

UNDERSTANDING THE MEANINGS OF VALUE

The 2 meanings of value

1. A value is a statement of principle shared by all who work in a health service eg 'This service values the right of patients to decide what treatment they want'
2. Value is a measure used to appraise the balance of benefits and harms resulting from the investment of resources eg 'The use of aspirin to reduce the risk of a second heart attack is a high value intervention'

Evidence is objective

Value is subjective

The meaning of value being ‘a measure used to appraise the balance of benefits and harms resulting from the investment of resources’ is used in different ways by different groups of people, notably by

- patients
- clinicians
- people who manage healthcare
- payers and policy makers
- industry

1. IS OUR SOCIETY SPENDING TOO MUCH OR TOO LITTLE ON HEALTHCARE?
2. IS THE MONEY ALLOCATED FOR THE INFRASTRUCTURE THAT SUPPORTS CLINICAL CARE AT A LEVEL WHICH WILL MAXIMISE VALUE?
3. HAVE WE DISTRIBUTED THE MONEY TO DIFFERENT GEOGRAPHICAL POPULATIONS BY A METHOD THAT RECOGNISES VARIATION IN NEED
4. HAS MONEY BEEN DISTRIBUTED TO DIFFERENT PATIENTS GROUPS, E.G. PEOPLE WITH CANCER TO MAXIMISE VALUE ?
5. ARE ALL THE INTERVENTIONS BEING OFFERED LIKELY TO CONFER A GOOD BALANCE OF BENEFIT AND HARM, AT AFFORDABLE, FOR THIS GROUP OF PATIENTS?
6. ARE THE PATIENTS MOST LIKELY TO BENEFIT, AND LEAST LIKELY TO BE HARMED, FROM THE INTERVENTIONS, CLEARLY DEFINED?
7. COULD EACH PATIENT'S EXPERIENCE BE IMPROVED?
8. IS EFFECTIVENESS BEING MAXIMISED?
9. ARE THE RISKS OF CARE BEING MINIMISED?
10. CAN COSTS BE REDUCED WITHOUT INCREASING HARM OR REDUCING BENEFIT?

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PAYERS

PROVIDERS

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20th Century question;
is the evidence?

21st Century question;
how good is the evidence ?

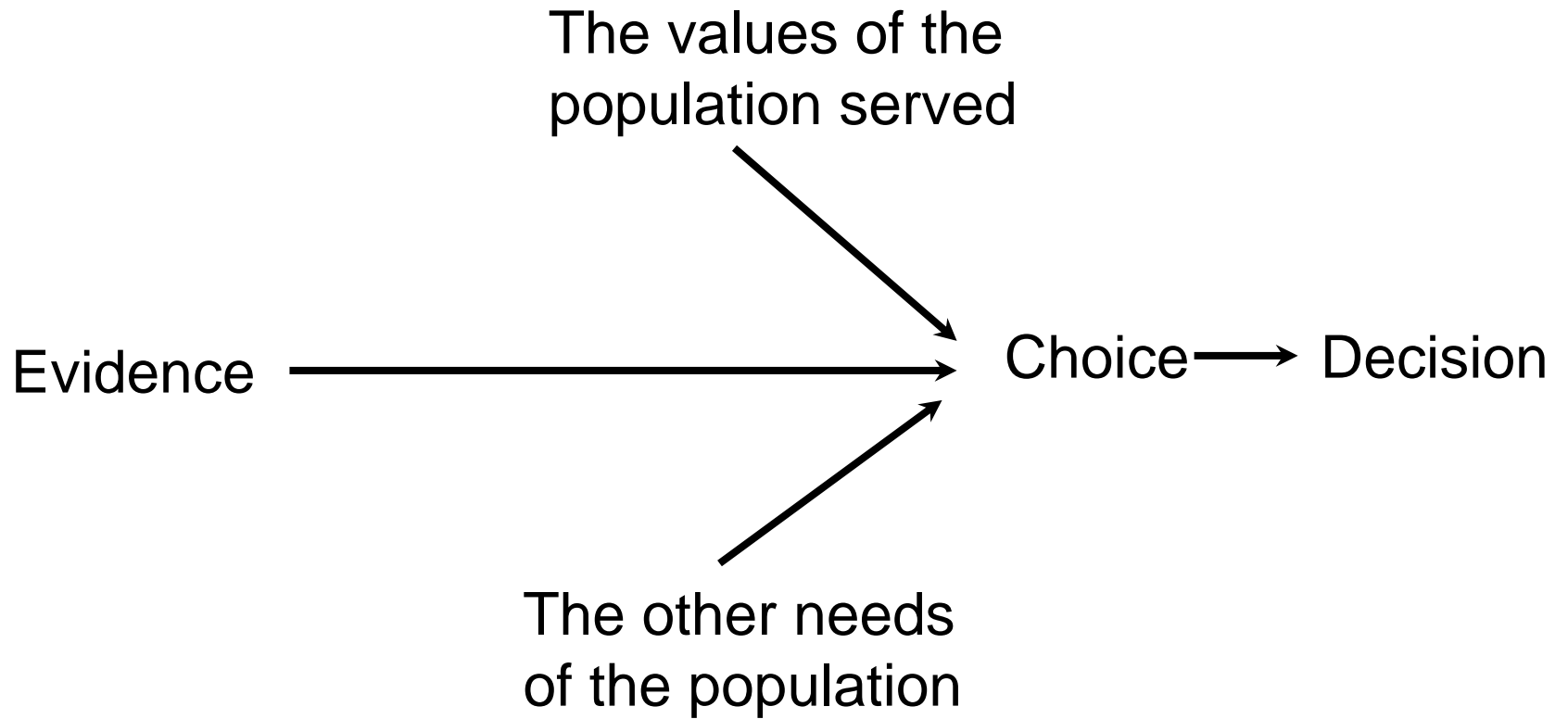
20th C question 'is it cost-effective?'

