The science of the COAG Coordinated Care Trials

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Objectives: To explicate the organisational change agenda of the COAG coordinated care trials within the Australian health system and to illuminate the role of science in this process.

Methods and Results: This article briefly outlines the COAG coordinated care trial aims and the effect of the trial as a change initiative in rural South Australia. It is proposed that although the formal trial outcomes are still not clear, the trial had significant impact upon health service delivery in some sites. The trial involved standard research methods with control and intervention groups and with key hypotheses being tested to compare the costs and service utilization profile of intervention and control groups. Formal results indicate that costs were not significantly different between intervention and control groups across all sites, but that the trial, nonetheless, had a powerful impact on the attitude and behaviours of service providers in the rural trial on Eyre Peninsula in particular. Some of the key structural changes now in place are outlined.

Conclusions: The COAG trial has had many and varied impacts upon those organisations and individual providers involved with it. It is argued here that since successive initiatives had been implemented before final evaluation results were published, other agendas were served by the trial apart from those of standard scientific research and hypothesis testing. That is, the main impact of the coordinated care trial in Eyre Region at least has been change by stealth, and not through scientific research and demonstration.

Implications: The COAG trials have set in train a series of structural and procedural changes in the methods of delivery and management of primary health care systems; changes that are embodied in the Enhanced Primary Care packages (EPC) and other initiatives recently introduced by the Commonwealth Government. These changes have occurred and are occurring across the system without formal evidence as to their efficacy, suggesting that other financial motives are driving these new approaches apart from the goal of improving health outcomes for consumers. Also, if science is to be used in this way to drive policy and procedural change ahead of actual outcome evidence, it is important that we examine the more subtle agendas of such research projects in future if the integrity of the scientific method is to be maintained. The occurrence of such phenomena questions the very foundation of scientific endeavour and weakens the application of scientific principles in the arena of social and political science.

Key words: Coordinated Care Trials, Scientific Method, Change Processor

The COAG trials were established to test the principal hypothesis that improved coordination of services for patients with chronic conditions could improve health outcomes for that population within existing resources (COAG principal hypothesis). The concept of “coordination” also carried an implication of fund streamlining; the alignment of all major government funding streams associated with certain patient groups (Commonwealth of Australia, 1999a, p144; Podger, 1999) for management within new operational structures such as those modelled by the Regional Demonstration Unit (RDU) concept initiated by SA HealthPlus. The SA HealthPlus trial, for example, stated its primary hypothesis as:

Coordination of care for people with multiple service needs, where care is assessed through individual care plans and funds are pooled from existing Commonwealth, State and joint programmes, will result in improved individual patient health and well being within existing resource. (Commonwealth of Australia, 1999a)

In the Eyre Peninsula, coordinated care trials around 1350 intervention patients with chronic and complex conditions and 500 matched control patients were enrolled. The Eyre RDU was established to manage the government health service resources normally allocated to those enrolled patients, and to deliver a more coordinated and integrated package of essential services designed to prevent hospital admissions and other
health-related crises. The RDU employed registered nurses, in the main, as local service coordinators to support defined groups of patients, funded best practice service provision through GP surgeries, and organised rehabilitation and education programs for patients.

Principally, the trial managers postulated that by tracking all costs and health service utilisation of the intervention group against a matched control group, it would be possible to determine the extent to which health crises, and hence health expenditure, could be reduced through improved coordination and more detailed service management. A financial value was placed upon “saved admissions” and prevented “health crises”, which, if all resources were pooled for the enrolled cohort, could amount to savings sufficient at least to fund the extra coordination and service provision required to manage chronically ill patients better.

Improved primary care, it was conjectured in the trial hypotheses, might also reduce the growth in demand in the acute sector by preventing progression of complications in relation to chronic illness and result in improved quality of life for consumers of health services. This would enable a much more efficient use of national resources than would the building of new hospitals to meet burgeoning and unchecked growth in acute demand, much of which is deemed to be avoidable if programs could be established to support preventive approaches to population health care.

