Some economic arguments for investing 10% of GDP in the health sector, higher payments for high quality integrated care, demand-side incentives and public-private partnerships

Invited address

National Health Summit

Old Parliament House, Canberra
Monday 18 August 2003

Two monologues are not a dialogue

Claim	Counter-claim
Single public insurer is more efficient or cheaper than our mixed system	OECD data 1975-1998 Compare relevant costs-Danzon
Proposed hospital agreements will cost the states billions	States won’t get better offer until efficiency gains are obvious
PHI rebates are not reducing the use of public hospitals	Harper report March 2003
Paying GP’s the RBRVS rate will open up medical inflation	Bulkbilling without an increased rebate is dead Health care without GP’s is really expensive

Overview

- $6 billion shortfall in funding in 2003
- Six assertions about the future funding mix
- One reform needed in Medicare

Shortfalls in funding, 2003

Roughly A$ 6 billion = extra 1 percentage point of GDP

Australia:healthcare funding gaps

GAP	COMPONENTS	TOTAL SHORTFALL- A$M
Medicare public hospitals	New technology Health IT for quality improvement	2,500
GP reimbursement	MBS fee increase GP desk retooling	1,200
Management of chronic conditions	Supply side restructuring[1] Demand side education Risk factor reduction	800

Australia:healthcare funding gaps

GAP	COMPONENTS	TOTAL SHORTFALL-A$M
Aboriginal health	Primary care and community capacity building Unmet needs in drug and alcohol abuse,mental health, suicide prevention[1]	200-300
Rural health	Equalising Medicare cost gap	100-300[2]
Adolescent health	Mental health and sexual health	100-200

Australia:healthcare funding gaps

GAP	COMPONENTS	TOTAL SHORTFALL-A$M
Disability prevention	New income support and service benefits New preventive strategy	100-300
Aged care	New capital subsidies for residential care Expanded CACP and coordinated care packages	300-500

Protected growth in numbers and costs of care of the elderly, Australia 2002-2020:Myer

Indicator	Year		CAGR-%
	2002	2020	
1. Numbers of persons over age 65 - million	2.4	4.2	3.2
2. Cost of maintaining present system of aged care - $billion	7.3	12.1	2.9
3. Share of GDP (%)	1.17	1.84	

Indicators of shortfalls in supply of care of the disabled and aged, Australia

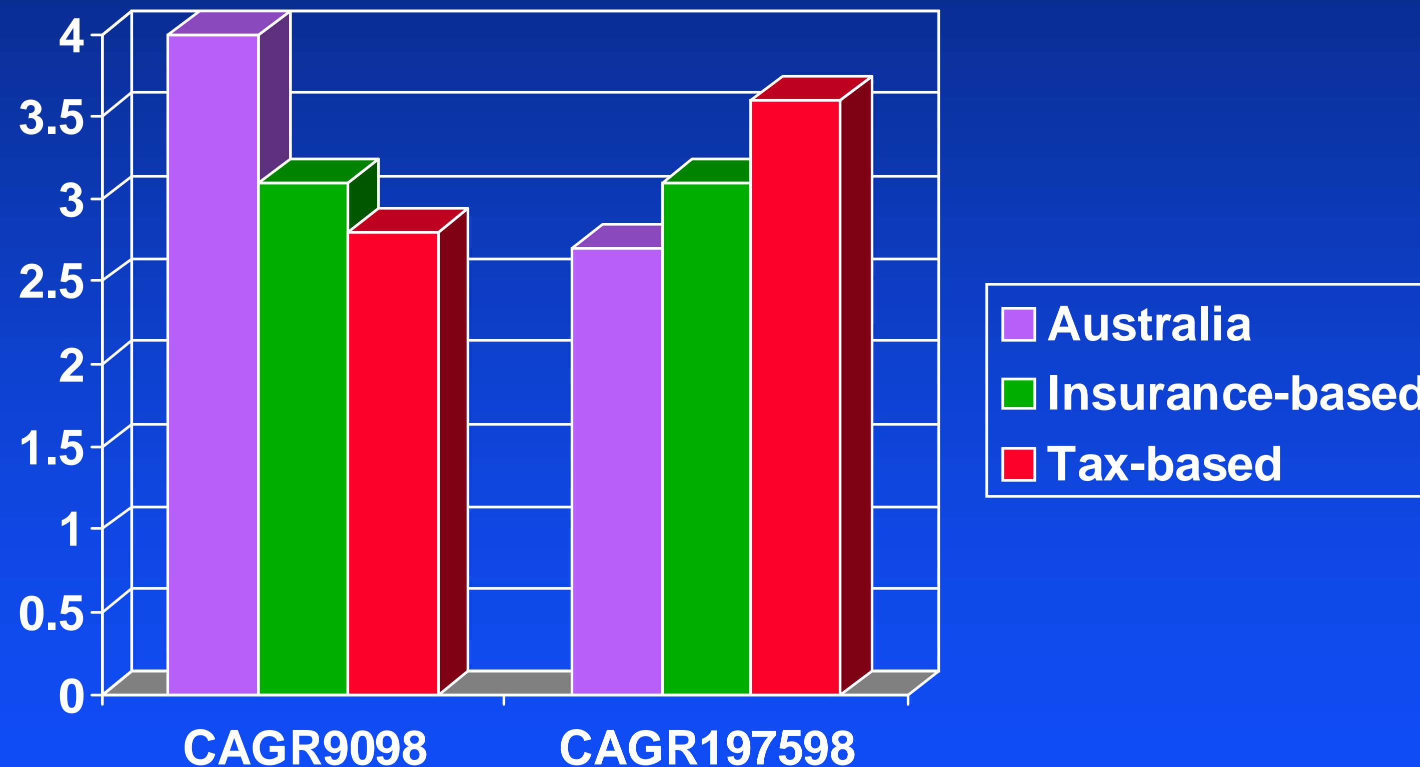
Population subgroup	Indicator	Estimates
1. Persons with a profound or core disability[1] (all ages) living in a household, 1998	Percent reporting their *needs not met at all* Percent reporting their *needs only partially met*	2.5% 40%
2. Retirees	Waiting period to enter residential care between 1998/99 and 1999/00	Increased
3. Persons living at home, aged over 65 years	Hours of HACC services provided per 1000 persons over 65 years, 1996 to 1999/00	Decreased 17%[2]

