

Moving from hospitals to primary care for chronic diseases

KDI Seminar

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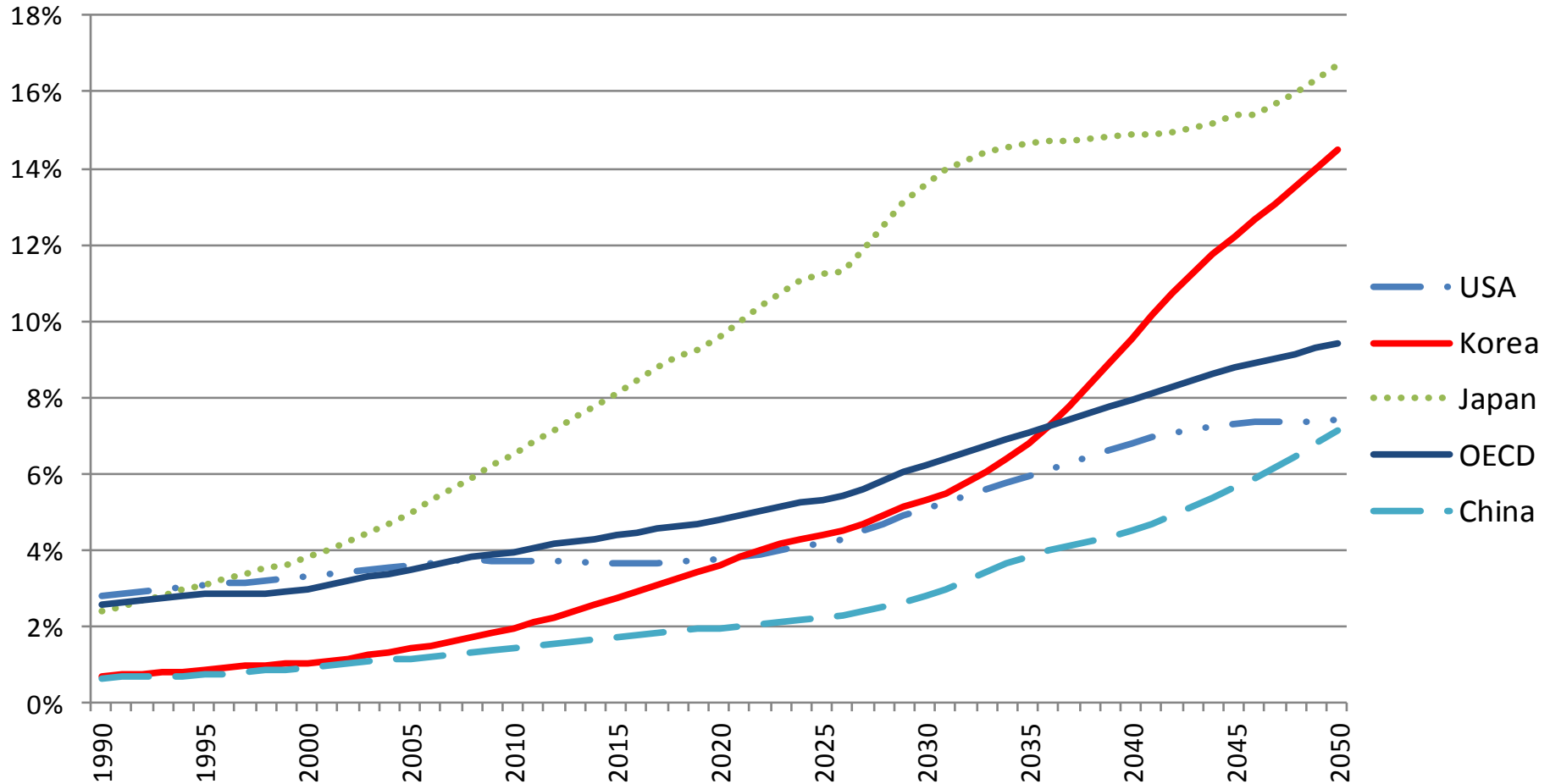
5th February 2013

In short

1. Health spending is growing quickly, the problem is it isn't going to the right places
2. Specialists dominate health care service delivery and deliver too much specialist care
3. Korea should scale up primary care clinics and locate multiple private specialists there
4. Primary needs more funding and smarter payments to play a greater role in improving social cohesion

