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

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## Executive Summary

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

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

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

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

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

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

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

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

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

Given the financial challenges posed by the ever-escalating cost of health to government budgets, we

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

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

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

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





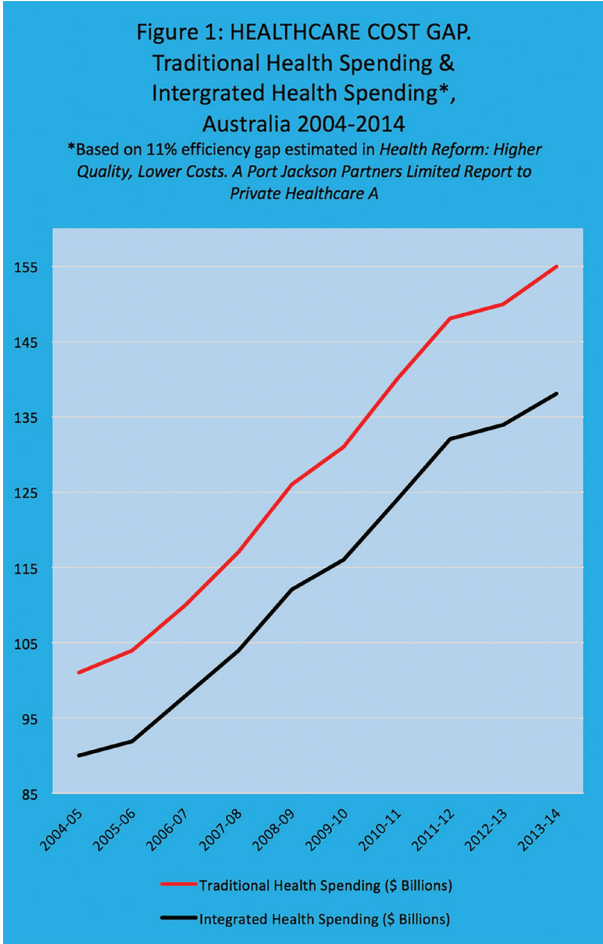
## Introduction: The Trouble with Health Reform

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

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

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

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



institutional impediments to change that plague the health sector.

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

## Public Sector Rigidities

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

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

The Productivity Commission rightly argued that these structural inefficiencies are allocative in nature. Alternative models of care that would spend existing health dollars more effectively are not adequately resourced as a result of the “effects of current institutional and funding structures on the performance of Australia’s health system.”<sup>5</sup> Policy objectives and financial incentives are misaligned because, in both the public and private health systems, the bulk of health funding is locked up in inflexible fee-for-service payment models. Healthcare providers, mainly doctors, are principally rewarded on a basis for providing one-off episodes of either medical (mainly GP) care or hospital care when acute illness or

disease strikes.<sup>6</sup> Rather than a comprehensive health insurance and risk management system, the rigid public health system and regimented private insurance system both primarily function as provider-captured payment mechanisms for separate sets of hospital-based care and community-based primary care.<sup>7</sup>

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

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



## Private Health Regimentation

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

In Australia, however, the restrictions on private cover prevent private health insurers from funding preventive and chronic services and developing alternative cost-

effective models of care that may reduce the disease burden, manage chronic illness more effectively, and minimise expensive hospitalisations. In practice, private health insurers are able to push the cost of the more complex task of managing the community-based treatment of their customers on to the public system — which is where most fund members with chronic disease receive primary care — leaving the private system with the simpler, principle task of providing hospital-based procedural services.<sup>13</sup>

