



# Politically-Feasible Health Reform: Whatever Will It Take?

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# ‘Silicon Valleys’ for Health

**Dr Jeremy Sammut**

**H**ow to achieve politically feasible health reform... this is a phrase and an aspiration, which on the back of the Medicare federal election, might appear a contradiction in terms.

The stimulus for tonight’s event is the report we recently released called Medi-Vation—co-authored by me and Gerald and Peta—which we think contains an idea for health reform that is politically-feasible.

Before I talk briefly about that idea, I want to provide a bit of background. If you follow the health debate—if you read the endless reports or attend the perpetual conferences about health—you will find that the major problems in the health system that increase costs and lower quality are well-known.

These problems concern one of the chief challenges threatening the financial sustainability of the health system—the rising burden of chronic disease.

The problem is that we spend too much on some kinds of care that are very expensive, and not enough on different kinds of care that could reduce costs and improve outcomes for patients.

We spend more than we should on costly hospital-based care for chronic disease patients, and not enough on non-hospital based primary care that could prevent them from having to be admitted

to hospital. Figuring out how to deliver more cost-effective care is a major issue with huge financial implications.

The 5% to 10% of so-called ‘frequent flying’ chronic disease patients who are heavy users of healthcare, are said to account for nearly 50% of total costs across the system.

Total health spending in Australia continues to grow faster than GDP, and now exceeds \$150 billion annually.

So if we can use the 50% of our health dollars spent on chronic care more efficiently, the financial implications are obvious in terms of bending the otherwise ever escalating health cost curve downwards.

It therefore seems a no-brainer that we should go all out to reorganise the system given the stakes, given how much money is on the table—and given how much more money will be required as the population ages and the cost of caring for the chronically ill mounts.

I note that this was the conclusion drawn at the Innovation in Healthcare Roundtable hosted by The Australian Financial Review early this month.

According to the write up in the AFR, the consensus among the stakeholders and experts around the table was that “our health system needs to be re-engineered to better meet the needs of the future”, and that “real innovation will come from a more integrated, more coordinated approach to health service delivery across the sector”, which will “provide prevention and treatment at the optimum time for patients and the community.”

Stripped of the jargon, this is simply to say we should deliver different types of care, at different times, in different places, to keep chronic patients healthier, and stable, and out of hospital.

This begs the question: if what we need to do is so obvious and agreed, why don’t we just do it?

The answer is that the political obstacles are formidable. We can’t simply say, ok, let’s use all these billions of health dollars more wisely, because these dollars are locked up—literally—in the existing health payment systems.

The real structural problem that we need to grapple with is that Medicare and the private health systems are both rigid and inflexible.

What both mainly do is pay doctors for one-off appointments,

tests and procedures. These payment systems literally reward providers for doing the same old things in the same old way—and on a fee-for-service basis that rewards ‘activity’ rather than outcomes, meaning there is no incentive across the system to stop a patient coming to hospital.

These structural impediments prevent the development of those alternative, cost-effective models of chronic care we hear so much about in theory, because those who might develop those models literally cannot get their hands on any of those health dollars to develop these kinds of services.

Taxpayers, of course, are on the hook for the inefficient cost of funding and delivering health services in the traditional way. But so are private health fund members.

The rising cost of premiums has become a hot button hip pocket issue about which politicians of all stripes are prone to indulge in ‘feel your pain’ type grandstanding.

But health funds have very limited ability to control their costs and hence their premium charges. They are legally obliged to operate as hands-off third party payers for basically whatever doctors decide a patient needs. They are unable to operate as risk managers able to make informed and strategic purchases of healthcare from the best price and quality providers.

This especially applies to treating chronic disease in the private system—a gap laid bare by the fact it is illegal for health funds to pay for any primary care service covered by Medicare. In other words, the health funds hands’ are pretty much tied and can do little to stop chronic patients ending up in hospital.

This is the kind of systemic irrationality that the Medivation report is targeting.

However, the political obstacle is that any move in this direction—which is towards pooling all health funding for hospital and non-hospital services and allowing new, more cost-effective models of care to be funded from out of that pot—is vehemently opposed by the Australian Medical Association.

Any move in this direction is branded ‘Managed Care’ or the Americanisation of the health system - and once the end of ‘free’ bulk

billed GP visits is foretold, politicians back away at a million miles an hour for fear of the electoral implications.

The result is a stalemate—a stalemate that means that much of the health debate is simply in love with talking about the problem, because no politically feasible solution and way of moving forward and allowing payment and service innovation and integration to occur is offered.

Until now: three of the four speakers tonight believe they have come up with a real solution.

