GRATTAN Institute

Getting primary care right

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Grattan Institute Policy Pitch
State Library of Victoria
August 2016

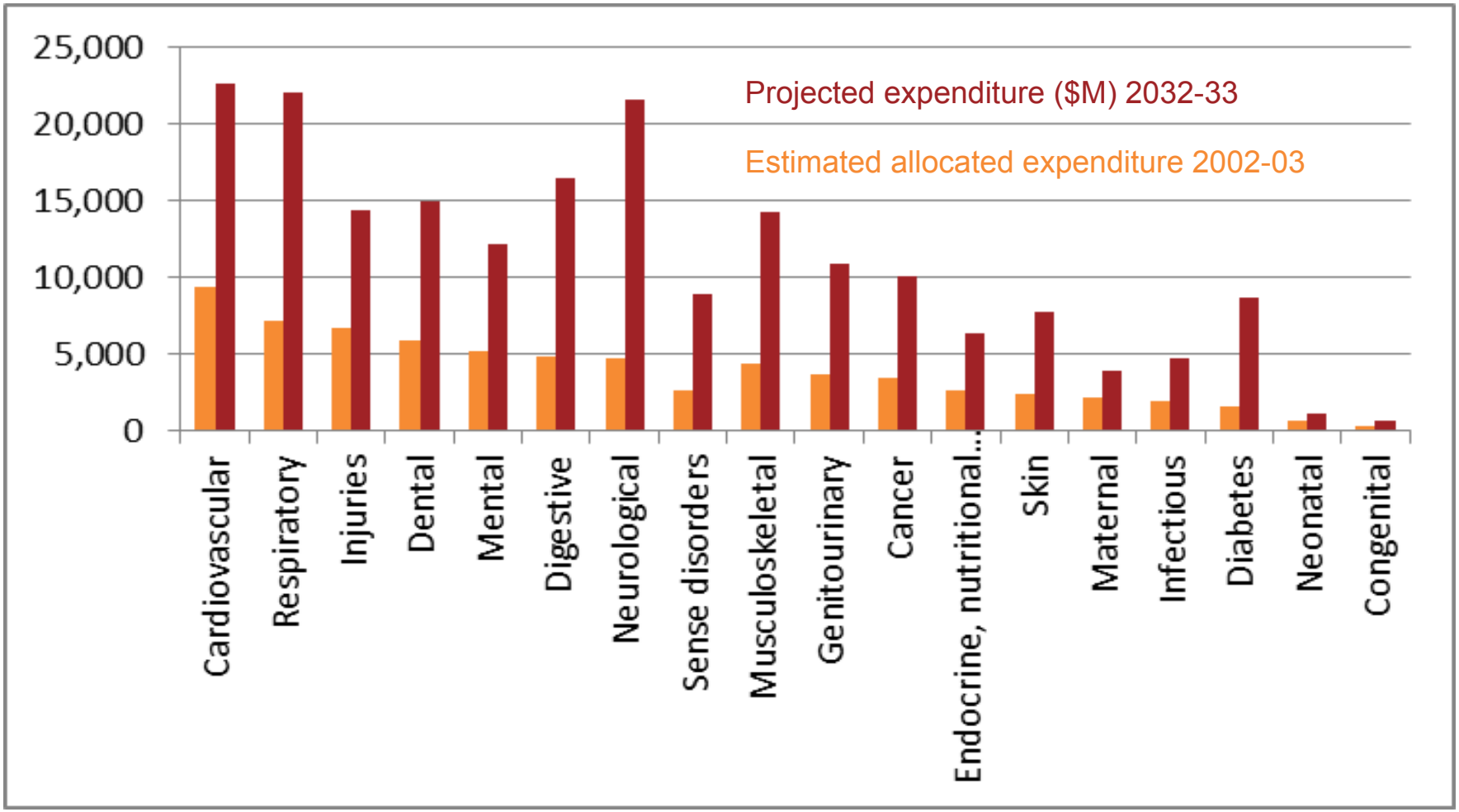
Outline

- Some background
  - A warning: statistics can be tricky

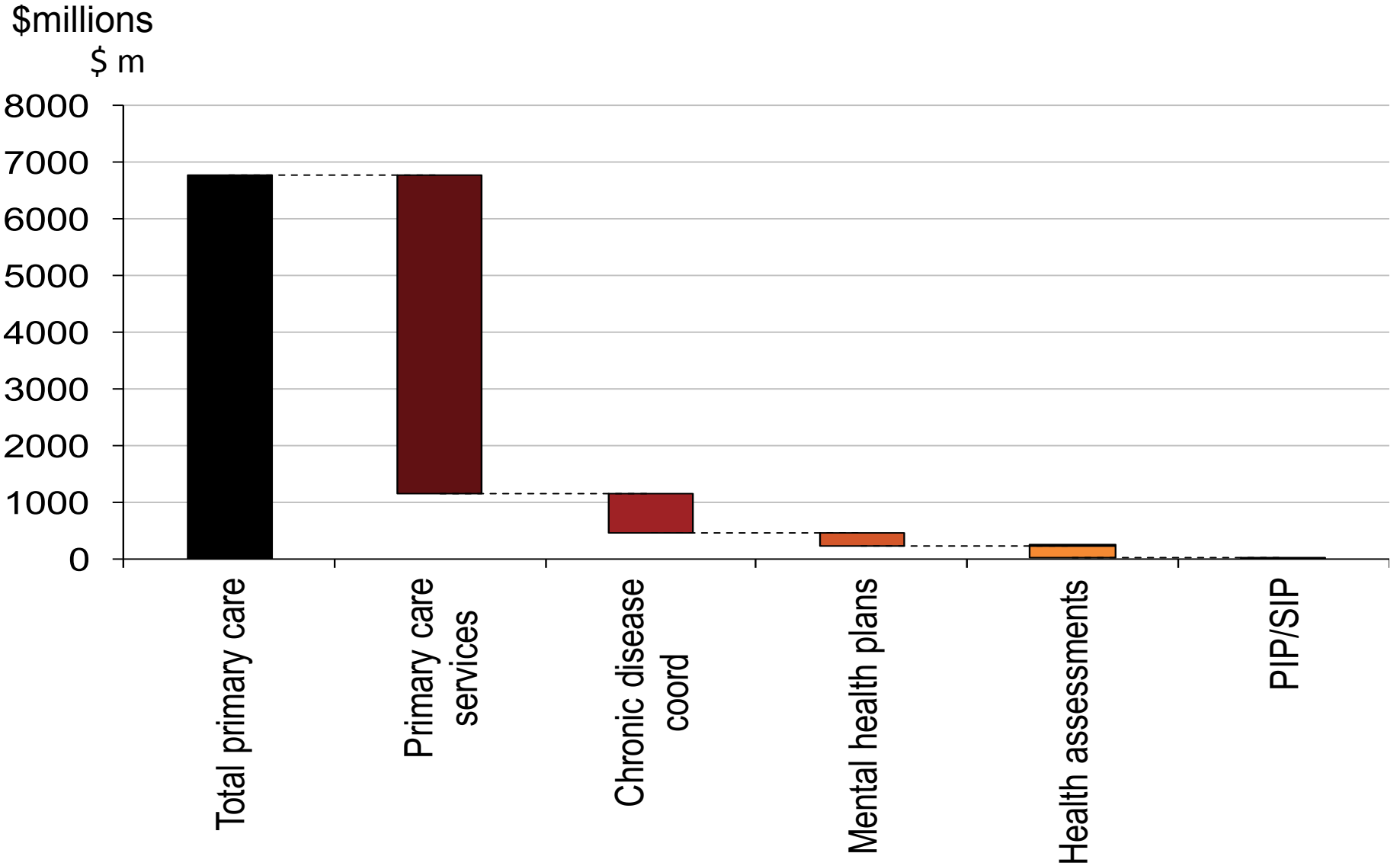
- Some broad policy options
  - Place?
  - Payment?

