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Approaches to appropriate care delivery from a policy perspective: A case study of Australia, England and Switzerland

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ABSTRACT

Background: Appropriateness is a conceptual way for health systems to balance Triple Aim priorities for improving population health, containing per capita cost, and improving the patient experience of care. Comparing system approaches to appropriate care delivery can help health systems establish priorities and facilitate appropriate care practices.
Methods: We conceptualized system appropriateness by identifying policies that aim to achieve the Triple Aim and their consequent trade-offs for financing, clinical practice, and the individual patient. We used secondary data sources to compare the appropriate care approaches of Australia, England, and Switzerland according to financial, clinical, and individual appropriateness policies.
Findings: Health system approaches to appropriate care delivery varied. England prioritizes public health, equity and efficiency at the expense of individual choice, while Switzerland focuses on individual patient preferences, but has higher per capita and out of pocket costs. Australia provides equity in public care access and private health care options that allows for more patient choice, with health care costs falling between the two.
Conclusions: Integrating the Triple Aim into health system design and policy can facilitate appropriate care delivery at the system, clinical, and individual levels. Approaches will vary and require countries to negotiate and justify priorities and trade-offs within the context of thehealth system.

1. Introduction

Health systems globally face challenges of under-provision and over-provision of health care services that undermine population health and health system sustainability [1–6]. Many health care systems have attempted to address these challenges by focusing their efforts on delivering appropriate health care. Appropriateness has been conceptualized at the health system level as a health care quality indicator by the OECD [7], a safety and quality health care goal in Australia [8], and as a legal criterion for health care coverage in Switzerland [9]. Behind the concept of appropriateness lies a multitude of ethical choices, culturally determined prioritizations, clinical uncertainties, and perspectives. Care may be clinically appropriate, designed to deliver evidence-based care; financially appropriate, defined according to cost-effectiveness and affordability; and/or individually appropriate, tailored to meet the needs and preferences of individual patients.

Abbreviations: $, US dollar; $AU, Australian dollar; £, British pound sterling; ACSQHC, Australian Commission on Safety and Quality in Health Care; ANQ, The National Association for Quality Development; CHF, Swiss Franc; DRG, Diagnosis related groups; FFS, Fee for service; GDP, Gross Domestic Product; GP, General Practitioner; HTA, Health Technology Assessment; MBS, Medicare Benefits Schedule; MSAC, Medical Services Advisory Committee; NICE, National Institute for Health and Care Excellence; NHS, National Health Service; OECD, Organization for Economic Co-operation and Development; OOP, Out of pocket; PBS, Pharmaceutical Benefits Schedule; PPP, Purchasing power parity; QALY, Quality Adjusted Life Year; QOF, Quality Outcomes Framework; SAS, Swiss Accreditation Service; SDM, Shared decision-making; SIGN, Scottish Intercollegiate Guidelines Network; UK, United Kingdom; WHO, World Health Organization.

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1.1. Defining appropriate care

Many attempts have been made to conceptualize and measure appropriateness [10–15], however, it still remains a patchwork concept with no universal definition [12]. A review by Sanmartin et al. (2008) found that most current conceptualizations of appropriateness focus on clinical effectiveness guidelines, namely benefit-harm ratios for the average patient, (e.g., timeliness metrics for administering aspirin to patients at the emergency department with suspected myocardial infarction) [11,12,16]. However, qualitative studies in the Netherlands and England have found that physicians believe that appropriate care delivery is an interpretive process that must be tailored to each individual patient's needs and preferences, and therefore, cannot be limited to care prescribed by clear-cut guidelines [17,18]. Furthermore, rising health care costs since the 1980s have driven many providers and policy makers to include health care utilization and cost-effectiveness as factors for appropriateness [19,20].

The US Institute for Health Care Improvement's Triple Aim of health system performance incorporates clinical, individual, and financial aspects of appropriateness by promoting population health and enhanced patient experience, and aiming to curb per capita costs of care [21]. Striking this balance requires health systems to navigate a complex matrix of competing interests in a way that is culturally and socio-politically relevant. In this paper we illustrate how the Australian, English and Swiss health systems define and facilitate financially, clinically, and individually appropriate health care.