Notes:
1. Persons over 65 years are one-third of those persons with a profound or core disability.
2. To a level below that in 1993/94.

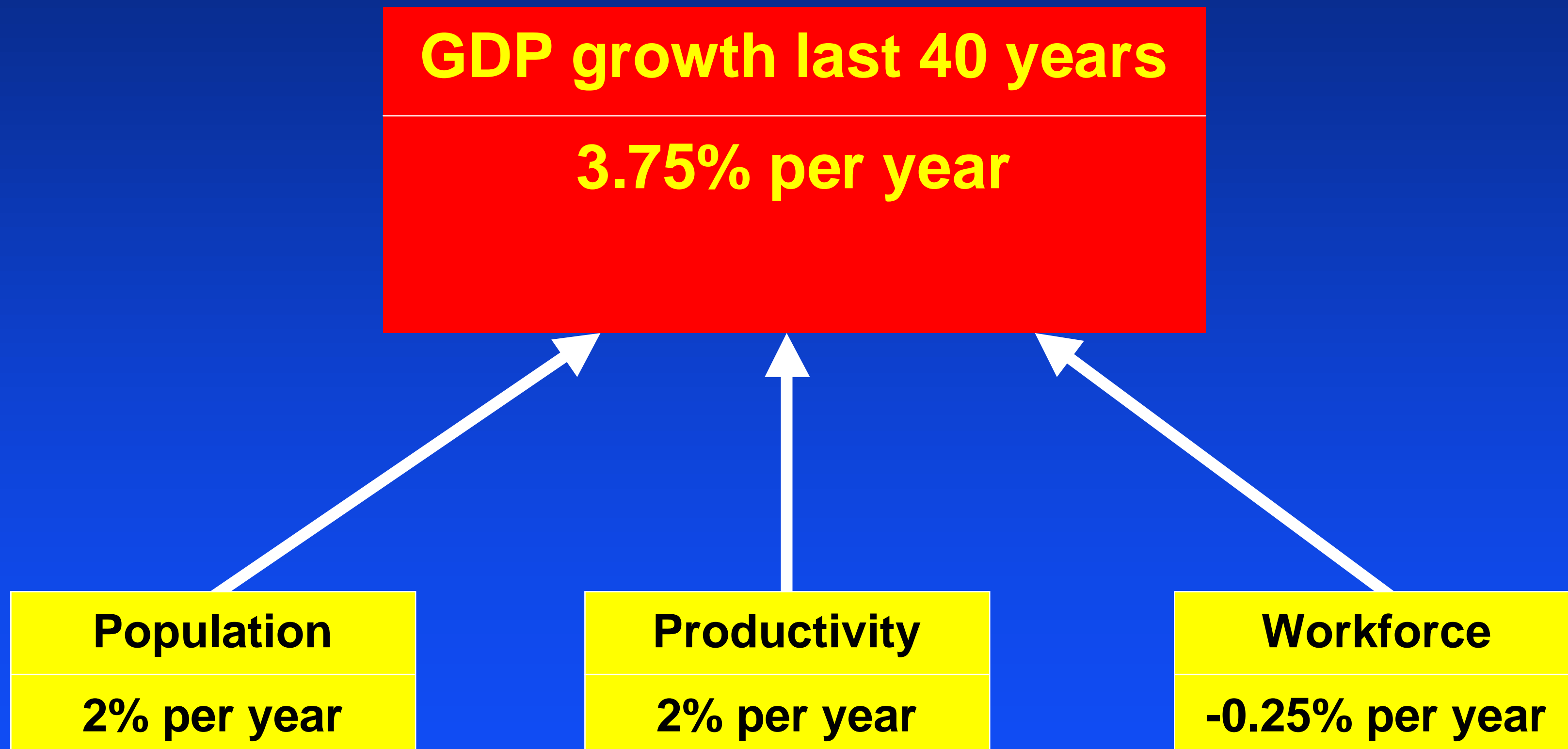
- $6 billion shortfall in funding, 2003
- Six assertions about the future funding mix

