Maintaining a quality health service during the economic downturn

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Overview

- Basic principles and problems
- Challenges for Irish health care
  - Demography
  - Progress in healthcare
  - Healthcare restructuring
  - Care delivery
  - Private care
  - Financial collapse
- Why are we where we are?

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Overview 2

- Budgets and resources in HSE
- Concepts for health service financing
- Responses to the immediate crisis
  - Drugs
  - Acute care
  - Private care
- Hope for the future?

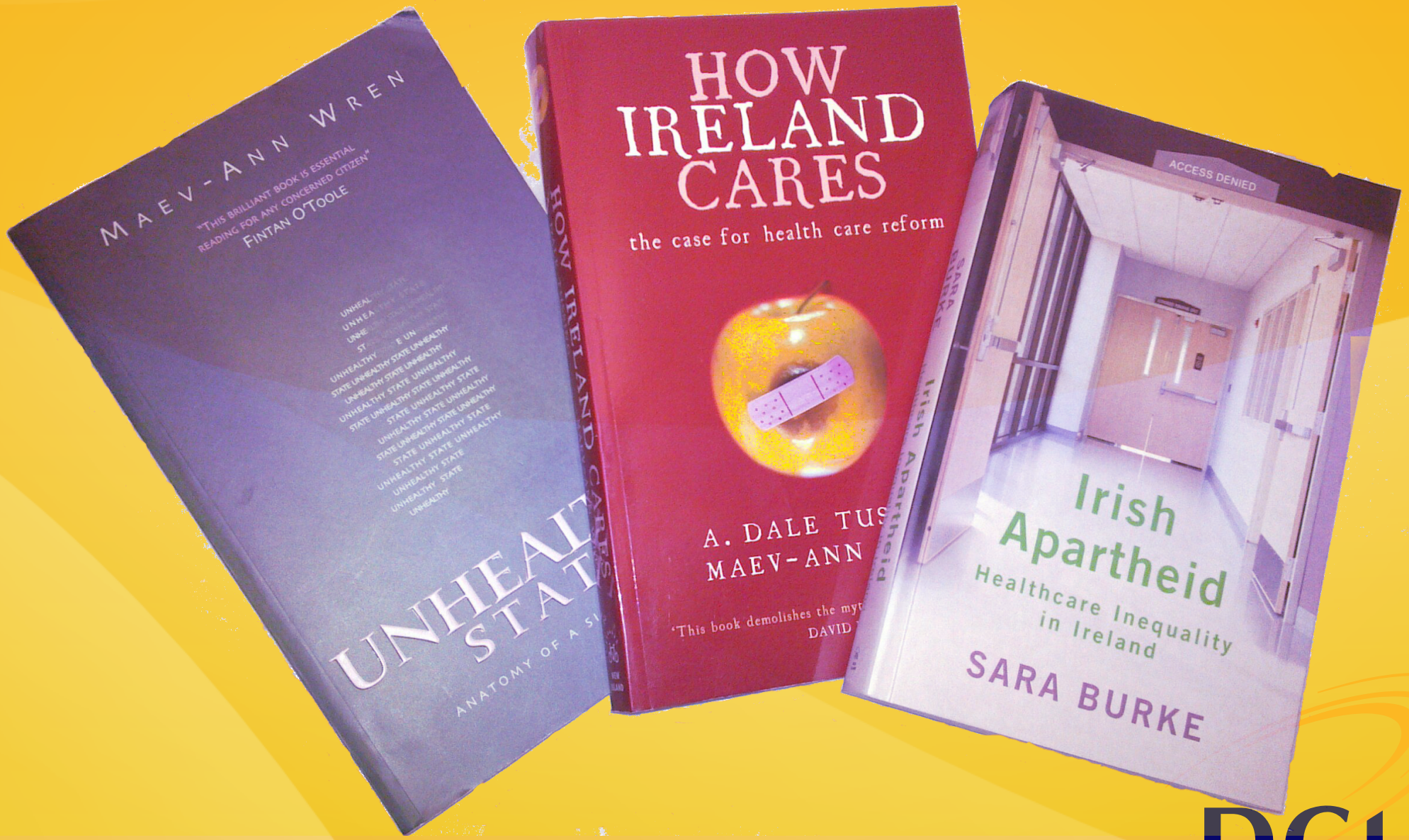
Basic Principles

- "Every system is perfectly designed to get the results it gets."
  - Paul Batalden 1996
- “Insanity is doing the same thing over and over again but expecting different results”.
  - Rita Mae Brown 1983

Basic problem

- We have a truly weird health care system
  - Not nice weird
  - Scary weird

A happy ship?



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Not for the passengers, anyway.

What's wrong with it?

