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ASIA EDITION

Taking a patient-centric approach to value-based care in APAC

March 10, 2023 | Analysis | By Tim Morris, Commercial Portfolio and Partnership Director for Elsevier

Tim Morris, Commercial Portfolio and Partnership Director for Elsevier, shares his thoughts on how hospitals can deliver value-based outcomes for truly patient-centric care



The value-based care model is gaining momentum in the healthcare industry, and it is not hard to see why. After all, value-based care – which rewards healthcare providers with incentives based on the quality of care they provide to patients – has been shown to improve healthcare outcomes and reduces costs for patients.

On paper, value-based care should be an easy sell for hospitals. However, the application of such a care model is not as straightforward as it sounds.

Implementation (of a value-based care model) is incredibly hard, and I think it represents, in this region, the difficulties where you have a private-public relationship.

The majority of care for patients in the long-term is outside of the hospital. If we can manage our patients in that pre-illness phase, they may never get to the point where they actually have to be in the hospital. That's quite a difficult concept when you're a provider who's looking at your bottom line – how do you manage that?

There are four broad definitions when it comes to trying to understand what value means.

- **Personal value**: Appropriate care to achieve patients' personal goals
- **Technical value**: Achievement of best possible outcomes with available resources
- **Allocative value**: Equitable resource distribution across all patient groups
- **Societal value**: Contribution of healthcare to social participation and connectedness

Implementing a value-based care model with a patient-centric view, however, is not just about reducing the cost of care for the patients, but also using an evidence-based approach to improve healthcare outcomes.

If you're only reducing cost, using that to improve patient value is not necessarily the same thing. We often think of the patient as a customer, and that's perhaps the wrong view of the patient. When a patient is a customer, they'd potentially want the most expensive drug because it's perceived to be the best. It won't necessarily be based on evidence.

This view is supported by the findings from a value-based healthcare study conducted by PwC for one of India's largest healthcare providers, Narayana Health. Through adopting an assembly line concept for surgeries to reduce the length of stay and re-engineering the design, material and use of equipment, Narayana Health was able to perform many surgeries in a row by limiting the work of surgeons to only performing the task they are specifically qualified to do, while other staff do the administrative and preparatory tasks. This enabled surgeon in India to perform more than double the procedures each year in a safer manner – between 400-600 in comparison with 100-200 in the US, a significantly lower average cost of open heart surgery, with a 1.4% mortality rate within 30 days of coronary artery bypass graft surgery compared with 1.9% in the US.

It's essential that when we start developing our value-based care models, we think of the patient, but we also think about how do we provide the best possible care, the evidence-based care, relevant to that as well. Elsevier spends a lot of time developing evidence-based content to try and improve outcomes, and oftentimes, the evidence says we do not intervene. We reduce the amount of treatments. We may not do surgery; we may do something different.

So, a patient-centred view of care needs to take into account the patients' values, their needs, and their express wishes. But you need to do that within the construct of the value that you're trying to achieve for your population.

Taking an interdisciplinary, multi-disciplinary view of value-based care

In order to get the best outcomes for patients, healthcare providers have to look at adopting a multi- disciplinary approach to their value-based care model – this means combining the knowledge and experience of the physician within the hospital with the primary care physicians, as well as working with nurses in the community, and working with the patient themselves.

It's an interdisciplinary approach in terms of developing those measures that you want to put in place for health outcomes, and then actually learning from them.

What we do know is that you implement something and if you measure it, then you should be adapting it, it should be a feedback loop to ensure that you improve the patient outcome as you go forward. You need to measure the health outcomes specifically, against the cost that you're putting in.

Unless you're looking at the cost across all of the healthcare elements – into the primary care, the home care elements – you won't have a full understanding of the total cost of care. Once you have this framework in place, you can then expand that across larger populations, and the more hospitals you have engaged in value-based care model, the better the success will be.