1. Cost containment: tax-based government controlled systems are NOT the most effective

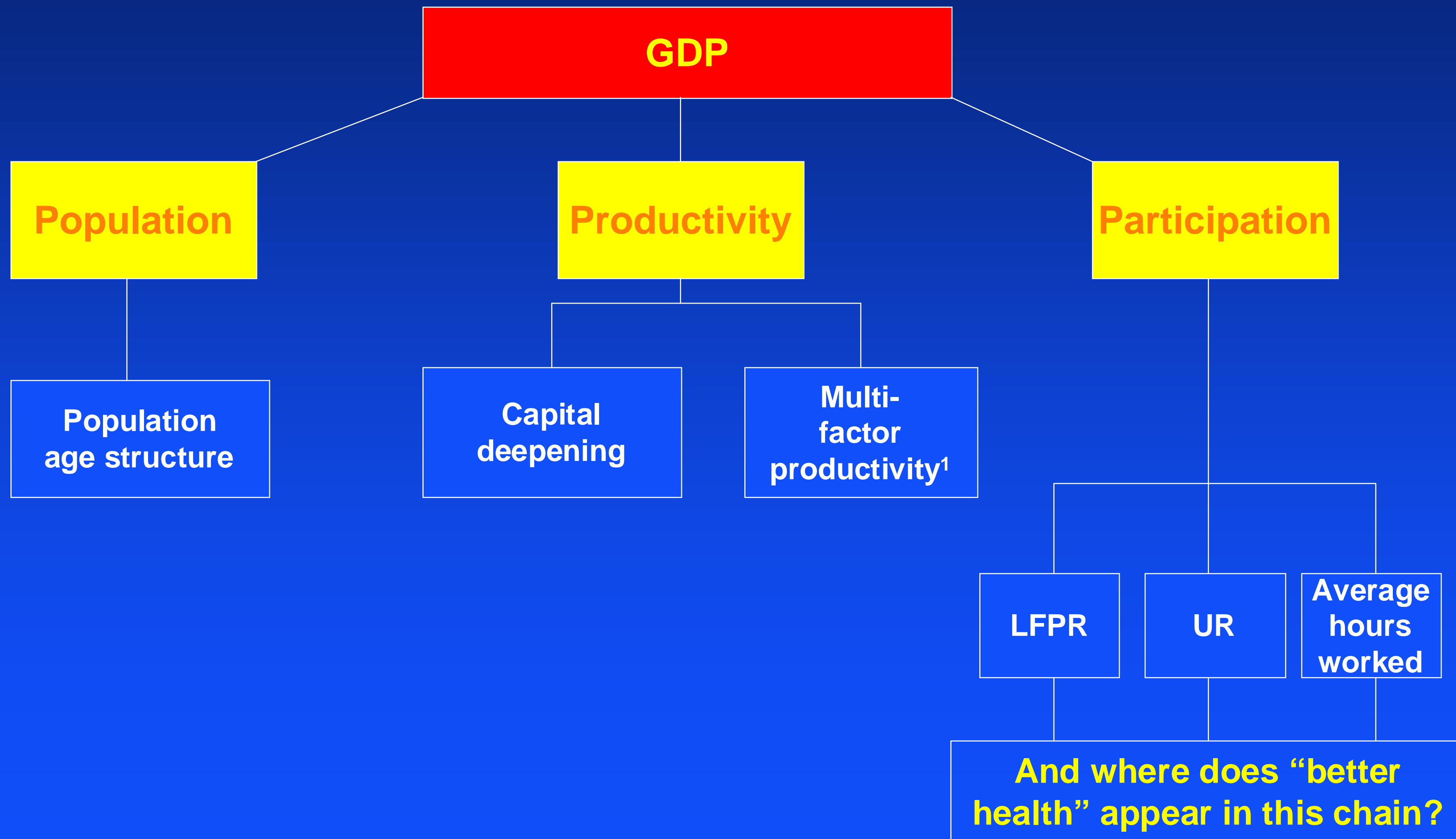
CAGR real NHE per capita,1975-1998 local currencies at 1995 prices insurance v tax-based nations-%



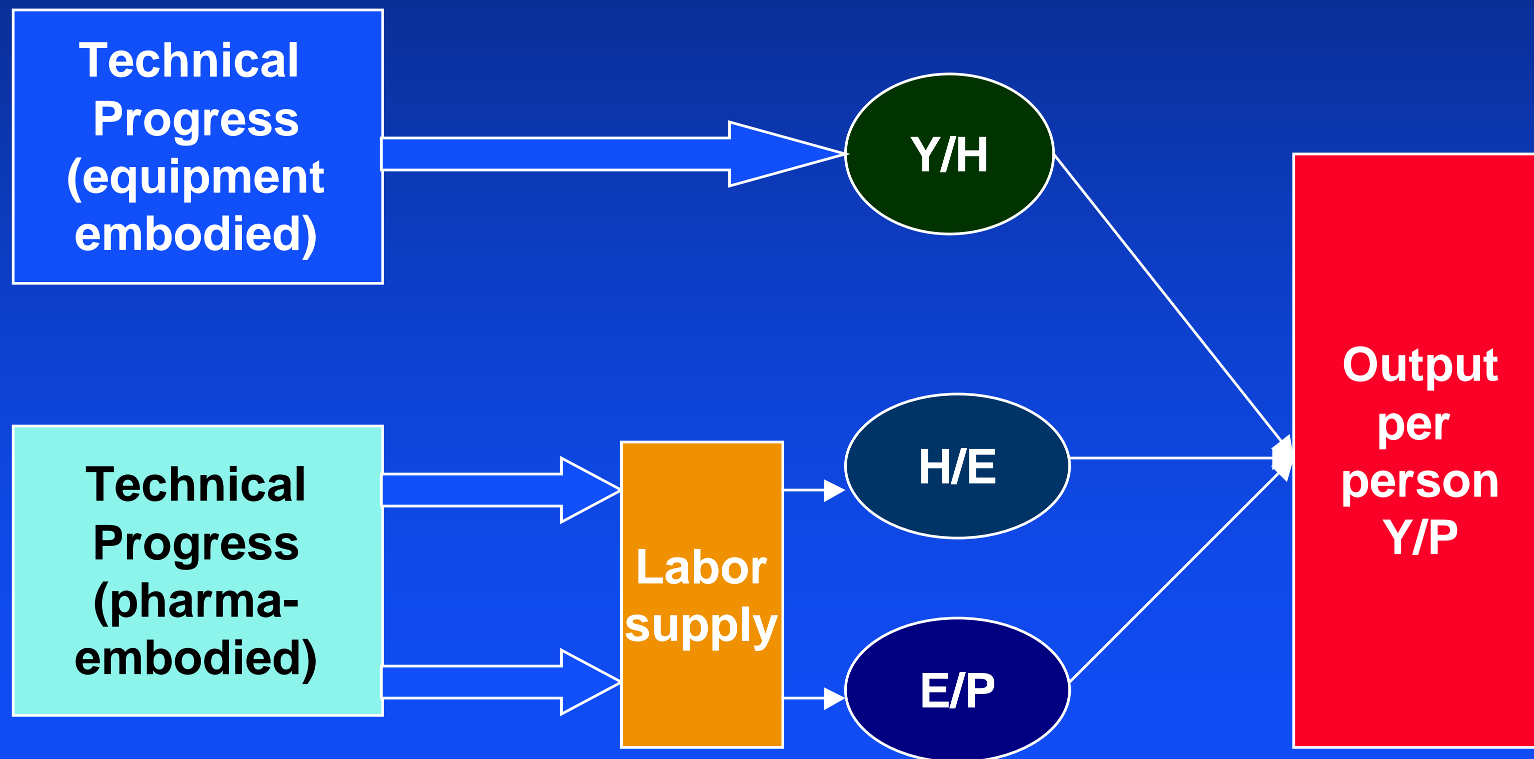
2. Restricting access to innovative treatments affects Australian productivity and GDP



