Submission to Productivity Commission Human Services Inquiry

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Summary

The Human Services Inquiry is 'examining policy options in the human services sector that incorporate the principles of competition, contestability and informed user choice'. This submission puts the case that such policies have the potential to improve quality, equity, efficiency, and accountability and responsiveness in school education through expanding competition, contestability and informed user choice.

A policy that meets these criteria is the establishment of charter schools or free schools — public schools that are managed by private organisations. Charter and free schools differ from traditional public schools (TPS) in that they are able to operate with more autonomy and are schools of choice (they do not have enrolment zones). Charter and free schools differ from non-government schools because they are fully publicly funded and cannot charge tuition fees.

There are also policy options that can be implemented to achieve improvements in the specified policy outcomes within the existing school sector structures. Reforms to improve sector-neutral school funding and school zoning can drive greater competition, and a concerted effort to open up delivery of non-government and government school services drives greater contestability.

Policy outcomes: Improved quality, equity, efficiency, and accountability and responsiveness

CIS Research Report 6 (RR6) — *Free to Choose Charter Schools* — is attached to this submission. It provides a review of the international research on charter schools and free schools and discusses how such a policy might be implemented in Australia. More information and references for the following points can be found in the report.

Quality

Studies of charter school impacts on reading and maths test scores, compared to traditional public schools, show effects ranging from null and mixed to large (larger than a standard deviation) positive impacts. In almost all cases, impacts were stronger for charter schools with a focus on traditional

instruction methods, frequent testing, and strict discipline and behaviour standards. Some of the strongest impacts in the literature are driven by local areas where these 'no excuses' schools proliferate (RR6: page 11).

Equity

Charter and free schools have shown particular benefits for low-achieving students and for students from disadvantaged backgrounds. (RR6: page 13-14)

Charter and free schools expand school choice to families, especially lower-income families, who cannot afford tuition fees for non-government schools (RR6: page 29).

Efficiency

The evidence on charter schools in the USA and free schools in England is that there is high potential for significant gains in student learning, at the same per student cost as traditional public schools. (RR6: page 33)

Accountability and responsiveness

Charter and free schools are accountable to the authority that provides the charter or contract to operate. The terms of the charter would specify numerous performance criteria (e.g. NAPLAN, attendance) and expectations, including financial transparency. If the charter or free school does not meet the terms of the charter or contract it can be revoked by the issuing authority. (RR6: page 32)

Charter and free schools are schools of choice and are therefore accountable to the parents who choose to enrol their children. Funding for charter and free schools is based on enrolments. If they do not satisfy parents, their funding will decline. (RR6: page 32)

Feasibility

Australia is in the fortunate position of being able to review two decades of charter school research in the US, as well as more recent policy developments in England and New Zealand. Recently published analysis of free school performance in England reflects the US research, showing large gains for students in low achieving and disadvantaged schools. Australia's long and successful experience with non-government schools and school choice makes it well-placed to establish governance arrangements that allow autonomy and flexibility while maintaining stability and quality.

School education policy could have more competition, contestability and user choice

While choice of public and non-government schools is widespread, there is room to expand choice of schools to more families, and increase the diversity of school provision, especially in the public school sector.

CIS Research Report 9 (RR9) — *One School Does Not Fit All* — is attached to this submission. It provides an overview of school provision and governance in Australia. More information and references for the following points are contained in the report.

Competition

As in other markets, competition has the potential to improve the delivery of education services. The strongest international evidence for this comes from Sweden, where sector-neutral funding for schools, portable across local government areas, has driven improvements in Swedish education relative to business-as-usual. The literature on Swedish school reform and student achievement shows that competition had statistically significant positive effects on test scores for all students, not simply the students in 'free schools' — the so-called 'rising tide' phenomenon (See RR6: page 15).

'Competition' in school education in Australia is often considered as being between non-government and government schools by sector rather than between schools. This is because non-government schools can compete on price amongst each other for users willing and able to pay, but for those who cannot afford or do not wish to purchase a non-government school education for various reasons (they are almost all religious in nature), choice and therefore competition is limited (RR9: page 12).

There is significant scope to improve competition between individual schools, regardless of their sector. There are two main policy levers to achieve this:

1. Portable, sector-neutral funding: If students were entitled to the same amount of funding for their education irrespective of which school sector they enrol in, there would be greater incentive and capacity for enrolment growth in non-government schools.

2. Easing zoning regulations: At present, all states and territories implement 'zoning' (the practice of allocating students to a particular school based on proximity) to varying degrees. Overlapping school zones, such as those used in the ACT, provide students and parents with choices between up to five schools in the local area. With a more mobile user base, schools then have an incentive to compete on various aspects of service delivery, most notably quality and responsiveness.

Contestability

Contestability is often under-examined in education policy, with a great deal of research and commentary focusing on competition and choice. The findings of RR6 and RR9 together prompt a few observations about contestability in education service delivery:

- A statistical analysis of non-government schools shows that few are not linked to a broader structural framework, be that religious (Catholic systemic or religious denominations under the independent banner) or alternative, such as Steiner and Montessori (RR9: page 6). Lack of contestability in this area in turn affects the degree of choice.

- There is a body of knowledge on the process of starting a new school within the non-government sector that is concentrated in the hands of incumbents and not easily accessible to newcomers. This also applies to access to finance.

This lack of contestability within the non-government sector can be addressed by creating or enabling the policy conditions that allow new entrants into the school sector — for example, by creating a New Schools Network that guides newcomers through the process of establishing a new school and the requisite regulations and compliance measures that must be undertaken.

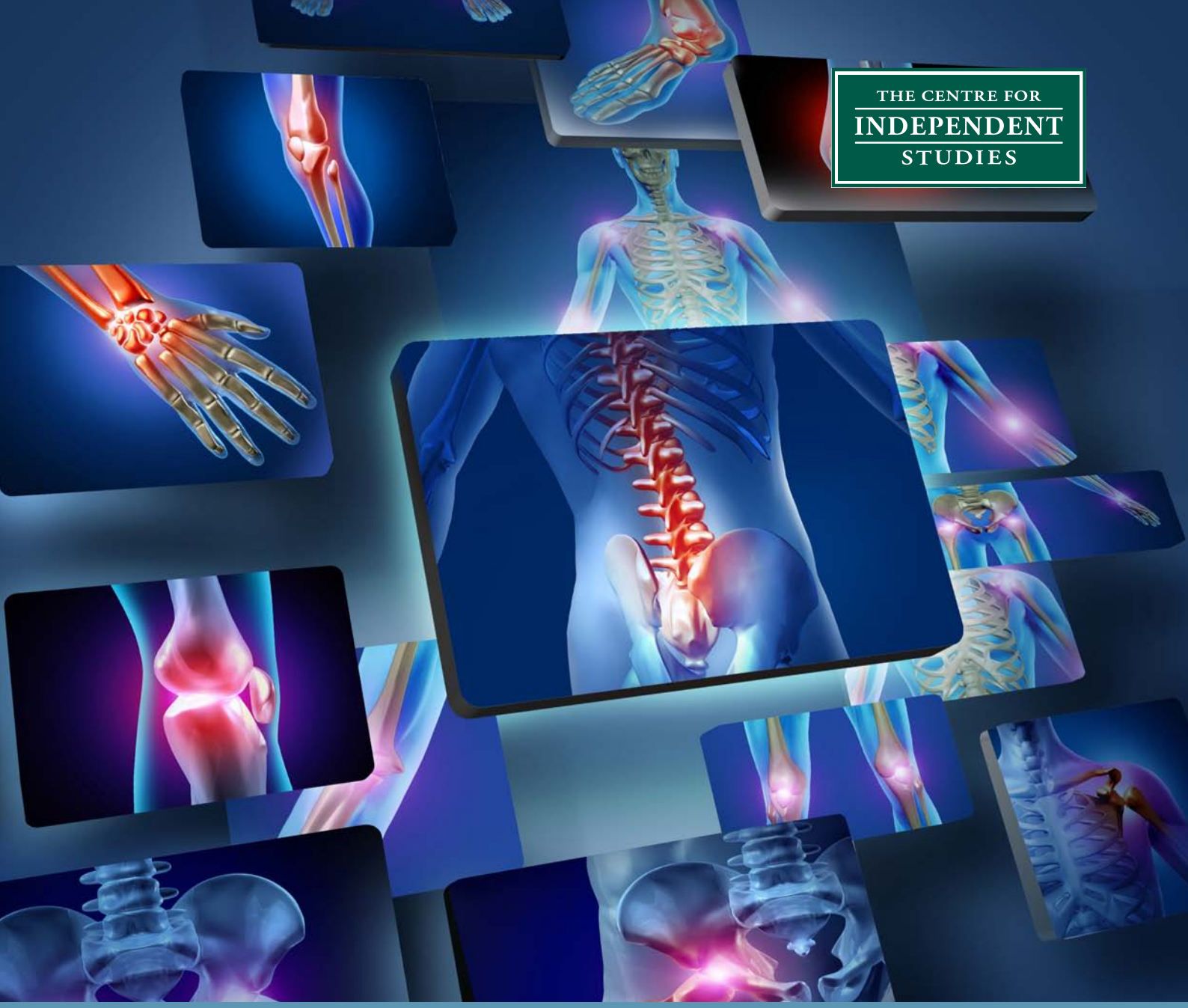
For government schools, by contrast, neither knowledge of the market and its constraints, nor access to capital funds, are considerations. This is because there is no contestability in terms of 'public' school provision — they are funded and managed exclusively by government. Charter schools, with open enrolment and full public funding, maintain the spirit of public schools but can operate outside of the rigidities of a centralised system.

Informed user choice

Australian families are accustomed to school choice. Prior to the introduction of the MySchool website – which provides school results in literacy and numeracy tests (NAPLAN) — decisions about school attendance were largely made on the basis of school self-reporting and word of mouth. The MySchool website gives parents objective and contextualised data about the performance of schools in their area and allows them to make informed choices.

Conclusions

The foundations for expanding competition, contestability and informed user choice in school education service delivery are already laid, as Australian families are accustomed to school choice and policymakers largely recognise their right to choose between different options. Competition and contestability are also evident in the current education landscape, but more reform is needed. The range of literature referred to in the *Free to Choose Charter Schools* (RR6) and *One School Does Not Fit All* (RR9) reports makes a strong case for big-picture reforms such as charter schools and smaller reforms within the existing school sectors, recognising that they can contribute to improving quality, equity, efficiency, and accountability and responsiveness in education service delivery.



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Jeremy Sammut

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PM114 Jeremy Sammut, *How! Not How Much: Medicare Spending and Health Resource Allocation in Australia* (2011)

Contents

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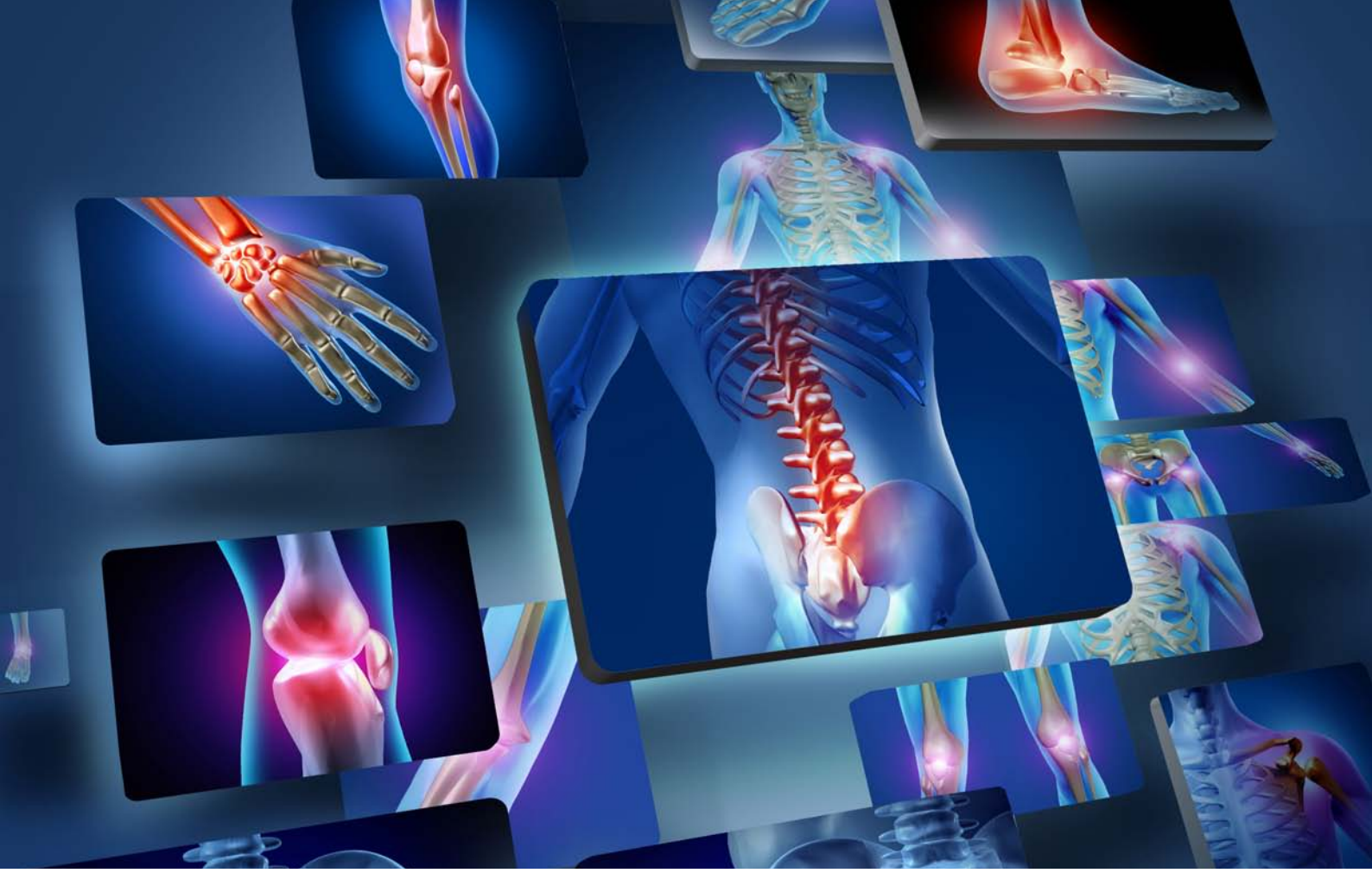


Executive Summary

Aspects of the Australian health system resemble a black hole. Many of the billions of dollars of the near 10% of total GDP expended annually on health is spent ineffectively and inefficiently because health services are not provided in a market environment that delivers the best value for money — all necessary care at the highest quality and least cost. The problems created by cost-ineffective health spending include not only the increasingly unaffordable cost of health to the nation, but also the fact that the sickest and often poorest patients can miss out on all the care they require.

Hence many health experts in Australia maintain that the financial sustainability of Medicare — Australia's 'free and universal', taxpayer-funded health insurance scheme — can be improved by expanding the provision of lower-cost, 'coordinated' primary care services that will prevent chronically-ill patients from requiring high-cost hospital services. 'Gaps' in the Medicare system for chronic disease care — defined as a lack of access to a full range of community-based, multidisciplinary, medical, nursing, and allied healthcare — are reputed to cause hundreds of thousands of 'potentially preventable' hospital admissions per annum at a cost of hundreds of millions of dollars to the health system.

A primary care-focused health reform strategy designed to keep people well and out of hospital has been endorsed by the Turnbull government in the shape of the 'Healthier Medicare' program — a $20 million trial ahead of a national rollout that aims initially to enrol 65,000 chronic patients across 200 GP practices in a "Health Care Home" to better coordinate their care. But despite the apparent scope for new Medicare services to address the ever-escalating cost of hospital care, multiple Australian and international studies have shown that publicly-funded and administered coordinated primary care and chronic disease programs have not achieved the anticipated reductions in use of hospital services.

Expecting health bureaucracies to centrally plan supposedly innovative programs is a demonstrably flawed approach. Real innovation is not driven from the top down, by bureaucrats paying providers to comply with clinical protocols at a set funding 'price' as is, in essence, the design of the government-driven Healthier Medicare program. In efficient markets, innovations are generated from the bottom up, by entrepreneurial providers operating in competitive and contestable environments who discover better ways to deliver services.

For healthcare innovation to flourish, there needs to be a real market for health services in Australia. Providers that deliver cost-effective, patient-centred care should be rewarded for increased efficiency and lower costs by being able to sell that value-proposition to cost- and quality-conscious purchasers. For innovation at the delivery level to occur, system-wide innovation is required of the way Australian healthcare is insured and

financed, including fundamental changes to payment mechanisms to promote integrated care.

Replacing Medicare with a publicly-funded, privately-operated health insurance scheme is one of the reform options that has been suggested to create a more dynamic health economy. The 'Medicare Select' national health reform proposal would see all Australians receive taxpayer-funded, risk-adjusted health insurance vouchers to fund the purchase of private health plans.

A Medicare Select-style scheme would be designed to remedy the structural problems plaguing Medicare, which account for chronic care gaps and overuse of hospitals. Due to the complex division of health responsibilities between the federal and state and territory governments under Australia's federation, no single funder is solely accountable for the entire healthcare needs of patients. Rather than a comprehensive health insurance and risk-management system, Medicare primarily functions as a series of provider-captured payment mechanisms for separate sets of hospital-based care and community-based primary care (mainly GP and medical imaging and diagnostic services).

Under Medicare Select, individual health funds would hold the full financial risk for members' healthcare needs across the full service spectrum. Instead of functioning as passive payers of medical and hospital bills, funds would act (on their members' behalf) as active purchasers of health services from competing providers. To limit premium and benefit costs, funds would seek to ensure health resources are used as efficiently as possible so patients receive the most appropriate and cost-effective care, including all beneficial primary care and outpatient specialist care to avoid expensive hospital admissions.

Structural change on the insurance side of the Australian health system would drive structural change on the services side of the system — with Medicare Select possibly offering a pathway to alternative payment models that are cost-effective. Australian and overseas experience has shown that traditional health reform initiatives struggle to bridge the institutional divide between non-hospital and hospital-based health services due to the fee-for-service payment legacies of established health systems, which financially reward providers for inefficient practice and encourage over-servicing. To improve overall health system efficiency, innovative private insurers, mainly in the United States, have developed integrated 'managed care' payment models that combine traditional health funding streams into one bundled payment, and are designed to share financial risk for healthcare costs with health service providers.

Integrated payment models are also aptly known as 'value-based contracting'. Insurers enter into contracts with health management companies who provide all the healthcare of patients funded from an agreed global budget. Health service providers would therefore have a financial incentive to innovate — to change traditional patterns of care and efficiently manage the full pathway of patient care — and deliver all necessary and effective care in the most economical fashion. Providers are able to share in the value they create by better management of the healthcare costs and outcomes, because they can retain all or part of the savings made by more efficient use of health resources.

The potential impact of financially accountable health service provision is suggested by the promising results of the 'shared-risk' Alternative Quality Contract (AQC) developed by Blue Cross Blue Shield of Massachusetts. The ACQ experiment has bent the cost curve down and yielded cost-effective savings by reducing use of procedures, images and tests, and by directing patients away from high-cost hospitals towards alternative, lower-cost, community-based facilities for specialist procedures.

Other successful integrated models that deliver cost-effective, high-quality care — such as the Californian Health Maintenance Organisation (HMO), Kaiser Permanente — have also limited health costs primarily by rigorous management of hospital admissions and length of stays rather than by chronic disease management. The insights gained from the American experience with using managed care to address spiralling US healthcare costs suggest major savings are more likely to be made on the cost of hospital care by managing utilisation. This is especially significant to the health reform debate in this country, given very high rates of hospital use in Australia compared to other OECD nations, including the US and UK, and given that the rising cost of health to government budgets is being largely driven by the increasing cost of hospital care.

The implication of these findings is that calls to increase the rate of the GST, and/or other tax increases to pay for the rising cost of health to government budgets could well serve to prop up latently inefficient hospital-based health services. Pouring larger sums of taxpayer's money into the Medicare system is antithetical to Prime Minister Malcolm Turnbull's statement that he wishes to lead a government committed to innovation and economic reform.