Chronic diseases cost a lot, and will cost a lot more

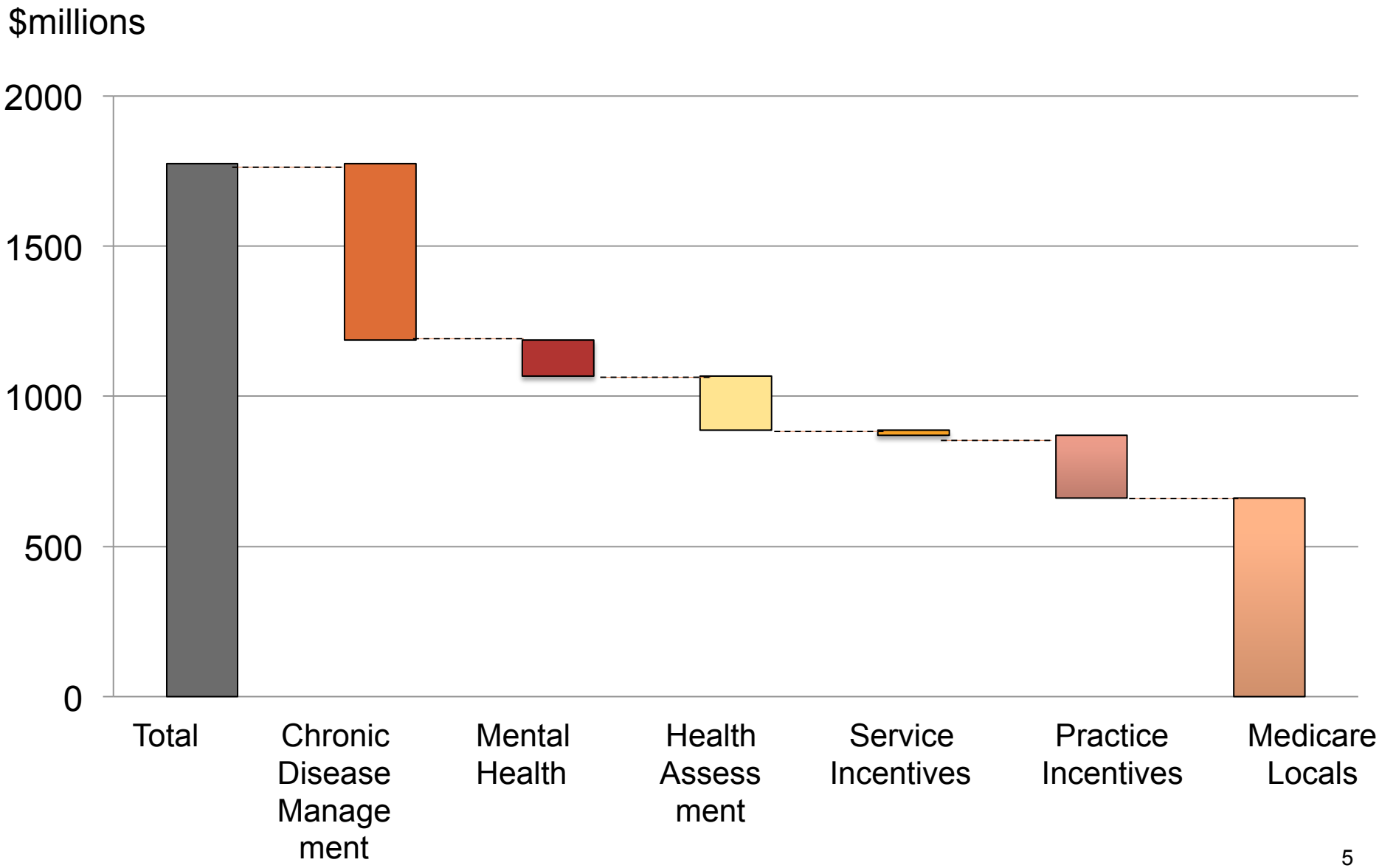
$millions, by disease



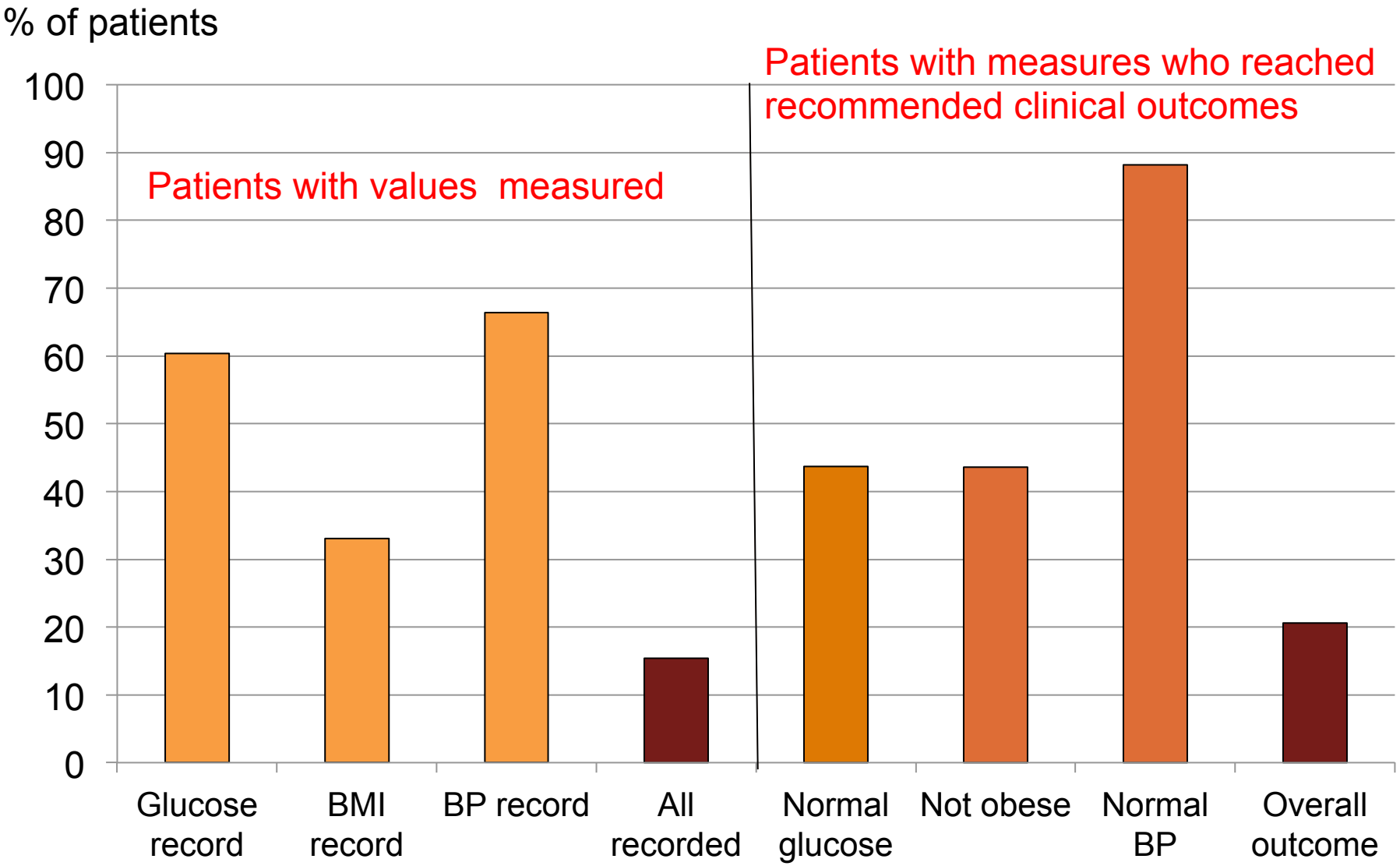
The vast bulk of MBS GP spend is fees for service