Economic growth strategy: 2003 Budget



Technical and pharma-induced progress



Lichtenberg (2002):productivity and access to modern drugs

The rate of pharmaceutical-embodied technical progress with respect to activity limitations was about 18% per year

MESSAGE: Don’t kill innovative technology

3. Quality improvements in hospital care require additional funding :USA

Warning	Option	LIKELY ACTION
IOM report 1999 showing 90,000 deaths in hospitals	Pay both hospitals and individual doctors for measured improvements in patient safety	Medicare program pay-for-performance bonuses(1-2%) for eight medical conditions- stroke, heart attack, hip surgery, pneumonia, CHF Leapfrog Group payments for quality

The business case for better quality and safety

"Current payment mechanisms allow, and even reward, defective care because they are unable to reward future benefit."

S. Leatherman et al. "The business case for quality; case studies and an analysis". *Health Affairs* 2003: 22(2)

Extra payments for P4P: current US trends

Target provider	Range of extra payment to provider
Primary care doctors	0-40% of professional component Median: 10%
Specialists	90-110% of fee schedule[1]
Hospitals	2-4% of all paid claims for CPOE use[2] 2-4% additional increase in annual fee schedule with downside risk[3]

Notes:
1. Care First MD
2. Empire BCBS, Verizon, GE
3. Independence, BC

P4P criteria, four US health funds, 2003

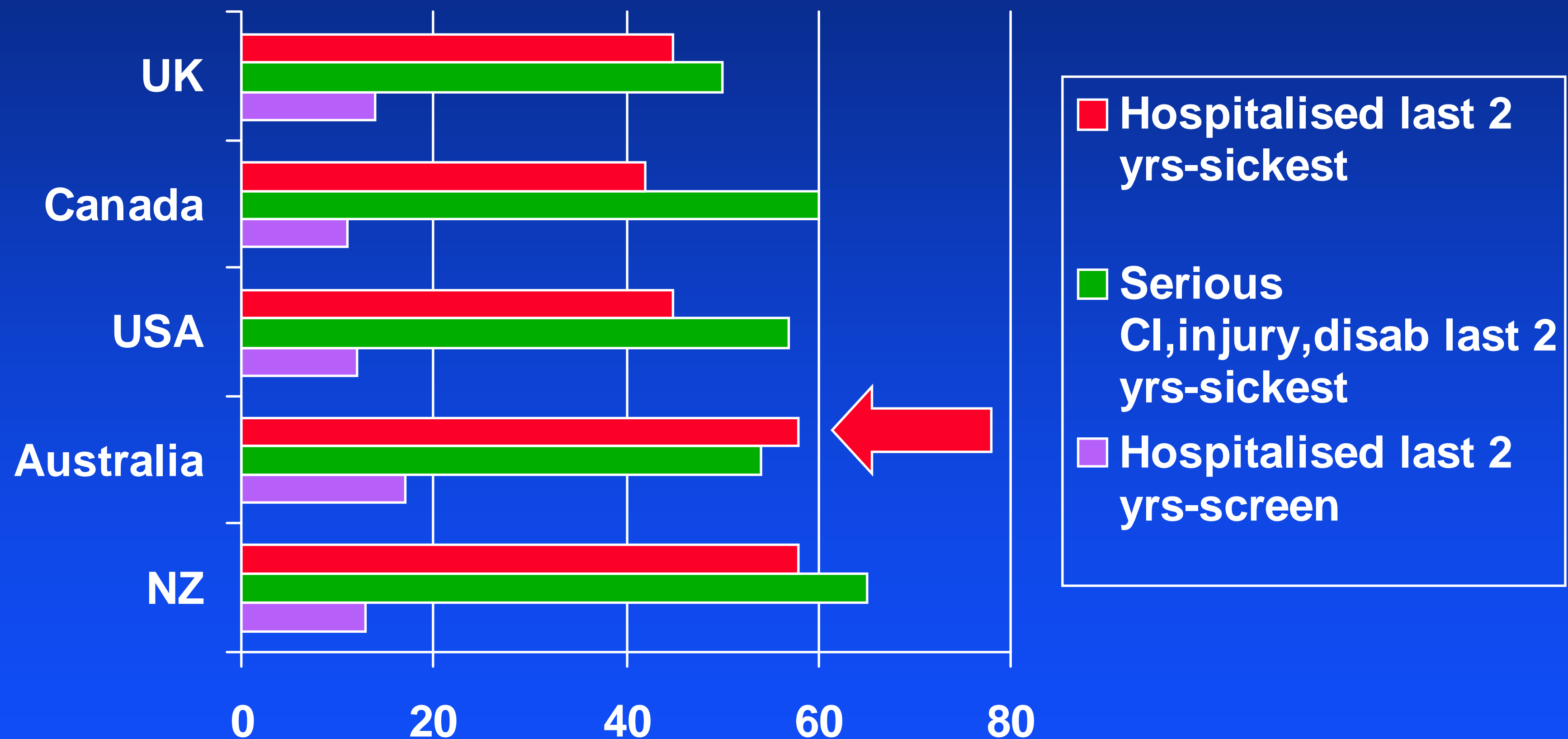
Category	BCBS-HI	IHA[1] (California)	Excellus (Rochester IPA)	BCBS-MI (hospital)
Quality	40		40	45
Patient satisfaction	30	40	20	
Connectivity	15			
Efficiency	15		40	
Clinical measures		50		
IT investment		10		
Appropriate utilisation				45
Community health:CI				10
TOTAL	100	100	100	100

