CIS EVENT **Tuesday, 22 September 2015**

Health Innovation

Rohan Mead
Mark Fitzgibbon
Angus Taylor MP
Dr Jeremy Sammut

THE CENTRE FOR INDEPENDENT STUDIES

It's time to reposition health research. In the wake of the Medicare co-payment debate it is clear that talking about health reform solely in the context of debt and deficits is producing diminishing returns. **We need to change the conversation about health by emphasising the benefits – to consumers and taxpayers – of improving the operation of the health system.**

Speakers **Rohan Mead** (Group Managing Director and CEO, Australian Unity), **Mark Fitzgibbon**(CEO and Managing Director, NIB), **Angus Taylor MP** (Federal Member for Hume), **Dr Jeremy Sammut**(Research Fellow, CIS) outline why it is important to reposition the focus of health reforms.

Dr Jeremy Sammut

Good evening ladies and gentlemen, and on behalf of The Centre for Independent Studies thank you for attending.

I would also like to thank NAB for hosting us tonight and their support is very much appreciated.

I'm Dr Jeremy Sammut and I am a research fellow in the CIS's health research program.

The genesis for tonight's event is the rather dispiriting recent events that have marked the health policy debate.

As I'm sure we are all aware, the federal government's Medicare copayment proposal was defeated by community opposition, led and orchestrated by the organized medical profession.

The demise of the copayment could well lead you to think that the chances of achieving meaningful health reform are slim, and that any proposal that interferes with the sacred cow of Medicare is the third rail of Australian politics.

But a more positive response – which has been the stimulus for these proceedings – is to try to learn the lessons of the copayment failure.

To try to frame the issues and discussion this evening, I want to briefly set out what I think those lessons might be, and their significance for how the conversation about health reform might be refreshed.

I think the chief lesson is that the strategy used to try to generate impetus for change for the last 12 years has failed. The fourth Inter-Generational Report was released in March this year, and delivered the same message as the previous three reports concerning the unsustainable cost to the budget of rising health costs in an ageing Australia.

But IGR 4, on the back of the scrapping of the copayment, has sunk without a trace.

I think it is time to recognise that the theme of long-term health affordability – crucial though this is to the nation's finances - hasn't taken hold in the public mind as a justification for health reform. In fact, we are closer to the scenario of higher income tax or a GST hike to fund health, which is exactly what the IGRs have warned about and encouraged us to avoid.

Any doubts about the failure of the debt and deficits approach should have been removed by the failure of the attempt to link a small copayment to budget repair. The message sent by the electorate was its unwillingness to accept the claw back of taxpayer-funded health entitlements for the sake of the budget.

The public health lobby has presented this a symbol of the public's undying commitment to the fairness of the Medicare system. But I suspect that what drove the rejection of the copayment was an understandably selfish but rational calculus.

When the opposition talked of a 'GP Tax' they said more than they intended. Medicare is one of the ways that people feel like they are getting some of their taxes back from government.

If you accept that the rejection of the copayment was the rejection of another 'tax', the implications for health reform are important. What it suggests is that for reform to be feasible, the clear winners out of the process have to be individual voters and taxpayers.

This is to say that the health reform debate needs to be framed not around cuts, or higher taxes or preventing budget deficits and debts. But around offering something better, and the benefits that will flow to individuals of doing things differently. This is why we need to talk about health reform in terms of innovation, especially when in modern political parlance, the term 'reform' has become a dirty word synonymous with the creation of 'losers'.

Tonight's event has become unintentionally timely, given recent events in Canberra and the renewed focus on 'communicating' the message of economic reform.

I would like to think that the CIS has already contributed to trying to recast the health debate and communicating the message and substance of reform.

I, along with our Senior Fellow, David Gadiel, have devised a Health Savings Account proposal that would allow individuals to opt out of Medicare, cash out their annual health entitlements, and deposit their own health dollars, their own taxes, in a health savings account.

Based on the much more cost-effective Singaporean health system, the political logic behind our opt-out plan is that as well as contributing to long term health system and budget sustainability, individuals would gain financially by opting for a more efficient way to finance their own health care.

I also believe that our plan embodies the kind of principles that need to be front of mind when thinking about health policy innovations and whether they would address the core structural issues facing the health system.