What our Medi-Vation report has proposed is to create ‘Health Innovation Communities’ in designated geographic regions. Within these HIC-declared areas—we suggest the Hunter region, the Westmead hospital catchment, and the state of Tasmania—healthcare providers could apply for exemptions from existing Medicare and private health insurance legislation, and be allowed to create and use alternative payment and service delivery models that are currently banned.

Exempt providers—including companies, start-up entrepreneurs, charities, private health funds, and federal and state government health agencies—could then recruit individuals who wish to voluntarily opt-in to receive integrated care—supported by a funding model that pooled all federal, state and private health funding to give providers the flexibility and incentive to innovate and integrate.

We have dubbed HICs ‘Silicon Valleys’ for health that would catalyse the development of novel healthcare products; once functioning models were established and proven, they could provide workable blueprints for change that could be rolled out across the entire health system.

But the first and most important step is having the opportunity to discover what works. This is the key point about HICs, in terms of the politics of health.

We believe that HICs are a viable way of initiating health reform, because the current Medicare and private health insurance payment and services arrangements of the vast majority of health consumers and providers will remain intact. Exemptions from the existing rules will be permitted only within dedicated regions and apply only to

those consumers and providers within HICs who choose to opt-in to the new arrangements.

Critics might say that there is already similar change occurring in the sector. It is true that the federal government's 'Health Care Home' program has taken preliminary steps towards creating a pooled or capitation funding mechanism.

Also, the latest iteration of NSW Health's Chronic Disease Program has adopted a more flexible approach to allow Local health agencies to figure out for themselves what works. But funding for Health Care Homes is \$120m. NSW Health has committed \$180m to its chronic care program.

These are drops in the health funding bucket. If you were an existing health care provider—be it a GP, a public hospital, a private hospital operator, or a corporate primary care provider—you would look at the size of these so-called 'investments' in new models of care and think that governments aren't really serious about innovation—why would you bother to start thinking about disrupting your established fee-for-service business model?

A national health innovation strategy focused on HICs, by contrast, would send a clear signal that governments are serious about innovation—by adding much greater scale to existing initiatives and by giving many more innovators the opportunity to enter the market and discover new and better ways of delivering healthcare.

A final point: I'm sure this all sounds anti-doctor to some ears. No one begrudges doctors earning incomes commensurate with their training, expertise and experience. The issue is how, or rather what doctors are rewarded for doing.

I think that in a reorganised system with different incentives, doctors would rightly play a leading role in innovating and be appropriately rewarded for their role in delivering cost effective care by sharing in the financial dividend—the value released by innovation. There is sufficient waste in the system that I suspect doctors' incomes would be increased.

So that is the sketch of the background and of our idea. Two of our three speakers may wish to amplify aspects of the HIC concept, as well as all three offering their insights and perspectives—as insiders



and outsiders—on health reform and the politics of health. Our first speaker is Dr Peta Seaton. Peta is a former member of the NSW Parliament who has also worked as a policy director in the NSW Department of Premier and Cabinet.

Among her current roles, Peta is a consultant, speaker, and writer with a wide span of policy interests, including health—and including the work she is doing to drive health innovation within the public health system in Western Sydney, which was the entry point for her involvement in the Medi-Vation project.

Gerald Thomas, our second speaker, is a director of Altruus Health. Gerald is an entrepreneur, with an extensive background in consulting and strategy, who is currently trying to drive healthcare innovation.

He is the true father of the HIC concept, the spur for which derived from his coalface experiences of trying to achieve change in a sector that was closed to innovation—despite all the talk about doing things differently. I think he is keen to illuminate those experiences for us to tonight to make the case for HICs.

Our final speaker is Terry Barnes, who is a prominent health policy consultant and commentator. With extensive experience as political advisor, Terry was a member of Tony Abbott's staff when he was health minister in the Howard Government.

Terry also holds the dubious distinction—along with myself—of being the loudest proponent of the Abbott government's ill-fated Medicare co-payment proposal—an episode that has generated a number of political lessons about health reform, which Terry may care to touch on. But his brief is broader than that—and we anticipate that he might stir the pot again by making some remarks that are counter-heterodox, if not heretical, regarding health policy.

# Driving the Health Debate Forward

**Dr Peta Seaton**

**W**hen Jeremy and I were talking health policy one day, he mentioned the Medi-vation project. I told him about my long-held enthusiasm for being able to ‘opt out’ of statutory monopolies like Medicare, and take my own responsibility for my health care, so he invited me to join this project.

Thank you for this opportunity to work again with the CIS, which has been kind enough to include me in other publications in the past. It was also timely because I had recently been asked by Deloitte’s Parramatta team to be one of their 20 or so innovation ‘Champions’ in their Shaping Future Cities—Designing Western Sydney project (on a pro-bono basis).