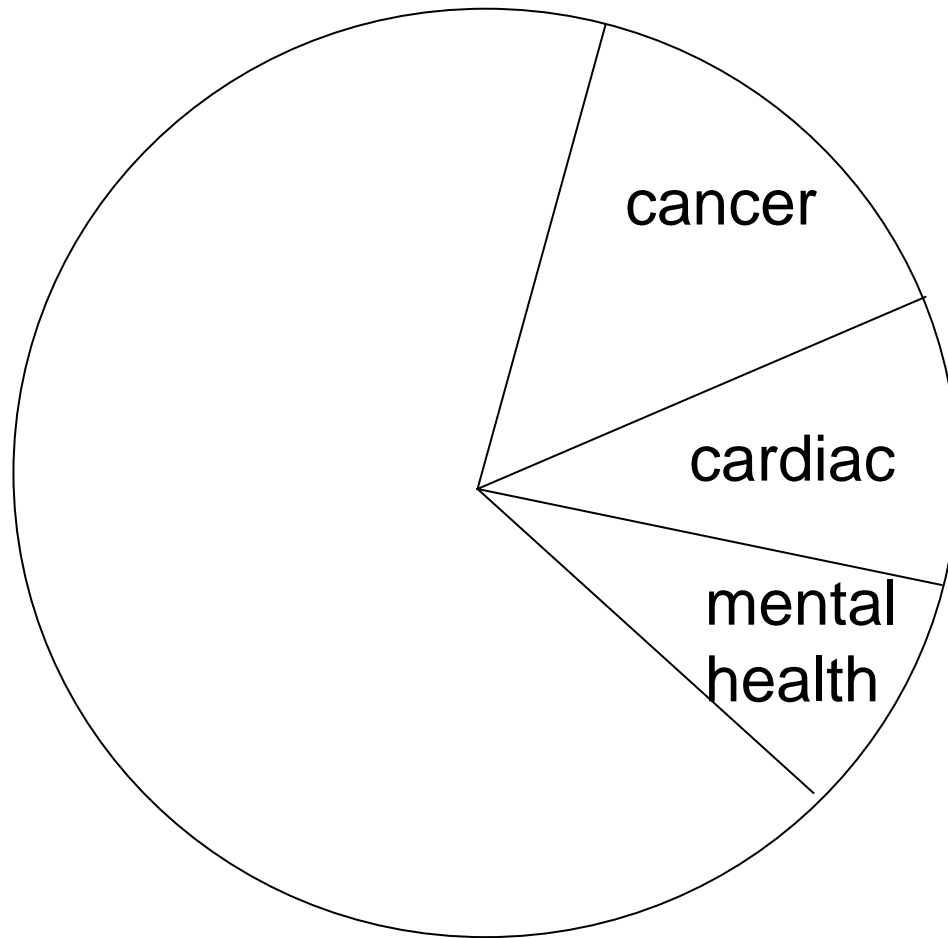
21st C question 'what is its added value and opportunity cost?'

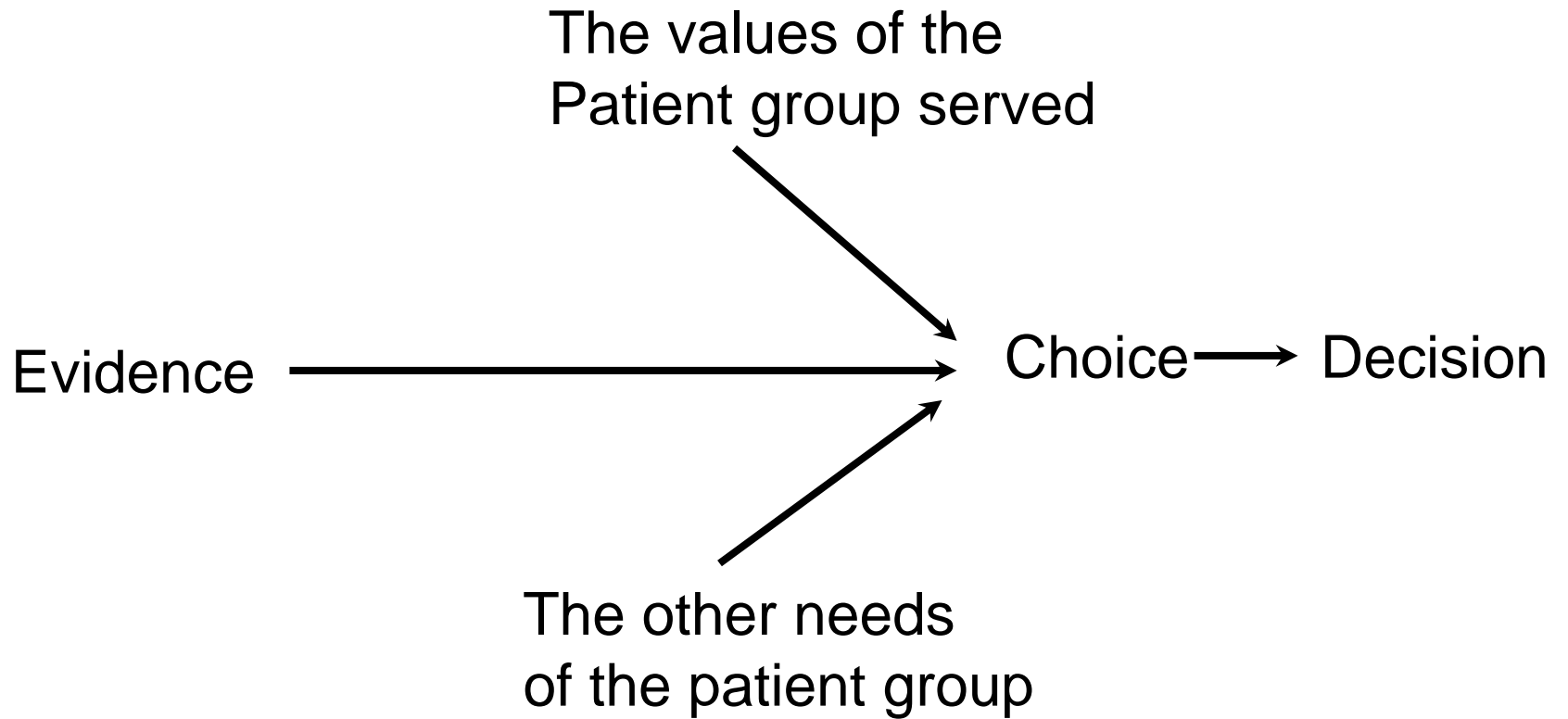
20th C question 'can our budget be increased ?'