We spend a lot on assessment and incentives



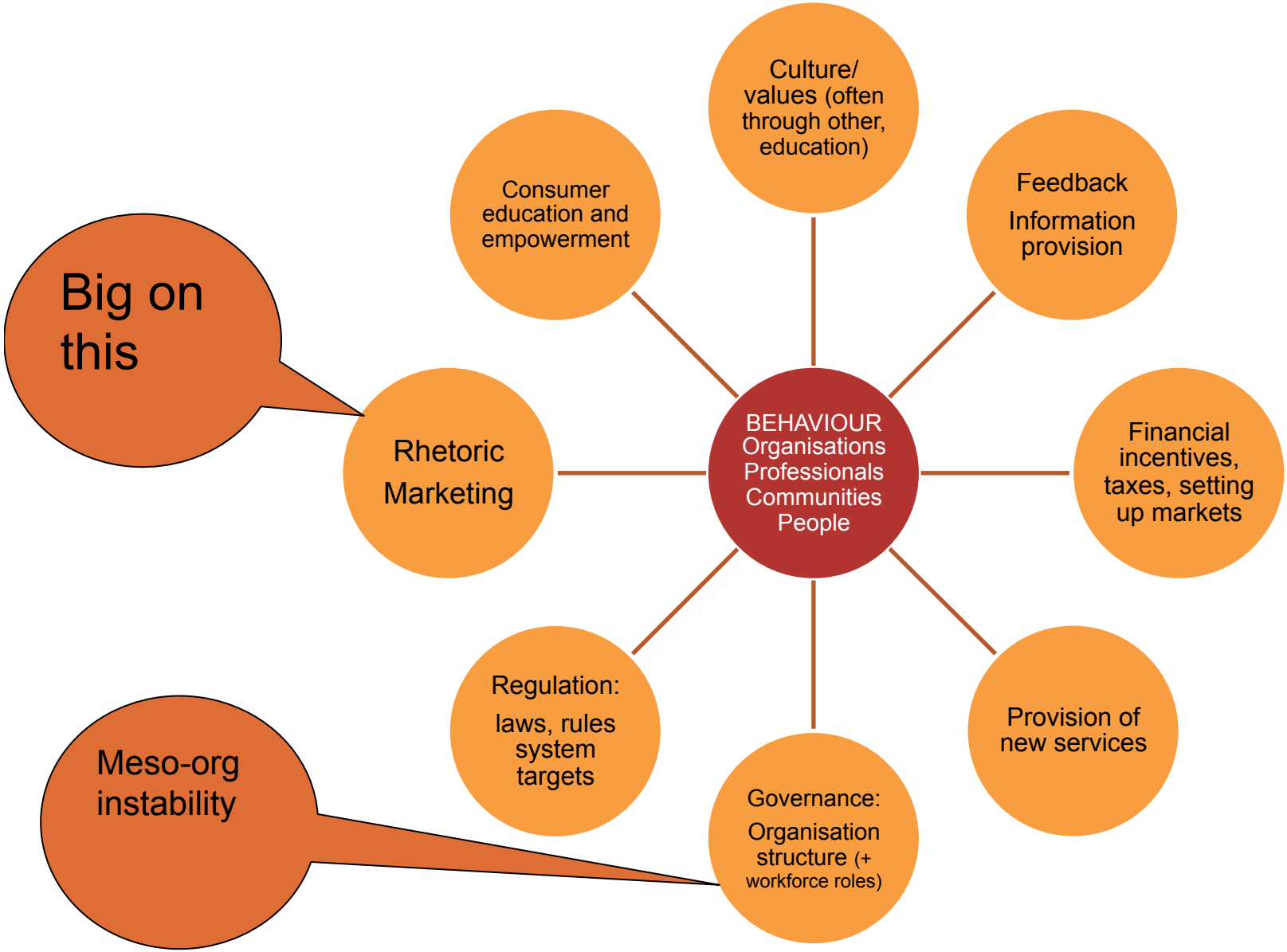
Only 20 per cent of people with diabetes reach all recommended treatment goals



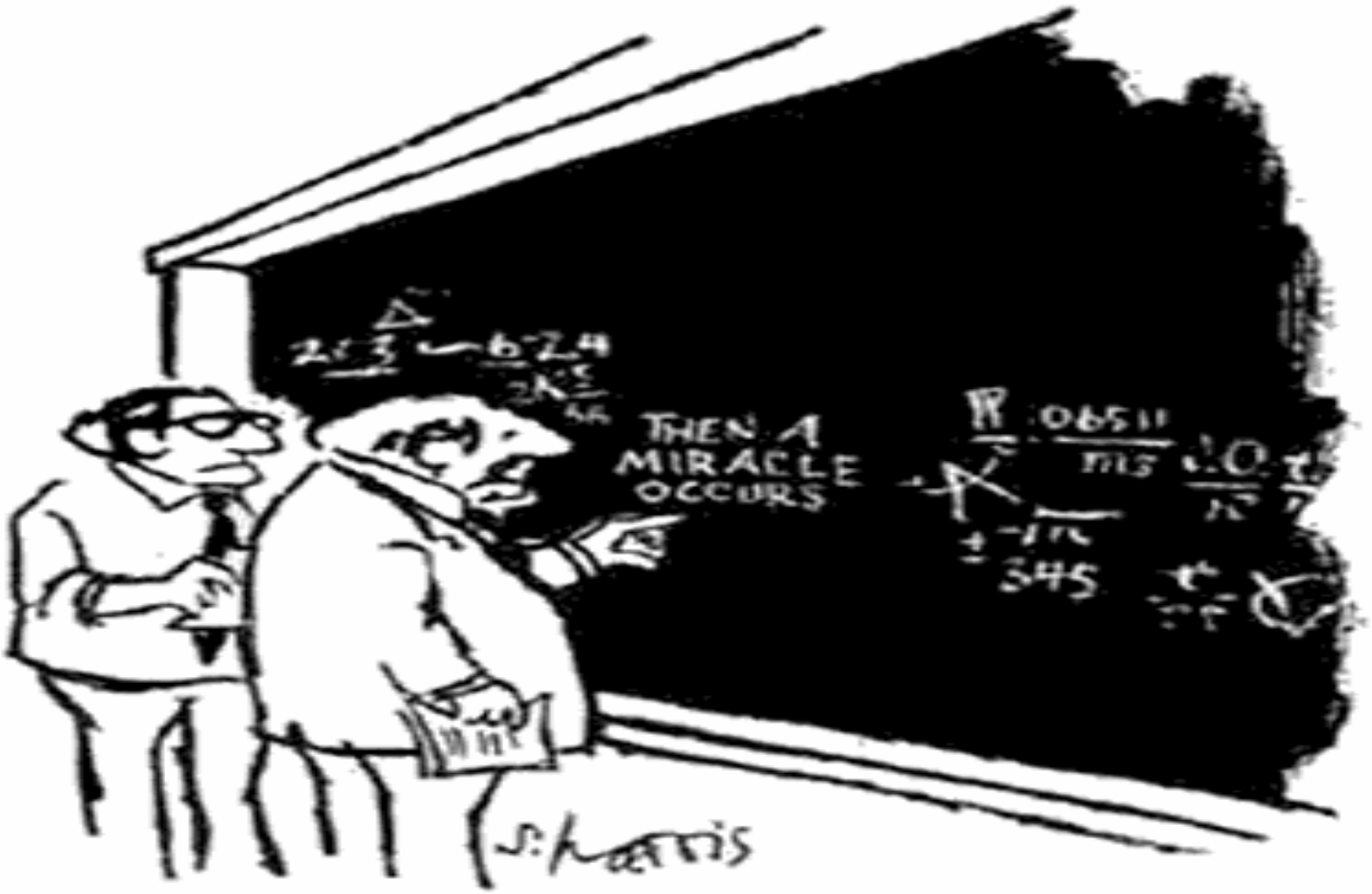
Community prevalence and GP interventions are out of sync

	Community prevalence	GP advice/ counselling (% of encounters)
Smoking	20% smoke daily	0.6% smoking cessation advice
Nutrition	• 75% low veggie intake • 45% low fruit intake	3.4% nutrition/weight counselling
Alcohol	10% harmful drinking	0.3% alcohol advice
Physical activity	34-54% insufficiently active	1.1% physical activity advice
Overweight	54% overweight	3.4% nutrition/weight counselling

