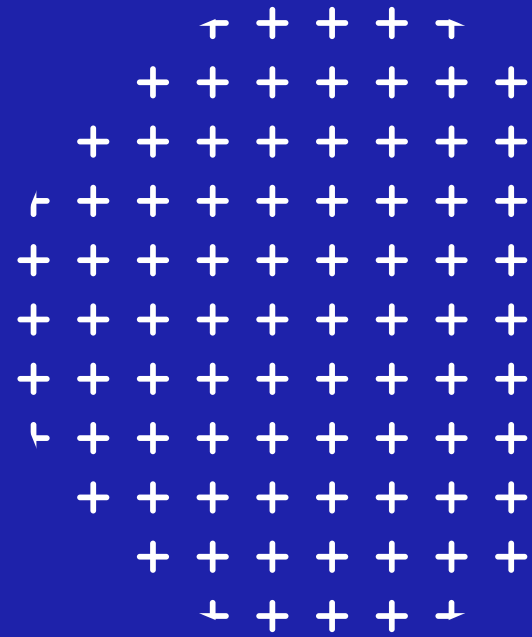




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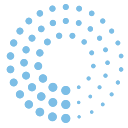


Now is the time to strike: how the Asia-Pacific region is rising to the challenge of value-added care

Five key takeaways from the second
HIMSS APAC government virtual
roundtable

Knowledge Partner: **McKinsey
& Company**





Overview

The transition to value-based care is complex and highly dependent on the unique context and status of any individual country's health system. But in each case, the shift in focus from the volume of health services to the quality of care provided presents significant challenges for governments, providers, physicians and patients themselves.

As they continue along or begin their own journeys to value-based care, many countries in the Asia-Pacific region are looking to the growing number of examples and models developed around the world, particularly in the U.S. and some European nations, for frameworks that can be adapted to their own situation.

HIMSS held a virtual roundtable on 25 May 2022, with McKinsey & Company as its knowledge partner, to examine the progress made in advancing value-based care by some of the region's pioneers, identify the barriers and challenges that are impacting their evolution, and learn about the preparedness of others to begin their own journey.

The discussion was attended by representatives from governments and regional health authorities from seven Asia-Pacific countries: Australia, India, Malaysia, New Zealand, Pakistan, the Philippines and Singapore. As the roundtable was held under the Chatham House Rule, the participants quoted in this report have been de-identified.

Moderators:



Jeff Coughlin
Senior Director,
Government Relations,
HIMSS



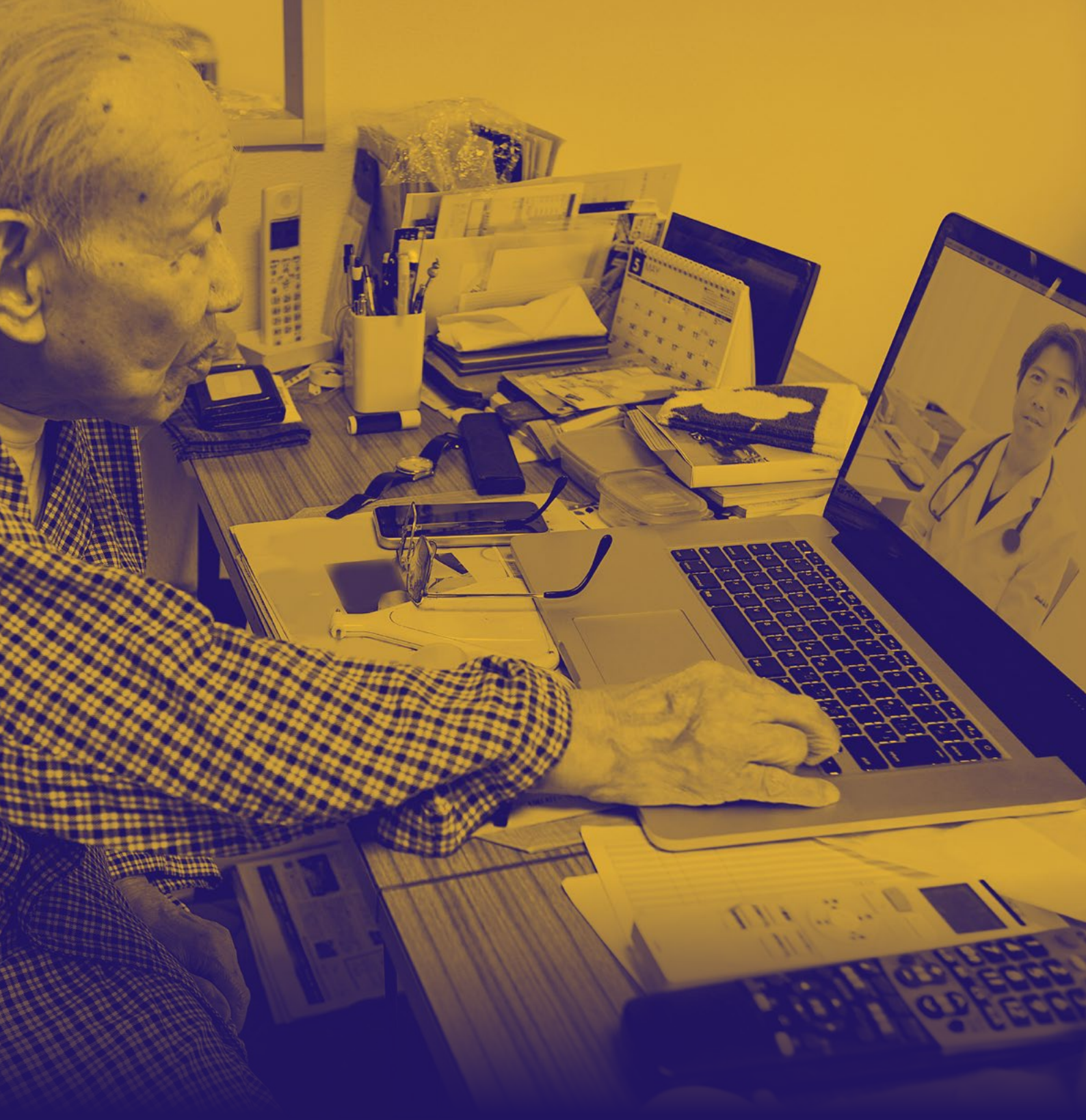
Amanda Krzepicki
Manager,
Government Relations,
HIMSS



Senthu Arumugam
Partner,
McKinsey & Company



Adheet Gogate
Senior Solutions Leader,
McKinsey & Company



Key Takeaway 1:

A number of common factors are coming together to make the case for value-based care and create a sense of urgency around the need for transition. In many ways, the COVID-19 pandemic has exposed the inflexibility of legacy systems as they face the escalating health costs associated with chronic disease and ageing populations.



A successful transition to value-based care requires the participation and support of stakeholders across the entire health ecosystem – a fundamental consideration with implications for every level of governance and provision.

Jeff Coughlin, Senior Director, Government Relations, HIMSS opened the discussion by explaining how HIMSS' policy recommendations for advancing value-based care delivery embrace all of these levels: robust incentivisation for providers to participate and help evolve care delivery; the alignment of laws and regulations in support of the shift to value-based care; the prioritisation of patient choice and maximisation of patient engagement opportunities; investment in IT tools to support the transition; and the sharing of experiences that demonstrate what aspects of value-added care work for different populations in different settings.

Coughlin referenced the current landscape of value-based care in the U.S., which includes the Shared Savings Program, the Center for Medicare and Medicaid Innovation (CMMI) ACO Reach Model, and a Commercial ACOs layer, which share common goals of improving efficiency, reducing costs, engaging patients in their own healthcare management and delivering a focused, higher quality of care.

“Some of the work we've undertaken in the United States is important to understand in terms of how a country and a health system can evolve into directing more value-based payment,” he said.

Co-presenter Senthu Arumugam, a partner in McKinsey & Company, described a landscape in which change is being driven by universal factors, including the increasing value of the disease burden across the region: medical unit costs are growing, and service utilisation is growing. The underlying issue of ageing populations, particularly in countries like Japan and Singapore, will only exacerbate these challenges.

“Now, more than ever, there is really a need – you could think of it as a burning platform – to make this transition to value-based care, which we all need to recognise is not only clinically and administratively challenging, but also a politically challenging transition to make.”

