



Improving the efficiency of the health care system: what can Australia learn from Canada and the UK?

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Summary: In the midst of tighter budgets, and increasing demand for health care, the pressure is on both Federal and State governments to be more efficient and effective with the allocation of limited health care resources. This opinion piece looks at the lessons from Canada and the United Kingdom and concludes that taking a more explicit approach to priority setting and disinvestment that includes relevant stakeholder groups can lead to successful service redesign and disinvestment activity.

Robinson S., Dickinson H., Mitton C., Williams I. Improving the efficiency of the health care system: what can Australia learn from Canada and the UK? New South Wales, Health Services Research Association Australia and New Zealand. <http://www.hsraanz.org/fact-sheets/>

Many other countries face similar economic challenges around healthcare spending, yet their policy response is somewhat different than what we have traditionally seen in Australia. In a number of countries including Canada and some parts of Europe there is a move to more explicit and transparent decision making and priority setting processes. These processes include resource allocation (investment) and withdrawal (disinvestment) decisions. This short article will explore the Canadian and English priority setting practices around disinvestment and consider the transferable lessons for Australia.

Healthcare is complex and cuts, or a move to raise taxes to pay for increased spending, are not vote winners. This begs the question about what options are available to politicians and decision makers in this scenario. Without increased funding the thorny issue of how to spend less on certain healthcare services, and in some instances withdraw outmoded practices, becomes even more important. This problem is not unique to Australia and international attention has focused on the disinvestment and decommissioning of public services.

Disinvesting in services is often viewed negatively by many, but current research highlights the development of a number of tools and processes which can aid decision makers when they are faced with making tough spending choices. The intention of these approaches is to be more explicit and focused in their decision making. Drawing on the current evidence base, these approaches offer an alternative to the usual knee jerk reaction to saving measures or blunt instruments sometimes employed such as across the board cuts - that may provide short term savings – but much more extensive long term costs.

Even before the recent global recession, both England and Canada had started to undertake disinvestment activity across the health sector. The move towards explicit priority setting saw the utilisation of a number of technical approaches which aimed to aid decisions makers allocate health care resources. Technical approaches often include offerings from economics and ethics and include techniques such as Programme Budgeting and Marginal Analysis (PBMA)¹ and Health Technology Assessment (HTA)², as well as Accountably for Reasonableness (A4R) which has emerged as a popular framework for ensuring decision making processes are fair.³

In England

There are some examples of disinvestment in the United Kingdom that may be instructive for the Australian context, both in terms of strategies and challenges. At national government level, the National Institute for Health and Care Excellence (NICE) provides information on health interventions that might be suitable candidates for withdrawal. However, this remains only a relatively peripheral activity and much less guidance exists on how such do-not-do lists might be put into practice. Australia is just about to introduce its own version of the Choosing Wisely Program⁴ which uses evidence based practice to identify disinvestment opportunities for value procedures. Whilst disinvesting in low value procedures is important, there is recognition in the UK that this alone will not provide all the efficiency savings needed. Health Technology Reassessment⁵ combined with well-resourced change management processes⁶ are likely to be important ingredients for future practice.

At local levels in English health care, disinvestment is very much bound up in the role of Clinical Commissioning Groups, many of whom are now embarking on relatively ambitious disinvestment programmes as a response to chronic funding shortages, although it is too soon to draw any firm conclusions about

¹ Include Mitton et al reference

² <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3846380/>

³ Daniels N, Sabin J.E Limits to Health Care: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurers. *Philosophy and Public Affairs* 1997; **26**(4):303-502

⁴ <https://www.mja.com.au/insight/2014/34/richard-king-what-not-do>

⁵ <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8693000&fileId=S0266462312000438>

⁶ <http://www.implementationscience.com/content/9/1/123>

these.⁷ At the national level 'NHS England' is responsible for specialist services, and again is seeking to respond to budgetary pressures via service re-organisation. Clearly, the nature of the challenge facing these bodies will vary according to the scale and ambition of any planned changes, and the level of political resistance and system upheaval. These considerations notwithstanding, it seems likely that the earlier experience of UK local government authorities in disinvesting in obsolete models of social care will offer some important lessons and good practice models.⁸ The emergent themes around disinvestment activity across local government authorities include: the need for strong leadership and wider stakeholder engagement and support (especially the need to involve clinician and practitioners); the importance of a strong evidence base and rationale around the need for change and a clear explicit, transparent decision making processes with strong project management. Disinvestment is an emotive activity that needs to be cast as a programme of change, with a shared commitment to both the disinvestment decision and subsequent implementation.

In Canada

Unbeknownst to many international observers, Canada actually does not have a single national health care system but rather has 10 Provincial and 3 Territorial systems that function largely independently. As such, the concept of 'postcode rationing', particularly with respect to high cost drugs, is alive and well in Canada. That said, most provinces have organized themselves through geographically oriented regional health authorities, which both commission and provide services across the full continuum of care and are governed by a single board of directors. A recent national survey indicated that only about 50% of these organizations have a formal priority setting and resource allocation process in place⁹, which should be seriously concerning for many reasons including the fact that in most cases health expenditure accounts for up to 45% of the provincial budget.

For those entities that do have a formal structure and process in place for priority setting, the most common approach is PBMA with the A4R ethical conditions built in.¹⁰ A multi-criteria decision analysis (MCDA) approach to benefit measurement is commonly employed. While PBMA has traditionally been used as an explicit means of re-allocating resources, due to the challenging fiscal environment, disinvestment has very much been part of the game the last few years. In these organizations we have seen disinvestments ranging from a few hundred thousand dollars in more micro programmatic activity right up to \$50M or more within a given budget cycle at an organization-wide level. Keys to success have been around strong leadership (i.e., a political imperative followed by clear action), engagement of clinical champions (who often can identify opportunities for disinvestment), and application of rigorous decision criteria to enable relative value assessment across disparate program

⁷ <http://hsr.sagepub.com/content/early/2014/12/22/1355819614564813.full>

⁸ <http://onlinelibrary.wiley.com/doi/10.1111/hsc.12046/abstract>

⁹ <http://www.biomedcentral.com/1472-6963/13/247>

¹⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1382553/>

areas.¹¹

So what for Australia - the introduction of the choosing wisely program and review of the MBS is an encouraging start however, this alone will not bring about the efficiencies needed and disinvestment needs to be part of wider system reform. The lessons and advancements in other countries such as UK and Canada are useful starting points – but the differences in context need to be considered. The new Primary Health Networks, as commissioning organisations, could look to develop and change service provision which should include service redesign and disinvestment. However, as experience from UK and Canada demonstrates this cannot be in isolation and needs to be part of a wider change program, that includes both health service (secondary care) and primary care representation and involves clinicians and practitioners, especially those who will be impacted or implementing decisions. It also needs to involve the wider community including patients and consumers. Whilst the economic challenge continues to pressure Governments to ‘cut services’ it is crucial that any disinvestment decisions that are taken are influenced by what constitutes best practice and service redesign puts the patient at the heart. As other countries demonstrate taking a more explicit approach to priority setting and disinvestment that includes relevant stakeholder groups can lead to successful service redesign and disinvestment activity.

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¹¹ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961627/>