Our plan would:

- establish non-government sources of health funding
- increase personal responsibility for health expenditure
- transform health insurance from a payment mechanism to a risk management mechanism
- shift delivery of health care to financially responsible private sector operators
- change incentives for health care providers to focus on outputs and outcomes.

That is the rough framework for tonight– looking for ways that those with a serious commitment to doing things better in health can get the opportunity to implement those strategies, and giving us a peek at what might be possible in the future.

This particularly applies to our first two speakers. Both run private health funds that compete with Medicare. But even when health funds wish to innovate in ways that would not just benefit their customers, but also promote government policy objectives in areas including cost-containment,

quality, and preventive health, they find the path to change is blocked by political obstacles.

Our third speaker is now a politician, but comes from an innovation background before being elected to the federal parliament, having had a distinguished career in the consultancy industry. This is the kind of mindset and skillset that the formulation of good health and other public policy requires.

Rohan Mead, who will speak first, was appointed Group Managing Director of Australian Unity Ltd in 2004. He is Chairman of Platypus Asset Management, Deputy Chair of Acorn Capital, and a Director of Seres Asset Management (Hong Kong).

As well as chairing the Business Council of Australia's Healthy Australia Task Force, Rohan is a director of the Australian Centre for Health Research, and Private Healthcare Australia.

He is also a member of the board of The Centre for Independent Studies.

Rohan will be followed by **Mark Fitzgibbon**. Mark is the Chief Executive Officer and Managing Director of Hunter-based private health insurer, NIB.

Since joining NIB in 2002, Mark has overseen the organisation's national and international expansion, as well as its demutualisation and listing on the Australian Securities Exchange.

Prior to joining NIB, Mark served as CEO of both the national and NSW peak industry bodies for licensed clubs and held several CEO positions in local government, including General Manager of Bankstown Council.

Mark has a Masters in Business Administration and Masters in Arts. He is a fellow of the Australian Institute of Company Directors and a former director of the Australian Health Services Alliance.

In 2014 he was appointed by the National Rugby League as a director of the newly formed Board of the Newcastle Knights.

Our final speaker is **Angus Taylor** MP, who is the federal member for Hume. Prior to entering parliament Angus was a director at Port Jackson Partners where he was a strategy and business advisor to a number of global and Australian companies and public sector organisations. He provided advice at a CEO and board level in the resources, agriculture, energy and infrastructure sectors.

At Port Jackson Partners Angus also authored two major reports on the opportunities and challenges faced by Australia's commodity exporters, and on the opportunities available in the Australian soft commodity boom. In 2010 he appeared before the Australian Competition Tribunal as an expert economist in the Pilbara rail access case.

Prior to his time at Port Jackson Partners he was a partner at global consulting firm McKinsey & Co. In his private capacity Angus has founded or advised a number of small, fast growing start-up businesses, many in the agriculture sector.

Angus has a Bachelor of Economics (First Class Honours and University Medal) and a Bachelor of Laws (Honours) from the University of Sydney. He also has a Master of Philosophy in Economics from Oxford, where he studied as a Rhodes Scholar. His thesis was in the field of competition policy.

Just a note on format. Each speaker will talk for 20 minutes and the panel will then take questions. We will conclude at 8.00 pm when you are invited to remain for a drink and chat courtesy of NAB.

Dr Jeremy Sammut – Research Fellow, CIS

Rohan Mead

On some dimensions healthcare (broadly defined) is rampantly creative—a lantana of invention. On other dimensions, however, it is a petrified desert of fossilised forms.

Imagine this:

We summon Alexander Graham Bell from the grave, transport him into an average Australian household occupied by millennials — and ask him to identify the telephone. He is stumped and then, when shown, amazed at both the technical progress and the diffusion of the technology aided by its extraordinary cost/quality efficiency.

Imagine this, on the other hand:

We summon Florence Nightingale and take her to an Australian hospital. After an hour's in-service Florence is almost ready to clock on for a shift. She has identified the nurses' station, orientated herself to a familiar set of patient beds and nurses' duties — and has identified that familiar (still rankling), socially conveyed, demarcation between the doctors and nursing staff. Florence isn't just almost ready for work, she feels at home.

