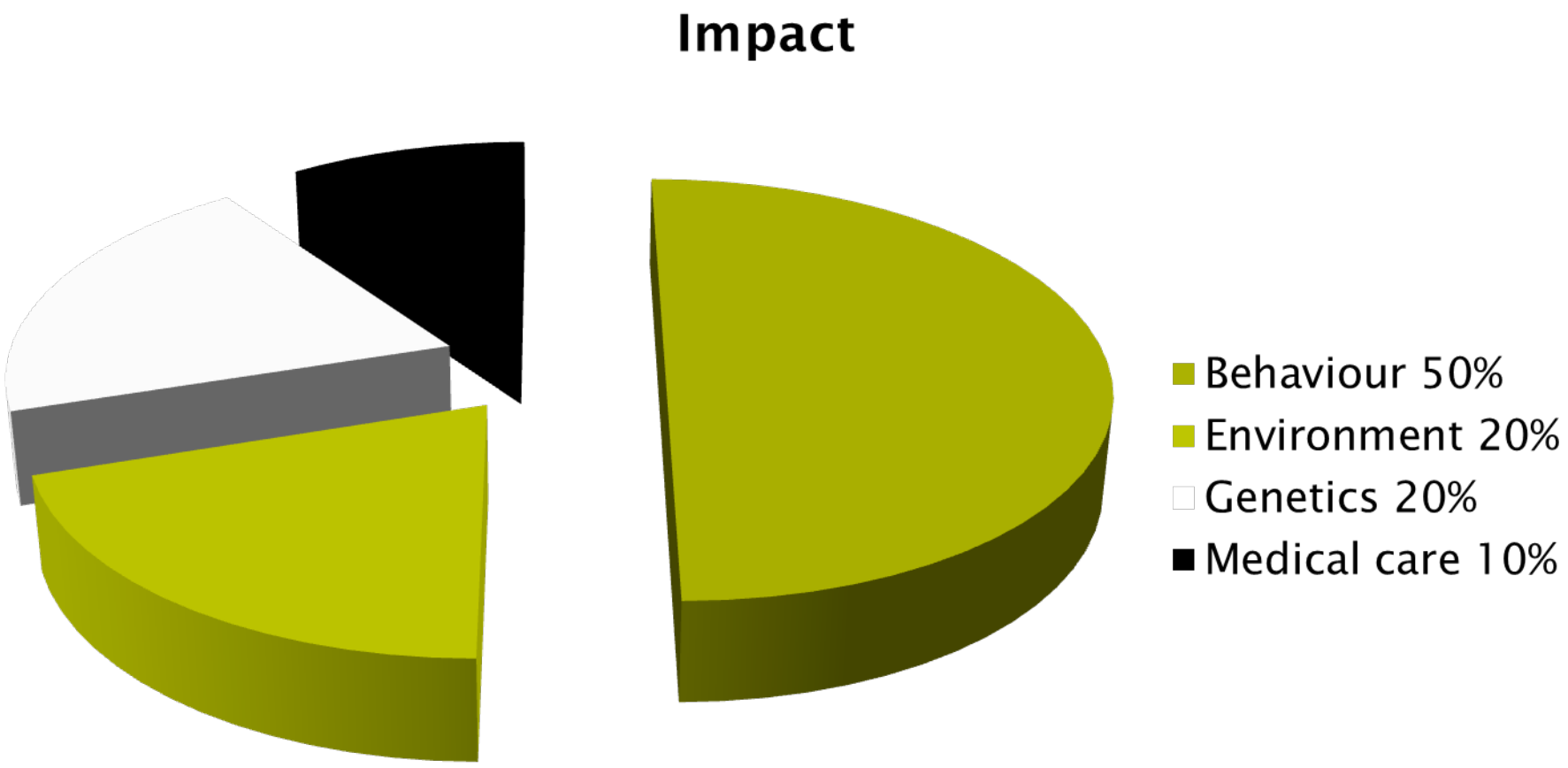
…but only 5 % of all Americans fulfill all five criteria…….

One third of all cancers can be avoided if…

- →You don't smoke
- →Eat healthy (daily fresh fruits and veggies)
- →Move enough
- →Moderately drink alcohol
- →Don't lie in the sun too much
- →Keep your weight

