

Towards an outcomes-based system

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THE DILEMMA over how best to satisfy unlimited demand with limited resources is the core problem of health care funding, management and politics. Governments and health authorities have struggled with the conflict throughout history and dealt with it with varying degrees of sophistication and success. Current strategies in Australia predominantly involve limiting supply by limiting access, most commonly by limiting workforce, physical facilities, equipment, pharmaceuticals and operating funding, in any combination. Application of these strategies inevitably results in delays in service or non-provision of service for some. While such a pragmatic approach to the problem is effective for the purpose of financial control, it causes funding tensions and is a weak system for ensuring that the limited resources are used to best effect.

Casemix funding is well established in Australia, but is primarily used in an attempt to equitably distribute available resources. Although it is touted as a system for funding output, it is a simplistic and inaccurate system based on weighted throughput of patients and makes no attempt to take into account the effectiveness of services provided.

Responsibility for monitoring effectiveness has primarily rested with clinicians. Most studies have been disease specific and focused on clinical measures rather than patient opinion on outcome or change in health status. Enormous advances have been made in treatment and care as a result of this type of activity, but it has many limitations as it is clinician-dependent, very specific and does not lend itself to aggregation for broader studies.

Demand for increased accountability, consumer involvement and improved clinical governance has

encouraged research aimed at better determining the relationship between treatment and outcomes and changed the emphasis from measuring clinical outcomes to measuring patient-centred outcomes based on change in health status. As a result of this activity a number of generic multidimensional measures of health status have been developed and tested and are readily available including the 36-Item Short-Form Health Survey (SF-36) (Ware & Sherbourne 1992), the 12-Item Short-Form Health Survey (SF-12) (Ware, Kosinski & Keller 1996), the Dartmouth COOP Charts (Nelson & Berwick 1989), Quality of Well-Being Scale (Kaplan et al. 1989). While instruments of this type were initially developed to enable public health community surveys they have been found to be equally suitable for measuring change in health status following treatment if used with care. The more effective instruments are designed for completion by patients rather than health professionals.

With these developments, the opportunity does exist to move away from a system which is driven by the blunt tools of financial control, rationing and queuing to a system based on effectiveness as assessed by consumers (the opinion that ultimately counts).

The possibility of easily and inexpensively measuring health status when a patient first presents, at the end of an episode of care and again 6 months later offers many opportunities, although results need to be risk-adjusted and aggregated into groups of an adequate size to be meaningful and have broader application. The results can be correlated with information that already exists in the medical record such as clinician, unit, hospital, disease or procedure to measure effectiveness and improve the knowledge base and inform decisions regarding resource allocation and quality and appropriate care pathways or protocols. A major advantage of such a system is that the information can be easily incorporated into a comprehensive electronic database which is easy to access and understand.

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An example of a possible application exists in relation to the frequently quoted observation that the average person consumes more health resources in the two years immediately before death than in the rest of life. It is a true but trite observation which can be made in retrospect but does not assist when considering appropriate future treatment and care for an individual. Risk-adjusted outcome studies could provide informed guidance on an appropriate course of treatment and care which would assist to achieve more humane care and lead to better use of health resources.

A further possibility would be to use information on effectiveness and outcomes to show what improvement in health status has been, or could be, generated by a given level of resources. It could even be used as the basis for sending price signals for priorities in a casemix funding system.

There has been a puzzling reluctance on the part of governments, health departments, providers and clinicians in Australia to proceed down this path. Perhaps this is due to false fears regarding introduction of managed care, or because disease-specific studies have consumed

the available resources. Or perhaps it is because governments, health authorities and hospitals have been slow to understand the potential.

Acceptance of change in health services has never been fast, but moving to a system based on effectiveness as measured by patient opinion on change in health status appears to offer many advantages over that which currently applies.

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