Policy levers to achieve change in primary care

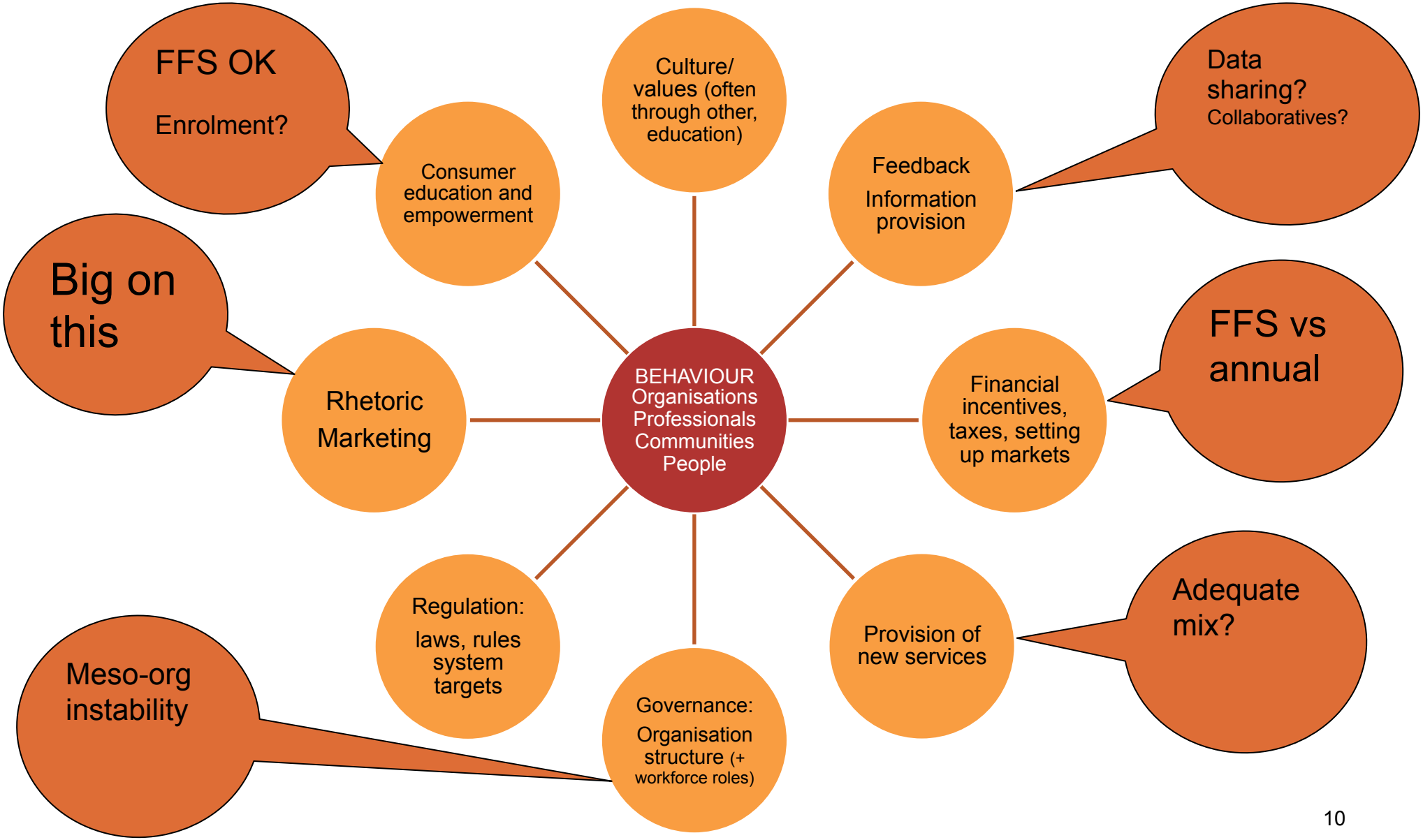


The magic of PHNs



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Policy levers to achieve change in primary care



Comprehensive reform of primary care management and funding is needed

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Reform element	Description
Regional health systems management	GPs and primary care providers to be supported by and accountable to regional health system authorities
Performance framework	A national performance framework for standards and outcomes for chronic disease is needed
Care pathways	Consistent care pathways have to be used by all health providers for people with chronic disease
Alignment of financial incentives	Targeted payments for quality and outcomes for chronic disease should be introduced
Service innovation and development	GPs should be supported to improve prevention and management of chronic disease through service development, data systems, performance monitoring, feedback and payment incentives.
Staged implementation	Changes should be introduced progressively over a five year period

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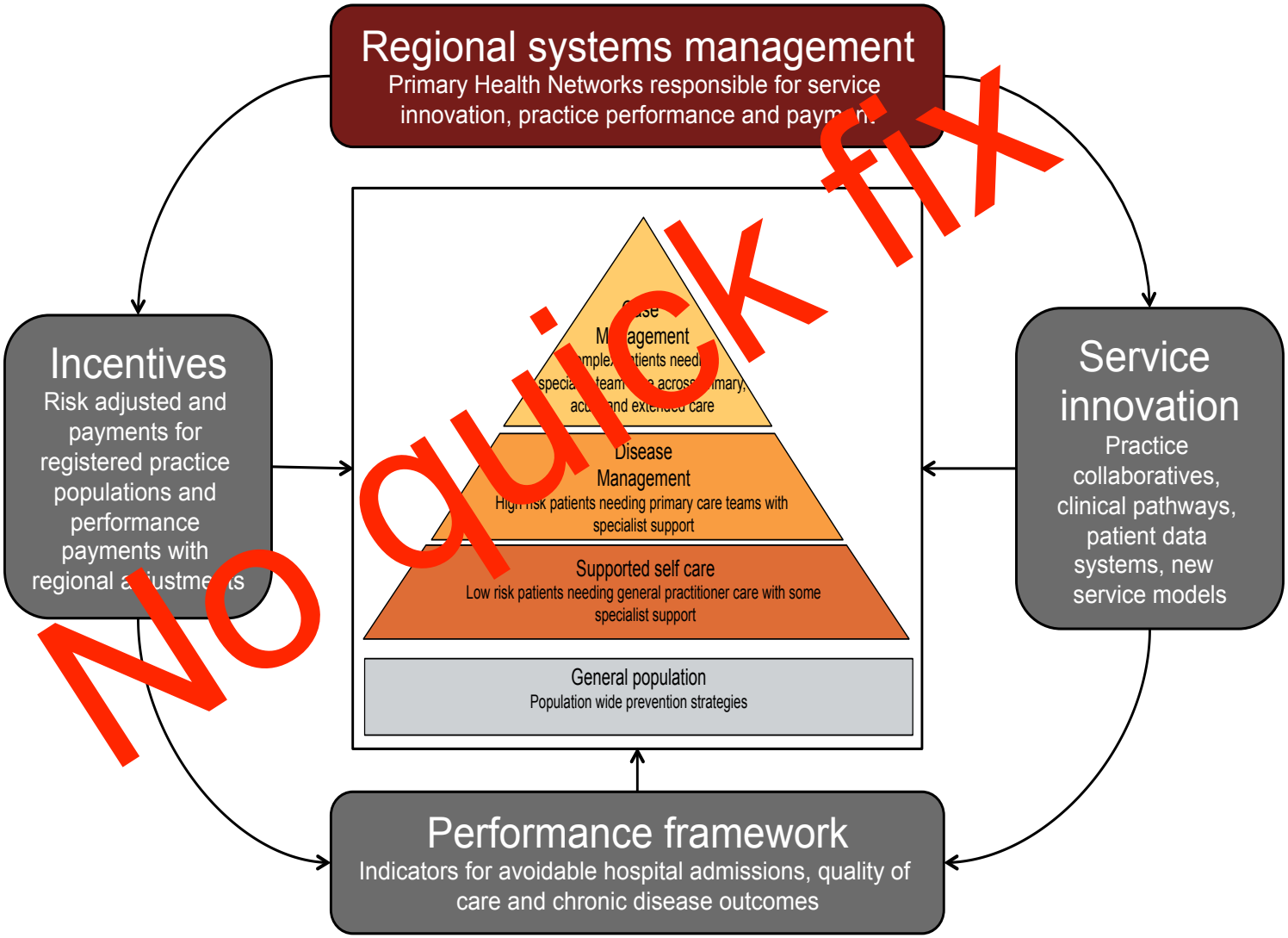
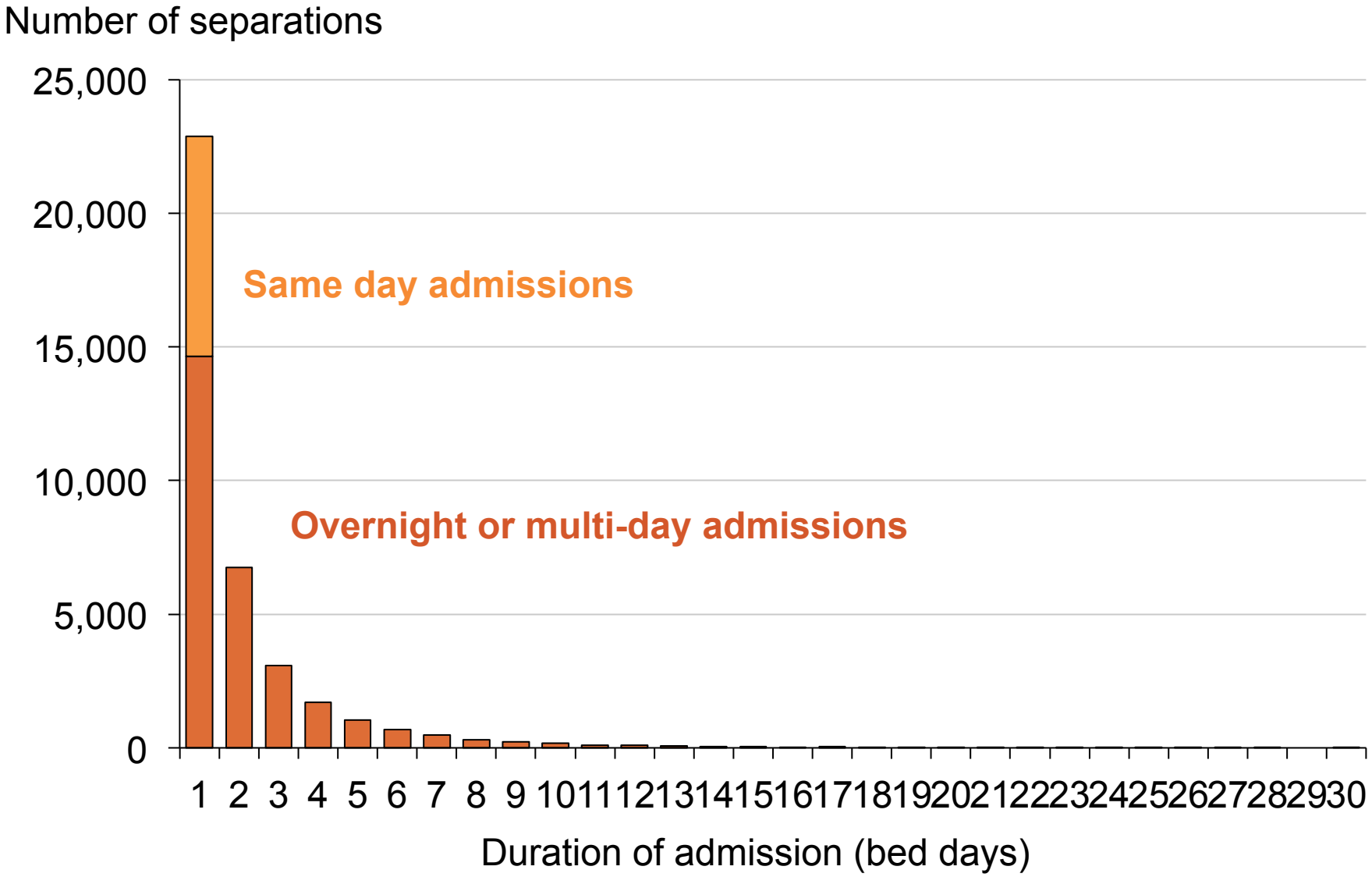
No quick fix