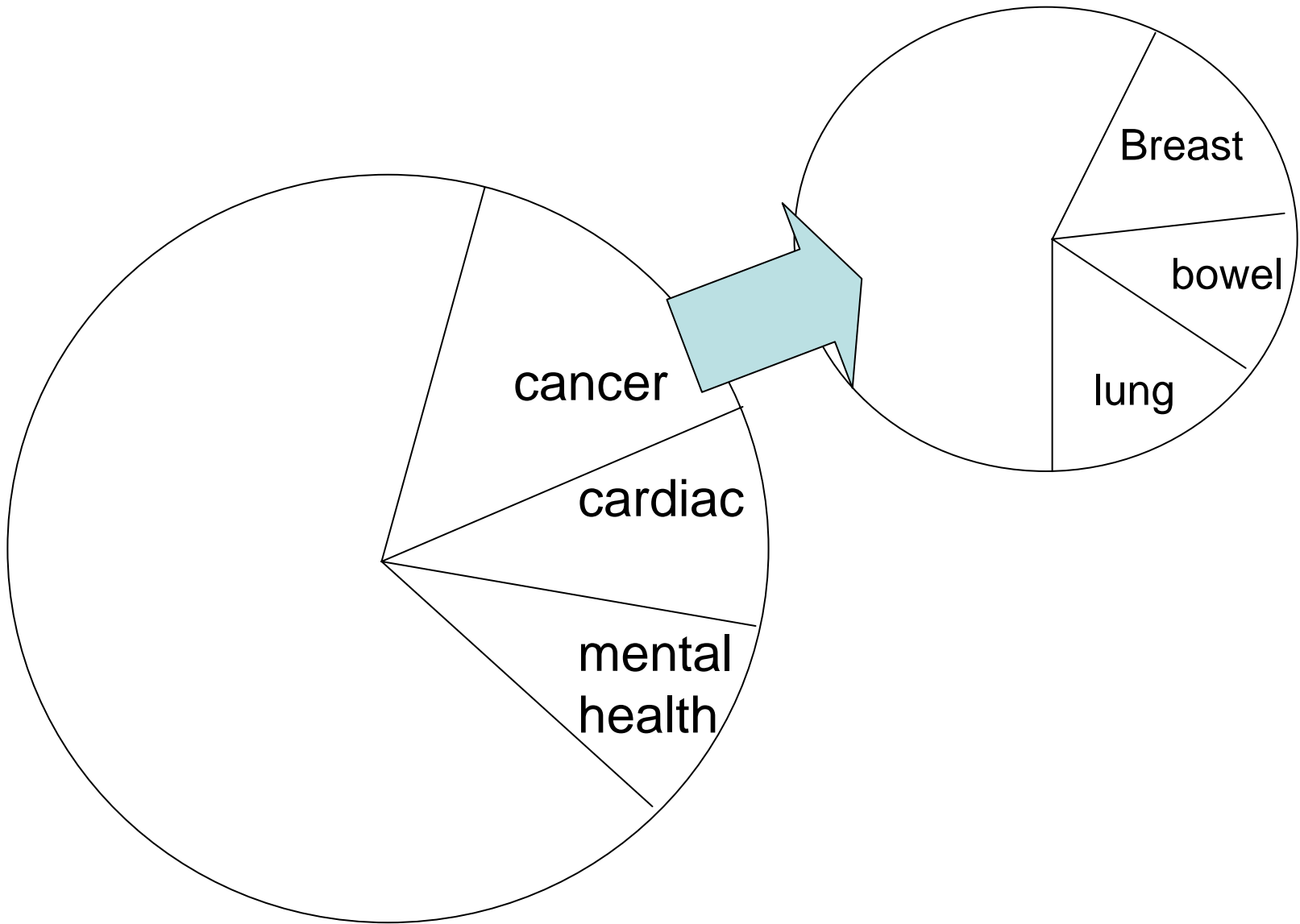
21st C question 'is this of higher value than other interventions for this group of patients'