Its objective is to stimulate ideas and resolve to make the most of the billions of investment in western Sydney in transport and health—especially the Westmead Hospital Precinct—by State and Federal Governments.

One of the great things about the current Westmead project is that the leadership teams of the various public health institutions have been visible and active for more than two years saying that they don’t want to just build a bigger hospital—they want to take this generational opportunity to build into the design the capacity to partner, innovate, - and reduce the number of traditional health interactions that have

to be done in a traditional hospital setting by using data science, translational research and technology to create more individualized health treatment. and to tackle the growing rates of chronic disease including obesity, in the population—so more people never or rarely have to use a hospital. In fact, some Western Sydney health leaders say that they see this as a moral responsibility to use this investment wisely to improve the way health services are delivered and ‘wellness’ is developed.

So the good news is that in Western Sydney there is great open-mindedness and willingness to consider new ideas, including from health leaders, researchers, universities, private sector, and many in the community.

After all, they are probably aware of the Productivity Commission Report into Health costs, the Tony Shepherd 2013 Commission of Audit Report which said health costs are the longest running fiscal challenge, and the McKeon Review that called for better use of research in solutions to health challenges.

So as Champion for Health and Education, I believe we have the opportunity—and imperative—in Western Sydney to lead policy and ideas to leverage this historic investment and global reputation in health and education into a responsive, effective and competitive growth engine for the next century.

As Jeremy said, I have experience as a local MP, front bencher, shadow treasurer, and senior government policy strategist.

In the 20 years since I was first elected, I think it’s got harder to propose meaningful policy change, especially in an area like health.

This is astounding when the Productivity Commission estimates we waste around \$15 billion a year—10% of the Health spend—because of structural inefficiencies. So you’d think everyone would be calling out for ideas to fix this—the bleeding obvious.

But my experience in Parliament, and especially in election periods, is that change is hard to prosecute, especially when it’s a bit complex—like our health system. It’s really hard to get a chance to debate a new idea, because opponents—usually union bosses defending 60 year old command and control labour supply models, lash out with slogans

about ‘Americanisation’— all completely untrue. If you put an interesting idea out before an election, politicians are asked to rule it in or out before they’ve even read it.

Last week I did a half hour on ABC radio on ‘what keeps me awake’—in my case, debt funded public sector budgets and rampant expense growth. If governments continue to find it impossible to implement change that everyone privately admits, in guilty discussions in corridors, has to happen — health and welfare will eat the budget.

So I offered that if governments can’t effect reform (for whatever reason, including hostile upper houses), why not let voluntary consenting adults like me opt out of monopoly government systems—like Medicare, the Award Sydney, statutory insurances—and take my own responsibility for buying those services, or making my own employment arrangements, in a market. In effect, be a completely voluntary ‘policy lab-rat’. And if it all goes pear shaped it’s my problem. But if it doesn’t, governments will have some success to point to.

And yes, predictably I got hate mail (or probably actually very-cross mail )— accusing me of saying I wanted to dismantle Medicare.

A couple of months ago, I was really pleased to see the Baird Government invite non-government providers to submit ideas about how to run better and more efficient services in public hospitals in places like Goulburn. But union bosses immediately hijacked the issue, claimed ‘Americanisation’, and caused local members to back down.

Some of this is a failure by politicians to invest the time in articulating the problem over a period of time, gathering some proposed solutions, testing them and then making a decision on evidence. This takes time. And I think John Howard was one of the last to do it well on a national scale (GST, ports reform).

So I believe that we have a role in helping drive this debate—to help normalise conversations in our communities, dinner tables, bbqs, about solutions to sticky problems—to help arm and inoculate intelligent and practical taxpayers and citizens against the rabid punitive irrational claptrap and intellectual bullying that union bosses, and some parts of the media, think is acceptable discourse in

the civic domain.

Projects like Medivation are a valuable contribution—rationally put, well researched, peer reviewed, and offered with genuine and sincere expectation that politicians and decisions makers can take on board.

We have to stop threatening to fine or jail people like me who want to be independent, take my own personal responsibility, make mutually agreed arrangements with full consent, and reduce the burden on fellow taxpayers.

Unless we enable some competitive tensions in our health system, and at least some sections of it try an alternative model in which there are real incentives to keep people well longer, or stop them getting sick at all, and get them better faster, we will simply run out of taxpayers' money.

So for those people in our Parliament and our bureaucracies, here's a chance to pick up a good idea, and be confident that if they do, they will have our support when the Kremlin inevitably staggers to its feet and lashes out.