Regional systems management
Primary Health Networks responsible for service innovation, practice performance and payment
Incentives
Risk adjusted and payments for registered practice populations and performance payments with regional adjustments
Service innovation
Practice collaboratives, clinical pathways, patient data systems, new service models
Disease Management
Supported self care
Low risk patients needing general practitioner care with some specialist support
General population
Population wide prevention strategies
Performance framework
Indicators for avoidable hospital admissions, quality of care and chronic disease outcomes
No quick fix

Are all asthma admissions preventable?



Policy options

Place-based solutions

Payment-based reforms

How are we to account for that puckish and inexplicable rise and fall of inspiration?

My questions, of course, are purely rhetorical.

Explanations exist; they have existed for all time; there is always a well-known solution to every human problem - neat, plausible, and wrong.

Mencken, H. L. (1920). *Prejudices: second series.* New York: Alfred A. Knopf., p 158, 'The Divine Afflatus'

High rates of potentially preventable hospitalisations are not stable < 3 years

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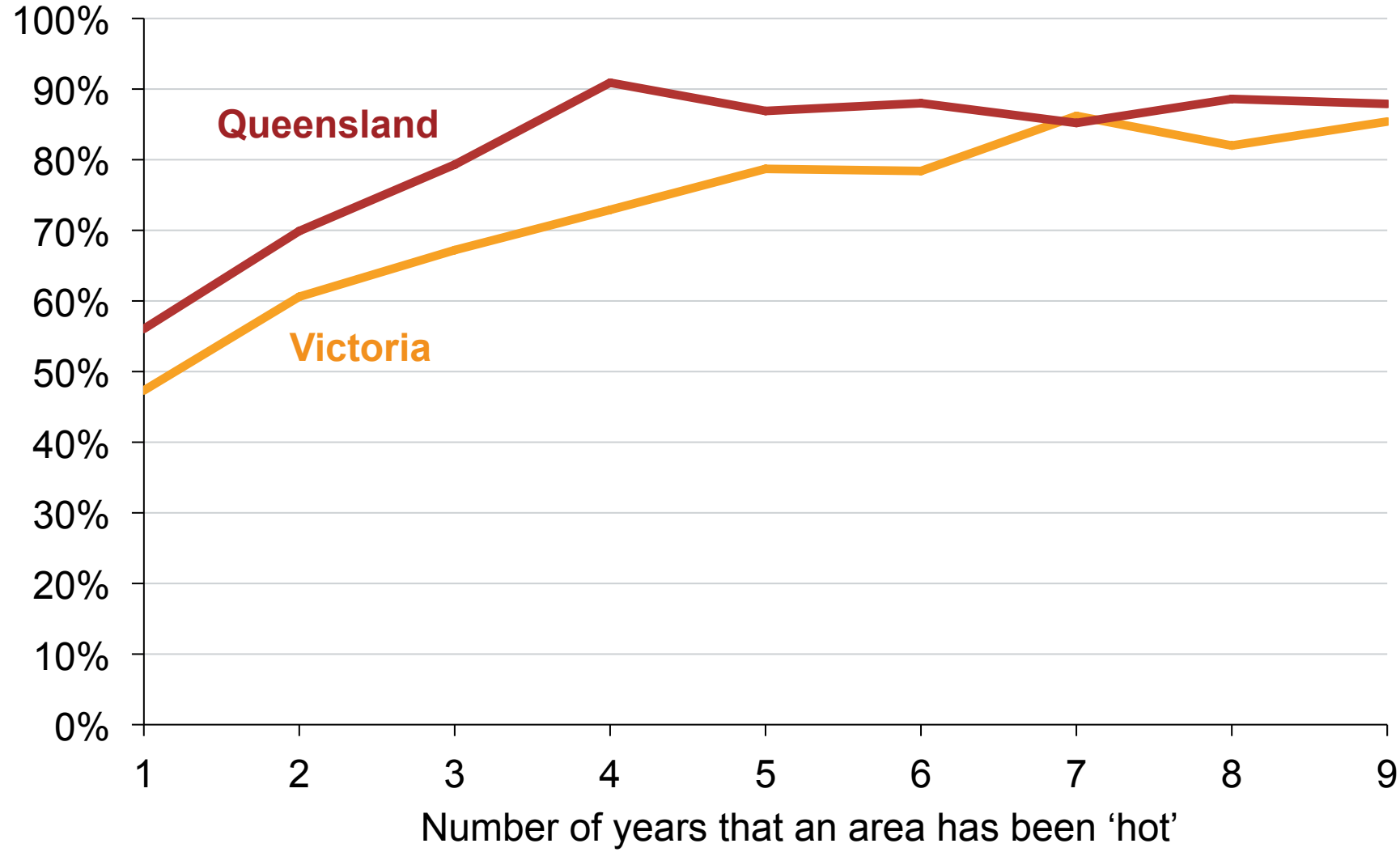
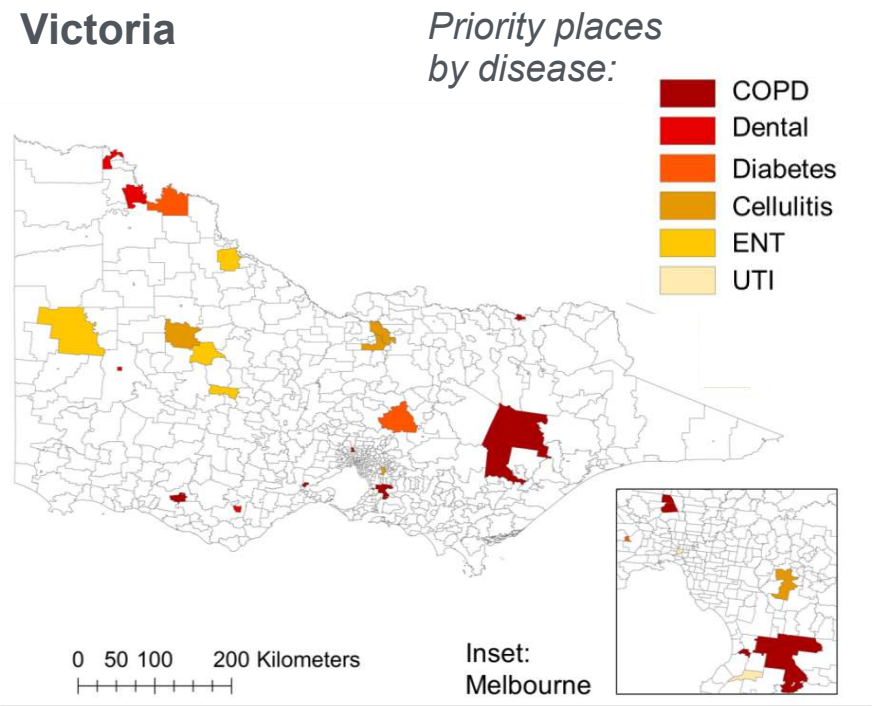
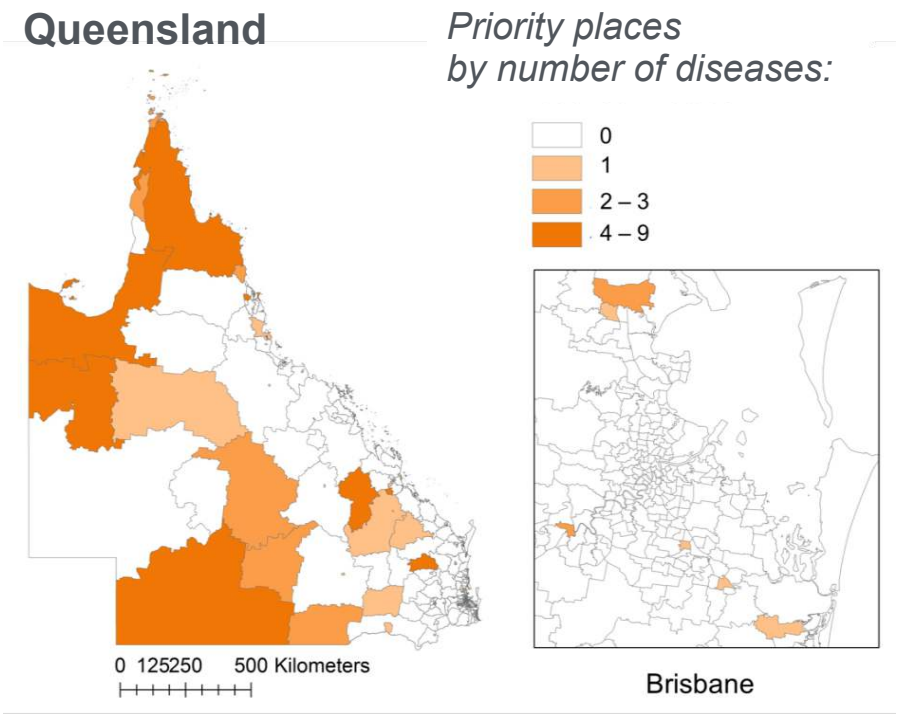
Proportion of places that stay hot as a percentage of the previous year