Healthcare has innovated its procedural clinical interventions, its curative molecules, its diagnostic capacities, its treatment possibilities, etc — but its managerial and business systems have been glacial in their rate of change and innovation, or at best sporadic, non-persistent and not transforming of the mainstream of activity in the sector.

The fossilised business systems of healthcare are now among the most consequential barriers to valuable innovation and that industry structure militates against the achievement of the Triple Aim of healthcare's Improvement Movement:

1. Improved patient experience (quality and satisfaction)
2. Improved population health
3. Reduced per capita cost of healthcare

To unleash innovation that tackles the Triple Aim, we need to think both broadly and clearly about healthcare as an economic system. A system of incentives that needs to be re-orientated around consumer needs — which it currently isn't.

Arguably, in economic terms, today's healthcare system can be characterised as an arrangement of producer interests. An arrangement with any number of voices raised, all claiming the consumer or patient interest—but a notably weak voice of the consumer or patient themselves.

This arrangement of producer interests runs deep. We are talking about a 200 year-old (or more) process of institutionalisation—a process that has produced an imposing edifice of healthcare, buttressed by powerful elements:

- Information asymmetries between clinician and patient;
- Funding arrangements for activities not outcomes;
- Persistent industrial practices that shape relations between clinicians, between primary care and specialisms, between clinicians and allied healthcare;
- Capital formation processes that strongly influence the allocation of capital to physical assets, and certain types of assets at that, for instance acute hospitals;
- Demarcation and boundary management issues that riddle the sector;
- Training models that too often reflect and entrench existing boundaries; and
- Relationships with bureaucracy that are inflected by government's many and sometimes conflicting roles, including as funder, regulator and as itself a producer.

In parallel, technology and managerial systems have leapt ahead—leaving the healthcare sector flailing expensively; trying to deal with chronic disease, explosions in scientific knowledge and ageing populations using increasingly outmoded industrial, technological and managerial models.

Against this condition, one might suggest a number of prescriptions as to how you might foster business systems innovation. Clearly, micro-economic reform approaches have much potential value to offer.

In part, the sector eluded such an approach during the major reform era due to its inherent complexity, the splayed nature of healthcare across all levels of government and across market sectors, its structural rigidities (including its connection with the rigidities of our federal system and the powerful persistence of its historical clinical configuration) and its relatively unsurveyed nature. Governments at all levels fail to generate effective, system-wide regulatory and accountability frameworks because of their incomplete and fragmented coverage together with their essential complicity in the operations of parts of the sector.

In this vein, there is much to pick up from the recent Harper Review of Competition policy; including the material opportunities to challenge business models in the service economy, particularly where governments are themselves participants and complicit in industry shape—including the resistant and self-forgiving configurations of the healthcare sector.

The Productivity Commissioner has this week been reiterating the ready availability of savings in the healthcare sector of some 20 percent, by driving it towards levels of efficiency that it manages to achieve in some of its parts, but which it seems unable to generalise across the sector.

20 percent of the some $150 billion dollars that is expended annually on healthcare (by all payers) is more, at $30 billion, than any likely increase and nett reallocation of GST to healthcare is ever likely to achieve.

Further, real and extensive business model innovation (rather than just improved accountability and efficiency in the current system) could lead to even more considerable improvements in the value achieved for our health dollar.

At the very least we need to invest in public, transparent and improving systems of measurement for healthcare and its participants. Even this limited call can raise howls of protest about the complex exceptionalism of healthcare by many a complicit stakeholder. To them, I offer Galileo's insight:

"Measure what is measurable, and make measurable what is not so."

Rohan Mead – Group Managing Director, Australian Unity Limited Chairman; Business Council of Australia Healthy Australia Taskforce.

Mark Fitzgibbon

Rohan's story about Alexander Graham Bell reminded me of a wonderful tome by Bill Bryson, *A Short History of Nearly Everything*. In it, he outlined that when Bell announced the telephone he said to the audience that every city in the world will one day have a telephone — much to people's astonishment and disbelief.