As a participant from Singapore – a country noted for its success in managing healthcare costs – explained, these challenges are likely to increase rather than lessen as the transition gathers pace. Singapore launched its “3 Beyonds” strategy for sustaining quality healthcare in the face of rising demand in 2017.



Much of its focus has been directed at value-based purchasing, which has proved a transformational approach for the pharmaceutical industry but also creates potential cultural and political challenges for providers and patients. Outcomes have been positive in many areas – an average fall of 25% in the cost of diabetes drugs, for example, and some hospital stays reduced from five days to one day. In others, improvements have been slower to materialise. But the transition continues as new streams are brought into the value development care programme.

Added the participant: “When you move to value-based care, one of the issues is that doctors fear you are trying to cut their income, hospitals as well, and the patient feels you are trying to cut back on benefits. So it was very important to show that we’re actually improving outcomes while reducing costs, and that any cost-savings that come into the government are redistributed to subsidise other parts of the health system.”



Key Takeaway 2:

Countries and health systems making the transition to value-based care must define what “value” means at every stage and on every level. Successful strategies are based on having a clear mandate for care outcomes and accountability.



Adheet Gogate, Senior Solutions Leader at McKinsey & Company, explained the radical change that moving towards value-based care demands at every stage of the journey.

“What we see is moving towards value-based care represents a fundamental shift from the way healthcare has been delivered for almost 100 years, where the physician waited and the patient made the first move, to a world where the system is more sentient and aware, and starts influencing stakeholders to make sure they are doing the right thing at the right time – and the move is a phased journey that starts small and covers the entire population over time.”

However, when it comes to reaching a clear idea of “value” in healthcare, the picture across the Asia-Pacific region is mixed. Some countries such as Singapore are relatively advanced in their transition, while others are still in the process of deciding what a successful model should look like for their health systems. Fundamental concerns are consistent across the board, regardless of the status of their transition: the continuing fall-out from the disruption of the pandemic (particularly in primary care), the rising cost of healthcare provision, funding, and an uneven understanding of the concept of value-based care at every touchpoint.

“We are taking some steps towards value-based care, but it is not embedded and there is not a good understanding of what it means among providers,” said one participant from Australia. They described a context of rapid change in which providers are being asked to do more with less; the workforce is still coming to terms with the impact of COVID-19 on service delivery models, and there is a need for improved regulatory balance across the system.”

Coughlin said that the challenges of training and educating the workforce in pushing value-based care forward are widely under-estimated. “Making sure frontline providers are educated and understand the direction in which the model is headed, and what their role is, is critical,” he added.

A participant from New Zealand, which is going through an intense period of healthcare reform following a significant review, suggested that defining “value” is an ongoing challenge – even for a country with experience of moving to a value-based purchasing model for pharmaceuticals.

“We aren’t only moving to a national system, but also to an integrated care system with a focus on better investment in the primary community. A major arm will be national commissioning for equity and value. New Zealand’s health system isn’t called an accountable care organisation, but I think it’s pretty close to being one – and we’re still trying to learn what ‘commissioning’ is, as opposed to ‘contracting’.”



Key Takeaway 3:

Funding is one of the most challenging aspects of the transition to value-based care, impacting every level of public healthcare provision, from payer models and risk management to government decisions about how and where to invest. Creative, innovative ways of funding value-based care will have to be at the forefront of the drive towards new models.

Where does funding sit, and who benefits? Even for countries with well-developed health systems, these questions are asked constantly. A participant from Australia said that in order to achieve value-based care, money needs to be spent outside the traditional domains of the service.

“That’s very hard for governments. I remember having discussions around telehealth in the early days, and the first response was, ‘There’s no funding for it’. But value-based care will be very important in addressing deficiencies in areas like age – keeping patients at home and out of the hospital.”

In some Asia-Pacific countries the lack of a healthcare financing system, while not necessarily an impediment to transition, means that regulation is becoming a central focus. A participant from Malaysia said that while the government has made a lot of progress, particularly in terms of accessibility, the cost of digitalisation could require a change in approach for the fee-for-service based system. While indicators are being monitored, the shift to accountability based on outcomes or clinical performance has yet to be fully embraced. “There are isolated situations where the ministry would like certain services to be outsourced. We need to have some kind of regulatory mechanism to make sure value-based care can be carried out.”

