PLANNING AND STRATEGIC CONTROL FOR PUBLIC HEALTH IN ITALY

Convegno Costi Standard e Misurazione delle Performance nei Processi di Approvvigionamento.
Impatto sul Modello delle Decisioni

Realizzato in Collaborazione con
Associazione Triveneta Provveditori ed Economi (ATE), ARSS Veneto

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Palazzo della Gran Guardia, Verona, Italy
30 September 2010

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TWO MAJOR THEMES

**WHERE IS THE ITALIAN HEALTH SYSTEM GOING?
ARE YOU HAPPY ABOUT THESE DIRECTION?
IF NOT, WHAT MUST YOU CHANGE?**

HOW CAN ITALIAN LOCAL HEALTH UNITS PLAY A CREATIVE ROLE IN HELPING TO ADDRESS THE NEEDED CHANGES?

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THE CHALLENGE

FOUR ISSUES CONFRONT YOUR HEALTHCARE SYSTEM

THEY WILL BECOME INCREASINGLY SERIOUS
AND COSTLY IN THE NEXT 5 TO 8 YEARS

**DEMOGRAPHIC TRENDS
SPENDING IMBALANCES
MORBIDITY PATTERNS
A DYSFUNCTIONAL DELIVERY SYSTEM**

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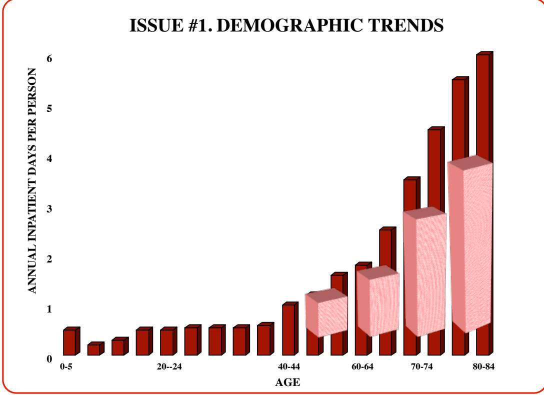
ISSUE #1. DEMOGRAPHIC TRENDS



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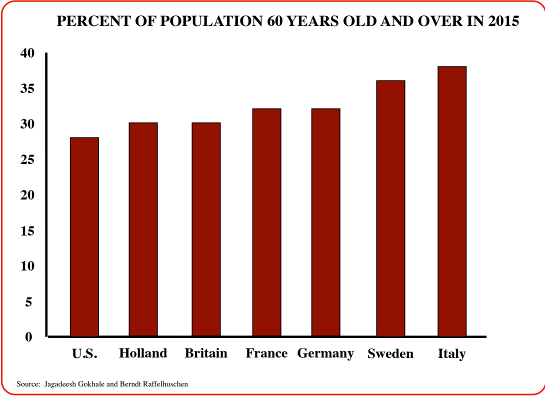
PERCENT OF POPULATION 60 YEARS OLD AND OVER IN 2015



Source: Jagadeesh Gokhale and Berndt Raffelhuschen

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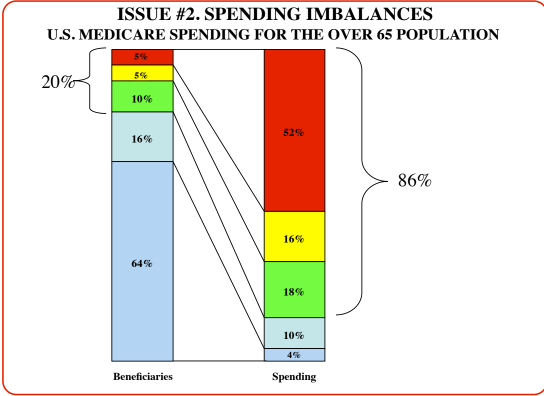
ISSUE #2. SPENDING IMBALANCES

