
Healthcare: Why we need to do things differently

Australian Healthcare and Hospitals Association's (AHHA) Blueprint Refresh Roundtable, Brisbane, 2 September 2019

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Today I want to start with Newton's third law. It says that for every action there is an equal and opposite reaction.

Here's how it applies to public policy: usually someone comes up with an idea, someone else opposes it and a vigorous debate ensues, on intellectual or ideological grounds.

And then, as the fog lifts, you can sometimes vaguely discern a winner, and policy starts to shift.

In other cases, things don't change much at all because two sides have fought things to a standstill.

There is an inertia that comes about because of the lack of consensus.

But when it comes to integrated, patient centred health care, it's totally different.

Here, everyone seems to agree. There really isn't an intellectual battle at all, and yet the power of inertia remains and progress is slow.

It's easy to attribute that to vested interests, but it is most likely more complex than that.

So in thinking about the refresh of the 2017 Blueprint, I think your task is as much tactical and strategic as it is intellectual.

The main question is how to get traction – to build and maintain some momentum.

There are some grounds for optimism.

Some primary health networks and local hospital networks have collaborated in very successful approaches to manage the health of their regional populations — Western Sydney for instance.

While we have criticised aspects of the Health Care Home Trial, it is a genuine effort to tackle the problems that can arise from a pure fee for service system, particularly in addressing chronic disease.

Whatever the progress to date, there is certainly a strong case for change.

To give you a sense of the potential benefits from a better health system, we drew on micro data from the most recent ABS Australian Health Survey for 2017-18 and other research, and found:

- a working age person with poor health has a probability of participating in the labour market more than 50 percentage points lower than someone in excellent health
- people in poor health work fewer hours, with more than one in five working 15 hours or less weekly compared with about one in ten for those in excellent health. This and the two other preceding labour market measures are derived from analysis of the microdata release of the Australian Bureau of Statistics (ABS) 2017-18 Australian Health Survey. The figures on personal income and welfare dependence below also are from the AHS.
- people with generally poor health have 50% more sick leave days
- the hourly wage – a proxy for productivity – is 18 per cent higher for someone in good health than poor health
- Welfare dependency rates for those with poor health are nine times higher than for people in excellent health.

Mental illness has a particularly adverse effect on people's capacity to participate in work and life as we are discovering in our current Mental Health inquiry.

Since many mentally ill people are young, the lifetime effects are very pronounced.

Now I know what you're thinking: these are impressive stats, but what if the causation runs the opposite way – that people participate in the labour force, find jobs, earn income and their health improves.

Or, alternatively, it's down to other factors which influence both health and employment outcomes – like a quality education, a good lifestyle, a positive attitude.

All those correlations are possible – even likely – but we shouldn't be too worried about that for our purposes.

When it comes to human capital, there are all sorts of inter-linked causal connections. Humans are complex.

But health isn't the only policy lever we are trying to influence. We also advocate policy reforms in areas like school education, skills or workplace relations to improve workforce

participation and if they in turn have a positive influence on health outcomes, then that's just fine.

The point is that if we are trying to boost participation and productivity, then improving health outcomes is a key part of the policy mix.

What about the productivity of the health industry itself?

In a very general sense, we do pretty well.

Australia's health system delivers high life expectancy and very high healthy life expectancy for a comparatively low spend as a share of total Gross Domestic Product (GDP).

And if you think about productivity as measuring outputs per unit of input, then in some ways the system performs very well. Maybe a bit too well.

After all, think about our activity based funding system in public hospitals, and our fee for service system for out of hospital care. One thing you can say of them is that they certainly encourage a lot of output!

That's not to be too critical of Activity Based Funding (ABF). I think it has made a huge difference to the efficiency of our hospital system in the last 25 years, since the early days of casemix in Victoria.

But we have much less assurance that all procedures performed have strong clinical evidence,

One of the best indicators of this is the marked degree of variation in health services by location revealed in the Atlas of Healthcare Variation produced by the Australian Commission on Safety and Quality in Healthcare.

