AHIA 2009 Conference

Health Care Reform – Out of Hospital Care and Improving Health Outcomes

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Overview

- Introduction
- Context – How badly do we need reform?
- International experiences
- Integrating care - Do we have the courage
- Next steps
- Questions

How badly do we need reform?

Services – What do patients and staff think?

Australia's overall ranking of health is average, with strengths in safe and appropriate care provision, but limitations particularly around equity and health lifestyles. Overall systems efficiency is considered moderate.

Country Rankings	
	1.00–2.66
	2.67–4.33
	4.34–6.00

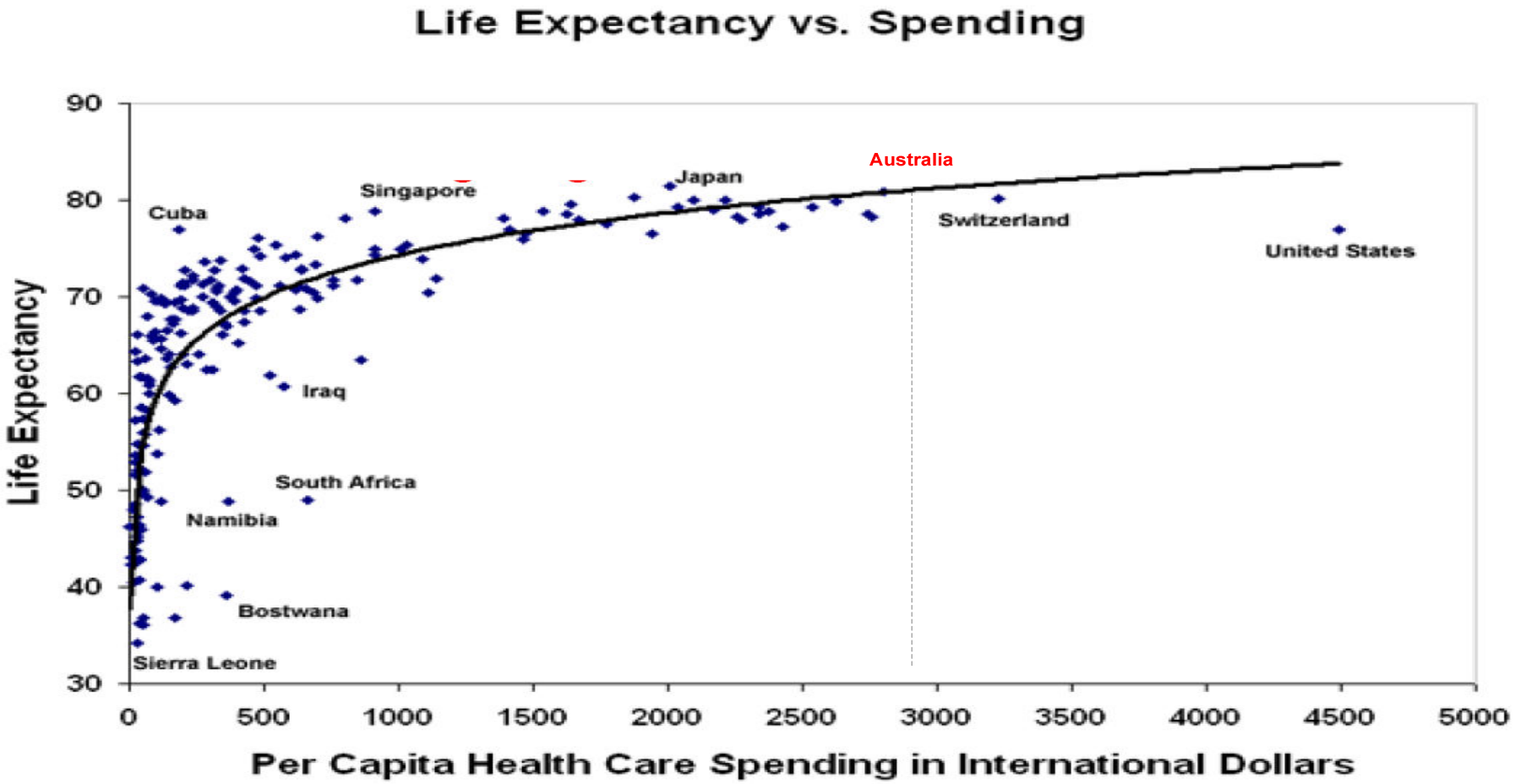
	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data