Behaviour is the major contributor to your health



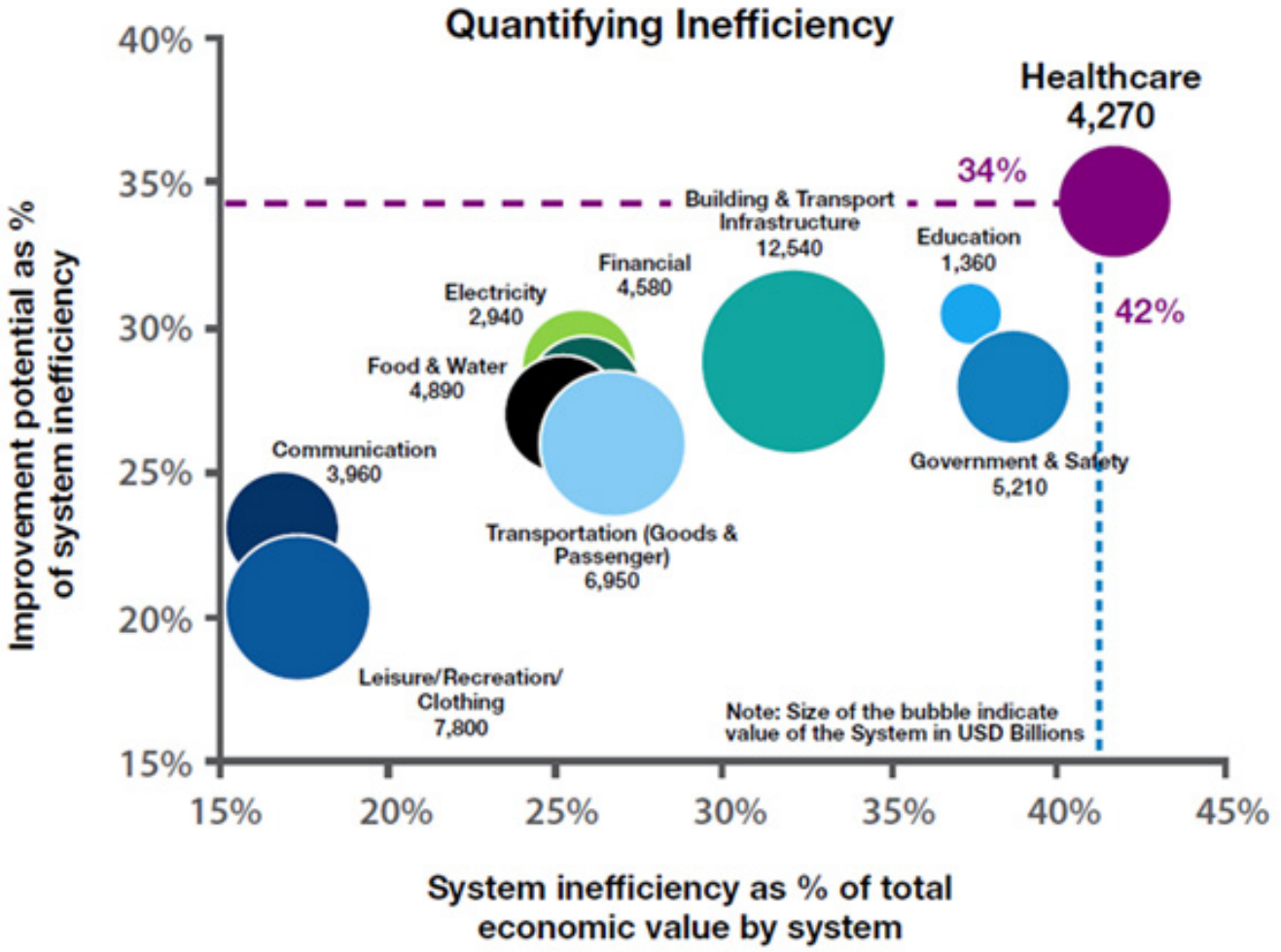
Health Care and (in)efficiency

- Deficiencies in contemporary health care
  - → Upto 45% of patients do not receive recommended evidence-based care
  - → Treatments are targeted to low-moderate risk patients rather than high-risk of preventable clinical events (risk-treatment paradox)
  - → Upto 30% of administered tests, procedures and medications are unneccessary
  - → Upto 50% of health care spending goes toward unneccesary bureaucracy, duplicative tests, and other waste
  - → Upto 20% of patients are harmed by healthcare (which costs 30c/dollar to correct)
  - → There are large and unexplained variations in quality and safety of care

Scott et al, Int Med J 2009;39:389-400

Bohmer R, Harvard Business Rev 2010;apr:63-73

Leading the Pack in Inefficiency

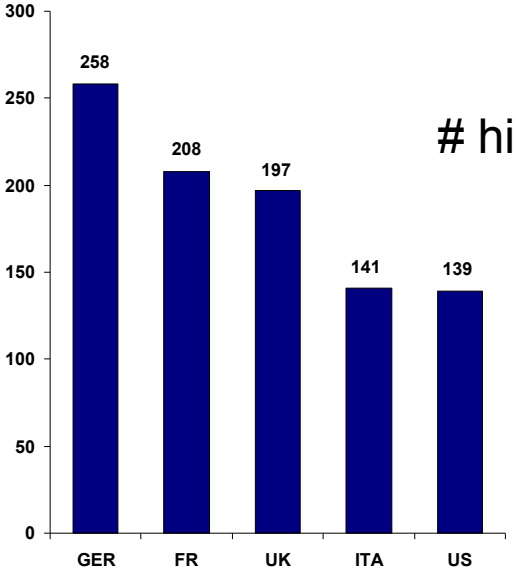


Main reasons :

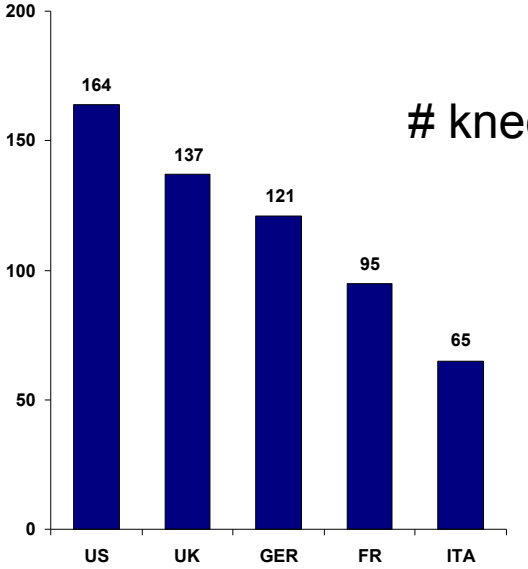
- 1. Overemphasis on expensive advances in medical technology that yield incremental improvements in outcomes with inadequate consideration to cost
- 2. Myopic focus on capacity for acute care to the detrement of wellness, prevention and population health strategies
- 3. the use of volume-based reimbursement models

Smarter Healthcare and Life Sciences, IBM, 2012 Corporation,www.ibm.com/healthcare

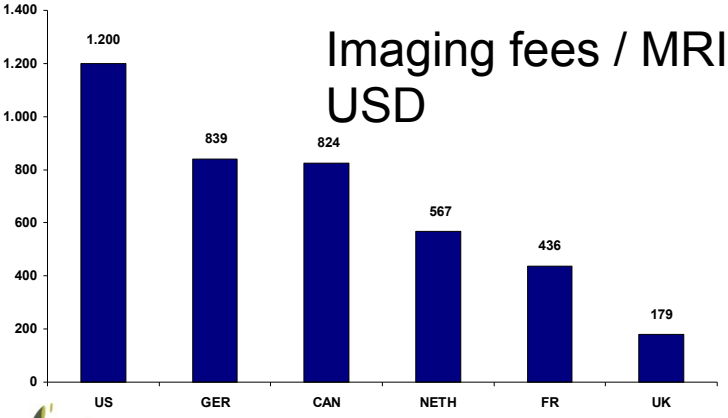
Discrepancies between models, expenditures, and outcomes : room for improvements!



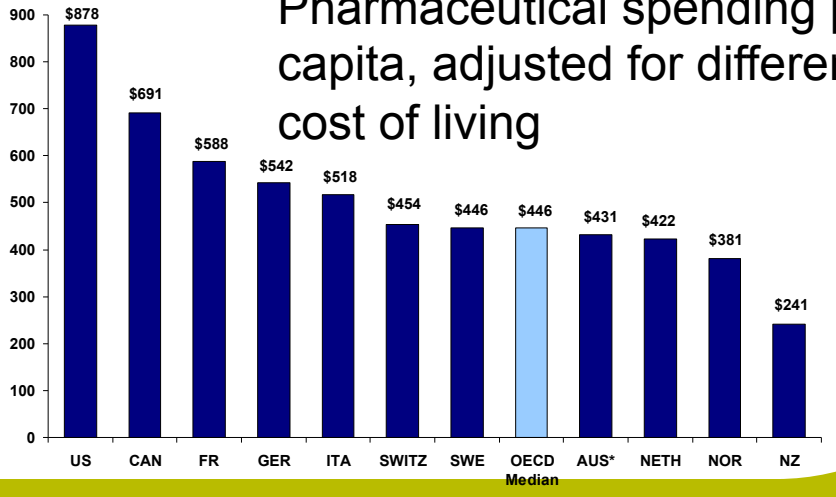
hip inplants/100,000



knee inplants/100,000



Imaging fees / MRI scan, USD



Pharmaceutical spending per capita, adjusted for differences in cost of living

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Belgium today : the “ average hospital” inefficiencies (Portella, 2014)