I'm going to take you back to 1980: Carter is in the White House and US spending has just hit 10% of GDP and everyone in Washington is panicking about this unsustainable healthcare spending and how it's going to bankrupt the country. Well of course it didn't, and today the US spends over $3 trillion on healthcare, about two times the size of our economy. Healthcare spending right across the entire OECD, if you believe McKinsey & Company, has been increasing by about GDP +2% very consistently.

Of course we're seeing even greater acceleration in spending in the developing world. So I get slightly bemused about this rhetoric you hear from time to time that healthcare spending is unsustainable. Of course it's not. We might end up spending 98% of the economy on healthcare if that's what we choose as a civilised society (or uncivilised society) to spend. There are two real questions for policymakers and economists. First, what are we prepared to trade off and sacrifice to accommodate that spending, which is really an issue around allocative efficiency. How can we ensure that capital is allocated in a way that actually reflects the invisible hand, society's approximation of their overall welfare? Second, what level of inefficiency are we prepared to tolerate in this system? Which is really a discussion around the technical efficiency — what it is actually costing us to produce widgets rather than what is a reasonable level of demand. I will come back to those two issues in a moment.

The other thing I want to mention is actually a very happy problem. For anyone who is in the business of healthcare like I am — and I assume many of you here today are involved in healthcare — it's a rising sea we sail. It's also making the world a better place. People are living longer and healthier lives, particularly people in the developing nations. Also, it's good for the economy if it's productive spending and production.

There's a lot of hammering that goes on about healthcare: 'isn't it terrible' and 'it's going to blow up the economy one day'. Well, it's not. Not if we're sensible and we're smart about it. I've been in the job about 12 years now and I've been scratching my head all that time wondering 'what is actually wrong here?'

There is too much government reliance in the system. That always rings alarm bells for me in terms of innovation. There are so many barriers to entry, particularly in our private healthcare system. We have risk equalisation, and we have government regulation which scares off a lot of would-be competitors with things like pricing control.

Why is this market for healthcare by and large different from the market for cars or coffee tables or TVs? What is it about healthcare? When you think about it there are two fundamental issues at work here.

The first is information asymmetries, which Rohan talked about briefly. How do you actually cure these information asymmetries, which are really at the heart of a lot of unwarranted demand and the over-servicing that is well evidenced in the system? We know that the chances of having a knee replacement can be vary between four to five times depending on where you live in the country. This is not based upon any clinical factor but purely where you live. It's a story of supply induction. So information asymmetries are very important to think about how we tackle the challenge. I can walk into Harvey Norman and when the salesman tries to sell me a brand new TV, I know if I need a brand new TV. But if my cardiologist says, 'Mark, you need three stents in your heart tomorrow and by the way they should be drug-eluting', I say 'what time, Doc?'.

Tackling these information asymmetries is a big question and yet another big question is what to do about moral hazard. Moral hazard is implicit in the system, of course. Once upon a time it wasn't such a huge issue. You pretty much only ended up at doctors or hospitals if you were hit by a bus or had cancer, etc. Today we well know, people choose to have healthcare and there is a big grey area of discretion, which is just an invitation to moral hazard, because typically there aren't any pricings because of our social insurance system (which we call Medicare). Moral hazard is a real issue that we need to think about tackling and there are a raft of issues to be thought about there, including health savings accounts. Health savings accounts would give us an opportunity to create a pricing system without any detriment to the consumer. They would eliminate the risk of people going without care that would actually be worthwhile for their health and well-being.

Both those issues are at the heart of this other mismatch I've thought about for many years now. What do you do about managing demand in the system? What the system has sought to do — not only in Australia, but worldwide — is manage it on the supply side. They have rationed supply, and this is the essence of the national health system in the UK and even Medicare for that matter. That's been a control. They have sought to make the system more efficient through the application of technology. But as we know, technology, particularly in healthcare, has this unfortunate tendency to actually drive costs, with robotic surgery and so forth.

They have sought to redefine what is actually reasonable to be funded. There is no better example of that than the current review of the Medicare Benefits Schedule. It's important that we wipe out 5000 services if they have no clinical efficacy anymore. It's been about making sure we only pay for what has clinical efficacy and then making sure we don't pay anymore than we have to.

