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Is the strategy to fix healthcare in shared value?

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'The problem in healthcare is that it doesn't improve health enough.' It is a big statement from Elizabeth Teisberg but can we say that it is just healthcare causing it? Australia spent approximately A$241 billion on health goods and services in 2021–2022 while also recording a major shift in the burden of disease (from 2003 to 2023) to non-fatal burden of disease, surpassing fatal. We are now living with illness and injury more than dying prematurely from it.[1] A study by Health and Wellbeing Queensland[2] found that for the next generation of children born in Queensland are now at risk of shorter lifespans than their parents if rates of obesity are not halved. Sobering data but the outcomes of these children are not the sole responsibility of healthcare. If we are to improve health, improving healthcare is one part of the equation.

For this part of the equation, it is less about improvements and more about reimagine and redesign. Healthcare can not improve health in its current structures of funding segregation and volume driven reimbursement resulting in fragmented service delivery. This fragmentation creates barriers to integrating care overburdening hospitals, variation in care and workforce burnout. The resultant impact compounds, the more burnt out the workforce the higher risk of providing unsafe care.[3] It becomes cyclical and we can not seem to change it.

But change is happening everywhere just without any cohesion. Our ecosystem of healthcare is complex, and each actor exists within its own legislative parameters, physical and digital assets and boards. For governments, economic policy articulates that the health of a population is a key contributor and driver of labour, capital investment and economic growth[4] yet this still does not shift the dial. Their respective departments constrained budget cycles, the values of the government of the day and risk cultures where failure whilst trying to innovate is seen as a fait accompli. For healthcare services reporting to boards or shareholders risk aversion or the status quo comes in other forms, such as focusing on throughput over quality due to activity driven funding, minimising impacts to quality and safety and cultures where hierarchy silences opportunity.

While this paints a stark picture it is not to say that innovation and extraordinary work is not happening, it is just not happening at scale or fast enough.

So why is it not moving fast enough? It is not moving fast enough because all actors within the ecosystem are all working on the same components in a similar way and not considering who or which part of the ecosystem is best placed to address or change. All actors have similar ideals and continue to work towards their shared purpose of creating an ecosystem system that focuses on the outcomes that matter to the people and populations they serve.

In my opinion shared purpose is not enough. Systemic change requires a consistent set of principles that can provide the framework to deliver on true and lasting changes to healthcare delivery. Value-based healthcare was created as a theory to reimagine healthcare, to reorient the systems that exist away from focusing on outputs and towards focusing on outcomes. A significant shift in how to approach service delivery because the fundamental driver becomes maximising value for the person receiving the care rather than the system or direct deliverers of that care. It becomes a way to allocate resources to effectively to achieve the best outcome for that person.

There are excellent examples of value-based healthcare in being piloted or implemented across organisations,[5] but one key challenge is scale. How do we take so many great

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Special Issue: Value-based Healthcare

initiatives and build them into scalable opportunities that will change outcomes for whole populations?

Moving towards a greater focus on shared value could be a way to do it. Shared value is defined by Porter and Kramer[6] as, 'corporate policies and practices that enhance competitive advantage and profitability of the company whilst simultaneously advancing social and economic conditions'.

By seeking out organisations or corporations committed to shared value, who are willing and able to partner with government or the public sector and use their capabilities to create sustainable, high value service delivery could reimagine healthcare at scale and the pace of change needed. This type of scale takes significant investment that corporations can bring complemented by the power of government to control, share or transfer risk.[3]

One can feel the unease a statement such as this can bring and rightly so. The commercial determinants of health fundamentally balance the equation in the wrong direction contrary to what the healthcare sector struggles against; this the opportunity to partner with those corporations willing to lean in and acknowledge not only their role in changing the outcomes of people and populations, but also in what the sector can learn from focusing on value. Each has equal accountability to the other. Profits must not outweigh or misalign service provision and policy must not hamper or delay progress. Vested interests in healthcare must be closely monitored.[7] Examples in the United States highlight the negative impact to cost, outcomes and quality, only further driving disparities in care.[8]

Australia has used the public and private partnerships models to support infrastructure development, but the principles could support direct service delivery.[9] Finding the balance is what is important.[3] Understanding the interplay between social responsibility and corporate profitability is smart business.

Oak Street Health is a great example of when you take the best of the public and private sectors to reimagine care delivery. In my conversations with the former chief executive officer and now President of Healthcare delivery at Consumer Value Stores (CVS), Mike Pykosz, he reflected on his time at Boston Consulting Group (BCG) and how he could see there truly was a way to reimagine healthcare that would focus on the outcomes that mattered to the person, the social determinants of health and cost reduction. At Oak Street Health they created a full-risk primary care model to keep people out of hospital.

With private investment Oak Street Health built a model of care that leveraged the United States Government's capitated payment, namely Medicare and used it to redesign a primary care model in the most socially disadvantaged areas of Chicago. A deliberate decision knowing that so much of healthcare misses those who need it the most.

If Mike did not have this marriage of public funding and the capital to establish the centres, would it have had the same success? Perhaps, but at a much slower pace and perhaps not at the scale he built before selling to CVS.

Granted this is one example, but it is less about Oak Street Health itself and more about the grasping of the opportunity to do what we all want to but have not or think we can not. If one part of creating a high value delivery system requires government and corporations to partner in service provision, then we can look to this as but one example of how it might work or are we still too far from all of this?

If we have a long way to go then perhaps, we are not commercial enough in our thinking, but not for profit but for outcomes, because value-based healthcare was developed and designed to create a competitive advantage for healthcare systems around outcomes which may have been lost in part in Australia. Not from any conscious attempt to derail the theory but more from the focus on simply creating pilots or programs that are seeking to at the very least understand the outcomes that matter. You must start somewhere which clinicians and services are doing so well but for financially constrained governments to shift health outcomes and create a society that is both socially and economically prosperous we must look to approaches used in other areas of commercial value creation and complementary policy and be open to its possibilities.

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Data availability. The data that support this study are available as referenced in the article.

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