Source: Calculated by The Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

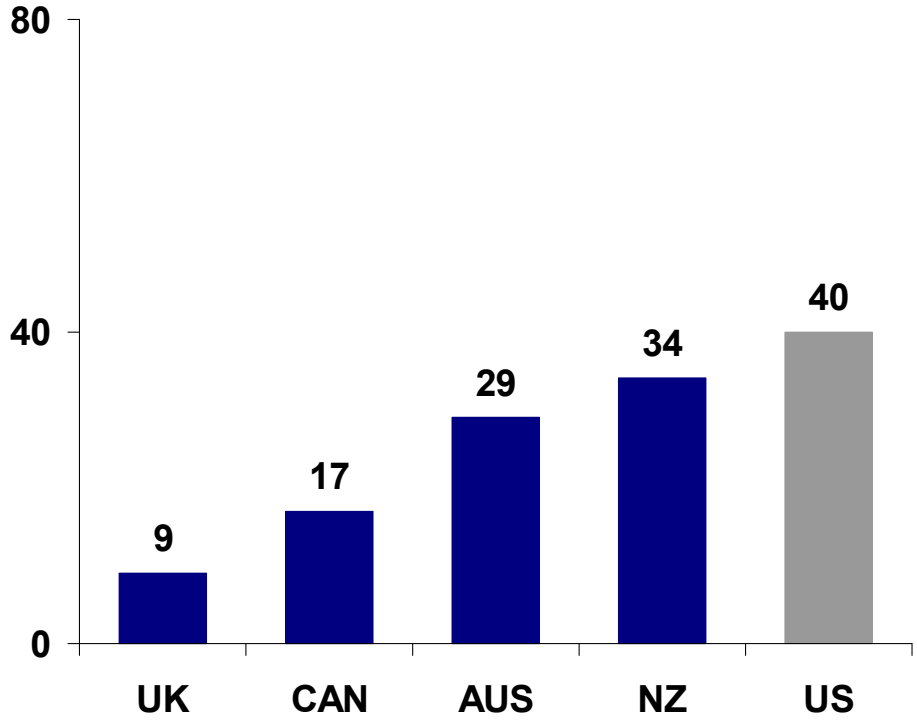
Cost vs. Life Expectancy – Do we need more money?

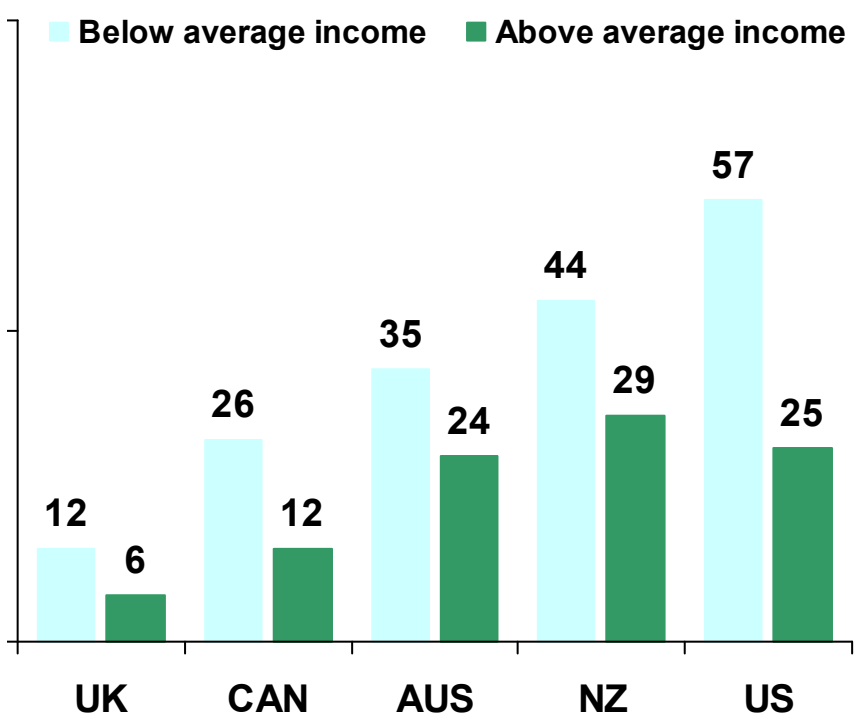
Australia's life expectancy sits at 80.5 years, with average per capita health care spending sitting at approx. $2,900.



