

**MEDI-VALUE:
Health Insurance and Service
Innovation in Australia—Implications
for the Future of Medicare**

Jeremy Sammut

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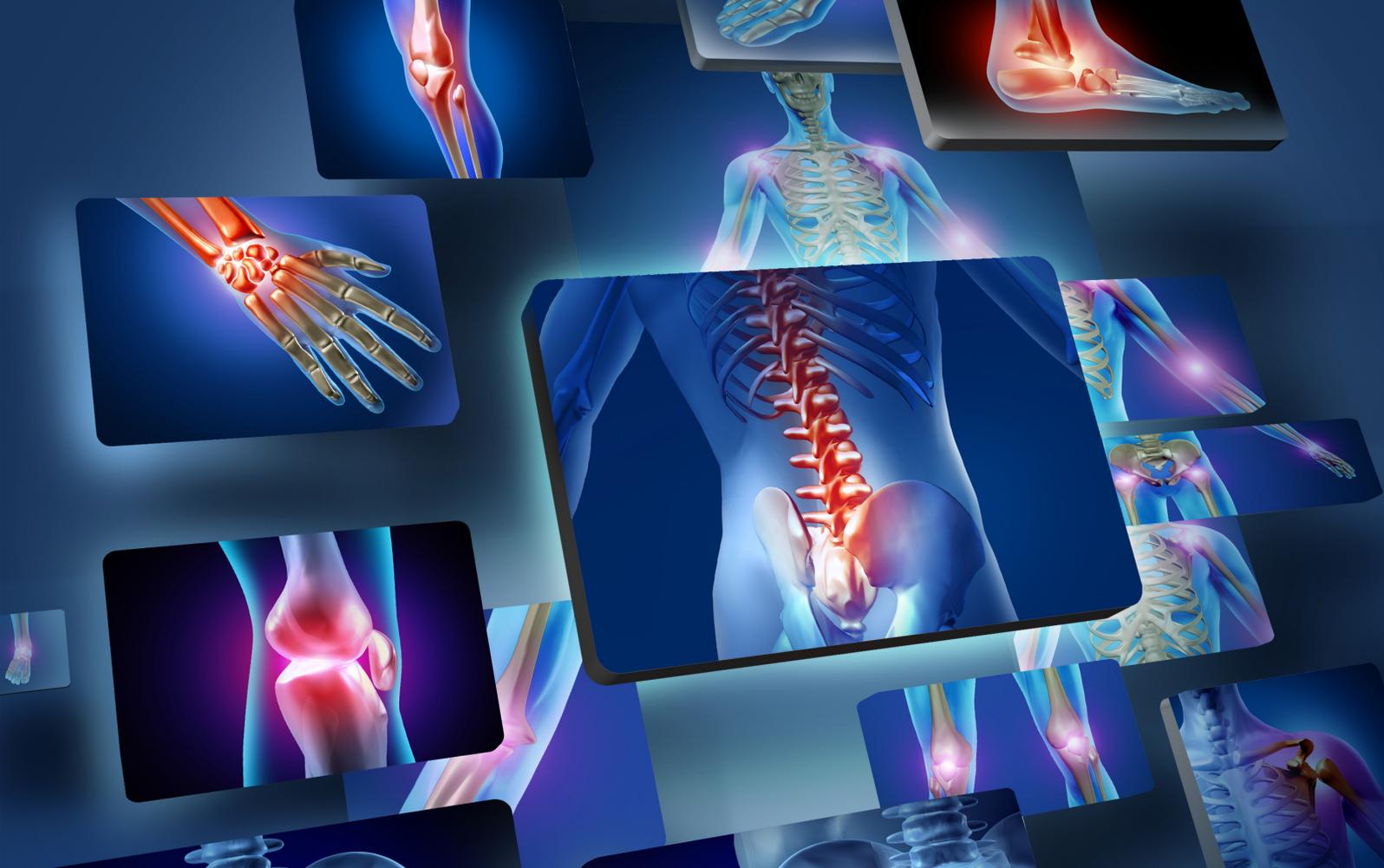
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Executive Summary