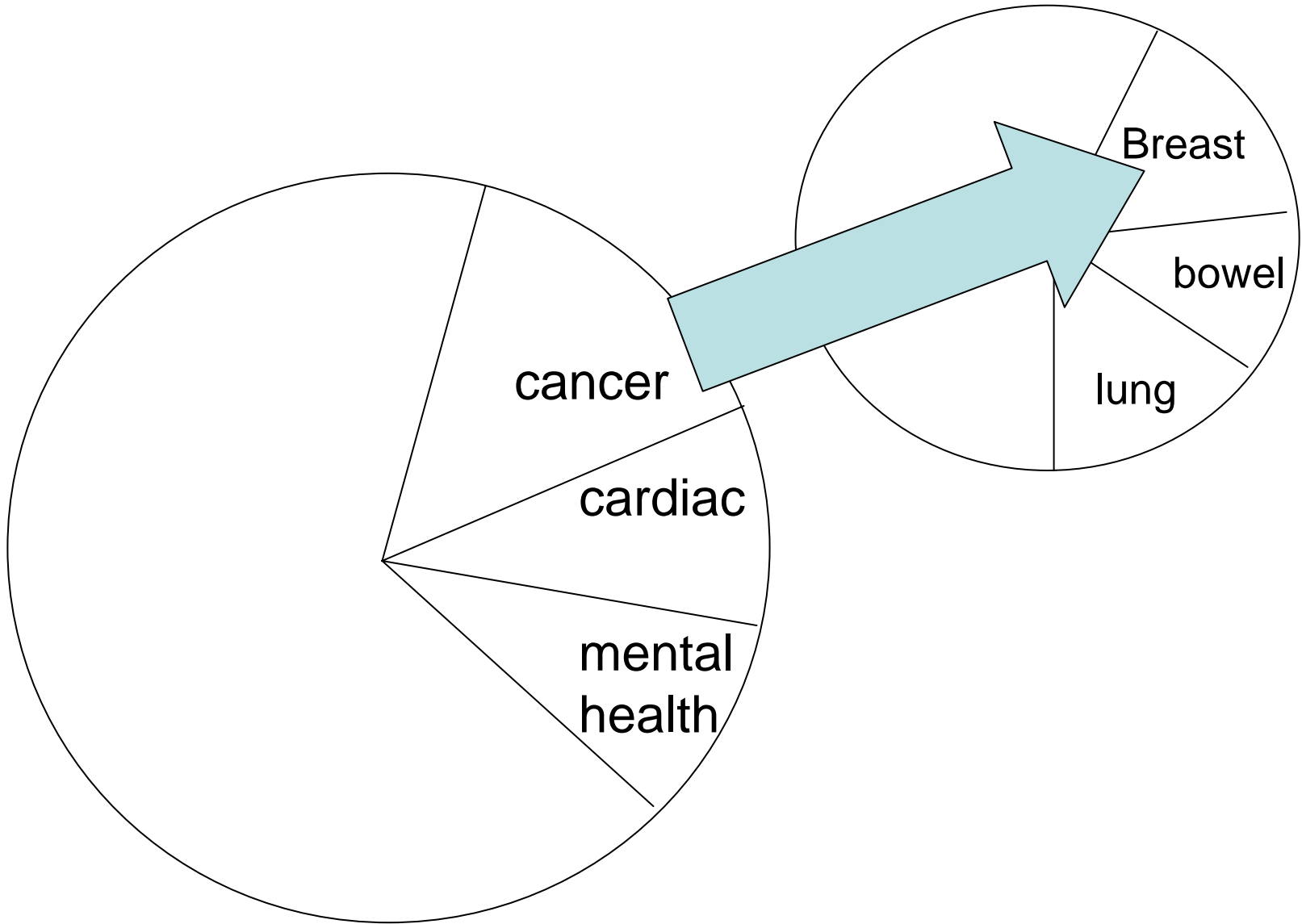
Choosing what to fund





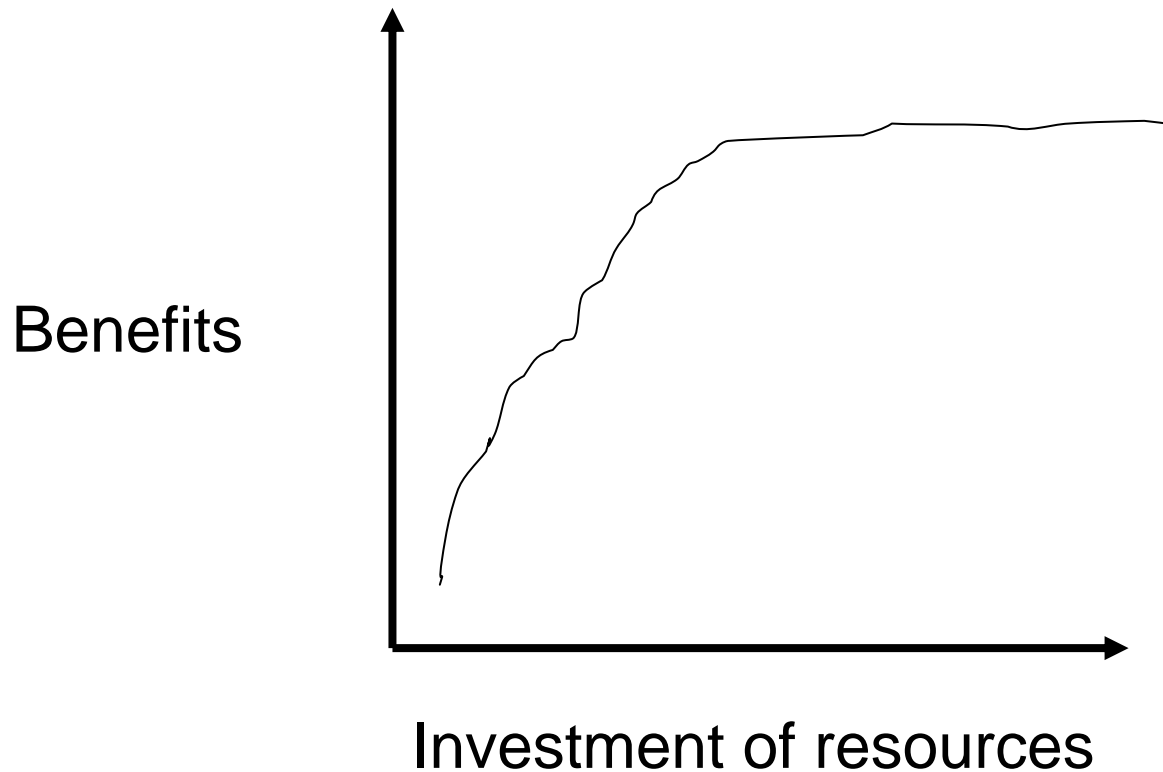




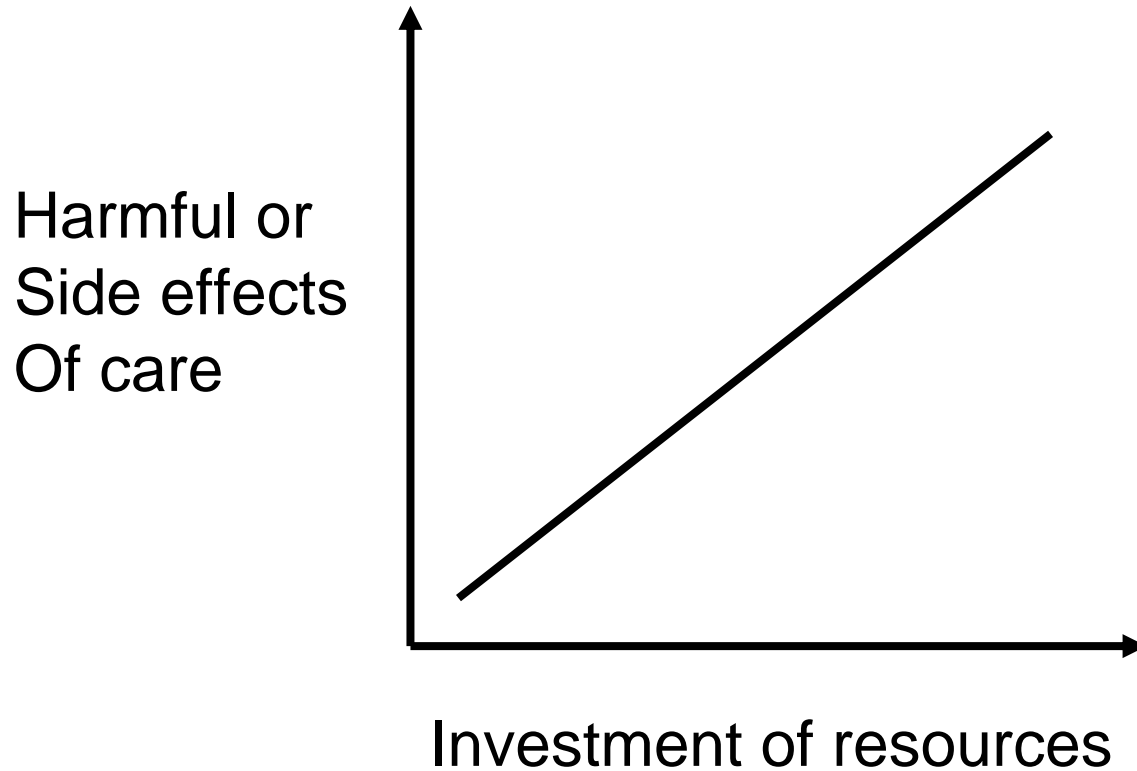