What the Turnbull Government ought to consider — going well beyond its limited primary healthcare 'reforms' — are the structural changes to the architecture of the health system that are necessary to transform the way health services are purchased and provided to deliver the best value healthcare. A truly innovative national health reform agenda should explore ways of emulating the private sector managed care and alternative payment models that could potentially reduce the cost of health by effectively and efficiently controlling the use of hospital services.

To accentuate the possible benefits of supply-side insurance and payment reforms, demand-side initiatives — such as the CIS Health and Ageing Program's Opt-Out Health Savings Account (HSA) plan — should also be considered in formulating the Coalition's health reform plans. HSAs should be on the table as a reform option alongside Medicare Select because self-funding of, and greater personal financial responsibility for, health care expenditures would be the most effective way to curb the healthcare use and cost spiral endangering the sustainability of the Australian health system.

Introduction: "A Dramatic Health Reform Plan"?

The most problematic public policy ideas are those that seem intuitively correct. These ideas attract support because they appear to be soundly-based and to offer obvious answers to important policy problems. But the intuition may well be wrong; there may, in fact, be little evidence to support the effectiveness of what seems to be an entirely plausible and purely commonsense approach to policy making. These points apply to one of the most popular and perennially suggested health policy ideas.

At the December 2015 Council of Australian Government's (COAG) meeting, Victorian Premier Daniel Andrews presented his federal and state and territory government counterparts with what the media billed as a "dramatic health reform plan" that could save the health system up to $1.5 billion a year. The Premier's proposal was to hire a new kind of publicly-employed health worker, a "care coordinator", whose role would be to work with chronically ill patients to ensure they have "coordinated patient care plans." The rationale for the proposal was that many thousands of chronically ill patients end up being admitted to hospitals each year because their conditions are not properly monitored, because they are not properly medicated, and because they do not access the full range of medical care from health professionals including nurses, podiatrists, and physiotherapists that can help them stay well and out of hospital. The care coordinators could remedy these defects, as well as fix defective communication between state-funded public hospitals and federally-funded GPs, pharmacists and allied health professionals, which was claimed to be a key driver of the 285,000 hospital admissions each year, or 10% of total annual national admissions, considered potentially avoidable. Mr Andrews argued health reform that addressed "the biggest problem in health at the moment"—by delivering different, better managed, and better organised chronic disease care—was a matter of ensuring government spending on the health system "is as efficient and effective as it possibly can be."[1]

In reality, there was little that was new in the proposals. Health experts and stakeholder groups routinely suggest that Medicare—Australia's 'free and universal' taxpayer-funded health insurance scheme—can be re-established on more sustainable fiscal and clinical foundations by re-orientating the system away from an over-reliance on very expensive hospital-based health services and by expanding the provision of lower-cost, 'community-based' primary healthcare services. This approach to "restructuring our health system to improve the effectiveness of primary care" is commonly said to be "about rational health economics", as this kind of "innovative healthcare reform" is based on "a very strong evidence base" and will result in "far fewer needing inpatient hospital care."[2]

The rationale for following this advice appears compelling. Hospitals are designed to provide acute bed-based care for patients when major illness strikes. The services that Australia's 750 public hospitals provide reflect the healthcare needs of the period when hospital systems were founded, between the mid-nineteenth through to the mid-twentieth century. But the times, and the health needs of the community, have changed. In the twenty-first century, the major health challenge is not simply to provide one-off treatments for acute illnesses. The major challenge is to provide ongoing care to address the rising burden of chronic illnesses—such as diabetes, heart disease, and respiratory disease—the onset of which is being driven on the one hand by the impact of a rapidly ageing population, and on the other hand by lifestyle factors principally related to obesity and unhealthy eating, drinking, and smoking habits.[3]

The argument goes that the failure to access non-hospital-based chronic disease services increases the demand for, and reliance on, hospital care. Because insufficient attention is paid to ensuring that chronic conditions are properly cared for in the community, many of these patients end up suffering acute episodes that require admission to hospital for treatment at substantial cost to taxpayers, and frequently at cost to private insurance funds as well, when patients have private cover and are admitted to private hospitals or privately to public hospitals.

Medicare's Structural Flaws

The problem of unnecessary or 'potentially preventable' hospital admissions by chronic patients also draws attention to the structural flaws in the complex funding and service arrangements that distinguish the Medicare system.

The federal government runs and funds the primary care part of Medicare. This is part of the function of overseeing the Medical Benefits Scheme (MBS), the principal function of which is to pay benefits to meet or assist in covering the cost of fees for GP care, medical imaging and diagnostic services, and other specialist ambulatory and inpatient attendances and procedures on a fee-for-service, on-demand, and open-ended basis. The federal government also gives state and territory governments a fixed amount of money each year to partially fund the operation of public hospitals. Federal hospital funding is provided on condition that all Australians are entitled to receive 'free' public hospital care at point of access; but otherwise state and territory governments are responsible for hospital governance and administration.

Jurisdictional complexity—with the result being that neither level of government is solely accountable for the entire healthcare needs of patients—distorts responsibilities and incentives in ways that partially account for the service gaps (and ironically sometimes duplications, such as repeat tests and imaging services) for chronic patients. Medicare does not in all cases provide access to the full range of medical, pharmaceutical and allied healthcare that might ensure chronic conditions are properly managed to stop patients ending up in hospital.

Hence chronic disease services are often described as 'multi-disciplinary' or 'coordinated care'. These terms mean that in addition to the care of a general practitioner, a care coordinator, who may be a nurse, will monitor the condition and manage the care of the chronically ill to help patients navigate different parts of the health system successfully and receive all available care from a wide variety of allied health providers. Coordinated care also involves educating patients about their disease so they can better self-manage their condition and maintain their health. Self-management is particularly important if patients' conditions are complex and they have comorbidities that can cause complications and more frequent, longer, and costlier hospital stays. Hence, the cost-benefit rationale is that the additional costs associated with coordinated care compared to traditional GP care may be justified by both the improved health outcomes for patients and by the cost savings associated with avoiding the use of expensive hospital services.

The more targeted the approach, the more cost-effective the care coordination intervention is likely to be. This is because the population suffering chronic illness is not homogenous. Many people, even with multiple conditions, suffer relatively few adverse effects on their lives and use of health care with little impact on health costs. Standard GP care, combined with self-management, is sufficient for this patient group. It is highly complex patients, at severe risk of deteriorations and complications, who generate a disproportionate share of health costs, for whom more intensive assistance in the form of care coordination is appropriate—due to the real potential to relieve the burden otherwise imposed on scarce GP and hospital resources.[4]

The debate about chronic care has provoked a long-running 'blame game' between federal and state governments, as each would prefer that the other take responsibility and bear the cost of funding chronic disease services. State governments claim that closing the service gaps in the primary care system is a federal policy responsibility, and blame the persistence of the problem on federal government inertia. This seems fair enough, especially when the federal government can be said to foot part of the resulting financial burden, and is ultimately paying more in health grants to the states than it ought in order to fund otherwise preventable hospital admissions. Yet it could be said that state governments act equally irrationally, and that if there are cheaper and better ways to treat chronic disease in the community, they should just do it. Indeed, states do operate, on a piece-meal basis, a range of community-based programs with a focus on management of chronic disease. But despite the promised savings on the cost of hospital care, finding the additional resources to fund comprehensive chronic care services, amid limited budgets and competing priorities, is something neither level of government has proven capable of doing.

Action by either level of government has also been stymied by a common problem. Despite the widespread belief that existing funding is not being used optimally to meet the health needs of the community –that is the approximately $20 billion and $40 billion of taxpayer's money spent annually on Medicare-funded primary care and hospital care respectively - both federal and state governments have been unwilling to reallocate resources away from existing medical services or hospital services respectively. The reason for this is health politics: such action would be highly likely to generate significant opposition from affected provider groups, especially from general practitioners and hospital-based specialists whose current professional lives and incomes depend on the maintenance of the Medicare status quo. This includes the ability of specialists to admit privately-insured patients to public hospitals for treatment, and to thereby, in effect, use publicly-funded hospital infrastructure to operate private, fee-for-service medical business at considerable (and opaque) cost to taxpayers (see page 22).[5]

The bottom line, and political reality, is that neither level of government has been willing to address the real chronic condition in the Australian health system: the structural problems that mean that Medicare is not a 'health system' per se, but primarily functions as a series of provider-oriented payment mechanisms for separate sets of non-hospital and hospital-based services. Medicare does not operate as a comprehensive health insurance system that offers patients all necessary and beneficial care, no matter the setting or provider. Since neither the funders nor providers of health services share full financial risk for all the health costs of patients, they thus do not have authority or sufficient financial incentives to ensure health resources are used as efficiently as possible to ensure patients receive the most appropriate and cost effective care and do not fall through the cracks.[6]

It must be noted, however, that the gaps in Medicare persist despite recent federal initiatives to improve access to chronic care services. Since 2005, MBS payments for chronic disease management have been available to doctors and allied health practitioners, at a cost to the federal budget now approaching $1 billion annually. It is highly likely that some chronic patients have received improved quality of care as a result.[7] But the addition of GP Management Plan (GPMP) and Team Care (TCA) items to the MBS is unlikely to have proved cost effective, due to the untargeted nature of these programs. Patients with low-level chronic illness, along with other consumers with no chronic disease at all who simply want to use subsidised allied health services, receive the same level of access as highly-complex patients. Hence there is evidence—according to the former head of the Medicare watch-dog, the Professional Services Review—that the writing of boilerplate GPMPs and TCAs for patients irrespective of clinical need has become a lucrative way of maximising the incomes of some practices. Likewise, adding allied health services to the MBS may have satisfied the professional aspirations, and enhanced the incomes, of physiotherapists and psychologists, but the creation of a new layer of services has had little observable effect on the quality and outcomes of chronic care in terms of realising the promised overall impact on health costs.[8]

This raises a further question: even if Australian governments find more money for chronic disease programs, will these new services actually work? In the perpetual push to fix what appears to be so obvious a defect as the chronic care gaps in Medicare, the lack of evidence demonstrating the effectiveness of publicly-funded and administered chronic disease programs is overlooked. Worse is that innovative patient-centred rather than provider-centric approaches, that might better address the chronic care gaps in the system and also achieve the system changes required to address Medicare's underlying structural problems and inefficiencies, do not receive the consideration they deserve.

Déjà Vu All Over Again – Primary Healthcare Debate 2007-2016

Abbott-Turnbull Primary Healthcare Policy

The current Federal Coalition Government, under the leadership of former Prime Minister Tony Abbott and now under Prime Minister Malcolm Turnbull, has embraced the idea of enhanced chronic care as a major feature of its health reform agenda. This embrace occurred mid-stream, as it were, during the government's first term, and the context requires explanation.

After winning the 2013 election on a platform of pledging to repair the budget deficit, the Abbott government announced that as a savings measure it would introduce a $5 compulsory patient copayment for Medicare-funded GP and select medical services. The copayment was designed to apply to services that formerly had been 'bulk billed'—which, that is, were paid for entirely by the benefit received by doctors under the MBS with no out-of-pocket charges being incurred by consumers. Due to the unpopularity of the new savings measure, and in response to a vigorous anti-copayment campaign orchestrated by the implacable Australian Medical Association (AMA), this policy was withdrawn in early 2015 after it was clear that it would not pass in the Senate due to lack of cross-bench support.

Following a change of portfolio, the new Health Minister, Sussan Ley, set about reconstructing the Coalition's health policy. This amounted to conducting a national listening tour in fulfillment of her pledge to consult more widely with health professionals, thereby addressing a complaint of the AMA that the copayment had been sprung on doctors without warning. The government's demand-side rationale for a mandatory copayment was that consumption of fee-for-service, bulk billed medical services at zero prices inevitably resulted in over-servicing. The new supply-side approach to tackling the problem of waste in the health system took the form of the commissioning of a number of reviews under the banner of 'Healthier Medicare' initiative.

The Medicare Benefits Schedule Review Taskforce was charged with the job of 'modernising' the MBS. This amounts to seeking to eliminate waste by subjecting all the services funded through the MBS to evidence-based assessment to ensure that Medicare funding is delivering quality and value in the form of the best

patient outcomes possible for the health dollars expended. In announcing the MBS review, Ms Ley went to great lengths to stress that the broader reform objective was not simply to de-fund low-value, out-of-date or unsafe services for the sake of budget repair, but rather to free up resources that could be better and more sustainably redeployed to meet the healthcare needs of the community. "Any reform would need to have a core focus on delivering better patient outcomes," she said. For what the government had learned, through the minister's wide-ranging consultations with health professionals and consumers, was that Medicare urgently needed to be modernised to assist patients and practitioners better manage chronic illness.[9]

Clarifying that the government's policy was about health (hence the 'Healthier Medicare' moniker) not budget savings, was the purpose of the second expert-led review that was also commissioned. The Primary Health Care Advisory Group (PHCAG) was tasked with advising the government on the primary care reforms necessary to fill the chronic care gaps in Medicare. Allied to the objectives of the MBS review, the PHCAG also identified that the problem with the current fee-for-service MBS system was that it "largely links payment to an interaction between a doctor and patient" and rewards "episodic rather than coordinated, multidisciplinary care" involving a number of different health practitioners.[10] The PHCAG also identified that the reform challenge was to ensure the sustainability of the health system by ensuring resource allocation was efficient, and ensure "the most effective use of existing primary healthcare funding to appropriately target and support people with chronic and complex health conditions."[11]

The Coalition's embrace of primary care reform filled its post-copayment health policy void in a dual sense. The Abbott Government, also in pursuit of budget repair, had reneged on the hospital funding agreement struck by the Gillard Government in 2011, and had reduced the future level of federal health funding the states and territories would receive.[12] Promising to do 'something' about chronic care represented an attempt to make up for the funding shortfall by achieving savings to state hospital budgets by addressing the problem of potentially avoidable hospital admissions.

In early April 2016, the Turnbull government released its pre-election health policy proposals. The Abbott government's 'cuts' to hospital funding would be reversed, but for only four years until 2020, at an additional estimated cost of $2.9 billion.[13] At the subsequent COAG meeting, all jurisdictions agreed to continue to take action to reduce avoidable hospital admission—including the federal government through primary care reform.[14] Unveiled on the eve of COAG was a new federal 'Healthier Medicare' program—a $20 million trial ahead of a national rollout that aspires to enrol initially 65,000 chronic patients across 200 GP practices in a 'Health Care Home' with capitation funding for primary care service and coordination costs provided on a quarterly basis.[15]

Rudd-Gillard Primary Healthcare Policy

Yet the Coalition's approach to primary healthcare reform is largely reminiscent of the approach taken by its predecessor Labor Government. Before the 2007 federal election, the then leader of the opposition, Kevin Rudd, promised to "end the blame game" over health. In early 2008, as Prime Minister, Mr Rudd appointed a 10-member expert National Health and Hospitals Reform Commission (NHHRC) to review the health system and advise on the long-term reforms required to address the major health challenges of the twenty-first century. After conducting extensive consultations with health professionals and consumers, the 15-month NHHRC review culminated with release of its final report in July 2009. The 300-page A Healthier Future for All Australians made over 100 recommendations, but its major findings focused on the need for primary care reform.[16]

To consult the NHHRC report is to learn that the Coalition's Healthier Medicare initiative is traversing exactly the same ground. Like the PHCAG,[17] the NHHRC argued that the chief systemic barrier to better outcomes was the fragmentation of health services owing to the limitations of the MBS and the federal-state split in health responsibilities, which meant that patients with chronic conditions often received un-coordinated care and did not receive all the services they needed from a range of the health professionals. Hence, the major reform challenge, and the way to end the blame game, was to find ways to improve access to Medicare-funded (i.e. federal government-funded) coordinated, multidisciplinary primary care to prevent avoidable hospital admissions.[18]

Like the PHCAG,[19] the NHHRC has already flagged that effective primary care reform may require changes to the existing Medicare fee-for-service funding arrangements and the introduction of payment models better suited to the requirements of longer-term, 'team-based' care. This included ideas such as requiring chronic patients to enroll with a primary care 'home', which would receive capitation funding—a fixed or block amount of funding per enrolled patient—to support the coordination and provision of primary care services across the spectrum.[20] The idea of a 'Health Care Home' was the major recommendation of the final report of the PHCAG, [21] and is now the Turnbull government's official primary healthcare policy in the shape of the Healthier Medicare program.[22]

The NHHRC maintained that the major health reform challenge was to improve health outcomes and health system sustainability by changing how and where health funding was spent; shifting away from a hospital-centric system required "evidence-based investment in strengthened primary healthcare services."[23] The problem, however, was that the evidence-base surveyed as part of the NHHRC process, did not support the claims made about the effectiveness of coordinated primary care.

Evidence-Based Policy—Or A Policy Looking for an Evidence-Base?

The idea of reorienting the health system around strengthened primary care services has been in vogue since at least the 1990s. To test the efficacy and build the evidence-base for this approach, the federal health department established the Australian Coordinated Care Trials. Funding from existing state and commonwealth health programs was 'pooled' and reallocated to nine community-based 'fundholding' organisations in six states and territories in order to support the provision of multidisciplinary care. The results of the trials were counter-intuitive.[24]

In general, the evaluation of the trials published in 2002 found that they had not improved health outcomes among participants and that most programs operated at a loss.[25] For example, one of the trials conducted in the northern suburbs of Melbourne coordinated the care of a trial group of elderly and chronically ill patients aged 75. But this was found to have produced no significant reduction in hospital use, compared to a control group that continued to receive their usual level of care from their GP.[26] The South Australian 'Health Plus' trial was partly successful and achieved some improvement in patient outcomes. Yet even in this trial—one of only three to register a significant reduction in hospital admissions—the savings on hospital costs were not sufficient to cover the higher costs of coordination.[27]

Commenting on the results in the Medical Journal of Australia, Adrian Esterman and David Ben-Tovim explained the trials showed: the essential premise that better coordination reduces hospitalisations is misguided. It may be that lack of coordination in a complex care system operates as a functioning rationing system, so better care coordination reveals unmet needs rather than resolving them.[28]

This conclusion was consistent with the overwhelming bulk of the research assessing the results of coordinated care programs.[29] Rather than reduce use of hospitals by preventing avoidable admissions, a range of studies and evaluations has suggested that lack of coordination does indeed act as rationing device, whereby insufficient access to primary care prevents referral to hospital care. Hence a significant effect of coordination that has been observed is to actually increase use of hospitals by uncovering unmet need and ensuring patients (particularly low socio-economic status patients who lack the means or knowledge to coordinate their own care) receive all beneficial hospital care.[30] (Box 1)

That patients who receive coordinated care can receive all beneficial primary and hospital care is clearly a good outcome for patients. Nevertheless, this contradicts the central claims that have been made about its supposed effects on use of health services.[31] The evidence that coordinated care programs haven't delivered the foretold reduction in hospital admissions was evaluated by the discussion paper written by Professor Leonie Segal, which was commissioned by the NHHRC to supposedly

Box 1. A Rationing Device

In 2003, for example, the UK government commissioned a pilot coordinated care program. Practice nurses conducted comprehensive geriatric assessments of elderly patients not in regular contact with general practice services, designed individual care plans, and undertook follow-up monitoring.