Note 1: IHA Integrated Healthcare Association “Rewarding Results” National Grant

4. Fed/state revenue agreements can target chronic illness & quality:Germany

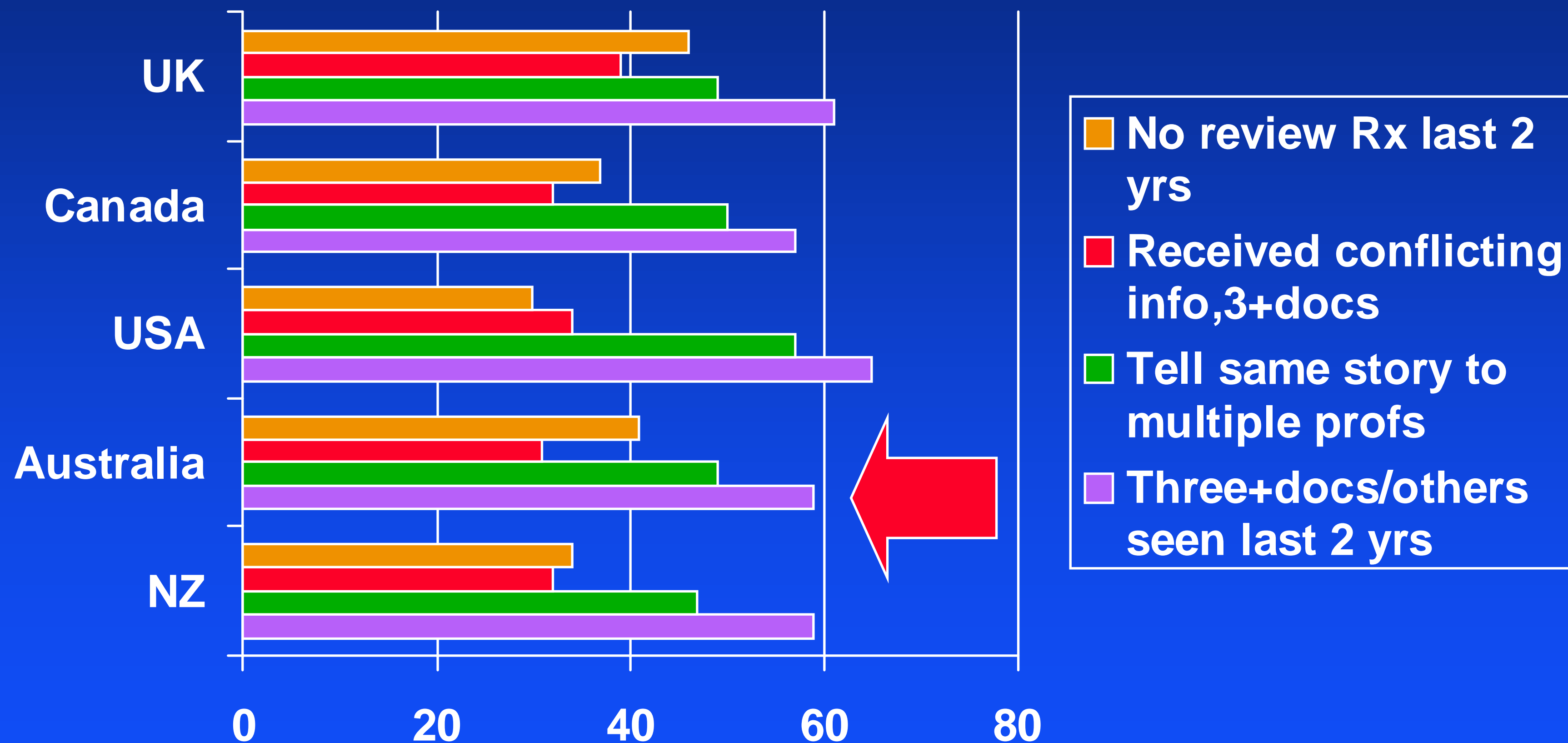
Warning	Indicator	LIKELY ACTION
Deficits in social health insurance	Need for networked, patient-centered and appropriate care Inadequate competition between insurers and providers	Restructuring of social health insurance to include disease management of four diseases in revenue-sharing Selected contracts based on quality indicators

