Building a better working world

Mr Gary Howe, EY Global Head of Health

"Sustainable health care for Europe in the 21st century"

Transcript of the speech delivered at the Lithuanian Presidency Conference "Vilnius Health Forum" on 19-20 November 2013 in Vilnius, Lithuania

Good afternoon everyone. I don't intend to use any slides as I want to share with you lots of examples of organizations delivering really great pieces of work in the space of sustainability and viability.

I have spent over 24 years of my life supporting providers and commissioners of health care in looking at issues of service viability, in looking at health system sustainability and in looking at the delivery of cost reduction and performance improvement.

Unfortunately, and increasingly, in the last three years I have been working with organizations that are very much in distress. Organizations with serious financial deficits. And usually organizations with big financial deficits have clinical problems as well. Peter mentioned earlier in his presentation one of our health care provider organizations in the UK that has been put into formal administration. EY is now supporting the running of that provider. The provider organization had well-documented clinical failings, with a stated one thousand avoidable deaths over a period of a few years. The provider also had a financial problem and our regulator of foundation trusts and government has intervened to address the issues facing that particular hospital.

But they are not the only ones in trouble. All across the globe I see health systems where individual organizations are in serious distress. In many of the world's most respected health systems such as Canada, Australia, the USA and many parts of Europe, health systems are facing a tough financial future. Some of the very big names in international health including the USA, names that we all recognize, are losing money, and commercial private sector, and well run public sector organizations, don't lose money for long. Solutions will have to be found.

But there are many examples of great work we can look at to help us. There's some really great work in the Netherlands, in Sweden, in the UK, in Australia and in other locations: really great examples of organizations delivering transformative work.

It is interesting that in all of those organizations where we are asked to go support our clients in the area of sustainability, there are usually two questions we have to ask our clients. One is: do you want to do everything you currently do for the least amount of money? Or, are you trying to find what you will be able to do with the amount of money you have available to you? And those are two very different questions. I am sure eventually every government across the EU will have to answer the second question. Eventually, we will have to say what a health system stands for? What should it provide?

For example, we've already heard in the conference today many examples of health care interventions of limited clinical value for the patient. Should health systems continue providing those things?

Every government eventually will have to face the second question. Indeed the debate in the UK is already happening about what the UK Government can afford to provide as part of its health system.

But we don't have to be there yet! I am massively optimistic and enthusiastic about the prospects for health systems. Simply because we still waste huge amounts of resource in the delivery of health care across the EU and indeed across the globe. We probably only operate at something like 70% of our real capacity. Health care providers are wasting resource on industrial scale. And they don't need to! The fixes are easy. There's an opportunity available to us now.

I would like to share some real examples to bring the waste point alive because I have made some fairly bold statements:

- I'll start with an example in the north of the UK. A high performing foundation trust in the UK. In fact, last year it was one of the highest performing foundation trusts in the UK. Last week, it brought together a group of 500 doctors from across the region in a room, a big room, to discuss their future. The medical director stood up and said we will face and indeed are facing the same financial pressures as the rest of the UK, but we can fix the problem ourselves. We do not need to do some of the dramatic things that other organizations are doing. We can solve our problems in this health community ourselves. He set the challenge to the audience of "why?" He said: "we actually harm, actually harm, between 1 in 7 and 1 in 10 of every patient that comes into our health system"; "we then have to fix the harm that we do to those individuals"; at any one point in time "we have 250 patients in beds who shouldn't be there"; the variation in referral by primary care physicians, the variation in referral from one physician to another across their patch for the same presenting condition is fivefold. So in his clinic alone he will see large volumes of patients he does not need to see; and that variation we can fix. We as clinicians can stop that. We can use our resources so much better.
- Theatre utilization across Europe often runs at a little over 70%. There's a fantastic example in the Netherlands where this waste has been addressed. A number of years ago in the Netherlands, a hospital organization across Almelo and Hengelo had very poor access rates for surgery. Like some of the rates described earlier by Peter. Patients had to wait long time for elective surgery. The hospital also had escalating costs. The position was unsustainable. In this organization, the doctors got together and introduced a system they refer to as "Tactical Planning." "Tactical Planning" is simply doctors managing themselves. They introduced a process where every two weeks each individual consultant's performance was analyzed. And the question was asked: did you use the resources we gave you? Did you use your beds? Did you maximize the use of your out-patient clinics? Did you actually use the theater sessions that we gave to you? And if you didn't, why not? And every three months they run a planning event, at which if the individuals have not utilized the capacity, it can be taken away from them. The surgeon or the physician has the right to earn it back, but they do have to earn it back. Utilization in theater went from 70(ish)% to 90+%, waiting times went down from over several months to several days, and they saved €8m.
- My colleagues are working on a piece of work in Oslo as we speak. They have increased out-patient productivity in a health care provider in Oslo by 50%, simply by ensuring good discipline, good governance and regular review of performance — it's transformed the out-patient service — doctors will now have more time with their patients.
- A fantastic example in the United States. Recently, I was with the Surgeon General for the navy, Admiral Nathan. The navy had introduced a pilot scheme a year ago

to monitor patients using smart technology post operatively. Patients post-surgery were monitored and supported by use of the telephone and use of smart TVs in their own home. The outcome measures against a control group (not being monitored) were dramatically improved: simply by calling the patient post-operatively, or using video conference facilities with them in their own home. However, the pilot also brought other major consequences — the volume of primary care attendances dropped by 50%. Patients felt empowered, the public felt empowered not to have to go see their GP anymore, and it had a huge impact on the capacity in primary care.