The evaluation of the pilot program found that "case management had no significant impact on rates of emergency admission, bed days, or mortality in high risk cohorts." The evaluation suggested that while better coordination might avoid hospitalisations in individual cases, overall, instead of reducing admissions in the wider population, improved access to coordinated primary care uncovered new cases requiring hospitalisation.[32]

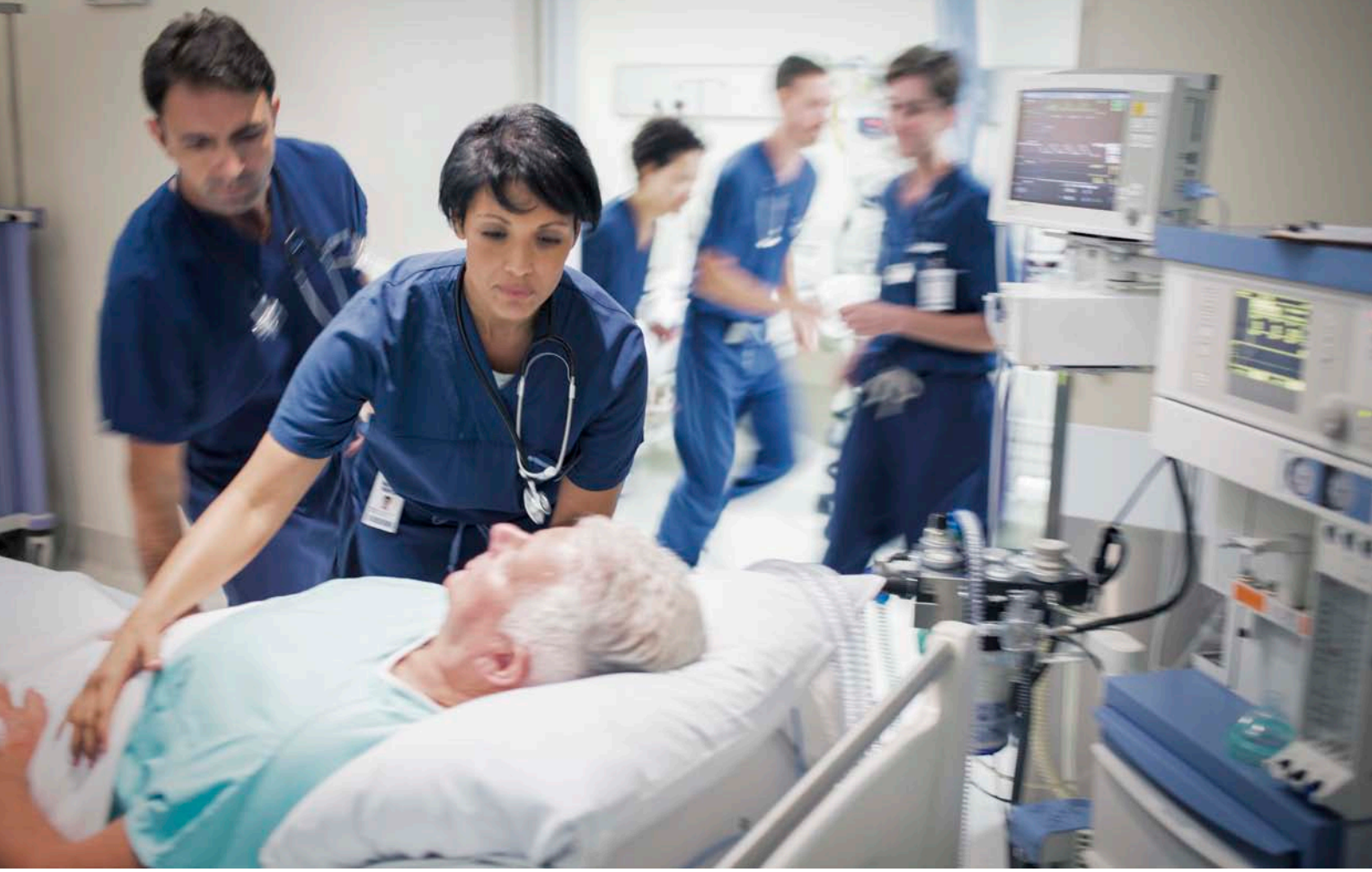
In 2004, the New Zealand Ministry of Health introduced a new scheme to coordinate the care of chronic disease patients. The 'Care Plus' program allocated extra funding to New Zealand's eighty-one publicly funded Primary Health Organisations. This entitled the chronically ill to receive reduced-cost nurse or doctor visits, care planning, and self-management support.

The independent evaluation found that the program had improved the care of Care Plus patients, but had led to higher, not lower, utilisation of medical services. In this case, when coordinated care was translated from the trial to the real world, it led to consultation rates increasing by four visits per annum on average. This led to hospital admissions rising by 40%, an outcome attributed to better monitoring of chronically ill patients' conditions.[33]

inform its work. The summary of the evidence compiled by Segal was telling:

Whilst it has also been postulated that high quality primary care will reduce the use and cost of hospital services by substituting for less appropriate or more expensive tertiary inpatient or emergency department care and improving the quality of chronic disease management and lowering rates of disease progression and complications the evidence here is equivocal. Some success in small scale intervention trials is observed, but this is not necessarily translated into larger population based interventions. While reasons can be posited as to why the 'expected reduction' in hospital admission did not occur, it is plausible that high quality primary care may be additive to, rather than a replacement for hospital care. In any case, 'ambulatory care sensitive' admissions (potentially avoidable through high quality primary care), for diabetes complications, COPD etc. have been estimated to account for only 10% of hospital admissions. Reform of primary care should be justified in terms of its impact on health and wellbeing and equity, rather than presumed 'cost savings.'[34]

These findings—that coordinated care programs offer an additional layer of service for no cost-benefit (as opposed to health outcome) return—are also consistent with 2012 report by the United States Congressional Budget Office (CBO), which examined the effectiveness of chronic care programs implemented by the US federal government over the previous two decades.[35] The report examined 34 nurse-led care coordination 'demonstration projects' that aimed to educate patients, encourage compliance with self-care regimes, and track and target appropriate clinical services. In the words of America healthcare expert, John Goodman, the CBO found that on average these projects had had "little or no effect on hospital admissions" and that nearly every project's impact on "spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program."[36]



"Did Not Occur"—Top Down, Not Bottom Up

"So why is none of this working?" asks Goodman. The reasons seem hard to fathom. Many severely chronically ill people are socially disadvantaged and struggle for personal and financial reasons to access all beneficial services and comply with appropriate treatment regimes. There appears to be much scope for new services to succeed and yet the expected reductions in hospital use have not happened.

It is plausible that the failure of chronic care programs to yield the promised savings and to demonstrate their cost-effectiveness is due to a dual effect. The uncovering of unmet need among patients formerly receiving inadequate care has 'compromised' the initial results of the trials. If this is a one-off effect—which is yet to be demonstrated, particularly for elderly chronic disease patients—properly targeted care coordination could demonstrate its effectiveness over a longer time-frame as the benefits of secondary prevention and earlier intervention, particularly enhanced self-management, achieve reductions in the cost of care and absorb care coordination costs. It is also reasonable to suggest that the additional cost of coordination can be justified by discovering unmet need and improving health outcomes at a higher cost. Despite how inherently worthy such an outcome is, this is not the policy proposition that drives the coordinated care debate—which is that the investment in quality primary care will deliver a lower cost, and more cost-effective health system by reducing 'preventable hospital admissions'.

A recent report by the Grattan Institute restated the case for "much greater investment in supporting service development and innovation in primary care." The report underlined the gaps in the existing system for chronic care that were said to be a driver of higher costs, and reasoned that improving the management and quality of primary care would improve clinical outcomes and yield savings. It identified that the existing $1.7 billion in total government funding on chronic disease management was not effective, principally due to the funding having been grafted onto the existing Medicare fee-for-service system. Even the Practice Service and Incentive Program introduced in the 1990s—which was intended to supplement the fee-for-service system and standardise best practice chronic care—has had limited uptake by GPs, limited patient enrolment, and thus limited overall effectiveness. The authors argued that "[e]vidence from around the world suggests that much greater emphasis needs to be placed on service

coordination and integration with chronic disease." This is not the same thing as arguing the international evidence shows chronic care 'innovation' had achieved the promised results. The authors therefore admitted the evidence is limited with respect to what works, given the evidence-base primarily consists of the 'promising' results of some small scale studies. They also, however, rightly identified that the major barrier to large-scale and genuine innovation is the difficulty involved in achieving comprehensive structural reform of the existing health systems. The Grattan Institute may hereby have identified the problem, but not the solution. The report's major recommendation is to call for a 'system redesign' to resolve jurisdictional complexities in the split federal-state health system in Australia by creating a new layer of public sector bureaucracy: region-based health agencies responsible for coordinating and integrating care, for fostering innovation including in payment mechanisms, and for setting targets and measuring outcomes.[37]

The reform model recommended by Grattan—which can be described as a top-down approach to implementing 'public sector managed care'—actually points to another possible answer to the chronic care puzzle. This concerns not simply the clinical issues relevant to chronic care per se, but rather the method or means of production behind the delivery of these services. Goodman argues that expecting a public health bureaucracy to centrally-plan a supposedly innovative program is demonstrably flawed in conception and execution. This approach fails because the proper roles that ought to be played by buyers and sellers of goods and services are confused in bureaucratic health systems. "Successful innovations are produced by entrepreneurs, challenging conventional thinking—not by bureaucrats trying to implement conventional thinking." In the case of chronic care services, "buyers of a product (i.e. health bureaucrats) are trying to tell the sellers how to efficiently produce it".[38] In efficient markets, real innovation is not driven from the top down by buyers telling sellers what to do, but is generated from the bottom up by entrepreneurs operating in competitive environments who discover new, better, and lower cost ways to deliver services to cost-conscious buyers—who are free to choose between competing providers based on quality and price. (Box 2)

Another top-down approach to improving the quality of clinical care, particularly for chronic disease, is pay-for-performance (P4P) mechanisms that use financial incentives to encourage healthcare providers to meet pre-established performance targets. These schemes can range from reward payments for complying with evidence-based 'best practice' guidelines, to conditional payments for attaining particular outcomes, to no payment for poor results. Yet the limited evidence gathered from evaluations of P4P schemes is not promising. A 2011 systematic review of P4P chronic care programs by de Bruin and others found some positive effects on healthcare quality, as in compliance with the service targets that had to be hit to trigger the financial rewards. But the evaluations contained no evidence about the effects on healthcare costs.[39] Likewise, two 2011 Cochrane reviews of P4P schemes similarly found that while processes of care had been improved, there was no evidence concerning patient outcomes, and such measures (along with the consequent impact on health costs) were rarely even included in the evaluations.[40]

Box 2. The Dedicated Person Problem — Times Two

Goodman identifies another related problem with the bureaucratic production of chronic services: 'promising trials' (not only in health but in many areas of government activity in general) tend to fail because they do not scale.

Even successful trials frequently fail to translate in the real world because they strike up against the 'dedicated person problem'.

Firstly, a trial may have been successful due to the knowledge, expertise, and commitment of those who planned and staffed it. The same levels of skill and dedication are unlikely to be found throughout the workforce employed under a full-scale program.

Secondly, a chronic care trial may have been successful because the patients who participated were especially motivated to improve their conditions, and hence are unlike the de-motivated patients who are the real targets of these programs, and who may well have dropped out of the trial and thus distorted the results.[41]

For example, the UK 'Expert Patients Programme' had limited uptake and therefore limited success and applicability. A national evaluation published in 2007 found "some reductions in costs of hospital use," but warned that the results should be treated with caution because they "are pertinent to people who volunteer to go on such a course and not those with long-term conditions generally."[42]

The apparent design flaws in the evaluations are, in truth, a product of the inherent limitations of P4P schemes. By their very nature, these programs reward compliance with care processes that are simpler to measure rather than rewarding outcomes that are difficult to measure. It is particularly difficult to measure and reward the long-term impact on chronic disease, as it is hard to attribute the effect to a service provided at a point in the past, and when the determinants of patient well-being may lie outside reach of clinical services. Hence, in reality, P4P schemes can end up amounting to just another form of rules-based, centrally-planned fee-for-service payments.[43]

This seems to have been the result of the system-wide P4P scheme introduced in the UK. Under the UK National Health Scheme (NHS), GPs are funded by 'blended' payments combining elements of capitation, fee-for-service and performance payments. A key aim of the Quality and Outcomes Framework (QOF) introduced in 2004 was to improve the quality of primary care by encouraging GPs to better manage and coordinate the care of chronic patients to avoid hospitalisation. Hence, up to a quarter of GP income was at risk if quality targets for chronic care were not met. But about half of those targets concerned clinical process, and most of the remainder concerned administrative process and recording patient experience. Few targets, and only a small proportion of reward payments, were linked to patient outcomes.[44]

As would be expected, the things that were rewarded were the things that were done. The QOF was found to have improved care processes and quality to the extent of GP practices reorganising and systematising how they managed chronic patients. But there is no evidence that compliance with 'tick a box' process measures has had a positive impact on patient outcomes, particularly with respect to use of hospitals. Nor, therefore, could it be established that the QOF was cost-effective and that the additional cost reduced the total health cost across the system.[45]

Moreover, the scheme appears to have been gamed, created perverse incentives, and had unintended consequences. Most providers rapidly attained the targets to significantly boost GP practice incomes, but at the expense of neglecting other areas of patient care not subject to financial incentives.[46] There are also concerns that the link between income and the rigid framework led to rote practice and prevented the development of tailored services that suit the complex needs of local populations. In other words, the top-down approach to mandating so-called quality has actually operated as a barrier impeding genuine innovation.[47]

This has implications for the Healthier Medicare program that raise concerns. The Turnbull government's plan to create 'Health Care Homes' has some attractive features. The positives include the use of risk stratification to identify, and target for enrolment, the most high-risk chronic disease suffers. Yet enrolment is voluntary, which begs the question whether patients unmotivated enough to find a 'home' themselves will bother to participate and stick with the program. Also positive are promises of improved collection of data, information sharing between services, and development of performance and outcome measures. Yet the program will essentially be structured around the application of evidence-based clinical guidelines, and as such represents a top-down approach rather than leap into the discovery process that generates true innovation. The introduction of capitation payment is a significant development, and will create additional flexibility in terms of the potential access to a broader range of primary care services and coordination services. But will the 'Health Care Homes' be a home in name only? Both the PHCAG final report and the details released by the governments suggest a major focus will be on working to resolve jurisdictional complexities. By some undefined process, the herculean task of unscrambling the federal-state health split is anticipated in order to establish local care pathways for enrolled patients, which will also integrate primary and secondary care. This is despite the fact that the 'Health Care Homes' will have financial control only over the provision of out-of-hospital care. Hence the program is highly likely to struggle to achieve its objective of effectively coordinating, in an innovative fashion, all the care patients require across the spectrum, as Health Care Homes will instead have to rely on existing referral and treatment options for in-hospital services.[48]

Implications for Australian Health Reform

The insights that can be gained from the US and UK public health system's experiments in chronic care are important to the Australian health reform debate. Most of the proposals for enhanced primary care services in Australia plan on using the public health bureaucracy to implement 'innovative' chronic care, as the recent Grattan Institute report demonstrates. Yet the evidence is clear: all indications are that the envisaged public sector managed care reform options—which either entail getting the federal health department to fund, state health departments to fund, or the 'pooling' of federal and state funding to pay for, coordinated chronic disease programs—are destined to disappoint in terms of yielding the much-hyped and promised cost savings.

Expecting federal, state, or even new region-based joint federal-state health agencies[49] to act as purchasers of packages of chronic care services tailored to patient's needs, will inevitably replicate the design faults inherent in bureaucratic programs. The problem is that public sector bureaucracies need to know what they are buying and paying for before they commit taxpayer's money to particular programs. This is why government programs are designed from the top down, and consist of rules-based, centrally-administered protocols that dictate all the things providers must do. Providers do what the bureaucracies are willing to pay for; compliance stymies real innovation, and this explains why many public programs are ineffective. Governments under these inflexible command-and-control arrangements end up paying for things they know will be done, rather than paying for what works.

These problems are compounded by the culture of the public health system, given its essential nature as a payment system for a set of pre-determined clinical services. Program funding for care coordination, particularly if public sector employed and unionised nurses are funded to fulfil this task, will extend the provider-based nature of the public health system into the chronic care arena. Because the political economy of the public health system creates powerful vested interests, withdrawing program funding will be very difficult, even if the new chronic care services prove ineffective—which is highly likely if the nursing profession's declared ambition to secure community-based clinical roles for nurses is satisfied under the rubric of chronic care.[50]

Goodman cites an example of a successful chronic care program. An entrepreneurial doctor in New Jersey understood that healthcare costs could be lowered by targeting high-cost chronic disease patients who made frequent use of health and hospital services. The service he developed, the 'Camden Coalition', does more than simply provide conventional medical care. Patients are offered what really amounted to social work for those with a range of social problems (such as homelessness and drug abuse) that exacerbated their illness and made it difficult to properly manage their health conditions. Despite the savings generated to the public health system, the Camden Coalition has to rely solely on private philanthropy to fund its activities. This is because the top-down, command-and-control US public health system does not pay for this kind of unconventional medico-social work, despite it working. Attempts to secure public funding ran up against bureaucratic obstacles in government agencies used to dictating the services providers must supply and the amount they will pay based on a set of protocols.[51]

The lesson is that if innovation is to flourish, it needs to be nurtured by a real market in which there are real buyers and real sellers of health services. This is a challenging lesson because it stands much of the existing health economy on its head. Instead of paying health providers to carry out prescribed tasks at a set funding 'price', it speaks of a more dynamic, competitive and contestable environment that will enable innovative ways of providing health services to be generated from the bottom up. Entrepreneurial providers that deliver cost-effective, patient-centred healthcare need to be able to thrive and be rewarded for discovering what works to increase efficiency and lower costs, by being able to sell that value proposition to purchasers who care about price, quality, and effectiveness.[52]

Private Sector Managed Care—Medicare Select

Private health insurers in Australia face similar policy challenges to the public health system. They too confront the problem of a relatively small number of members who suffer complex chronic illness generating the bulk of health service costs, including frequent admissions to hospitals. The insurers also face the problem of adverse selection and individuals—particularly as they age—taking out, maintaining and upgrading their private cover when they believe their health status means they are most likely to access healthcare. Community rating rules mean health funds are obliged to insure all comers and are not allowed to refuse cover or charge higher premiums to 'bad risk' elderly or chronically ill patients.

In relation to addressing the issues that push up premium and benefit costs, and threaten to make private cover unaffordable, insurers' hands are also tied on two further fronts in trying to manage the financial risks involved in covering the cost of members' healthcare. Federal health insurance regulations prevent private health funds from covering any out-of-hospital services already funded through Medicare. This includes paying for the kind of community-based GP and other medical services that might, under the right conditions, reduce hospital admissions. Health funds also have limited ability to manage the utilisation of hospital services because they are subject to a strict insurance indemnity, which mandates that funds must pay for member's hospital care if the admission is approved by a registered medical practitioner—an arrangement that inherently carries the risk of supplier-induced demand and over-servicing, especially for procedural surgical care. These regulations are currently under reconsideration as part of yet another federal government review—the Private Health Insurance Consultations.[53]

The common problems faced across the public and private systems suggest that the resources deployed in both systems could be better used if combined to address the same challenges. This is part of the logic behind the national health reform plan under which it has been suggested the existing Medicare scheme be replaced with a new publicly-funded, privately-operated health insurance scheme, known as Medicare Select.

The proposal is that all Australians would receive taxpayer-funded health insurance vouchers, with the value of the voucher being risk-adjusted for factors such as age, gender, health status, and socio-economic criteria. Vouchers would be used to partly pay for the cost of purchasing insurance from a competing range of health and hospital plans that would cover a minimum mandatory set of essential services. Health funds would be responsible for purchasing services from hospitals and other providers on behalf of their members.

The advantages of Medicare Select compared to the status quo would include greater consumer choice and provider competition. In the new competitive environment, publicly-funded health cover would be portable and funds would compete on price and quality to win and retain members. To enhance competition on the insurance side of the new system, funds would also charge private premiums paid for out of individual's own pockets, with additional government top-up subsidies for low income groups. The key changes would, however, be on the services side of the health system. Instead of operating as passive payers of medical and hospital bills, health funds would operate as active purchasers of healthcare from competing producers. To limit premium and benefit costs, and attract and retain members, funds would seek to ensure the services they purchase are provided at the best price and highest quality, and successful providers will have to meet these cost and quality criteria to win service contracts.