A population ageing faster than most

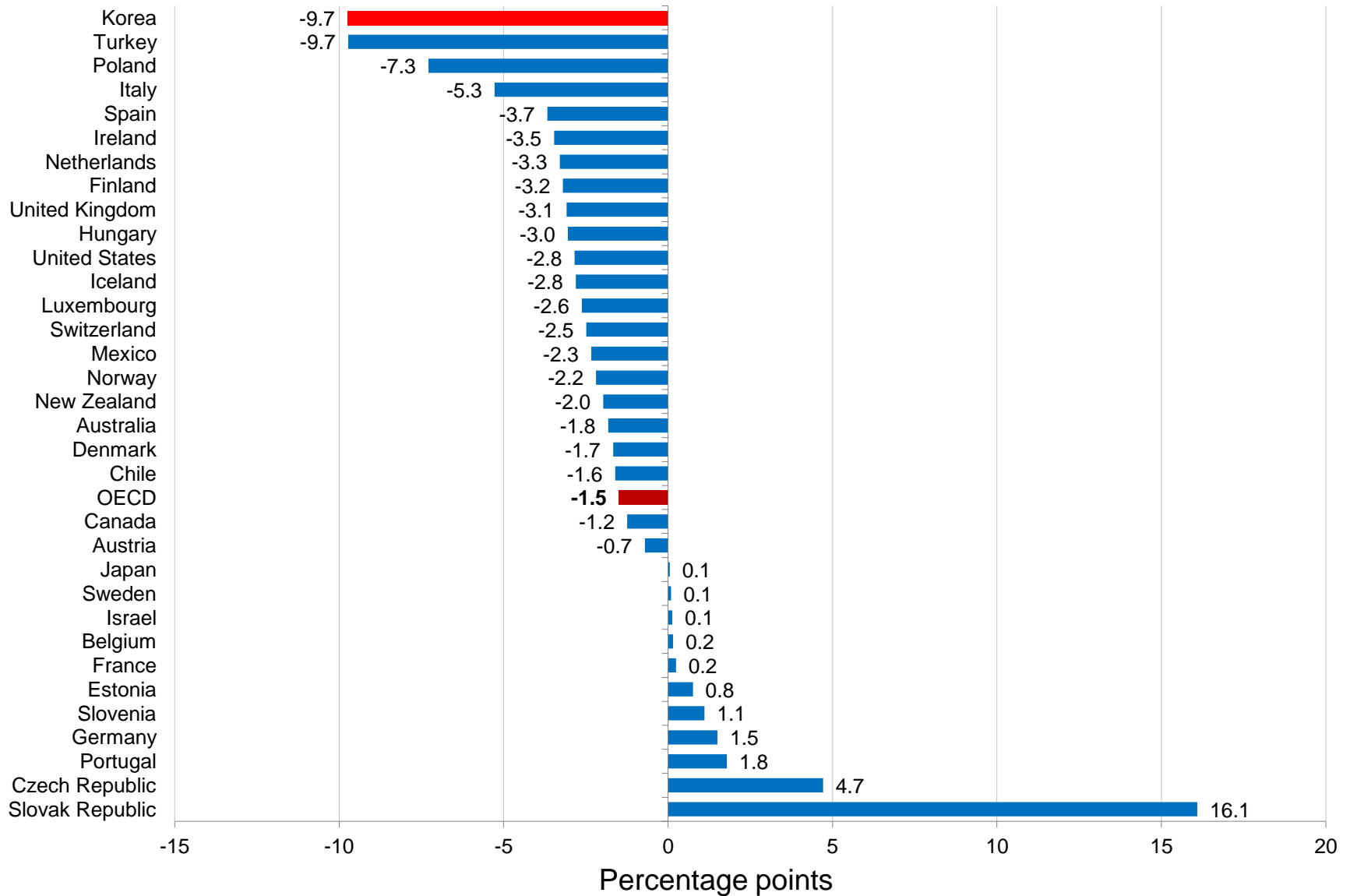
The share of the population aged over 80 years old will increase rapidly



Source: OECD Labour Force and Demographic Database, 2010.