Access problems because of costs in five countries - Total and by income, 2004

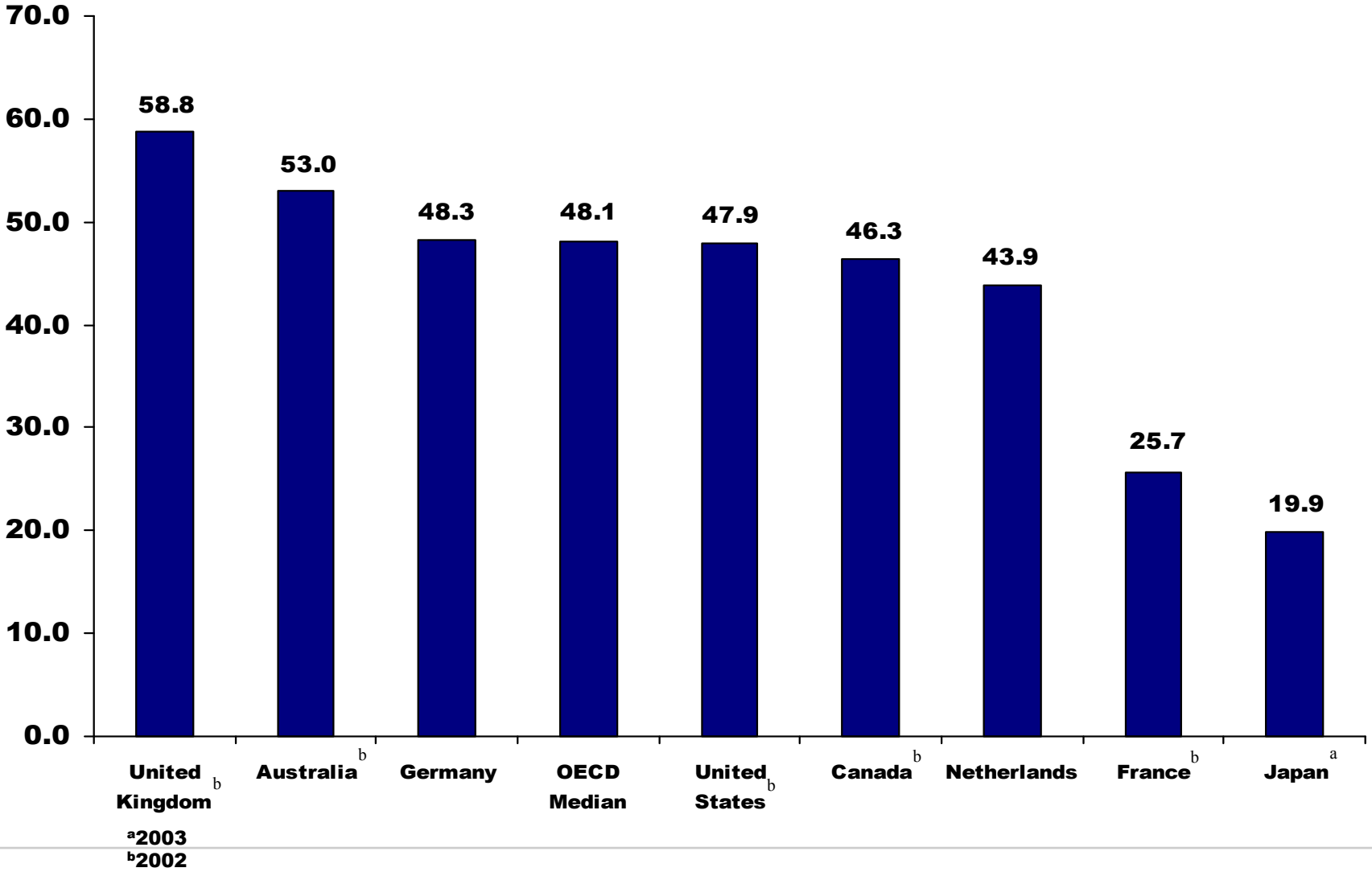
Percent of adults who had any of three access problems* in past year because of costs





*** Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.**
UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.
Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).

Acute myocardial infarction deaths per 100,000 population



[a]2003
[b]2002

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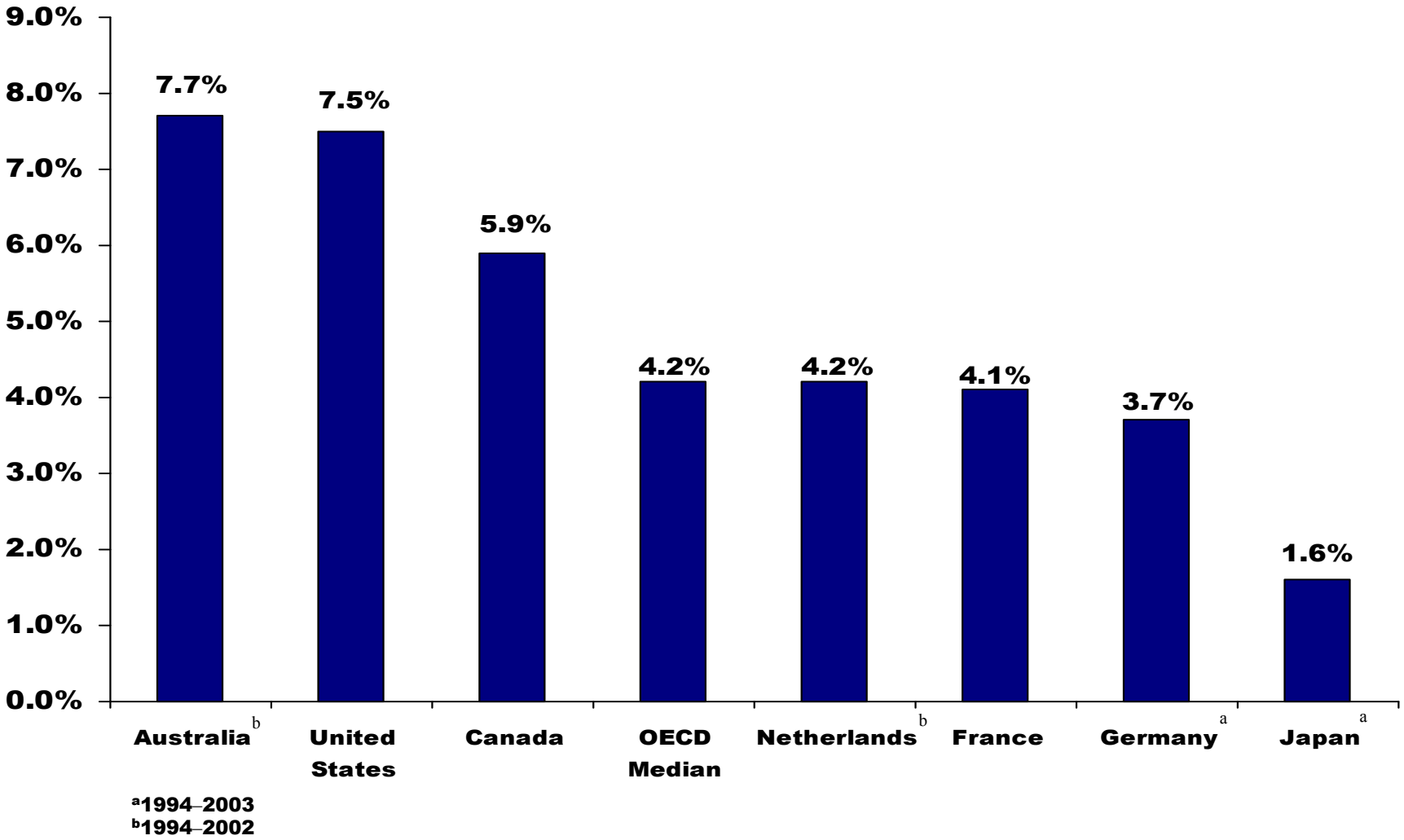
Average annual growth rate of real spending per capita on pharmaceuticals, 1994–2004



