Health Sector Innovation and Partnership: Policy Responses to the New Economic Context

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The pressure for change I

- Demographic
- Technological
- The global economic shift with increased fiscal challenges for the health sector
The pressure for change II

This paper:
  - explores organizational responses from European health systems to date
  - considers future needed responses
  - documents a number of interesting examples of innovation
The changing economic context

• Health systems have high interdependence on the broader economic context
• Falling rates of growth in developed countries
• Country difficulties from 2008 financial crisis—Greece, Portugal, Ireland, ?Spain, ?USA
• Re-distribution of economic growth towards China and Asian Rim
• Fiscal dilemmas – challenge to maintain adequate funding levels in many health systems
Modifying “contracts” between citizen and health system

• New discussion about individual responsibility
• Definition of ”the basket” – what to include in the ”insurance package” or public provision
• Prioritization agenda (rationing)
Health sector responses to the Changing Economic Context

- Financial pressure since the early 1980’s
- Systematic efforts to improve health sector efficiency – patient choice (Sweden 1988), self-governing hospitals (UK 1991), shift budgets to primary care holders
- Dekker report (Netherlands 1987), structural reforms (Germany 1992) – aimed at more market style competition, purchaser – provider reforms a variation (UK and Scandinavian countries)
- Change of boundaries between segments of care, incentive based financial reforms, DRGs, improving access and quality etc.
Innovation in the health sector

• The “most complex knowledge system” in society
• Biomedical innovation is the “engine” – an innovation model working
• Three types of biomedical innovation (Fuchs 2010):
  - The effect on quality
  - The effect on cost
  - The effect on the value of care (quality relative to cost)
Innovation in service delivery – a weaker process

• Health system typology – who pays, who deliver services, who judges quality?

• The “evaluation and quality agenda” - forming the base for an evidence informed policy and management:
  - Technology assessment
  - Outcomes research
  - Quality assessment/quality improvement/reengineering
  - Patient safety
Organizational responses to increasing numbers of patients with multiple chronic conditions - Netherlands

- The new structural and financial architecture (competition, multiple purchasers and providers) has generated considerable organisational innovation
- Integration, networks, expanding supply
- A focus on long term care
- Integrated care at the neighbourhood level
- Supply chain approach to primary care and hospitals
Responses in a tax-funded, highly integrated system - **Sweden**

- Tax-financed, 21 county councils responsible for both funding and delivery
- Responsibility for chronic care is functionally divided between hospital care, primary care (county councils) and social care/daily living (municipalities) – different financing, different "cultures" and "logics"
- Guidelines, treatment protocols – nationally, locally
- Open comparisons of data (professional incentives)
- Incentives in the payment structure
- Waiting time targets – linked to financial incentives
- The diversity of providers is growing within the public financing. Primary care provided by a mix of public (ca 50%) providers and private not-for-profit and for-profit (ca 20%)
A highly integrated system in the US – Intermountain Health, Utah

• Independent not-for profit health delivery organization covering about half of Utah’s 2.6 million inhabitants
• Ranked between 1 – 3 of US health delivery organizations for the last 10 years
• Highly developed process orientation throughout both inpatient and outpatient settings (seven broad diagnose areas)
• Detailed outcome is measured as well as resources for each step and the whole process of care
• Results linked to goals set
• Feed-back and evaluation used as a key management technique
• Investment in IT considerable
• Similar development at Kaiser Permanente, Group Health Cooperative, The Geisinger system and a few others
• Demonstration of the explicit use of ”knowledge informed” management techniques
Conclusion

• The challenges ahead are “real” and partly foreseeable
• Health systems will need to re-engineer and innovate at a more rapid pace – and more focused and determined
• The three country examples highlight the complexity of health systems and lessons about resistance to change
• There are also quite clear learning examples, that are possible to transfer – taking the cultural context into account
• Netherlands – matrix organizations
• US - integrated care achievements
• Sweden – conditions for innovation in an ”overstructured system”
• Partnership between actors is one key condition