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(in no particular order)

- Poorly developed primary care
- Unfair access to secondary care for poorer people
- Poor care for people with chronic disease
- Poor care for people with disabilities
- An acute hospital system of baroque complexity
- A large, unsustainable, private health care system, dependent on large public subsidies

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Challenges for Irish healthcare

- Demography
- Progress in healthcare
- Healthcare restructuring
- Care delivery
- Private care
- Financial collapse

Demography

- e.g. work by Richard Layte and colleagues
- 4% rise in people over 65 by 2021
  - Minimum 40% increase in day patient discharge expected
  - Minimum 45% increase in inpatient activity expected

Progress in health care

- New stuff gets invented
  - Sometimes it works well
  - Sometimes less so
    - e.g. rosiglitazone
- Regardless it costs more...
- People demand it
  - e.g. biological drugs for cancer care
- Costs rise

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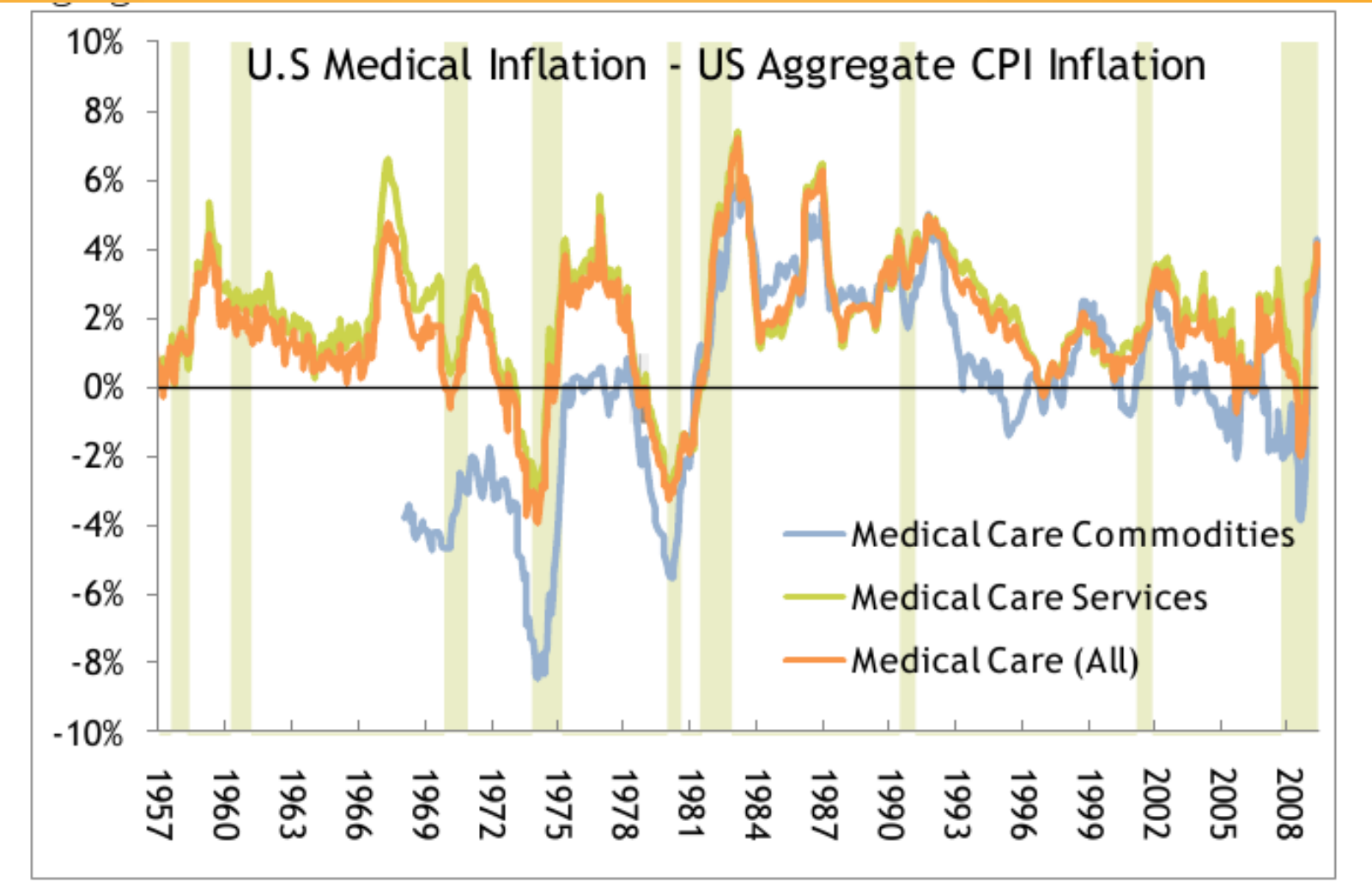
US Medical cost inflation



Source: Bureau of Labour Statistics and the NBER

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Healthcare restructuring

- As Charles Normand never tires of repeating
  - It takes 3 years to bed down a significant change in healthcare strucutres
- And he's right
- The NHS has had endless restructurings which have cost a lot, and delivered little

Health care restructuring

- HSE does not work well
- There's no reason to suppose that it will work any better after being re-organized again
- The health boards also worked poorly
- It's not the structure that's the problem

Care delivery

- Acute hospital care
- Primary care
- Complex chronic disease care
- Disability care
- Long-term care

Acute hospital care

- This is the political priority, as recent events sharply demonstrate
- It's not really the key problem
  - On the other hand we are quite short on specialists
  - We may be short on beds

Primary care

- We are woefully undersupplied with GPs
  - The ones we have do their best (largely) in remarkably poor conditions
- Irish primary care needs a major boost
  - It's not getting it
- The Primary Care Strategy (as implemented) won't work

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Complex chronic disease care

- This will dominate health service needs over the next decade
- It's not really happening at any level here
- There's no real integrated care process
  - Though one is being developed
  - Ray of hope on the horizon?