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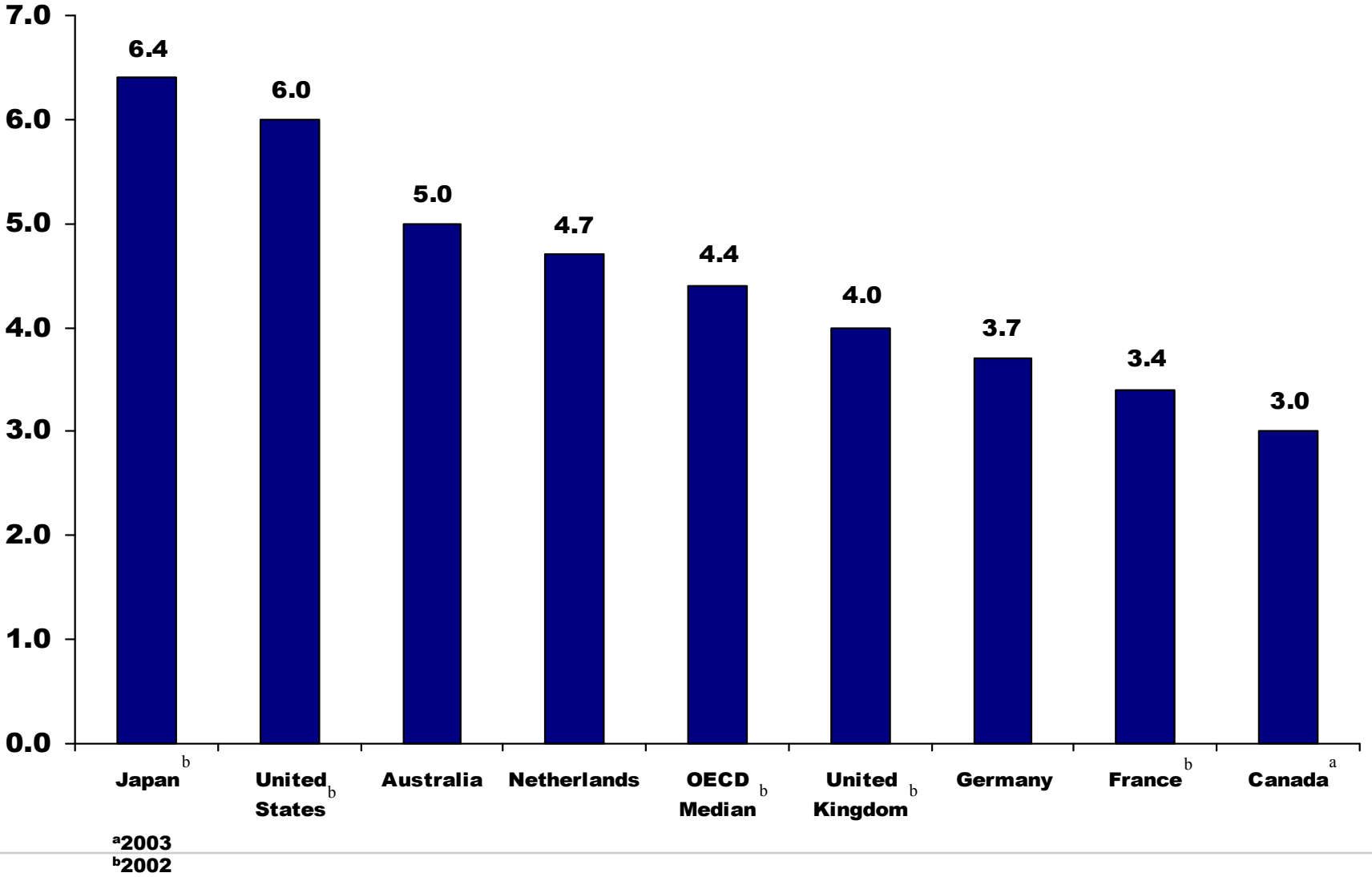
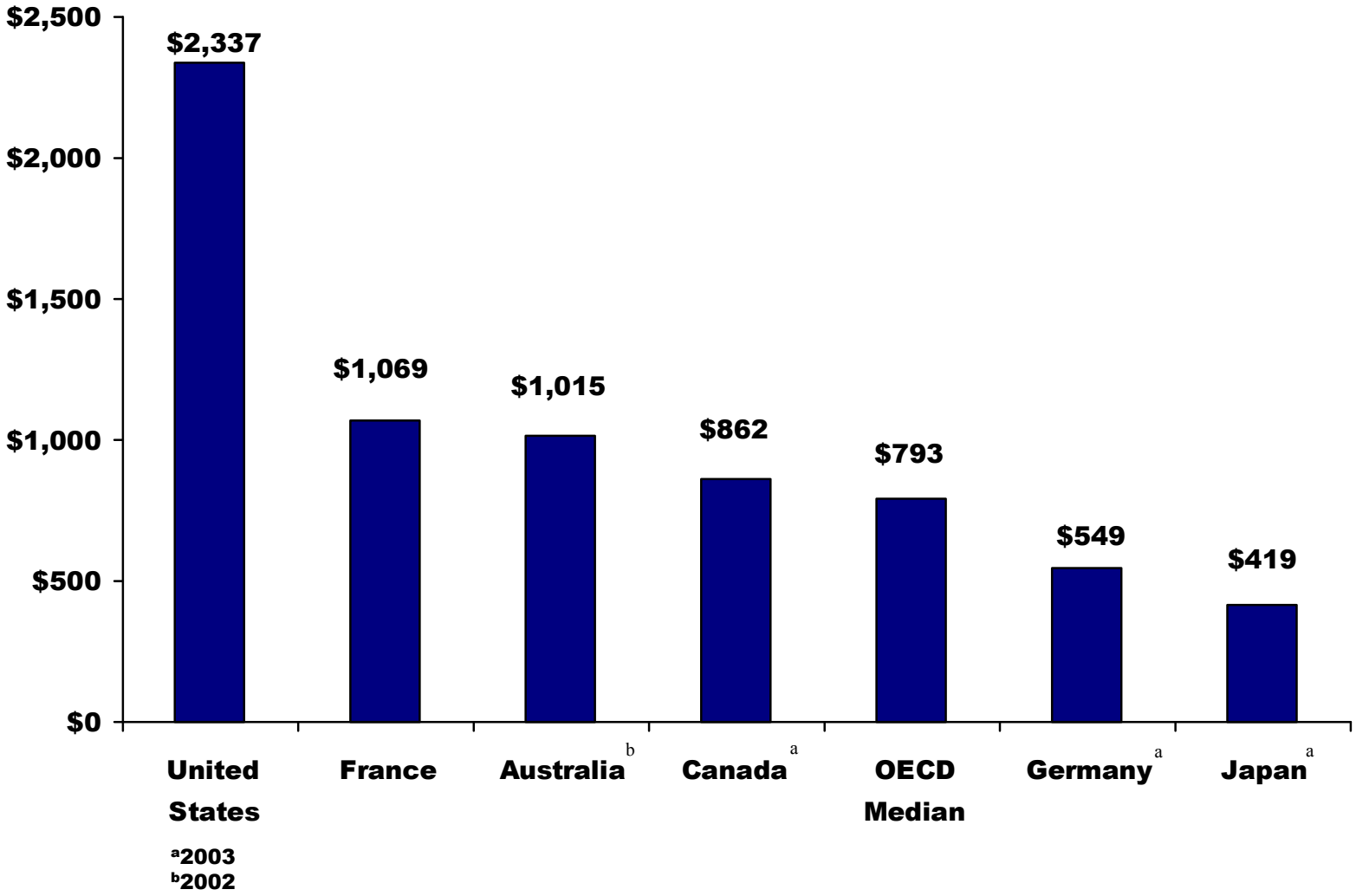
Bronchitis, asthma and emphysema deaths per 100,000 population



