DEFUSING 'MEDISCARE'

Health Innovation Communities are a politically viable pathway to long overdue reform, argue **Jeremy Sammut**, **Gerald Thomas** and **Peta Seaton**

The trouble with health reform

Conservative estimates suggest that structural inefficiencies in the $155 billion Australian health system currently cost the nation $17 billion annually—wastage of 11%. These inefficiencies mean we spend too much on some types of healthcare and not enough on different kinds of health services that may lower costs and improve outcomes. Although we are wasting 11% of the total national health spend, lack of reform at the systemic level prevents service re-designs that could deliver better value for money and more cost-effective healthcare.

The trouble with health reform is *not* that we do not know the kind of structural problems that need to be addressed to create a more sustainable health system. The rigid fee-for-service payment models, under both the Medicare and private health insurance systems, lock up the bulk of health funding and principally reward doctors for providing one-off services and unintegrated sets of either medical (mainly GP) care or hospital care. *The Health Insurance Act* also bans private health insurers from paying benefits for any out-of-hospital medical service for which Medicare rebates are available.

The inflexible public health system and regimented private insurance regime both prohibit the development of alternative models of integrated healthcare—especially for chronically-ill patients—covering the full service spectrum and full cycle of care. Moreover, the existing service systems provide no incentive, and limited assistance, for individuals to take responsibility for their own avoidable health risks.

There is a range of policy options that would deliver better value for money and more cost-effective healthcare. Many of these reform ideas are well-known in health policy circles, having featured in a litany of government and industry reports, reviews and inquiries into the health system over many years. However, 'big bang' reforms of the existing architecture of the health system would entail enormous dislocations of current practice and carry the risk of unintended consequences. Fundamental changes to current arrangements will also be opposed by vested interests and/or stymied by formidable political obstacles such as the recent 'Mediscare' federal election campaign.

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Hence much of what passes as discussion of the future of the health system tends to amount to simply describing the problems. The debate needs to focus instead on developing practical and achievable solutions to overcome the impediments to change that plague the health sector. The vital element lacking in the health debate is an effective, politically-feasible reform strategy that will allow solutions to be implemented.

The way to avoid the political impediments and other pitfalls—but still allow for innovation and disruption in health—is by establishing Silicon Valley-style 'Health Innovation Communities' (HICs).

In essence, HICs will make it legal for organisations, both public and private, to develop more efficient and sustainable models of care that would improve health outcomes. The key design features of HICs are outlined in the box on page 18.

It is important to note—with regards to political viability—that HICs will not threaten the access or equity principles of Medicare. Public subsidies will continue to provide universal access to health services. However, HICs will allow new ways to be developed to better use our increasingly scarce health dollars to provide improved and more sustainable health services to all Australians, potentially creating broader community consensus and support for reforms that release the shackles on innovative models of healthcare payment and service delivery across the entire health system.

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The problems

Public sector rigidities

A good recent example of the trouble with the health reform debate is the April 2015 Productivity Commission Research Paper, *Efficiency in Health*. The paper (re)identified three 'well-understood' structural inefficiencies in the Australian health system.

The first inefficiency is inadequate focus on preventive health to address problems—such as obesity—that are a leading cause of chronic disease. The second is inadequate focus on the ongoing management of chronic disease in a community or non-hospital based primary care setting. The combined effect of the first and second defects contributes to the third inefficiency, which is the significant number of high-cost hospital admissions (up to an estimated 10% of total admissions) that were potentially avoidable had prior, appropriate and lower-cost preventive and chronic care been available.

The Commission rightly argued that these structural inefficiencies are allocative in nature. Policy objectives and financial incentives are misaligned because, in both the public and private health systems, the bulk of health funding is locked up in inflexible fee-for-service payment models. Healthcare providers, mainly doctors, are principally rewarded for providing one-off episodes of either medical (mainly GP) or hospital care when acute illness or disease strikes. Rather than a comprehensive health insurance and risk management system, the rigid public health system and regimented private insurance regime both function primarily as provider-captured payment mechanisms for separate sets of hospital-based care and community-based primary care.

Fee-for-service payments not only prohibit the development of alternative models of integrated healthcare covering the full service spectrum and full cycle of care, but also encourage doctors to increase activity to maximise income, leading to costly and unnecessary over-servicing—including elevated rates of hospital use.

Jurisdictional complexity also accounts for the fragmented nature of health service provision. No single level of government or funder has full responsibility for all the health care needs of patients, and no direct control over the kind of services patients receive and the locations where those services are provided.

Private health regimentation

Complexity, fragmentation and inflexibility also afflict privately-funded health services, due to the regulations that apply to private health insurance. Private insurers are covered by a strict indemnity, which mandates that health funds must pay for a member's hospital care if the admission is

approved by a registered medical practitioner. This indemnity—and hence the blunting of price signals for insured services—has major implications for use of hospital services, especially for discretionary procedures and when co-payments are avoided via 'no gap' cover.