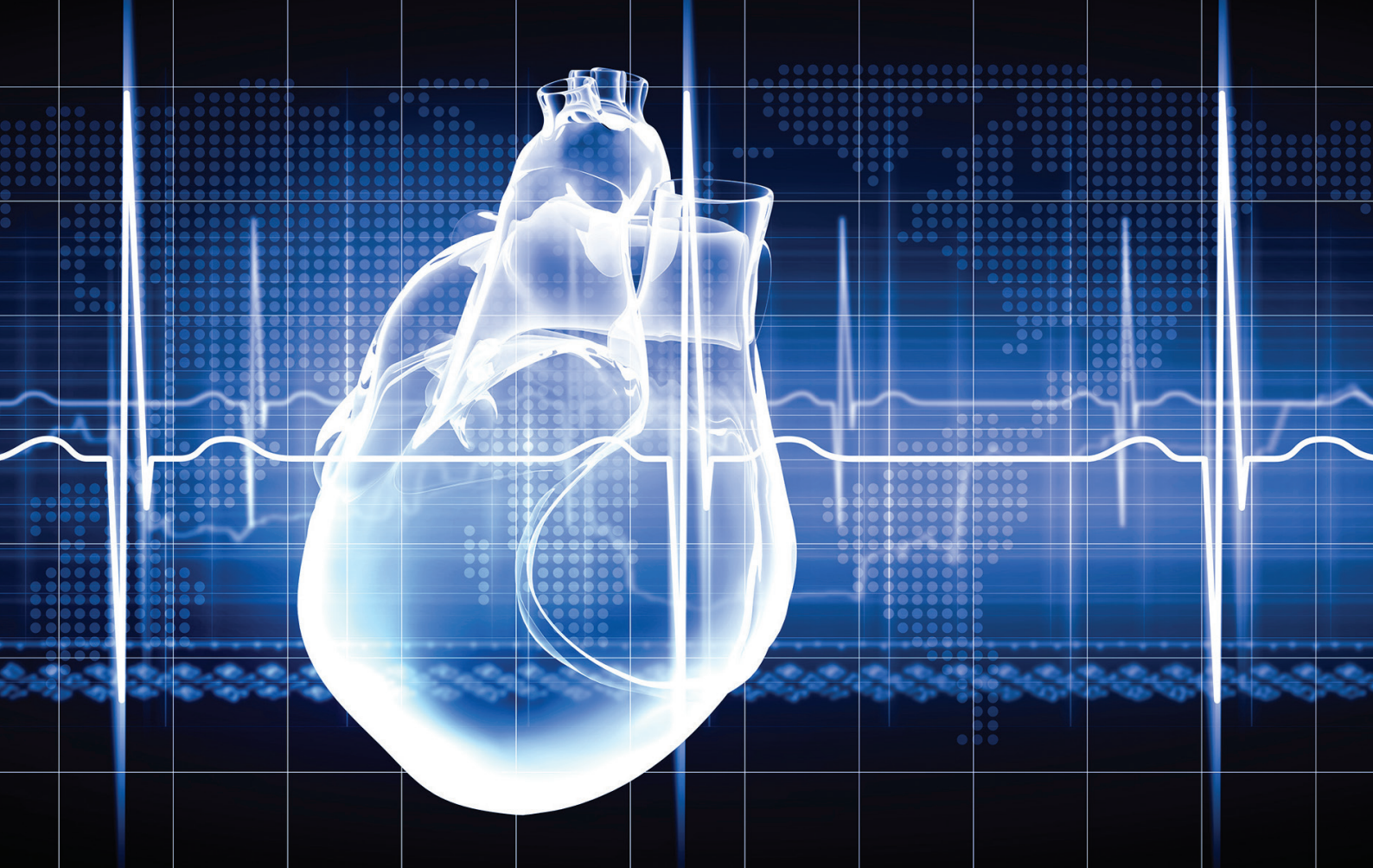
In both the public and private systems, therefore, providers are paid for doing the same things in the same way as mandated by current funding and payment systems, which means consumers get access to only the kind and mix of services that funders/payers agree to fund/pay for. The MBS Schedule, for example,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

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

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

pay benefits for additional care occasioned by avoidable adverse events and preventable errors.<sup>16</sup>

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



## The Limitations of Current Reform Strategies

### 'Within System'?

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

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

Similarly, the submission by Australia's largest private health fund, Medibank Private, argued — with respect to ever-rising use and cost of insured health services and the flow-on impact on the affordability of private insurance premiums — that "today's regulatory settings

have lost relevance and weakened competition leading to low-value practices that come at the expense of consumers." It was strongly asserted that "insurers should have the incentive and mandate to better manage their aged and chronically ill populations outside of hospital." But action in this direction was also absent from its list of "near-term recommendations on which government should act" — though the submission did flag support for "potentially moving towards a value-based or capitated model."<sup>20</sup>

### Big Bang/Damp Squib

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

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

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

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

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

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

## **Trials and Tribulations**

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

As the Productivity Commission rightly noted: "Implementing new payment models on a broader scale

(including across all primary care, or over both primary and hospital care) would be more challenging, and would likely require larger-scale changes to the funding responsibilities of each level of government and private health insurance."<sup>24</sup> But the reality remains that trials have come and gone in the past, and led nowhere in terms of long-term reform. As the Grattan Institute has observed:

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

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

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

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

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

## A Modus Vivendi for Disruption

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

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

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

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

In effect, Medicare operates as an approved provider-captured statutory monopoly. Registered medical practitioners, who have been issued a Medicare provider number, are the only providers able to bill Medicare for professional attendances and other items listed on the MBS. A patient is not permitted by law to purchase a private health insurance policy where the insurer is liable to pay for patient services that would normally be payable under Medicare. Under Section 126 of the *Health Insurance Act*, a person is liable to be fined

\$1000 for entering mutually and freely into such an arrangement. Moreover, the *Private Health Insurance Act 2007* contains 334 pages of rules on private health insurance products, how insurers are to conduct their business. The maximum penalty for a fund offering a non-complying insurance product is a five-year prison sentence.<sup>29</sup> In essence, establishing HICs would make it legal for organisations, both public and private, to develop more efficient and sustainable models of care that would improve health outcomes. HICs would also make it legal for consumers to choose a publicly-funded alternative to the current structure of the Medicare scheme (the existing MBS benefits for GP and other medical and primary care services and right of access to free public hospital care) on an opt-in basis.

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

## ICPs – Integrated Care Plans

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

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

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

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

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

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

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

in innovative and cost-effective ways — perhaps, for example, by using money, discounts, reward points, or concert or sport tickets to encourage obese people to lose weight or for diabetes sufferers to better control their blood glucose level. Similar upfront incentives could also be utilised to motivate patients to opt into ICPs.