So it's been about cost and driving down the cost of Calvary hospitals, or doctor's fees, or whatever the case may be. It's about trying to redesign the system to produce a more integrated experience for people with, for example, a chronic illness. But when you think about it they are all supply side driven solutions and a market won't find equilibrium if you are just working on the supply side. There has been far too little attention applied to the demand side of the healthcare economy equation. It is time to start thinking

about how we tackle some of the sources of market failure — the information asymmetries and moral hazard on the demand side.

All industry revolutions are pretty much led by consumers in the end. Just think about what's happening with the digital age: we are fundamentally seeing a shift of power from suppliers to consumers. So consumers are now able to exert their preferences through Airbnb, Uber etc. Therefore to tackle the problems which dog the system and which elevate the risk of allocative and technical inefficiency, we need consumers to behave in a way which improves health outcomes.

Think about 40 years ago when people were happily sucking on cigarettes at a rate of 30 in every hundred in the population. What was going on there? Was it information asymmetries at a behavioural level? Tobacco companies at some point knew exactly what was at stake, but consumers didn't. So how do we start to tackle some of those information asymmetries which lead to poor behaviour?

I think technology will go a long way to solving that. It's not too far away before we have little nano-capsules circulating in our bloodstreams and alerting us to any problems or even shooting out mutant cancer genes. This actually will happen. It's not too far away when I'll be able to look at my watch at any given time and know exactly about my blood sugar levels — way beyond the typical diagnosis we are familiar with — in a way which helps me manage my behaviour. 'Mark, do not eat that cake, your body has had enough sugar today. It's going to be detrimental to your health'. So those information asymmetries around our behaviour I'd like to think will gradually be taken care of.

This means that when I need treatment, I am sick, or I have a crook knee, or crook hip, then I would have to look at my best treatment alternative. Is it a knee replacement, is it weight-loss or is it 12 months of physio? And if it is one of these options then who do I actually see? Who is the best doctor? Who is the best physio? Who is the best weight-loss coach? Somehow we need to put consumers in a position where: a) they are behaving better; b) when the time comes for treatment they have a much greater understanding and knowledge of the best treatment option for them — because frankly, most people are clueless and just go with what the doctor says; and c) that they actually choose the doctor, hospital, dentist etc. based upon some measurable criteria.

How do we bring Trip Advisor to Healthcare? It is doable and I don't want to turn this into a commercial but 18 months ago we launched a Trip Advisor style site called WhiteCoat and you can go on it now and find a dentist, physio, GP, and soon-to-be specialists and hospitals. On this site, the consumer can find out what other patients have said about their experience, see a satisfaction rating, and link to the provider's website to find out more about their practice and their thinking. Gradually we're building content on it to help you make better decisions around your choices of treatment. So it's not as hard as it sounds, this idea of making consumers more informed and hopefully better consumers of healthcare. On the moral hazard side, as Jeremy touched upon, I'd like to believe somehow we need to create price signals to overcome an element of moral hazard. We need to be careful, just as Rohan mentioned with the GST, that we don't disadvantage those least equipped financially. There are ways and means for doing that and I think they are separate arguments.

Thank you.

Mark Fitzgibbon – CEO and Managing Director, NIB

The Hon Angus Taylor MP

It might surprise you that someone with a background like mine that didn't include health would be talking about health. But as a new Member of Parliament I realised very quickly that the single most important issue that faces the federal government is health policy.

So like any good consultant I made it my task to think deep and hard over the last couple of years about health policy. I got involved in it and looked at it on a very local level as well as at a much more macro level. I'll talk about some of that in a moment, but at the heart of the problem is the need for innovation and I am very fond of what's known as Moore's Law.

Moore's Law is a very simple idea. It is that we consistently overestimate the impact of innovation and technology in the short-term and we underestimated it the long-term. I've experienced Moore's Law in person with business. I have started seven different businesses over the course of my career; and generally the failures were because I breached Moore's Law and the successes were because we were aligned with it. Time and time again, I have seen that innovation, if focused on technology alone, will fail.

In my many years as a management consultant I learned again and again that for technology and innovation to succeed, you have to get a lot right. You have to get a whole series of things right. It can't be just the technology, it has to be the business model, the delivery model, the governance and everything else around it. When you finally get all of that right, innovation has impact.