Others, however, argue (Bindman, 1995; Callahan, 1998, p98; Chernow, Hirth, Seema, Ernann, & Fendrick, 1998; Katz, Mazhari, Kalus, & Nawaz, 1999; Leutz, 1999, p89; Weinberger, Oddone, & Henderson, 1996) that such savings and efficiencies are short-term phenomena unable to deliver sustainable cost reductions, and that it was by no means clear that such interventions could be both beneficial to patients as well as of financial value to the health system generally. The success of such ventures also depended upon extraordinary levels of cooperation between hitherto separate and often competing interests within the health care system.

GPs, understandably, were sceptical about the COAG trials when they were introduced. They saw the proposed model as being indicative of an inexorable drift towards managed care, fund-holding and GP-based risk management, all of which could result in changes to the working conditions of GPs and to their potential incomes (Commonwealth of Australia, 1999b, p50); the end of the world as we have known it! Most therefore only became involved peripherally in the trials on the understanding that their income would not be reduced as a result of their participation. The same sentiment pervades current and tentative endeavours by Divisions of General Practice to become partial fund-holders of primary care resources because the AMA remains “vigorously opposed to any notion of fund-holding” (Australian Doctor, 2001). Also, there is ideological opposition from some health professionals to more recent chronic illness self-management ventures sponsored by the Commonwealth Government and this trend has been reported in other countries (Heidelberg, 2002).

With the advent of the new Enhanced Primary Care (EPC) packages and Medical Benefits Schedule (MBS) health assessment and care planning options for GPs, the Commonwealth has implemented further reforms across the health system. It offered new funds for planned and coordinated GP services even before the evaluation reports from the first trials were finalised. Clearly this “up front” funding for health assessments and care planning, which is modelled on the Coordinated Care Trials, is being offered in the belief that such approaches to care will ultimately reduce demand for other MBS item services and change the pattern of GP service provision.

This assumes that the MBS pool for GP services overall will not increase, although this may not be the case in rural communities where GPs could shift activity to primary health teams and still maintain routine MBS services because of current levels of un-met demand for GP services. This appears to be a strategy for altering the conditions of payment to GPs for primary services and introducing much more prescriptive structures for the provision of those services. At the same time, however, this strategy could also exert pressure on the state-funded primary care system to provide additional services through collaboration with GPs to meet new care plan framework demands. The care planning processes will also increase pressure on state-funded community and allied health services to provide more primary care services and programs as detailed on patient care plans. The question remains though, who will pay the additional costs associated with change and in
whose interests is this change to function? In the final analysis, is the change worth the investment (Frenkel, 1999, p166)?

In addition, these developments also exert pressure upon the state-funded acute sector to shift resources from this area in the belief that improved primary care services provided in partnership with GPs will reduce demand for hospital services. In accepting the conditions of the new EPC packages and the next Coordinated Care Trials, GPs and state-funded primary care services are accepting an as yet unproven hypothesis that not only is Coordinated Care a good method for improving health outcomes, but that it is sustainable and affordable. It being affordable is contingent upon the state being able to shift resources from the acute sector permanently to the primary care sector by reducing the rate of increase in demand for and cost of hospital services. If this cannot be achieved, we will be faced with sustaining current per capita expenditure in the acute sector at the same time as increasing primary care funding; a situation that can only increase total health sector spending, not reduce or bring stability to it.

Alternatively, the state will need to find new and additional resources to fund the improved and more coordinated primary care systems being encouraged by Commonwealth investment in early intervention and prevention. This does not imply an absolute and immediate reduction in acute services, but rather a gradual shift in emphasis over time away from the currently expanding acute care sector demand and towards primary intervention. It is postulated that coordinated care could result in a flattening of the gradient of acute sector demand and spending, and enable an increase in the gradient of primary care provision while the overall spending growth remains quite stable.

However, as demonstrated by the SA HealthPlus trials in South Australia, there are many and varied forces at play in the current climate to prevent such substitution of resources. The task is not an easy one, although SA HealthPlus has demonstrated that it is possible to moderate demand in a sample population while maintaining health outcomes (Centre for Health Care Evaluation [CHCE], 2000). If the sample population were to be increased significantly, a relative reduction in demand might be achieved in hospitals, based on an increase in primary care activity to sustain lowered rates of acute demand. In such a situation, economies of scale within hospitals, together with the avoidance of “backfilling” of hospital beds through other demand, might ensure that hospital outcomes could be maintained without the need for increased resource allocations to this sector.