U.S. MEDICARE SPENDING FOR THE OVER 65 POPULATION



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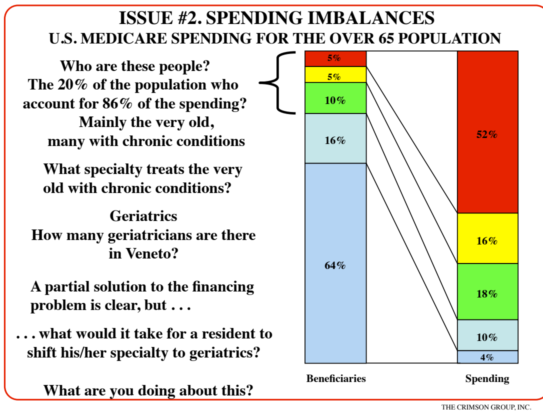

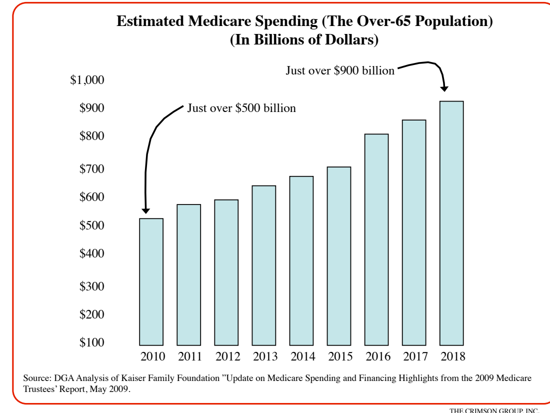

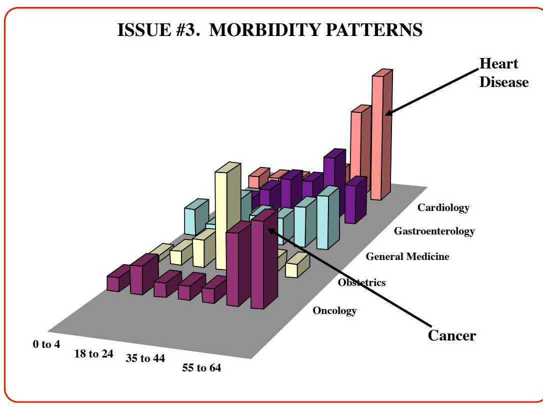

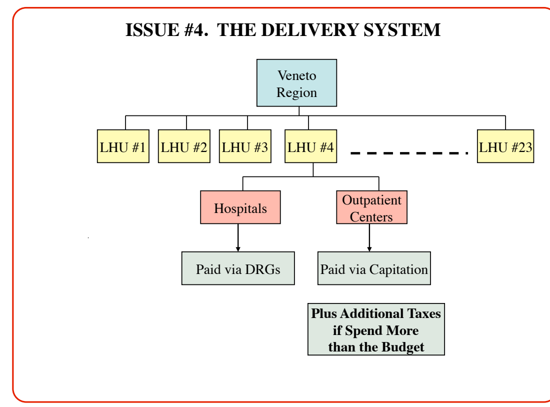

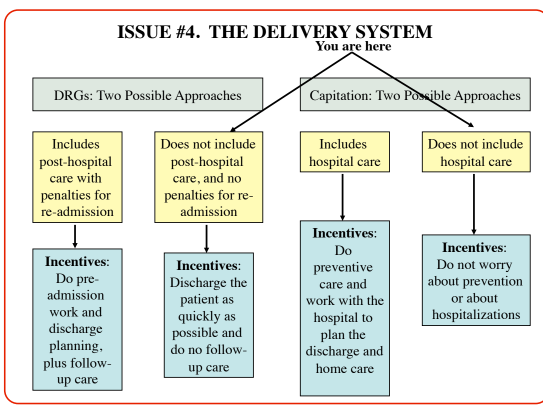

ISSUE #4. THE DELIVERY SYSTEM

The results:

1. **Outpatient centers (the territories) do not worry about prevention because the capitation payment does not include the cost of hospital care**
2. **When a patient is hospitalized the hospital tries to discharge him or her as soon as possible because the DRG payment does not include the cost of follow-up care. That is the responsible of the outpatient centers**
3. **In effect, a patient is a hot potato who everyone is trying to toss to someone else**