What I want to talk about tonight is what I think has to change in the health ecosystem — the whole system not just one piece of it — in order for genuine reform to have impact. And I actually agree that the co-payment as a standalone initiative was never going to be a genuine reform in the health system. It had to be much broader, much deeper, much more profound and much more fundamental.

I think it's incredibly important to articulate the problem we are trying to solve. Many failures in government in recent years have been because we haven't articulated the problem. The two previous speakers, Mark and Rohan, have articulated it pretty well but I bring it down to a very simple level, which is that we have spending growing at something like double-digits right now. I'm going to disagree with what was just said — I don't think that it is sustainable. The simple reason is that the compounding impact of spending growing at close to 7% or 10% per year, is that very soon that's all we'll be spending our money on — and in no economy will that work. Politically you have a revolution before we get to that point. We would have to raise taxes to a level where no one wants to work anymore, we'd have to stop doing everything else we do and that simply is not going to happen … so we do have a sustainability spending problem.

The recent Intergenerational Report was much-maligned, but at the heart of the Report was an incredibly simple proposition; and it was that if you have taxes rising at 3% and spending rising at 4% in a relatively short period of time debt will exceed GDP and you are Greece. That's all there is to it and it's unsustainable.

At the heart of spending rising faster than tax is health and welfare, the two biggest items in the federal budget and the two fastest-growing items in the federal budget. Frankly this is unsustainable and whilst I understand that service providers enjoy that growth of spending… I would too if I were a service provider. There is nothing better than an industry growing at double-digit rates. As a consultant those were the industries I always looked for.

But the truth is that as a purchaser of services, which is what the federal government is, (and we can debate about whether or not they should be) that is simply not sustainable. The second part of the problem is on the customer and the population side. Rohan articulated this well, I thought. The crucial issue here became very clear to me in my first week as a candidate in the electorate of Hume. Soon after I was preselected I got access to the previous member's database of every constituent. Every local member or candidate has access to a big database, and if your previous member likes you, they will allow you into their database. In that database there are many years of records about what people care about most. The overwhelming thing I saw was that the number one issue in my electorate by a country mile was health.

Now in my electorate (which runs from south of Sydney down to Canberra and west from there) there is an older demographic, but even when I looked at the regions with younger demographics it was the same result. Health was the number one priority. People care deeply about this, this is a big issue for them, it is a big political issue and it's a big real-world issue that they have to deal with. So that is the fundamental collision we've got going on. This is the number one issue certainly in my electorate, and we've got spending growing at a totally unsustainable level.

So what do we do about it? As I said a moment ago, the solution has to be broad and I bring it down to four different areas. The first is technology, specifically medical technology — and I'm using that term broadly to include both hardware and software information management. Second, we need breakthroughs in how we deliver health, including workforce and organisational models. Third, we need breakthroughs in how we fund and purchase health services. Fourth, we need breakthroughs in the governance model and that includes the intergovernmental relationships and the relationship between the private and public sector. Let me just expand on each of those four areas for a moment.

In terms of medical technology there is a lot of focus on eHealth Records and that is just the beginning. When you look at the whole information flow around the health system it is much more complex, much richer than just eHealth Records. There is patient registration, provider bookings, care tracking, the common patient record (which is the eHealth system effectively), patient portals, performance management and analytics, and the financial side of it. All of these have to be linked across multiple providers; hospitals,

doctors, specialists, pharmacists, allied health practitioners. Without that level of integration you don't solve the problem. So that integrated information management is absolutely fundamental if we are going to solve the underlying problem that I've described.

Of course, on the hardware side we have got a revolution happening in remote sensing and monitoring — not just in health but in many industries — and of course there's no doubt that'll have a big impact on health in the coming years. So that's the technology side and there are many elements to that which are a good starting point but none of that is even remotely useful if we don't solve problems in the delivery model.

Right now we have a system which is based on, at least in primary care, high levels of activity by GPs through consultations with a Medicare provider number which is used very regularly — and I would argue heavily overused — for a basic consultation, and you are rewarded for activity. What we actually need is a system where you have flexible team-based integrated workforces that don't overuse that simple model of the GP meeting the patient. I'm talking particularly here on primary health care, which is the federal government's problem but of course the same principle applies as you move to hospitals and specialist care and so on.