Sickest: hospitalisation rates-%



Highest admissions rate in the western world

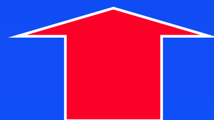
Sickest: coordination, advice on Rx-%



Multiple specialist and other visits, poor coordination

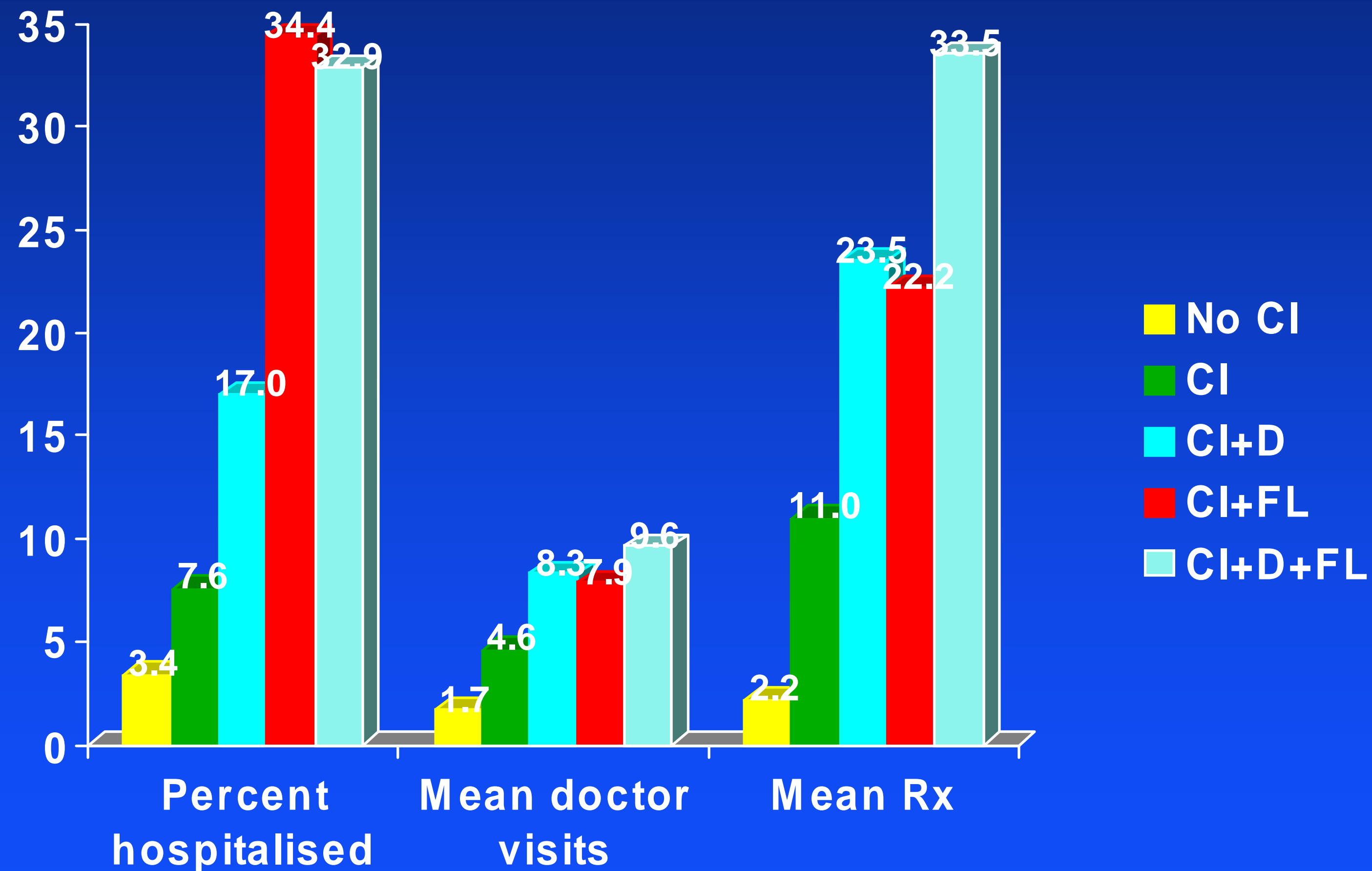
Use of hospital services for major chronic disorders Australia 1999/2000

Disorder	Number of risk factors implicated	Separations	Shares of total costs in		
			Hospitals	Drugs and nursing homes	Medical services
CHD	8	157,913	64	12	10
Stroke	8	52,843	45	2	5
Lung cancer	1	16,783	76	10	7
Colorectal cancer	3	23,758	85	2	5
Depression	3	59,909	NA	NA	NA
Diabetes	3	336,976	NA	NA	NA
Asthma	2	47,008	37	22	20
Chronic renal disease	4	535,396	56	2	8
Arthritis	2	55,758	48	9 (+19 for NH)	13
Osteoporosis	4	34,000+	65		



Are these being attacked systematically?