Choosing how much to fund

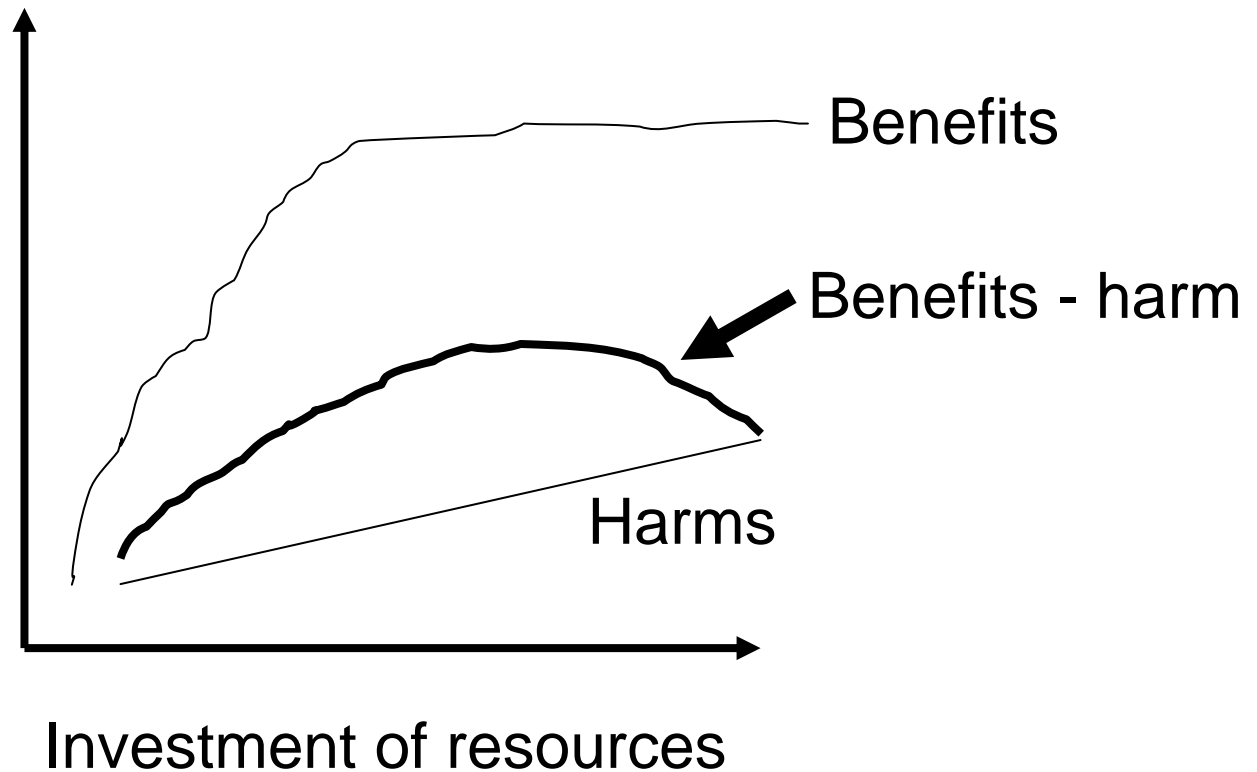
The law of diminishing returns; beneficial effects do not continue to increase in direct proportion to investment