The regional differences are so stark that they can only reflect different clinical norms, rather than any differences in the underlying health needs of the relevant populations.

And there is the lingering suspicion that we have created a funding incentive to expand the use of the highest cost part of our system, when perhaps some acute hospital episodes could have been avoided through prevention or alternative pathways.

Yet neither general practitioners (GPs) nor hospitals benefit financially from avoided hospitalisations.

It's also true that many parts of our system have important in-built safeguards around cost effectiveness, but still don't fully guarantee that we get the right outcomes.

Think of the Pharmaceutical Benefits Scheme (PBS): we have a robust test of clinical efficacy and cost effectiveness at the listing and pricing stage, but much less assurance about

whether prescribing decisions are optimal, and whether patients fill their prescriptions and use the drugs correctly (or at all).

Similarly with the Medicare Benefits Schedule (MBS): the Medical Services Advisory Committee (MSAC) does its work up front, but then it's over to the practitioners to use MBS items efficaciously, to avoid over or under servicing and for patients to engage meaningfully.

So these cost-effectiveness safeguards, along with ABF and fee for service, play a positive role as top down mechanisms to drive efficiency. That's positive, but it's not everything.

It's clear that to go the next step, we need stronger incentives for coordination.

Funding reform clearly has a role to play, given that existing funding models are a major reason for lack of integration.

Any funding model has to provide incentives for 2 main groups.

We should reward hospitals for initiatives that avoid hospitalisation, particularly through collaboration with primary health, and we should reward GPs for avoiding hospitalisation for better management of people with an avoidable high propensity, particularly, to emergency department (ED) admissions.

That requires changes to ABF, common funding pools from State, Territory and Commonwealth Governments, blended payments to GPs, and governance arrangements that bring Primary Health Networks (PHNs), Local Health Networks (LHNs) and community health together.

In mental health, it can involve social welfare and housing too.

None of this is easy

But we could do more to identify particularly high-cost vulnerable patient groups and introduce measures to address their health needs imaginatively and at lower cost.

A good example is the Royal Perth Hospital Homelessness Team, which is a collaboration between the hospital and Homeless Care General practice.

A thorough evaluation of the program found that in the one year after engagement with the Homeless Team, hospital utilisation fell with savings of over \$7000 per patient

In shifting the dial, we found that psychosocial interventions had similarly large impacts on frequent users of NSW ambulance services.

These piecemeal initiatives can help build momentum.

To get really systematic, we should aspire to the aspects of the investment approach that New Zealand has long had for users of social services (and that has partly been emulated in Australia).

But all these approaches are based on coordination between *providers* in the system.

Arguably to get really strong integration and good quality outcomes, we need more fully engaged and well informed consumers.

Sadly, the culture of the system - reinforced by a lack of competition and obsolescent funding models, remains very supplier-centric.

Consumers find it hard to exercise choice or control.

Health literacy is low in Australia. And around 40% of people in poor health say they have difficulty getting health providers to understand their problems properly – that could reflect shortcomings on both sides of the relationship.

In *Shifting the Dial* we estimated the cost of time spent in waiting rooms — (a very unusual term when you think about it and idiosyncratic to the health sector.

The cost amounted to around \$1 billion annually.

A Queensland patient satisfaction survey for outpatient maternity clinics found that three quarters of patients were never or rarely told how long they would have to wait after already waiting 15 minutes and around 40% of patients who had waited for at least this long rarely or never received an apology.

This culture of waiting arguably symbolises the general passivity of the system. Patients have to present to the system, rather than the system seeking people out to help them proactively manage their health.

Not all professions are like this. Just about every week I get some promotional blurb from another real estate agent, just in case I was thinking of selling my house.

Dentists are vigilant about reminding us that it's time for another check up.

But it's much less common in General Practice.

We even talk of GPs as 'gatekeepers' to the system, which is a well-meaning metaphor, but it hardly evokes a sense of outreach.

For all the data that our system generates (not that its necessarily used well) we have been slow to develop Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) – the indicators which genuinely put the patient at the centre of things.