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 sufferers. 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 agencies⁴⁹ 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-serve 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 contracting, 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 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. AQC's 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

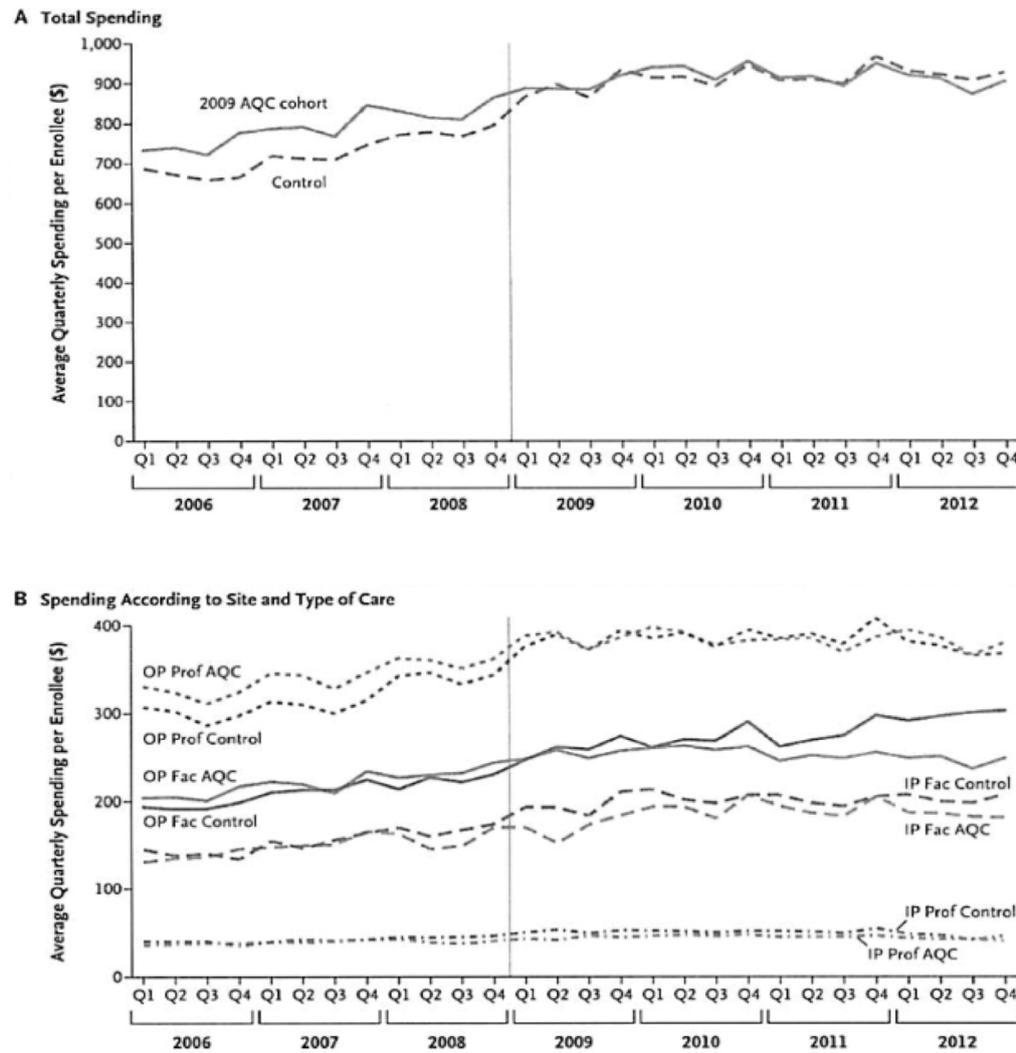
Low-cost groups focused on utilisation review and referral management to direct patients to less expensive facilities and settings. This involved implementing procedures to monitor referrals and educate clinicians about the cost of sending patients to much more expensive services outside the group's 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

