Paying for Value

October 2022 Newsletter

P4V Update

The Australian health care system is under stress. To some extent, this is the result of COVID-19, but not entirely. The challenge of maintaining universal health coverage for comprehensive, high-quality care that uses advances in technology and understanding of prevention, diagnosis and treatment while keeping total expenditure to a level the community can afford has been evident for decades. The development of patient-centred, integrated models of care, bolstered by innovative payment approaches, is critical to improving health system performance. There are many good ideas but little robust evidence to support change. This newsletter updates you on our recent activities with a focus on the **challenges of implementing, and paying for integrated care** in breast cancer, infectious disease and primary care.

Note that our regular webinars have recommenced with Professor Kees van Gool talking about the drivers of higher fees and out-of-pocket costs in radiation oncology on 27th September. And there's more to come for the remainder of 2022.

Many projects are now reaching the publication stage, and we have been busy preparing conference presentations and manuscripts. Our recent paper, published in Australian Health Review "Paying for value: options for value-based payment reform in Australia" has been widely read, and several groups have contacted us about further work.

Our most exciting new project is the work with GenesisCare, evaluating a bundled payment for breast cancer patients in WA. We have also been commissioned by OECD to contribute an Australian case study to a publication on how innovative payment approaches can improve care quality.

Highlights

- Staffing news – Welcome Dr Peyman Firouzi-Naeim to the P4V team, and bon voyage to Dr Sarah Neville
- Evaluating a best-practice bundle of care for early-stage breast cancer treatment in WA
- The impact of paying for value by focusing on the pathway to treat one disease
- Policy insights on the Health Care Homes experiment
- Our webinar series is back – registration for October open now
- P4V symposium review and planning
- Publication highlights

Welcome Dr Peyman Firouzi-Naeim to the P4V team

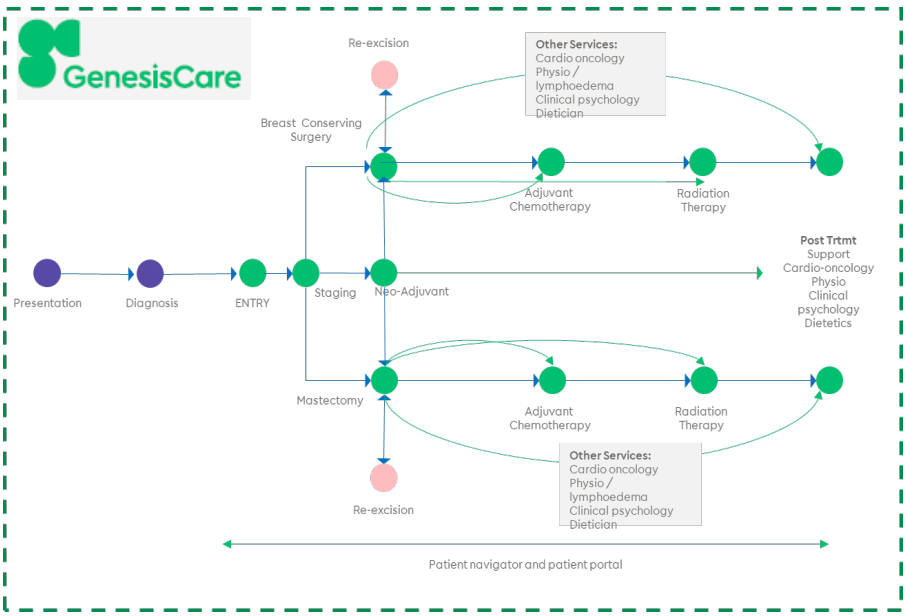
Peyman did his Ph.D. in Economics at the Andrew Young School of Public Policy Studies of Georgia State University, and holds a Masters in mathematics and statistics. In his Ph.D. he used health economics and applied econometric techniques to explore the health effects of counterfactual policy changes, including changes in the U.S. health insurance system introduced by the Affordable Care Act. In particular, he used Bayesian techniques and Item Response Theory to construct an objective measure of health, inserted it into a structural model of health and retirement, and estimated the dynamic discrete choice model using micro-structural estimation techniques. After completing his Ph.D., he joined the ARC Centre of Excellence in Population Aging Research (CEPAR) at UNSW where he worked on the design, development, and estimation of life-cycle models exploring age-dependent taxation schemes. We are looking forward to working with Peyman (peyman.firouzinaeim@uts.edu.au)

Good luck Sarah!

Dr Sarah Neville, Director of Analytics at IHACPA and member of our P4V team as part of our collaboration with the Authority, is Australia's newest Harkness Fellow. Sarah is heading to the U.S. to work with Professor Ezekiel Emmanuel and Dr Amol Navathe at the Health Transformation Institute, University of Pennsylvania. The Institute is a leading force in the development, implementation and evaluation of innovative payment systems. Bon voyage Sarah, we look forward to hearing from you as you learn close-up what is happening in value-based payment in America.