Having PREMs and PROMs across all disease registries would be a great initiative to drive a stronger patient culture, along with greater attempts to improve health literacy.

So when the Commission thought about what a more desirable, integrated system might look like, we came up with some key features:

- fewer boundaries between parts of the system, with more incentives for practitioners to cooperate, both across primary health (GPs with nurse practitioners, dieticians, pharmacists and the like) and between the primary and acute sectors
- a more patient-centred approach, such that the patient becomes the locus of that cooperation, and patient outcomes and experiences are monitored and used as the basis for learning
- better data and more data sharing
- a stronger commitment to disseminating clinical evidence about which procedures have merit and which don't
- greater health literacy, empowerment and engagement on the part of users of health services
- and a strong culture of community outreach, so that we aren't just waiting for people to present to the system.

The AHHA blueprint covers all these and more.

However, any policy reforms to healthcare has to start with the realistic premise that there is no big bang reform that will get us where want to go in a short period.

We face that same dilemma right now in our inquiry into mental health.

And here I want to make one more general point about policy reform in Australia.

Because of the experience of the 1980s and 1990s, with the floating of the dollar, corporatisation and privatisation of government enterprises, reductions in tariffs, reforms to the tax system or industrial relations,

Much of the public is conditioned to thinking that reform consists of large, singular actions – generally with a high profile and a measure of public controversy.

But that's not always right and in fact that's not always an accurate description of past reforms.

Often there was a single government decision which started the process.

But the real benefit of the 'reform' was the process that followed on from that initial decision.

Cutting tariffs might have fired the starter's gun, but it was then down to the private sector to take the thousands of decentralised decisions to improve domestic efficiency in the face of greater import competition.

Health reform is also an ongoing process, but this time it is often government, and the various parts of a publicly owned, funded and regulated system that have to take those thousands of decentralised steps.

So government is much more part of the journey – the implementation – than was the case with past reforms.

And frankly, government isn't always that nimble. So we need something akin to public sector entrepreneurship.

Still, there can be catalysts – or spurs to action, and as is so often the case, data is a good starting point.

It's notable that PREMs and PROMs, or an investment approach, e-health, and the use of artificial intelligence (AI) or data analytics all require that common resource — data — as well as complementary information technologies.

Unfortunately the use of information technology and transmission of information can fall well short.

Hospitals often still rely on paper, and while moving to a 'Digital Hospital' for clinical information is an obvious direction, implementing new complex systems has proven hard and costly.

Even something as simple as a high quality hospital discharge summary has proven hard to attain.

Our immediate imperative is not so much **more** data (aside from PREMs and PROMs) as more sharing and making better use of what is there, ensuring compatibility of systems and creating confidence by the public that privacy can be preserved.

And lastly, I wanted to give you one final, left field reflection.

It would be good to consider how private health insurance (PHI) fits into the picture.

We know that PHI has some challenges, both from demographics and from health price inflation.

But one of the things our insurers have made some progress on is innovative efforts to reduce hospitalisations through preventative programs.

Sadly the existing risk equalisation arrangements dull the incentive for insurers to perform this role more broadly.

But this could be overcome with careful policy design.

And going back to my earlier point that neither GPs nor LHNs have an incentive to prevent hospitalisations, I just note that insurers in general do, given they pay a portion of the bill for most episodes in private hospitals (and increasingly in public hospitals).

This is not a call for managed competition. The Productivity Commission looked at this in *Shifting the Dial* and concluded it was too big, disruptive and risky a change, for very unclear benefits.

But we should think hard about PHI, its policy settings and the private health sector more generally not least because it could play a greater role as part of a more integrated, patient centred system.

As I said at the outset, when it comes to building a more value-based system, the intellectual case is strong, and has many adherents.

The issue is overcoming inertia and building momentum.

Despite having pointed out what I see as some of the shortcomings of our current system, I am instinctively an optimist and as I said at the beginning, there are significant signs of progress, not least of which is the 2017 blueprint and today's Refresh Roundtable.

I look forward to your deliberations.