- 5% of beds occupied by chronic diseases
- 7% of beds occupied by readmissions < 10 days
- 19% of beds have a LOS > 30 days (27% > 20 days)
- Hence, more than 30% of bed occupancy is inappropriate for an “acute hospital” (and 70% of these patients are 80+ years old)
- Hence, current acute hospital bed offer and usage is poorly adapted to the demand

Current paradigm of HC delivery

- Sustained for decades, based on its own set of mutually reinforcing elements:
  - → "vertical" organisation by specialty with independant private-practice physicians
  - → Measurement of "quality" defined as process compliance
  - → Cost accounting driven not by cost but by charges
  - → FFS by specialty with rampant cross subsidies
  - → Delivery systems with duplicative service lines and little integration
  - → Fragmentation of patient population with no critical masses of patients with a certain condition
  - → Siloed vertical IT systems around specialties

RISING COSTS & UNSATISFACTORY AND UNEVEN QUALITY DESPITE THE HARD WORK OF WELL-TRAINED,WELL-INTENTIONED CLINICIANS

And furhtermore…

Patients Are Expecting More

- Expecting more treatment options
- Demanding faster delivery
- Want it personalized
- Digital everything

“In Healthcare, the days of *business as usual* are over.”

ME PORTER,TH LEE

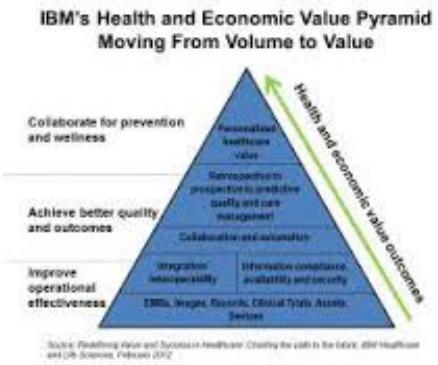
HBR 2013

It is time for a fundamentally new strategy

- Core: maximizing Value for Patients
  = achieving the best health outcomes (that matter to patients) at the lowest cost
- Move away from a supply-driven HC system organized around what physicians do toward a patient-centered system organized around what patients need
- Shift the focus from the volume and profitability of services provided, to the patient outcomes achieved

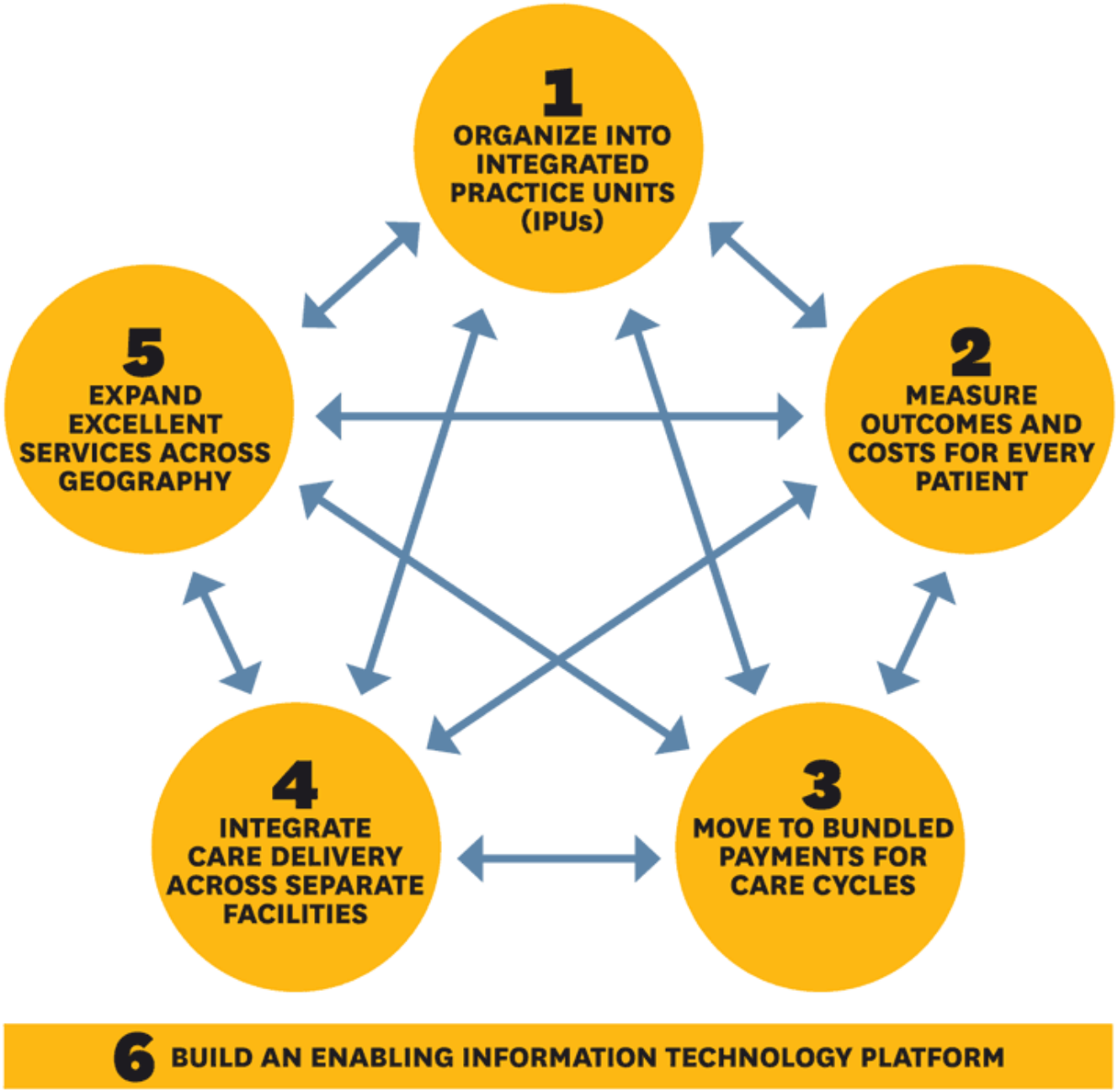
How to maximize value for patients in the HC system