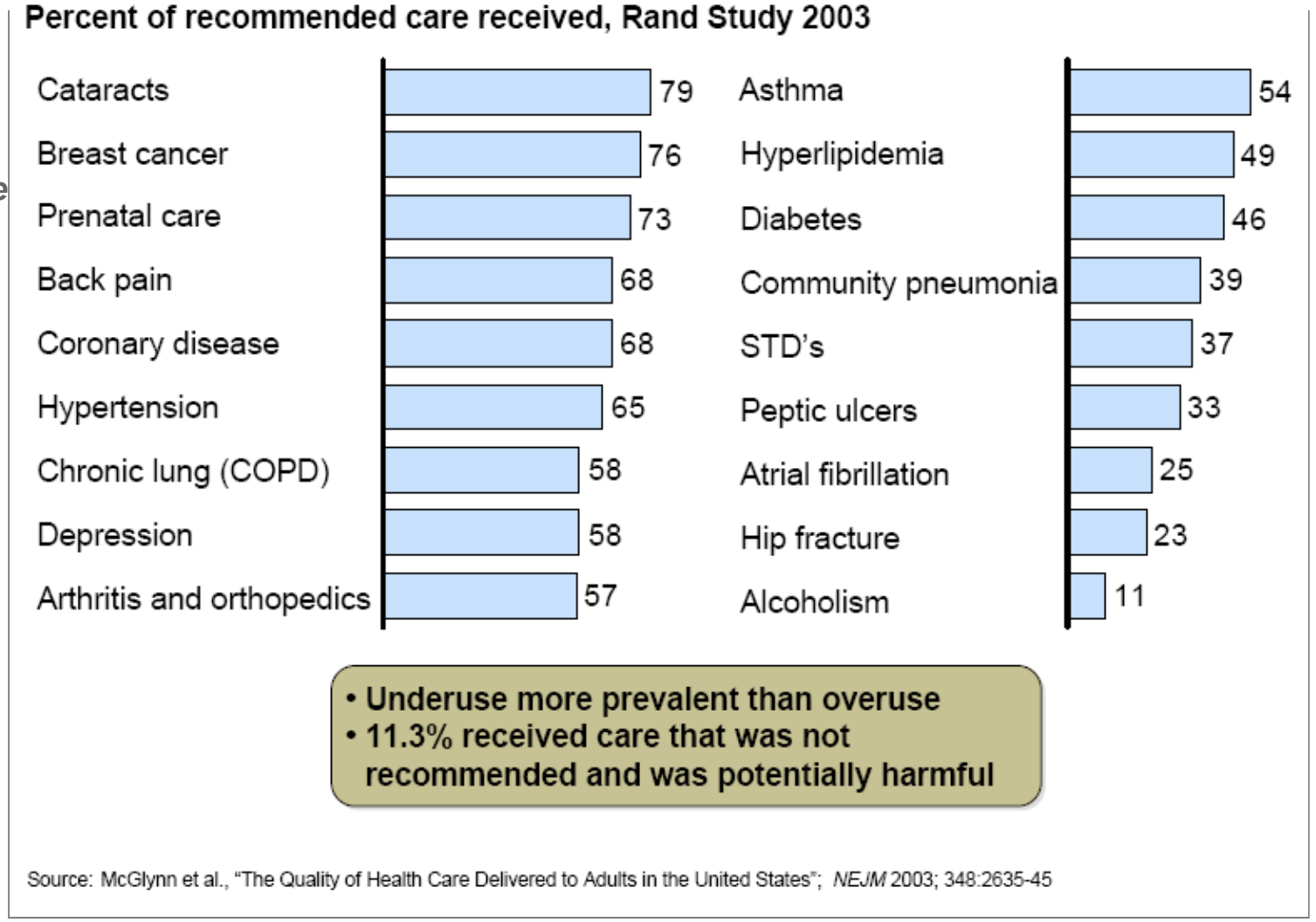
[a]2003
[b]2002

Hospital spending per inpatient acute care day in 2004



Evidence vs. Practice – The Gap – The US

Percentage of recommended care received, Rand Study 2003



Evidence vs. Practice – The Gap - Australia

- Patient groups not receiving most appropriate care;
  - Stroke in atrial fibrillation – 64%
  - Heart failure – 42% of patients over 60
  - Diabetes – HbA1c – 73%
  - Bronchitis and antibiotics – 80%
  - VTE in high risk patients – 50%
  - Colorectal cancer follow-up – 67%

Paying for Performance

- International experience
  - 83% achievement of 10 disease groups across all indicators in NHS
  - CMMS Premier QIPS (US) – 3% - 12% increase in quality of care scores across 270 hospitals
  - Cervical and breast screening (US) – 210,000 increase in one year in California
- Australian experience – The jury is out
  - Q Health – 7 key clinical areas 14 indicators – compliance with pathways through financial incentives

The approach to performance improvement has been ad hoc

Types of measures	Examples
• Governance structures	Financing models, outsourcing
• Incentives	Privatisation, competitive bidding, semi-market solutions
• Structural measures	Co-location, centralisation, mergers, reorganisation
• Clinical redesign	Six sigma and LEAN
• Performance management	Measuring output, quality, efficiency
• Purchasing	Centralisation, standardisation, framework agreements, co-sourcing
• Technology	eSolutions

UK - the 20B pound challenge

Managing supply – 2.5 % over three years

- Contract adherence
- Admission and discharge planning and utilisation management
- Reduction in clinical variation

