The role of healthcare purchasing in enabling improved patient care

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Context of the obesity epidemic

- QLD has the highest rate of obesity in Australia.
- 1 in 3 adults are obese and 1 in 3 are overweight.
- 7 in 10 children are a healthy weight, 2 in 10 are overweight and 1 in 10 are obese.
- Based on current trends about 3 million (55% of estimated total population) Queeslanders will be overweight or obese by 2020.

The impact

- Increasing obesity is driving up rates of diabetes leading to increased incidence of cardiovascular disease adding to health systems pressures with potential to constrain life expectancy gains.
The cost to healthcare

- In 2008 it was estimated that 5.4% of all hospital expenditure in Australia was related to obesity ($1.9 billion).
- In 2010 estimated that 17,200 deaths were indirectly or directly linked with obesity in Australia, equates to 3200 in QLD.
- CHO report 2014: based on 5.4% estimation, healthcare expenditure in QLD in 2011/12 linked with obesity was about $0.531 billion.
In Queensland

- We currently don’t have good data to understand the linkages between service activity and obesity.

- Obesity is currently only coded if this condition directly impacts on treatment. Obesity is very rarely reported as a principal diagnosis.

- The incidence of obesity will be better captured with the 2015-16 new chronic conditions codes (‘U’ codes). This will enable obesity to be recorded whether or not it impacts on treatment, allowing us to link obesity with adverse events, incidences of chronic disease, higher complexity and readmissions to obesity.

- For patients who have undergone gastric bypass surgery, obesity is mostly reported as the principal diagnosis.

- Rates of this procedure in QLD public facilities are relatively stable - typically around 400 a year for the last three years, mostly for privately/self-funded patients.
Promoting value in healthcare

Value in healthcare is the patient health outcomes achieved per the dollar spent

Why focus on value?

- Facing an environment of fiscal restraint, with Commonwealth stepping away from partnering in addressing demand from 2017-18
- Queensland context includes:
  - Continuation of 2% productivity dividend
  - Introduction of nurse: patient ratios
- Changing profile in population health need and demand
  - Increased chronic disease burden - different service models required
  - Technological capability to do more for patients
- Simultaneously need to continue to improve performance
  - Expected performance improvement of specialist outpatient wait list management
  - Inconsistent (and in some cases unknown) quality and/outcomes
- Means a need to more fundamentally question how we can deliver the best results (in terms of patient outcomes) from the $12bn allocated to healthcare services in Queensland each year – how can we improve value?
For example:

• Several studies have concluded that gastric bypass and gastric banding are cost effective treatments.
• The surgery reduces mortality and diabetes complications.

Questions that we should be asking:

• Should we be doing more?
• Does the current funding model support integrated chronic disease management to effectively address the increased rates of obesity and its health impact?
• Are we funding services in the right setting?
Promoting Value in Healthcare

The aim: To derive the greatest possible health benefit for the Queensland population by focussing on value, with value being the patient health outcomes achieved per dollar spent.

We will do this by:

• Working with experts to re-examine the healthcare services we currently purchase to ensure provision of the best value services to meet current healthcare needs:
  – How do we perform?
  – What do we spend?
  – Can we do it better?

• Making value based decisions around future investments
• Aligning the funding model and performance management framework to recognise and reward HHSs for delivering value
Value in health care

Poorly targeted services move into the 'disinvest' zone
AIM: To derive the greatest possible health benefit for the Queensland population by focussing on value, with value being the patient health outcomes achieved per dollar spent.

**Annual work program**

**Work Cycle**

- **Plan**: Work with stakeholders to identify potential topics of inquiry.
- **Implement**: Activate response to initiate and or support change.
- **Evaluation**: Determine impact, adapt levers if required.

**Outputs**

**Value reports on specific topics of inquiry**
- Based on an in-depth analysis, informed by collaboration with experts, that reviews opportunities and makes recommendations to improve value.
- Focus on ensuring delivery of recommendations.

**Value indicators benchmarking**
- Benchmarking information reported on a range of value indicators, hosted on CaPRS.
- Compares peer grouped facilities across the state and internationally.
- May inform future specific topics of inquiry.

**Value evidence dissemination**
- Horizon scanning for published research evidence of opportunity to improve value.
- Assessment of QLD opportunity.
- Dissemination of findings.
- May inform future specific topics of inquiry.
Where to focus efforts?

1. **Rationale** - is there a compelling rationale to review the topic?
   - Magnitude (in terms of health benefit and/or financial impact)
   - Compelling evidence/knowledge of potential value opportunity and/or known barriers to value
   - Requires whole-system (DoH and service delivery) response

2. **Feasibility**
   - Is the topic clearly definable?
   - Is analysis/assessment of the value opportunity feasible?
   - Is it feasible to realise the value opportunity?
Questions for consideration/discussion?

What should the Department do to:

- Improve value in the management of obesity?

- Incentivise new models of care and prevention?
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