



The Aussies are Coming



ACHSE Tour
of
Denmark and England
2008



- 11 community health CEOs (2 rural)
- 1 Division of GP CEO and 1 retired hospital corporate services manager.



What we expected to see:

- Unified national systems built around one major funding source and two jurisdictions with coherent vision, good infrastructure and collaboration.
- Commitment to early intervention, prevention backed by funding.
- Accessible and high quality services esp. for those with most need.
- Utilisation of IT to facilitate seamless service co-ordination.



What we found

- OK health systems popular with the public.
- Struggling with service co-ordination and primary care - acute interface
- Struggling with prevention and the growth in lifestyle diseases i.e. obesity and diabetes
- More health resources going to administration and governance. More than two levels of administration with health delivery responsibilities.
- Policy commitment to community based care and primary care not backed by resources.
- IT systems fail to fulfil hopes of effective service integration.



Denmark

- Major health reforms commenced 2005.
- 2007 reform of local Government led to further health reform.
- Small but growing private sector:
 - 34% Danes have private health for co payments/fees for dental, pharmaceuticals, private GPs. Other insurance provides private hospital care. Private sector is only 3%



- 20% of population accounts for 95% of health expenditure.
- Three levels of Government with overlapping health responsibilities.
- Guarantees of surgical and other hospital procedures to occur within 6 weeks of diagnosis otherwise Government must provide private service.



Key National Challenges

- Short average lifespan
- Illnesses related to lifestyle
- Lack of health workforce
- Inequalities in health
- Lack of Co-ordination



Challenges

- Paradox of social and economic equality, good housing etc. with the lowest life expectancy in the EU and one of the lowest in the OECD.
- High level of illness caused by preventable diseases.
- Poor service co-ordination, prevention and disease management beyond GPs.



Why?

- Liberal attitudes to alcohol, smoking, unsafe sex, workplace safety and illicit drug use.
- Strong civil liberties ethic that rejects state interference in personal choice, including lifestyle. (Recent campaigns for smoking cessation, workplace safety and alcohol have met with organised opposition).
- Reactive health care system.



What is being done?

- More spending on prevention, early intervention and reducing hospital admissions/re-admission. Unsuccessful so far because of entrenched culture and reactive nature of the Danish system.
- GPs required to take more active role in managing patient journey through system and for early intervention and screening.
- Targeted campaigns around avoidable diseases and lifestyle choices.
- Formal partnerships between Universities and Regions to gather data, study and report the causes of illness, and facilitate local innovation.



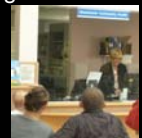
England

- Continuous change to NHS in the past 10 years
- 50% increase in health care expenditure.
- Reducing life expectancy compared to rest of OECD esp. in the north.
- Fragmentation. Poor service integration and investment in early intervention and prevention.
- Policy commitment to primary care has not been backed by resources.
- IT investment has failed to deliver.



Tensions

- Co-operation vs. Competition
- Local Autonomy vs. Central Control
- Prevention vs. Hospital Treatment
- Reducing Inequalities
- Clinical Leadership vs. Management
- Choice vs. Control





What is being done?

- Driven to promote service integration
- Adoption of targets and delivery services similar to our own. Shift from hospital to community settings
- Disease specific integrated services
- Practice based primary care team as prime unit for integration

University of Birmingham



Comparison

- Should be grateful for the MBS spine to our health care system.
- Diabolical problems with secure e-referrals and medical records. Five regions are experimenting with different models with only moderate success. Expecting IM to resolve systemic problems?



Positives-PCTs

- Complex but PCOs/PCTs empower local communities to identify health priorities and develop strategies for their management.
- Local Area agreements and joint health appointments with local Government
- Development of planning and budgeting/purchasing expertise.
- Alliances with Councils and other partners in resource allocation decisions.



Suggestions

- LIFT programme (UK)
- Primary Care Trusts – many features worth adopting.
- Patient registration and capitation funding for chronic illness.
- University relationships
- Marketing of health sector 'family' within the system.
- Decanting of some specialist acute services to community based clinics