Private care

- Major part of our system
- Strongly encouraged by tax breaks for new facilities
- Co-located hospitals
  - Not the cleverest idea
  - Will not substitute for shortage of public care beds

Private care

- The (limited) evidence is that private care costs more, and is of worse quality than corresponding publicly funded care
- No Irish data that I know of
- Lot of perverse incentives especially for acute hospitals, and their consultants
  - Some evidence that these incentives are being responded to

Financial collapse

- This is the real crisis
- We have had significant increases in resources, year-on-year, for the last decade
  - I agree this was largely catch-up on a huge deficit
- This has stopped

Financial collapse

- HSE are down about 600 million this year
  - And it's breaking, badly.
- How much next year?

Financial collapse

- Given the odd way HSE is run, budget cuts fall very disproportionately on front-line staff
- This affects patients directly, as is finally being admitted
- There is a price to be paid for all this

We are where we are

- Don't you just hate people who say that?
- Why?
- History and a wilful refusal to plan

Hospital services

- We still haven't implemented a plan drawn up in 1967, the Fitzgerald report.
- Indeed we still haven't implemented the similar plan drawn up in 1936.
- Don't talk about the 2003 plan.

Primary care

- Arguably, we now have a less integrated service than in the days of the dispensary doctors
- At the present rate of progress we'll have working, as opposed to nominal, primary care, in about a century
  - just in time for the 200th anniversary of the Easter Rising

Primary care

- This may sound harsh, but,
  - We have 240 odd teams, out of 600+ planned, holding meetings of some sort
  - Reports indicate that less than ten are actually working properly
- Counting tools, not objectives

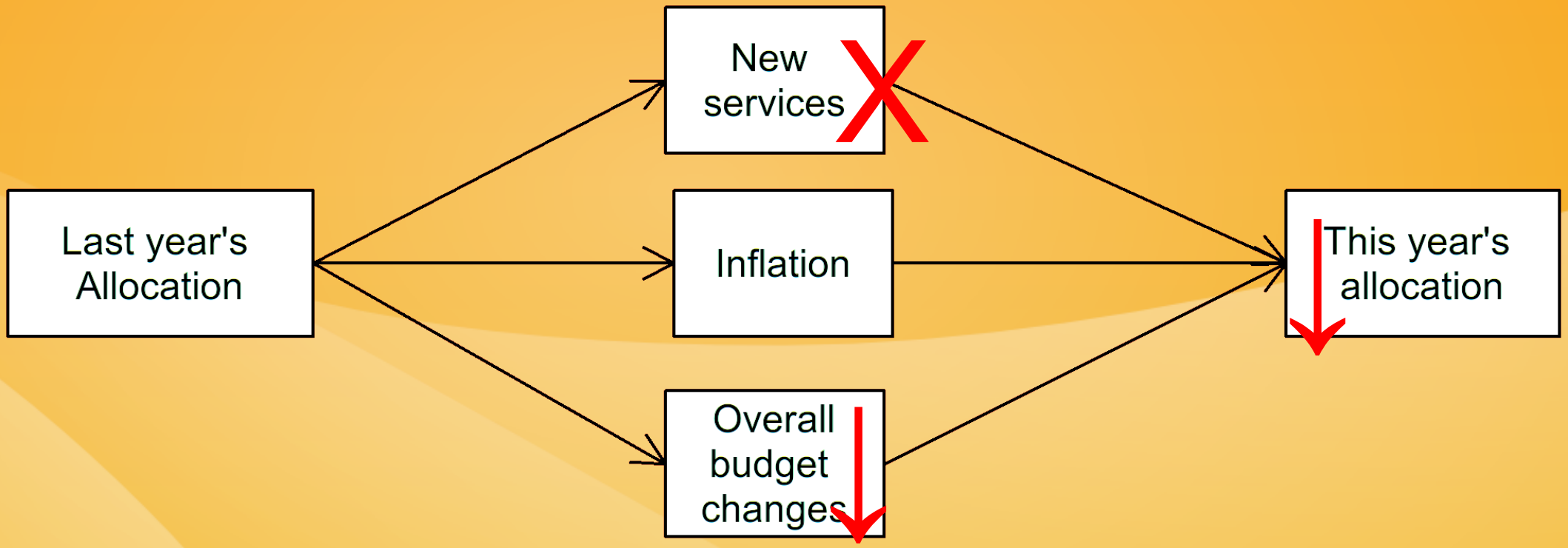
Budgets and resources in HSE

- There are no coherent systems of resource allocation in HSE
- Some are being developed, but this is not a real priority
- Staying under budget to year end is the only real priority for HSE just now

We know what to do

- My own work on primary, community, and continuing care
- The very comprehensive (700+ pages!) work of Francis Ruane and her colleagues

Typical HSE Budget 'process'



3.5 Concluding Comments

The Group's view of the current system of resourcing, funding and sustaining the present health system is that it fails to meet most of the guiding principles that the Group would consider essential to have a system that is fit for purpose. For example, while the system seeks to be patient/client centred, the resource mechanisms do not support that. While integrated care is seen as being crucial to meeting the health needs associated with chronic disease management and ageing, the resource allocation mechanisms fail to support this. While equity and fairness are key objectives of Irish health care, the financing mechanisms used in Ireland to finance health care are highly inequitable, placing particular burdens on people who are just above the medical card and GP visit card thresholds and/or who require regular contact with primary and community care services (e.g. people requiring chronic disease management). Thus while much has been achieved following the Brennan Report in terms of controlling expenditures on health care, very little has been achieved in terms of better allocation of the resources available to the system. Furthermore, the issues and risks associated with the current financing system have been exacerbated in the present economic climate. In the context of reduced resources for health care it is crucial that Ireland has a resource allocation system that can allow government to deal with budgets equitably, to prioritise different types of care and ensure the most efficient and effective use is made of the available resources.