	Volume-based	Value-based
Payment	FFS	Outcome based
Incentive	Volume	Value
Focus	Acute episodes	Populations
Role of provider	Single episodes	Care continuum
Information	Retrospective	Real-time & predicitve
Leadership style	Managerial divisional/ departemental thinking	Thinking across organisation



How to maximize Value for Patients in HC delivery (hospitals)(Porter & Lee)

- Organize into **Integrated Practice Units** (IPUs)
- **Measure Outcomes and Costs** for every patient
- Move to **bundled payments** for Care cycles
- **Integrate Care delivery systems**
- Expand **geographic reach**
- Build an **enabling ICT platform**


1
ORGANIZE INTO INTEGRATED PRACTICE UNITS (IPUs)
2
MEASURE OUTCOMES AND COSTS FOR EVERY PATIENT
3
MOVE TO BUNDLED PAYMENTS FOR CARE CYCLES
4
INTEGRATE CARE DELIVERY ACROSS SEPARATE FACILITIES
5
EXPAND EXCELLENT SERVICES ACROSS GEOGRAPHY
6 BUILD AN ENABLING INFORMATION TECHNOLOGY PLATFORM

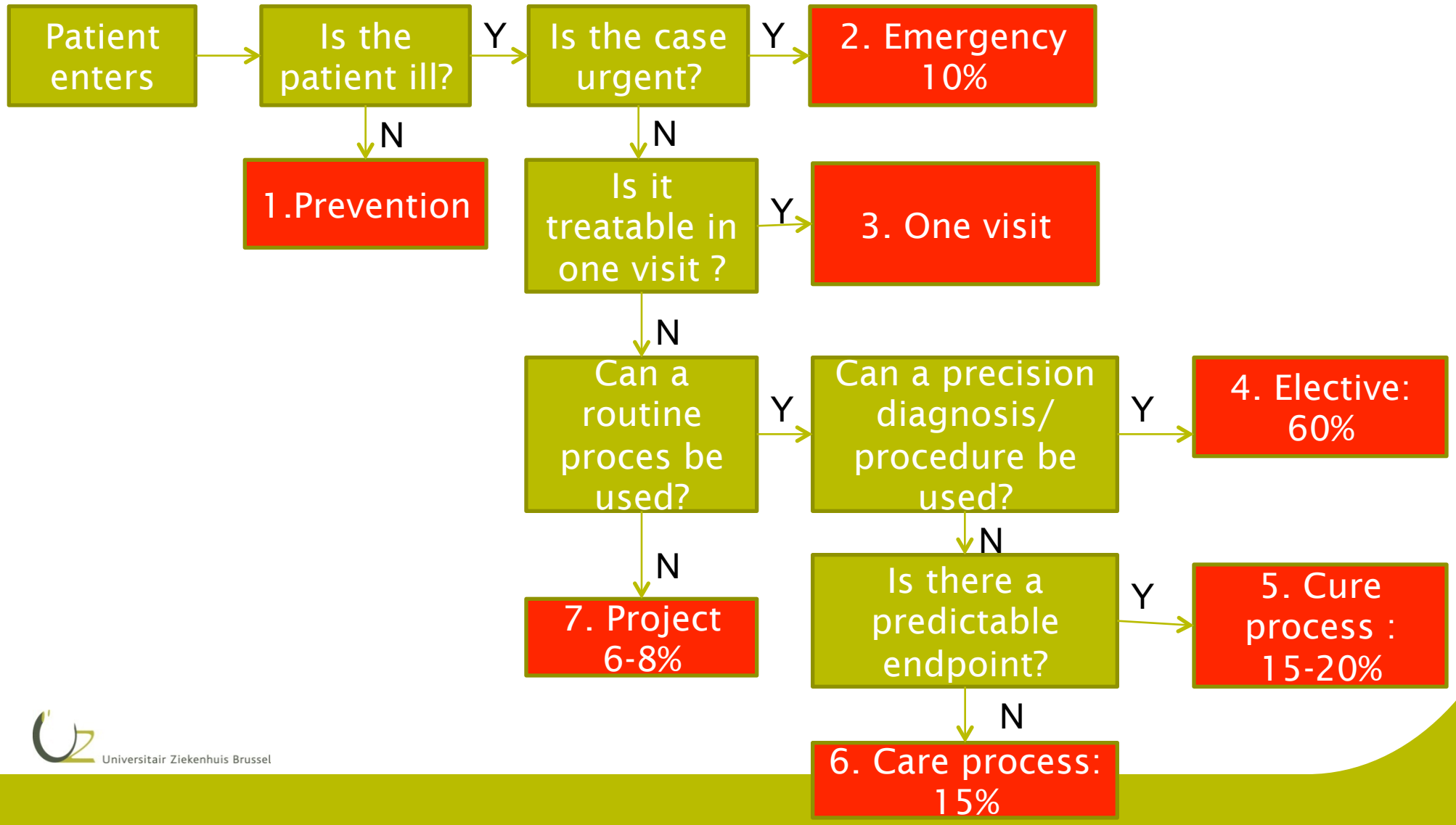
Organize into Integrated Practice Units (IPUs)

- Organize around the patient's medical condition with ALL related conditions ("horizontalization")
- ALL personnel work as a team toward one goal: maximizing patient's overall outcome as efficiently as possible
- Ideally co-located
- The team takes responsability for the full cycle of care
- The unit has a single administrative and scheduling structure
- A physician team captain or a clinical care manager oversees each process
- The team measures outcomes, costs and processes for each patient using a common measurement platform
- Joint team meetings, joint team accountability

“Extreme” example of IPU : “Focused factory”

- “Focused Factory” = an integrated health delivery system organised around, and focused on, a specific patient need
- It is one of the various possible “operating modes” of healthcare organisation
- Different modes require different management

Operating modes in Healthcare : “ “Taxonomy of the patient” (% hospitalisations in the average Belgian hospital)



Is it possible to run a hospital effectively which operates all these modes ?

Mode	Time	Management	Industry model
Prevention : monitoring, advice, managed networks, transmurality	Cost now, time long, outcome?, savings postponed	Risk management	Insurance business
Emergency : time-critical, random access demand, save-and-stabilize	Immediate	Rapid response, flexibility, prioritisation	Fire dept, army
One visit : discrete, non-urgent, end-to-end treatment	On-demand or on-schedule	Easy access, scheduling	Large volume retail
Elective : requires precision diagnosis & procedure, preparations, scheduling, mobilisation of resources, after care	Predictable	Resource mobilisation, processing, efficiency	Automobile
Cure : patient will recover, quality assessment, sequential steps, coordination of flow, cycle-time, value-added & non value-added time	Sequential cycle-time	Throughput time, process management	Technical development
Care: chronic/terminal state, regular monitoring, disease mgt	Long	Patient status, rhythm	Maintenance
Project : unusual, very complex/costly, multidisciplinar	Poorly predictable	Outcome, throughput time, resource optmization	NASA, ship building

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Focused Factory

“Need to separate solution shop hospital from value adding process hospital” *C.M. Christensen*

coxa
Hospital for Joint Replacement

and/or ?