After extensively reviewing and cataloguing the problems with the current health system, the NHHRC final report endorsed the Medicare Select model as its preferred long-term health reform option.[54] One of the chief recommendations for a Medicare Select-style, risk-rated, private sector 'managed care' scheme is that it would remedy the structural defects that plague Medicare. Private health funds would hold the full financial risk for member's healthcare needs across the full service spectrum. They would thus have a superior incentive to ensure health resources are used as efficiently as possible so patients receive the most appropriate and cost-effective care. This would include seeking to reduce the cost of insuring chronically ill members by ensuring their conditions are properly managed by appropriate primary care to prevent expensive episodes of acute illness requiring hospitalisation. Enabling health funds to operate active purchasing agents would establish the kind of contestable market environment that would spur providers to innovate and discover the most cost-effective means of delivering health services.

Under these conditions, a substantial reorganisation of health service provision could be envisaged. Chronic care could well be offered by disease-specific specialised clinics that will emerge to fill a clear gap in the market. Funds would negotiate contracts with these clinics, which would be the default 'medical homes' of members, and would be paid not solely for delivering 'inputs'—on a fee-for-service basis—but based on their ability to deliver innovative and high-quality 'outputs' in the form of cost-effective packages of care providing ongoing courses of treatment that maintain and improve the health of patients. As importantly, American experience with private sector managed care suggests there is considerable scope to directly address the over-use of hospitals in traditional health systems by delivering care in alternative lower-cost settings, either in specialists' outpatient rooms or in fit-for-purpose community-based specialist clinics. This is particularly important if, as the evidence suggests, improving the quality of primary care uncovers unmet need for hospital care, which better managed care could divert for treatment into lowest cost settings. This is to say that the Medicare Select option possibly offers a pathway to alternative payment models that are cost-effective.

Integrated Care and Alternative Payment Models

Literature discussing the failure of top-down primary care reform efforts reveals additional support for reconfiguring the insurance side of Medicare as a first step towards improving the quality and efficiency of health services. For healthcare to be considered truly coordinated across the health system, it needs to span the divide between hospital and community-based settings. Existing primary care reform strategies struggle to bridge this divide due to the institutional and fee-for-service payment system legacies of established health systems, which foster inefficient practice and encourage over-servicing. Herein lies the purpose of recent initiatives, mainly by private insurers in the United States, to develop integrated care and payment models to improve overall health system efficiency.[55]

Integrated care is fundamentally different to standard coordinated primary care programs.[56] Integrated payment models are designed to ensure that financial risk for both the hospital and non-hospital health costs of patients is shared with health service providers by combining traditional health funding streams into one bundled payment (which can be adjusted for risk factors). Providers who—in return for the specified payment—are contracted to deliver all the healthcare of patients for a specified time period have a superior incentive to change traditional patterns of care, efficiently manage the care pathway and the full cycle of care of patients, and provide the most appropriate care in the lowest-cost setting. They thus have a financial incentive to focus on improving both performance and patient outcomes by discovering what actually works best —the optimal service mix, design, and structure—to keep patients out of hospital. While fee-for-service payments encourage over-servicing by rewarding providers based on the volume of services delivered, and capitation payment alone (for siloed primary or hospital services) can encourage providers to under-service and deny care to limit costs without improving outcomes, integrated payments incentivise providers to deliver the right amount and right type of care at the right time—or bear financial responsibility for the additional cost of inefficiency and adverse outcomes for patients.[57]

Compared to the lack of evidence to support existing approaches to primary care reform, making service providers financially accountable for quality and cost across the continuum of healthcare looms as the logical and clear-cut way to generate cost-effective service innovations from the bottom up.[58] Examples of promising improvements in quality, efficiency, and reductions in cost of care include the Gesundes Kinzigtal scheme in south-west Germany, where a health management company has contracted with the government insurer to provide—in partnership with a local physicians' network—both primary and hospital care for insured patients.[59] The 'Alzira model' developed in the Valencia region of Spain has similarly achieved positive results after the private operator of the local public hospital also assumed responsibility for the primary care. The private

company made the integrated capitation contract work financially by both developing chronic disease programs and improving the productivity of the hospital.[60] Similar privatisation in other regions of Valencia has reputedly reduced costs by 25% through use of capitation funding and by permitting competition between hospitals.[61]

Integrated payments models are also known as "value-based contracting."[62] This is apt because the term more accurately describes the financial incentives in play, which allow providers to share in the value they create by achieving efficiencies, particularly by reducing use of hospitals. To put it bluntly, traditional health systems take large sums of health dollars off the table through payment systems that reward inefficient practice and over-use of services. Integrated payment models put that money back on the table, and give providers a financial incentive to gain a share of that money according to the value they can add to the system for insurers by eliminating waste and by achieving cost-saving improvements. Providers who create value by better managing the cost of care below the value of the service contract are rewarded by being able to retain (all or part of) the savings achieved by making more efficient overall use of health system resources.[63]

Before financial risk can be shared with providers through value-based contacting, the insurance side of public health systems must first be transformed from simple funding or payment mechanisms into authentic insurance risk-management systems. Literature canvassing the failure of existing approaches to health reform outlines that this initial transformation is essential if the problem of funding and institutional silos across primary care and hospital sectors—and the resulting system inefficiencies—are to be addressed. As Charlesworth, Davies and Dixon argued in their review of NHS payment reforms, real progress towards a more efficient integrated care and value-based contracting model would require substantial changes to the UK's taxpayer-funded public health system architecture, along the lines of that which has occurred in Netherlands, which in 2006 replaced its traditional Medicare-style public health system with a Medicare Select style system of publicly-funded insurance vouchers and competing private health insurance funds.[64]

The transformation of the insurance side of the Netherlands health system has led to experiments in new purchasing and payment arrangements. This includes pioneering development of 'episodic payments' for inpatient care, which bundle all the costs associated with a normal procedure, including the doctor's fee, into a single payment to a hospital. In combination with price contestability—the value of episodic payments is negotiated between insurers and hospitals—this has encouraged the development of more efficient specialist clinics that focus on treating particular conditions.[65]

In 2010, to further promote efficiency through enhanced care coordination, payments for chronic disease (diabetes, chronic obstructive pulmonary disease, vascular risk management) care were bundled together into a single contestable fee. Region-based 'care groups' (usually owned by GPs) have contracted with insurers to provide specific chronic disease services for patients—but only across primary settings. Not only was hospital care excluded from the disease-specific bundle (along with any general care required), but the generic services covered by the single fee (which included check-ups by practice nurses and sub-contracted allied healthcare by other providers) were centrally-determined by the national health department, complete with care protocols and aggregate quality targets and indicators.[66]

The Dutch 'innovations' more closely resemble the QOF in the UK, and thus seem to constitute a form of performance-based fee-for-service arrangement, rather than a truly integrated, outcomes-orientated, and value-based care and payment system. Unsurprisingly, an evaluation found that while processes of care had improved, the administrative burden was great, and large differences in price and performance not explained by differences in levels of care were are also found. This could be attributed not only to the lack of sufficient financial incentives to generate efficiencies, but also to lack of sufficient provider competition within regions dominated by a single care group.[67]

Despite the changes to health insurance architecture, the Netherlands appears to have persisted with a top-down approach to primary health reform. This suggests that even transforming the insurance side of health economy is not enough to transform service provision if this does not lead to sharing financial risk with truly integrated and financially accountable providers. The importance of integrating financial risk with service delivery is highlighted by one of the best-known but often misrepresented examples of fully integrated and accountable care health management and service provision: Kaiser Permanente.

Kaiser Permanente—Managing Care, Risk, & Utilisation

The managed care regimes pioneered in the United States by Health Maintenance Organisations (HMOs), are often cited in support of the promised benefits of coordinated primary care.[68] The cost-effective, high-quality model of care developed by the California HMO Kaiser Permanente is an especially popular example, but its lessons are selectively cited. One of the key lessons is to recommend a Medicare Select form of health insurance, which would allow insurers and providers to share financial risk for member's healthcare costs.

Kaiser Permanente attracted renewed international attention following the publication in 2002 of a study that compared its performance against the British NHS. It was found that Kaiser achieved better performance outcomes at a lower cost: far superior access to specialist and tertiary treatment compared to the much longer waiting times for specialist and hospital treatment in the NHS. The key finding was that "age adjusted rates of use of hospital services in Kaiser were one third of those in the NHS."[69]

Due to the competitive nature of the US health market, HMOs aim to provide almost immediate access to medical care, and they accomplish this by managing the care of patients to ensure all medical services are provided in the most appropriate, efficient, and cost-effective setting. HMOs like Kaiser Permanente take a cost- and access-conscious approach to managed care because they have to compete with other HMOs for the custom of health insurance buyers (mainly governments and employers) who bargain hard on price. They also have to compete against strict indemnity insurance rivals, and thus satisfy individual members, who are demanding customers and are free to move between HMOs if dissatisfied. Competition and choice create the incentive to keep costs low while being responsive to patient demand.

The Kaiser in-house model of service delivery is different to the medical network model—which integrates independent providers into a coordinated care system—discussed in the sections above and below. Kaiser operates its own community-based health centres that employ physician assistants and nurses to provide patient care, as well as accredited doctors who are able to perform quite complex procedures to free up other specialists for more serious cases. Kaiser, like other HMOs in the US, also identifies high-risk chronic disease patients and offers coordinated chronic disease programs led by practice nurses. Kaiser's salaried employees across the health professions, including doctors, are also committed to the philosophy of delivering team-based multidisciplinary care.[70]

The 2002 study found that compared with NHS patients: "Kaiser patients are far more likely to receive appropriate treatment and intervention for diabetes and heart disease."[71] This might appear to suggest that Kaiser's lower frequency of hospital admission

can be attributed to the resources-focused enhanced primary care services. However, this overlooks a 2004 study by Firemen and others, which found that Kaiser Permanente's programs, while improving the quality of patient care, did not decrease costs as expected. Higher spending on better-coordinated primary care had not produced the predicted cost savings on reduced hospital admissions—which "did not happen, despite increased use of effective medications and improved risk-factor control"—to offset the substantially higher cost of providing higher quality primary care.[72]

Moreover, the 2002 study actually found that what overwhelmingly accounted for "the nearly four times the number of acute bed days per 1000 population per year in the NHS than in Kaiser" was efficient use of expensive hospital beds. The reason for Kaiser delivering more care at lower cost was, as the study outlined, the striking difference "in the management of admissions and length of stays," which meant that "Kaiser members spend one third of the time in hospital compared with NHS patients."[73]

In other words, hospital beds were used more intensively or not used at all, due to rigorous management of hospital admissions and discharge procedures and because by overcoming the traditional institutional divide between primary and hospital care, Kaiser can treat more patients for more conditions in its lower cost community-based health centres. This—plus having two to three times the number of specialists the NHS does—was why "Kaiser can provide more and better paid specialists and perform more medical interventions with much shorter waiting times than the NHS for roughly the same per capita cost." The study also indicated that this was why Kaiser could afford the additional costs of superior-quality nurse-led chronic disease care.[74]

Accountable Quality Contracts in Massachusetts

There is a perception that the lessons of Kaiser Permanente have limited applicability to other health systems. This is because the outcomes Kaiser achieves are said to reflect the unique features of its in-house provision of care, including the internal culture of its staff (especially the willingness of doctors to work for salary as part of medical teams) which has taken decades to develop.

Yet there is emerging evidence that American insurers – seeking to rein in the out-of-control cost of US healthcare - can achieve Kaiser-style results if they strike the right contractual relationship with integrated and financially accountable providers. This shows that insurers do not necessarily need to run their own in-house facilities to achieve the same results as Kaiser, but can outsource management of all aspects of patient care to health management companies. Health management companies can then create a medical network by sub-contracting service delivery to individual providers, while providing the infrastructure necessary to overcome fragmentation and manage or coordinate the care of patients by: investing in communication and electronic health record IT; monitoring service usage and outcomes; redesigns of care pathways; and operating targeted chronic disease programs. The best evidence of the potential impact the right financial incentives can have is the promising results of the pioneering development of integrated contracts by Blue Cross Blue Shield of Massachusetts. Here, health management companies are providing Kaiser-style results by providing networks of otherwise separate healthcare providers with the leadership and management required to deliver integrated care.[75]

In 2009, Blue Cross Blue Shield initiated a new integrated payment program, the Alternative Quality Contract (AQC). Under the terms of the contract, health management companies agreed to manage the care of Blue Cross members in return for an annual risk-adjusted budget based on historic per-member spending. The 'global payment' covered the cost of care across the entire primary, specialist and hospital care continuum for a patient population for a specified period, combined with bonus payments for meeting specified quality indicators. All healthcare accessed by members, whether delivered by a provider belonging to the health management company's sub-contracted 'medical group' network or by a non-network provider, is funded from the medical group's budget. At the end of the year, total payments are reconciled with the budget, and any money left over is paid to the medical group company. ACQs are two-sided—or shared savings and shared risk—contracts. Part or full financial risk for exceeding the budget target is born by the medical groups on either 50% or 100% basis depending on the level of the risk accepted by the provider. By holding providers accountable for cost of care, Blue Cross's ambition across the five-year term of the contracts was to cut annual growth in healthcare spending in half.[76]

Under the ACQ, patients were enrolled with a medical group based on the affiliation of their doctor of choice. The group was thereafter responsible for managing their care by acting, in effect, as their medical home, or rather by creating a patient-centred 'medical neighbourhood'.[77] Alert to the need in a competitive insurance market to ensure members received excellent care, Blue Cross sought to ensure that medical groups did not skimp on services to reduce costs, by including in the contracts generous financial incentives (up to 10% of the global budget, 5% for primary care, 5% for hospital care) for high quality as measured by 64 process, outcome and patient experience indicators covering inpatient and outpatient care. Blue Cross does not just provide regular updates on group spending and service usage, including comparative data from other providers. In addition to the financial incentives, it also provides data and feedback on quality scores, practice variations, and other information that will assist medical groups hit quality targets such as by ensuring patients receive chronic care management services. To drive cultural change, encourage teamwork, and build support for the objectives of the ACQ contract, groups either used—or intended to introduce—bonuses for doctors, linked to quality improvements and efficient use of services.[78] Since 2011, ACQ contracts have linked quality to shared savings and losses, with higher quality scores entitling providers to larger savings and to smaller shares of budget overruns.[79]

However, ACQs are no standard pay-for-performance program, due to the way real financial accountability encourages innovations that improve financial performance. This was the key finding of the evaluation undertaken of the eight medical groups that signed the first contracts. The evaluators found, as might be expected, that the groups had implemented case management strategies that targeted high-cost 'frequent flyers'—members with multiple chronic diseases at risk of requiring expensive hospitalisations. This encompassed a range of initiatives that incorporated use of multidisciplinary coordinated care programs, but also included more intensive interventions with high risk patients—such as automatic contacting of discharged patients to ensure that discharge instructions were understood, medications were being taken, appropriate support services were engaged, and to monitor potential complications and side-effects. This also included home visits to monitor conditions and help with compliance with care plans. Some groups even employed their own clinicians to perform discharge planning, and placed case managers in hospital emergency departments to prevent unnecessary admission.[80] These efforts have been underpinned by investment in data management systems to improve both management of chronic care and clinician performance, and form part of overall efforts to increase efficiency of delivery systems by redesigning clinical and administrative processes.[81]

The evaluation found that ACQ groups achieved lower average growth in spending compared to other Blue Cross HMO providers. But even more significantly, this appears to have been due to rigorous management of hospital utilisation, more than due to successful management of chronic disease. These savings were found to be due to effective targeting of what was described as 'low-hanging fruit', or as having "accrued largely from shifts in services towards providers with lower outpatient facility fees."[82] To underline the point, the evaluation quoted one medical director's telling comments about the group's chief managed care objective: "What we really want to avoid is our patients receiving unnecessary care in the most expensive places in town." The focus on controlling hospital use was particularly important, in the words of the evaluators, because "in Massachusetts…nearly half of all hospital admissions are to high-cost teaching hospitals."[83]

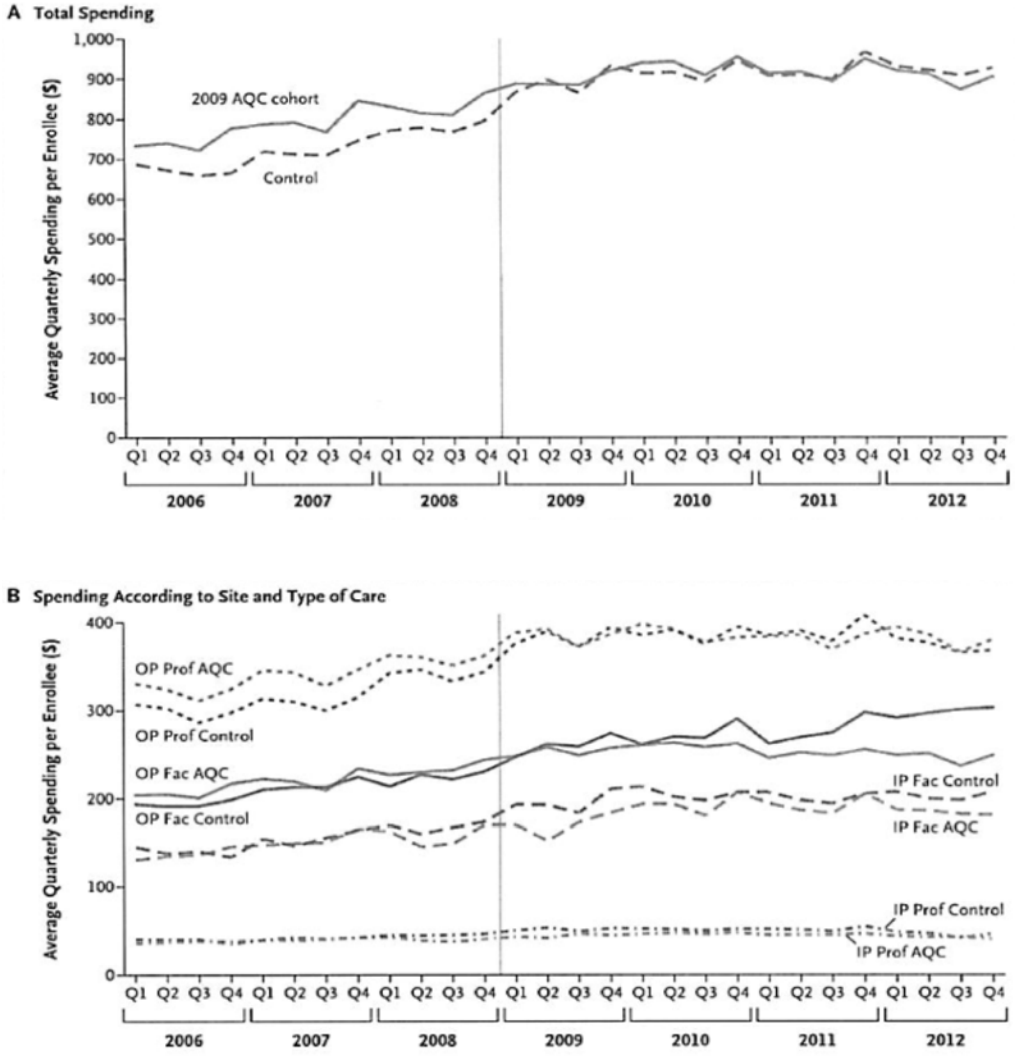
Low-cost groups focused on utilisation review and referral management to direct patients to less expensive facilities and settings. This involved implementing procedures to monitor referrals and educate clinicians about the cost of sending patients to much more expensive services outside the group's network of preferred providers. Hence, some groups explored adding specialists to their networks as the cheaper way to provide faster access to care. Managing referrals and hospital utilisation was found to be the highest priority for many groups because of the considerable cost savings that could be made by preventing admission to high-cost major hospitals. One group chose to sub-contract half its business from one preferred hospital to a different provider not only because fees were lower, but also because it was willing to share in the group's goal of using medical resources efficiently and agreed to assist with care coordination by sharing medical records and "to return patients to outpatient settings as quickly as possible."[84]

The initial evaluation found that the savings achieved by reducing prices and utilisation had not recouped the additional cost of quality bonuses. A subsequent evaluation of the first four years found that medical groups achieved an average saving of 6.8% compared to what was being spent on the same patients prior to the introduction of the ACQ. Average spending by ACQ medical groups was also found to have grown by less, compared to control groups in other states. These promising financial results were cost-effective; that is, they were achieved without compromising quality, with the improvements in quality achieved by ACQ medical groups generally exceeding those recorded elsewhere in the United States. Furthermore, by the fourth year of the ACQ's operation, net savings were achieved that exceeded the cost of quality incentives. It was found that 60% of the savings were generated by reduced prices (directing patients to less expensive providers) and 40% by reduced utilisation of procedures, imaging and testing, successfully bending the cost curve down for both inpatient and outpatient spending for ACQ groups compared to the control.[85] [Figure 1]

Figure 1. Cost Savings in Blue Cross Blue Shield ACQs

Unadjusted Spending in the 2009 Alternative Quality Contract (AQC) Cohort versus the Control Group, 2006–2012.