Now is the time to try new things, back our knowledge and commitment, and encourage decision-makers to be confident they can think outside the box with our support.

And more than just a single CIS publication—that if decision makers were to put a toe in the water and explore an idea like this, that people like us will continue to back them up if they decide to give it a go.

# HICs Can Change Our Healthcare Sector

**Gerald Thomas**

**T**oday I would like to talk about problem solving - how we as Australians are trying to solve the big problems in our healthcare system. I would like to share some experiences in trying to do that and why I believe that Health Innovation Communities is the kind of framework we need so that we get better at problem solving.

The current approach to problem solving in this space in Australia is through what I call institutional innovation.

In that context the most notable innovation the market has produced, at some cost, is corporate aggregation or 'corporatization'. This has produced some notable companies such as Ramsay Health Care, Sonic Healthcare, Primary Healthcare and Healthscope. On the other hand, we have not been able to successfully tap the problem solving capacity and capability of the entrepreneurial sector in this space to solve the big problems. Most startups in this sector to date seek to by-pass the current system in one way or another or seek to improve some aspect of the current system - for example, making GP appointments.

Similarly, the most notable government attempts at innovation, again produced at some cost, have been a series of inquiries and pilots at federal and state levels. The changes proposed by these inquiries inevitably attract opposition from one part of the health sector or another.

Sometimes a pilot is announced which then takes two to three years to run. In hindsight, we see that each of these pilots is a dart thrown at a \$155 billion sector with the hope that it hits its target. The health system is far more complex and unpredictable than the gravitational forces holding our solar system together. The trajectory of a Mars Lander can be calculated very precisely four years out. We are simply not able to do the same for changes in the health sector.

Altruus Health was started about three years ago with the aim of creating a scalable, private integrated primary care model within the current regulatory environment. It took us the best part of a year to put together a model that medically was in line with overseas and Australian experience and financially viable within the current Australian regulatory environment.

There were some contortions and the model had to rely on private health funds to fill in the gaps where Medicare was silent. So while the proposition could only work with privately insured patients, our goal, in true entrepreneurial style was to find a workable starting point. We believe we have such a point.

However, as you can well imagine, this venture was an exercise in lining up at least five ducks which kept swimming away each time one's attention was elsewhere. We don't wish to underplay the complexity of the challenge we took on. While challenging, I believe our team was up for that.

However, we increasingly came to the realisation that there was a greater shadow being cast over the entire venture - the shadow of regulatory risk. Regulations are like a great big dome covering the entire sector like a terrarium. All the players in the sector have evolved to succeed in this environment. Changing regulations is like changing the shape or composition of the dome. In this environment, regulatory risk showed up in different ways for us:

For our GPs, any change to the way they earned their income which was not part of the 'system' was seen as risky. They perceived risk in delivering health through team members or using rarely used Medicare item numbers. It was far safer to work as an isolated professional using standard claim numbers.

For our health insurance partners, the potential risk was of running

foul with the Private Health Insurance Act. Some didn't see a problem and for others it was a deal breaker. For corporate medical partners, the risk was of accelerating regulatory change that could upset their business models. A common response we received was "Let's wait and see what the outcome from the Diabetes Trial is."

For our investors, and finally all parties—especially when the Hambleton Review was announced—the risk was that the regulatory environment might change in unpredictable ways

It would be fair to say that independent innovation in this space is unlikely to happen in this environment. One needs extremely deep pockets. I assert that, perversely, even the trials being proposed as an outcome of the Hambleton Review also face regulatory risk. Think about this: any change or investments that participants make would have to be weighed up against the risk that the trial may not run its full course and final report. So we are expecting to test a revolutionary way of addressing chronic disease where the main actors have no incentive to make any incremental investments.

So, how can Health Innovation Communities help Australia generate solutions?

What we argue is that a HIC is a way of providing a defined regulatory environment that can be agreed on up front. As the HIC is operating over much smaller populations and on a voluntary enrolment basis, regulatory certainty can be provided to proponents of different models of healthcare at fairly low cost.

There is a big difference between a two year trial versus say a ten year framework available to health professionals in a HIC. Business plans can be developed that can target viable scale within HICs. I believe that we will unleash a tidal wave of creativity in the process.

As part of an ecosystem, the participants will be learning and improvising all along the way. New providers may emerge offering intermediary services such as training and health IT. There is no reason why the public sector should not also be tasked with being an active partner.

For Medicare today, for example, the introduction of a new item number or the exclusion of one would immediately touch over 23 million Australians and over 33,000 GPs. In a HIC, the scope of a



proposal can be scaled down and time bound. The risk of a proposal is reduced significantly. As participation would be voluntary, it takes the steam out of most objections. Ideas can be tested and an evidence base generated.