Shouldice Hernia Centre
Ontario Canada

LUNDBECKFOND CENTER
FAST-TRACK HOFTE- OG KNÆKIRURGI
WWW.FTHK.DK
v/Professor Henrik Kehlet, Professor dr.med. Torben Bæk Hansen & Professor Kjeld Søballe

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mk Martini-Klinik am UKE Hamburg-Eppendorf
Ein Unternehmen des UKE

Examples

- Shouldice Clinic, Canada
  → Hernia surgery
- Martini Klinikum, Germany
  → Prostate surgery
- COXA Clinic, Finland
  → Hip & knee joint replacement
- The Lundback Fast-track centre for knee and hip surgery, Denmark
  → Hip & knee joint replacement
- (CRG, Belgium)
  → Infertility treatment

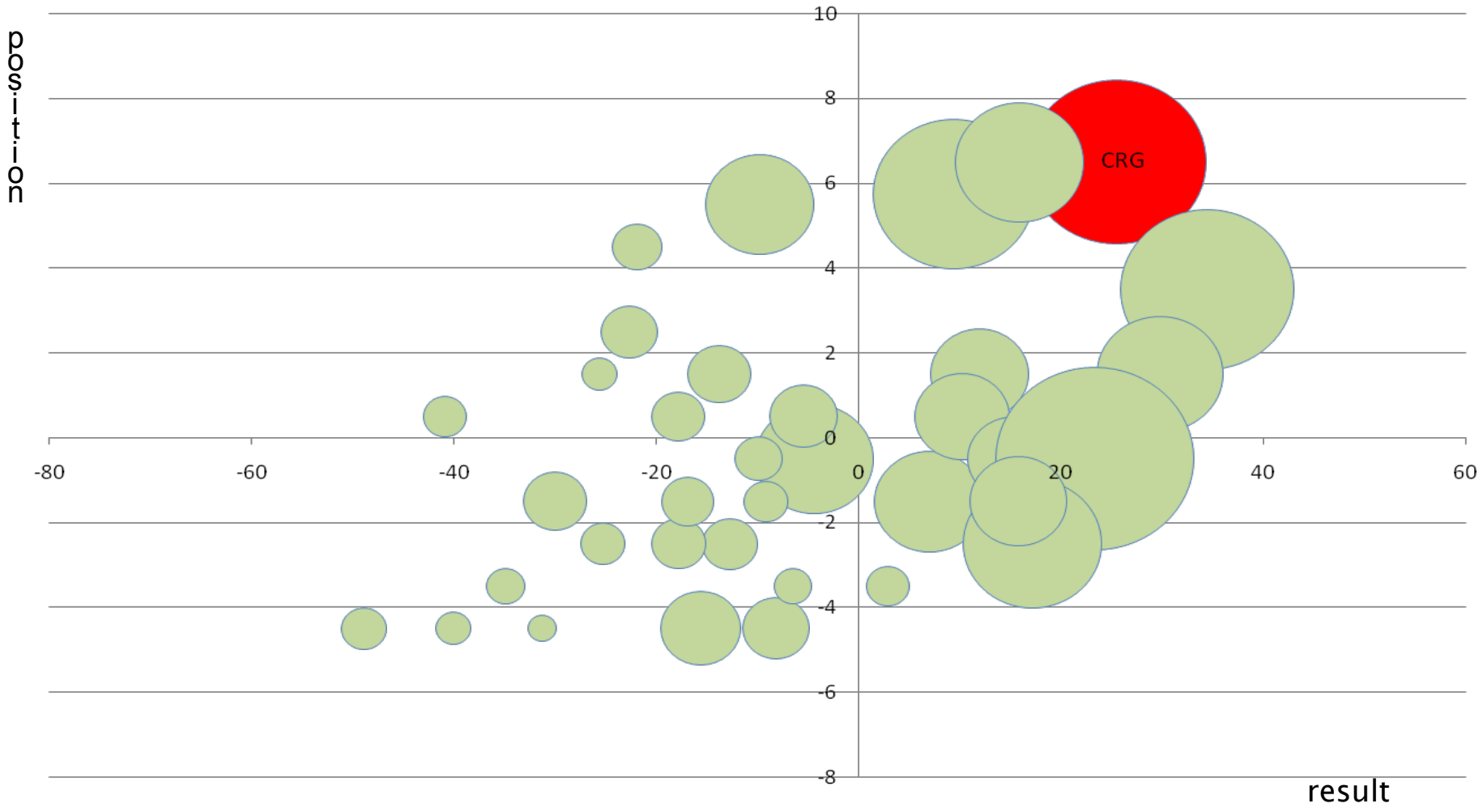
COXA Clinic (Tampere University Hospital)

- TUH is designing a hospital concept around “focus clinics”
  - → 1st(2002) : COXA clinic for hip & knee joint replacement
  - → Seperate legal entity (!) within university hopital walls, started as PPS (26% private), now 100% “public”
  - → Followed by TUH Heart Centre, TUH Lab Centre, TUH Eye Centre, TUH Traumatology Centre,...

COXA Clinic (Tampere University Hospital) : facts, as compared to rest of Finland

- Increased & increasing quality
  → 50% less revisions & dislocation rates
- Pricing
  → 45% cheaper!
- Patient satisfaction
  → 15-20% higher
- Staff satisfaction & retention
  → Around 80%
  → Higher salaries

