

POINT OF VIEW

SEPTEMBER 2014

MEASURING WELLNESS

EQUIPPING OUR LEADERS WITH THE EVIDENCE THEY NEED
TO DRIVE TRANSFORMATION IN CARE DELIVERY, MEASURABLY
IMPROVING OUTCOMES

AUTHORS

Crispin Ellison, Partner
Oliver Wyman

Cate Reynolds, Associate
Oliver Wyman

Charles Alessi, Chairman
National Association of
Primary Care

WHY ARE WE DOING THIS?

There is growing recognition of the urgent need to shift the health and social care system from reactivity to proactivity, from being focused on repair to driving prevention and pre-emptive action. To achieve this we recognise that public services will need to be more effectively integrated around the individual 'customer' rather than being organised around the provider and delivered in a siloed, fragmented way that does not meet the customer's quality and experience needs.

If change is to be driven in this way, a set of metrics is needed to measure success. This needs to reach beyond the standard "sickness and repair" metrics and allow us to measure how well populations are. The aim is to look at populations, from locality, local authority/CCG level up to the regional and national level, not to measure individual outcomes.

We need better ways to measure the effectiveness of programmes funded by pooled public funds.

Measuring wellness can be used to galvanise appropriate activity across the whole system—diverse actors can align for the wellness cause and be held to account for improving wellness. These actors include government, commissioners, and providers and reach across the healthcare, social services, and education sectors, even into areas such as employment, crime prevention, and policing. All of these areas affect people’s sense of wellness.

Aligning the diverse actors across the system with an agreed measurement approach will also facilitate collaboration around innovation in service delivery, for example new services focused on the mental health needs of young people could be delivered in schools with both the education and the mental health leadership driving for measurable improvement in wellness.

Now is the right time. There is a convergence of opinion that the current reactive approach to the provision of especially healthcare services is neither effective nor affordable. And, as other sectors have discovered some time ago, provider-centric provision delivers poor customer experience, poor quality, and high cost outcomes. We therefore need to be able to measure the impact of integrating services designed around patient needs and focusing more on proactive prevention than reactive repair.

Without an agreed approach to measuring wellness we have no consistent and comparable means of measuring the effectiveness of pilot programmes and innovations aimed at better integrating care and designed services more effectively centred on patient needs. The Health and Social Care Act 2012 established health and well-being boards as a forum where key leaders from the health and care system work together with the aim of improving the health and wellness of their local population and reducing health inequality. We need urgently to equip these system leaders with the evidence they need to ensure pooled resources are used more effectively. With an agreed approach to measuring wellness we will empower these leaders to measure the impact of their own innovations and to look for demonstrated examples of impactful interventions in other systems that they can adapt and apply locally to solve the challenges in their own area.

Health and social care funding policy is driving to reduce the budgetary siloes, aligned with the creation of the health and well-being boards in order to support increased integration of services. The Better Care Fund is currently the primary pooled budget available to commissioners, which has been ring-fenced for spend on out-of-hospital services and driving reductions in unplanned care. As the amount of government spending through pooled budgets increases it is imperative that we have better ways to measure the effectiveness of the changes that this funding supports. We need to drive accountability for the effective use of these pooled public funds.

There a strong linkage between wellness and physical health outcomes. In recent years there has been increased interest in the linkage between psychosocial wellness and health outcomes in both diseased and healthy populations. In 2008 Chida and Steptoe carried out a quantitative assessment of published prospective, observational, cohort studies assessing the association of psychosocial wellness and physical health¹. Their meta-analysis of 35 published studies concluded that that positive psychosocial wellness was associated with reduced mortality in both healthy and diseased populations (including patients with renal

Patient activation is a better predictor of health outcomes than factors like ethnicity and age

failure and HIV). The studies took into account both positive affect (e.g. positive mood, joy, happiness, vigour, energy) and positive trait-like dispositions (e.g. life satisfaction, hopefulness, optimism, sense of humour).

It is on the basis of this type of evidence that many prominent health organisations have communicated their support for a stronger focus on wellness and mental health. The World Health Organisation's Promoting Mental Health report (2005)² stated "Positive mental health is an integral part of health, including positive physical health".

In the UK the Prime Minister, David Cameron, has made it clear that the Coalition Government's success will be measured by the nation's well-being, not just by the state of the economy. The public health white paper 'Healthy Lives, Healthy People'³ is the first public health strategy to give equal weight to both mental and physical health, and the strategy "No Health Without Mental Health" published by HM Government in 2011⁴ was set out as a call to action across all of government services and partner organisations, with stated clear ambitions to improve mental health. This strategy stated that improved mental health and wellness is associated with a range of better outcomes for people of all ages and background, including improved physical health and a whole range of additional benefits e.g. improved employment rates and productivity, reduced anti-social behaviour and criminality and higher levels of social interaction and participation.