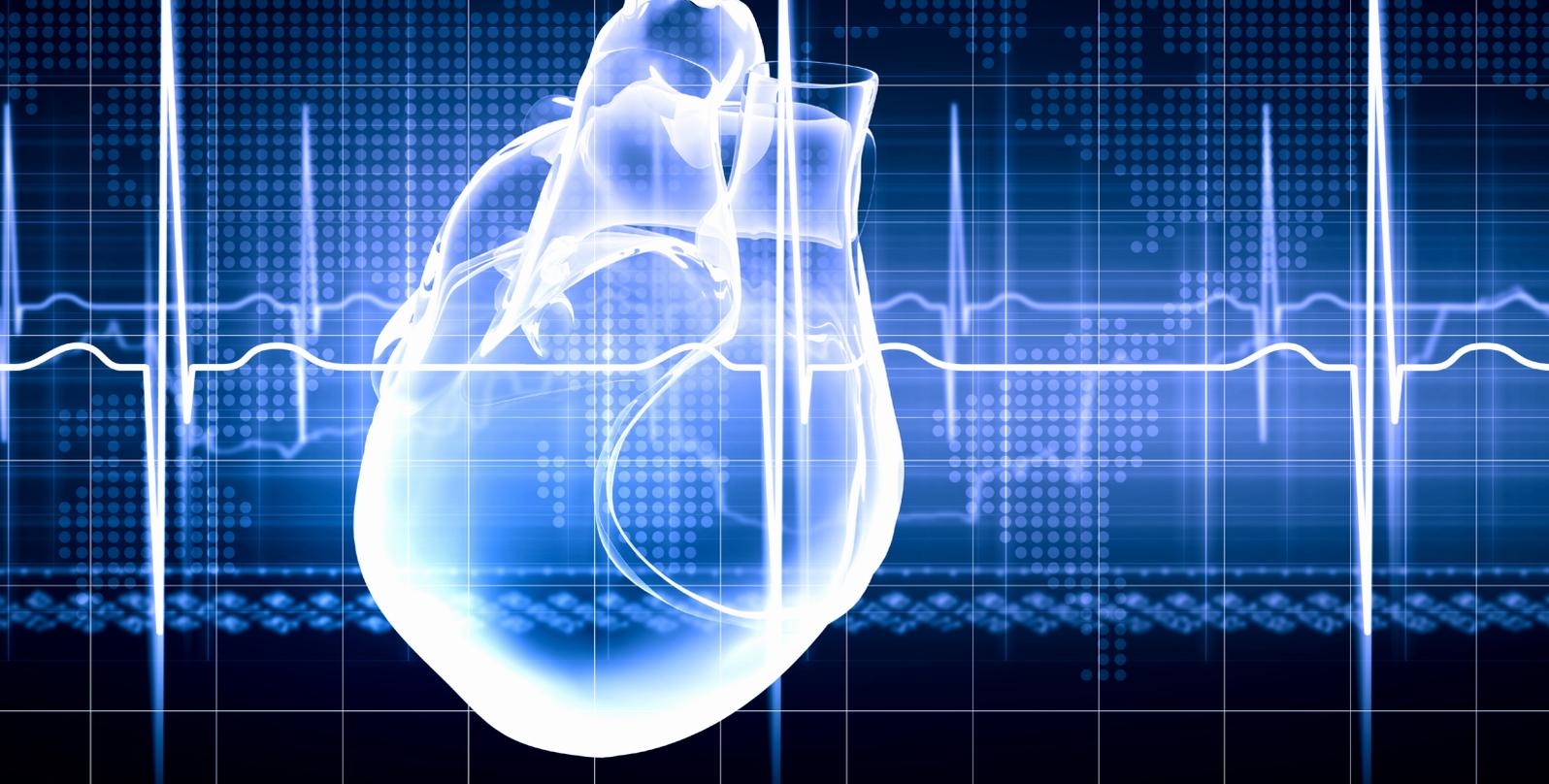
What do the lessons from US managed care regimes mean for health reform in Australia? Advocates of the Coalition's primary care-focused health reform agenda rightly argue that rising government health expenditure in Australia is being largely driven by the increasing cost of hospital care.⁸⁶ They also 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 utilisation 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 offer 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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About the Author



Dr Jeremy Sammut

Dr Jeremy Sammut is a Research Fellow at The Centre for Independent Studies.

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