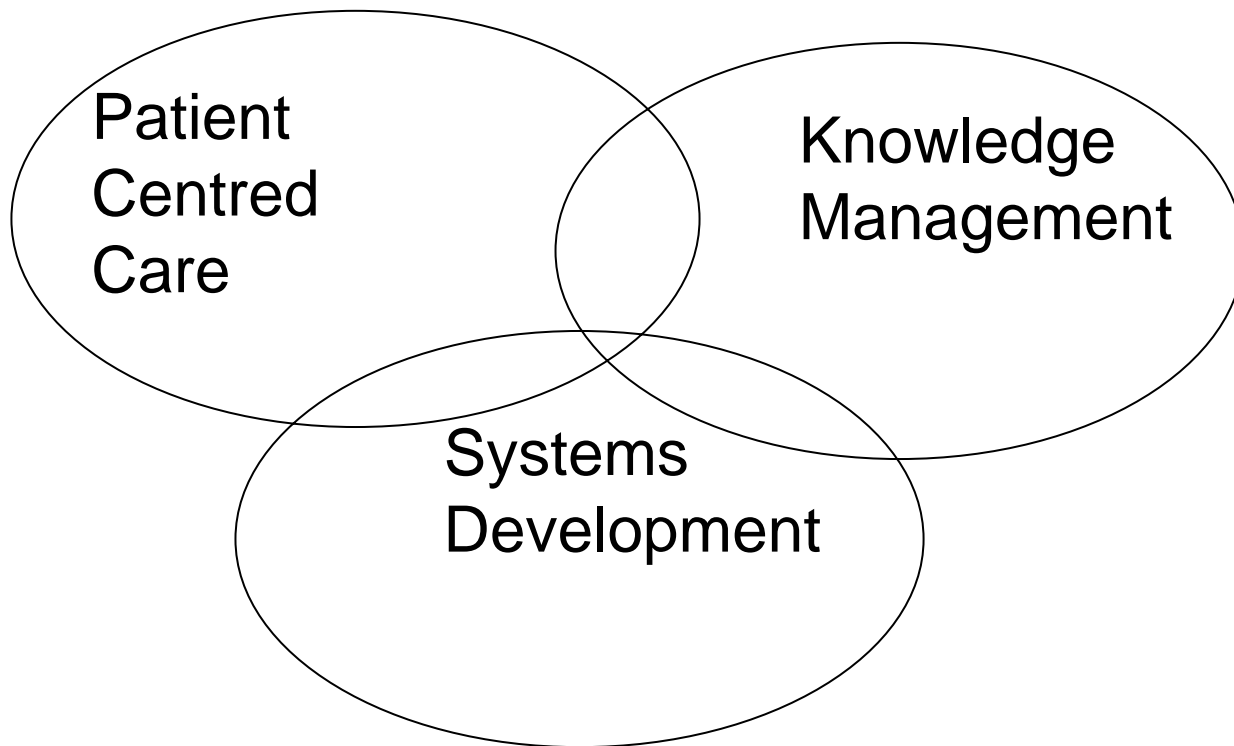


Harmful effects increase in direct proportion to the resources invested



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

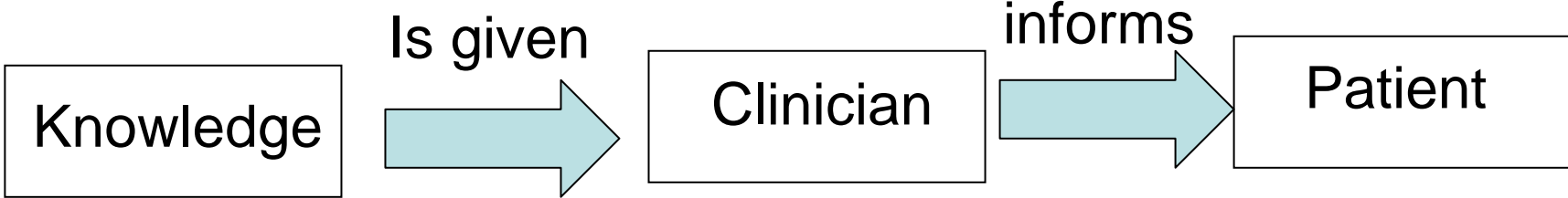






The Resourceful Patient

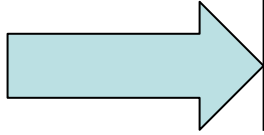
J A Muir Gray



Knowledge



Patient



Clinician

Knowledge