HOW WE CAN WE EXPLAIN THE LINKAGE BETWEEN PHYSICAL HEALTH AND WELLNESS?

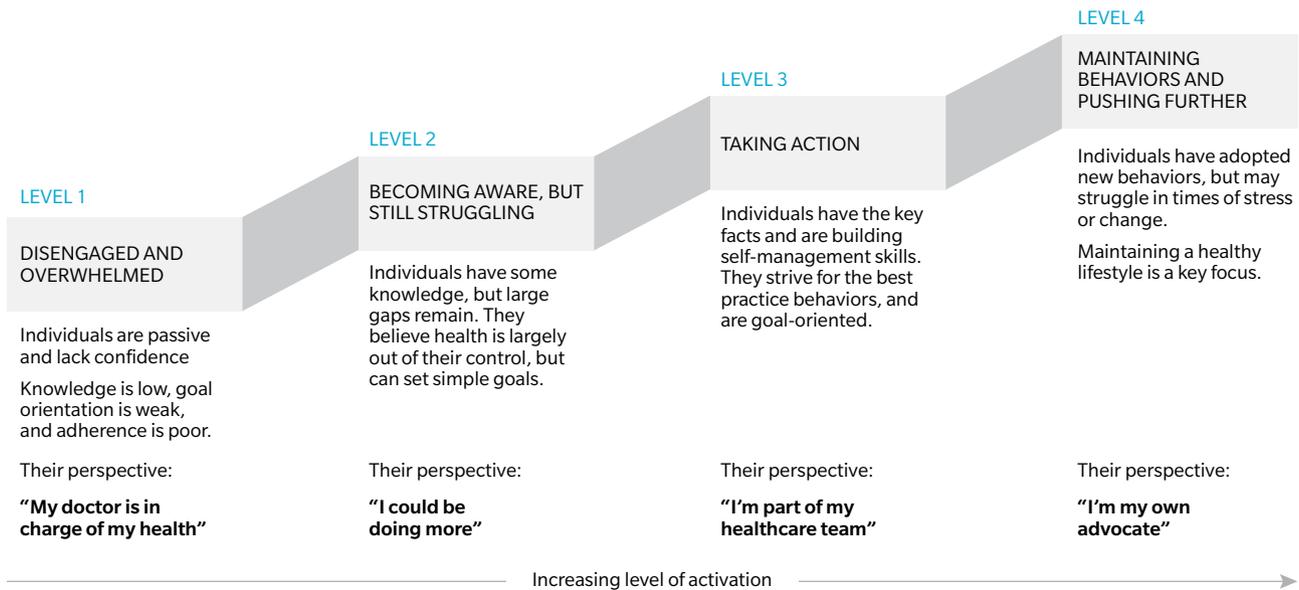
There is a strong and growing body of evidence that attributes associated with positive psychosocial wellness and resilience are correlated with increased access to health services and positive behaviour changes. This drives better physical health outcomes.

This is often referred to as 'Patient Activation'. A recent King's Fund paper by Judith Hibbard⁵ outlines how improvements in patient activation allow people to become good managers of their own health. There is a robust patient-reported measure (PAM) that measures an individual's knowledge, skill, and confidence for self-management. There are four categories of PAM level that have been defined and described, as shown in the Exhibit 1.

Patient activation has been shown to be a better predictor of health outcomes than known socio-demographic factors such as ethnicity and age. More activated people are more likely to attend screenings, check-ups, and immunisations, to adopt positive behaviours (e.g. diet, substance abuse, and exercise), and have clinical indicators in the normal range (e.g. blood sugar levels (A1c), blood pressure and cholesterol). Studies of interventions to improve activation show that patients with the lowest activation scores tend to increase their scores the most, suggesting that effective interventions can help engage even the most disengaged.

Studies have not yet been carried out to directly assess the link between general wellness level and patient activation, however the overlap in characteristics and attributes would suggest that there is strong correlation between the two measures. In fact, studies using

Exhibit 1: Levels of patient engagement in the Patient Activation Measure



Source, Insignia Health

the PAM have noted that positive PAM scores are correlated with non-health outcomes. For example, workplace studies highlight a relationship between patient activation, job satisfaction and absenteeism. Judith Hibbard notes in her paper "As such, patient activation may be tapping into a concept that goes beyond health".