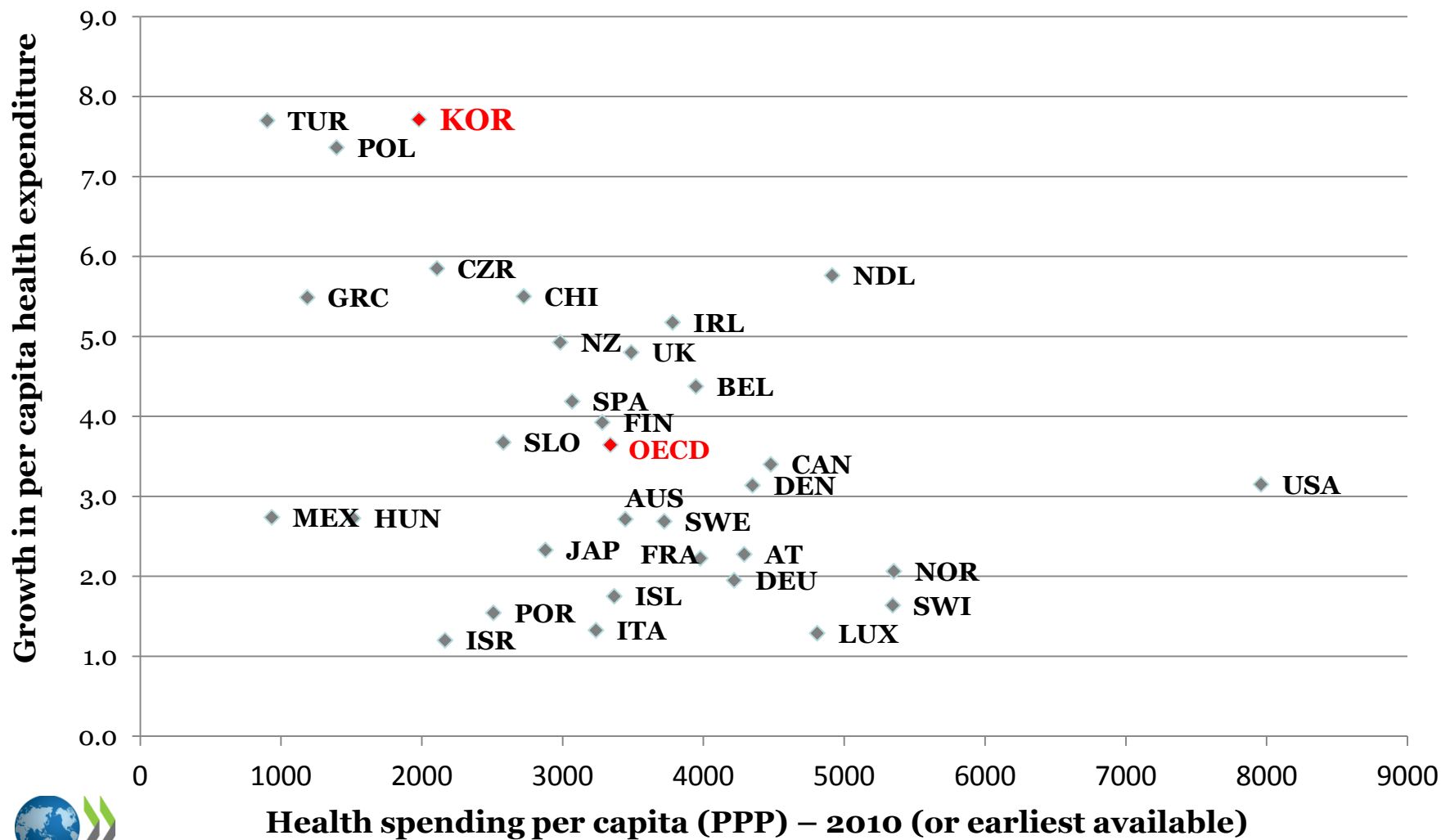
Integration to a single insurer helped improve equity

Change in out-of-pocket spending as a share of current expenditure on health, 2000-09 (or nearest)



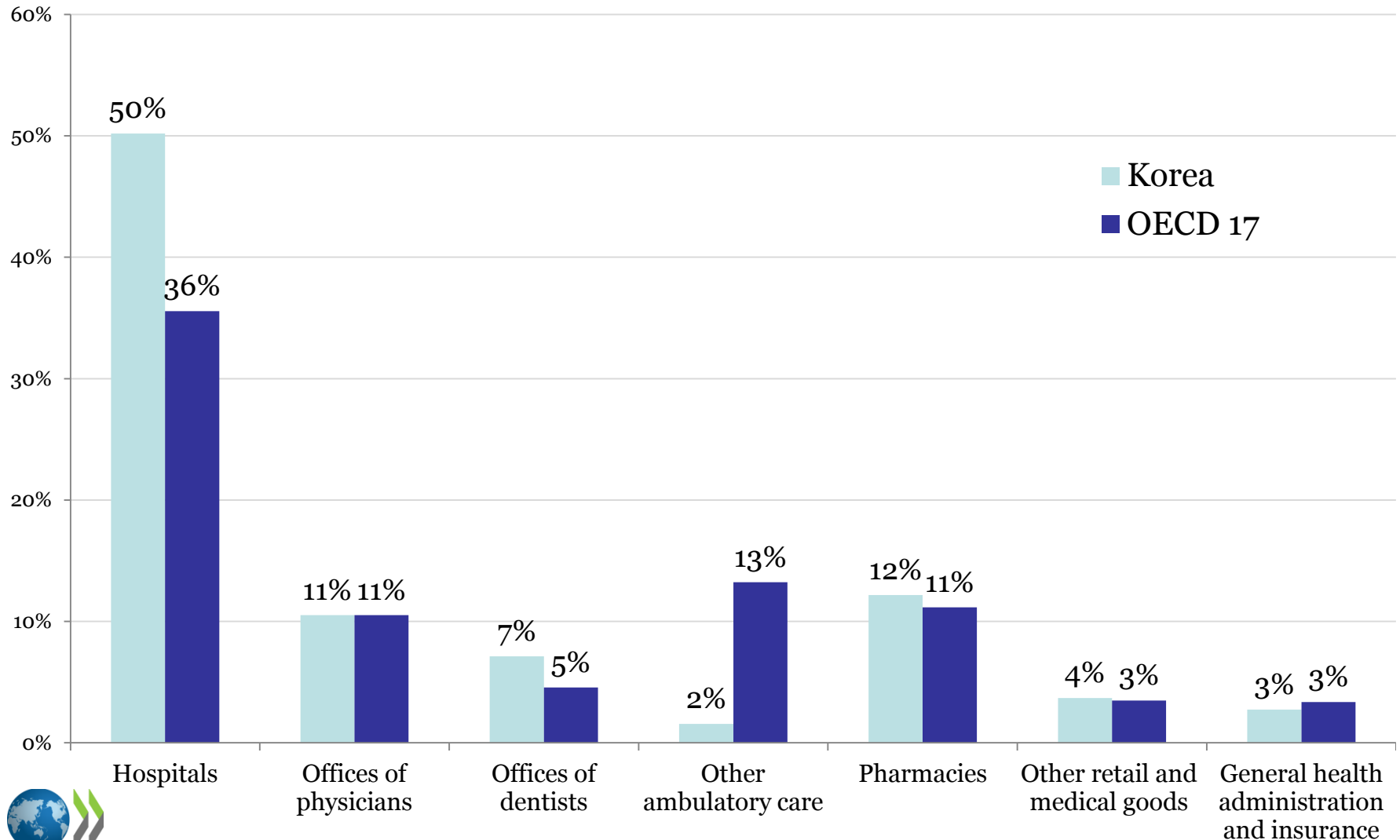
Rapidly rising spending, but from lower levels