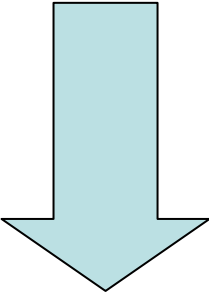


Patient



Clinician

Seeks
advice



WWW

Offers reflection

Knowledge

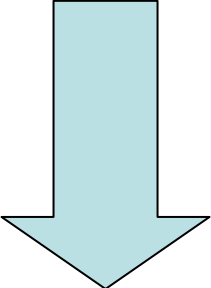


Patient



Clinician

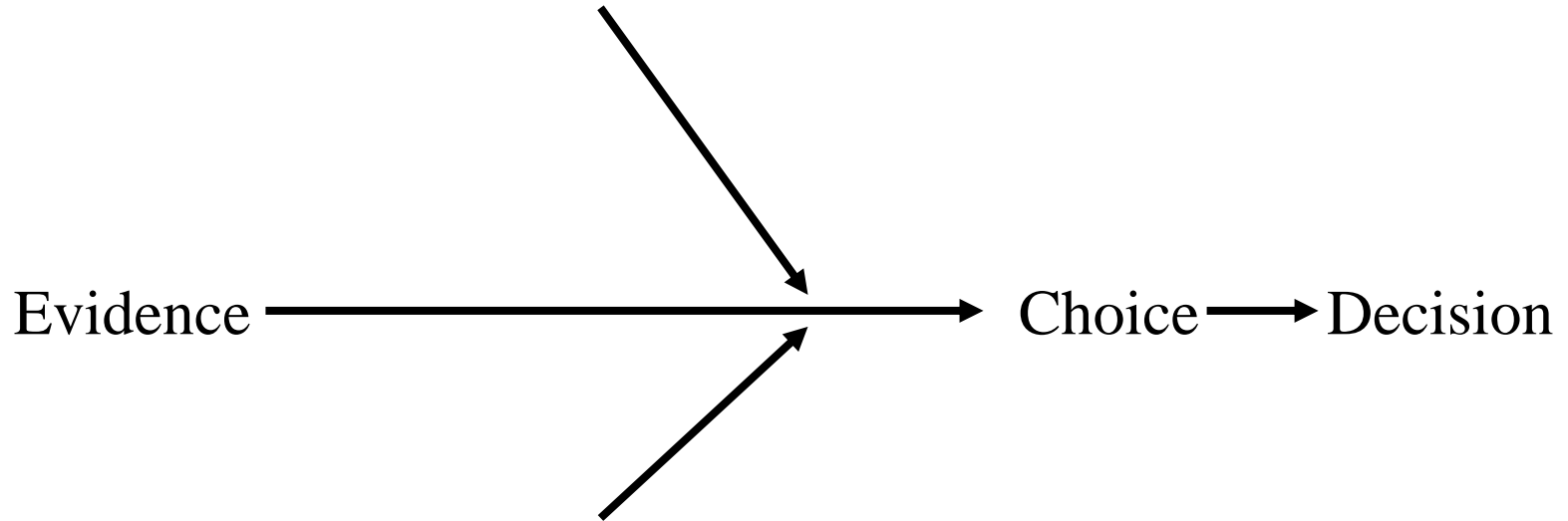
Seeks advice



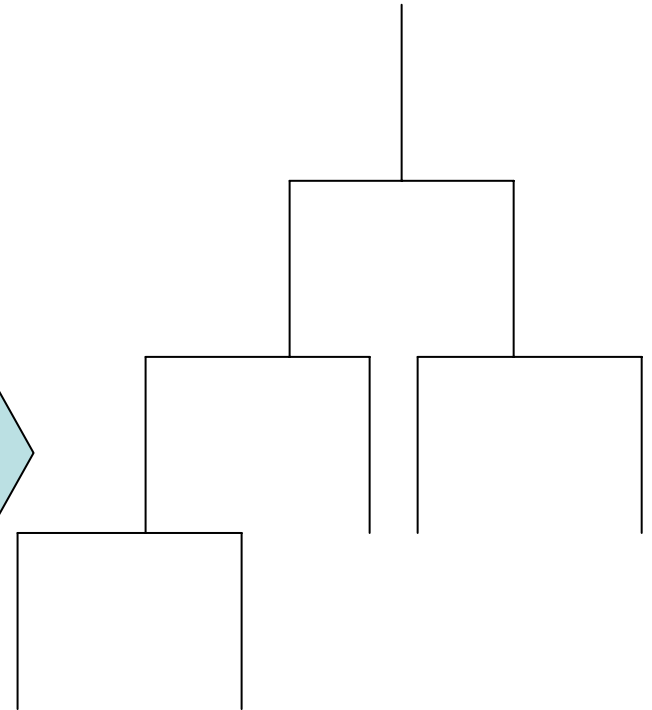
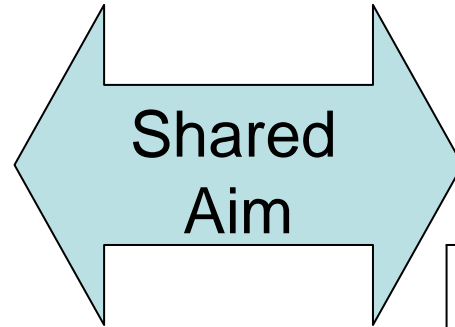
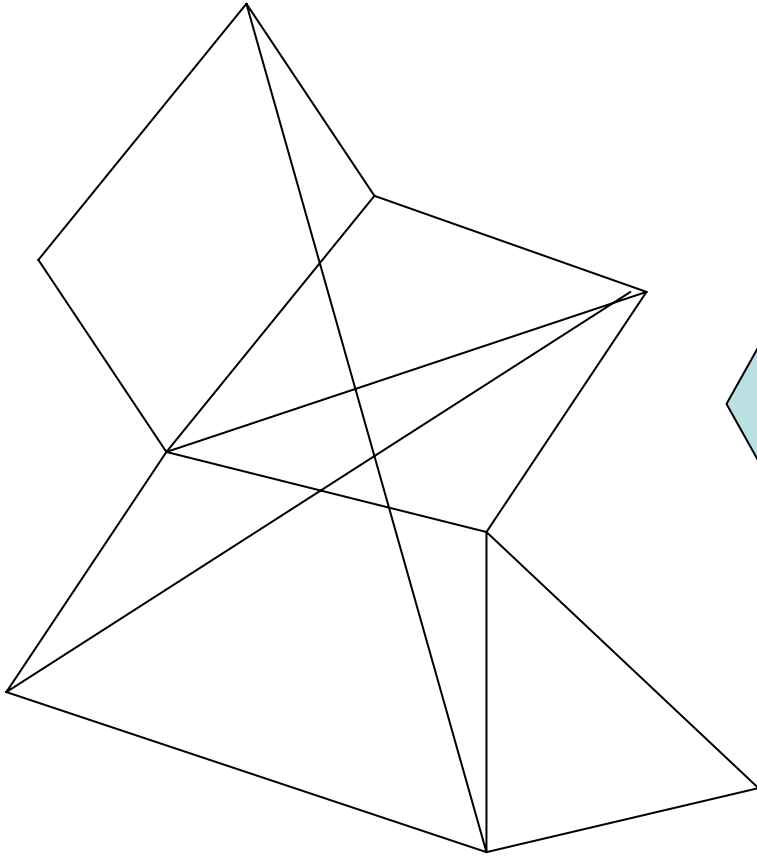
WWW