IS THERE AN ECONOMIC CASE FOR FOCUSING ON WELLNESS AND PATIENT ACTIVATION?

A US study published in Health Affairs in 2013⁶ showed that patients with the lowest levels of activation cost 8-21% more than the patients with the highest activation level of equivalent health status and demographics. Therefore, in addition to achieving improved health outcomes through activation there is also a powerful economic case for driving improvements in patient activation.

CONCLUSION

From this evidence base we have concluded that a wellness metric systematically and consistently measured across England would be a highly valuable tool to support system transformation.

WHAT ARE THE DESIRABLE CHARACTERISTICS FOR A WELLNESS METRIC TO GALVANISE THE SYSTEM?

We have defined a set of desirable characteristics, the metric should be:

- Simple, easy to understand
- Broadly accepted as a valid measure supported by a strong evidence base
- Proven to be amenable to change following intervention
- Applicable across all public services, not confined to health and social care
- Applicable to all population levels (national, regional, local, individual)
- Cost-effective to measure, can be implemented quickly

WHAT ARE THE POTENTIAL CANDIDATE METRICS?

Through consultation with expert mental health and public health practitioners two well-established subjective wellness surveys were shortlisted as candidate metrics

World Health Organisation Five (WHO-5)⁷ is an established methodology for diagnosing depression in primary care. It asks patients to assess five statements regarding how they have felt in the past two weeks:

- I have felt cheerful and in good spirits
- I have felt calm and relaxed
- I have felt active and vigorous
- I woke up feeling fresh and rested
- My daily life has been filled with things that interest me

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is another established methodology developed by the universities of Warwick and Edinburgh⁸. It has been used in population surveys (e.g. the Scottish Health Survey from 2008, Health Survey for England from 2010, Understanding Society, the UK household longitudinal study—40,000 households). It is based on 14 questions that are administered in a self-completion format generating a single score between 14 and 70. An example response is shown in Exhibit 2, green highlights responses with the resulting score at the bottom.

WEMWBS includes more questions than WHO-5, some focused on the respondent's ability to cope with problems and make decisions—linking the score to feelings of control over life and health. In our opinion WEMWBS is potentially the more powerful tool for measuring overall wellness in populations with the broader set of questions more likely to capture more of the key elements of wellness that are associated with patient activation and health outcomes.

There is also a significant amount of existing baseline WEMWBS data for England available from the Health Survey for England⁹. Analysis of WEMWBS data from the 2012 survey is available via the Health and Social Care Information Centre. WEMWBS scores range from 14-70 and the average in England in 2012 was 52.5 for men and 52.2 for women.

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People who met guidelines for physical activity had higher well-being scores, on average, than others.

Many factors were assessed for their association with well-being scores. One highlighted finding was that people who met guidelines for the recommended levels of physical activity had higher well-being scores, on average, than others.

There was also a strong association between physical health and well-being. People who reported their general health as bad or very bad had significantly lower well-being scores than those reporting their health as good or very good (see Exhibit 3, Health Survey for England 2012 Well-being report⁹). Aligned with this finding, those people with diagnosed limiting longstanding illnesses had on average lower scores than those with no illness.

Interventional studies using WEMWBS have been carried out by a broad range of organisations across a wide variety of services and population groups¹⁰

Examples include:

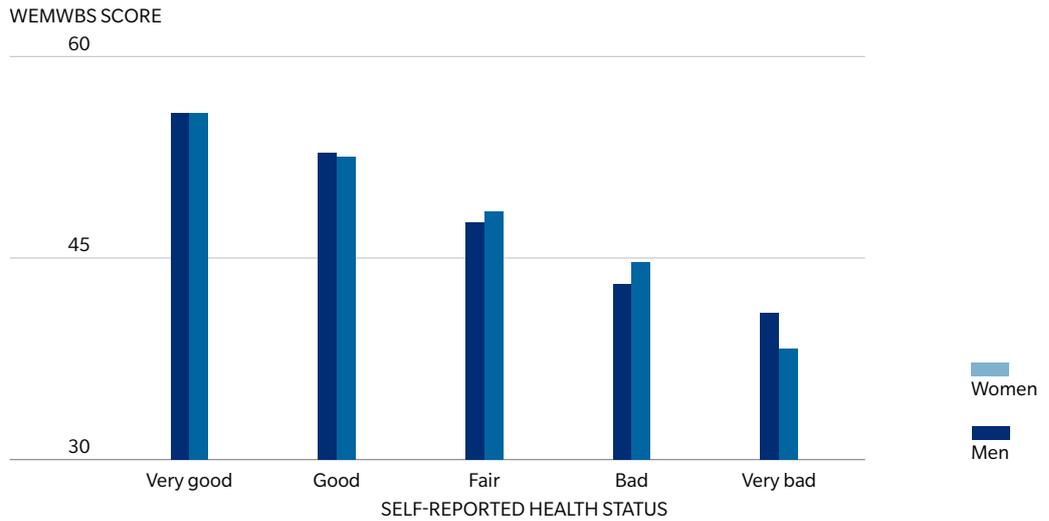
- Local Authority: Therapy to support unpaid carers
- Sport and Recreation Partnership: Impact of walking on positive mental health
- Family focused social enterprise: Group-based parenting programme