CASE : UZ Brussels' Centre for Reproductive Medicine



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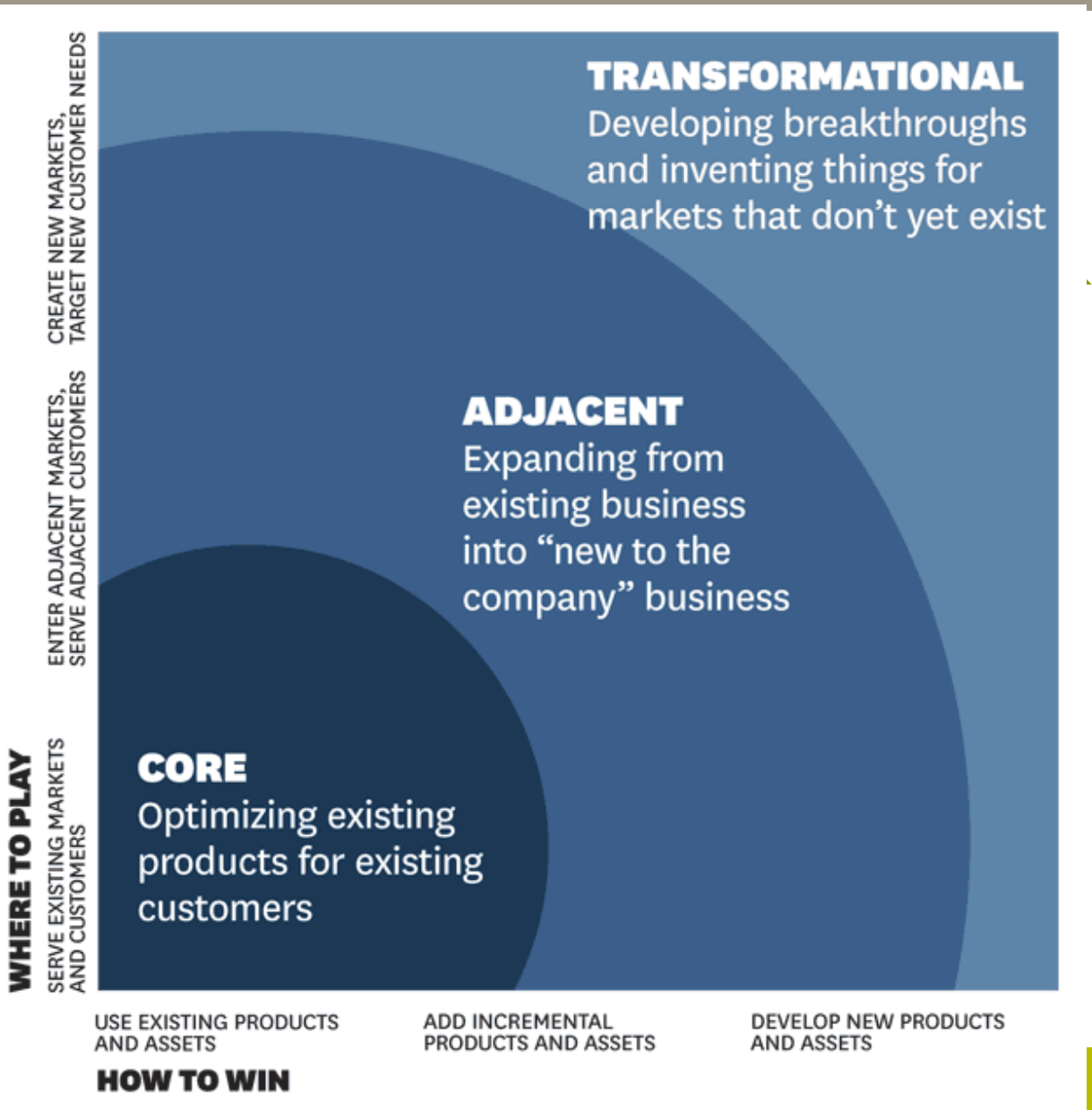
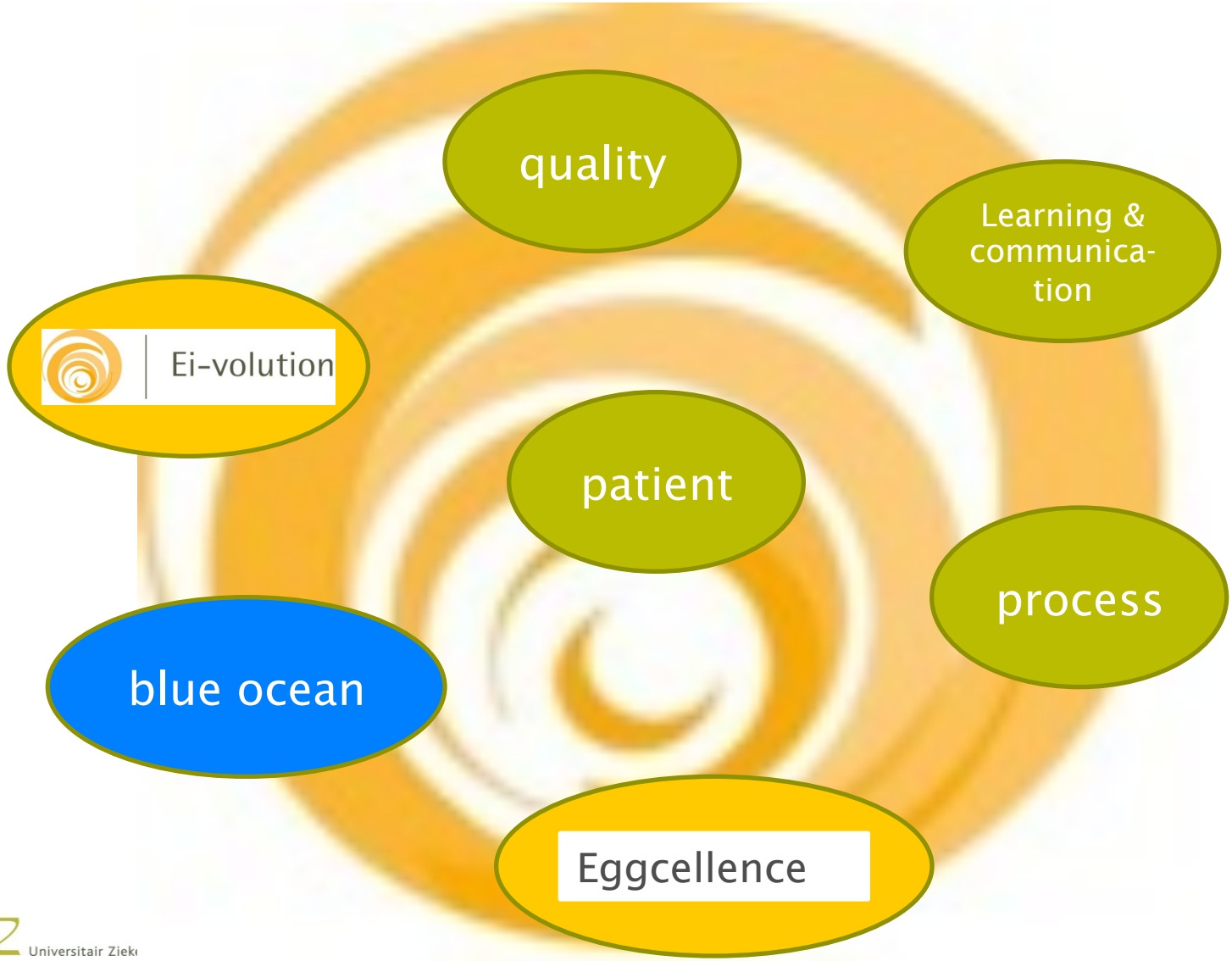
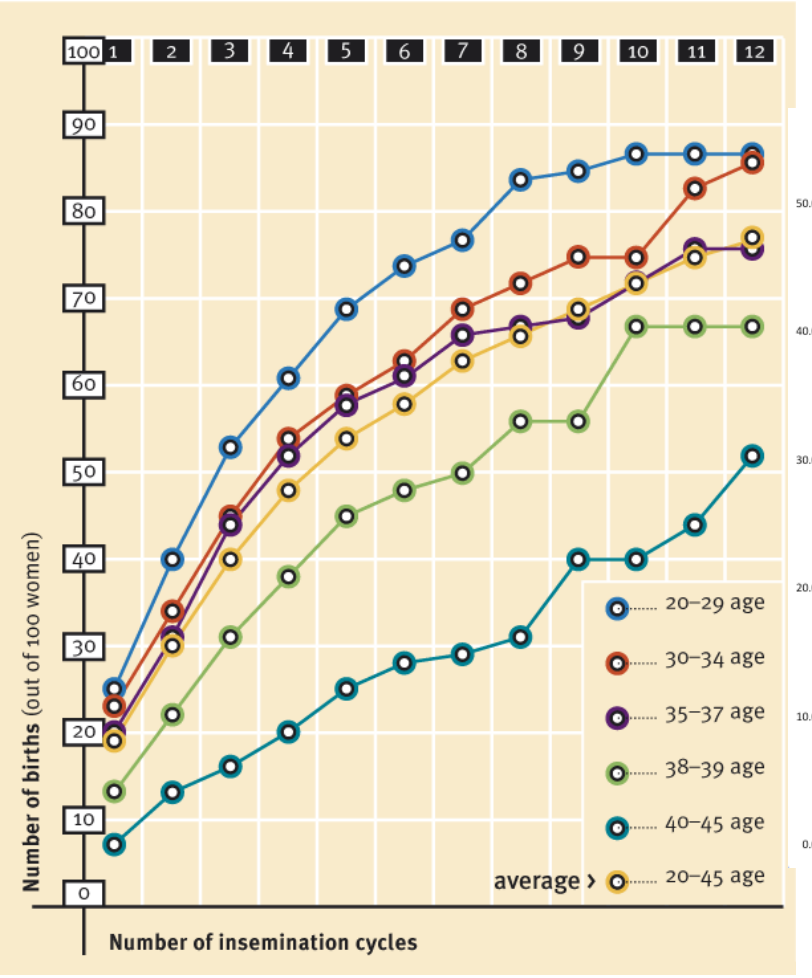
CRG@work : defined innovation strategy