The values the patient places on benefits and harms of the options



The clinical condition of the patient ;other diagnoses and risk factors



Hypertext organisation
(Nonaka & Takeuchi OUP 1995 ;
The Knowledge Creating Company

Bureaucratic Organisation

A National Epilepsy Service would have

A National set of objectives, criteria and standards

A National Dataset

A single specification for all information system providers

A National knowledge base updated annually

A nationally agreed template of a care pathway, expressed using the Map of Medicine

A National community of practice, including patients

the Screening Specialist Library

Doing more good than harm.

of the National Screening Committee

aged at the level of a large population to monitor quality effectively. In the UK, this is carried out by the use of research evidence to identify programmes that do more good than harm; the second is to make good than harm at a reasonable cost. In policy-making, the evidence for screening is often limited,

available evidence on screening. We have concentrated initially on the NSC policies, programmes NHS - the Cochrane Library, Health Technology Assessment (HTA) reports, NICE guidelines, Centre for Health Economics and Policy Law. We also include UK and international Health Technology Assessments contained in the Centre for Health Economics and Policy Law from the NHS Economic Evaluation database.

Screening information for health professionals in the UK, available at www.screening.nhs.uk

Policy positions have been examined, and updated if necessary. NSC screening policies can be viewed by document listing all policies is available - see [NSC policy positions 2006](#)

NSC policies & reports

[NSC Policies](#)

new July 2006

Summary of policy positions

[NSC criteria for appraising a screening programme](#)

View the criteria used to appraise the effectiveness and appropriateness of a screening programme

[NSC Annual Report](#)

new 2004/5

See the Programme Director's Annual report

[Distribution of screening programmes in England](#)

Map showing regional antenatal and newborn screening programmes

National Screening Programmes

[Bowel Cancer](#)

[Breast Cancer](#)

www.library.nhs.uk

HOW TO

HOW TO

GET BETTER VALUE HEALTHCARE

MUIR GRAY

OP

The need for better value healthcare will dominate the agenda of patients and clinicians, and those who manage and pay for healthcare in the 21st Century

No society can meet all the needs and demands for better health and healthcare. New technology, population ageing and new diseases, combined with the appropriate demands of better informed and more assertive patients create inexorable pressure. It is however possible to adapt to and use this pressure for transformation of care. There are ten questions about value that every society, manager and payer, and every intelligent clinician and patient must address. This book answers them all and gives advice on how to get better value healthcare by

- Better knowledge management
- Stronger systems of care
- Closer engagement of patients
- Continuous Quality Improvement

This book and the radio station www.soundshealthy.org will help the four partners for better value- patients, clinicians, managers and payer- and the industries which supply them, understand and act

□ GET BETTER VALUE HEALTHCARE

J A MUIR GRAY

Podcast coming soon!

Launching December 15th 2006

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From the Dictionary

Objectives | Criteria
Standards | Target

From the Bookshop

Redefining Health Care by Michael E. Porter and Elizabeth Teisberg

The Trouble with Medical Journals by Richard Smith

No society has enough resource to meet all the needs and demands for healthcare . Even the value it gets from the resources invested by patients, clinicians, managers and those of this web site and radio station is to help those four parties, and the industries which serve three key drivers of better value healthcare.

Systems development; So much of healthcare is **Brownian Motion**, random events with

Knowledge management; Knowledge is the enemy of disease. The application of what has an impact on disease than any drug or technology likely to be introduced in the next decade is clean clear knowledge which is as important to their health as clean clear water was to

Patient engagement and involvement; The 20th Century was the clinicians' Century; the 21st is the patient.

Quality Improvement; *Muda* is the japanese word for waste, and they hate it . Waste is inevitable but does not contribute to the desired outcome. *Kaizen* is the japanese word for quality improvement. *Muda* is the enemy of quality, destroyed ours, and can now transform healthcare.

These four activities have to be added to the agenda of everyone who manages, or pays for, healthcare to help them achieve this. They can prevent or minimise the seven problems that take value from healthcare: 1) Wasteful enthusiastic adoption of low value interventions 2) Errors 3) Poor clinical quality 4) Poor patient experience 5) Unknowing variation 6) Wasteful enthusiastic adoption of low value interventions 7) Failure to adopt high value interventions

NEW BOOK- HOW TO GET BETTER VALUE HEALTHCARE

These topics are also covered in a new book called 'How To Get Better Value Healthcare' available from October. If you want to see the contents [click here](#); if you want to read chapter 1 [click here](#) to see how it came to be written [click here](#).

BETTER VALUE HEALTHCARE BLOG

www.soundshealthy.org

Gravely long slow.

Christus ist
geboren.

Voice

Piano

The first system of the score features a vocal line on a single staff and a piano accompaniment on two staves. The piano part is marked 'p' and consists of dense, rhythmic chords. The vocal line begins with a treble clef and a key signature of one flat.

The second system continues the musical piece. The vocal line includes the lyrics "Christus ist geboren" and "in der Welt". The piano accompaniment maintains its dense, rhythmic texture.

The third system concludes the visible portion of the score. The vocal line includes the lyrics "auf dem Erden". The piano accompaniment continues with its characteristic dense chordal structure.