Statement of principle

- We propose a resource allocation model for the Irish health services, based on the principle that each Irish resident should be provided with access to health services, funded from general taxation, in proportion to their need for those services...

Statement of Principle

- ...the model we propose, although very crude, would be a place to start, and we urge that a start be made, as soon as possible. **Any reasonable system of resource allocation would be an improvement on the current situation.**
  - *Staines et al. 2010.*

Well!

- This is not hard
- This can be done
- If it's not done?
  - The sick, the poor, the old, and the disabled will suffer most.
    - As we see, rather visibly, in HSE West
    - Less visibly, everywhere else

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What do we need to do?

- There's a clear detailed roadmap in the two reports
- First, a few useful concepts

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Concept 1

- Be clear about the distinction between policy tools, and policy objectives
- Most discussion is actually about tools, not objectives
  - This is a problem in Ireland generally, not just in health

Tools vs. Objectives

- Tools
  - HSE
  - Health boards
  - Location of hospitals
  - Size of hospitals
  - Staffing mix
  - Tax support for private health care
- Objectives
  - QUALITY AND FAIRNESS
  - Health care access
  - Health care costs
  - Health care quality
  - Equity of access

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It's easier to do tools than objectives

- But it's a total waste of time
- Start with the objectives and work back

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Concept 2 – health system financing

- We do not need new policies
- I have about ten feet of Irish health policies in my office, and so do most of us
- We need to implement the ones we have
  - This is the real failure of the Department and HSE

So,Conceptual framework for health system financing (Kutzin 1999)

- The one minute guide to health service financing, with apologies to Joseph Kutzin

Conceptually simple

- Money comes from people
  - Tax
  - Employment levies
  - Out of pocket expenses
  - Charitable donations
- Services are used by people
  - Not necessarily in proportion to what they put in
  - This is called solidarity

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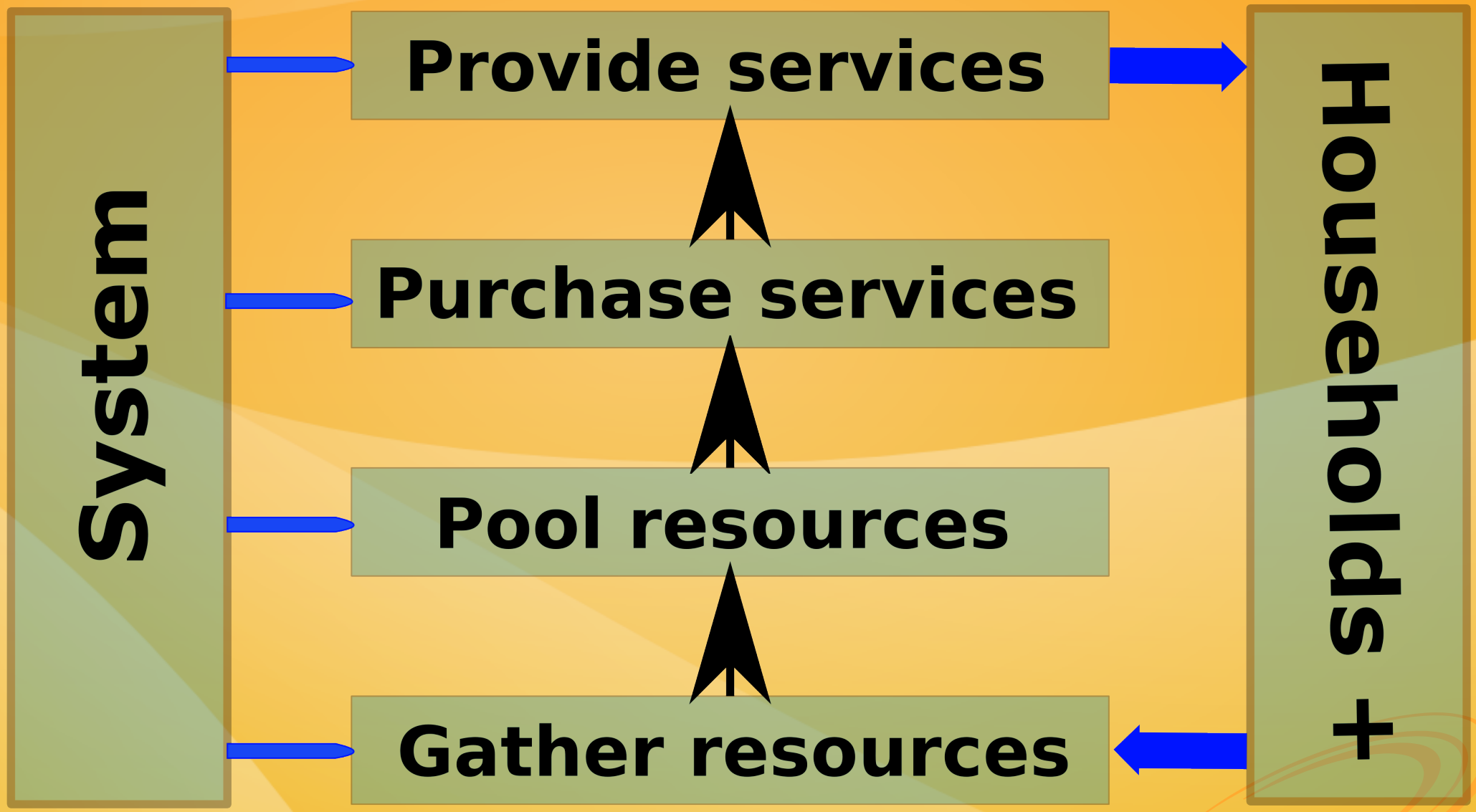
Basic roles