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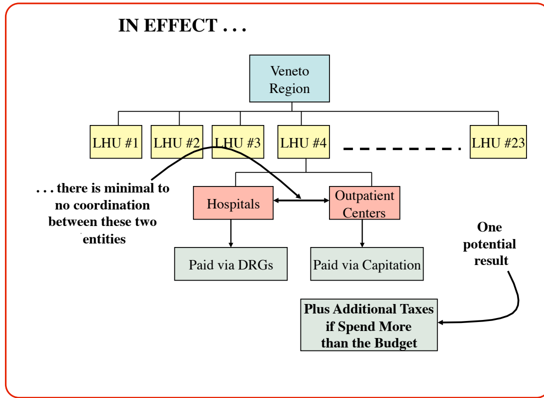


CONCLUSIONS

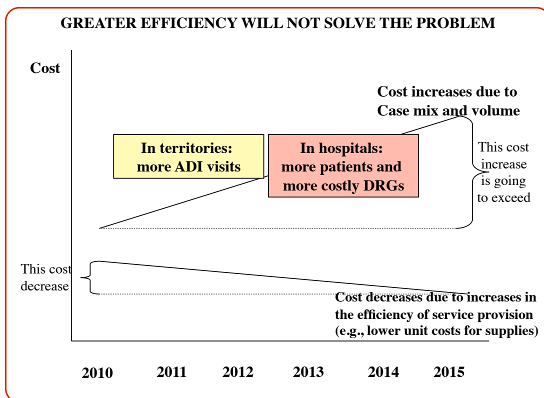
THERE ARE A DISPROPORTIONATE NUMBER OF PEOPLE CURRENTLY IN THEIR EARLY 60s, WHO WILL DEMAND INCREASINGLY LARGE AMOUNTS OF INPATIENT CARE AS THEY GROW OLDER

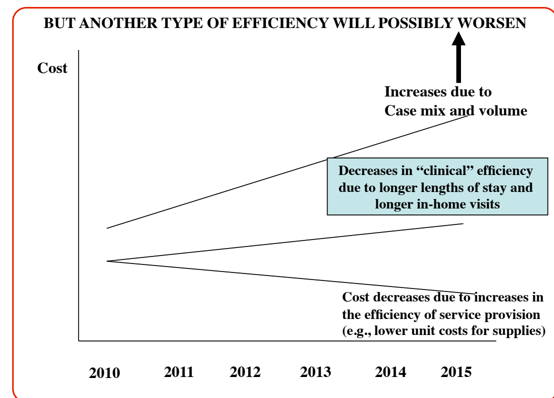
SINCE THEY LIVE LONGER THAN THEIR ANCESTORS, THEY WILL BECOME PART OF THE HIGH COST SEGMENT OF THE HEALTH SYSTEM

THEIR CARE WILL BE LARGELY IN AREAS SUCH AS CARDIOLOGY AND ONCOLOGY—AREAS THAT DO NOT LEND THEMSELVES EASILY TO A SHIFT TO OUTPATIENT CARE

THEY ALSO WILL DISPLAY AN INCREASING INCIDENCE OF CHRONIC CONDITIONS, THEREBY INTENSIFYING COST PRESSURES IN OUTPATIENT SETTINGS

RESULT: INTENSE PRESSURES ON COSTS AND A FRAGMENTED DELIVERY SYSTEM THAT DOES NOT HAVE THE INCENTIVES NEEDED TO SLOW THE RATE OF COST GROWTH





IN ADDITION TO WORKING TO IMPROVE EFFICIENCY, HOW CAN YOU SOLVE THESE PROBLEMS?

TO BEGIN, YOU MUST RECOGNIZE THAT COSTS ARE DRIVEN BY FIVE FACTORS, AND . . .