Through this evolutionary process, ideas can be germinated and evolved continuously. We can move away from the serial cathartic changes we face every 10-15 years to an environment where there is always something on the boil.

Going back to my terrarium dome analogy, HICs provide the opportunity to create small nursery terrariums beside the main one where we can create different environments to see what it would take to enable life to thrive. It's a place new conversations can be had.

I believe HICs can change our healthcare sector from being a drag on our economy to being an engine of economic growth. With HICs, health can become an economic generator, like our education system is today. By bringing our best hospitals, universities, and medical professionals together with corporations and startups, HICs will create a dynamic environment for problem solving.

We can do this, if we do it together.

# Healthcare Reform, Politics and Populism

**Terry Barnes**

**T**hanks for explaining the HIC concept as you have, Jeremy (Sammut). And Peta (Seaton), I thank you for your words of wisdom as always. It did worry me, Gerald (Thomas), that you said the Private Health Insurance Act was a big problem for you because in 2006-2007 I was the one who actually was responsible for steering it through the parliament, so not only being the GP co-payment guy, it looks like I've sabotaged your progress as well. For that I apologise.

I am going to talk, as I was asked, about the bigger picture in terms of the politics of healthcare reform, and the challenges of thinking innovatively about healthcare policy and healthcare practice in the ways we have just been hearing, because of the way that the political scene works in relation to health and Medicare in general.

I'm going to give you a bit of a case study from my experience as the 'GP co-payment guy'. It's all my fault, the entire problems of the healthcare system are all my fault: Tony Abbott, when I went around with him as his senior adviser, used to say to people "I'm Tony Abbott, I'm the health minister, I do all the good stuff. Terry Barnes is my senior adviser, he does all the bad stuff". Clearly that's followed me through the rest of my career!

So I'm going to talk about the GP co-payment experience as a case study, and then I'll draw some lessons for health care reform from that, and I also might ask a couple of tough threshold questions which I think that innovators and policymakers should keep in mind,

particularly as we look ahead to the needs of the Australian population in the next decade or two.

In terms of the politics of reform, the GP co-payment and Mediscare as in the election campaign showed how diabolical it can be to pursue structural and efficiency reform in the Australian health care system. Basically, to talk about changing the settings of Medicare is like killing Bambi. Voters value what they can see they have: Medicare is clearly a sacred cow.

The co-payment experience really highlighted that. Labor was able to run such an efficient scare campaign, which almost got them to office, on the basis of really nothing, because people perceived they were losing Medicare as they understood it. This became a disaster for the government.

On top of that, the sector is infested with powerful practitioners, experts and vested interests all convinced they know absolutely best and that government, state and federal, are merely payers for their grand schemes, ambitions and whatever they think is appropriate. And on top of all that, we saw with Mediscare it's too easy for opponents of change to distort, mislead and even lie to ensure that they get what they want, or that the status quo remains.

Governments and political parties attempting to place restrictions or conditions on access to healthcare therefore run a very risky gauntlet. Even positive and relatively benign reforms, like the 'healthcare home' concept, and the health innovation communities concept as well, change relationships between patients, providers and payers, and therefore threaten the status quo. So you have to expect a storm of opposition to come down upon you.

It is up to governments, and advocates of change, to make clear how that change will work, what the benefits will be, and how patients, consumers and taxpayers will be better off. And from my own experience it also means that you have to be willing to make a blood sacrifice to the ravenous Bugblatter Beast of Traal (for those of you who remember Hitch-Hikers guide to the Galaxy) which is actually known in Australia as the Australian Medical Association.

Having said that, in terms of the politics of the present health care debate I fail to understand why the Turnbull government went into the recent election campaign without a health policy. It had a couple

of announcements, including the health care home trial but, when you think about it, the last time a government went for re-election—or an opposition went for an election—without a clear, coherent, narrative for its health vision was 1990 when Liberal shadow minister Peter Shack actually stood up just before the election and said “Sorry, we don’t have a health policy”.

We saw a repetition of that this year. I think it actually cost the government dearly, because they couldn’t factually respond to Mediscare: the rest is history in that respect. Despite the fact they almost lost the election on Mediscare, I haven’t seen any real evidence of them forming a policy narrative after the election and, more to the point, making it clear that they see health and health care reform, health policy and the stability of the system as a top priority for the second term Coalition government.

On the other side, what have we got from Labor? Basically, what we have had for the last few years, really since the co-payment broke just after the Abbott government was elected in 2013, is just push back. It’s just been all negative. It’s just been “I hear your pain, so I’ll throw money at all the bad things governments have done and make it better for you”. Put a Band-Aid on it and kiss it better!

