

VHA ANNUAL CONFERENCE 2007

“DOES POLICY MATTER?”

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“POLICY”

A course or principle of action adopted or proposed by a government, party, business or individual

“MATTER”

Be of importance, have significance



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“POLICY”

Political

Fiscal

Quality



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“MATTER” to whom?

Government ?

Public Servants ?

Healthcare Providers ?

Community ?

Patients ?



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“POLITICAL POLICY”

Marketing of RU 486 in Australia

***15/2/2006 - Senator Kerry Nettle, Greens, NSW
“Mr Abbott, keep your rosaries off my ovaries”***

***16/2/2006 - House of Representatives passed
legislation removing the health ministers power of
veto over the approval of RU486***

Effect on patients **YES**

Effect on Hospitals **YES**



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“POLITICAL POLICY”

PORT MAQUARIE HOSPITAL

Transferred to private operation 1995 – 2005

With a new facility (\$50 million)

- *N.S.W Auditor General reported that the government had done the equivalent of “paying for the hospital twice then giving it away” after the deal was examined.*
- *Greiner Government believed private sector would treat public patients more effectively and that costs would transfer to the commonwealth*
- *May 2004 Threat by doctors to walk out because of budgetary problems they claimed were risking patients lives*
- *Government purchase back for ? \$100 million in 2005*

Effect on Patients - Possibly

Effect on Hospitals - Yes



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“POLITICAL POLICY”

US Council of State Governments – Eastern Regional Conference

The president does not believe that SCHIP funding should go towards parents or families who can afford private health insurance, restating SCHIP’s original objectives. “Our goal should be to move children who have no health insurance to private coverage, not to move children who already have private health insurance to government coverage.” the president said in an address to the House of Representatives. One in three children, the President argued, that would be covered by the increased SCHIP funding would be moving to SCHIP from private health insurance.

Senator Sheldon Whitehouse of Rhode Island, in a speech delivered to the Senate on October 4th, said that he was “ashamed of the President's decision.” The Senator adamantly defended the increased SCHIP funding, arguing that it would provide ten million uninsured children with health care coverage nationwide.



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“FISCAL POLICY”

POPULATION BASED OR OUTPUT BASED

“There is unequivocal evidence from across Australia of entrenched patterns of socioeconomic related health inequality.

These patterns are seen in mortality, morbidity, health risk factors and access to preventative health services”

Harris and Simpson 2003



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“FISCAL POLICY”

“There are however, no national or state policies that focus specifically on addressing health inequality in Australia” .

Specific policies for specific groups

Eg. Indigenous or homeless

UK post Acheson report 4 key areas

“Preventing illness and providing effective treatment and care”

Focus of care – “self sufficiency”



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“FISCAL POLICY”

POPULATION BASED OR OUTPUT BASED

Output Based

- *DRG, VACS and CMBS*
- *Don't break the cycle*
- *Caps on outputs combined with impenetrable access barriers (transport and language to give examples) mean that inequalities are sustained.*



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“FISCAL POLICY”

Population Based

NSW - 8 Area Health Services

- *Each has considerable freedom to change the balance between health promotion and treatment, between hospital and non hospital services.*
- *3 Funding Models*
 - *Input Based (Cost Funding)*
 - *Needs Based*
 - *Output Based (Casemix)*
- *Key component for Area Health Services is a needs based model*
 - *The resource distribution formula*



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“FISCAL POLICY”

Population Based

RDF

- *Incorporates and ‘overlays’ casemix*
- *Main aim to cope with tertiary importers because many tertiary services existed in a subset of areas.*
- *Cross boundary flows first*
- *Then allocate with a series of RDFs across 9 types of health services*
 - *Population Health*
 - *Oral Health*
 - *Primary and Community Based Services*
 - *Outpatient Services*
 - *EDs*
 - *Acute Inpatient Services*
 - *Rehab/Extended*
 - *Mental Health*
 - *Teaching/Research*



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“FISCAL POLICY”

Population Based

HEALTH NEED

- *Generic need index = 97.51 + 0.4 (SMR70)
- 0.4 (EDOCC) – 0.9 RUR*
- *Applied to 5 out of 9 components of RDF*
 - *Population Health*
 - *Primary and Community Based Services*
 - *Outpatients*
 - *Emergency*
 - *Acute Inpatients*
 - *Different measures of relative need applied to oral health and rehab/extended care.*



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“FISCAL POLICY”

Population Based

GENERIC NEED IS MODIFIED FURTHER

Eg, Emergency Includes:

- *Age/Sex based on ED cost weights*
- *Aboriginality*
- *Homelessness*
- *Tourist and working population effects*

Areas funded on need but required to use casemix to distribute those resources.



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“FISCAL POLICY”

Medicare Safety Net Policy

- March 2004 to provide financial relief for those Australians who face high out of pocket costs for outpatient medical services
- Estimated \$440 million over 3 years
- Viney and Savage (U.T.S.) study showed for specialist consultations of every dollar spent of the safety net \$0.68 went to the specialist and \$0.32 went to reducing patient costs.
- August 2004 Minister Abbott says there is evidence that obstetricians are billing some expensive hospital procedures e.g. delivering a baby as if they are consultations



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“FISCAL POLICY”

24th August on ABC radio

Minister Abbott “There's been a 9% increase in the average obstetric consultation fee, and the government is talking to the obstetricians about this”

Reporter “What have you told them?”