Panel A shows the total unadjusted spending. Panel B shows the results according to site of care (inpatient [IP] or outpatient [OP]) and type of claim (facility [Fac] or professional [Prof]). The control group comprised commercially insured enrollees in employer-sponsored plans across eight Northeastern states: Connecticut, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. The vertical line at the start of 2009 indicates the start of the AQC period.



Source: Z. Song, et.al, "Changes in Health Care Spending and Quality 4 Years into Global Payment', New England Journal of Medicine, 371, 18, 2014.

Hospital Utilisation—Identifying the Problem and Solution

What do the lessons from US managed care regimes mean for health reform in Australia? Advocates of the Coalition's primary care-focused health reform agenda rightly argue that rising government health expenditure in Australia is being largely driven by the increasing cost of hospital care.[86] They also point to the fact that acute hospital bed numbers in Australia have been stuck at 3.4 per 1000 people, while comparable countries in the OECD have achieved a considerable reduction in bed numbers over the last decade. It is claimed that "the only way to reduce bed numbers sustainably is to keep people healthy" and this is said to require "innovative models" that will offer "integrated care outside of hospital to avoid hospitalising, particularly for chronic disease"—as is the intent of the government's Healthier Medicare initiative.[87]

It is difficult to compare bed numbers across different countries and with different health systems, particularly given the geographical realities that dictate hospital bed provision in rural Australia. Nevertheless, there is strong evidence that Australia over-uses hospital care compared to other OECD nations. Australia has much higher acute hospital separations per person (0.41) and acute hospital bed days per person (2.36) than comparable countries such as the UK (0.27 and 0.57 respectively) and US (0.13 and 0.7 respectively).[88]

But does the high use of hospitals in Australia inexorably point to inadequate chronic care?[89] Not when just 10% of admissions are classified as 'potentially preventable'. A likely explanation for high hospital usage compared to the UK is the much larger number of privately-owned hospital beds allied with much higher rates of strict-indemnity, fee-for-service private hospital insurance cover—which reward both hospital operators and specialists for the volume of services provided, and encourages both to ensure that hospital beds are filled. The characteristics of Australia's private health system that encourage supplier-induced demand are reinforced by the characteristics of Australia's public hospital system. Under the terms of their contracts, specialists working as either Visiting Medical Officers (VMOs) or Staff Specialists have the right to admit private patients to public hospitals. The ability to access publicly-funded hospital infrastructure has allowed specialists, in effect, to operate small businesses offering procedural care to privately insured patients at public expense. The enduring ability of specialists to access free public capital (in addition to their private hospital work) seems to have militated against any wholesale shift away from hospital-based care in favour of delivering specialist procedures in community-based settings.

These systemic factors are almost certainly a major reason for the higher rates of hospital use in Australia. An additional systemic factor is the absence of US-style managed care organisations that have a real ability to minimise use of expensive hospital facilities by ensuring patients receive alternative specialist care as outpatients in lower-cost, community-based facilities. The evidence from the US experience with managed care indicates that major savings are more likely to be made on the cost of hospital care by managing hospital ultilisation rather than by chronic disease management. This suggests that it is unwise for advocates of health reform—be they advocates of private or public sector managed care—to place all their eggs in the primary care basket that is unlikely to generate efficiency gains on the scale desired. It also suggests that the health reform advocates should focus on the most cost-effective manner of treating the 90% of 'non-preventable' hospital admissions that account for the vast majority of demand for and cost of hospital services.

Conclusion: A Value-Based National Health Innovation Agenda

Prime Minister Malcolm Turnbull has said that he wishes to lead a government committed to "innovation" and "economic reform." Economic reform was in the 1980s known as structural or micro-economic reform, and consisted of measures that sought to boost local productivity and increase international competitiveness. One phase of that era of reform involved the deregulation of statutory monopolies through the privatisation of government agencies in areas such as electricity, ports, and other infrastructure such as roads and transport. Significantly, for political reasons, Medicare has been largely quarantined from this agenda.

In contemporary Australia, the chief economic reform challenge is to curb the ever-rising cost of health to government budgets. Hence, the Turnbull government has been encouraged by the Harper Competition Review to extend the market-based reform principles of the 1980s to the task of health reform. This would entail greater application of the principles of consumer choice, fostering greater competition between providers, encouraging the entry of private competitors into the health economy, and separation of regulatory, funding, and service delivery roles.[90] These are worthy goals, which have been optimistically taken up by advocates of the government's primary care reform agenda as establishing the framework within which these reforms will occur as a means of "opening up the health system to more contestability."[91]

Introducing a purchaser-provider split into the public system, particularly to enable the private provision of public hospital services,[92] is a natural extension of the reform principles of the 1980s. Yet the reform challenge is immense because these principles are foreign to the culture and political economy of the public system, and run up against myriad institutional and political obstacles—including public sector union opposition, to say nothing of the entrenched opposition of the organised medical profession to any proposal that even hints at the principle and practice of managed care. Institutional factors also include the lack of sophisticated contracting skills in public health bureaucracies. The later factor strongly suggests the tendency under any public sector chronic/managed care regime will likely be to default to the standard approach of top-down bureaucratic, primary-care focused program funding—which copious evidence indicates is a dead end if the intention is to develop genuinely innovative, effective and efficient, new and fully integrated, models of healthcare.

A different approach, consistent with the principles of economic reform, would be to bypass the bureaucracy in favour of outsourcing the task to the private sector more familiar with striking competitive commercial relationships between purchasers and providers. This is to recommend the Medicare Select model, and to envisage a situation wherein health funds managed the healthcare needs and financial risk of their membership by purchasing the most appropriate, effective and efficient services from financially-accountable and risk-sharing health providers. A fair question is whether health funds currently possess the skills to act as informed purchasers, given the long history of private health insurance essentially operating as a payment system guaranteeing that doctors' bills will be paid. The reform challenge for the private health industry is to accept that genuine reform would require a commitment to change long-established corporate mindsets and institutional structures to prepare for a new era of financial risk management and cost-effective management of care. The challenge for government is to recognise that a starting point for true economic reform and innovation in the health system would be to create a situation on

the demand-side of the health economy where there are cost and quality conscious purchasers, which in turn would stimulate innovations on the supply-side of the health economy to deliver the best quality and best value care.

In its recent review of the efficiency of the health system, the Productivity Commission argued there was some scope to achieve greater efficiencies that would improve the quality of, and access to, publicly-funded healthcare by undertaking 'within system' reforms that did not alter the current structure of Medicare.[93] But the Commission also argued that "the system's institutional and funding structures compromise its performance" and that "larger-scale reforms may be required to make real and enduring inroads into allocative and dynamic efficiency." In this context, the Commission singled out the need for reforms that addressed dominance of fee-for-service payments for both primary and hospital care, and flagged new integrated payment models that better aligned financial incentives and health outcomes. It also indicated the potential for private health insurers to play a leading role in addressing the systemic problems of complexity, perverse incentives, fragmentation and lack of coordination. Recognising the scale of the changes contemplated, it suggested that private health regulations barring health funds from involvement in primary care be relaxed in order to trial innovative integrated care initiatives that would help build the evidence base for reform. It also recommended that the process of long-term reform be "informed by a comprehensive and independent review of the health system."[94]

Such a review undertaken by a body like the Productivity Commission might well provide the intellectual ammunition required to build the case for structural health reform. But it cannot provide the political will and political capital that can only be generated not by committing to a process but by committing to a policy. Another review, moreover, would simply repeat the extensive work of the NHHRC, which has already concluded the Medicare Select model is the best option for systemic reform to achieve efficiencies and innovation through consumer choice and provider competition.[95]

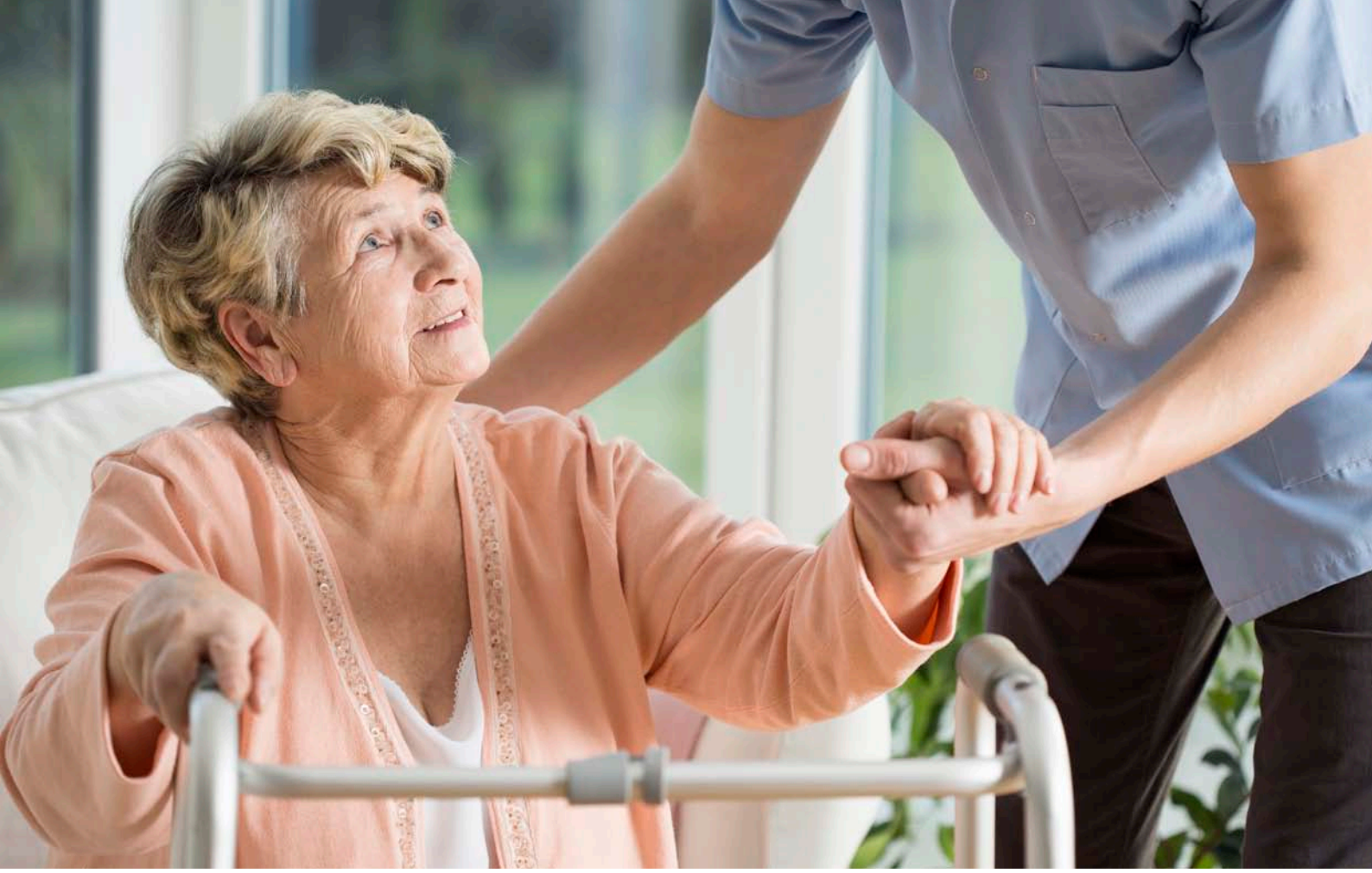
It is worth noting that this model is not as radical as it may sound: one of its first proponents was the health economist Richard Scotton, who was one of the architects of the original Medicare scheme in the 1960s. Scotton still believed in the provision of public subsidies to ensure access to essential health services regardless of means; the question he was prepared to face honestly was whether there were more efficient and effective ways of delivering those subsidies, and the care needed, than a 'free', universal, taxpayer-funded, fee-for-service payment system.[96]

It is also worth emphasising that the debate about alternative health payment models is anything but new. It dates to well before Scotton's disenchantment with Medicare, and back at least to the medical profession's success in breaking up the 'Friendly Societies' contract payment system in the 1950s at the time when federal government fee-for-service benefits for medical services were first made available under the Menzies government's National Health Scheme.[97] Discussion of alternative models has, however, always been shut down politically due to the strident and vocal opposition of the medical profession to any proposal to tamper with the fundamentals of the current fee-for-service arrangements.[98]

The political obstacles to structural health reform are thus formidable. The AMA has long signalled its preparedness to undertake 'managed scare' campaigns at any mention of introducing managed care regimes in Australia, in defence of the medical professions vested interest in the retention of the 'sacred (cash) cow' that is the fee-for-service Medicare system. Structural reform of publicly-funded services, however, requires telling existing provider-interest groups they can no longer have exclusive entitlement to public resources, because there are more efficient ways of using these resources and more efficient providers capable of providing the community with necessary services. The current Medicare system is captured by providers in a manner that permits inefficient practice to be perpetuated, and which principally benefits GPs and specialists by underwriting their private medical businesses.

Despite the intransigence of self-interested providers, the reality is that persisting with the Medicare status quo, and pouring additional taxpayer funding into the public health services to pay for coordinated care under the banner of so-called primary care reform, would represent the antithesis of genuine structural reform and health innovation. The further implication is that the calls by the Premiers of NSW and South Australia to increase the GST, along with all other mooted tax hikes to pay for the rising cost of public hospital care to state and territory government budgets, could well serve to prop up latently inefficient hospital-based health services. An economically rational approach to modernising the health system could free up and redeploy health resources in a more optimal and sustainable fashion to meet the healthcare needs of the nation.

To fulfil the Prime Minister's commitment to innovation and economic reform, the Turnbull Government should consider the structural changes to health system architecture that are necessary to transform the way health services are purchased and provided, to deliver to the community the best value healthcare for its increasingly scarce health dollars. A truly innovative national health reform agenda should explore ways of emulating the private sector managed care and alternative payment models that could potentially reduce the cost of health by effectively and efficiently controlling use of hospital services.



Coda: A Demand-Side Initiative—Opt-Out HSAs for Australia

In the interests of a better informed health debate—and heading off old leads across barren ground—this report has argued that correctly designed supply-side reforms have the potential to achieve positive outcomes for both the nation's health and its finances. It remains, however, that the effectiveness of these reforms could be significantly enhanced if policymakers are willing to consider and undertake simultaneous demand-side reforms.

The root cause of the ever-escalating demand for and cost of healthcare in traditional health systems is over-insurance of health services, particularly when insured services can be accessed for 'free' from the first-dollar spent on health in any year, as is the case with Medicare (so-called 'first dollar cover'). Excessive third-party payment, public or private, no matter the cost of care and no matter the acuity of condition, creates moral hazard. The propensity for over-use and over-servicing of 'free' healthcare is due to the absence of price signals—direct charges to patients—at point of consumption. Gadiel and Sammut have shown that Singapore spends a fraction of its national income on health than comparable OECD countries such as Australia (4% of GDP compared to over 9%), while achieving the same or better health outcomes. These cost-effective outcomes are attributable to Singapore's distinctive health system, the centrepiece of which is a national system of income-based, contributory, personal Health Savings Accounts (HSAs) that are used to pay for health services and health insurance. What sets the design of the Singaporean system apart from traditional health systems is that high levels of personal financial accountability for health expenditures are mandated by use of prices at point of consumption. In Singapore, individuals are required to fund minor health costs associated with GP care, allied health services and basic medicines, as of out-of-pocket expenses. The extensive use of direct patient charges is complemented by the use of insurance deductibles and co-payments for all inpatient care, thereby sharing the cost of insured services directly with patients.[99]

Behind Singapore's lower-cost health system is the design principle that people will spend their own money, their own health dollars, more wisely and judiciously than they will spend a third-party payment doled out by the government or health fund. The lessons taught by Singapore about the cost-effective way of financing healthcare are the inspiration for the CIS Health and Ageing Program's HSA-based health reform plan. Gadiel and Sammut have proposed that all Australians be given the choice of opting-out of Medicare, and converting their current taxpayer-funded health entitlements into a yearly 'voucher' for deposit into a tax-advantaged HSA. The value of the voucher would be annual, indexed, per person government health spending, currently $4300 in 2013-14.[100] Money deposited in HSAs would be used to pay for high-frequency, low-acute health services, including an approved list of GP and other non-hospital care. HSAs are designed to operate in conjunction with high-deductible chronic and catastrophic conditions. HSA

funds would also be used to pay for health insurance premiums to cover high-cost hospital admissions and major illness, and to cover co-payments and insurance deductibles.[101]

A HSA system would be fundamentally different to a Medicare Select-style scheme, but it would also facilitate insurance and payment reforms along similar general lines. A HSA system would also permit health funds to operate as financial risk holders and integrated care managers, responsible for catering for the chronic and catastrophic care needs of HSA holders by acting as informed purchasers and negotiating service contracts and preferred provider arrangements on behalf of their new, cost-conscious clientele. As an alternative to Medicare Select, HSAs would also avoid the need for the complex risk-rating of health insurance vouchers that are an essential feature of that model. Nor would it require the community rating of insurance premiums, which currently allows insurers to shift the cost of high risk patients on to a secondary re-insurance risk pool. The Risk Equalisation Trust currently administered by the Private Health Insurance Administration Council compensates those insurers paying higher than average benefits by redistributing money contributed from insurers paying less than average benefits. The operation of this risk equalisation mechanism essentially blunts incentives for insurers to effectively manage insurance risk. Under the HSA model the CIS has proposed, no health fund would be allowed to deny cover based on health status, but rather than community rating, bad risk would instead be priced into the cost of insurance premiums to encourage funds to properly manage the care of their members, contain benefit costs, and keep premiums competitive and affordable. Hence, the likely innovations a HSA system would spur include the efficiency and quality improvements canvassed elsewhere in this report with respect to enhanced chronic care, and the effective management of access to specialist care in hospital and outpatient settings.[102]

The dual advantages of a HSA-based model are therefore that it would address moral hazard through the use of prices across the entire health system to control demand, while also creating a contestable market for more efficient and cost-effective provision of insured health services—with the efficiency effects on the supply-side enhanced as providers compete on price and quality to satisfy customers spending their own health dollars to access care. Allowing individuals to self-fund their own healthcare and save over time to fund old age health costs would also improve health system sustainability and reduce future health costs to government budgets. Eliminating the inflated cost of moral hazard and over-insurance would improve overall health system affordability, including by lowering the cost of health insurance premiums. HSAs would also minimise the administrative costs of health insurance by reducing the volume of benefit claims requiring processing, while also reducing the operational costs incurred trying to direct members to preferred provider GPs, specialists and other ambulatory care.

The further advantage of a HSA-based system, moreover, is that it seems to offers a politically feasible path to health reform. This is not only due to the element of choice the CIS model entails—since those who do not wish to opt out can stay with Medicare—but also because of who would emerge as the winners from this reform process. Political support for HSAs could be mobilised by selling the 'hip-pocket' advantages to individuals, who stand to reap a financial benefit by opting out and choosing a lower-cost way to pay for health care. Under the CIS model, accumulated HSA funds will be merged with superannuation balances upon retirement, and thus be available to fund both rising age-related health costs and/or retirement incomes.