And in the election campaign itself, besides the fact it was founded on a lie, all the health policy that Labor put forward was of that nature. I wrote recently that the real imitator of Donald Trump in Australian politics is not Pauline Hanson but actually Bill Shorten, because of the populism that under his leadership the Labor Party is resorting to, and therefore is actually creating a big problem for the healthcare conversation, and the health policy conversation in general.

But the government doesn’t have a clear sense where it’s going, so that actually creates very fertile ground for scare campaigns, for uncertainty, and for making discontent.

So with that, I’ll tell you about my own experience and my thoughts about the GP co-payment debate, which in political terms came from nowhere and just blew up as a story that just kept on going. And now I’m the GP co-payment guy, the “architect” of the government’s ill-fated plan according to everybody who doesn’t realise that I had nothing to do with that plan.

The government did its own thing: they just let me run the debate

before they were ready to go public. It got currency because of the fact that just after the government was elected, I did a paper for another think tank called the Australian Centre for Health Research, and it was reported that it was being put to the Commission of Audit—and the PM at the time, Tony Abbott, was asked about the idea of a co-payment but didn't confirm or deny anything in true budget speculation style.

So off we went, and it was on for young and old. And really what happened over the next year or so, I think, has really set the cause of health reform back a long, long way, and I'm personally quite so sorry for that.

The co-payment should rightly have been considered a second-order structural efficiency measure, which is the way it was brought forward. It was no magic bullet and it was never a magic bullet, never intended to be. It was, however, meant to be part of suggesting how the system could be made more effective, more robust and more patient and payer responsive. It was not intended to be the single measure to solve the problems of the system. The co-payment became an ugly cackling hag that hijacked the political policy agenda.

Besides the fact it wasn't the magic reform bullet, the implacable opposition and resistance of vested interests, especially Brian Owler and the AMA, was totally underestimated. And the budget decision itself to link the outlay saving to a humongous Medical Research Fund, instead of recycling those savings into health and hospital services, and infrastructure, was mystifying and totally out of left field, politically naive and frankly a big, big mistake.

What the government really didn't do before that budget 2014 was read the politics of the Senate and therefore gauge the chance of the enabling legislation passing. They thought that they would have a better chance after July 14 with the new Senate including people like Jacqui Lambie and the Palmer United Party, but how wrong they were. They needed to start making a rational policy case of greater patient contributions for primary care. They didn't. There is a genuine equity argument that says people on higher incomes shouldn't expect bulk billing as a right, and should actually contribute in some way, according to their capacity, to help those less well off— but we never heard it.

The government didn't start sending a message to those who could afford to do so that they must do their bit, but they—ministers—didn't understand details and implications of what they were proposing in many respects. Post-budget estimates hearings revealed that modelling of the co-payment measure was minimal or non-existent, and I understand a lot of the thinking actually happened in political offices, not in the bureaucracy or by using expert advice.

They certainly didn't seek my advice, or at least consult me, on my experience in trying to explain the concepts publicly.

The other issue, which is key here, is that it showed the government was not concerned about access and efficiency, but about booking budget bottom line savings in 2014. So they rushed to judgment to get a proposal out there so they could actually have a figure in the budget papers that could actually show that they were reducing our debt and deficit. And the government's subsequent attempts to refine and then redesign the co-payment plan later in 2014 and into early 2015 did not make things better, in fact I think they made things a lot worse.

The government and its key ministers: health ministers, treasurers and even the prime minister didn't quite look like they knew what they were doing. 'Improvements' were actually more complex and messier than the co-payment mark 1, and again the government's attempts at explaining and defending these changes were awful.

The change of minister in December 2014, in my view, made little difference but the fallout from the whole co-payment debate and the political outcomes were a disaster for general healthcare reform.

Both the Coalition and Labor have adopted a common position, and it is this: that they, be it the Labor Party or the Coalition parties, will not pursue difficult reform in healthcare unless the medical profession is on board, and in practice that means that the AMA is the arbiter of who comes to Medicare and the circumstances in which they come.

And despite the AMA leadership changing from the outspoken demagogue Brian Owler to the far more reasonable and moderate Michael Gannon, that hasn't really changed. Really, the AMA sets the pace. In terms of their proposal, Jeremy, Peta and Gerald need

to convince Michael Gannon and his members that what they are proposing will work if it is ever going to succeed. And whether that's a good thing... you can make your own judgement. I don't think it is a good thing.

What the government should have done is this: It should have started tilling the ground well before the 2014 budget, perhaps even before the 2013 election, notwithstanding the political risks in getting public acceptance of the need for some reform around bulk-billing and patient contributions.