Health expenditure per capita across OECD countries and growth in per capita health expenditure (2002 – 2009)



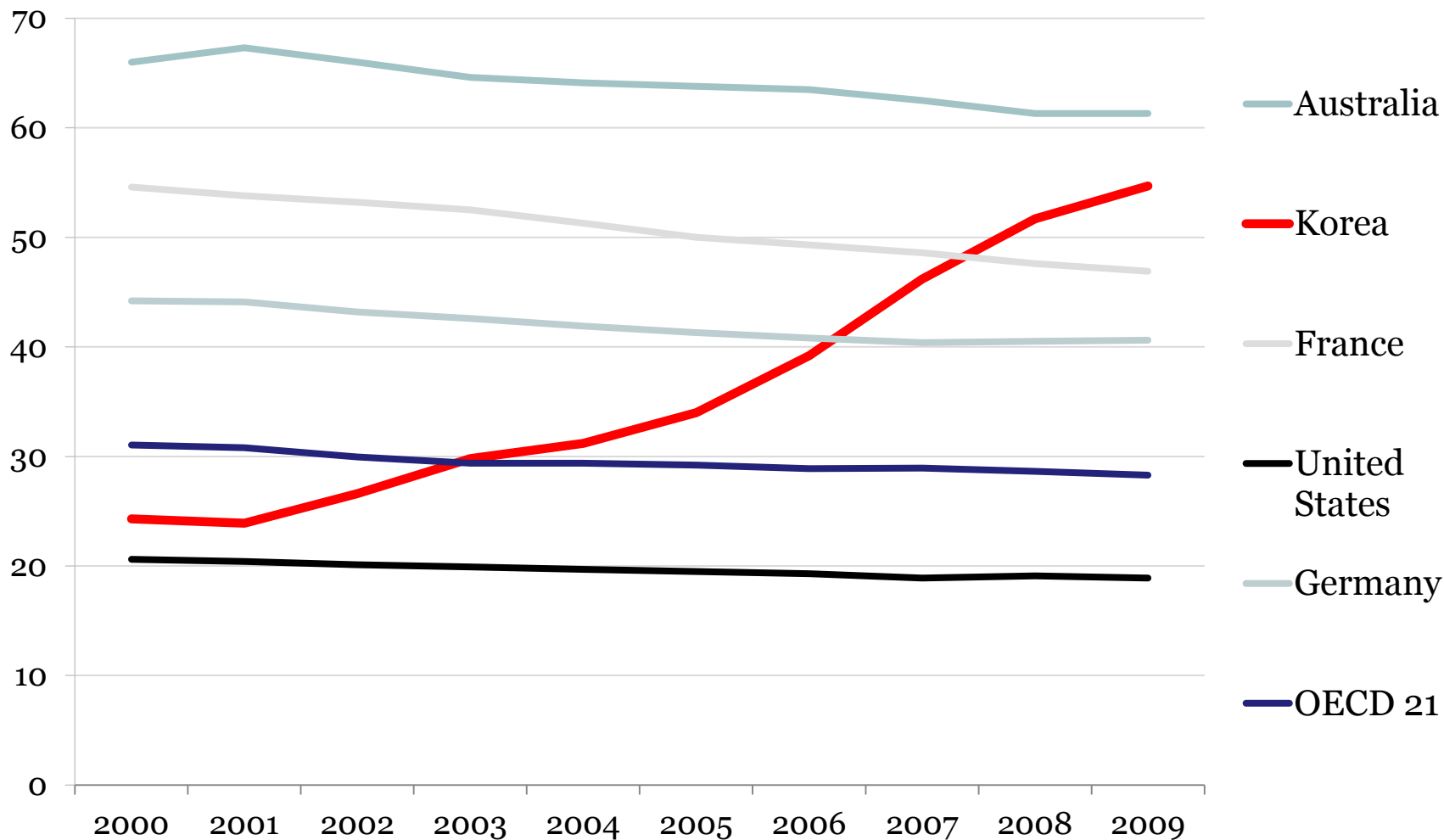
Hospitals are driving spending...