Our HSA-model could also potentially reduce the political obstacles to introducing a greater element of managed care into the portion of health services that would be covered by health funds. HSAs would allow for the retention of self-funded, fee-for-service payments and free choice of doctor for the vast majority of GP and specialist consultations—potentially weakening the medical profession's resolute opposition to the introduction of an element of managed care into the health system. Moreover, GPs could also benefit financially from integrated payment models that rewarded them for managing care efficiently. Allowing GPs to share in the money put back on the table in reducing hospital utilisation would address the disparity between GP and other specialist incomes that has long been a source of tension within the medical profession. The creation of a genuine private medical practice system, underpinned by patient choice, professional independence, and retention of the 'sacred' doctor-patient relationship, would also help to avoid the excesses of early forays into managed care in the United States, where some HMOs sought to contain costs by skimping on care by limiting the range of approved providers and services. These concerns about denial of access and lack of choice of doctor are at the heart of the campaign techniques used by the AMA to foster public concern and political timidity around the subjects of insurance and payment reform.

To accentuate the possible benefits of supply-side reforms, the Turnbull Government should also give due consideration to the benefits of demand-side initiatives as it formulates the Coalition's health reform plans. It is conceivable that the CIS Opt Out HSA model could be offered alongside, and as an alternative to, Medicare Select for those who prefer it, should the government decide to go down the path of structural reform. HSAs should be on the table as a reform option for the simple reason that self-funding of—and greater personal financial responsibility for—health care expenditures would be the most effective way to curb the healthcare use and cost spiral that endangers the sustainability and affordability of the Australian health system. A HSA-based health financing model would also allow for the appropriate retention of fee-for-service medicine in a real market setting, and for the innovative integration of insured services at the high-cost, high risk end of the health system—a combination that might smooth the rough political waters that all meaningful health reforms must navigate.

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MEDI-VATION:
'Health Innovation Communities' for Medicare Payment and Service Reform

Jeremy Sammut
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Contents

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Executive Summary

Conservative estimates suggest that structural inefficiencies in the $155 billion Australian health system currently cost the nation $17 billion annually. Based on this estimate of wastage of 11%, the aggregate 'healthcare cost gap' attributable to cost-ineffective health spending over the decade since 2004 is $140 billion – a sum sufficient to have nearly halved what in 2014 was Australia's $320 billion national debt. These inefficiencies mean we spend too much on some types of healthcare and not enough on different kinds of health services that may lower costs and improve outcomes. Although we are wasting 11% of the total national health spend, lack of reform at the systemic level prevents service redesigns that could deliver better value for money and more cost-effective healthcare for Australians.

Under both the Medicare and private health insurance systems, the bulk of health funding is locked up in inflexible 'fee-for-service' payment models that principally reward doctors for providing one-off services and unintegrated sets of either medical (mainly GP) care or hospital care. The *Health Insurance Act* also bans private health insurers from paying benefits for any out-of-hospital medical service for which Medicare rebates are available.

The rigid public health system and the regimented private insurance system both prohibit the development of alternative models of integrated healthcare covering the full service spectrum and full cycle of care — including innovative preventive and chronic care services involving novel care pathways that could reduce the disease burden, manage chronic illness more effectively, and minimise the use of high-cost hospital services. The existing service systems also provide no incentive, and limited assistance, for individuals to take responsibility for their own avoidable health risks. Input-focused and transactional in nature, providers are rewarded simply for delivering discrete health interventions irrespective of the results, rather than rewarded based on 'outputs' — overall improvements in health status and wellbeing.

Despite these defects and limitations, 'Big Bang' reforms of the existing architecture of the health system would entail enormous dislocations of current practice and carry the risk of unintended consequences. Fundamental changes to existing arrangements are also likely to be stymied by political obstacles, especially the vocal opposition of vested interests, together with the Australian electorate's conservatism regarding significant changes to Medicare.

The way to avoid these impediments and pitfalls — but still allow for innovation and disruption in health — is by establishing 'Health Innovation Communities' (HICs — see Box).

HICs would maintain the core principles of fairness at the heart of Medicare – that is; taxpayer-funded, equitable access to high quality and affordable health services for all Australians irrespective of means. This report questions the current fee-for-service Medicare arrangements, and especially its GP-centric approach to primary care, given its well-recognised limitations in addressing chronic diseases and preventative health. But the report also affirms the core principle at the heart of Medicare — universal availability of healthcare for all citizens — under the new and potentially diverse payment and service models that are foreshadowed here as emerging within Health Innovation Communities.

HICs are based on the concept of free trade zones, which throughout history have been established to relax existing cultural norms and laws and thereby remove disincentives that impede commerce and prevent the development of new modes of doing business. In essence, HICs would make it legal for organisations, both public and private, to develop more efficient and sustainable models of care that would improve health outcomes. They would also make it legal for consumers to choose a publicly-funded alternative to the current structure of the Medicare scheme (the existing MBS benefits for GP and other medical and primary care services and right of access to free public hospital care) on an opt-in basis.

Each HIC would essentially constitute an Australian 'Silicon Valley' for health – hubs for research and development within which innovation will flourish as a plurality of different providers create novel health products and solutions.

The opportunities that HICs will open up for payment and service innovations will demonstrate the benefits of doing things differently in health. Individuals will benefit both financially, and in terms of health and wellbeing, from innovations that not only lower the cost of health to government and the cost of private insurance, but also reallocate and use resources more efficiently to improve health outcomes. HICs will, for the first time, put the needs of chronic patients at the centre of the health system, as cost-effective Integrated Care Plans (ICPs) are developed that provide continuity of care and ensure chronic patients receive the full cycle of all necessary care to properly manage and maintain their conditions. The good examples and real world (as opposed to trial quality) evidence of better practice and outcomes that will be rapidly generated — by weeding out unsuccessful from successful ICPs — will seed structural reform and establish functioning models and workable blueprints for systemic change.

Given the financial challenges posed by the ever-escalating cost of health to government budgets, we must start somewhere to catalyse change. Health Innovation Communities are a viable and creative way of disrupting the unsustainable status quo and initiating the health reform process. A national health innovation policy that establishes HICs can ameliorate the toxic, innovation-killing politics of health. The current Medicare entitlements and private health insurance arrangements of the vast majority of the population, and the familiar public and private payment and service systems, will remain intact, with exemptions from the existing rules applying only within dedicated regions and with fully consenting individuals. ICPs will apply only to those consumers living within HICs who choose to opt-in to the new system.

HICs will not threaten the primacy or principles of Medicare. Public subsidies for health will continue to provide universal access to health services, and no Australian will go without healthcare due to lack of income. However, HICs will allow new ways to be developed to better use our increasingly scarce health dollars to provide improved and more sustainable health services to Australians. The superior financial results achieved, combined with the improved outcomes for patients, could potentially create broader community consensus and support for releasing the shackles on innovative models of healthcare payment and service delivery across the entire health system.

Box: Health Innovation Communities (HICs) – Key Design Specs

- Within geographic areas declared to be HICs, healthcare providers would apply for exemptions from existing health legislation and regulations to permit creation and use of alternative payment and service delivery models that are currently banned under Medicare and the *Health Insurance Act*.
- Companies, start-up entrepreneurs, charities, private health funds, and federal and state government health agencies would all be eligible to apply for registration as HIC-exempt providers by a joint government and industry-led HIC Commission.
- Exempt providers will accept and recruit individuals who want an alternative to the existing public and private health systems and who voluntarily choose to opt-in to an Integrated Care Plan (ICP). To prevent cream-skimming and a two-tiered system, a condition of the grant of exempt-provider status will be that ICPs must cater to both public and private patients; successful models will hereby be built fit for purpose, and be suitable for potential national, system-wide roll out under Medicare.
- ICPs will require inter-governmental and health sector agreements to 'pool' existing public and private sources of health funding (depending on the insurance status of each volunteer) on a capitation basis; a pooled funding model is essential to support genuinely integrated care, and give providers the ability, flexibility, and financial incentive to develop new, cost-effective care pathways.
- Appropriate safeguards will include a right for customers, when outside HICs, to access emergency care from traditional Medicare and private health insurance providers. Customers within HICs will also have the right to break the ICP service contract, and return to default Medicare and private insurance arrangements, in exceptional or egregious circumstances as arbitrated by an ICP Ombudsman. When ICP providers fail, consumers will also default back to Medicare, meaning no one will ever miss out on access to essential healthcare.
- HICs will be established in three to five areas to provide critical mass, benchmarking and competitive tension, and be allocated between the capital cities and also regional areas to ensure sufficient differentiation. Preferred locations will have proximity between a major hospital, university or medical school to support research, collaboration, training, measurement and control in partnership with Australia's renowned and world-leading publicly-funded medical research industry.
- Ideal sites will also have a target population base with high rates of obesity, chronic disease, and frequent use of hospital services related to chronic illness, and may include, for example, the catchment area for Westmead Hospital in Western Sydney, the Hunter region in mid-north coast of NSW, and the state of Tasmania.

Introduction: The Trouble with Health Reform

The trouble with health reform is *not* that we do not know the kind of structural problems that need to be addressed to create a more sustainable health system in Australia. There is a range of policy options that would deliver better value for money and more cost-effective healthcare. Many of these reform ideas have been canvassed in recent major reports both by official government bodies and health industry groups. Many of these solutions are well known, having long been discussed in health policy circles and featuring in a litany of reports, reviews, and inquiries into the health system over many years.

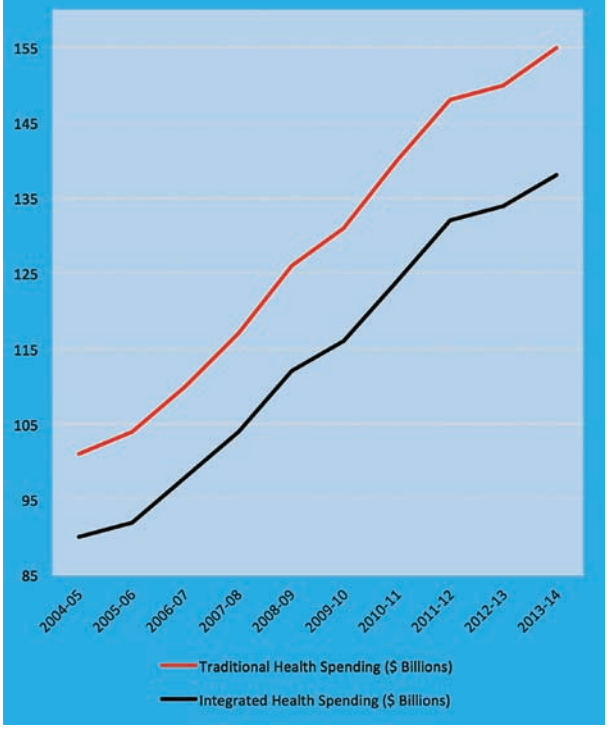
For example, the 2015 OECD review of the Australian health system flagged, yet again, the perennial problems posed by the fragmented nature of the system. The fact that in both the public and private systems, no single funder is responsible for the entire healthcare needs of patients, skews incentives, reduces efficiency, and increases costs by preventing the integration and coordination of primary and hospital care.[1]

The allocative and technical inefficiencies in Australia's $155 billion health system mean that many Australians are not receiving the right care in the right place at the best price possible. Conservative estimates suggest these inefficiencies currently cost the nation at least $17 billion a year — wastage of 11%. Based on this estimate of the level of inefficiency in the health system, the aggregate 'healthcare cost gap' attributable to cost-ineffective health spending over the decade since 2004 is $140 billion — a sum sufficient to have nearly halved what in 2014 was Australia's $320 billion national debt (see Figure 1). The 11% of the total national health spend that is wasted represents a significant net welfare loss that could potentially be saved, redeployed or redirected through cost-effective service redesigns.[2]

But despite the great deal of attention paid to expounding these well-known problems, the vital element lacking in the health debate is an effective, politically-feasible reform strategy that will allow the solutions to be implemented to improve the outcomes and performance of the health system. Because the political obstacles to achieving significant change and redesigns of health funding and service arrangements are so formidable, there is a tendency for much of what passes as the discussion of the future of the health system to be obsessed with simply describing the problems. The debate needs to instead focus on developing practical and achievable solutions to overcome the technical and institutional impediments to change that plague the health sector.

Figure 1: HEALTHCARE COST GAP. Traditional Health Spending & Intergrated Health Spending*, Australia 2004-2014

*Based on 11% efficiency gap estimated in *Health Reform: Higher Quality, Lower Costs. A Port Jackson Partners Limited Report to Private Healthcare A*



Review of the existing health debate therefore serves the dual purpose of not only clarifying the problems within the existing health system, but of identifying the limitations of the debate itself with regard to initiatives and mechanisms that can lead to genuine innovation within the health sector. This report argues that both of these deficiencies — both the structural problems and the shortcomings of the so-called 'solutions' that are offered — can be overcome by taking the national discussion of health reform in a new direction. A national health innovation policy that establishes the 'Health Innovation Communities' proposed and described herein, is first step towards reaching the long sought-after solution for the healthcare funding and delivery problems that continue to stubbornly resist change.

Public Sector Rigidities

Another good, recent example of the trouble with the health reform debate is the April 2015 Productivity Commission Research Paper, *Efficiency in Health*, which re-identified three "well-understood" structural inefficiencies within the Australian health system. These inefficiencies mean we spend too much on some types of healthcare and not enough on different kinds of health services that may lower costs and improve outcomes.

The first inefficiency identified by the Productivity Commission is inadequate focus on preventive health to address problems — such as obesity — that are a leading cause of chronic disease. The second inefficiency is inadequate focus on the ongoing management of chronic disease in a community or non-hospital based primary care setting. The combined effect of the first and second defect contributes to the third defect, which is the significant number of high-cost hospital admissions (up to an estimated 10% of total admissions) that were potentially avoidable had prior, appropriate and lower-cost preventive and chronic care been available.[3] In general, the Australian health system is 'hospital-centric', and has considerably higher rates of hospital use compared to comparable OECD countries due to systemic factors, especially 'fee for service' payments for specialist services (see below).[4]

The Productivity Commission rightly argued that these structural inefficiencies are allocative in nature. Alternative models of care that would spend existing health dollars more effectively are not adequately resourced as a result of the "effects of current institutional and funding structures on the performance of Australia's health system."[5] Policy objectives and financial incentives are misaligned because, in both the public and private health systems, the bulk of health funding is locked up in inflexible fee-for-service payment models. Healthcare providers, mainly doctors, are principally rewarded on a basis for providing one-off episodes of either medical (mainly GP) care or hospital care when acute illness or disease strikes.[6] Rather than a comprehensive health insurance and risk management system, the rigid public health system and regimented private insurance system both primarily function as provider-captured payment mechanisms for separate sets of hospital-based care and community-based primary care.[7]

Fee-for-service payments not only prohibit the development of alternative models of integrated healthcare covering the full service spectrum and full cycle of care; they also encourage doctors to increase activity to maximize income, and thus lead to costly and unnecessary over-servicing — including elevated rates of hospital use.[8] Jurisdictional complexity also accounts for the fragmented nature of health service provision. Under Australia's complex division of health responsibilities, the federal government is primarily responsible for healthcare delivered outside hospitals, and state governments responsible for public hospital care. No single level of government or funder has full responsibility for all the health care needs of patients, and no direct control over the kind of services patients receive and the locations where those services are provided.[9]

Lack of systemic reform to remove structural rigidities is throttling service delivery innovation that could improve the quality of care, save scarce health resources, and redeploy existing funding more efficiently. With regards to public hospitals, for example, joint federal-state funding is paid on 'activity-basis' at the so-called efficient price determined by the average cost of particular hospital services across the system. Activity funding (which is essentially another form of fee-for-service) not only continues to encourage over-servicing; it also rigidly ties funding to existing hospital-based models of care — at a large recurrent and capital cost to the public finances — and prevents service redesigns that may increase efficiency and improve outcomes.[10]

Private Health Regimentation

Complexity, fragmentation and inflexibility also apply in relation to privately-funded health services, due to the regulations that apply to private health insurance. Private insurers are covered by a strict indemnity, which mandates that health funds must pay for member's hospital care if the admission is approved by a registered medical practitioner. The indemnity — and hence the blunting of price signals for insured services — has major implications for usage of hospital services, especially of discretionary procedural care and when copayments are completely avoided via 'No Gap' cover.[11] These demand-side problems on the private insurance market are compounded by problems on the supply side. The *Health Insurance Act* also bans health funds from paying benefits for any out-of-hospital medical service for which Medicare rebates are available. The rationale for these regulations is to prevent a two-tiered health system, in which privately insured patients secure preferential access to doctor's services due to the higher payments available. These concerns are debatable given the experience in other comparable health systems: private insurers in New Zealand are free to cover the full spectrum of healthcare costs without undermining 'free and universal' objectives of the government-run health system, and without raising even the fear — let alone the reality — of a two-tiered system.[12]

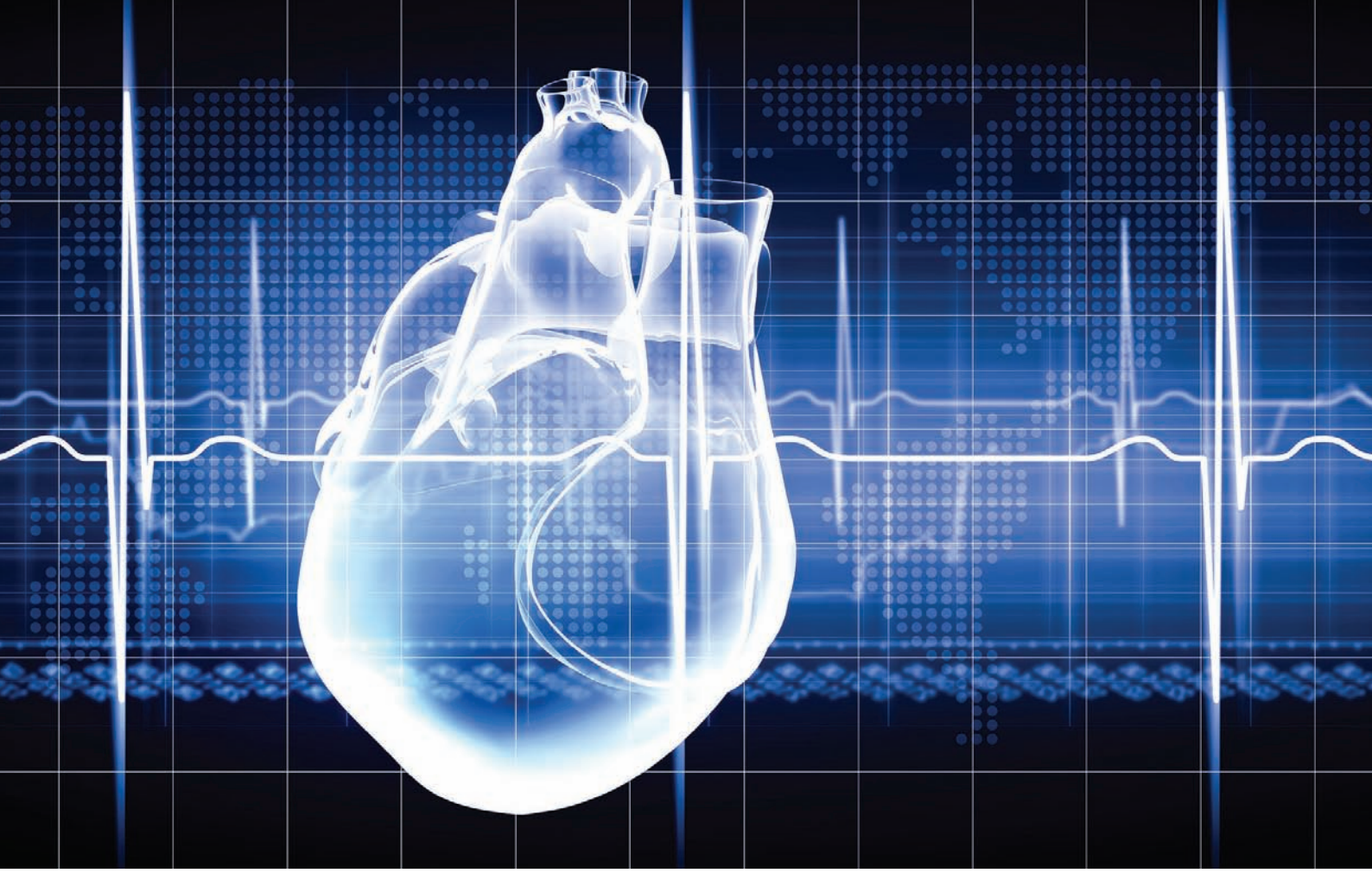
In Australia, however, the restrictions on private cover prevent private health insurers from funding preventive and chronic services and developing alternative cost-effective models of care that may reduce the disease burden, manage chronic illness more effectively, and minimise expensive hospitalisations. In practice, private health insurers are able to push the cost of the more complex task of managing the community-based treatment of their customers on to the public system — which is where most fund members with chronic disease receive primary care — leaving the private system with the simpler, principle task of providing hospital-based procedural services.[13]