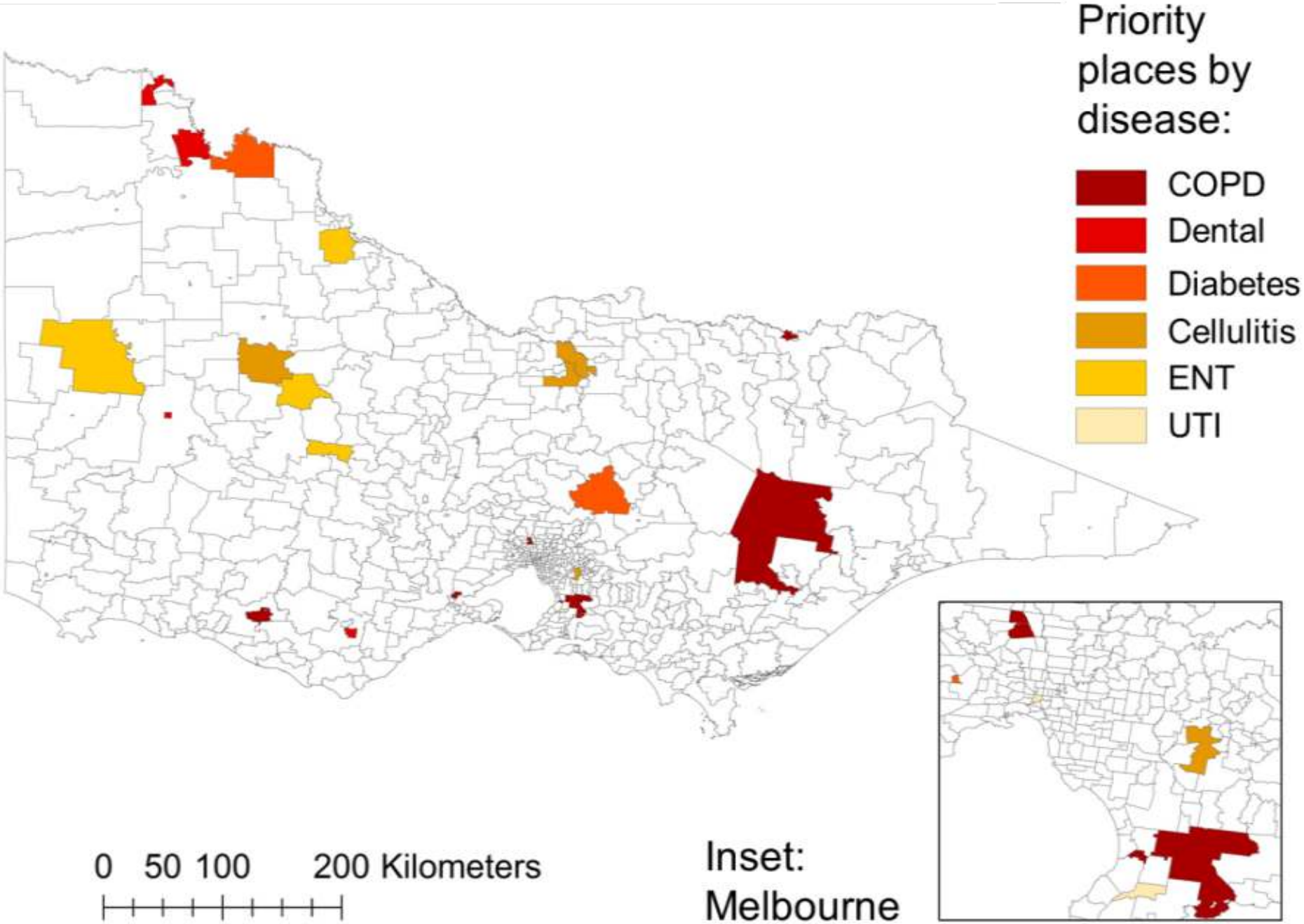
Our health system is consistently failing some communities

Some places have had appalling rates of potentially preventable hospitalisations for at least a decade:





These are the places where health inequalities are already entrenched and are most likely to endure (without intervention)


Priority places by disease:
COPD
Dental
Diabetes
Cellulitis
ENT
UTI
0 50 100 200 Kilometers
Inset: Melbourne

Tackling readmissions will be part of the solution in some priority places (Victoria)