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

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

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





## Governance and Safeguards

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

Preferred locations would also have proximity between a major hospital, university or medical school to support research, collaboration, training, measurement and control. Australia's publicly-funded medical research sector, spread across teaching hospitals, the universities, and research institutes, is a renowned world-leader in the field. HICs would contribute to the growth of the sector by generating additional sources of research funding, as ICP providers will look to partner with leading research facilities to solve problems and measure and evaluate the performance and outcomes of their models. HICs will also be fertile territory for better 'bench-to bedside', community and 'home-side' translation of medical research into innovative, evidence-based clinical practice via incorporation into ICPS to improve health outcomes,

thereby addressing a defect — a longstanding failure to firmly embed the findings of medical research into the delivery of health care services — that was identified by the former CSIRO Chairman Simon McKeon's 2012 *Strategic Review into Health and Medical Research*. HICs would also be consistent with the McKeon review's recommendation that a more strategic approach to investment in medical research is required to improve the effectiveness and efficiency of Australian healthcare, and thus contribute to the health system sustainability by addressing the financial challenges posed in health by population ageing and the anticipated unaffordable increase in health costs in coming decades.<sup>33</sup>

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

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

Customers who sign up to ICPs would also need protections, such as a right to access emergency care when outside HICs from traditional Medicare and Private Health Insurance providers. Under these circumstances, it might be that the existing system absorbs these extraordinary costs for the sake of security and simplicity. However, the ICP provider could conceivably be required to cover these costs in fulfilment of a universal service obligation. In a mature market, it is likely that competitive HICs would develop provider relationships for their subscribers across the country or even overseas. However, apart from emergencies outside the HIC, strict rules would be needed to prevent doubling-dipping: a condition of signing up to an ICP would be to forfeit any right to traditional Medicare-funded services (either within or outside the HIC) for the duration of the contract. During that period, the commercial objective of the ICP provider would be to convince customers

to renew their enrolment by providing a demonstrably superior service. Most importantly, however, customers within HICs would also have a right to break the ICP service contract, and return to default Medicare and private insurance arrangements, in exceptional or egregious circumstances. These circumstances may be stated upfront in the contract, as triggers for consumers to return to traditional payment and service arrangements. The right to default back to Medicare would also act as a safety net when ICP providers fail, meaning that consumers will never miss out on access to essential healthcare. The right of exit could also be protected and enforced by establishing the office of ICP Ombudsman. The Ombudsman would act as an honest broker and arbitrator for the resolution of disputes between providers and patients — and determine the financial consequences for providers that have failed to fulfil their end of the bargain, when patients leave due to bad experiences and the cost of their care is shifted back to Medicare.

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



## Silicon Valleys for Health

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

The founding principle of HICs — in stark distinction to the ‘trial and test’ model of service development that is the standard approach to reform and innovation within traditional healthcare systems — is the acknowledgment that no single entity, no single repository of collective wisdom, can come up with the complete solution to complex problems. Contrast the possibilities within HICs with the results of the existing trial-based approach. Take the federal government’s \$30 million, three-year Diabetes Care Project: Despite many promising elements — including investments in IT and data, quality payments linked to patient outcomes, flexible funding and funding for Care Facilitators — the evaluation showed the outcomes achieved and improvement in patient experience were not cost-effective.<sup>34</sup> 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.<sup>35</sup> While there is learning, and promising signs that can be taken away from each project, the cycle of periodic, serially-

funded trials results in a very slow cycle of innovation, and the lack of follow through leading to systemic payment and service changes, and major improvements in chronic care outcomes, speak for themselves.

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

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

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

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

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

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

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,<sup>38</sup> are inspiring investment, albeit uneven, in some leading Australian health provider communities. HICs could catalyse further health data science investment in diagnosis and therapy, and use real time analytics to make best use of resources. The potential of health informatics could be further unlocked if HIC providers shared their data with a mutually incentivised public system. The United States government’s open source health data program — which “has resulted in an explosion of patient and provider focused applications and technologies” — could serve as the model for HICs to gain access to existing local stores big data.<sup>39</sup>



## What This Report Is and Is Not Advocating

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

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

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

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

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

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

The top-down approach to health innovation also means consumers are left to take what they are given by the

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

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



## Bi-Partisan Health Reform

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

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

The failure of the federalism reform process is another reason state governments — particularly in those states

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

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

## Conclusion: Releasing the Shackles on Innovation

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

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

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

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

Health reform would return a dividend to the community not only in the form of higher-quality and more cost-effective health services, but also by releasing resources to pay for additional health services, or to fund other areas of government activity, or to cut taxes and increase private income and wealth. Individuals would benefit financially, and in terms of health and wellbeing, from innovations that not only lower the cost of health to government and the cost of private insurance, but also reallocate and use resources more efficiently to improve

health outcomes. The trouble with health reform is that the changes that are needed to deliver highly desirable innovations are too big to be imminently achievable; hence we need to focus on reforms that are possible as opposed to optimal but unattainable.

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

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

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



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

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

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

depend on the quality of patient experience provided, and thus the ability of ICP providers to attract and retain customers.

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

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