. . . YOU MUST REDESIGN THE PAYMENT MECHANISMS IN LHUs TO PROVIDE THE APPROPRIATE INCENTIVES ON BOTH THE OUTPATIENT AND INPATIENT SIDES

HEALTH CARE COST DRIVERS

Cost Driver		Examples	Controlling Force(s)
Case Mix	Morbidity-Related	Diabetes, cancer, heart disease . . .	Environment, genetics, health habits.
Volume	Morbidity-Related	10,000 cases diabetes, 15,000 cases cancer. . .	Environment, genetics, health habits. (Public Health)
Resources Per Case	Utilization/Efficiency	8 outpatient visits 2 glucose tests, 2 CBCs . . .	Physicians, clinical protocols, available technology.
Cost Per Resource Unit	Utilization/Efficiency	\$40 per OPD visit \$25 per glucose test \$12 per CBC . . .	Service-providing units. (Operations)
Fixed Facility Costs	Technology	Plant & equipment depreciation; managerial & administrative staffing.	Senior management, physicians, health policy. (Strategy)

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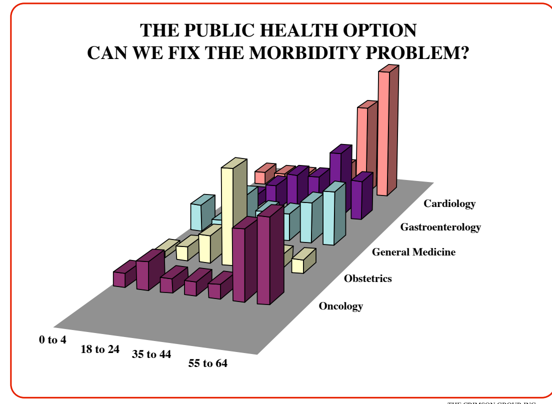
OPTIONS AND CONSEQUENCES

Cost Driver	Option	Consequences
Case Mix	Reduce the incidence or don't treat certain diagnoses	Morbidity may improve, or some patients will suffer and/or die prematurely.
Volume	Don't treat all patients with certain diagnoses	
Resources Per Case	Treat certain case types with a more cost-effective mix of resources	More outpatient care and shorter lengths of stay in hospitals. Perhaps fewer tests and procedures.
Cost Per Resource Unit	Provide resources in a less expensive way	Lower wages, lower supply prices, greater efficiency. Result is fewer staff and/or different skill mixes.
Fixed Facility Costs	Invest in lower cost capital, reduce size/ salaries of administrative staff	Less technology, fewer administrators, less qualified administrators.

THE PUBLIC HEALTH OPTION CAN WE FIX THE MORBIDITY PROBLEM?



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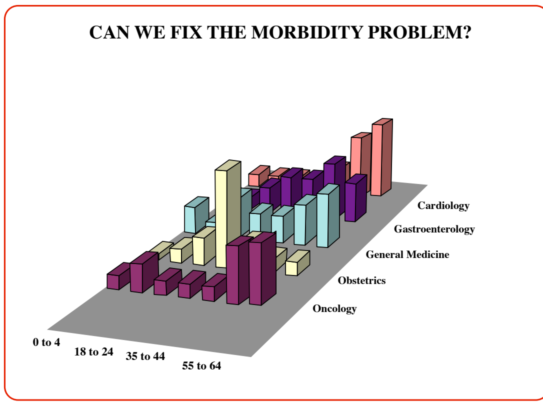
CAN WE FIX THE MORBIDITY PROBLEM?



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BUT . . .

. . . DO PEOPLE *WANT TO* IMPROVE THEIR HEALTH?

