Responding to Changes in Funding and Payments.

Roundtable 7 Summary Report

INNOVATING health

creating a new conversation

INNOVATING health series

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About the Series

HISA is delivering a new thought leadership series - ***Innovating Health. Creating a New Conversation.***

Through an ongoing series of roundtable events and other activities, we aim to lift and support the digital health innovation agenda in healthcare.

To create a new conversation, we seek to bring together health leaders with industry experts, challenge current thinking with new and different perspectives, harness our collective knowledge and ideas, and ultimately share topics and discussion with others to stimulate sector change. The series is in collaboration with and supported by Accenture.

Never has there been a time of such pressure on the healthcare system. The need to transform is vital.

Conjointly, the conditions and promise of innovative change are tangible through the development and application of new digital technologies, rapidly changing business models, Government policy reforms, the rise of health consumerism, and service led reform.; a

"Many of the ways we go about improving health and care were designed in a different mindset for a different set of circumstances.

Given the radical and complex nature of our transformational challenge, these 'tried and tested' methods increasingly won't deliver what we need to deliver for patients."

Helen Bevan and Steve Fairman NHS UK

Event 7 – Responding to Changes in Funding and Payments
Sydney 3 May 2017

Overview

The Innovating Health Series was in Sydney pre-Federal Budget 2017 for a roundtable examining the important area of healthcare funding and payment. The health leader roundtable discussed **Responding to Changes in Funding and Payments** against a backdrop of innovation.

The MBS Review Taskforce published its Interim Report earlier in 2017 and has extended its scope of work. It is anticipated that there will be further recommendations to the Health Minister in both funding models and policy changes. These recommendations have the potential to deliver changes in health business and service models that are moving in the right direction. The Health Care Homes primary care policy funded by a new, capitated funding model is one such example.

With a focus on funding changes to build robustness and system sustainability, address specific patient cohort treatment needs and provide access to more services in the home or community settings; there is the potential for health system deconstruction paving a new way for healthcare to be accessed and delivered.

We welcomed Dr Jeremy Sammut, a leading advocate in market-based health reform to present alternative models and ways of thinking about health system change and sustainability in the context of evolving health funding and payment arrangements. The discussion sought to explore the opportunities for change and innovation within current and future funding and payment models. Dr Sammut provides independent advice on healthcare funding and economics with the Centre for Independent Studies.

Of note, our guide introduced the notion of Health Innovation Communities as an alternative way of viewing system payments through free trade zones and enabling community and service innovation. The argument was made that the current funding model structures are rigid and continue to reward existing system inefficiencies. This inflexibility stifles innovation and disables change toward more consumer-centric models of care. Health Innovation Communities set the context for a challenging and thought provoking discussion whilst also reflecting on the complexity of the healthcare system and delivering change.

The take-away points from this health leader discussion are highlighted in this summary.

Highlights and Take-Away Points:

1. **New Ideas and New Ways to Implement –** It is well recognised that it is impossible to build the number of hospitals we need to meet the growing demand in healthcare and that we are continuing to spend too much on hospital care and not enough on primary care. The current health funding and payment system is built around a model that funds activity and episodes of care. Health service provision, both in public and private sector, continues to rise, health insurers and government are continually challenged with the inability to control their costs. We need new thinking and new ways to implement system change by using system levers such as funding and payments.

   Agreed efforts have been made to institute structural changes to hospital and health service performance and tie-ins for funding. Whilst these have been good measures, they are only able to deliver technical efficiencies within the current model and cannot adequately address the problem of escalating cost and increasing demand for service. Policy initiatives around Primary Health Networks (PHNs), managed care plans and Health Care Homes are important steps for progressing integrated care and addressing certain patient groups in chronic disease, however are they just bolt-on solutions to the current system or part of the solution?

   Is there a case to reorganise the system? There are certainly barriers and restrictions for new entrants, service innovations, care models and ways to implement new ideas. In the current funding and payment model it is difficult for new ideas and service innovations to get their 'hands on' funding to implement new services, as the dollars are generally locked in the current model with fee for service payment rules. How do we allow for new service innovations to be picked up and get implemented at scale? How do we provide greater opportunity to discover what works? As health leaders, we all need to consider innovation in the light of not just what can be done, but how it can be implemented.

   "We have been here before and we know the complexities.
   It is not so much what can be done, but how it can be implemented. "

   Dr Jeremy Sammut, Centre for Independent Studies

2. **Enabling Consumer Choice and Directed Care –** The National Disability Insurance Scheme (NDIS) and other consumer directed care examples were discussed as potential models for health funding and payment reform focused on greater consumer choice. Stimulating innovation through a consumer directed care approach did provide the opportunity to reorganise care pathways and implement competing innovative service models designed to respond to consumer choice.

