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, and industry.

BVHP The Better Value Healthcare Programme
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**

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**Providers**
1. Is our society spending too much or too little on healthcare?
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**PAYERS**

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?
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
Evidence

The values of the population served

The other needs of the population

Choice

Decision
Evidence

- The values of the Patient group served
- The other needs of the patient group

Choice \rightarrow Decision
Choosing how much to fund
The law of diminishing returns; beneficial effects do not continue to increase in direct proportion to investment.

Benefits

Investment of resources

BVHP The Better Value Healthcare Programme
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 is given to the Clinician who then informs the Patient.
Knowledge

Patient

Clinician

Seeks advice

www
Knowledge \rightarrow Patient \rightarrow Clinician

- Patient \rightarrow Clinician: Offers reflection
- Knowledge \rightarrow Patient: Seeks advice
- Patient \rightarrow WWW: Seeks advice
Evidence

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

Choice

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

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

Shared Aim

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

Caring: doing more good than harm.
of the National Screening Committee

gaged at the level of a large population to monitor quality effectively. In the UK, this is carried out by the
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
We also include UK and international Health Technology Assessments contained in the Centre for
from the NHS Economic Evaluation database.

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

positions have been examined, and updated if necessary. NSC screening policies can be viewed by
ocument listing all policies is available - see NSC policy positions 2006
www.library.nhs.uk
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.
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 website and radio station is to help those four parties, and the industries which are the key drivers of better value healthcare.

**Systems development:** So much of healthcare is Brownian Motion, random events with no apparent pattern. We need to understand how the system works and then improve it.

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

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

**Quality Improvement:** *Muda* is the Japanese word for waste, and they hate it. Waste is but does not contribute to the desired outcome. *Kaizen* is the Japanese word for quality improvement, and can now transform healthcare.

These four activities have to be added to the agenda of everyone who manages, or pays for, or delivers healthcare. They can prevent or minimise the seven problems that take vast amounts of time and money:

- Waste
- Errors
- Poor clinical quality
- Poor patient experience
- Unknowing variations
- Enthusiastic adoption of low-value interventions
- 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." If you want to see the contents click here; if you want to read chapter 1 click here.

**BETTER VALUE HEALTHCARE BLOG**