Chronic illness, disability and functional limitations, USA 2001



Disease management:what works USA

Condition	Programs with PROVIDER EDUCATION	Programs with PATIENT REMINDERS	Programs with PATIENT FINANCIAL INCENTIVES
Asthma	1.1 (0.04,2.1)	0.03 (-0.1, 0.19)	
CAD	0.4 (0.18,0.62)	0.31 (-0.01,0.63)	
Chronic pain	0.87 (0.27, 1.47)		
COPD	0.01 (-0.38,0.39)	0.29 (-0.3, 0.86)	
Depression	*0.27 (0.18, 0.36)*	*0.34 (0.14, 0.35)*	*0.26 (0.1,0.43)*
Diabetes	*0.22 (0.15, 0.30)*	*0.31 (0.1,0.44)*	
ESRD	-0.25 (-0.4,-0.06)		
Hyperlipidaemia	*0.20 (0.07, 0.33)*	*0.90 (-0.27,0.44)*	*0.25 (-0.04,0.48)*
Hypertension	*1.6 (0.3,2.9)*		*0.48 (0.44, 0.53)*
Rheumatoid arthritis/ osteoarthritis	0.1 (-0.11, 0.30)	0.21 (-0.31,0.73)	
ALL CONDITIONS	0.24 (0.07, 0.4)	0.27 (0.17, 0.36)	0.4 (0.26,0.54)

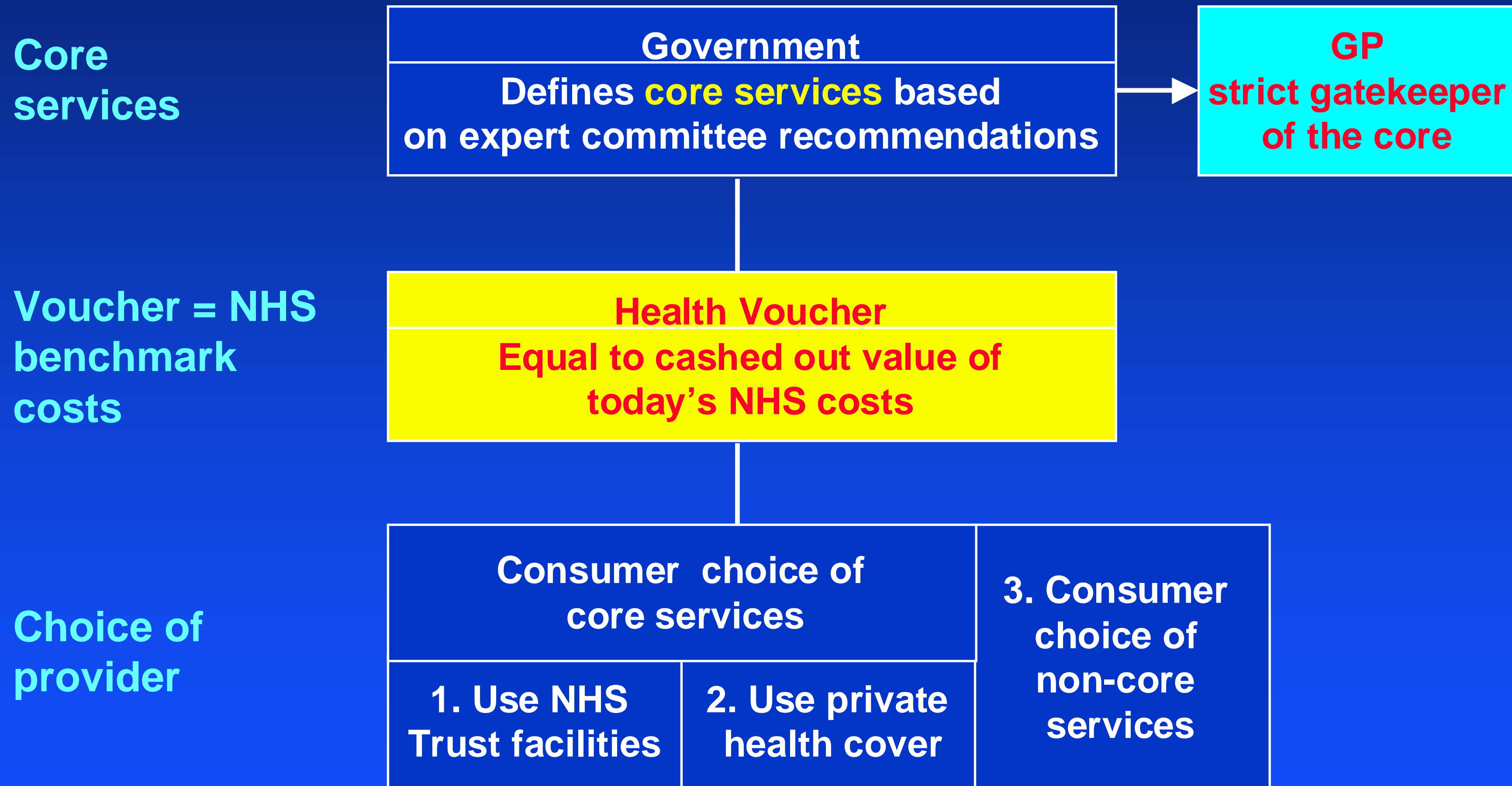
Payback period, various patient education strategies

STRATEGY	Payback
High cost patients with multiple risk	Reduced hospital admissions within one year
Diabetes management	$500 savings within 2 years
Risk factor reduction (BMI,smoking,alcohol,exercise)	Reduced work loss days Reduced use health care next 12/12 ROI within 6 years

5.In the absence of a mandate to raise the Medicare levy, government tax incentives might favour LTC insurance: USA

