

# Performance Improvement and Health Cost Reductions

## Abstract:

Health care expenditure in Ireland has reached 9.5% of GDP (2009 data). This figure is similar to the UK and is in line with most other European countries apart from France and the Netherlands which are higher at over 11%. In most western societies health spending is rising faster than economic growth, a trend that was first observed in the 1970s and has continued unchecked. The spending on health in the US at 18% is almost twice as high as Europe and has now reached crisis point. This represents \$7960 per capita compared with the OECD average \$3223. Yet despite this massive investment the US cannot guarantee access to healthcare for all its population. With the global down turn there is an increasing impetus for all countries to contain their health spend. Healthcare is barely covering its costs. Resources are finite and without properly planned containment, rationing may become necessary. It is imperative that the health professions set down the priorities for medical care rather than having a solution imposed on them and their patients.

The challenge is how to contain medical costs without adversely affecting the patient's wellbeing. It is accepted that the main drivers to cost increases are technological advances, the aging of the population, less healthy lifestyles and patient demands driven by increased knowledge of the spectrum of treatments available. It will require a substantial investment in research, time and discussion to determine how savings can be achieved and value for money obtained. US commentators have been grappling with these difficult issues. Blumenthal vision must include concrete cost-containment and quality improvement targets. The spending on health needs to keep in line with the growth in GDP plus 0.5%. The improvement in the annual health care quality should be increased from the current 2.3% to 4.6% by 2016. The improvement can be measured using a range of mortality and morbidity metrics. The Agency for Healthcare Research and Quality (AHRQ) produced formal outcome measures. The quality of care for children has been measured by determining how 4 paediatric conditions are managed, pain control, UTIs, ADHD, and Asthma. In adults it addresses atrial fibrillation and the prevention of stroke, the heart failure program, back pain management and diabetes care.

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The disturbing gap in quality, the difference between treatment success rates and those thought to be achievable with best practice, has led many healthcare systems to examine the factors around the provision of medical care. The rate of adoption of best practice remains low. The interval between the publication of new proven clinically important findings and their wide implementation is on average 17 years. Another frustrating feature is that the uptake is patchy and some patients do not benefit from the new knowledge. The factors that drive the adoption of new more effective clinical practices are ill-understood. One of the problems is that hard pressed clinical staff do not have sufficient time or resources to assimilate the positive findings from the rapidly expanding medical literature. The solution is the development of national quality improvement strategies. The clinical lead programmes are well placed to provide a helpful role.

Reducing the expenditure on wasteful, ineffective practices has become increasingly important. It is estimated that 30% of the health budget is spent on interventions that are of no benefit to the patient or on investigations that are unnecessary. The process is not about denying a patient effective medical care but rather preventing tests and treatments that are of no use. Incorrect treatment can lead to harmful side-effects. Inappropriate tests can produce false positive results leading to anxiety and further unnecessary investigations. To date physicians have not been sufficiently united in their condemnation of treatments that clearly lack any benefit.

Patients with complex and chronic conditions understandably require a disproportionate amount of medical and nursing care. The sickest 10% of patients account for 65% of health expenditure. This category of patient needs a more co-ordinated management approach. Strategies should be developed to streamline home visits, outpatients, hospital admissions and effective medication. The US program proposes the establishment of up to 100 health improvement communities (HICs) to direct services for high cost patients.

The relationship between demand and capacity is a recurring challenge in the planning of quality efficient health care. It is a major problem in primary care. Ghorob and Bodenheimer <sup>2</sup> have provided some clarity. Capacity is the number of doctor consultations per day multiplied by the number of working days annually. Demand is the patient panel size times the expected annual number of visits per patient. Problems arise when demand exceeds capacity. One of the solutions is to reassign some of the doctor's duties. The role of practice nurses should be expanded particularly in the areas of prescription refills and chronic care management. Almost 20% of the doctor's time is spent on preventive care which could be reallocated to a nurse or health educator. Similarly 37% of the time spent on patients with chronic conditions relates to patient education, counselling and medication compliance. The authors recognise that this suggested transfer of duties from clinicians to non-clinicians may cause alarm among some doctors. However it does appear that the 'share the care' programme does offer benefits to the patient while providing the doctor some space to co-ordinate the overall management.

The quality of care provided to patients is dependent on the resources available and the manner in which the resources are rolled out. Healthcare is a social right for every person but the care that is provided must be clinically effective and cost contained. It is imperative that reliable systems are put in place that are capable of assessing and identifying the technological and therapeutic innovations that are genuinely effective. Ineffective therapies must be recognised at an early stage in order to prevent their introduction into clinical practice. A smarter provision of healthcare is required.

JFA Murphy  
Editor

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2. Agency for Healthcare Research and Quality. [www.ahrq.gov](http://www.ahrq.gov)
3. Ghorob A, Bodenheimer T. Sharing the care to improve access to primary care. N Engl J Med 2012;366:1955-7.
4. Brody H. From an ethics of rationing to an ethics of waste avoidance. N Engl J Med 2012;366:1949-51.

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