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Collection

- Taxes
  - Direct
  - Payroll
  - Indrect
- Levies
- Charges
- Insurance premia
  - Voluntary
  - Compulsory

Pooling

- HSE/DoHC
- Insurance companies

Purchasing

- HSE/DoHC
- Insurance companies
- Individuals (basically primary care)

Provision

- Acute care
  - Mainly public hospitals
  - Private hospitals
- Long-term care
  - Large scale
  - Small scale e.g. Fair-care
- Primary care
- Chronic care?

Concept 3 Patient centred care

- We need patients centred care
- We need primary care led care
  - To avoid confusion, this really means care teams led by GPs
  - Services to patients orchestrated from primary care

Client-centred care

- At the moment, most health services are run to suit the people who run them
- To change this, patients have to bring value to providers, and also have some choice of services
- Services have to reconfigure to do this
  - Financial tools can support the delivery of such a system

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Primary care now

- Really marginalized, fragmented, woefully underfunded
- Not really co-ordinated within itself
- Not co-ordinated in any real way with other sectors
- User fees substantially discourage appropriate use of services

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This has to be fixed

This will cost money

Imagine

- A primary care led patient centred acute hospital service
  - Where the main goal of the facility was to service and support primary care
- What would it look like?
  - Patients would be at the heart of the system
  - GPs and other primary care team members would be the most important outside stakeholders

Concept 4 - Economic incentives

- Funding designed to effect behaviour change in health care suppliers
  - All payment systems will be gamed
  - Make sure obvious incentives are aligned with policy objectives