The value-based care model can also help to reconnect clinicians with their patients as healers. This allows clinicians to think of their patient as a whole, rather than to just be responsible for a particular disease.

This can reinvigorate clinicians becuase if our doctors start to think of themselves as healers of their patients, then we start to reduce burnout in clinicians, and we can start to help clinicians engage again in their future role.

We know we have a crisis across the globe – we don't have enough physicians, nurses, and allied healthcare workers. But if we can engage them, and give them value back to their roles, then we can reduce the number of people who are leaving.

In this sentiment, Singapore's Ministry of Health launched a "one resident, one family doctor" scheme as part of a larger nationwide healthcare transformation strategy, to bring healthcare closer to where citizens reside. Under this scheme, the home hospitalisation programme aims to provide alternative care models to inpatient delivery through outpatient monitoring solutions, multidisciplinary care, and telehealth solutions. Upon discharge, hospitals would refer patients to the family physicians they are enrolled with, to ensure continuity of care. This significantly reduces the strain on healthcare workers, and provides added value to the roles of clinicians.

The road to zero harm

One of the biggest issues the healthcare industry is facing today is the number of adverse events that occur to patients while receiving care in hospitals.

Statistics have shown that one in 10 patients is subject to an adverse event while receiving hospital care in high-income countries. There are approximately 134 million adverse events that take place due to unsafe care in hospitals in low-and middle-income countries. An estimated 2.6 million people die as a result of an adverse event within hospitals, and the social cost of patient harm across the globe is valued at one to two trillion dollars.

If you want to do value-based care, what you could actually do is reduce cost dramatically by not having adverse incidents in hospitals. If you want to improve outcomes, you can actually reduce the numbers of people who die in our hospital due to adverse events.

For context, we're at the end of close to three years of the pandemic, and six million people have died across the globe because of it. It's absolutely appalling the damage it has done to our globe. But if we're losing 2.6 million people a year to avoidable deaths, then we're not doing enough of ensuring that we're improving quality and safety within our hospitals.

Focusing on outcomes that matter

In order to understand whether they have improved the value to their patients' lives, healthcare providers will need to put in place appropriate measurements which focus on the outcomes that matter.

Namely, the three main outcomes that hospitals can start to measure in terms of the patient experience within the care they provide are:

- **Capability**: The ability of patients to do the things that define them as individuals, and enable them to be themselves
- **Comfort**: The relief from physical and emotional suffering
- **Calm**: The ability to live normally while receiving care

A significant problem that hospitals face in improving healthcare outcomes, however, is the lack of health literacy among their patients.

Patients don't necessarily understand the care they're receiving. Up to 80% of information is immediately forgotten by adult learners. 50% of adults have trouble understanding the healthcare information they've been provided.

So, if we're planning on improving outcomes for patients, and the majority of care is managed outside of the hospital, we need to look at health literacy to reduce hospitalisation, particularly in low health literacy groups of patients.

In a study conducted by Elsevier, which saw close to 3,000 clinicians from around globe interviewed, patient empowerment was identified as a key area that could potentially reduce patient complexity for clinicians.

In the discussions, clinicians expected patients to take more responsibility in the next 10 years. We think there's going to be a shift into preventative care as well – this is a value-based story, if we're looking to impact populations, we need to do it outside of the hospital before they become unwell.

We need to look at dietary, exercise management for people in pre-diabetic states, so we can reduce the number of those who need to go on medication. 56% of clinicians believe more patients will attend regular health check-ups in the future.

There is also an emphasis on public health, and where governments are involved, then we can see that we can actually start to impact people in that public health space. Often this is a space that is not currently funded in our insurance models at the moment. And by harnessing big data over the next 10 years, patients will be better prepared to work with clinicians and anticipate the likely conditions that are going to impact them in the future.So, I think the future looks good. But we do need to join up how we fund these models. We have to look at how we work across primary and secondary care. And we need interdisciplinary teams to work with patients and empower patients in the future to manage their own care.

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