There are lots and lots more examples.

- In Canada recently, I shared a radiology example. EY was working with a health care provider and had analyzed how the demand for main X-ray had been translated into the resource you needed to use to maintain your X-ray department. The provider had said it's very simple: each X-ray takes 15 minutes; at peak periods, we have a number of X-rays; therefore we need this many radiographers; and that's how we staff the department. We examined, with them, what happened in the 15 minutes, and every X-ray only took 6 minutes. Their effective capacity was 2.5 times that capacity they had introduced as their own constraint. They could have improved dramatically the throughput in radiology at no additional cost. Or, indeed could have reduced their costs.

Another example:

- In a European renal center, we examined the costs of the renal service that was very high compared to benchmarks. In particular, drugs spend in this renal center stood out. The spend, particularly on Epoetin (EPO), was very high. The center had 35 patients who couldn't go into dialysis, needed dialysis but couldn't go into dialysis, not because there wasn't dialysis capacity, but because they didn't have capacity in their theater to provide the vascular access to put patients into dialysis. The center opened its theaters for the weekend to prepare patients for dialysis. The effect was the volume of EPO prescribing went down, patients were being treated properly, and the total cost of the renal service went down €350,000.

These are just a few examples and they may appear trivial, but every single organization I work in has exactly the same issues. We are all facing exactly the same problems. And the potential for improvement in the delivery of health care — in primary care, in secondary care — really is massive. And, it's an opportunity we can all take now. Across the EU, we have a fantastic opportunity to share some of our experiences and actually drive major improvements with very little or no investment. We don't need policy reform, we don't need permission, we don't need incentives or innovation. We could make a huge difference, now!

And let's face it, sustainability is a function of two things: it's a function of effectively using all the resource we actually have available to us and, at the same time, then deciding what health care should actually stand for, what it should provide.

One of the big debates in the UK right now is in deciding what the health system is there for, and I am sure, every other member state in the EU has the same debate. We treat huge numbers of frail elderly patients in hospitals, because there's nowhere else to put them. Is that what the health care system should be there for? We need to provide alternative provisions to treat this cohort of patients, and we can. Surely it

would be a better solution for everyone if we did. The utilization of the health care resource we have available to us would then be significantly improved.

There are many organizations that do the things I have introduced above well, but the vast majority still don't.

A large teaching hospital in London has been a client of mine for years. They were in serious financial distress 18 months ago. And in 18 months, they have saved around £100m (they have a turnover of just over £1b). I am not suggesting that we delivered this for them more just highlighting that in 18 months they saved recurrently, annually, improvement of £100m. And they are not unique. They really are not unique.

With the right building blocks in place we can all deliver so much more.

So why have some of these organizations done so well? The one thing that really makes a difference is leadership: organizational leadership. It's not policy leadership, it's organizational leadership. Our recently departed Chief Executive for the NHS in England, David Nicholson said: "organizations need to look out, not up". In other words, don't look at the policy-makers, don't look at the strategists, look around you, the inspiration is out there.

And I'm saying also, look within, eliminate the variation within and the opportunity is immense.

Let me give another example:

- If you analyze, for every single disease resource group, the length of stay for every individual consultant treating the same condition and then you calculate if every single senior doctor got their length of stay to the average of their own colleagues, the reduction in bed days would be staggering. Interestingly, we heard in one of the sessions earlier an example of the North East Sector of Manchester, being a very deprived part of the UK, being an area where you are more likely to die from cancer than most other places. That organization in Manchester used to have around 2,000 beds. When they did the calculation I've just described above, they needed 750 fewer beds to treat the same group of patients. 750 fewer! Today they have 1450 beds and they are treating more patients. Just by eliminating that variation within. If we can then really draw on best practice across the UK and across Europe, just think how big the further improvement potential would be.

If we are to realize this potential available to us, then leadership is critical — organizational leadership. We don't need permission; I don't think we need policy reform. There isn't a magic bullet, a silver bullet that's going to slay the werewolf and make health suddenly better for us. Organizations can do this for themselves. But there are three really important policy, leadership or system enablers that can help. I will introduce theses enablers and I will then finish:

- The first is stability. Every time we reorganize health systems, they get more expensive and the outcome goes down for a while. Stability would be good. Organizational stability and policy stability would help, because leaders can then focus on the provision of health care, and they don't have to focus on whether they have a job in a year's time. So, certainly, stability would help.
- Policymakers and administrators can also help with incentives. There are some really perverse incentives across health care across Europe. For example, we have incentives in the UK for some of our clinicians not to treat too many patients in the

Building a better working world

NHS. Because if they treat a lot of patients in the NHS, they would have no private work to do. They make more money from their private work. Well, that just can't make sense. And there are a whole series of other incentives of that type across health care systems that could be fixed, relatively easily. So, simply taking away some of these unusual incentives can help.

- And I think the third thing and the most important one is a philosophy of relentless delivery. It is all about the execution. We heard many times over the course of the last day and a half that the policies are clear, we know what to do. How many times have we heard that over the course of the conference? "We know what to do." So surely then we have to just do it. To steal an expression from a very well-known manufacturer of sportswear – let's "just do it." Let's execute, make this happen, it after all is what distinguishes the really good organizations from the ones that haven't yet got there.

And at that point I am happy to end.

Thank you for the opportunity to talk to you at such an important event.

Thank you.

EY | Assurance | Tax | Transactions | Advisory

About EY

EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. For more information about our organization, please visit ey.com

The views reflected in this article are the views of the author and do not necessarily reflect the views of the global EY organization or its member firms.

ey.com