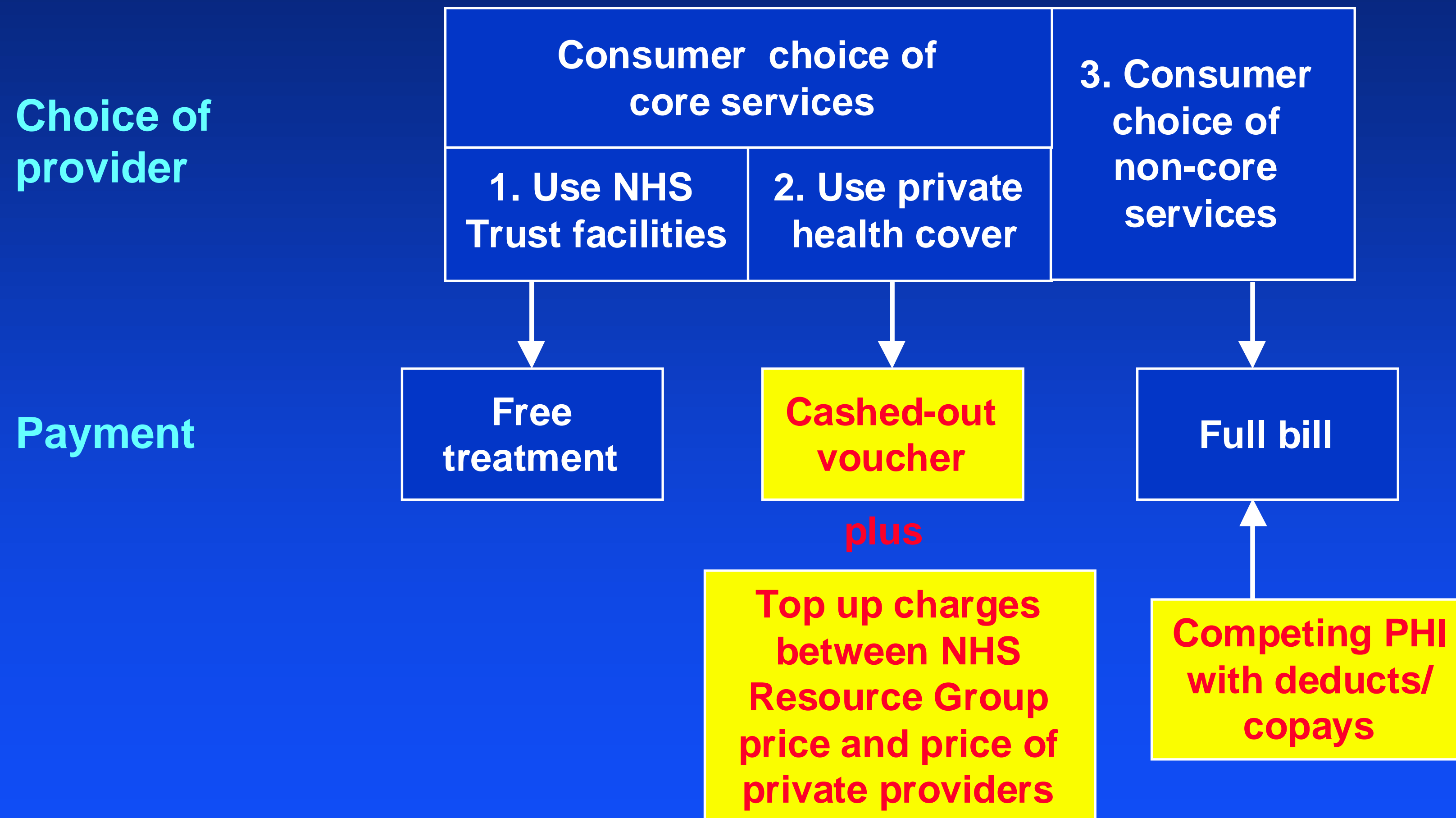
Warning	Indicator	LIKELY ACTION
Inadequate access to long term care (LTC)	50%+ of US$ 82 billion spent on LTC is funded by government Only 10% of Americans have LTC insurance	Congressional bill to allow write off of 25% of the cost of LTC insurance for taxpayer,a spouse or dependents

6. Governments can define the core benefits and the role of PHI:UK



Source: Health Policy Consumers Group. "Step by step reform". London, February 2003

Governments can define the core benefits and the role of PHI:UK, 2003-continued



Source: Health Policy Consumers Group. "Step by step reform". London, February 2003

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One certainty: Medicare and PHI need rejigging

Transforming Medicare: paying for quality in chronic care management

GOALS	1. Reduce the health risks of at-risk target populations 2. Provide the quality and safety of care
COMPONENTS	1. EB decision-support for doctors and patients 2. New business model: pay for population-based outcomes 3. New administrative role for DHAC - setting goals - contracts with public and private patients - managing and analysing HIC and health fund data in ways that improve the outcomes of care.

Public-private partnerships under Medicare: chronic care

1. Minister of Health would be empowered to enter into contracts with

- State health regions (maybe States?)
- Private health insurers
- Pharmaceutical companies
- GP Divisions
- Royal College of Physicians

2. Targets: patients in defined geographical areas with ten major chronic conditions

Public-private partnerships under Medicare: chronic care

3. Performance-based funding: MBS, PBS, health fund benefits

4. Additional annual upfront payments to GP's:

- $400/patient
- GPs (and practice nurses) agree to take on added responsibilities for patients with 3+ chronic conditions or designated risk factors
- GP coordinates care, maintains simple longitudinal patient records
- Additional quality bonus payment (patient satisfaction, health and functional outcomes)

Public-private partnerships under Medicare: chronic care

5. Eligible CI management programs:

- Patient voluntary enrollment
- Develop and use care plans and CPGs
- GP coordination
- Clinical trials vs non-enrollees ($20 million funding)
- Specified patient information, education & outreach

Public-private partnerships under Medicare: chronic care

6. Minimum data for payment:

- Monitoring of health and functional status
- Reductions in hospital and medical treatment errors
- Hospital readmission rates
- Patient satisfaction
- Cost :direct and indirect

New proposals in health care, 2003: Chinese analogy

“ Reformers have the idea that change can be achieved by brute sanity”

GB Shaw