Within that is a fundamental competition problem which is that there is no doubt we have created barriers to entry for the workforce, in particular specialists. The Harper review looked hard at this and there is no doubt we are going to have to deal with that in time. It's been a big problem in the US health system and is it is undoubtedly a problem in our system. The other part of the delivery model that clearly needs reform is in the quality improvement processes — and measuring and using those measurements to adapt and change the way we actually provide the services will be fundamental.

The third area I talked about is reforms in payment and funding models and I think that this has to be much more significant than many realise … and this is where I depart from the idea that just simply having a co-payment is going to do the job.

We do have a fundamental problem of moral hazard and information asymmetry in health. Around the world we are seeing pretty significant changes in payments and funding models. We are seeing worldwide a shift to what many like to call blended payment models where instead of paying a practitioner for activity you are paying them for outcomes and you are thinking hard about how you actually reward doctors and other health practitioners in ways other than just giving them a few dollars every time they actually do something.

Now much of that innovation is being led by the private insurance sector and that I think is an important lesson that I'll come back to. That shift to blended funding models is particularly important when we get to chronic disease. There is no doubt about it — whether it's diabetes, or a cancer, or respiratory disease or so on — that chronic disease and how we actually pay practitioners for dealing with chronic disease will be critical. We are seeing this shift to blended funding models based on risk stratification and understanding the risk associated with each patient, who's a high risk patient, who's a low risk patient, where are we prepared to pay more and where are we prepared to pay less will be central to the sort of payment systems that are going to succeed in the future.

All of that requires integration across primary care, hospital care, specialists and so on — and that integration of course is at the moment being impeded by our federal model again which I'll come back to in a moment. There is a lot of money in getting that right; and avoiding hospitalisation through better primary care is going to be a critical element in containing costs in the future. We know within the payment models there is a lot of work to do on compliance, on the MBS items which we heard about earlier and in the way we purchase the goods themselves. There is no doubt in my mind that the Pharmaceutical Benefits Scheme (and I know some of you here in the audience will differ from me on this) has left a lot of money on the table, and I think there are significant ways of reducing our costs particularly when looking at generics which again the government has been doing in recent times.

Let me finish with governance because I think it is the most important part of all. There is no doubt that there is dysfunction between governments in the way we manage health. The UK and New Zealand health care systems have a big advantage in that you don't have the multiple layers of government that are causing dysfunction. The Federation White Paper, if it is to deliver anything useful, must deal with that dysfunction across federal and state governments in health. Secondly we failed to harness private-sector insurers and private-sector service providers in the way that I think we need to. Most innovation in my experience will always come from the private sector. Yes, fundamental R&D can be facilitated by government but if you don't have fiercely competing innovators out there looking for solutions to problems then you're not going to get the solutions to problems.

Government as I'm learning very quickly is the biggest conglomerate in the economy, and therefore it is not innovative and it struggles to ever come up with innovative solutions to difficult problems if it's trying to do it on its own. That failure to harness private-sector insurers and service providers is a big issue we are going to have to deal with in the future. We have very serious resistance to that from unions and we're going to have to politically find a way through that.

I think the most important thing of all we can do on the governance side to drive those reforms is something that's already been mentioned which is shifting power to customers. In sector after sector people are saying how terrible it is that politicians don't seem to have the courage

to drive reform. The fact of the matter is politicians have one incentive given to them above all and that's to win the next election. So if you really want reform then don't give the power to the politicians, give the power to the customer.

Whether it's in education, health or any other sector that the government plays a big role, I think shifting power to customers will force reform at a pace that government and politicians themselves will never be able to achieve. That means transparent information, it means taking away information asymmetries. I actually felt, and I'll use an analogy from education, one of the best innovations of the last government was the My School website because for the first time ever we could compare the performance of schools. Why don't we see that with doctors, why don't we see that with hospitals? We are starting to see that emerge around the world now, and that measurement and that feedback to customers and practitioners will be fundamental in driving reform in the coming years.

Thank you.

The Hon Angus Taylor MP – Federal Member for Hume