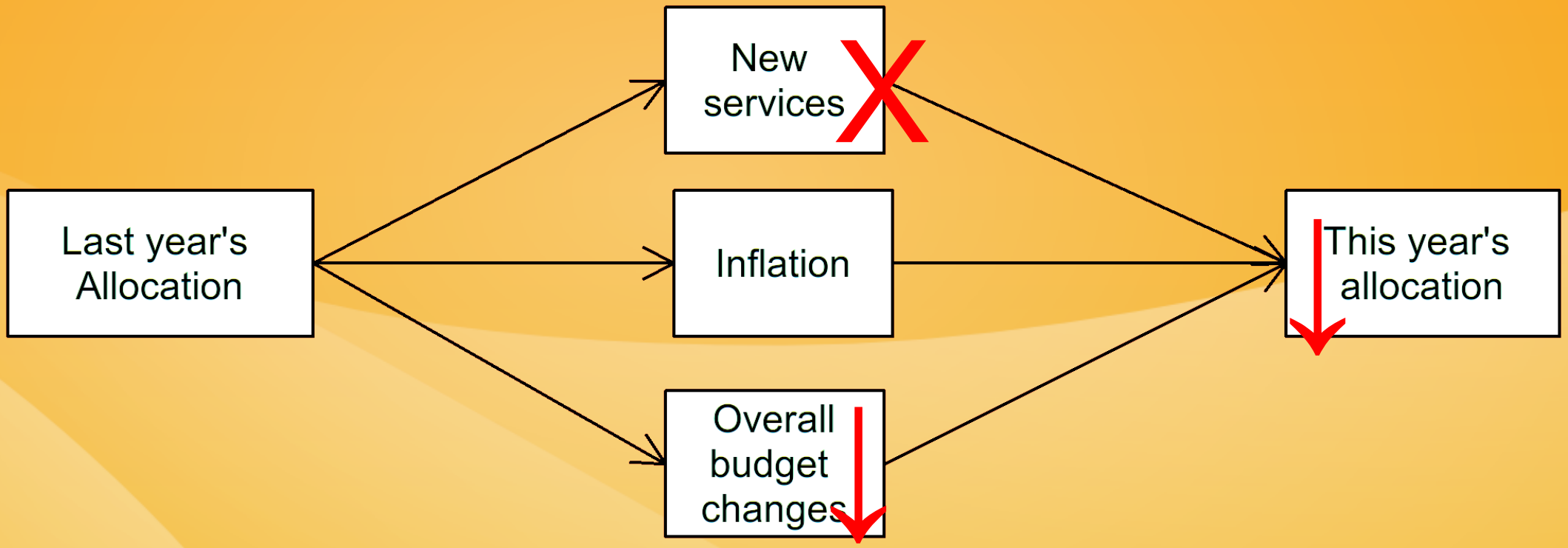
Policy priorities

- Equity of access
- Primary care leadership
- Client centred services

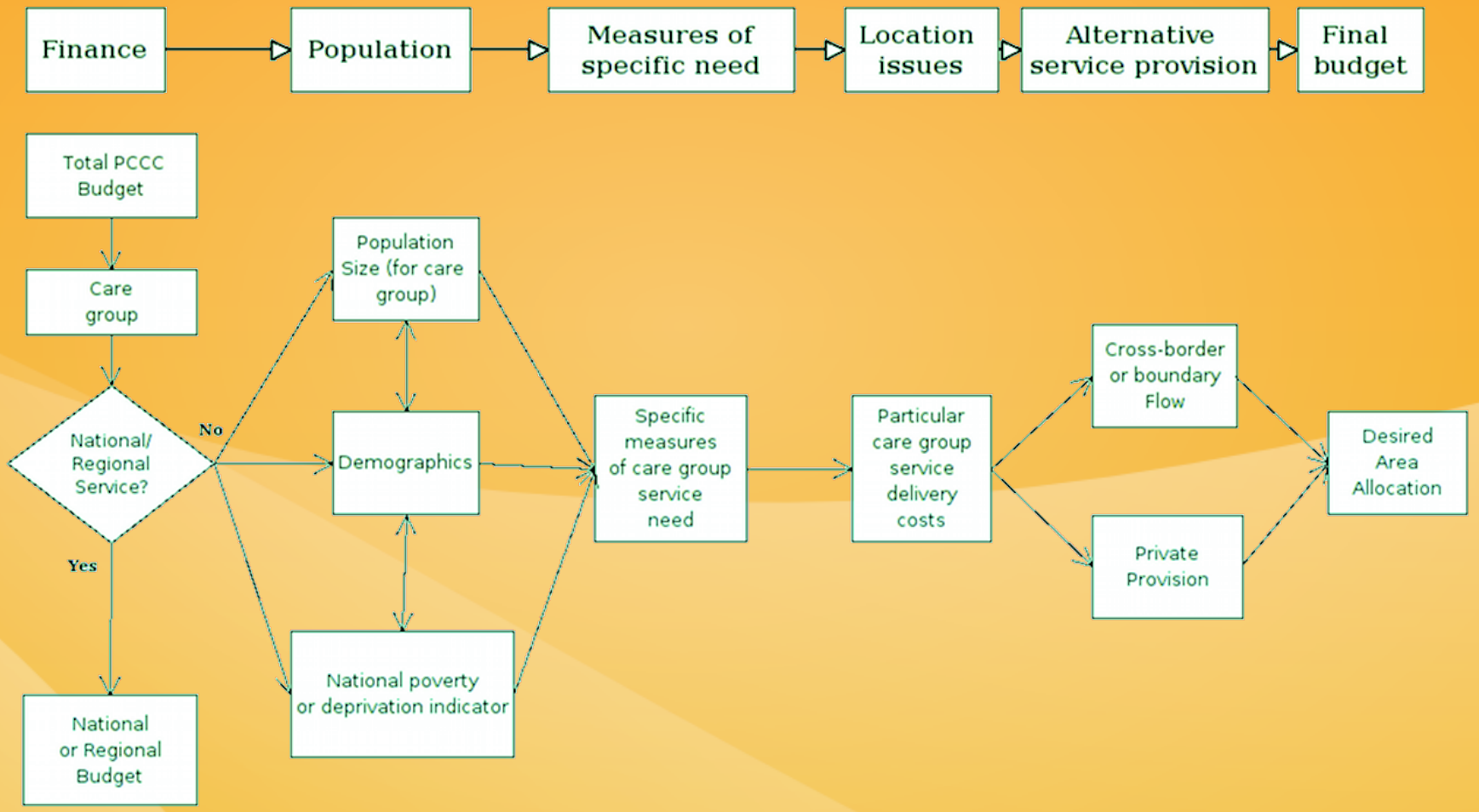
Implications

- Budgets based on individuals
- Resources based on a mix of services provided and capitation
- Clinical control in primary care
- Resources for acute care flow from primary care out
- Chronic care managed in primary care

Typical HSE Budget 'process'



Our Model for PCCC



These models are simple

- Money per head for services
  - Top-slice some very costly rare items
- Resources provided are dominated by population
- Can weight this allocation by age, sex, deprivation, other measures of real need