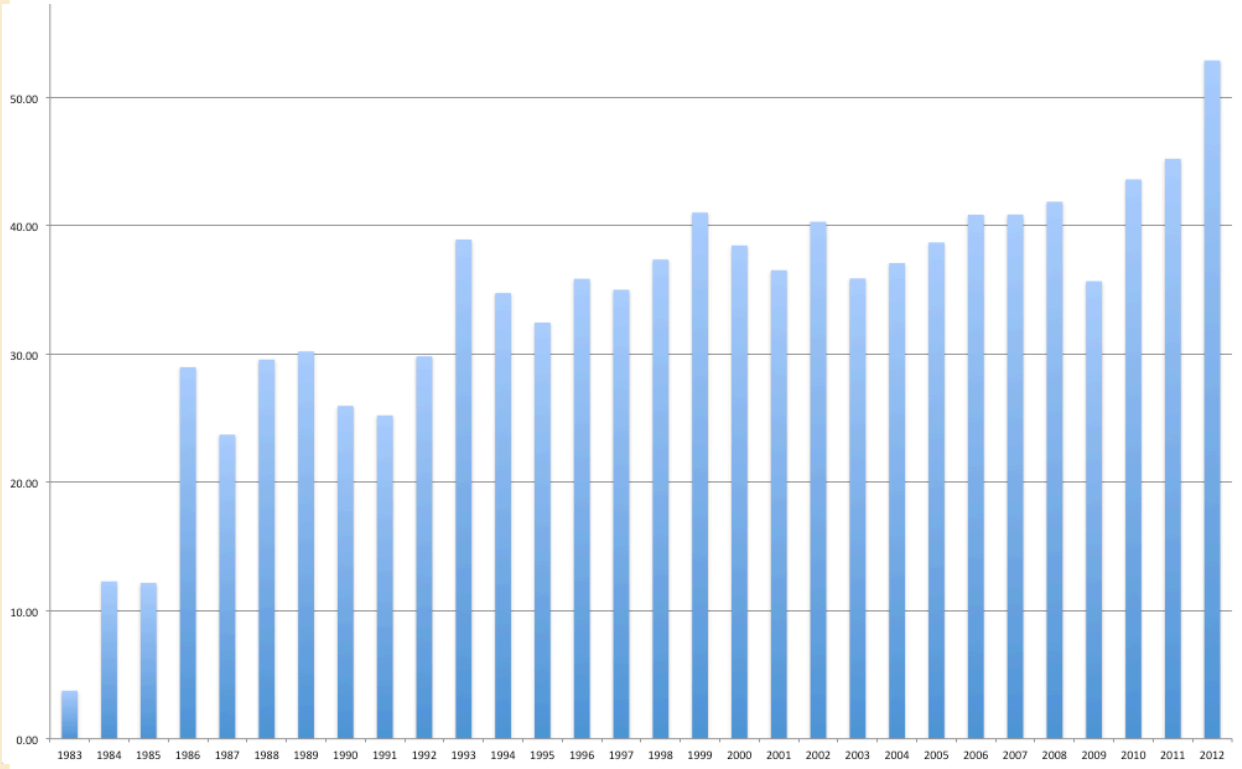


CRG@work : Innovation Strategy
e.g., also in Operational Excellence

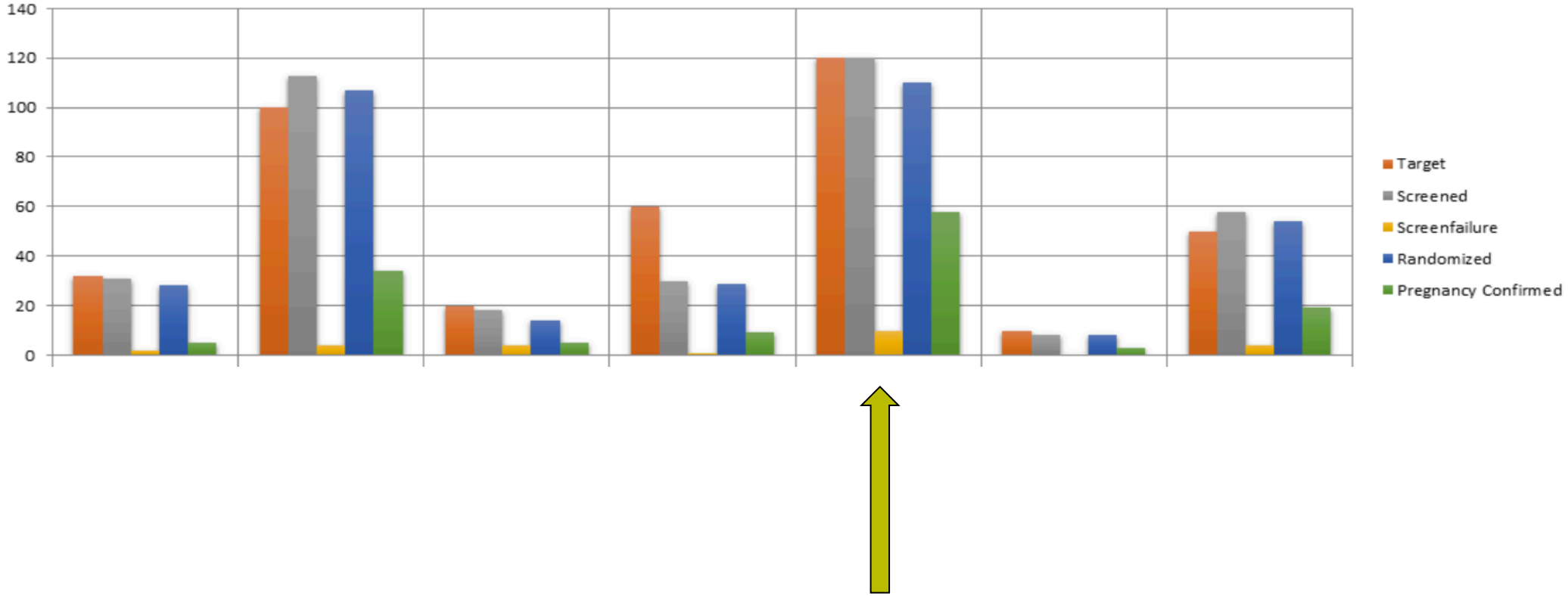


Results : Objectively superior pregnancy results

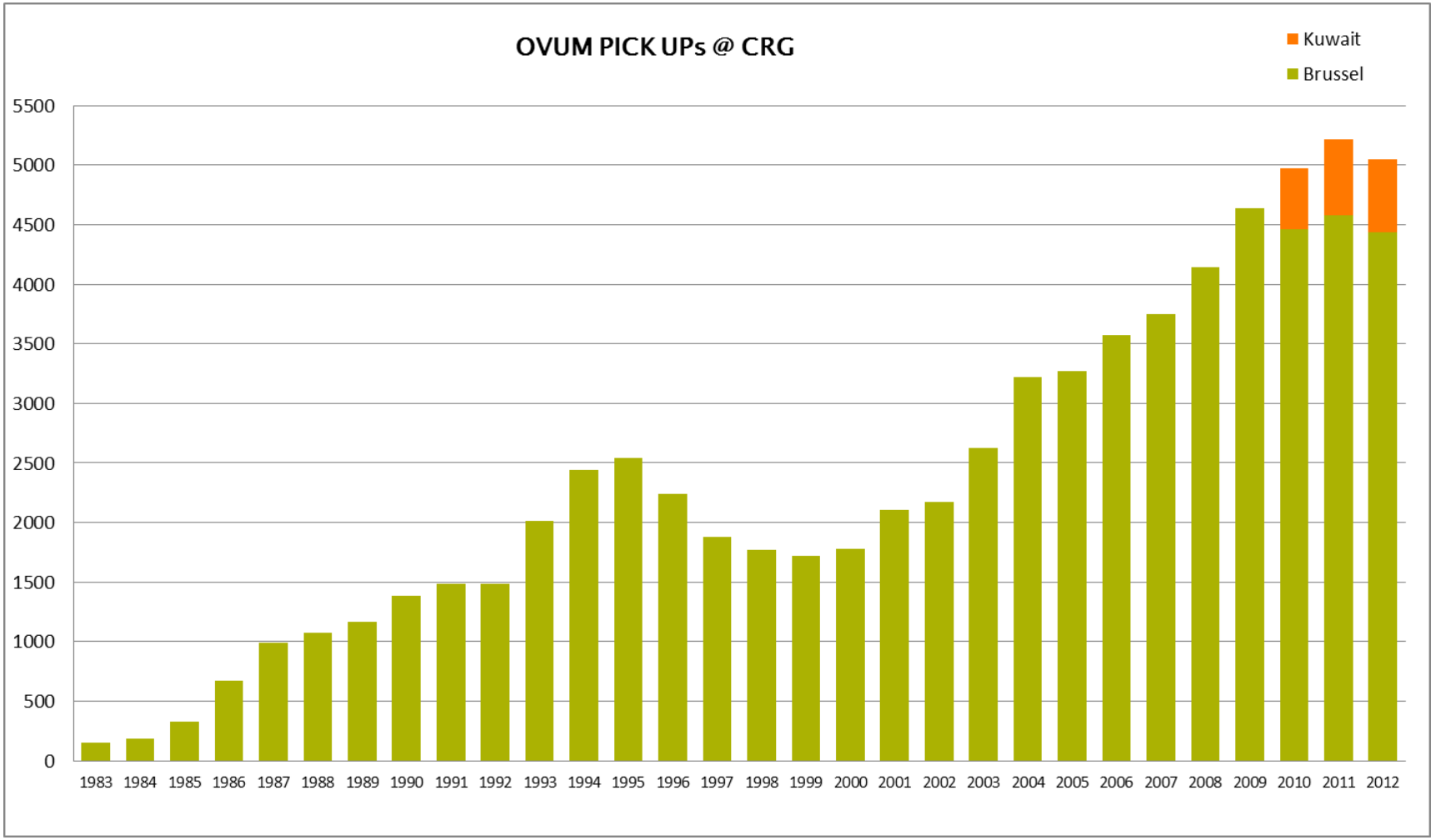




National Benchmark 7 largest centres



Results : The largest academic ART centre in Europe



3 Things to do

1. You cannot predict the future
2. First decide *who* you are and *why* you are doing what you are, then *how* you want to do that, than *what* you are actually going to do (then “strategy” will be automatic and good…;-)
3. Become something else

3 rules

1. Better before cheaper
2. Revenue before cost
3. There are no other rules

…and : never forget The Human Factor…