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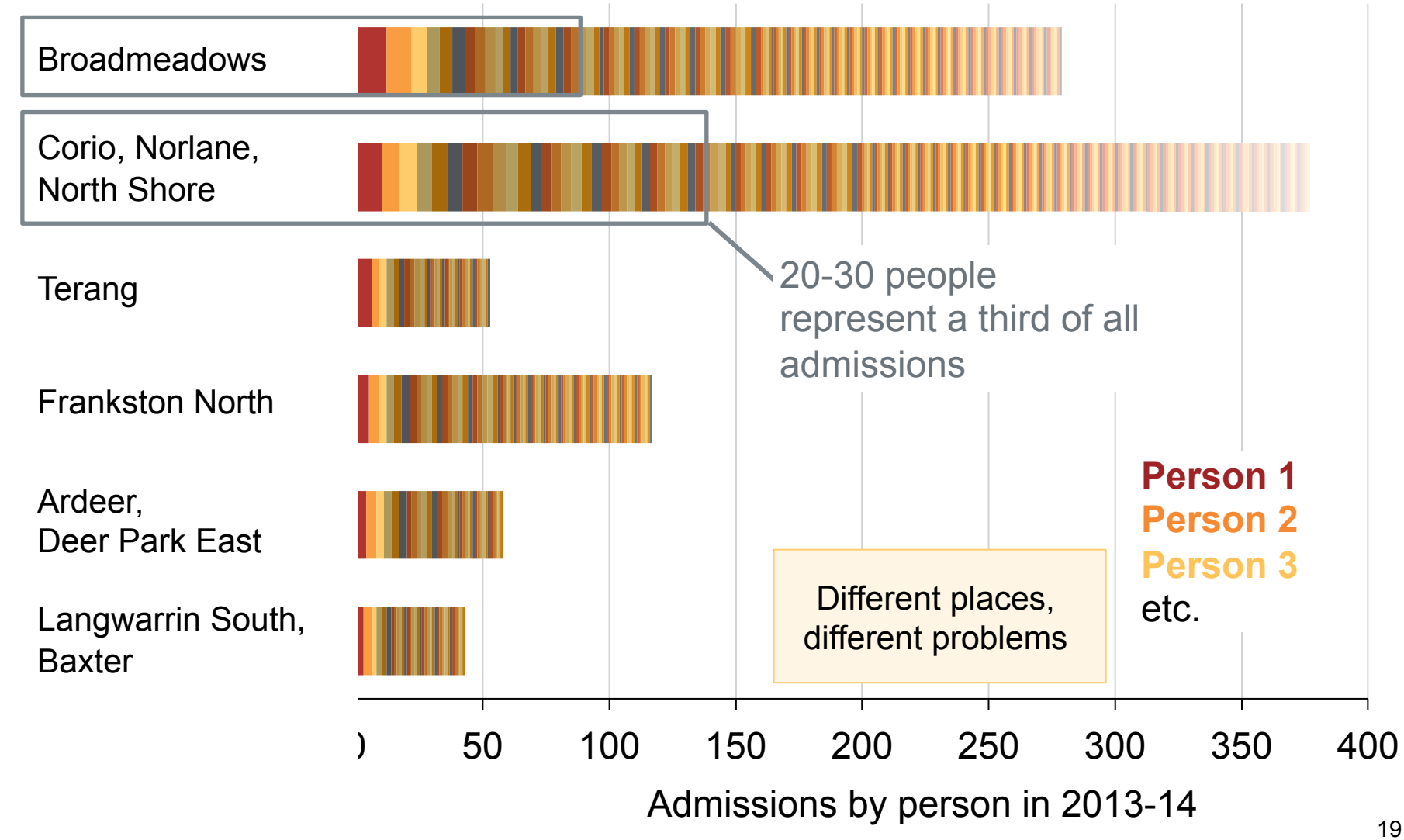
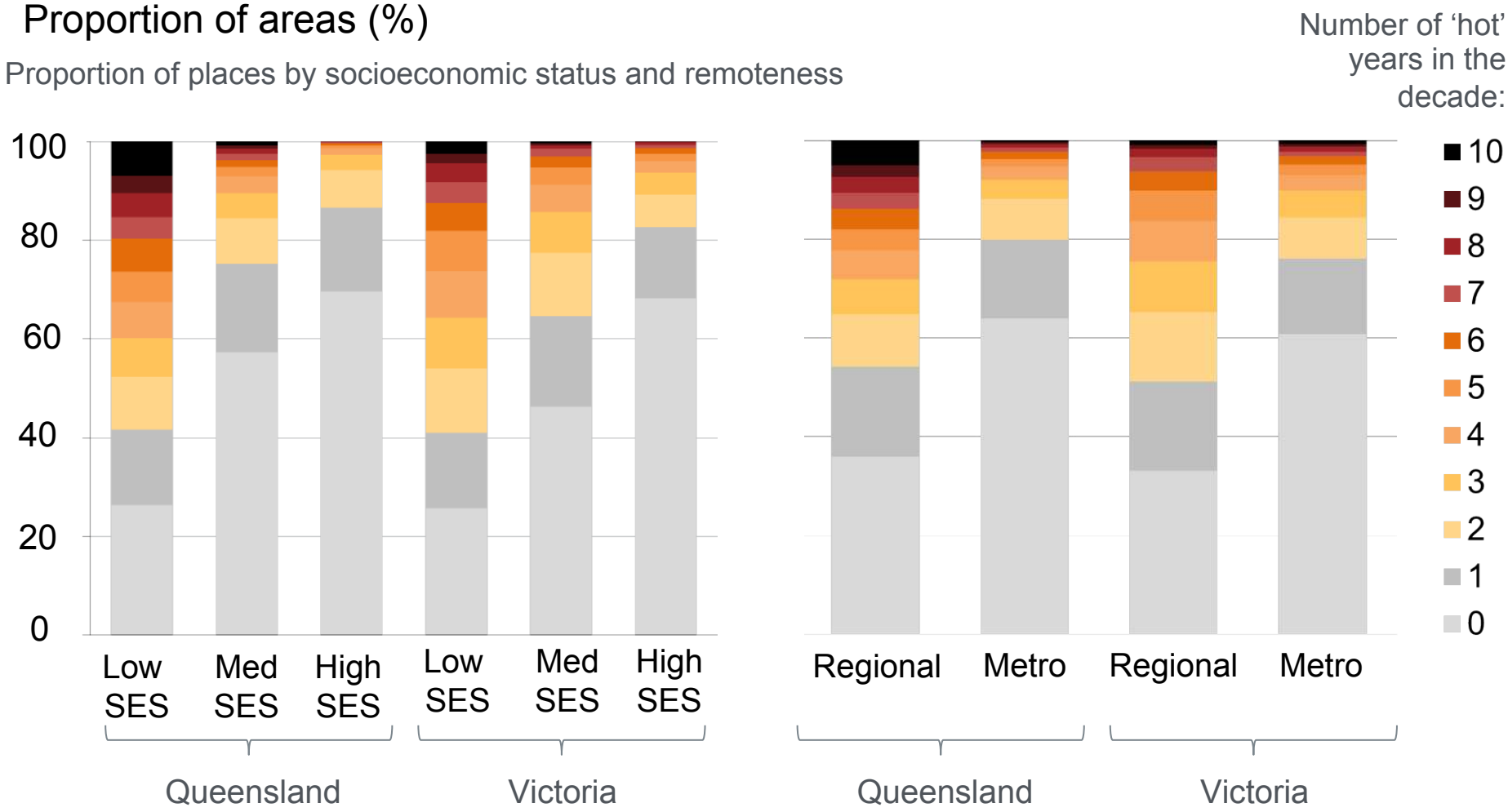
Priority places for chronic ACSCs

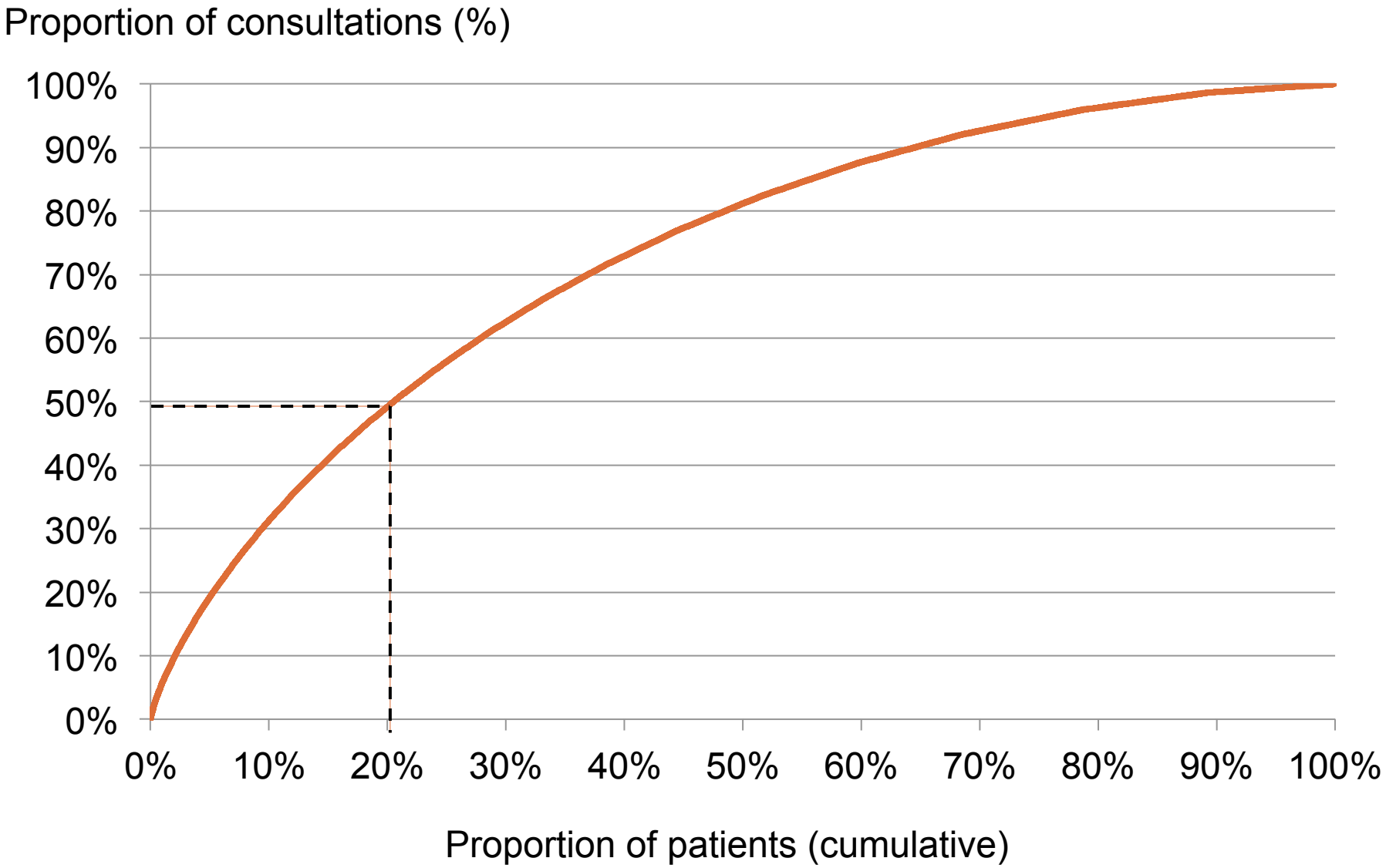


Disadvantaged areas are more likely to experience health inequalities, but most do not