Major contributors to growth in health spending per capita (2004 – 2009)



...dominating health service delivery...

Hospitals per million persons, 2000 - 2009



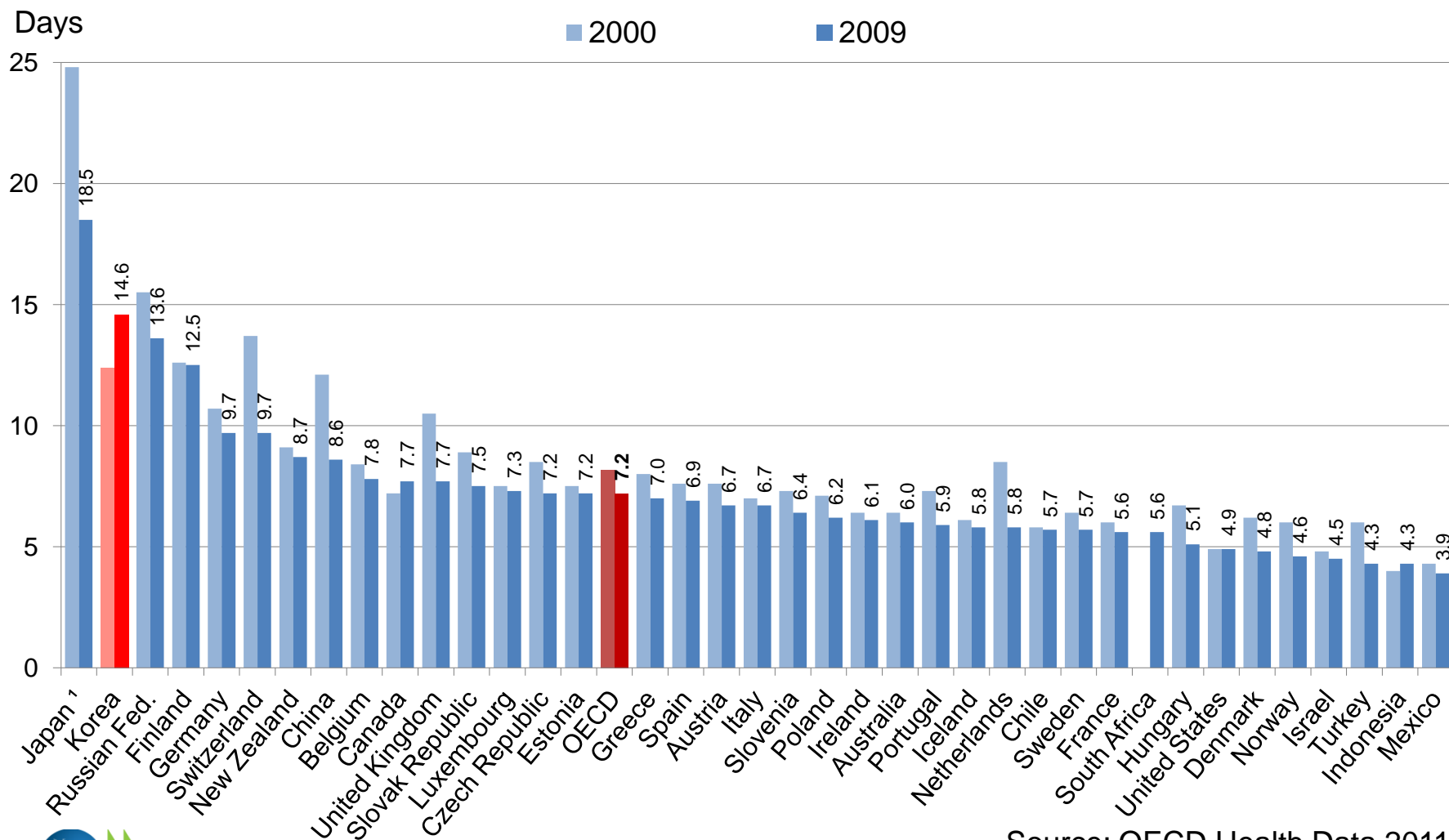
...and too many are small

	Tertiary hospitals	General hospitals	Hospitals	Clinics
2006	43	253	1 322	25 789
2007	43	261	1 639	26 141
2008	43	269	1 883	26 528
2009	44	269	2 039	27 027
2010	44	274	2 182	27 469