An Australia first: best-practice bundle for private breast cancer treatment

Contributed by Sarah Wise



The P4V team has been commissioned to evaluate GenesisCare's Early Stage Breast Cancer Bundle being piloted through St John of God Hospital Subiaco in WA. It is open to eligible women insured with HBF or Medibank.

The Bundle was developed by radiology provider GenesisCare, leading breast surgeon Professor Christobel Saunders, and UWA. They identified a need to provide certainty in out-of-pocket costs for women choosing to go through the private system, reduce the stress of navigating their care and improving outcomes through timely access to services.

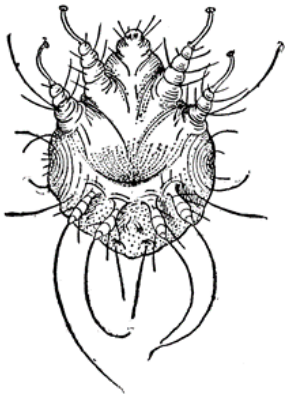
The Bundle works by placing a cap on out-of-pocket costs - $2,500 for HBF members and $2,800 for Medibank members. It spans one year of treatment from staging and includes a dedicated patient navigator and the services shown above, regardless of usage (with some limits on the number of allied health consultations).

The evaluation is collecting a uniquely comprehensive set of clinical, service use, and financial data, ICHOM PROMs, EQ-5D, all.Can PREMs as well as conducting interviews with patients, providers and insurers. It will compare the outcomes and experience of Bundle patients with those receiving treatment in the same hospital whose care is organised and paid for in the normal way. It will also assess the financial sustainability and broader applicability of the payment model. We have already completed the first round of provider interviews and gained valuable insights into motivations for payment reform. Contact sarah.wise@uts.edu.au for more information.

Paying for value by focusing on the pathway to treat one disease

Contributed by Kees van Gool

While rare, crusted scabies (CS) is a chronic, debilitating and disfiguring condition characterised by thick skin crusting and fissuring. Individuals with CS often experience a poor quality of life, stigma and shame, and repeated hospitalisations. In Australia, CS predominantly affects Indigenous communities living in the Northern Territory (NT).



In 2016 a philanthropic organisation called One Disease began implementing a structured approach to achieve significant reductions in CS numbers by the end of 2022. In collaboration with communities and providers, One Disease brought together patients, communities, public health, health care and social care systems to develop and implement an integrated pathway specifically for CS prevention, detection and treatment.

Research conducted by UNSW and UTS shows that the strategy is working. The annual recurrence rate has dropped to 3% from 37% in 2016/17. Each case recurrence avoided saves the health care system an estimated $35,000 over 12 months. This figure does not account for the positive impact of prevention on patients' quality of life, their families and the community. In 2020-21, the One Disease budget was just over $1.7 million (in Government grants and donations) which supports a small team working on the ground with key stakeholders. The program is currently on track to significantly reduce CS by the end of this year; their funding will largely be offset by savings to the health system.

Click on the links below for additional reading:

1. Health care cost of crusted scabies in Aboriginal communities in the Northern Territory, Australia.
2. A systematic review of scabies transmission models and data to evaluate the cost-effectiveness of scabies interventions.
3. Evaluation of the one disease crusted scabies elimination project

P4V Webinars

NEXT: Tues 11th October, 12-1 pm

Health care costs at the end of life and associations with palliative care

Patricia Kenny, Dan Lui and Denzil Fiebig

The use and costs of health care rise substantially in the months prior to death. Although the use of specialist palliative care (SPC) services may be expected to reduce the use of costly hospital services, the evidence is mixed. This webinar focuses on the costs of care over the last year of life and their association with the use of SPC for a cohort with an underlying cause of death of cancer or another life-limiting illness. We adjust for selection factors and examine costs over different time periods closer to death. We find different patterns of use of SPC, with a longer duration of SPC contact associated with lower costs nearer to death.

Click here to register

FOLLOWING: NOVEMBER

Registration opening soon

Inaugural P4V Symposium

Our first Paying for Value Symposium in December 2021 was a great success. It brought together academics, policymakers and others to reflect on work completed and to shape our future research agenda. On day one, the research team's presentations were followed by a panel discussion on building evidence for value-based payment reform with lead policymakers and researchers: Andrew Hallahan, Dorothy O'Keefe, Martin Ijzerman and Sanchia Aranda.