Clearly ministers needed to explain what the problem was, and there is a problem. Certainly, if you are going to change the system, and given that Medicare is such a social sacred cow, you need to be able to start talking sooner rather than later. But, because of budget secrecy, neither confirming or denying what's in the budget, they didn't do that. Instead, they were quite happy to let me be the canary in the coal mine—and as you can see I'm not the best communicator in the world—but they wanted to see if I suffocated and died in the political hothouse of the co-payment debate. I didn't, and I'm quite proud of that. I was actually able to prosecute a case publicly and in the media, and in writing, to show that this could work and it had a reasonable basis to it.

But the government didn't realise, they seemed to say, "If Terry can do it, we can do it too". The thing is, I was just an obscure former government advisor doing a paper for an obscure think tank, not the Treasurer and the Prime Minister and government of the country making this measure the centrepiece of a tough budget. They just didn't expect the flak they got because they thought, the actual debate in the run-up to the budget was relatively benign in broad political terms.

They also did not set the whole plan in a wider health policy, or a wider fiscal and general reform context. They didn't actually till the ground themselves. They may have flagged, could have flagged, their intentions instead of going into the 2014 budget with a fully-developed plan. They could have started a process of consultation and engagement that might've got an outcome that was sound policy, politically defensible, and avoided most of the unfair features of the

budget plan and also a lot of political pain. I actually suggested at one point when the going was rough for them that perhaps they could give the Productivity Commission a reference to do that process and to leave those consultations at arm's length from government, but that didn't go anywhere either, except to the back page of the Financial Review.

As I say, taking the timing out of the budget process would have helped a lot, and most of all, sacking the bright spark who proposed hypothecating those savings to that Medical Research Fund. That person or persons had no sense of policy and they had no sense of politics, and I suspect their knowledge of the healthcare sector could be written on the back of a postage stamp. I've named no names but you could possibly guess who I'm talking about.

In terms of the consequences of policy failure, it certainly killed off the Coalition's appetite for doing anything more than tweaking Medicare and healthcare generally. It has also emboldened Labor to make itself a populist champion of the people, blocking even minor changes such as the proposed reducing of pathology and diagnostic imaging bulk billing incentives, and in a way it's set Medicare in politically unbreakable concrete. If you accepted Bill Shorten and Catherine King's (the shadow health minister) rhetoric from the election campaign about Medicare: "we will not cut Medicare—we will not touch Medicare"—to cut even a dollar from Medicare would be a breach of Labor's election promise.

Labor has actually dug itself in such a hole that if it ever got to implement that plan, it would be in political trouble perhaps even more diabolical than the co-payment experience. But the other side of that, because of Mediscare in particular, is that it is going to be very hard for rational policy plans and proposals to get a fair hearing, and that's a real worry we have to consider.

Again, that reinforces the AMA as the chief arbiter of what is possible and what isn't in terms of the healthcare system, and further entrenches the power of the vested interests that strangle Australian healthcare innovation: the 'I' people in the system and those self-appointed experts who believe that they are the guardians of Medicare. The fact that somebody else has to pay for their ideas (basically it's



you and I) doesn't really occur to them. The ultimate consequence, of course, is that we will continue to waste billions of taxpayer dollars that could be better spent or saved.

Peta talked about that, the waste, before. When I worked in the health department many years ago, I had a colleague with a screensaver: "Half of all health expenditure is wasted, the problem is we don't know which half". My role in this debate— while I didn't start it, I certainly kicked it along— helped create an anti-reform state of affairs. For that I am truly sorry and I apologise.

In terms of implications for major healthcare reform from here, as I said the GP co-payment was a relatively minor proposal in the bigger scheme of things that got blown out of proportion. It almost brought down the government and was a big factor in the downfall of a PM. In fact, I thought of calling this talk "Tony Abbott, my part in his downfall". Yet there is no doubt the truly fundamental reform of the system, such as we've been hearing about tonight, is needed as the Australian population ages and the whole population starts to show the acute and especially chronic consequences of our soft and namby-pamby sedentary, self-indulgent and lazy lifestyles.

And sugar taxes won't solve those problems, by the way.

Let's also not forget the spiteful dysfunctional marriages of federal and state, and public and private, responsibilities for health care funding and service delivery. Our federation indeed is perhaps the biggest single drawback to meaningful healthcare reform, yet we cannot easily remake the federation and that sets the agenda whether we like it or not. In fact, I remember at the time of the GP co-payment a then Liberal state health minister I knew decided to blame me for his troubles, and he also harked back to Tony Abbott's push to have a single federal payer of public health money, saying if Abbott did something like that, it would actually do a lot of state politicians out of a job.