Minister Abbott “Well we've told them that we certainly don't believe in medical price control, but we also believe in trying to ensure the system is fair to taxpayers as well as fair to patients”



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“FISCAL POLICY”

14th April 2005 on AM

Prime Minister Howard announced increases in the Safety Net threshold ie. 80% of costs against \$500/\$1000 thresholds

September 2007

Shadow Health Minister Roxon promises to maintain the safety net



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“QUALITY POLICY”

Victorian sentinel events monitoring - 9 Reportable Events

- Procedure involving the wrong patient or body part
- Suicide in an inpatient unit *
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Intravascular gas embolism resulting in death or neurological damage
- Haemolytic blood transfusion reaction resulting from ABO incompatibility
- Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
- Maternal death or serious morbidity associated with labour or delivery
- Infant discharged to wrong family
- Other catastrophic event (any of the following):
 - * Lead to catastrophic patient outcomes
 - * Are likely to point to serious system failure



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“QUALITY POLICY”

What has this policy achieved?

↑ System awareness of “Quality”

↑ System capacity e.g. RCA’s

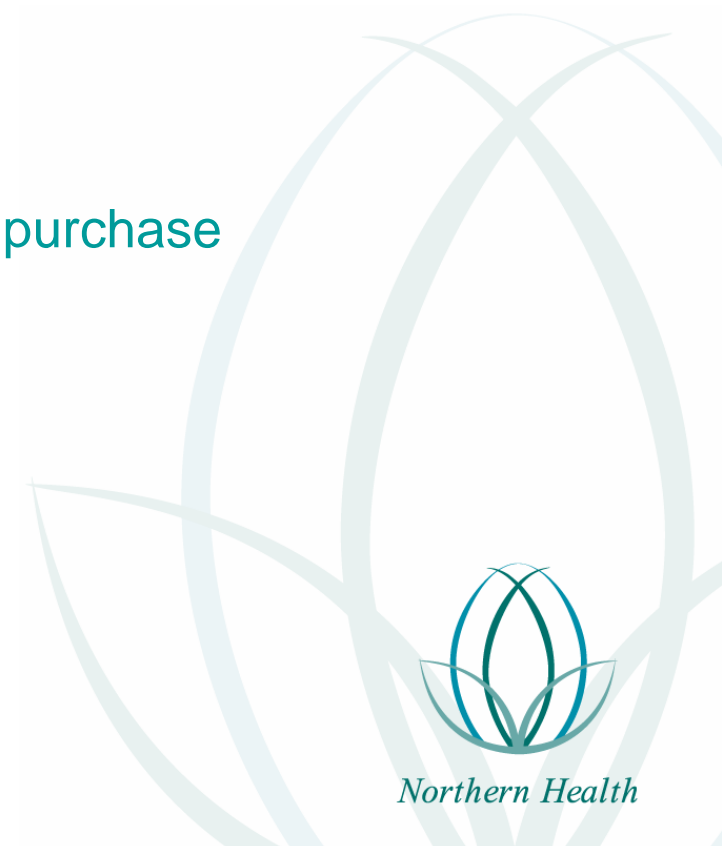
- Funder(DHS) identifies quality as an object of purchase

What has this policy achieved?

↓ Sentinel events

Effect on patients - Possibly

Effect on Hospitals - Yes



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“QUALITY POLICY”

Emergency and elective access KPI's

KPI 1 Percentage of operating time on hospital bypass

KPI 2 Percentage of emergency patients admitted to an inpatient bed within 8 hours

KPI 3 Percentage of non-admitted emergency patients with a length of stay (LOS) of less than 4 hours

KPI 4 Number of patients with a LOS in the emergency department of greater than 24 hrs

KPI 5 Percentage of Category 2 elective surgery patients waiting 90 days or less.

KPI 6 Percentage of Category 3 elective surgery patients waiting 365 days or less.

KPI 7 Number of patients on the elective surgery waiting list.

KPI 8 Hospital Initiated Postponements (HiPs) (revised definition).



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“*QUALITY POLICY*”

What have we achieved by this policy?

Arguably a concentration on the issues and improvement of some parameters

e.g. Your Hospitals Report current (2006/07) and 2 to 6 years ago



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“QUALITY POLICY”

Emergency Performance

12 monthly reports to June 2004 compared with 12 months to June 2007
Ambulance Bypass times 6.7% - 1.7%

Policy Matters YES

Admissions within 8 hours

67% in 2000/2001
71% in 2006/2007 against government target 80%
56% growth

Policy Matters YES But what about 29%

Non Admitted emergency stays less than 4 hours

71% in 2000/2001
77% in 2006/2007 against government target of 80%
30% growth

Policy Matters YES But what about 23%



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“QUALITY POLICY”

Elective Surgery

Category 2: semi urgent

Admissions within 90 days desirable for a condition coming in some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency, such as hip and knee joints requiring replacement.

Target 80% within 90 days

In 2000/2001 78% within 90 days

In 2006/2007 75% within 90 days

Growth of 13% in admissions over period

Policy Matters YES but target of 80% unmet

Elective Surgery

Category 3: non urgent

2000/2001 90% within 365 days

2006/2007 91% within 365 days

Growth of 2.8% in admissions over the period

Policy Matters YES target of 90% met



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“QUALITY POLICY”

Hospital Admissions Risk Program 2001/2002 Results from pilot Program

1 in 5 HARP projects targeted Chronic Obstructive Pulmonary Disease

These patients experienced

- 63% fewer ED attendances
- 65% fewer emergency admissions
- 50% fewer days in hospital

1 in 5 HARP Projects targeted Diabetes

These patients experienced

- 38% fewer ED attendances
- 73% fewer emergency admissions
- 40% fewer days in hospital

Does policy matter - How many dollars are assigned to HARP versus whole system spending.



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“QUALITY POLICY”

Major DHS Policies

- Performance accountability framework
- Elective surgery access policy
- “BETTER FASTER POLICY”

\$508 Million over 4 years to

- Increase hospital system’s capacity to meet community demand for essential services
- Expand chronic disease management programs
- Provide substitution and community based services to relieve pressure on hospital E.D.’s



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