AHCRA- Advocate for the Structural Reforms needed for the Equity and Sustainability of our Health System

- Canberra July, 2014
- Professor John Dwyer AO

Health Care Reform

- Our goal–
- *A system focused on the individual that emphasises prevention is demonstrably equitable, sustainable and provides evidence based quality care in a timely manner available on the basis of need not personal financial wellbeing*.

New Government Promises

- No reduction in health expenditure
- Support for Labor's NDIS
- No cuts to education
- No hint that University education would become more expensive
- So -----

WHAT DID WE REASONABLY EXPECT?

- A clearly delineated vision for the health system contemporary Australia needs
- The necessary changes to unshackle reform efforts i.e. a commitment to system reform not just asking us to pay more for the same old!
- A renewed commitment to health care equity

Request to Abbott Government

- Almost all health reform experts said to the government pre budget----
- “GDP expenditure on health is only 9.1%, no cause for panic, and your concern for the rising cost of Medicare (19 B $ a year)is misplaced when hospital expenditure exceeds $140 B a year and is growing faster than Medicare”.

Advice to Abbott government

- “ We know Mr. Dutton that you are focusing on Medicare expenditure because of the wretched jurisdictional divisions that uniquely plague Australian Health care, but true leadership from your government would see more spent on Primary and Community programs to save many more dollars from reduced hospital admissions”.

Wasted or poorly used health dollars

- $35 Billion on avoidable admissions
- $20 Billion on low value/no value care
- $5 Billion on PHI rebate
- $2-4 Billion on DOH duplication
- $2-3 Billion on “Supplements” and pseudoscience
- $2 Billion on unnecessary length of Medical Education

Public Hospital problems

- Demand outstrips financial and physical capacity
- On average a 3-5% increase in admissions of sicker, older medical patients each year
- In NSW ED's experienced 7-11% increase in visits 2103.
- Physical infrastructure hinders efficiency

Funding needs and the PHI rebate

- Tax payer subsidy of PHI has not removed significant pressures from public hospitals
- Public and Private hospitals occupy different care universes
- PHI uptake increased 2% after introduction of subsidy
- Levy and age rating saw significant increase

Hospital Problems

- System wide intense efforts to improve efficiency and mimimise misadventure.
- Activity based accounting good tool for understanding costs and clinical efficiency
- ABF a misnomer. Hospital budgets are fixed and no retention of savings by more efficient units.

Hospital problems

- Political imperatives so often hinder cost and quality improvements e.g. Role delineation and rebranding of many Eds that aren't!
- Continuous operational improvement always possible but will never solve all the problems

Then comes the May budget

- COAG agreement on Commonwealth contribution to hospital funding ripped up
- States loose 80B dollars of promised funding and a partnership in sharing rising costs equally
- Plus hundreds of millions from needed Commonwealth grants cancelled.

Future of Quality Hospital Care

- Already most ON beds in OECD
- Need more in present system!
- Quality hospital care into the future all dependant on demand reduction
- Fewer medical cases but more surgery
- Gap payments for surgery will only fall with public hospital competition.

Some pertinent facts

- Management of a huge societal burden associated with Chronic and Complex disease management costing us a fortune and results in much personal suffering.
- There is no doubt that much of this suffering is preventable but only by providing our PC system with the prevention infrastructure needed.

Some more pertinent facts

- Many quality studies have been done looking at preventable hospital admissions in Australia.
- Defined as “avoidable” had there been an effective community intervention in the three weeks prior to admission.
- 600,000 avoidable admissions utilising 7 million bed days pa. Economics 101?
- NSW, 8.9% readmission within a month

INTEGRATED PRIMARY CARE

- World wide shift
- "Team medicine"; Practice team consists of doctors nurses and allied health professionals (including dentists) with team funded by extension of MBS
- Team learning to prepare for IPC practice.

What do we need from contemporary Primary Care?

- Personalised medicine to prevent illness
- Currently 2% of budget
- Early intervention strategies
- "Team Management" of C & C disease
- "Hub and Spoke" models for better clinical, business and quality outcomes
- Care in the community for many currently sent to hospital.

Integrated Primary Care

- Importance of voluntary enrollment
- Mutual contract to keep you and your family well
- Emphasis on appropriate continuity of care and case management led by the most appropriate health professional
- Care model attractive to health professionals (young doctors)

Three major prevention deficiencies

- Despite an abundance of evidence of cost effectiveness and good outcomes we are failing in three major areas-

  "Good Start" programs (25% of children starting school have a health vulnerability)

  Adolescent Mental Health

  Oral Health. All addressed by "IPC"

IPC well established internationally

- KP in western USA good model
- IPC and electronic record for ten years
- Best outcomes in USA for 8 of 10 most common Chronic conditions
- 2 million face to face consultations now done by email
- Very significant reduction in hospitalisation

INSTEAD!

- A co-payment for Dr visit, tests and medicines. Billions of dollars required from our most disadvantaged. The rich protected.
- National body for Prevention abolished!
- OOP expenses already fastest growing health expenditure ($29B pa)
- Huge research fund for future cures while we struggle to implement current EB strategies.

Primary Health Networks

- Replacing Medicare locals which did need better role delineation
- Lost a lot of PC Money
- Fewer but larger PHNs hopefully better aligned with hospital networks.
- Asked to align themselves with PH providers! Danger of two tiered system.
- PHI for Primary Care will drive up costs.

SYSTEM WIDE REFORM

- A single funder—The Commonwealth
- A separate agency for contracting providers
- Regional Health Authorities
- Patient focused integration
- Establishment of “Integrated Primary Care”
- A national Electronic Health Record

SYSTEM WIDE REFORM

- Policies targeting Rural Disadvantage
  - Training more rural affiliated students
  - Embracing Inter-professional learning
  - Return of the GP proceduralist etc.
- Partnership between Public and Private sectors
- Means test or remove PHI rebate

Concept of a Reform Journey

- One plans a journey after deciding definitively on a destination.
- Plan--a month in Paris next summer!
- Hurdles along the way, careful and thorough planning essential.
- Unforeseen problems must be addressed
- COAGs “Paris” is patient focused integration and a transition authority to implement the journey to a new model for care. The destination (model of care) is non-negotiable
- The length of the journey is less predictable but the journeys milestones are well marked.

AHCRA and the Future

- Urgent- meet with new Senators
- Champion equity; emphasise that inequity is very expensive.
- Expand “Conversation with Australia”
- Warn of possibility of a “two tiered” system.
- Medicare is in real danger from the “Best friend Medicare ever had”!
- Work on Labor/Greens policies

AHCRA and the Future

- Continued expansion
- AHCRA Blog
- Championing of Oral Health campaign
- More involvement with Rural health inequities.
- Continue emphasis on structural reforms.