Significant changes in WEMWBS scores have been measured, demonstrating that the measure is amenable to change and therefore suitable for evaluation of interventions at the individual and group level¹⁰.

Exhibit 2: The WEMWBS Survey, showing example answers and score calculation

STATEMENTS	NONE OF THE TIME	RARELY	SOME OF THE TIME	OFTEN	ALL OF THE TIME
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've has energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5
Scores	0	0	4 x 3 = 12	4 x 4 = 16	6 x 6 = 30
Total score = 0 + 0 + 12 + 16 + 30 = 58					

Exhibit 3: WEMWBS mean score (age standardised), by self-reported general health and sex



Source: Health Survey for England 2012, Well-being report

* Base: Age 16 and over

HOW COULD COLLECTION OF WELLNESS DATA BE IMPLEMENTED ACROSS ENGLAND?

Self-assessment across the population using a survey such as WEMWBS would be required to measure the overall 'baseline' of data with a clear plan to regularly repeat the measurement to understand overall shifts in wellness at the population level.

Mobile/web-based technology and social media could be harnessed to engage people in providing their wellness data in a cost-effective way, complemented by 'low-tech' methods to ensure sufficient coverage of all population groups.

A toolkit could be developed for service providers and commissioners who are keen to understand the impact of specific initiatives aimed at improving wellness and health outcomes. This toolkit would provide guidance and methodology for collecting additional baseline data if required and measuring the impact on wellness as service innovation and development gets underway.

Mobile/web-based technology could be harnessed to engage people in providing wellness data in a cost-effective way

WHAT OTHER METRICS SHOULD BE CONSIDERED TO SUPPORT THE SHIFT FROM REACTIVITY TO PROACTIVITY?

In addition to wellness metrics it will be important to assess hard metrics that the system is also aiming to improve alongside overall wellness.

For example, Emergency Bed Day usage per 1,000 65+ population is a simple and powerful measure that has been used by the King's Fund to assess the effectiveness of elderly care

In the US some ACOs have demonstrated performance as low as 800 days per 1,000 65+

provision across commissioning areas in England¹¹. In addition, this metric is commonly used by accountable care organisations (ACOs) in the US to assess their effectiveness in delivering care for the elderly, for example the elderly care ACO CareMore.

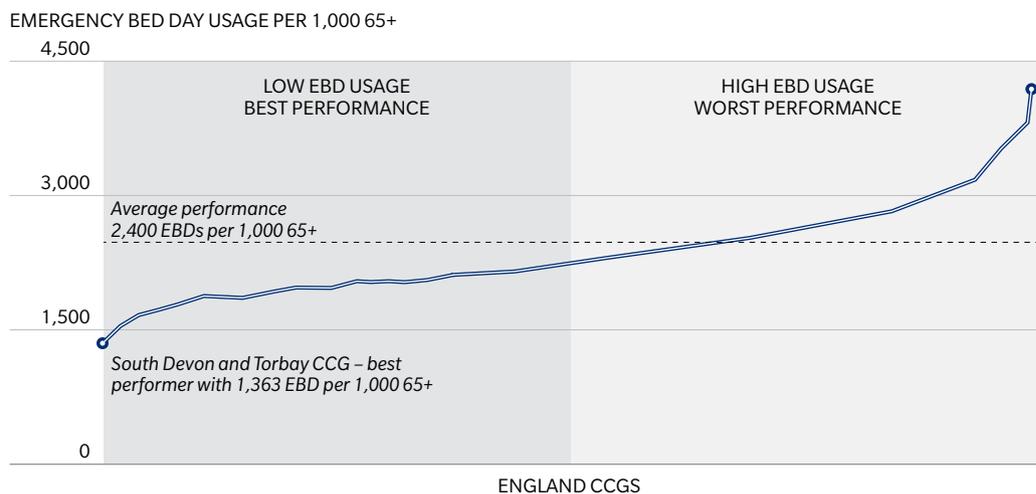
In England this can be easily calculated using basic Hospital Episode Statistics (HES) data and Census population data.