   However, in these models it is important to ensure that the governance is appropriate and that there is minimal opportunity to game the system. There have been challenges experienced by the NDIS in managing the distinction between purchaser and provider. These experiences highlight examples where consumers are not given the appropriate information to make a choice, and the assessment to access care is made by the provider that will deliver that care. This example challenges the principles of choice and potentially perpetuates nepotistic control by the dominant providers. From a governance point of view, if we selected a different funding and payment model path we would need to separate the assessment from the provider to ensure appropriate

governance and minimise opportunity to game the system. It was agreed that as we move forward it is crucial to delineate separate budgets for independent care advocates and service providers.

In regards to delivering consumer directed care approaches or any new funding model to scale, we need to have a model where the providers themselves will have the incentive to participate. The aim should be to get the 'best of managed care without the downside of managed care' such as perverse or unintended incentives of whatever payment models are put in place.

"…it is crucial to start separating out the budget for independent care advocates from the service provider"

Health Leader Roundtable Participant

3. **Focus on Regional and Community Led Approaches –** A focus on geographical, regional and community boundaries is generally a good approach. We can see good examples such as Health Direct Australia and Primary Health Networks (PHNs) when we focus services on a geographic population. Whilst there are good examples of regional approaches, people are often transient and it is very difficult to control peoples' movement and access to care. We don't have the controls in place for this at present. From a system funding and payment model this makes it challenging to move away from a fee for service model.

   In addition, front loading spending for people with complex conditions and chronic disease still does not get people making investments in their own health early enough. Are we getting the benefit for the spending or contributing an additional cost? It will be interesting to see how the Health Care Home model performs moving forward and the benefits of care being provided closer to home.

   The Connecting Care Program for Chronic Disease Management has highlighted that we have interventions in place that are of benefit, there is more we can do about making the system less complex and confusing. The program targets consumers with chronic diseases once they are acutely ill, instead of predicting which consumers will be admitted to hospital before their health deteriorates and making the right interventions in the home.

   The factors contributing to peoples' health are many and varied. We have approaches around population health, disease prevention, screening, managed and integrated care. Factors including income, social status, education, housing, living conditions etc. are all factors in the larger context of our society today. Are the social determinants beyond the reach of the health system? Whatever the case, the burden in our health care system starts at primary care. The PHN's are a vehicle for a geographical approach to joined-up care and health outcomes. We need to revitalise the role of PHNs. How can we intelligently use PHNs to encourage system change? Are there other ways to stimulate innovation at the primary care level to address health demand and people's individual health and wellness earlier before they become reliant on the system? …such as those described in Health Innovation Communities?

"Are the social determinants beyond the reach of healthcare?"
Is this a place for innovation?

Health Leader Roundtable Participant

4. **Choosing the right system?** Healthcare is a complex system where the general mind set is at first, 'do no harm'. We require an evidence base to prove models and to implement change to ensure that it is based on peer review knowledge and experience. The trouble with this approach is how do we work with innovative change in a system that is inherently risk adverse, slow to respond and implement, and resistant to change because of the many moving parts and competing interests?

   How do health leaders and decision makers know what is the right solution? There are many solutions that implement innovations that deliver incremental improvements and better services and care models. Examples in both private and public sectors included collective information and service resources for chronic disease, collation and integration of services such as primary care, pharmacy, and hospital services to encourage connected services, and end of life care alliances enabling greater consumer choice and coordinated care management among others. Whilst these achievements are note-worthy and admirable, are they enough of a change to address the broader healthcare system issues? It was highlighted that if you try to do it all (multiple system changes) the dialogue is difficult and causes confusion and ultimately a lack of uptake. That leaves decision makers with making incremental changes that are smart within the confines of the current system, rather than radical changes to address sustainability of the system.

   Lining up institutional support is important with any innovative policy change and implementation in healthcare in Australia. Both Sweden[1] and Spain[2] have examples of new policy and funding model changes which are encouraging bottom-up community led change, rather than top-down change from the bureaucracy. We can look to and learn from these examples about other ways of incentivising health system change through funding and payment mechanisms. We do need a circuit breaker to leave the provider capture model, and to better enable and involve practitioners, patients and consumers to move towards a more sustainable health system. These circuit breaker solutions need to be valuable across multiple stakeholders and be able to drive the politics of the day.