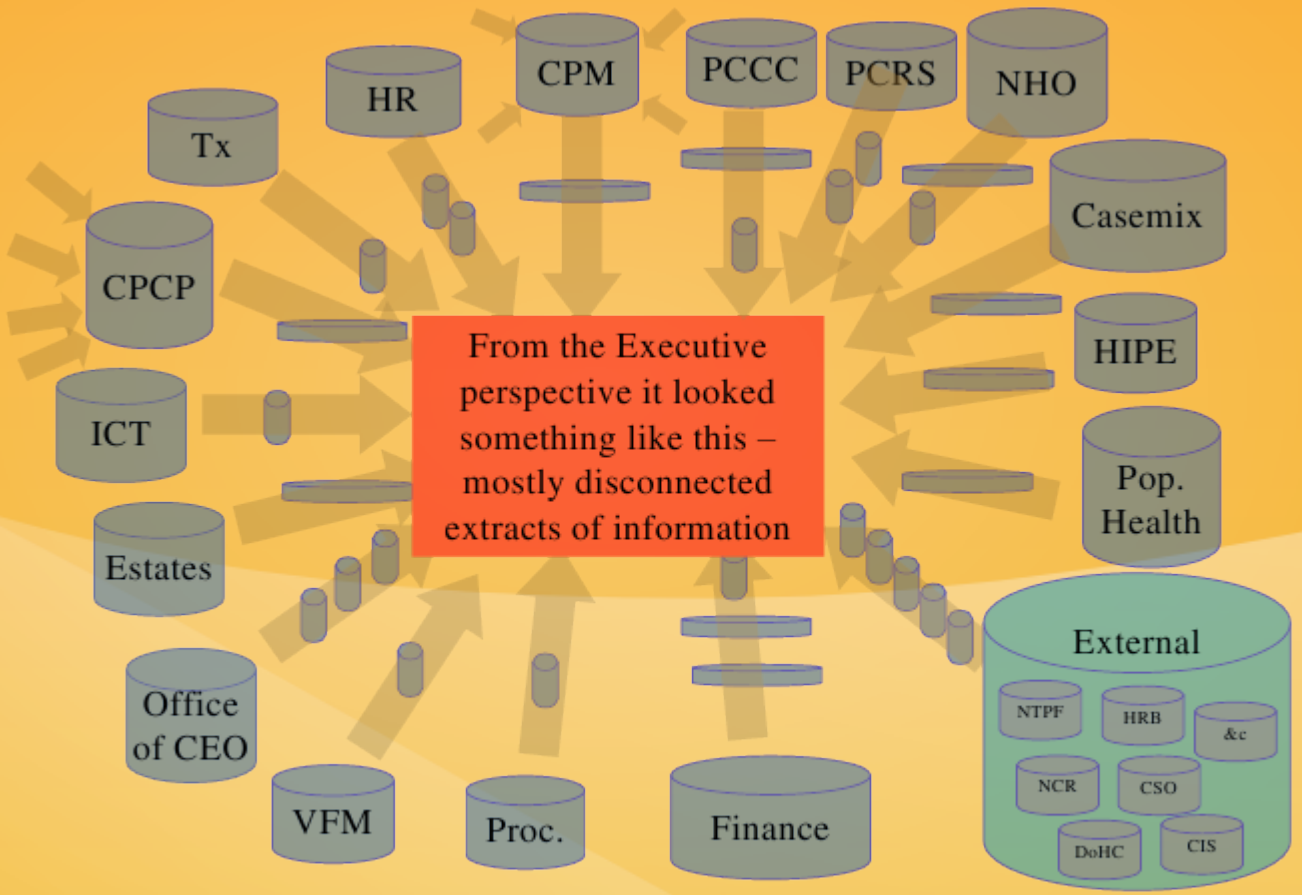
Who will purchase?

- HSE, nationally regionally or locally
  - or
- Insurance companies
  - Primary care led purchasing is a long way off, and would be impossible at present

What do they need

- Unique ID
  - Today please!
- Working information systems
- Finance systems aligned with policy goals
- Much less messing around

Not this!



HSE Performance Information reporting in 2007

Turner M, JSISSI, April 2009

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Diraya

- Example of working system
  - Cost €70 million to develop and deploy
- Covers 11 million people in Andalucia
- Integrated primary, secondary and community care system
  - Includes EHR, PACS, lab tests, prescribing, dispensing, high security, patient control of their data
- The IT system budget for the proposed new children's hospital is €125 million +