Managing demand – 2.6 % over three years

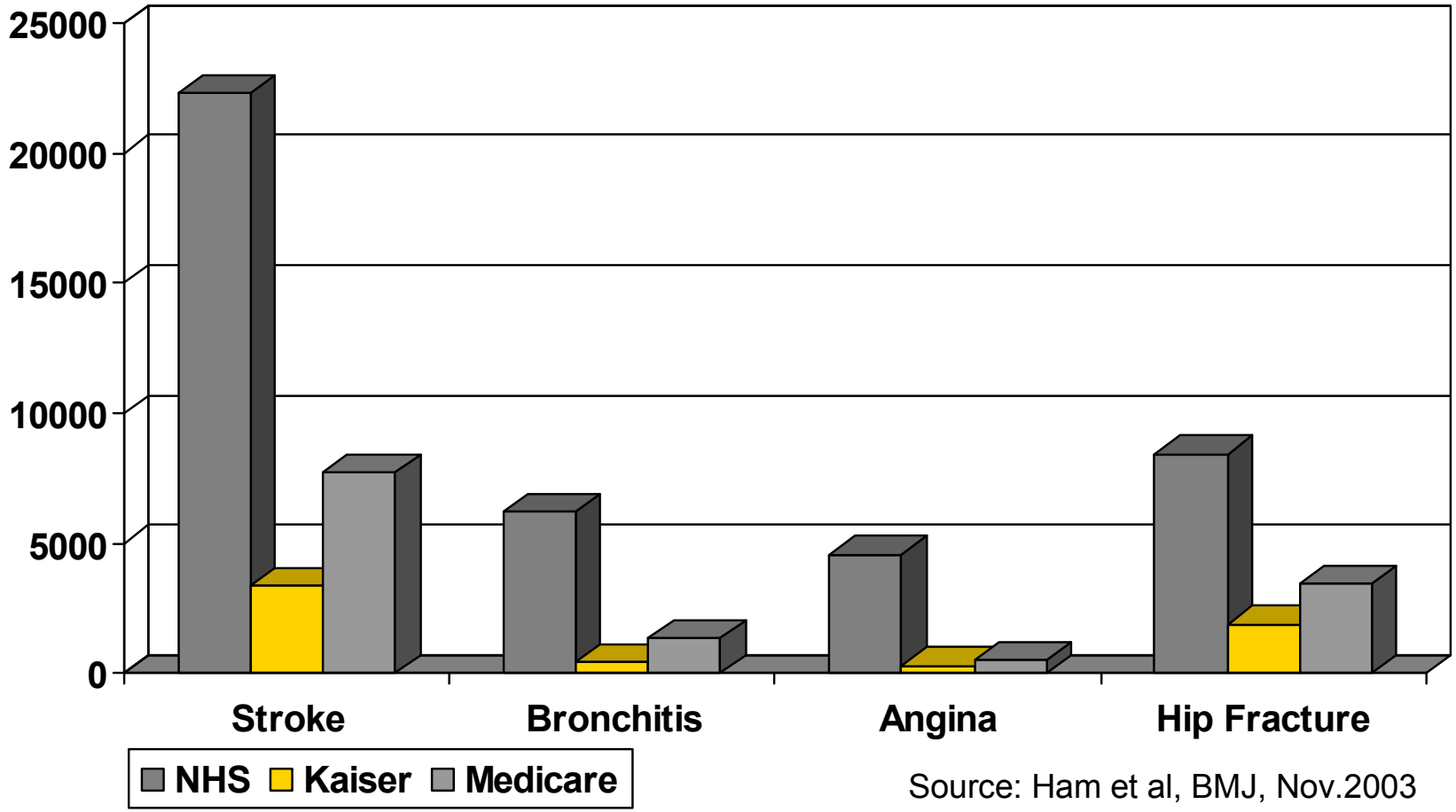
- Reducing emergency admissions for ambulatory care sensitive admissions
- Reducing procedure rates
- Risk stratification and case management
- Long term condition management
- Empowering and activating consumers

Creating new policy levers

- Pricing and priced based competition– 4 % over three years
- Tariff changes – rigorously applying “best practice” pricing – the so called “efficient price”
- People, processes data and technology
- Reforming the GP contract
- Self management – 0.4% over three years

Acute bed usage – What's possible?

International Comparator – Bed Days used per 100,000 population



Source: Ham et al, BMJ, Nov.2003

The Netherlands - Reforms

The system

- Relation between the price and the cost of a product
- You get paid for what you do
- Prices are negotiable
- Patients are no longer bound to one provider
- There is competition

New basic insurance for curative care (2006)

- New private insurance for all
- Obligation for citizens to buy health insurance
- Obligation for insurers to accept insured without risk selection
- Legal description of entitlements
- Free choice of insurer; choice of policy (different deductibles)
- Fixed nominal premiums
- Employer contribution
- A legal system of risk adjustment
- State compensation for low income people
- No claim refund

Population Health - Cost Efficiency

Activity	Characteristics	Cost efficiency
Consumer self management	preventative programs, consumer health literacy, community health support programs	✸✸✸ ✸✸✸
General Practitioner services	quick access, quality diagnostic & treatment services, medication management, effective referrals	✸✸✸ ✸✸
Coordinated community care	care plan based services, goals & targets, regular monitoring, early intervention, rapid care adjustment	✸✸✸ ✸
Hospital specialty clinic & Outpatients	complex care plan review, high clinical risk assessment	✸✸✸
Hospital avoidance services	early discharge, step down care, rehabilitation services, home nursing, domestic support	✸✸
Acute & intensive inpatient hospital care	complex treatments, high clinical risk, services of last resort	✸