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HEALTH INDICATORS IN MASSACHUSETTS A RELATIVELY "HEALTHY" STATE

	MA %	MA Rank
overweight	52	4th
obese	17	5th
Any exercise in past month	76	13th
fruit and vegetable consumption	31	4th
current smoker	20	8th

1 = best; 50 = worst

Source: Massachusetts Department of Public Health

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Leading causes of death in the United States

- Tobacco: 435,000 deaths, 18.1 % of total U.S. deaths
- Poor diet and physical inactivity: 400,000 deaths, 16.6%
- Alcohol consumption: 85,000 deaths, 3.5%
- Microbial agents: 75,000
- Toxic agents: 55,000
- Motor vehicle crashes: 43,000
- Incidents involving firearms: 29,000
- Sexual behaviors: 20,000
- Illicit use of drugs: 17,000

Almost 35% here

Source: *Journal of the American Medical Association*

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Cost Per Resource Unit	$40 per OPD visit $25 per glucose test $12 per CBC . . .	Service-providing units.
Fixed Facility Costs	Plant & equipment depreciation; managerial & administrative staffing.	Senior management, physicians, health policy.

Utilization/Efficiency

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CAN WE FIX THE UTILIZATION PROBLEM?

ANNUAL INPATIENT DAYS PER PERSON

0 1 2 3 4 5 6

0-5 20--24 40-44 60-64 70-74 80-84

AGE

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CAN WE FIX THE UTILIZATION PROBLEM?

ANNUAL INPATIENT DAYS PER PERSON

0 1 2 3 4 5 6

0-5 20--24 40-44 60-64 70-74 80-84

AGE

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TO REDUCE UTILIZATION, A LHU NEEDS TO THINK CREATIVELY ABOUT DISEASE MANAGEMENT STRATEGIES

- OUTPATIENT VERSUS INPATIENT TREATMENT
- PHARMACEUTICALS RATHER THAN SURGERY
- PRE-ADMISSION ACTIVITIES TO SHORTEN LENGTH OF STAY
- IN-HOME CARE TO SHORTEN LENGTH OF STAY

Territories Hospitals

BUT IT IS HARD TO DO THIS WHEN THERE IS NO COORDINATION BETWEEN OUTPATIENT AND INPATIENT SERVICES

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MOREOVER, YOU NEED TO REMEMBER SEVERAL IMPORTANT ELEMENTS WHEN YOU BEGIN TO THINK ABOUT STANDARDS:

- A HOSPITAL CAN EXERT SOME CONTROL OVER THE COST OF TREATING A GIVEN DRG (LENGTH OF STAY, TESTS, PROCEDURES, ETC.)

  . . . BUT IT HAS LITTLE CONTROL OVER EITHER THE NUMBER OR MIX OF DRGS THAT IT IS ASKED TO TREAT. THAT IS A RESULT OF MORBIDITY PATTERNS, OVER WHICH THE TERRITORIES (AND PATIENTS THEMSELVES) HAVE MORE CONTROL

- THE TERRITORIES CAN EXERT SOME CONTROL OVER THE EFFICIENCY OF A HOME VISIT (HOW LONG IT TAKES) AND THE MEDICAL SUPPLIES THAT ARE USED FOR THE VISIT . . .

  . . . BUT THEY HAVE LITTLE CONTROL OVER THE NUMBER OF PATIENTS WHO NEED A HOME VISIT. THAT IS A RESULT OF PATIENTS HEALTH-RELATED BEHAVIOR AND THE GENERAL AGING OF THE POPULATION

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IN ADDITION, THE COST OF TREATING A GIVEN DRG IS A COMBINATION OF:

- THE RESOURCES USED TO TREAT THE PATIENT: LENGTH OF STAY, TESTS, PROCEDURES, ETC.)

  WHICH ARE CONTROLLED LARGELY BY PHYSICIANS AND THEIR ORDERING PATTERNS

- THE COST OF EACH RESOURCE UNIT, SUCH AS A LAB TEST OR A DAY OF CARE

  WHICH ARE CONTROLLED BY ADMINISTRATIVE PEOPLE (NURSE MANAGERS, LAB MANAGERS, DIETARY MANAGERS, HOUSEKEEPING MANAGERS, ETC.

  AND WHICH ARE A RESULT OF A COMBINATION OF WAGE RATES, SUPPLY UNIT COSTS, PRODUCTIVITY AND EFFICIENCY

The focus of this afternoon's talk

THE CRIMSON GROUP, INC.

THANK YOU!

PLEASE SHARE YOUR THOUGHTS

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