Improving value in health care through practical steps

Andrew Wilson
Adam G Elshaug

Australia faces competing challenges of a growing burden of chronic disease, an increasing range of disease interventions, increased expectations of timely access to care and economic pressures to rein in the growth in health care expenditure. The single biggest contributor to growth in health care costs is the increase in care volume per case.[1]

In this issue of *Australian Family Physician*, three papers coalesce broadly around the challenges faced in managing increasingly complex patient presentations in a resource-scarce world. A concern for safe, effective and efficient care is central to all three articles.

Doust and Glasziou[2] sketch a compelling scene in which overdiagnosis is on the rise. They point out that, due to disease definition 'creep' and amplified labelling, patient care can increasingly consist of a prescription and/or a referral, even when there is little evidence for long-term benefits. And there is potential for harm as increased diagnosis and spurious labelling can result in a snowball effect of further testing and treatment whereby harms and costs might outweigh benefits. Consequences of overdiagnosis can also come through direct-to-consumer advertising[3] and tests with questionable diagnostic accuracy.[4] Doust and Glasziou seek to raise awareness of overdiagnosis, and call for more systematic approaches in which investigations, referral and treatment are used more cautiously in the general practice setting. With the overdiagnosis conversation gaining traction internationally, it is imperative that dimensions of the issue, and any solutions, be informed by physicians on the ground.

Patients with chronic diseases (eg. heart disease, cancer or diabetes) make up at least 50% of GP consultations; importantly, at least 10% of hospital stays for patients with chronic conditions are potentially preventable with timely and adequate non-hospital health care.[5] Harris et al[6] explore key roles and strategies for GPs when managing multimorbidities. They outline the need to act effectively as coordinator and integrator of specialty care and other referral services, working in partnership with patients and other health care personnel. They aptly canvass the need for, and role of, improved guidelines, expanded and new models of multidisciplinary care planning, and negotiation with patients to meet goals of shared care. To complement this recipe, a yet-to-be-written paper must address questions of financing and incentives to bring the moving parts of management together in an efficient way. The fee-for-service model of financing is, arguably, blunting the potential for truly shared, coordinated care. International models are moving in this new direction. Trials of partial-to-full capitation with pay-for-performance are yielding promising results wherein payments and other incentives are aligned with longer-term clinical and patient-important health outcome targets. Here Harris provides a sage outline of the necessary mechanics; the challenge ahead is to finance its efficient operation.

Byrnes and co-workers[7] plot the time demanded to fulfil care across three dimensions: traditional acute care, planned secondary and tertiary prevention, and primary preventive medicine. Unsurprisingly, meeting these growing expectations requires a commitment barely possible on Earth's orbiting cycle. So without more hours in the day, identifying waste comes under focus. The saying 'one person's waste is another person's profit', however, suggests the notion of waste can depend on perspective, which Byrnes et al highlight. The conduct of low-value services might be wasteful to society and futile to patients, but a fee-driven model of payment arguably incentivises towards quantity over selective quality.[8] The 75+ health assessment is used as an example, as are some that health economists might call 'technical inefficiencies' (eg. inefficient use of nursing and allied health personnel, poor patient flow management, etc.). These observations are matched with several possible remedies. As with Harris's analysis, one is left wondering if the elephant in the room here has to do with (in)appropriate financing and incentive measures that could otherwise align time management and services rendered towards high value. To be sure, inefficiency can and should be tackled where it lies, and Byrnes et al offer insight here. But physicians are actors in a system. The challenge is to recognise inefficiencies open to remedy at the practice level and which might require structural reform at the root cause. All three papers present a practical primary care perspective on the broader issue of achieving better value in health care.

Authors

Andrew Wilson BMed Sci, MBBS (Hons), PhD, FRACP, FAFPHM, Professor and Director, Menzies Centre for Health Policy, The University of Sydney, NSW.
a.wilson@sydney.edu.au

Adam G Elshaug MPH, PhD, Associate Professor and HCF Research Foundation Principal Research Fellow, Menzies Centre for Health Policy, The University of Sydney, NSW

Competing interests: None.

Provenance and peer review: Commissioned; not peer reviewed.

Acknowledgements

Adam G Elshaug is supported by the HCF Research Foundation and holds an NHMRC Sidney Sax Public Health Fellowship (627061).

References

1. Daley J, McGannon C, Savage J. Budget pressures on Australian governments. Melbourne: Grattan Institute, 2013.
2. Doust J, Glasziou P. Is the problem that everything is a diagnosis? Aust Fam Physician 2013;42:856–859.
3. Vreugdenburg TD, Willis CD, Mundy L, Hiller JE. Pre-market approval and post-market direct-to-consumer advertising of medical devices in Australia: a case study of breast cancer screening and diagnostic devices. Intern Med J 2013;43:53–58.
4. Willis CD, Metz MP, Hiller JE, Elshaug AG. Vitamin B12 and folate tests: the ongoing need to determine appropriate use and public funding. Med J Aust 2013;198:586–88.
5. National Health and Hospital Reform Commission. A Healthier Future for all Australians Final Report. Canberra: Commonwealth of Australia, 2009.
6. Harris M, Dennis S, Pillay M. Multi-morbidity: negotiating priorities and making progress. Aust Fam Physician 2013;42:850–854.
7. Byrnes PD, Crawford M, Sieh E. 'If this…, then…' Resource allocation in a finite world. Aust Fam Physician 2013;42:846–849.
8. Elshaug AG, McWilliams JM, Landon BE. The value of low-value lists. JAMA 2013;309:775–76.