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Chronic Care - Logistics Challenges

Promote prevention, health literacy, self management across the population

Manage chronic disease out of hospital

- ✓ identify & recruit
- ✓ coordinate & schedule services
- ✓ monitor wellness, intervene on risk

Gate keep patients heading towards hospital:

- ✓ influence GP referrals, DEM & OPD attendances, ICC referrals
- ✓ reserve hospital capacity for truly acute

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Acute care - Logistics Challenges

Assess and pre-prepare prior to admission (elective)

Optimise patient flow during acute episode

Gate keep patients out of hospital:

- ✓ Assess for best follow-on option
  - step down care
  - rehabilitation services,
  - home care/early discharge
- ✓ Manage inter-service transfer
- ✓ Monitor & mitigate clinical risk in the transfer

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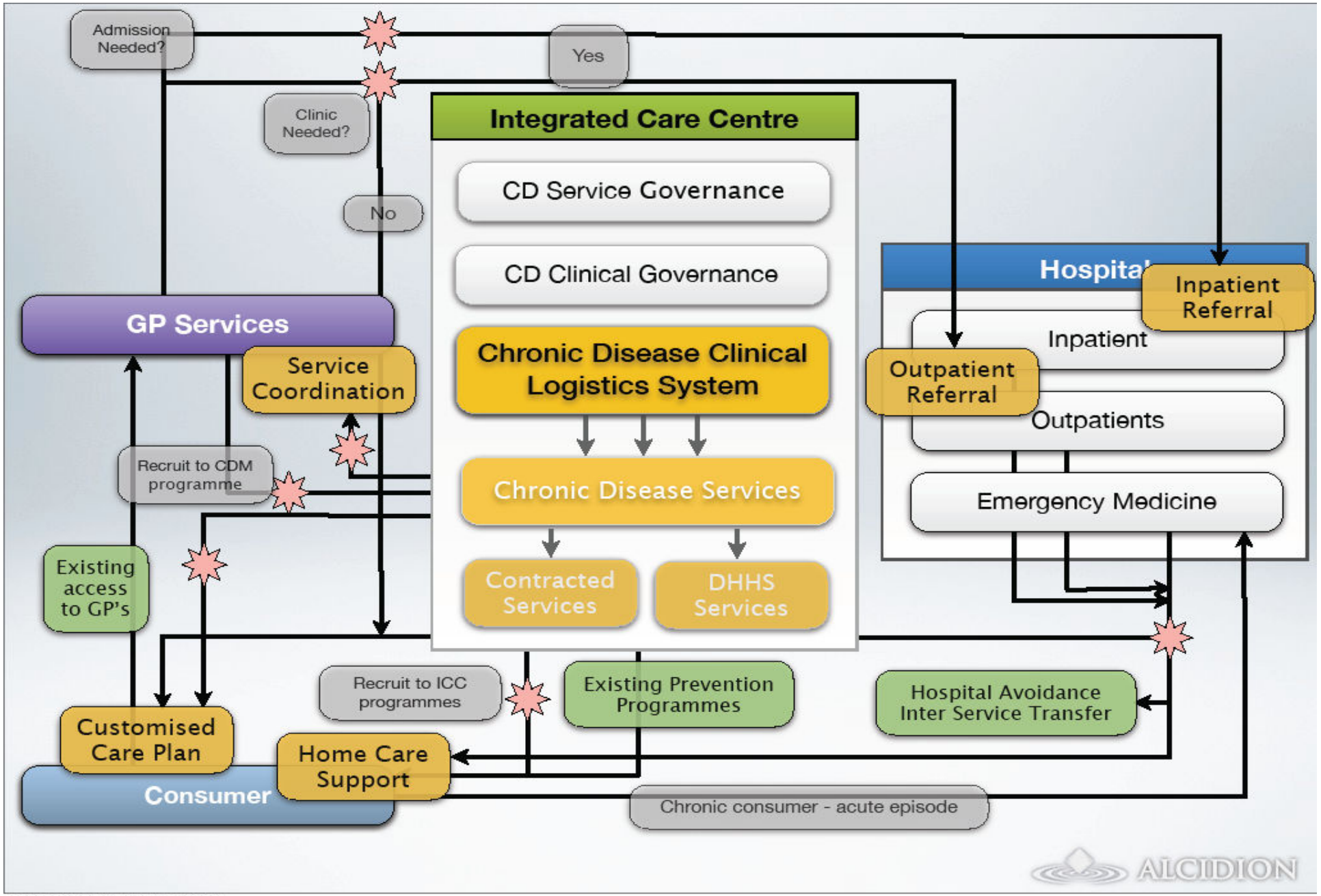

Wednesday, 21 October 2009

Summary

- Implementation of single levers will do very little
- Need to as much as possible move to a “closed” system financing best practice and outcomes
- Health insurance reforms are vital to achieving choice and competition whilst keeping system costs in check
- Financing reform of providers and fee for service reform
- Payment for performance
- E Health
- National targets, clinical guidelines, prevention programs, safety and quality initiatives and public reporting
- Real workforce reform – not just dabbling at the edges