Source: HIRA

Longer stays than other OECD countries

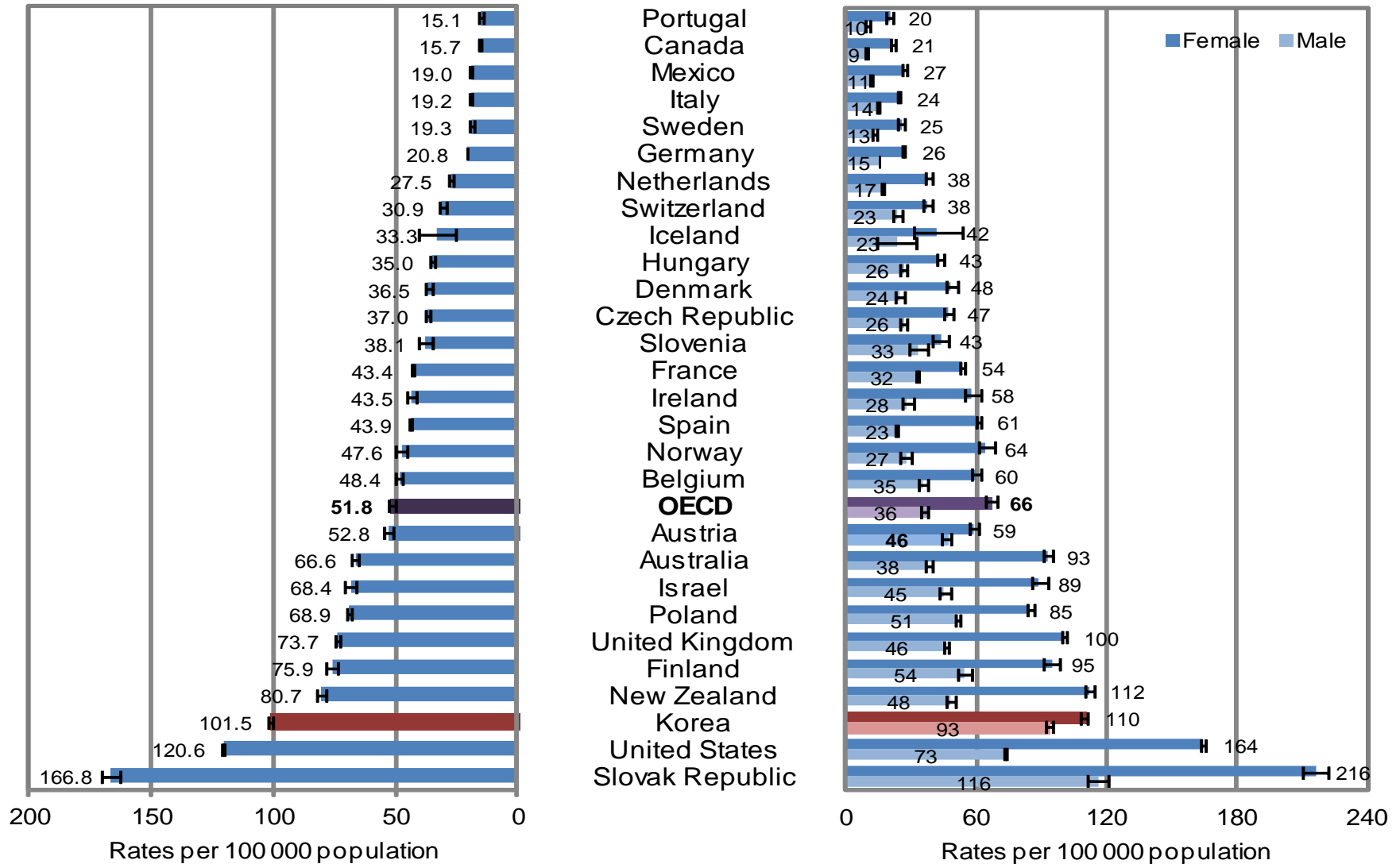
Average length of stay in hospital for all causes, 2000 and 2009 (or nearest year)