"We try to tinker with systems that we have got, rather than stand up new innovations"

Ian Manovel, Principal Health Innovation Accenture

5. **Where to start? –** The current funding and payment model is transactional based with fee for service in episodes of care. We need to be moving to outcomes funding models which address both clinical and quality outcomes, but which also provide individual health education and education of the system. We cannot keep talking about funding beds and buildings – it has to change. If we are funding activity, what is good activity? Essentially, it is contingent on our political and health leaders to create the environment for change and health system improvement.

   There are some regions like NSW where the Activity Based Funding hospital payment system is maturing into a more outcome focussed payment vehicle. The addition of patient reported outcomes might create a more customer centric payment model for acute care. Nevertheless, such a model would have to incentivise the prevention of hospital admission which Activity Based hospital patient models do not effectively address if PHNs are to be enabled to keep patients with chronic conditions healthy at home.

[1] Cited 16 September 2017 at https://www.theguardian.com/public-leaders-network/2014/jan/03/sweden-healthcare-coordinate-oecd

[2] Cited 16 September 2017 at http://www.euro.who.int/__data/assets/pdf_file/0004/128830/e94549.pdf

It was agreed that innovation is challenging under the current system. We need to create the environment to allow sufficient opportunities for innovation and community led bottom-up change. Innovative changes need to be scalable and lead to whole of system approaches to have impact. From the discussion, a focus on creating that environment in a geographic region, focus on health priorities, and allowing a mechanism to reward innovation and system change was essential. Priorities in areas such as:

- Management of diabetes
- Management of asthma
- Health of children
- Mental health

Finally, whatever changes are made, they need to recognise societal changes and embrace the customer in regards to focus, access, choice and outcomes. Customers include health practitioners, patients, families, carers and individuals. A funding and payment model that incentivises health system change around these areas is important.

"We need to be customer focused. If not, we will all get limited outcomes."

Health Leader Roundtable Participant

Conclusion - HISA Reflection on the Event

There was a high level of information sharing at this **Innovating Health Roundtable**. It was an insightful discussion and we thank the attendees for their participation. We also thank Dr Jeremy Sammut for steering the direction in discussion and challenging our thinking in this area.

Our key take-away as participants and observers at the event were:

- Not just to think about new ideas for health system improvement and change, but more importantly **how to implement those changes**. Funding and payment models have the ability to stifle change or to stimulate system innovation.
- In any future funding and payment model we would need to separate the assessment from the provider to ensure **appropriate governance** and minimise opportunity to game the system.
- **Regional and community led approaches** are where we can best be innovative and stimulate change. Stimulating regional innovation and change should be a key focus for policy change. Are there ways to intelligently use Primary Health Networks to support these changes?
- Decision makers are making **incremental changes that are smart** within the confines of the current system and operations, rather than radical changes to address system sustainability.
- Need to be more **customer focused** from now on. If not we will get limited outcomes.
- **System innovation is hard** in healthcare because of the complexities and multiple competing stakeholders. Funding and payment mechanisms have the ability to change the way system works with incentives. This requires political drive and will to change.

We look forward to our next instalment in the series on the **Innovative Models of Private Healthcare**. Innovating Health – Health Leaders in attendance for this Roundtable:

- Dr Jeremy Sammut, Centre for Independent Studies (Guide)
- Dr Josie Di Donato, Advocacy and Leadership Director, HISA
- Lynelle Hales, CEO Northern Sydney Health Network
- Dr Robin Mann, National Chief of Innovation, Calvary Healthcare
- Neville Onley, Director, Activity Based Management, Ministry of Health, NSW Health

- Nigel Lyons, Deputy Secretary, Ministry of Health, NSW Health
- Ian Manovel, Principal Innovation Accenture
- Paul Peterson, Product Lead, Lorica Health
- Eimer Boyle, Talent Leadership, ASE
- Dr Mike Bainbridge, Director ASE
- Denis Tebbutt, Director, Dragan Claw
- Dr George Margelis, Assoc Prof Telehealth Research and Innovation Lab Western Sydney Uni
- Jean Evans, Consultant and Program Director, Ministry of Health, NSW Health
- Dr Michael Moore, CEO Central and Eastern Sydney PHN
- Dr Tim Smyth, Board Member Central and Eastern Sydney PHN
- Karl Suess, Senior Manger Accenture
- Paul Preobrajensky, Health Industry Consultant, President (NSW) ACHSM
- Greg Moran, HISA Host

Innovating Health Series website resources - http://innovatinghealth.org.au/resources/