The *Health Insurance Act* also bans private health funds from paying benefits for any out-of-hospital medical service for which Medicare rebates are available. The rationale for these regulations is to prevent a two-tiered health system in which privately insured patients secure preferential access to doctor's services due to the higher payments available.

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

In both the public and private systems, therefore, providers are paid for doing the same things in the same way as mandated by current funding and payment systems, which means consumers get access to only the kind and mix of services that funders/payers agree to fund/pay for. The Medicare Benefits Schedule (MBS), for example, proscribes the way patients can and cannot be treated by only paying for certain 'items' of care on a fee-for-service basis. Public hospitals—as with private health funds—are also prohibited from re-organising their services and providing care outside hospitals, even if it is cost-effective and clinically appropriate.

Moreover, the existing service systems provide no incentive, and limited assistance, for individuals to take responsibility for their own avoidable health risks. Providers are rewarded irrespective of results. Community rating regulations, which prohibit the charging of different premiums based on health risk, also permit health funds to shift the cost of high-risk patients ('high cost' claims and customers aged over 55) onto a secondary re-insurance risk pool.

More cost-effective integrated care requires removing the artificial barriers between primary care and hospital care that plague the Australian health system. This would include removing current regulations that restrict private health funds' involvement in primary care. Integrated payments would also remove the incentives to over-service on hospital care created by fee-for-service payments, and encourage the development of new ways of delivering the same care in lower-cost settings, such as in community-based clinics or through the provision of sub-acute care in 'hotel-style' accommodation.

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The limits of current reform strategies

The Productivity Commission has drawn a useful distinction between what it has called 'within system' reforms—which could deliver beneficial outcomes without 'changing existing institutional and funding structures'—and larger scale, 'big bang'-style reforms of the existing architecture of the health system. The problem is that 'within system' reforms will leave major structural problems and inefficiencies untouched. At the same time, proposals for 'big bang' changes to the health system may ultimately prove to be a damp squib, as evidenced by the 'Mediscare' federal election campaign that forced the Turnbull government to rule out any moves to privatise any part of Medicare.

Given the obstacles to fundamental change, the Commission has proposed an 'incremental approach to reform'—a trial and test process that circumvents the difficulties associated with large-scale reforms. However, beneficial outcomes would be constrained by the limited nature of trials. The long-term significance of any results would be questionable, since trials (by their very nature) are not the real world, and often prove to have limited

Health Innovation Communities (HICs): Key Design Features

HICs will be established in three to five areas (including a mix of urban and regional regions) to provide critical mass, benchmarking and competitive tension. Preferred locations will have proximity between a major hospital, university or medical school to support research, collaboration, training, measurement and control in partnership with Australia's renowned and world-leading publicly-funded medical research industry.

Ideal sites will also have a target population base with high rates of obesity, chronic disease, and frequent use of hospital services related to chronic illness, and may include, for example, the catchment area for Westmead Hospital in Western Sydney, the Hunter region in mid-north coast of NSW, and the state of Tasmania.

- In areas declared HICs, healthcare providers will apply for exemptions from existing health legislation and regulations to allow for the use of alternative payment and service delivery models that are currently banned under Medicare and the *Health Insurance Act*.
- Companies, start-up entrepreneurs, charities, private health funds, and federal and state government health agencies could all apply for registration as HIC-exempt providers by a joint government and industry-led HIC Commission.
- Exempt providers will accept and recruit individuals who want an alternative to the existing public and private health systems and who voluntarily choose to opt-in to an Integrated Care Plan (ICP).
- ICPs will require existing public and private sources of health funding to be pooled on a capitation basis. This is necessary to support genuinely integrated care, and give providers the ability, flexibility and financial incentive to develop new, cost-effective care pathways.
- Appropriate safeguards will include a right for customers, when outside HICs, to access emergency care from traditional Medicare and private health insurance providers.
- Customers within HICs will also have the right to break the ICP service contract, and return to default Medicare and private insurance arrangements in exceptional or egregious circumstances as determined by an ICP Ombudsman. If ICP providers fail, consumers can also default back to Medicare, meaning no-one will ever miss out on access to essential healthcare.

applicability and success by the time promising trials are ready to be fully rolled out to the general population. Hence, trials have come and gone in the past, and led nowhere in terms of long-term reform.

Health Innovation Communities (HICs) can circumvent and avoid the pitfalls of 'big bang' reform, and minimise the inherent dangers of gambling $155 billion or the 10% of GDP spent annually on health on one big 'solution', but still allow for innovation—for disruption of established health payment and service delivery models—in a real world-applicable, commercial and competitive environment that would yield hard evidence beyond trial quality, as well as establishing governance and institutional structures that would support the case for scaling up reform.

The solutions

A modus vivendi for disruption

HICs are based on the concept of free trade zones, which offer tax and other incentives to promote trade and development. Removing rigid rules, regulations and other disincentives that would otherwise impede new ways of doing business creates an 'ecosystem' in which innovation can flourish and percolate into the rest of the economy.

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

HICs would not only liberate organisations, both public and private, to develop integrated models of care. HICs would also make it legal for consumers to choose a publicly-funded alternative to current Medicare arrangements—the existing MBS benefits for GP and other medical and primary care services and right of access to free public hospital care—on an opt-in basis.