Sorry Peta, but that's the way many people at state level think, and I suppose preselection candidates worry about it too.

The GP co-payment and Labor's successful Medicare, I think, ultimately showed that the Whitlam-Hawke Medicare settlement is not easily tampered with. The Australian public won't readily tolerate

even minor changes to that settlement, let alone major renovation, and that's because of the politics around it. The ground for such changes therefore needs to be well-tilled, and in the populist rent-seeking mentality that now dominates our politics, this requires real political courage that I think is sadly lacking.

Indeed, I fear genuine big thinking by genuine big thinkers, such as referred to tonight, scares politicians and government, and provides easy targets to the oppositionists and populists who dominate federal and state agendas these days. And by opposition I don't just mean Shorten Labor: I mean any party or leader seeking to gain office by playing to the fears of voters rather than to their aspirations. Indeed, when vote-hungry oppositions shred a government's record on obsolete measures like bulk billing rates, public hospital beds and waiting times and pander too much to the wishes of doctors, that is to say the AMA, rather than the best interests of patients and taxpayers, we get reform paralysis not a climate of innovation.

So aligning reform aspirations to community aspirations and expectations therefore is a big challenge for genuine health policy thinkers and reformers. The first big step is understanding those aspirations and expectations and making the fundamental change evolutionary rather than revolutionary, and I also think it needs to ask some pretty tough questions and make some challenging conclusions. So, despite the failure of the co-payment, essentially plugging away at the Australian community's entrenched mindset about Medicare and healthcare provision matters.

Medicare is a healthcare access scheme. It is not a middle-class welfare entitlement scheme as politicians, particularly those on the left of politics, condition us to think. The better-off should not expect bulk-billing, and all this should not assume that health services are an ever-running, bottomlessly-funded tap.

We also need to start asking ourselves some very difficult social and ethical questions about what services are provided and paid for by taxpayers, including people who voluntarily assume risks that damage or destroy good health. Smokers, for instance, shouldn't expect to be top of the queue for expensive treatment arising from their habit. People who attend emergency departments to be patched up after

alcohol-fuelled brawls should not expect free treatment. People who contract Type II diabetes because of their lifestyle choices shouldn't expect everyone to pick up the full tab for their treatments, and private health insurance should at least have some element of risk rating, including positive rewards for those doing the right thing by themselves and by others—and that includes taking steps to do the right things.

And as medical science gets better and better at keeping people going, is there such a thing as providing too much healthcare? There are too many people with chronic conditions, in my view, particularly the very old who are kept going but whose quality of life is reduced or perhaps even almost non-existent. We do need I think to have a conversation about the right balance between keeping people alive when lives become miserable, and whether people and families perhaps should not expect the taxpayer to help keep stringing things out indefinitely.

But, on the other hand, I think perhaps we as a community need to change our own mindsets and own expectations about what's right, particularly as we reach the end of our lives. We can't go forever. And in areas like IVF, where the physical and emotional cost on patients is terribly high, the chances of successful outcomes depressingly low, and corporate imperatives actually manipulate demand, it's arguable that treatment subsidies should be strictly limited if they are to be applied at all.

I also think that preventing and mitigating illness and injury should be a greater part of the healthcare service delivery and funding picture provided that it involves genuine harm reduction based on people taking responsibility for themselves. I've taken a lot of policy interest in vaping, quitting smoking and getting people off the deadly weed, because—according to the emerging body of evidence—some experts say it's at least 95 per cent safer than smoking.

Yet Australian regulation virtually suppresses vaping if it involves nicotine. The thing is, when the Australian public healthcare establishment prefers to keep things as they would like them to be, and is opposed to accepting the possibility of disruptive innovation actually leading to genuine improvement in health outcomes, we

have a real problem. But when we also have a situation where our politicians as funders and regulators of the healthcare system are too afraid to do anything that challenges the status quo, that challenges received wisdom, and aren't prepared to go elsewhere for advice and guidance, we are going to get nowhere. We're talking right across the board, but I just think in the public-health space it is really a problem.

To wrap up, these are tough, emotional and confronting conversations but they need to be had, I believe they must be had. A genuine climate of healthcare reform can't be created if questions like these are set aside. They help create a definition of what is possible, but I think the point of all this is that sadly our political class is not up to providing a courageous thought leadership that makes innovative reform possible.

Peta talked about inoculating the public, I think it's the other way around. We should be inoculating our political leaders to feel that they can take on the populists and the opportunists, and actually do something courageous to set us on the road to a better healthcare system, better healthcare outcomes, and a more efficient use of taxpayers' money.



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