Source: OECD Health Data 2011

Admissions rates for key chronic diseases are too high

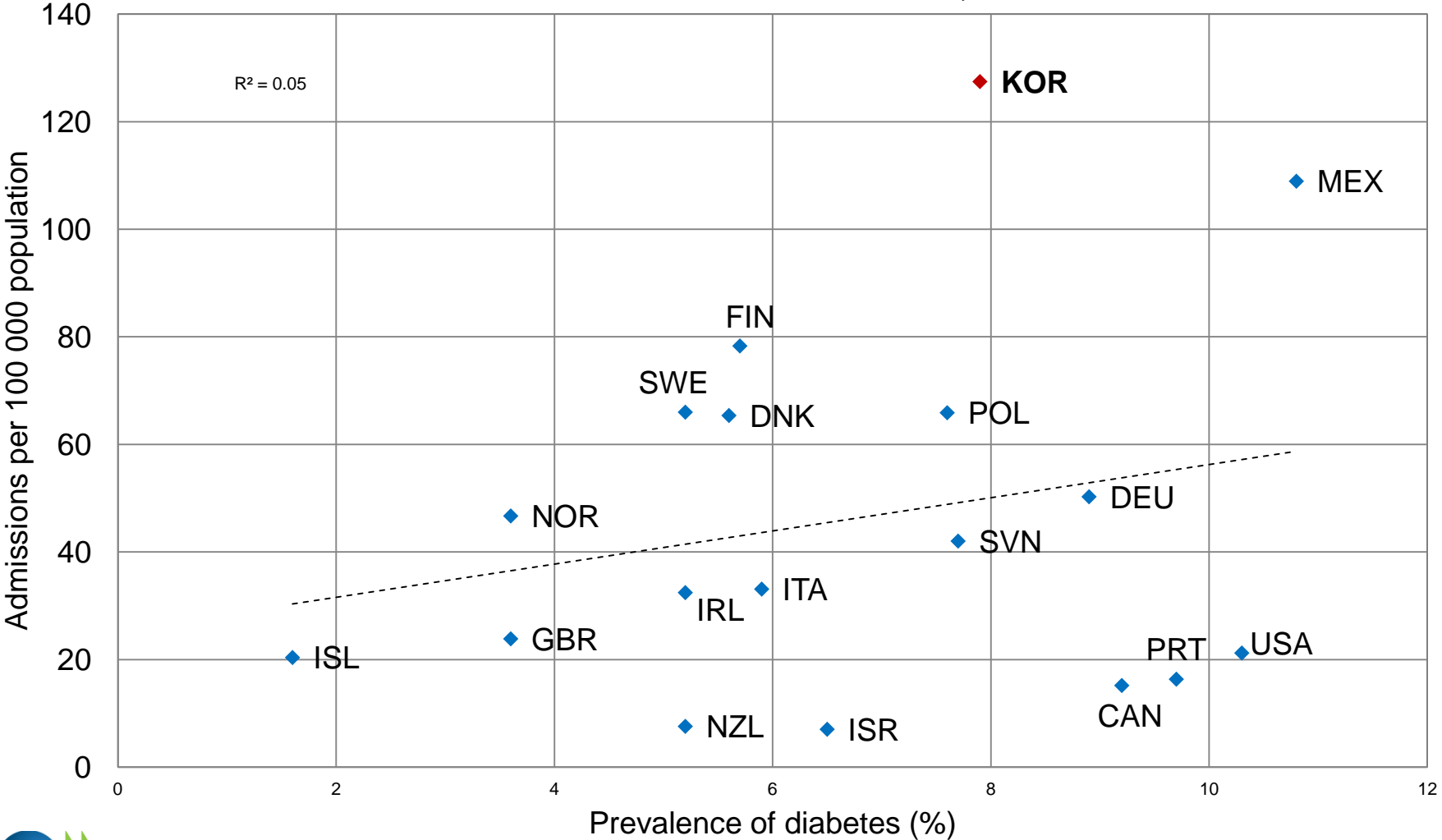
Asthma hospital admission rates, population aged 15 and over, 2009 (or nearest year)