2. Materials and methods

2.1. Defining and conceptualizing appropriateness at the systems level

Building on these integrative concepts of population health, patient experience, and curbing health care costs, this paper provides a working definition of system appropriateness as health care that integrates clinical, financial, and individual perspectives of appropriate care to achieve the Triple Aim in a reasonable way that is acceptable to the population. We argue that providing appropriate care at the health system level will require identifying policy goals and priorities and weighing relative trade-offs that are inevitable in resource constrained systems. The perspectives and respective policy goals are adapted from Sanmartin et al.'s (2008) perspectives of appropriateness that include financial appropriateness that focuses on allocating health care resources in a just way, clinical appropriateness that focuses on delivering clinically effective care, and individual appropriateness that focuses on responding to individual needs and preferences [12] (Fig. 1).

2.2. Comparing health system approaches to appropriate care

We compared Australia, England, and Switzerland's national approaches to implementing appropriate care using secondary sources, peer-reviewed articles, and gray literature, including data and reports from national health systems and international organizations. We distinguish England from the United Kingdom (UK) since countries within the UK have different health care approaches; however OECD statistics are only available at the UK aggregate level. These health systems were selected because they are industrialized nations that provide universal coverage, but differ in how they manage, finance, and allocate health care. We summarized how the case countries balance policy priorities and discussed the implications of these approaches for countries that are currently defining and improving appropriate care strategies within their own health systems.

3. Results

3.1. Assessing Triple Aim indicators

The Australian, English, and Swiss health systems provide universal coverage to their citizens and have overall high population health outcomes (Table 1). However, each country faces its own challenges for population health and equity, such as disparities in rural and urban health care access and in indigenous and non-indigenous health outcomes in Australia [24], health care utilization variations between cantons in Switzerland, and lower OECD reported perceptions of good health in the UK compared to the other two countries (Table 1).

Switzerland has the highest overall costs of the three, spending 11 percent of its GDP on health care in 2012 compared with Australia and the UK that spent slightly less than the OECD average at 8.8 percent and 8.5 percent, respectively (Table 1). Switzerland also has higher per capita out-of-pocket costs than Australia and the UK; however, a low average annual growth rate of health care costs indicates that it has been successful at curbing health care spending (Table 1).

Patient experiences of care also vary by country (Table 1). According to OECD surveys, patients reported issues with timely access to specialty appointments in Australia (18% versus 7% in the UK and 3% in Switzerland) and access barriers due to cost in Australia and Switzerland (16% and 13%, respectively versus 4% in the UK) [22]. Overall, approximately half of respondents in Australia and Switzerland and 63 percent of respondents in the UK believed their health system worked well.

3.2. Assessing appropriateness policies

These differences in access, costs, and patient experiences may be explained by different geographic, cultural, and historical factors, but are also impacted by allocation policies that determine access, guideline and quality monitoring practices that guide clinical decision-making, and policies that foster patient involvement in health care decisions.

3.2.1. Financial appropriateness policies

Australia, England, and Switzerland have social health care systems that cover similar health care services, including medically necessary inpatient and outpatient care, and certain pharmaceuticals [23]. However, while England and Australia provide tax-funded health care for the population regardless of individual ability to pay, Switzerland has a regulated, market-based statutory insurance system that requires residents to purchase insurance from competing non-profit insurers. Insurance premiums are regulated, cannot be based on risk, and are subsidized for low-income individuals and families, but are otherwise not based on ability to pay. Australia and Switzerland also have higher rates of optional private health insurance use than England, which provides patients with a wider range of treatment choice largely based on ability to pay [23], although Australia regulates and provides some subsidies for private insurance premiums [24,25].

Social insurance coverage for new health care innovations are determined using cost-effectiveness evaluations by the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee in Australia, the National Institute for Health and Care Excellence (NICE) in England, and the Federal Office of Public Health (FOPH) in Switzerland (Table 2). The PBAC has been a model for economic evaluation for Commonwealth funded drugs since the early 1990s, providing recommendations based on