Arumugam explained that there are levers available to governments which could help patients identify lower-cost settings and drive more value in care.

A participant from Singapore identified the challenges faced by governments in applying value-based purchasing to specific care streams such as cancer, not least because the subject is highly emotive for clinicians and patients. And at a time when the cost of cancer drugs is rising by more than 25% every year, governments are looking at unsustainable levels of spending.

“No government can afford to pay for what are often low-value drugs – from a value-based perspective, they are a poor investment. But as a government, you have to. And you can’t have the same threshold for different conditions. Care is complex – so do we implement higher taxes to pay for it? It’s very difficult for any government, even in a one-party state. And I’d be very surprised if any other country is doing as much in value-based care as Singapore.”



Key Takeaway 4:

The transition to value-based care depends on an infrastructure of data and analytics systems capable of providing accurate information to support definitions of “value” that are constantly evolving.

Building appropriate payer capabilities is essential to value-based care, according to Gogate. He outlined how data can help inform every aspect of care provision in a value-based delivery model: understanding health risk, which tends to be weak; using that understanding to design policies and incentives; designing and enforcing contracts to ensure viability and stability; encouraging members to take control of their own health data and actively seek healthy behaviour – reducing the population-level risk burden; and creating policy and financial adjustment to facilitate self-care and control utilisation.

According to a participant from Pakistan, data was central to the country's COVID-19 response – a nationwide programme that connected all the capacities available in public and private healthcare services, as well as the diaspora of clinicians around the world. Within six months, 1.5 million people had accessed the telemedicine system – including many without smartphones. When data revealed that 97% of enquiries were non-COVID-19 related, an education campaign based on text messages was initiated.

“ We are now taking it to the next level, putting everything onto the data, making the system scalable so it can pivot to every disease and using AI algorithms to build predictive models for the future. We are building an integrated framework for bringing everything under one umbrella. The work has just started but I think it's a unique example of using technology.”

A participant from India said that data is not just valuable for payers or providers – the whole health ecosystem needs insight in order to overcome associated problems. National initiatives such as the Ayushman digital health scheme are helping to build this ecosystem to ensure that appropriate care reaches every patient. Every year, the cost framework is re-examined to see how it can be optimised from the payer and caregiver's perspectives while benefiting the patient – a juggling process that helps to define health packages.

“There are still issues: how you define approaches to pricing, the methodology of data mining, how you can bring in a value-based pricing system, what are the parameters and metrics you will use to define it. These are all issues the government is looking into.”



Key Takeaway 5:

While there is an increased urgency around the need to escalate the transition to value-based care, countries in the Asia-Pacific region are learning from their pioneering counterparts in the region and around the world that a phased, carefully managed progress offers the best route to a successful outcome.

Every stage of the transition to value-based care raises fresh questions and challenges. Addressing them requires strong leadership from the top of a national government in order to drive change across the entire landscape of providers, payers and stakeholders.

Some more advanced value-based systems are now starting to think about global capitation and the potential of bundled payments. Arumugam said that physicians are beginning to understand the concept of episodic payment models and bundled payments – even if execution remains a challenge. Any shift to population-based models will also be seen as a complex issue by hospitals, as they work out how to set incentives for acute care physicians.

A participant from Singapore said that while the country is looking at capitation, it is still at an early stage in the thought process and identifying what the optimal model of capitation looks like. Meanwhile, they said, more basic hurdles still need to be overcome – not least in IT, which is beset with legacy system integration challenges.

“When I tell a cluster as we roll out value-based care that we need to make changes to the system, one of them will tell me that it will take two weeks and cost \$30,000, while another one will need a year and \$300,000. Because they all have different legacy systems. Even more basic outcome indicators are not as straightforward as one might think!”

Ultimately, as Gogate said, attending to the details, and expanding data and analytics in a thoughtful, necessary and efficient manner at every stage of system evolution, will allow for a measured transition to value-based care.

“The journey is a long and complex one, and it’s almost always impossible to maintain pace,” he said. “But it’s important to keep your direction going, and bring more and more services, outcomes and patients under the ambit.”

This report features takeaways from the second HIMSS APAC Value-based Care Government Virtual Roundtable. To get the insights from the first roundtable, [click here](#).