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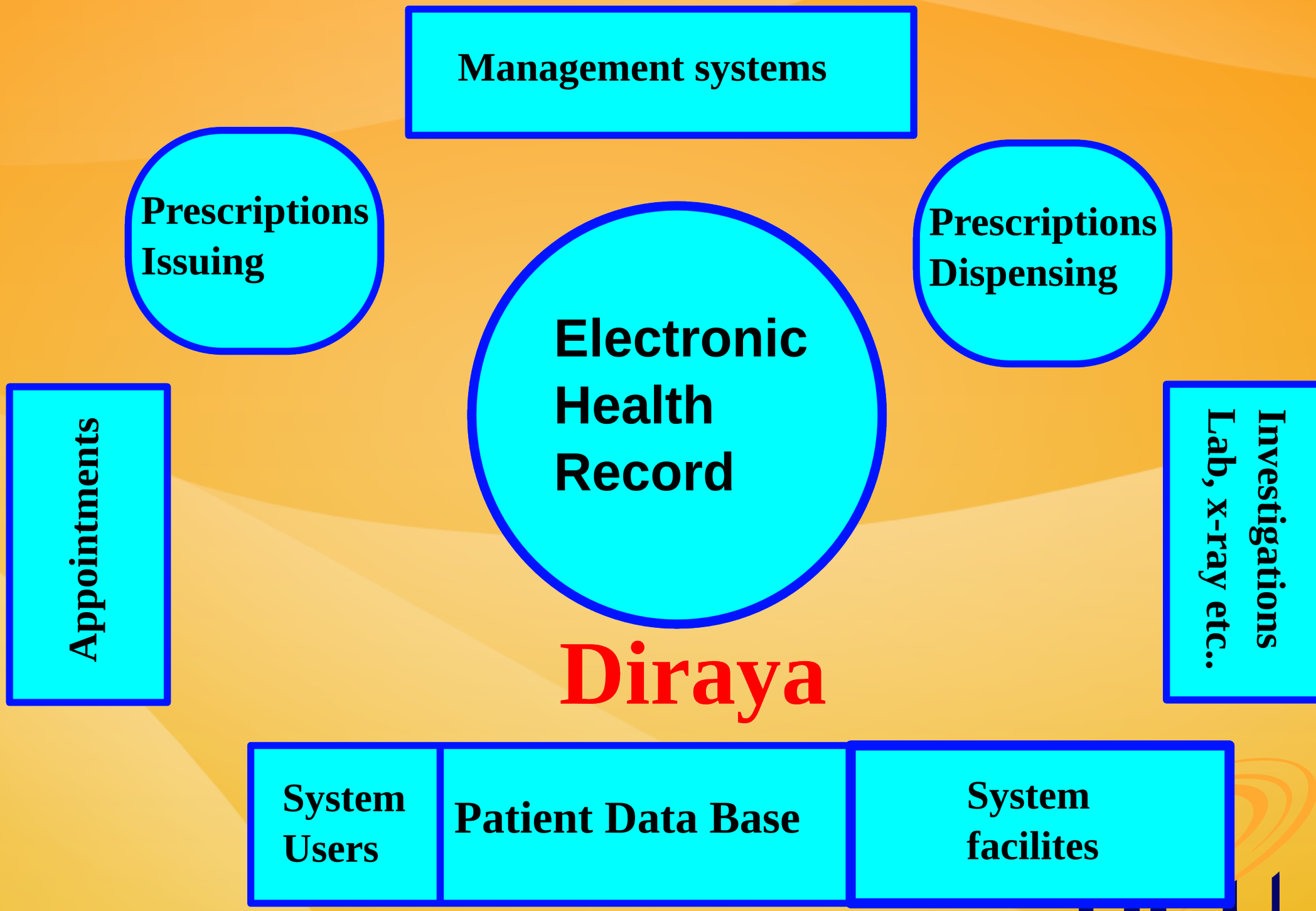
Management systems
Prescriptions Issuing
Prescriptions Dispensing
Electronic Health Record
Appointments
Investigations Lab, x-ray etc..
Diraya
System Users
Patient Data Base
System facilites

Immediate crisis

- 2010 is bad
- 2011 will be much worse, unless we do something drastic
  - 2012 could be worse again
- HSE is likely to be asked to find another 500 million to 1 billion euro in savings in 2011

Immediate crisis

- There won't be any more money
  - In fact, there will be a lot less money
- More money in primary care and long-term care means less in acute care
- Best bet for hospitals might be to build care plans running from primary care into secondary care and back

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Immediate crisis

- These cuts will hurt a lot anyway
- It will cripple the service unless it is done very cleverly indeed
- The trick is to do it in a way which pushes forward the more sensible declared health policies

Health care cost reductions

- We need a rapid program of effective cost-reduction measures
  - Drug use and costs
  - Return visits
  - Skill mix
  - Change in work practices
  - Support for caring and curing out of hospital
- Within 6 months

Health care cost reductions

- Clear, fair, transparent and enforced budgets will be vital
- Based on population served and on measures of service need
- Services will (still) be inadequate, they need to be evenly inadequate
- Targets?

Some obvious targets relevant to you

- Drug costs
- Wasteful and inefficient acute hospital care
- Private health care

Drug costs

- Some progress has been made
- Still quite high costs
- Suggestions
  - restricted drug lists
  - generic prescribing
  - payment by protocol
  - budgets for very costly drugs
  - requiring proof of cost-effectiveness

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Inefficient care

- Economies and diseconomies of scale
- Measure hospital efficiency against peers
- More shared purchasing
- Shared services across voluntary providers
- Unified governance and budget for hospital networks
- NTPF closed down

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Private care needs huge subsidies

- €260 m tax relief on premia
- Tax relief on buildings tens of millions at least
- NTPF €100m at least
- Subsidy for private patients in public hospitals €50m to €100m
- Co-location costs – 'commercially confidential'

Private care needs huge subsidies

- Training costs – unknown, but €20 million would be a very conservative guess
- Costs for indemnity insurance - unknown, but a very conservative €10,000 per consultant gives another €20 million
- Opportunity costs are not known, but might be huge
- Patient safety and the working time directive
  - It's dangerous to work silly hours

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Is it worth it?

- None of this is a smart use of public money

Private care

- Provides lots of perverse incentives, which need to be reduced
- Consultant fees unknown
  - Private insurance premium income roughly €1.5 billion
  - So a very rough guess would be €350 million, paid to people who also hold public contracts
- Could be levied directly by your employers, say 50%, gives us €175m to play with

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Would this be enough?

- No, but it would be a start
- If we don't do something radical all health service users will suffer
  - These are, largely, the elderly, the disabled, the poor, and the sick
- Services will (still) be inadequate, they have to be evenly inadequate

Is there any hope?

- Yes, in the people who work in our awful system
  - People like you
- The people who make it work day in, day out
- The people who do their best for their clients/patients morning, noon and night

Hope

- “Real care does not reside in the building or its facilities, but rather in the spirit of the people within.” Alan Gilsenan 2010

Acknowledgements

Thank you

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