In both the public and private systems, therefore, providers are paid for doing the same things in the same way as mandated by current funding and payment systems, which means consumers get access to only the kind and mix of services that funders/payers agree to fund/pay for. The MBS Schedule, for example, proscribes the way patients can and can't be treated by only paying for certain 'items' of care on a fee-for-service basis. Public hospitals —as with private health funds — are also prohibited from reorganising their services and providing care outside hospitals, even if it is cost-effective and clinically appropriate. This is despite international evidence showing health systems that break down the traditional divide between hospital and non-hospital care are more efficient. The existing service systems also provide no incentive and limited assistance for individuals to take responsibility for their own avoidable health risks. Input-focused and transactional in nature, providers are rewarded simply

for delivering discrete health interventions irrespective of the results, rather than being rewarded based on 'outputs'— overall improvements in health status and wellbeing.[14]

With specific regards to the private health system, community rating regulations — which prohibit the charging of different premiums based on health risk — also permit health funds to shift the cost of high risk patients ('high-cost' claims and customers aged over 55) on to a secondary re-insurance risk pool. The Risk Equalisation Trust currently administered by the Private Health Insurance Administration Council compensates those funds paying higher than average benefits by redistributing money contributed from funds paying less than average benefits. The effect is to blunt incentives for funds to develop new products and services to manage health risks and costs, since funds that bear the cost of additional preventive or chronic care will not receive a full return on any savings generated — which are instead shared across the industry.[15] Hence one of the few risk-management and cost-containment strategies available to health funds is the relatively blunt instrument of re-negotiating the value of benefits paid to hospitals and specialists, in addition to pioneering efforts by some funds to 'pay for quality' by refusing to pay benefits for additional care occasioned by avoidable adverse events and preventable errors.[16]

As the consulting firm Port Jackson Partners argued in a 2014 report for private health fund peak body Private Healthcare Australia, embracing more cost-effective integrated care requires following the lead of international leaders in healthcare reform and taking steps to remove the artificial barriers between primary care and hospital care that plague the Australian health system. This would include removing current regulations that restrict private health funds' involvement in primary care. Necessary reforms would also include exploring alternative capitation-based payment models that covered the full spectrum of both primary and hospital care, and which would allow greater involvement of private sector health management companies in the organisation and coordination of care pathways. The report argued that integrated payments would also remove the incentives to over-service on hospital care created by fee-for-service payments, and encourage the development of new ways of delivering the same care in lower-cost settings, such as in community-based clinics, or through the provision of sub-acute care in a 'hotel-style' accommodation, as occurs in more efficient health systems overseas.[17]



The Limitations of Current Reform Strategies

'Within System'?

The Productivity Commission has drawn a useful distinction between what it has called 'within system' reforms — which could deliver beneficial outcomes without "changing existing institutional and funding structures" — and larger scale reforms of the existing architecture of the health system that would involve enormous dislocations of current practice, carry the risk of unintended consequences regardless of the expertise and experience informing the design, and be stymied by political obstacles including the vocal opposition from vested interests wedded to the status quo.[18]

In a December 2015 submission to the Turnbull government's review of private health insurance, Private Healthcare Australia identified a list of what were called "near-term priorities for change." Notably absent from this list was demanding the federal government take action to open the primary care sector up to private health funds. Instead, the submission was content with merely warning that the incremental changes were "not a substitute for the broader reform necessary for the Australian healthcare system to deliver much higher quality outcomes at lower cost."[19]

Similarly, the submission by Australia's largest private health fund, Medibank Private, argued — with respect to ever-rising use and cost of insured health services and the flow-on impact on the affordability of private insurance premiums — that "today's regulatory settings have lost relevance and weakened competition leading to low-value practices that come at the expense of consumers." It was strongly asserted that "insurers should have the incentive and mandate to better manage their aged and chronically ill populations outside of hospital." But action in this direction was also absent from its list of "near-term recommendations on which government should act" — though the submission did flag support for "potentially moving towards a value-based or capitated model."[20]

Big Bang / Damp Squib

The problem, of course, is that 'within system' reforms will leave the major structural problems and inefficiencies that compromise the system's performance untouched. The Port Jackson Partners/Private Healthcare Australia report argued that potentially large and significant quality and cost gains:

> …are not possible within the current healthcare framework — they demand more significant structural reforms, and the introduction of competition, such has been driven in most other sectors of the Australian economy.[21]

This call for structural reform went beyond permitting private insurers to get involved in primary care, and included a call to 'privatise' Medicare by contracting

out a 'Universal Service Obligation' to private health funds that would manage and purchase the care of their members — a market-based framework that would facilitate the entry into the health sector of innovative private sector providers of integrated, better quality, and lower cost care.[22]

The problem, however, is that proposals for 'big bang' changes to the health system may ultimately prove to be a damp squib. Despite the well-known fiscal imperative to control the escalating cost of health and achieve better value for money, fundamental reforms are highly likely to be blocked by institutional and cultural factors — especially the competing interest of rival stakeholders, together with the Australian electorate's conservatism regarding significant changes to the operation of Medicare. This sentiment was on display during the 2016 federal election in the Labor Party's 'Mediscare' campaign, which forced the Turnbull Coalition Government to rule out any moves to privatise any part of Medicare.

With respect to reform of private health, the Productivity Commission has commented that changes to the private health insurance regulations, while justifiable by the potential benefits, could undermine the equity objectives of Medicare if resulting in a two-tiered level of access to care. The Productivity Commission also flagged the likely opposition of the organised medical profession. The influential doctors' lobby group, the Australian Medical Association (AMA) has long been virulently opposed to private funds having a greater involvement in the organisation and coordination of primary care, and opposed to any suggestion of new models of 'managed care' that could restrict doctors' access to fee-for-service payments. Given the considerable obstacles to fundamental change, what the Productivity Commission has therefore proposed is an "incremental approach to reform" — a trial and test process. It has suggested that the federal government could permit health funds to operate designated preventive or chronic care services in particular regions or for a particular patient group, which would be evaluated to assess all the benefits, costs, and potential adverse consequence to build the case for reform.[23]

Trials and Tribulations

There are obvious advantages to the process proposed by the Productivity Commission in order to circumvent the difficulties associated with large-scale reforms that would struggle to win support and be implemented. However, the beneficial outcomes achieved by the recommended approach would be constrained by the limited nature of the trials. The long-term significance of any results would be questionable, since trials (by their very nature) are not the real world, and often prove to have limited applicability and success by the time promising trials are ready to be fully rolled out to the general population. Yet the systemic changes that could yield substantial efficiency gains are too big to be achieved in one big leap.

As the Productivity Commission rightly noted: "Implementing new payment models on a broader scale (including across all primary care, or over both primary and hospital care) would be more challenging, and would likely require larger-scale changes to the funding responsibilities of each level of government and private health insurance." [24] But the reality remains that trials have come and gone in the past, and led nowhere in terms of long-term reform. As the Grattan Institute has observed:

> Australia now has a considerable history of trials, pilots and demonstration projects investigating the introduction of chronic disease management in one form or another. These range from the ambitious coordinated care trials of the 1990s to the more recent Diabetes Care Project. But it has proved difficult to achieve major improvements in outcomes for chronic disease in the absence of broader change to the funding and organization of primary care and its relations to acute and extended care for regional populations.[25]

This poor track record of follow-through on trials may be the reason the Productivity Commission has also recommended an extended process-driven pathway to structural reform, supplemented by a "comprehensive review of the Australian health care system" that "could assess the potential benefits and costs of alternative payment models' draw lessons from past trials and international experience, and consult with relevant stakeholders."[26]

Trialling and testing, in combination with a holistic review, is the sum of what the Productivity Commission describes as reform process predicated on "steady and ongoing adjustment" as opposed to "abrupt and disruptive change."[27] Yet the benefits of a process-driven reform process are questionable, particularly less than a decade after the 2009 Final Report of the Rudd Government's National Health and Hospital Reform Commission (NHHRC). The expert-led NHHRC was established to advise the 'root-and-branch' reforms necessary to ensure the sustainability of the Australian health system in the twenty-first century. The NHHRC's major recommendation for long-term structural and payment reform was to advocate the replacement of Medicare with the 'Medicare Select' model, which sees all Australians receive taxpayer-funded, risk-adjusted health insurance vouchers to fund the purchase of private health plans.

The rationale behind the Medicare Select proposal was to address the major structural problems with the current arrangements. Individual health funds would hold the full financial risk for members' healthcare needs across the full service spectrum, and would operate as active purchasers of (instead of passive payers for) health services from providers competing to ensure patients receive the most appropriate and cost-effective care. Structural change on the insurance side of the Australian health system would in theory drive structural change on the services side of the system, and promote more efficient use of health resources.[28] However, the Medicare Select proposal — which is essentially the same model dubbed the 'Universal Service Obligation' by Private

Health Australia — was not translated into policy action. This was in part because the NHHRC's reform 'blueprint' contained no political strategy to circumvent the institutional and cultural obstacles to implementation — a defect highly likely to feature in a report produced by an apolitical body such as the Productivity Commission.

A Modus Vivendi for Disruption

What if there was a way to circumvent the impediments and avoid pitfalls of big bang reform, and minimize the inherent dangers of gambling $155 billion or the 10% of GDP spent annually on health on one big 'solution', but still allow for innovation — for disruption of established health payment and service delivery models — in a real world-applicable, commercial and competitive environment that would yield hard evidence far beyond trial quality, as well as establish governance and institutional structures that would support the case for scaling-up and for systemic reform?

There is a way to do all this, and this is the logic of and rationale for 'Health Innovation Communities' (HICs – see Box p.#).

The idea of creating HICs is based on the concept of free trade zones that have been used throughout history to encourage commerce. The origins of free trade zones date back to the founding age of international trade. When eastern and western civilisations first started trading, free exchange of goods was facilitated by relaxing existing cultural norms and laws to the mutual benefit of both trading parties within strictly bounded areas to limit any unforeseen effects. In modern times, Free Trade Zones offered tax and other incentives to promote trade and development. Removing rigid rules, regulations and other disincentives that would otherwise impede new modes of doing business creates an 'ecosystem' in which innovation can flourish and percolate into the rest of the economy.

Drawing on these longstanding and successful examples, establishing 'free trade zones' for health innovation in Australia would be more than just another reform 'process'. Within the geographic areas declared to be HICs, healthcare providers could apply for exemptions from existing legislation to permit the creation of alternative payment and service models that are currently banned under Medicare and the *Health Insurance Act*. Companies, start-up entrepreneurs, charities, private health funds, federal government health agencies: the Primary Health Networks (PHNs) and state government health agencies: Local Hospital Districts (LHDs), would all be eligible to apply for registration as HIC-exempt providers of approved clinical services.

In effect, Medicare operates as an approved provider-captured statutory monopoly. Registered medical practitioners, who have been issued a Medicare provider number, are the only providers able to bill Medicare for professional attendances and other items listed on the MBS. A patient is not permitted by law to purchase a private health insurance policy where the insurer is liable to pay for patient services that would normally be payable under Medicare. Under Section 126 of the *Health Insurance Act*, a person is liable to be fined $1000 for entering mutually and freely into such an arrangement. Moreover, the *Private Health Insurance Act 2007* contains 334 pages of rules on private health insurance products, how insurers are to conduct their business. The maximum penalty for a fund offering a non-complying insurance product is a five-year prison sentence.[29] In essence, establishing HICs would make it legal for organisations, both public and private, to develop more efficient and sustainable models of care that would improve health outcomes. HICs would also make it legal for consumers to choose a publicly-funded alternative to the current structure of the Medicare scheme (the existing MBS benefits for GP and other medical and primary care services and right of access to free public hospital care) on an opt-in basis.

Within HICs, many different models would be able to be developed by a plurality of different providers offering different answers to the same problems. The discovery and knowledge-creation processes that would be unleashed would allow the proverbial '1000 flowers' to bloom — and to be simultaneously tested against each other — by releasing the existing structural and regulatory shackles on more innovative, efficient, and sustainable healthcare provision.

ICPs – Integrated Care Plans

Within HICs regions, exempt providers would be able to accept and recruit customers who seek an alternative to the existing public and private health insurance systems and who voluntarily choose to opt-in to an Integrated Care Plan (ICP). This would create a market for taxpayer-funded health services by giving consumers the option of choosing to leave the hitherto compulsory public system — and for funding to follow consumer choice.

ICPs will require inter-governmental and health sector agreements to pool existing funding (federal and state health funding, combined with private health funding — depending on the insurance status of each volunteer) on a per-capita basis in order to support an integrated, capitation-based funding model. Preliminary steps in this direction, away from strict fee-for-service remuneration, have already been taken with federal funding for the new $121 million chronic disease 'Health Care Home' trial to be provided on a quarterly capitation-basis in order to increase the range of allied health services, in addition to GP care, able to be purchased for patients who enroll with a general practice.[30]

However, a per-capita pool is not the only potential funding model that might be applied within HICs. One alternative would be to permit people across the socio-economic spectrum to contribute to the pool what they actually pay into or take out of the health system in the pursuit of securing superior services, better value for money, and, ultimately, premium reductions. For some individuals, this would be the value of their Medicare Levy and private health insurance premiums. For those reliant on government benefits, their contribution to the pool would be the amount of money calculated to normally be spent on their health care by the public system. Designing an individualised funding pool could open the way to including in the pool the individual

funding available for people with disabilities under the National Disability Insurance Scheme.

Maximising the funding pool would enhance the chances of achieving early scale and increase the scope of innovations made possible, thereby raising the chances of longer term success of HICs, which would be jeopardised if ICP providers are under-capitalised at the outset. An important condition of granting exempt-provider status will be that ICPs must cater to both public and private patients. Privately insured patients would continue to have the option of choice of treatment in a private hospital. However, the requirement to enroll both public and private patients in ICPs will avoid cream-skimming and the creation of a two-tiered system, and will also mean that successful models will be built fit for purpose, and be suitable for potential national, system-wide roll out under Medicare.

Pooled funding (under any iteration) would give providers the ability, flexibility and financial incentive to develop more cost-effective ICPs. HICs would therefore allow for much more extensive funding and service innovation and integration. Under a pooled funding model, ICP providers will bear full financial responsibility for patient's entire health care needs, and will keep (or share) in the savings achieved, while being free to develop new care pathways that involve efficiencies and may incorporate novel services. For these reasons, HICs may provide an opportunity to revise the reinsurance arrangements for private health insurance. A system of prospective risk-adjusted payments based on the risk characteristics of fund members (as recommended by the 2013 National Commission of Audit)[31] could conceivably be added to the funding pool for ICPs.

Once freed from existing health cultural, institutional, and funding restrictions, providers would be free to include in their ICPs non-traditional services and incentives beyond standard clinical medical and hospital care. As well as managing utilisation by directing patients to lowest cost clinical settings, the real advantage ICP providers would have is the flexibility to fund and develop truly innovative preventive and chronic care plans. This could involve new behaviour change and social work-style services — perhaps coaching and financial incentives to change unhealthy lifestyles, or addressing the social problems (substance abuse, housing, employment, etc.) that make it hard for a low-income chronically ill person to self-manage their condition, receive full courses of treatment and access all appropriate and beneficial care. In the market environment created by HICs, we can anticipate providers drawing on the insights developed by the burgeoning field of behavioural economics. Research that informs about the incentives that work for different groups of people could potentially be applied to address the growing epidemic of 'lifestyle disease' in innovative and cost-effective ways — perhaps, for example, by using money, discounts, reward points, or concert or sport tickets to encourage obese people to lose weight or for diabetes sufferers to better control their blood glucose level. Similar upfront incentives could also be utilised to motivate patients to opt into ICPs.

Once the exemption was granted, PHNS, LHDs, and health funds may choose to develop their own 'in-house' ICPs. But — consistent with good public and private sector procurement practices — both health funds and government agencies may choose to develop a purchaser/provider split, and contract out service delivery to competing private sector health management companies that will develop their own models of care and virtual care networks by sub-contracting service delivery with GPs, specialists, hospitals, pharmacies, allied health, and other healthcare providers. This would also permit both government agencies and private funds to decide to give customers a choice of providers between competing ICP providers. This would facilitate the entry of new players into the health system, as well as giving established corporate primary care companies — whose business model currently relies on vertically integrating Medicare-funded GP, pathology and diagnostic imaging services — the opportunity to branch out into new areas of integrated care.

Private sector providers are also preferable — particularly start-ups — due to the risk management tools they will bring to evaluation and measurement of their services to demonstrate outcomes; creating a marketable value-proposition to sell to purchasers, and to ultimately produce returns for investors and shareholders. With regards to integrated care, non-traditional providers in other countries have innovated (and managed risk) by investment in information technology and data analysis to monitor service use, prevent duplication of tests and procedures through electronic medical records, and give feedback to clinicians and develop care protocols that achieve the best health outcomes. Investment in IT and analytics is where innovative providers are likely to seek to establish their competitive advantage.[32]

The new market-based system envisaged within HICs is not as radical as it sounds, given the precedent that exists. Under the Australian Defence Force's 'Garrison Health' contract, Medibank Private is responsible for organising the healthcare of all members of the ADF and for creating a 'preferred provider' network of medical, hospital and allied health services. A payment and service model that is good for the health of Australia's defence personnel would also be good for the health of many other Australians living in HICs.

Governance and Safeguards

HICs should number between three and five regions to provide critical mass, benchmarking and competitive tension, and be allocated between the capital cities and also regional areas to ensure sufficient differentiation. Ideal sites would have a target population base with high rates of obesity, chronic disease, and frequent use of hospital services related to chronic illness, and may include, for example, the catchment area for Westmead Hospital in Western Sydney, the Hunter region in mid-north coast of NSW, and, even, the state of Tasmania due to its geographic size and the location of its major health services concentrated in the cities of Hobart and Launceston.

Preferred locations would also have proximity between a major hospital, university or medical school to support research, collaboration, training, measurement and control. Australia's publicly-funded medical research sector, spread across teaching hospitals, the universities, and research institutes, is a renowned world-leader in the field. HICs would contribute to the growth of the sector by generating additional sources of research funding, as ICP providers will look to partner with leading research facilities to solve problems and measure and evaluate the performance and outcomes of their models. HICs will also be fertile territory for better 'bench-to-bedside', community and 'home-side' translation of medical research into innovative, evidence-based clinical practice via incorporation into ICPS to improve health outcomes, thereby addressing a defect — a longstanding failure to firmly embed the findings of medical research into the delivery of health care services — that was identified by the former CSIRO Chairman Simon McKeon's 2012 *Strategic Review into Health and Medical Research*. HICs would also be consistent with the McKeon review's recommendation that a more strategic approach to investment in medical research is required to improve the effectiveness and efficiency of Australian healthcare, and thus contribute to the health system sustainability by addressing the financial challenges posed in health by population ageing and the anticipated unaffordable increase in health costs in coming decades.[33]

Given that the fundamental objective of HICs is to encourage innovation, there is a need to ensure genuine flexibility and diversity in service provision by avoiding proscriptive regulation and administration as far as possible. This is particularly so when the intention is also to create a competitive and contestable environment for health service provision, in which the chief accountabilities will be determined by the market — by the ability to attract and keep customers enrolled in ICP programs, and secure service contracts from public or private purchasers. Part of the attraction of ICPs should be price competition for private insurance as customers see downward pressure on their premiums through provider success in improving the effectiveness of health care.