Oliver Wyman analysis for clinical commissioning groups (CCGs) using 2011 HES data shows South Devon and Torbay to have the lowest (1,363) emergency bed day usage per 1,000 65+ (see Exhibit 4). This is consistent with the King's Fund report 2009/10 data analysis, which also found Torbay to have the best performance¹¹. Torbay is well-known for its integrated health and social care system focused on prevention for elderly patients. Torbay's performance based on this metric provides further evidence for the effectiveness of their model. In the US some ACOs have demonstrated performance as low as 800 days per 1,000 65+.

A key trend across England is that rural CCGs tend to perform much better than urban CCGs (see Exhibit 5). Hypotheses have been proposed to explain this, however it is clear that urban CCGs need to work hard to improve performance.

Additional hard metrics could be assessed and tracked to support system leaders in measuring their performance in the shift from reactive provider-centric care to proactive patient-centred care. A focused set of metrics based on existing data that supports the shift from reactivity to proactivity should be agreed to complement the wellness measure.

Exhibit 4: 2011 emergency bed day usage per 1,000 65+ by CCG



Source: HES data, 2011 Census

HOW COULD ROBUST WELLNESS DATA BE USED TO SUPPORT SYSTEM TRANSFORMATION?

Robust wellness data could be used to identify specific populations with low wellness and target resource to these populations. It is well understood that one of the key challenges facing health and social care leaders is health inequality, wellness data could be a powerful tool to support tackling this.

Data-driven identification of groups with low wellness could also usefully drive more effective collaboration and links between parts of the system with a shared aim of improving population wellness. For example it could bring healthcare, social care and education together around a common set of objectives and measures.

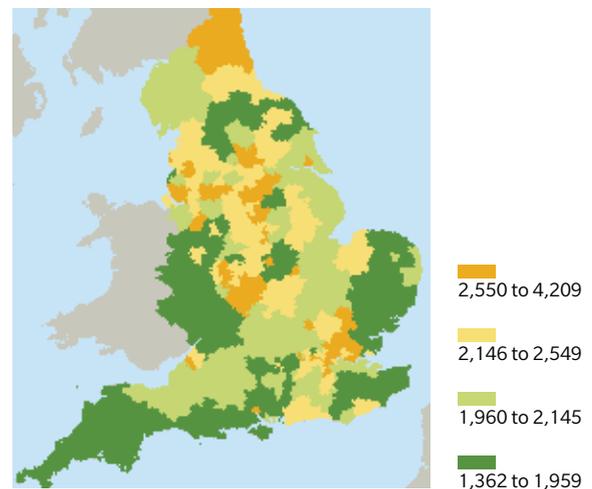
Wellness data could usefully provide the basis to assess the effectiveness of innovations in service delivery, especially those developing integrated services that work across the traditional health and social care boundaries.

With a consistent approach to the assessment of the effectiveness of innovations and interventions different health systems could learn more effectively from each other.

Demonstrated successes can be quantified, key success factors identified, documented and shared to enable health system leaders with common problems to develop effective services building on the successes of others.

Finally, wellness data can be used to hold central and local government, commissioners and providers to account. Those leaders who demonstrate ongoing improvement to wellness, health outcomes and reducing health inequality can be held up as trusted stewards of our public services, effectively leading their shift from reactivity to proactivity.

Exhibit 5: 2011 emergency bed day usage per 1,000 65+



Source: Oliver Wyman analysis

ACKNOWLEDGEMENTS

The authors would like to thank all those at NAPC, Public Health England, and Oliver Wyman who contributed to this paper.

Full list of contributors:

National Association of Primary Care

- Dr Charles Alessi (chairman), Dr Nav Chana (vice-chair), Dr Sanjiv Ahluwalia (executive member), Dr Minesh Patel (executive member), Dr Niraj Patel (executive member)

Public Health England

- Dr Heema Shukla (consultant in public health), Richard Kelly (policy manager)

Oliver Wyman

- Crispin Ellison (partner), Andrew Chadwick-Jones (partner) and Dr Cate Reynolds (associate)

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You can contact the marketing department by email at info-FS@oliverwyman.com or by phone at one of the following locations:

AMERICAS

+1 212 541 8100

EMEA

+44 20 7333 8333

ASIA PACIFIC

+65 6510 9700

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