Integrated Care Plans (ICPs)

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

ICPs will require inter-governmental and health sector agreements to pool existing funding (federal and state health funding, combined with private health funding—depending on the insurance status of each volunteer) on a per-capita basis in order to support an integrated, capitation-based funding model. Preliminary steps in this direction, away from strict fee-for-service remuneration, have already been taken with federal funding for the new $121 million chronic disease 'Health Care Home' trial.

However, a per-capita pool is not the only potential funding model that might be applied within HICs. One alternative would be to permit people to contribute to the pool what they actually pay into or take out of the health system. For some individuals, this would be the value of their Medicare Levy and private health insurance premiums. For those reliant on government benefits, their contribution to the pool would be the amount of money calculated to normally be spent on their healthcare by the public system.

Maximising the funding pool would enhance the chances of achieving early scale and increase the scope of innovations made possible, thereby raising the chances of longer term success of HICs, which would be jeopardised if ICP providers are under-capitalised at the outset. Moreover, the requirement to enrol both public and private patients in ICPs will avoid cream-skimming and the creation of a two-tiered system. It will also mean that successful models will be built fit for purpose, and be suitable for potential national, system-wide roll out under Medicare.

ICPs and chronic care

HICs are designed to use financial incentives and financially accountable delivery of health services to spur the discovery of more effective ways to reorganise the complex and costly care of the estimated 5-10% of chronic disease patients who suffer multiple co-morbidities. These are the 'frequent flyers' whose care is currently estimated to account for approximately 50% of total health spending. They are readily identifiable and thus will be able to be targeted by ICP providers and encouraged to opt-in.

Multiple studies in Australia and internationally show that government-operated 'coordinated care' programs have been ineffective. To give but one example, the flagship, multi-million dollar NSW Health Chronic Disease Management Program targeted 'frequent flying' chronic disease patients. Yet despite implementing a range of new protocols and services to coordinate the care of these patients, the 2014 evaluation showed the anticipated reductions in hospital admission had not occurred.

The service gaps, out-of-pocket expenses, and stress, frustration and bewilderment many chronic disease patients experience in navigating a fractured and complex health system are well-known, and the multiple band-aids that have been applied over many years have failed to heal this long-weeping sore. HICs will, for the first time, put the needs of chronic disease patients at the centre of the health system, as cost-effective ICPs are developed that provide the full cycle and continuity of necessary and appropriate care to ensure chronic disease patients can properly manage and control their conditions.

Silicon Valleys for health

The great advantage of HICs will be their superior agility as a means of incubating and developing good ideas into marketable health service products.

Contrast the possibilities within HICs with the results of the existing trial-based approach. Take the federal government's $30 million, three-year Diabetes Care Project: Despite many promising elements—including investments in IT and data, quality payments linked to patient outcomes, flexible funding and funding for Care Facilitators—the evaluation showed the outcomes achieved and improvement in patient experience were not cost-effective. And we are no further down the track to discovering what works—only what doesn't. In fact, the federal government is retracing its steps and has committed to another three-year

$20 million trial of a fairly similar model. While there is learning, and promising signs that can be taken away from each project, the cycle of periodic, serially-funded trials results in a very slow cycle of innovation, and the lack of follow-through leading to systemic payment and service changes as well as major improvements in chronic care outcomes, speak for themselves.

The problem with trials is that governments need to know what they are buying and paying for before they commit taxpayer's money to a particular model. But these top-down, rules-based, centrally-administered trials and programs that dictate all the things providers must do are the antithesis of the way real innovation occurs in the rest of the economy. HICs, by contrast, would create an environment in which innovations are generated from the bottom up, especially by entrepreneurial providers operating in a competitive and contestable market.

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Technological advances are also revolutionising the health sector. But if we are to discover alternative approaches quickly, apply the lessons rapidly, and realise the benefits in a timely fashion, we cannot linger over the current trial and test-based approach to incubating change. Continuous innovation is essential. The flexibility and adaptability of HICs would permit a constantly evolving industry founded on the pursuit of innovation. Each HIC would essentially constitute an Australian 'Silicon Valley' for health—hubs for research and development attracting the best and brightest to these locations to have the opportunity to create novel health products and solutions.

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

Conclusion

The growth of the Australian economy in the 21st century will depend on our ability to develop high-skill, value-adding industries. Without innovation, the living standards and well-being of all Australians will suffer. The same principles of economic reform need to apply to health, given the large and ever-increasing proportion of the nation's income (nearly 10% of GDP) consumed by health, and the deleterious financial and other consequences of continuing to do our health business as usual in a less than efficient—and ultimately unsustainable—fashion.

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

Health Innovation Communities are a viable and creative way of taking steps now to disrupt the existing system and defuse the toxic, innovation-killing, 'Mediscare'-style politics of health reform. They would affirm the principles of fairness at the heart of Medicare whilst, at the same time, mark a real step towards addressing the future challenges we face in health by initiating the reform process in a competitive and market environment.