However, appropriate safeguards and oversight are needed. HICs would require a regulatory body or commission, whose joint, industry-led members would include representatives of the federal and state governments and health departments, the private health funds, and medical and consumer groups. The primary responsibility of the HIC Commission would be to vet and approve the registration of HIC exempt providers, and determine eligibility for access to pooled funding, based on appropriate clinical criteria consistent with the goal of access to universal healthcare.

Customers who sign up to ICPs would also need protections, such as a right to access emergency care when outside HICs from traditional Medicare and Private Health Insurance providers. Under these circumstances, it might be that the existing system absorbs these extraordinary costs for the sake of security and simplicity. However, the ICP provider could conceivably be required to cover these costs in fulfilment of a universal service obligation. In a mature market, it is likely that competitive HICs would develop provider relationships for their subscribers across the country or even overseas. However, apart from emergencies outside the HIC, strict rules would be needed to prevent doubling-dipping: a condition of signing up to an ICP would be to forfeit any right to traditional Medicare-funded services (either within or outside the HIC) for the duration of the contract. During that period, the commercial objective of the ICP provider would be to convince customers to renew their enrolment by providing a demonstrably superior service. Most importantly, however, customers within HICs would also have a right to break the ICP service contract, and return to default Medicare and private insurance arrangements, in exceptional or egregious circumstances. These circumstances may be stated upfront in the contract, as triggers for consumers to return to traditional payment and service arrangements. The right to default back to Medicare would also act as a safety net when ICP providers fail, meaning that consumers will never miss out on access to essential healthcare. The right of exit could also be protected and enforced by establishing the office of ICP Ombudsman. The Ombudsman would act as an honest broker and arbitrator for the resolution of disputes between providers and patients — and determine the financial consequences for providers that have failed to fulfil their end of the bargain, when patients leave due to bad experiences and the cost of their care is shifted back to Medicare.

Consumer groups — as well as medical bodies and other community organisations — could also play an important role within HICs by offering advocacy services. Such patient advocacy would be important not only in case of disputes, but to also help guide patients to appropriate ICPs, thus providing another layer of scrutiny and oversight to promote informed consumer choice and encourage providers to be responsive to consumer's needs.

Silicon Valleys for Health

Notwithstanding the necessary regulations and safeguards, the great advantage of HICs will be their superior agility as a means of incubating and developing good ideas into marketable health service products.

The founding principle of HICs — in stark distinction to the 'trial and test' model of service development that is the standard approach to reform and innovation within traditional healthcare systems — is the acknowledgment that no single entity, no single repository of collective wisdom, can come up with the complete solution to complex problems. Contrast the possibilities within HICs with the results of the existing trial-based approach. Take the federal government's $30 million, three-year Diabetes Care Project: Despite many promising elements — including investments in IT and data, quality payments linked to patient outcomes, flexible funding and funding for Care Facilitators — the evaluation showed the outcomes achieved and improvement in patient experience were not cost-effective.[34] And we are no further down the track to discovering what works — only what doesn't. In fact, the federal government is retracing its steps and has committed to another three-year $20 million trial of a fairly similar model.[35] While there is learning, and promising signs that can be taken away from each project, the cycle of periodic, serially-funded trials results in a very slow cycle of innovation, and the lack of follow through leading to systemic payment and service changes, and major improvements in chronic care outcomes, speak for themselves.

The problem with trials — along with the rigid program funding model that health departments employ in general — is that governments need to know what they are buying and paying for before they commit taxpayer's money to a particular model. But these top-down, rules-based, centrally-administered trials and programs that dictate all the things providers must do are the antithesis of the way real innovation occurs in the rest of the economy. Taxpayers end up paying for what is known will be done rather than paying for what actually works.[36] Achieving buy-in is also difficult, since providers, especially doctors, rationally calculate that it is not worthwhile re-inventing current practice in line with requirements that are likely to no longer apply after the end of the trial. HICs, by contrast, would create an environment in which innovations are generated from the bottom up, especially by entrepreneurial providers operating in a competitive and contestable market.

Technological advances are also revolutionising many aspects of the economy, including health. But if we are to discover alternative approaches quickly, apply

the lessons rapidly, and realise the benefits in a timely fashion, we cannot linger over the current trial and test-based approach to incubating change. Given the lengthy periods of time such processes involve, and given the pace of change, the outcomes are liable to merely prove or disprove a model or advance that is already out of date. Outside the artificial confines of a trial, bad ideas and practices will be proven to have failed far quicker and will be weeded out, while successful ideas and practices will form the basis of further innovation — and guide investment decisions based on the risk management techniques that are standard in business but foreign to the health sector where strategic and operational decisions are guided by the availability of funding streams. Continuous innovation is essential – the kind of flexibility and adaptability that HICs would permit by creating an entire and constantly evolving industry founded on the pursuit of innovation. Each HIC would essentially constitute an Australian 'Silicon Valley' for health – hubs for research and development attracting the best and brightest to these locations to have the opportunity to create novel health products and solutions.

HICs would also allow competing models to be developed and results to be assessed simultaneously in parallel and real world settings. Commercially successful ICPs will be those developed by the providers that discover new and effective ways to deliver cost-effective and high-quality healthcare. These models will be marketable — they will be able to be sold to consumers, or funds, or government agencies — based on their demonstrated outcomes, initially within the HICs. Federal and state governments may also choose to roll out the best models outside the HICs by, for example, contracting a particular provider to manage the chronic care of patients within a certain local government or defined patient catchment area. Success would also give rise to export opportunities — HICs could potentially transform health from a drain on the public purse into a powerhouse of the national economy.

The comparison with Silicon Valley is especially apt given the significant potential for HICs to operate at the cutting edge of digital health innovation. As the Business Council of Australia has noted:

> Healthcare is reaching new levels of connectivity, automation and analysis. Leading providers are driving quality and efficiency with common technologies such as remote monitoring and clinical decision support, as well as next-generation innovations in analytics, genetic testing, 3D printing, etc. Consumers are being empowered to manage their own health and navigate the health system more effectively. They are adopting new tools such as online patient communities and fitness wearables, they are demanding care based on a universe of clinical information, and they are increasingly selective of providers and care plan. This affords new opportunities for innovative funding models to reward healthy behaviours, consumer education, and bottom-up momentum for change.[37]

Health is the last major sector to exploit data to improve customer focus and performance, but this is changing. Global advances in health informatics, such as at the UK's Farr Institute,[38] are inspiring investment, albeit uneven, in some leading Australian health provider communities. HICs could catalyse further health data science investment in diagnosis and therapy, and use real time analytics to make best use of resources. The potential of health informatics could be further unlocked if HIC providers shared their data with a mutually incentivised public system. The United States government's open source health data program — which "has resulted in an explosion of patient and provider focused applications and technologies" — could serve as the model for HICs to gain access to existing local stores big data.[39]

What This Report Is and Is *Not* Advocating

To ensure the key principles and purposes of Health Innovation Communities are not misinterpreted, it is important to clarify what this research report is and is *not* advocating.

The shift from fee-for-service payments to a capitation-based model that is envisaged may create the false impression that HICs will simply create an environment in which the Medicare Select idea can be trialled and tested. This impression could also be created by the fact that individuals opting-in to ICPs will have their healthcare provided by a 'fund-holding' organisation that will function as the 'insurer' or 'payee' covering medical expenses. However, the obvious point of difference between HICs and Medicare Select is that private health insurance funds will not be the sole fund-holders as Medicare Select would entail. Instead, within HICs, a range of public, NGO and private providers will be free to gain HIC-exempt status and compete as ICP providers, including, most crucially, new entrants into the market — start-ups firms that will introduce genuinely innovative thinking and new service models into the health sector. This is the crucial difference: whereas Medicare Select is conceived of as the 'One Big Solution' for the structural problems in the health system, HICs, by clear and absolute contrast, are not the solution but are rather the first step to creating the environment in which solutions can be proposed and refined *at the coal-face of patient care and service delivery*.

The Medicare Select model also envisages general risk pooling via a taxpayer-payer funded, risk-rated insurance premium payment mechanism — a 'voucher system', essentially, which would be portable and would follow customers to their private health fund of choice. Under these arrangements, health funds would assume responsibility for managing the care of all members — regardless of how costly or complex that care is. However, HICs are designed instead to use financial incentives and financially accountable delivery of health services to spur the discovery of more effective ways to reorganise the complex and costly care of the estimated 5-10% of chronic patients who suffer multiple comorbidities. These are the 'frequent flyers' whose care is currently estimated to account for approximately 50% of total health spending, and who are readily identifiable and thus will able to be targeted by ICP providers and encouraged to opt-in through strategies including use of upfront incentives.

Misleading comparisons could also be drawn to the health reform agenda of the Obama administration in the United States. The US Medicare Innovation program implemented under the *Affordable Care Act* permits Accountable Care Organisations (ACOs) to apply to the federal government's 'Medicare and Medicaid Services Innovation Center' to participate in tests and trials of "innovative payment and service delivery models to reduce program expenditures."[40] The parallels with the HIC concept might appear obvious, but more important

are the key differences. American ACOs must apply to the Innovation Center to gain approval of a pre-determined model of care that will be subject to evaluation. This top-down approach essentially entails a bureaucracy centrally-planning a series of new programs, which consist of rules-based, centrally-administered protocols that dictate all the things that providers must do.

As the American healthcare expert John Goodman has explained, the ACO model of 'innovation' is demonstrably flawed in conception and execution because the proper roles that ought to be played by buyers and sellers of goods and services are confused in bureaucratic health systems. "Successful innovations are produced by entrepreneurs, *challenging* conventional thinking — not by bureaucrats *trying to implement* conventional thinking." In the case of chronic care services, "buyers of a product (i.e. health bureaucrats) are trying to tell the sellers how to efficiently produce it."[41] The fact that compliance with bureaucrat mandates stymies real innovation helps to explain why the available evidence — multiple studies in Australia and internationally — shows that government-operated 'coordinated care' programs have been ineffective.[42] To give but one example, the flagship, multi-million dollar NSW Health Chronic Disease Management Program targeted 'frequent flying' chronic disease patients; but despite implementing a range of new protocols and services coordinating the care of these patients, the 2014 evaluation showed the anticipated reductions in hospital admission had not occurred.[43]

The top-down approach to health innovation also means consumers are left to take what they are given by the government agencies, with little choice of alternatives. Real innovation in the rest of the economy is generated from the bottom up: entrepreneurs operating in competitive environments discover new, better, and lower cost ways to deliver services to consumers who are free to choose between competing providers based on quality and price. HICs recognise, and are specifically designed to lift, the dead-hand of command-and-control rigidities over the production of health services. The rigidities that mar the health sector will be avoided due to the light regulatory framework that is proposed. Consistent with sound regulatory principles, the regulatory impact of the HIC Commission and Ombudsman will be targeted squarely at dealing with bad performers rather than focused on micro-managing good performers. HICs will therefore create, as far as possible and practical, a flexible environment that replicates the dynamic and innovation-spurring features of efficient and competitive markets.

Another key difference with the HIC concept is that ICP providers will be required to include performance measurement and evaluations in their model of care, rather than be subject to external evaluation by government agencies as per the standard test and trial regime. Measurement of outcomes is standard practice in the private sector in order to justify business cases, inform rational decisions about resource allocation, and maintain and add to shareholder value. Performance measures and evaluation data will also be an important way for ICP providers to market their services to consumers, who will be empowered both by the freedom to choose their provider and by the information publicly available about competing providers.

Bi-Partisan Health Reform

Given the recent 'Mediscare' federal election, it might appear a bad time to be proposing health reforms of any description. The political challenges are reinforced by recalling the 2015 Queensland state election, where the health reform agenda of the Newman government contributed to the electoral disaster that befell the Liberal National Party and returned the Labor Party to office after just three years in the political wilderness.

Yet it is state governments — regardless of whether they are of Labor or Coalition stripe — that stand to benefit from working with the federal government to create solutions to the health policy puzzle. Health expenditure accounts for between 25% to 33% of total state government expenditure, and the ever-rising cost of health is acknowledged as the major source of fiscal pressure and the major threat to the long-term sustainability of state budgets. The fiscal challenges in health are exacerbated by the vertical fiscal imbalance in the federation — by the states' dependence on the federal government for funding to operate health and other services. The states literally cannot afford to wait around for the intractable problems that surround federal financial relations to be fixed. This is underlined by the Turnbull government's recent decision to abandon its White Paper on reform of the federation because of the inherent political difficulties that canvassing significant changes to the federation (such as a state income tax) would inevitably create.

The failure of the federalism reform process is another reason state governments — particularly in those states most heavily reliant on what is likely to be dwindling Commonwealth funding, given the size of the federal budget deficit — ought to look favourably on the HIC proposal, which would allow state governments to reap the financial rewards that would flow from achieving more cost-effective health service provision. A state, for example, such as South Australia — which under the Weatherill Labor government is implementing a major restructure of the public hospital system[44] — should welcome the HIC concept, not only due to the financial benefits of reducing avoidable hospital admissions. HICs would also address a long-running sore point within the federation by permitting the federal government's 'own program' health expenditure to be directly applied and more effectively deployed to address state government's health expenditure and service delivery challenges.

Additional fiscal bribes — federal 'incentive payments' to the states — ought not be needed to get states to commit to the HICs. But financial inducements may be a necessary evil to make states act rationally in their own best interest. Regardless of this, uptake of the HIC proposal ultimately depends on genuine political leadership at both state and federal levels to rise above the popularism and 'magic pudding' attitudes that have unfortunately dominated the health debate in recent times. State government buy-in to the objectives of HICs will also be essential to help ameliorate the potentially fatal squabbling that negotiation and calculation of state and federal contributions to the capitation funding pool will inevitably involve.

Conclusion: Releasing the Shackles on Innovation

It is widely recognised that the growth of the Australian economy in the twenty-first century will depend on our ability to develop high-skill, value-adding industries. Without innovation — unless our resources are used more wisely and productively to create the goods and services we need and want — the living standards and wellbeing of all Australians will suffer. The same fundamental principles of economic reform need to apply to health, given the large and ever-increasing proportion of the nation's income (near 10% of GDP) consumed by health, and the deleterious financial and other consequences of continuing to do our health business as usual in a less than efficient — and ultimately unsustainable — fashion.

Given the financial challenges posed by the ever-escalating cost of health to government budgets, we must start somewhere to catalyse change. The report of the 2013 National Commission of Audit described health spending as the "single largest long-run fiscal challenge." The report went on to state that:

> Australia's health system is not equipped to face these future challenges and a universal health scheme is unlikely to be sustained without reform. We need to make the system we have work better. Putting health care on a sustainable footing will require reforms to make the system more efficient and competitive. The supply of health services must increase in line with growth in demand and improvements in productivity are a natural way of ensuring this. More deregulated and competitive markets, with appropriate safeguards, have the greatest potential to improve the sector's competitiveness and productivity…[T]here are no instant or easy solutions to the challenges of health care. But we should be prepared to take steps now to begin strengthening the health system, otherwise more difficult and painful reforms will be needed later.[45]

Structural health reforms could release billions of health dollars that are currently locked up in the rigid Medicare and regimented private health systems. The financial prize is large; but so are the political, institutional, and cultural walls protecting the vested interests of stakeholders with privileged access to the 'rents' generated by the existing health regulatory regimes. More efficient providers of healthcare need to have an opportunity to compete for this money in a market environment.

Health reform would return a dividend to the community not only in the form of higher-quality and more cost-effective health services, but also by releasing resources to pay for additional health services, or to fund other areas of government activity, or to cut taxes and increase private income and wealth. Individuals would benefit financially, and in terms of health and wellbeing, from innovations that not only lower the cost of health to government and the cost of private insurance, but also reallocate and use resources more efficiently to improve health outcomes. The trouble with health reform is that the changes that are needed to deliver highly desirable innovations are too big to be imminently achievable; hence we need to focus on reforms that are possible as opposed to optimal but unattainable.

Health Innovation Communities are a viable and creative way of taking steps now to disrupt the existing system — their creation would mark a real step towards addressing the future challenges we face in health, by initiating the reform process in a competitive and market environment. Allowing health funds to control benefit outlays by purchasing more efficient services is crucial at a time when spiraling use of insured services is driving rises in premiums and threatens to make private health insurance unaffordable for consumers. The service gaps, out-of-pocket expenses, and stress, frustration and bewilderment many chronic disease patients experience in navigating a fractured and complex health system are well-known, and the multiple band-aids that have been applied over many years have failed to heal this long-weeping sore. HICs will, for the first time, put the needs of chronic patients at the centre of the health system, as cost-effective ICPs are developed that provide continuity of care and ensure chronic patients receive the full cycle of all necessary care to properly manage and maintain their conditions.

The potential outcomes of HICs should also be compared with the prospects of the Turnbull government's health policy. The Medical Benefits Schedule Review Taskforce, which has identified a number of rorts, wasteful and inefficient MBS items, is another band-aid that fails to adequately address the fundamental systemic issues. The as yet uncosted savings generated by the MBS Review, which will in theory offset cost of the Health Care Home trial, are certain to be relatively puny compared to the scale of potential savings — the estimated $17 billion annual net welfare loss due to inefficiencies across the health system — that could be achieved through innovative integration of services.[46] The federal government should embrace HICs as a way of harnessing the creativity and initiative of non-government organisations and as a means of helping the private sector to help solve the government's intractable problems in health.

A national health innovation policy that establishes HICs can ameliorate the toxic, innovation-killing politics of health. The current Medicare entitlements and private health insurance arrangements of the vast majority of the population, and the familiar public and private payment and service systems, will remain intact, with exemptions from the existing rules only applying within HIC-declared regions. Moreover, ICPs will apply only to those consumers who live within HICs and who choose to opt-in to the alternative system. These are the answers to the inevitable scare campaign the public health lobby and other defenders of the status quo will mount of the 'thin edge of the wedge' variety, and by claiming HICs are a wholesale attack on Medicare. Such claims are inherently false, of course. HICs will maintain

the core principles of fairness at the heart of Medicare — that is: taxpayer-funded, equitable access to high quality and affordable health services for all Australians, irrespective of means.

Critics also need to understand that healthcare innovation is currently occurring; albeit in a limited and piecemeal fashion — and with access to new models of care determined solely by income. Those who can afford to self-fund their care can already avail themselves of privately-operated aged care and chronic disease services. Those with higher incomes can thus pay to receive integrated care and assistance to navigate the fragmented private and public health systems. [47] HICs would help stem the development of the much-feared two-tiered health system by making these kind of services available to patients regardless of income, and funded entirely from the public purse.

Another likely scare tactic will be allegations that 'rich corporates' will cut services to make money at patients' expense. This not only ignores the important safeguards built into the HIC design, but also the media scrutiny that such a high-profile experiment in healthcare innovation will generate. Providers will be acutely aware of the reputational risks — and risk to shareholder value — of failing to satisfy customer needs. In the new market environment, moreover, the success or failure of the new models of care developed in HICs will ultimately depend on the quality of patient experience provided, and thus the ability of ICP providers to attract and retain customers.

HICs will not threaten the primacy or principles of Medicare. Public subsidies for health services will continue to provide universal access to health services, and no Australian will go without necessary healthcare due to lack of income. However, HICs will allow those living within HICs to choose an alternative form of healthcare provision, and allow for new ways to be developed to use our increasingly scarce health dollars to provide better and more sustainable health services to Australians. The opportunities that HICs will open up for payment and service innovations will, however, demonstrate the benefits of doing things differently in health to achieve more efficient and cost-effective services. The good examples and real world evidence of better practice and outcomes that will be rapidly generated will seed structural reform by establishing functioning models and workable blueprints for systemic — and sustainable — change. The superior financial results achieved, combined with the improved outcomes for patients, could potentially create broader community consensus and support for releasing the shackles on innovative models of healthcare payment and service delivery across the entire health system.

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