Source: OECD Health Data 2011

Diabetes admissions higher than countries with similar prevalence

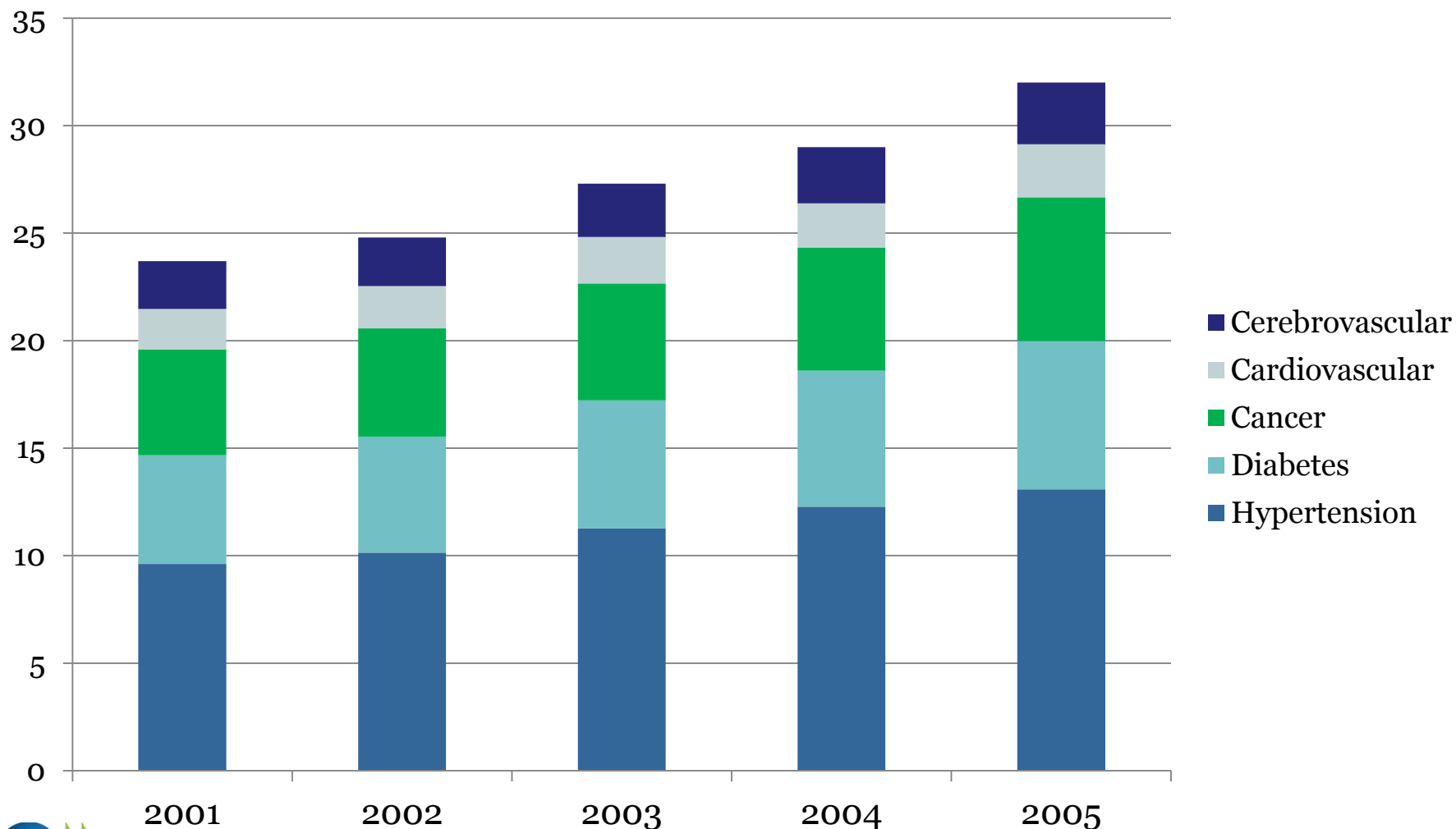
Uncontrolled diabetes hospital admission rates and prevalence of diabetes across OECD countries, 2009



Source: International Diabetes Foundation (2009) for prevalence estimates; OECD Health Data 2011 for hospital admission rates.

Costs from chronic diseases are climbing

Proportion of NHI medical expenses accounted for by chronic disease, by category



The challenge of better primary care

- Establishing stronger primary care in Korea will be a major challenge, as today:
 - Gate-keeping is weak
 - A culture of seeking hospital care is entrenched
 - Primary care professionals are in short supply
 - Lack of physical infrastructure and ‘intellectual’ support
 - Fees for basic primary care are very low
- A single insurer is a good tool, but is not actively focused on developing primary care

A specialist dominated workforce

Specialty	2009	
	No	(%)
General medicine	9,179	28
Internal medicine	4,505	14
Orthopedics	2,057	6
Obstetrics & gynecology	2,484	8
Pediatrics	2,601	8
ENT	2,284	7
Family medicine	777	2

What is primary care?

- Primary care would:
 - Be a first point of contact
 - Offer health promotion and disease prevention advice
 - Deliver public health services such as vaccinations
 - Diagnose common health problems like hypertension and depression
 - Refer and coordinate health care for patients — managing their journey through the health system
 - Use outreach services to reach the disadvantaged

Converging models of primary care?

- OECD countries have been moving to larger clinics with multi-speciality teams, for example:
 - UK: GPs lead (and may specialise) along with nurses and allied health professionals
 - US: Paediatricians, Internal medicine, obstetrics and gynaecology (etc) specialists lead, supported by nurses and allied health professionals

Specialists in solo practices are inefficient

Solo and Group practice amongst clinics in Korea (2010)

	Solo practice		Group practice	Total
	Private	Incorporated		
Number	24,792	629	1,606	27,027
(%)	91.70%	2.30%	5.90%	100%

Source: HIRA

A 'uniquely Korean' model?

1. Develop multi-speciality group practices staffed by private professionals
2. Provide targeted government investment to house multi-speciality clinics
3. Provide these clinics with increased funding to undertake preventative services, counselling, management and outreach to the poor

Good things to do

1. Increase payments for preventative services, patient counselling and management of chronic health care conditions
2. Expand medical education of doctors and nurses in primary care
3. Link clinical guidelines to reimbursement, strengthen professional societies and provide better access to information for patient self-management
4. Primary care ought to coordinate with other social services – education, employment and social protection – to improve social cohesion

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