Trinity College Dublin
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Multi-morbidity, Complexity and End of Life Care:

Challenges for financing and delivery of care.

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Outline of Presentation

- The unimportance of the unexpected
- Demographic change is interesting
- Why focus on end of life care?
- What do people want?
- Rationing without barriers
- Implications for funding and delivery of care.

The Unimportance of the Unexpected

- Care needs, (similar to room service), are complex, varied and individual, but overwhelmingly predictable
- We should be surprised by who needs but not how many need
- Rationing by price, insurance status or by waiting should be largely unnecessary since volume of needs to be met are known.

Demographic change is interesting

Life Expectancy at 65 Canada

	1997-99	2007-09	Gap
Men	16.3	20.1	3.8
Women	18.5	21.6	3.1

Source: Statistics Canada

- In 10 years the gap narrowed by 8.4 months
- The absolute number of single elderly households is falling in most developed countries
- Roles of formal and informal carers are changing.

Why focus on end of life care?

- Provides lens on common issues and problems
- No second chance: system only gets it wrong once
- People die of disease(s) and with diseases
- Decision making near the end of life has to confront complexity
- End of life care involves and affects other parties strongly
- Costs of care are concentrated in last year and especially last 3 months.

What do people want? 1

- Process as well as content, but sometimes mainly process – how services are delivered can be key
- Availability (even if not used) - very easy access with no hassle to patient or family
- Minimising burden on family – care time commitment of families is largely fixed, and should be used for what they alone can do.

What do people want? 2

- Prepayment – no worrying about paying at time of service use – timing of payment more important than level of payment
- Participation in making choices
- Expert help in making choices (even in US)
- ‘It’s bad enough to be dying without all this nonsense!’

Rationing without barriers 1

- Rationing by delay destroys its product
- Rationing by hassle and confusion is hated
- Free at point of use is highly valued, rationing by price is hated
- Rationing is easier when most important services are available
- Current benefit and utility metrics are of limited use in complex cases.

Rationing without barriers 2

- Some capacity can be released by not doing inappropriate things
- Care protocols and pathways can help, but currently tend to be too disease specific
- Brokerage and case management will have roles
- Formal charging and insurance systems are largely pointless.

Implications for funding and delivery of care 1

- Funding system needs to be simple, with strong pre-payment – we might name this taxation
- Avoid the distress and transaction costs of pay and reclaim
- ‘Single pipe’ for funding to cover all relevant health and social care services
- Where charges do apply make them easy to pay (sometimes after death) and access should not be contingent on paying.

Implications for funding and delivery of care 2

- Delivery system should have strong hospital and community links
- There need to be strong links across professions, specialisms and provider organisations to manage complexity and multimorbidity
- Provision will need to adapt over time to account for more older people but fewer single older people
- We will need to find ways to value availability as well as use of services.

He's watching and listening

- What exists exists for a reason
- Alternatives that seem too good to be true probably are
- Failed mechanisms probably failed because they were not very good
- Advocates for complex and innovative funding are normally advocating transfers from poor to rich
- Private health insurance, user charges and pay and reclaim systems are increasingly inappropriate
- The fact that something works is not a reason to change it.

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Thank You