Similar trends have been noted in other countries, as the demand for hospital services appears to be outstripping the ability of governments to fund this demand. Assuming that Australia, like the New Zealand or the Czech republic, for example, (Krupinski, 1999, p15) will support only moderate growth in the private sector insurance system to take up this increasing demand, strategies will need to be developed to manage acute sector demand.

The participation of GPs and health units in the Coordinated Care process has led, progressively, to an increasing demand for primary care and allied health services. It may also lead to a further shifting of funding responsibility from the Commonwealth to the states for health care generally as GPs seek substituted funding directly from health units to subsidise and support their hitherto MBS-funded activity. A similar impact may also be felt in the private health sector where the direct cost of GP services will increase if the Commonwealth is able to convince more Australians to insure privately for such services or to offer gap insurance with the introduction of new item numbers.

However, these strategies for change are running ahead and independent of the evidence from the formal trials, suggesting again that the trials were not really about testing new processes scientifically, but rather about introducing new policies in the guise of science. The agenda appears to be more about change by stealth than about scientific demonstration and logical development of more effective processes for managing care and improving health outcomes (Harvey, 2001).

There is little doubt that the trials are an effective strategy for creating a culture of change, but as Leutz (1999) notes, this change culture costs money before it returns benefits, if indeed it ever does so. Given that new coordinated care initiatives proceeded even before the final evaluation of the initial round of trials was completed, and accepting that the new EPC packages may result in the burden...
of this coordination being carried by GPs and state health units, what might be concluded about the aim of the COAG trials?

This recent chain of events in the implementation of coordinated care type initiatives without adequate scientific evaluation and verification suggests that the agenda for change has been set more by political and economic imperatives than by demonstrated health outcomes. That is, one component of the coordinated care thesis has driven these changes; that component that speaks of “no additional cost” while the other, the improved health outcome component, has been less important in the equation.

It appears that scientific method and analysis has been used as a Trojan horse to enter under the guard of health professionals and to promote the single agenda of introducing new management and funding structures to cap, manage or reduce the overall cost of per capita health care services. The science being done in the guise of a formal trial has enabled a range of new funding and service management processes to establish a foothold in the fabric of the health system as “best practice” even before the efficacy of this practice has been demonstrated.

New coordinated care processes may well result in better management of chronic illness and improved health outcomes for consumers, but this is yet to be conclusively demonstrated in the Australian context. Certainly Chronic Disease Self Management (CDSM) programs, based on the work of Lorig and Fries and which followed the first round of coordinated care trials, have been shown in the US to improve patient quality of life and reduce service utilisation (Fries et al., 1993; Fries, 2000; Fries et al., 1994; Fries, 1997; Lorig, Mazonson, & Holman, 1993; Lorig et al., 1999). Evolving work in Australia may continue this trend and lead to improved accountability for outcomes across the system, but to date many systems changes in Australia have simply been introduced by stealth, not through replicable scientific process.

Resource substitution may now have a more “outcome focus” and be designed to achieve improved health outcomes, but we need to quantify and validate the actual impact of these new structures. If the public sector is going to manage health funds as a whole, waste or inefficiency cannot be allowed to constrain the capacity of the whole system to achieve desired population health outcomes. We do need, however, much more evidence of the actual impact that these new management strategies are having on population health outcomes and patterns of health service provision in order to determine which approaches are most effective and therefore most likely to be sustainable.

In this evolving system, however, is the wellbeing of patients a high priority? Will this government-controlled demand management, which is ultimately aimed at rationalising resources for the public good, achieve better outcomes for all concerned? Ultimately, we need to know objectively if there is really any substantial evidence that the new management mechanisms being implemented actually produce improved health outcomes for patients, as well as business and financial outcomes for funders and providers of health services.

Finally, this recent series of events prompts important questions about the independence of science in the processes of leading and testing new initiatives that may ultimately change the way we live and work. Is science the handmaiden of social and political change or is it an independent arbiter in the change process? If science is to be used as a tool to introduce change, as appears to be the case in the COAG venture, this process may threaten the very premises of scientific endeavour (Popper, 1969) and weaken its application to the tasks of social and political reform in Australia.

References


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