Professor Ezekiel Emanuel of the Health Transformation Institute, University of Pennsylvania was our keynote speaker on Day Two. He spoke about his experience of implementing bundled payments to improve patient care. Our second panel session focused on the contribution research can make to ease the path to payment reform with industry leads Shane Solomon, Robyn Ward, Stephen Duckett, Mark Cormack and Ezekiel Emanuel. **We are currently planning the next symposium for early 2023**. More information to follow

Health Care Homes: another experiment in integrated primary care ends

Contributed by Jane Hall

Integrated models of care to improve patient outcomes and experience, and avoid costly hospital admissions have been part of the primary care policy landscape in Australia for decades. Health Care Homes (HCH) is the latest approach to be trialed, running between October 2017 and June 2021. The evaluation report has just been released by the Department, and the P4V team was involved in the economic analysis component of the trial.

HCH involved patients with a chronic condition enrolling with a preferred GP. Fee-for-service MBS payments were replaced with a partial capitation payment (or bundle) to cover the services associated with their chronic condition for one year. The payment included previously unfunded time for coordination with specialists and other providers. MBS payments for other conditions were not covered, nor were services from other GPs. HCH was designed to promote flexible service delivery through team-based care, telehealth, and better information sharing between providers.

Repeated patient-reported outcome surveys were conducted, but no significant changes were identified over the course of the trial. Only enrolled patients were surveyed, there was no comparator group so we cannot conclude whether patient outcomes were better than normal care. It is also worth noting that, given HCH was seeking to effect change in the progression of chronic conditions, the trial period was relatively short. Patient outcomes and engagement in the program may also have been impacted the COVID-19 pandemic.

The evaluation of hospital use was more rigorous, with enrolled patients matched to non-enrolled patients, and with linked hospital, MBS and PBS data. HCH had little effect on hospital admissions, lengths of stay and emergency department visits. Thus, we did not see anticipated savings from reduced hospitalisations.

MBS payments to practices reduced (as expected) and HCH payments more than compensated for this lost revenue. Thus, HCH did not reduce health expenditure. Practices also reported problems in determining what was, and was not covered by the payment, and in managing different payments within the practice (since it was individual GPs that signed up, rather than whole practices).

The HCH experiment provides many lessons on the barriers and enablers to implementing payment reform in Australia.

P4V Publication Highlights

Gravelle, H., **Liu, D.**, & Santos, R. (2022). How do clinical quality and patient satisfaction vary with provider size in primary care? Evidence from English general practice panel data. Social Science & Medicine, 301, 114936.

Yu, S., Fiebig, D. G., Viney, R., Scarf, V., & Homer, C. (2022). Private provider incentives in health care: The case of caesarean births. Social Science & Medicine, 294, 114729.

Wise, S., Hall, J., Haywood, P., Khanna, N., Hossain, L., & Van Gool, K. (2021). Paying for value: options for value-based payment reform in Australia. Australian Health Review, 46(2), 129-133.

Hall, J., & Viney, R. (2021). Quality-adjusted life years in the time of COVID-19. Australian Health Review, 45(1), 12-13.

de Oliveira Costa, J., Pearson, S. A., Elshaug, A. G., **van Gool, K**., Jorm, L. R., & Falster, M. O. (2021). Rates of Low-Value Service in Australian Public Hospitals and the Association With Patient Insurance Status. JAMA Network Open, 4(12),

Fiebig, D.G., van Gool, K., Hall, J., & Mu, C. (2021). Health care use in response to health shocks: Does socio-economic status matter?. Health Economics, 30(12), 3032-3050.

Kenny, P., Street, D. J., **Hall, J**., Agar, M., & Phillips, J. (2021). Valuing end-of-life care for older people with advanced cancer: is dying at home important?. The Patient, 14(6), 803-813.

Blankart, C. R., **van Gool, K**., Papanicolas, I., Bernal-Delgado, E., Bowden, N., Estupiñán-Romero, F., ... & ICCONIC Collaboration. (2021). International comparison of spending and utilization at the end of life for hip fracture patients. Health Services Research, 56, 1370-1382.

Costa, J. D. O., Pearson, S. A., Elshaug, A., **Gool, K. V.**, Jorm, L., & Falster, M. (2021). 1437 Rates of low value care in NSW public hospitals: variation between public and private inpatients. International Journal of Epidemiology, 50 (Suppl.1), 168-195.

Wright, M., Versteeg, R., & **van Gool, K.** (2021). How much of Australia's health expenditure is allocated to general practice and primary healthcare? Australian Journal of General Practice, 50(9), 673-678.

Scarf, V. L., **Yu, S.**, Viney, R., Cheah, S. L., Dahlen, H., Sibbritt, D., ... & Homer, C. (2021). Modelling the cost of place of birth: a pathway analysis. BMC Health Services Research, 21(1), 1-11.

van Gool, K., Mu, C., & **Hall, J**. (2021). Does more investment in primary care improve health system performance?. Health Policy, 125(6), 717-724.