Notes: "Hot" or "high rate" refers to rates at least 50% higher than state average for one or more conditions where hospitalisation is preventable or reducible. Sources: Grattan Institute analysis of state hospital admissions datasets - QHAPDC and VAED

A new blended payment scheme



FFS and capitation have weaknesses

	Fee-for service payment	Capitation payment
Strengths	Encourages responsiveness to patients	Encourages continuity of care
Weaknesses	No incentive on doctor to manage number of consultations or to provide continuity of care	Risk of underservicing and 'cream skimming' – selecting healthier patients
Risk mitigation to address weaknesses	Add payment to encourage continuity of care	Provide higher capitation payments for more complex patients Allow patients to swap to other practices on a regular basis

FFS and capitation have weaknesses

Two issues need to be clarified:

- The patient population has to be defined; and
- The services to be included have to be determined

Three conditions need to be met:

- Good quality data has to be available and a risk adjustment method developed;

Variations in consultations (per person) hard to explain

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Whole data set

7.8 average consultations
(100% of data set)

Split on age

<70
6.4 consults
(70%)

≥ 70
11 consults
(30%)

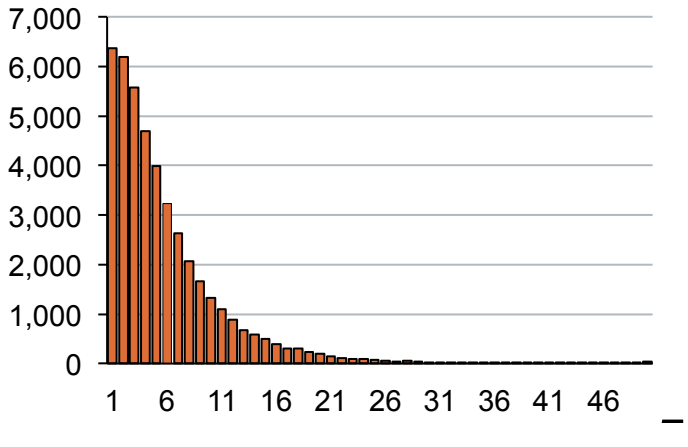
Split on number of conditions

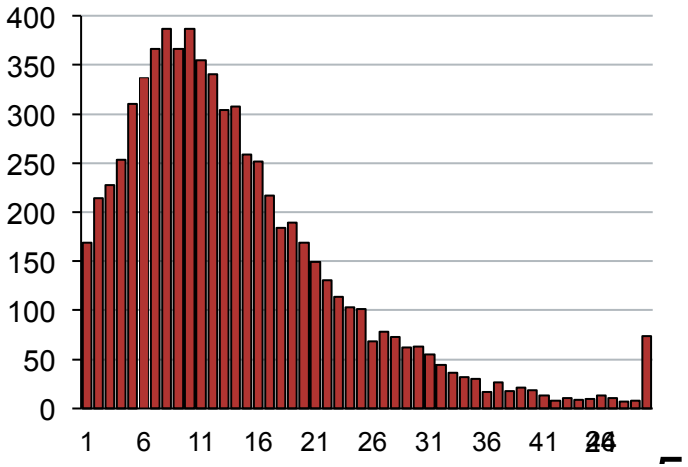
1 condition
5.9 consults
(61%)

≥ 2 conditions
10 consults
(9%)

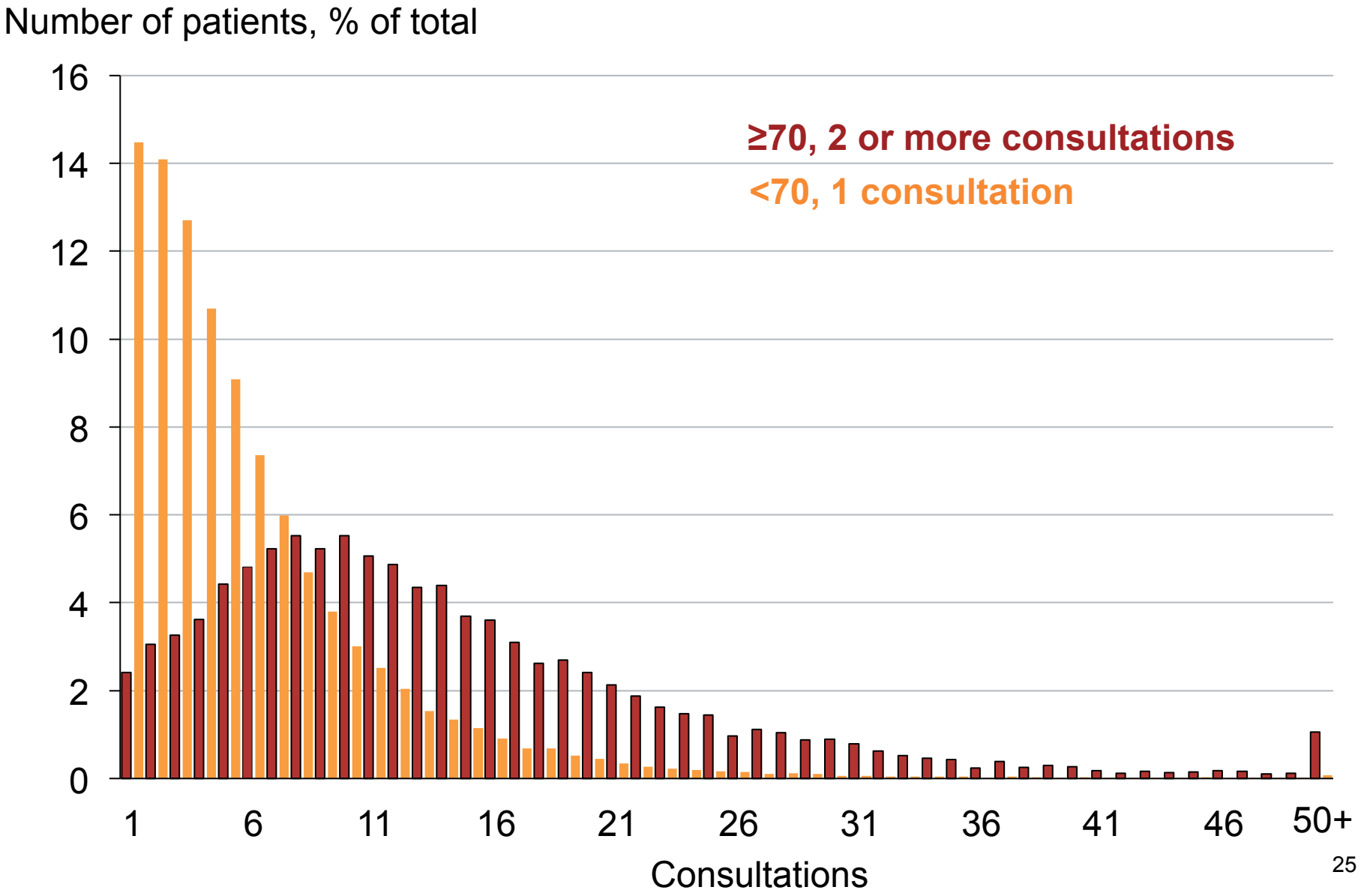
1 condition
9.7 consults
(21%)

≥ 2 conditions
14 consults
(9%)





There is a big overlap in the distributions



Work needs to be done

Two issues need to be clarified:

- The patient population has to be defined; and
- The services to be included have to be determined;

Three conditions need to be met:

- Good quality data has to be available and a risk adjustment method developed;
- Performance indicators for quality of care and patient outcomes have to be agreed; and
- The capacity of practices and Primary Health Networks to work in the new model needs to be built.

Policy options

Place-based solutions

Payment-based reforms

- Beware of jumping on band wagons
- Evidence base very weak so need to proceed with caution

Explanations exist; they have existed for all time; there is always a well-known solution to every human problem - neat, plausible, and wrong.

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What's your story?

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