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PwC commentary on the Productivity Commission Health review

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As we saw recently, the Productivity Commission report puts health front and centre. We at PwC fully agree about the importance of Health. We all know the challenges today: whilst Australia has a globally highly regarded healthcare system with good health outcomes at reasonable costs, it is not sustainable. Costs are growing faster than GDP due to the rise of chronic disease, an aging population and access to new medical technologies and advances. Shifting the narrative from challenges, we see a real opportunity in Health: it is social good for each of us, our families and our communities; Health delivers economic benefits from a more productive workforce; and Health is an opportunity as a key sector in the economy both for job creation and for exports. Perhaps most importantly, we see significant opportunities to shift the dial in how health and care are currently focused, delivered, funded and incentivised.

Integrated care – in particular around the lack of interconnectedness around primary & acute care and the impact this has on the patient, information, funding, prevention and local innovation.

Using information effectively – information fragmented (exacerbating integration, transparency and patient centredness) and slow dissemination of learning & leading practice.

Patient centred care – poor patient literacy, choice, attention to experience and relationships between care providers and recipients.

Quality of health – too many hospital acquired complications, too many outdated procedures still delivered and funded.

Funding for health – fragmentation, activity rather than outcomes focused – incentivising the wrong thing.

The following table summarised from the Productivity Commission report provides their thinking on problems, solutions and benefits

Problems

Solutions

Benefits

Integrated care

- Primary and hospital care poorly integrated
- Information flows do not follow the patient
- Funding is too little focused on long-run health or prevention
- Insufficiently devolved funding prevents locally efficient solutions

- New regionally-located care model offering funding and fostering attitude changes
- Regional alliances between Local Hospital Networks, Primary Health Networks and others
- Move retail pharmacy into an integrated care system
- Use information effectively (see below)

- Direct structured support for disease prevention and management
- Less duplication of services
- Care takes place in the right place
- Data follow patients as they move through the system

Patient-centred care

- Insufficient attention to patient experiences and outcomes
- Weak capacity for partnerships between patients and clinicians
- Poor level of patient literacy
- Low levels of choice

- Develop Patient Reported Experience and Outcome Measures, and publish
- Use My Health Record to improve information flows to patients and increase health literacy
- Identify and focus on high users of system

- Improved clinical outcomes
- Greater empowerment
- Self-management
- Fewer medication problems
- Patient convenience
- Lower costs

Funding for health

- Funding not oriented towards innovation or outcomes. Rewards activity instead
- Commonwealth/State funding split creates poor incentives to integrate

- Funding pools for Local Hospital Networks and Primary Health Networks to use for preventative care and management of chronic conditions at the regional level
- Provide greater autonomy to allow regional solutions

- Better health and reduced hospitalisations and other costs
- More experimentation and innovation, including in prevention
- Capacity to tailor solutions to specific regional communities

Quality of health

- Too many services known to be ineffective or outdated are still funded
- Too many hospital-acquired complications

- Require fast-track assessment of low-value care identified by overseas agencies
- Educate clinicians and measure and divulge their use of low-value procedures
- Improve patient literacy
- Defund demonstrably low-value procedures
- Remove subsidies for ancillaries in private health insurance

- Better patient outcomes
- Less waste and more ability to redirect savings to new and effective procedures
- Reduced outlays on rebates

Using information effectively

- Data and information flows are inadequate for genuinely integrated care, and frustrate research into 'what works'
- Innovation lessons are disseminated too slowly, including process innovations

- Follow recommendations of the Commission's 2017 inquiry into *Data Availability and Use*
- Adoption of eHealth throughout the health system
- Disseminate best practice through existing agencies

- Quicker learning about best practice
- Better, more and faster research into what works
- More integrated care with improved clinical outcomes
- Innovation in health care delivery

Further details are available here *https://www.pc.gov.au/inquiries/completed/productivity-review/report*

There have been different reactions from stakeholders to the observations and recommendations, some more positive, some more negative. Cutting across this though, a recent article in the Australian absolutely supported the Commission's shifting focus from the likes of banking and retail into the public sector – Government and Health.

Thinking about the response and the reform agenda more broadly, there is a lot in train already.

The Federal Health Minister has outlined four priorities:

1

Guaranteeing the Medicare and the Pharmaceutical Benefits Schemes – this includes restoring the immediate sustainability gaps, alongside the broader review of the 5,700 MBS items (the Bruce Robinson review) that includes a focused on outdated ineffective procedures; in addition savings on essential medicines are to be reinvested in funding for new innovative medicines

2

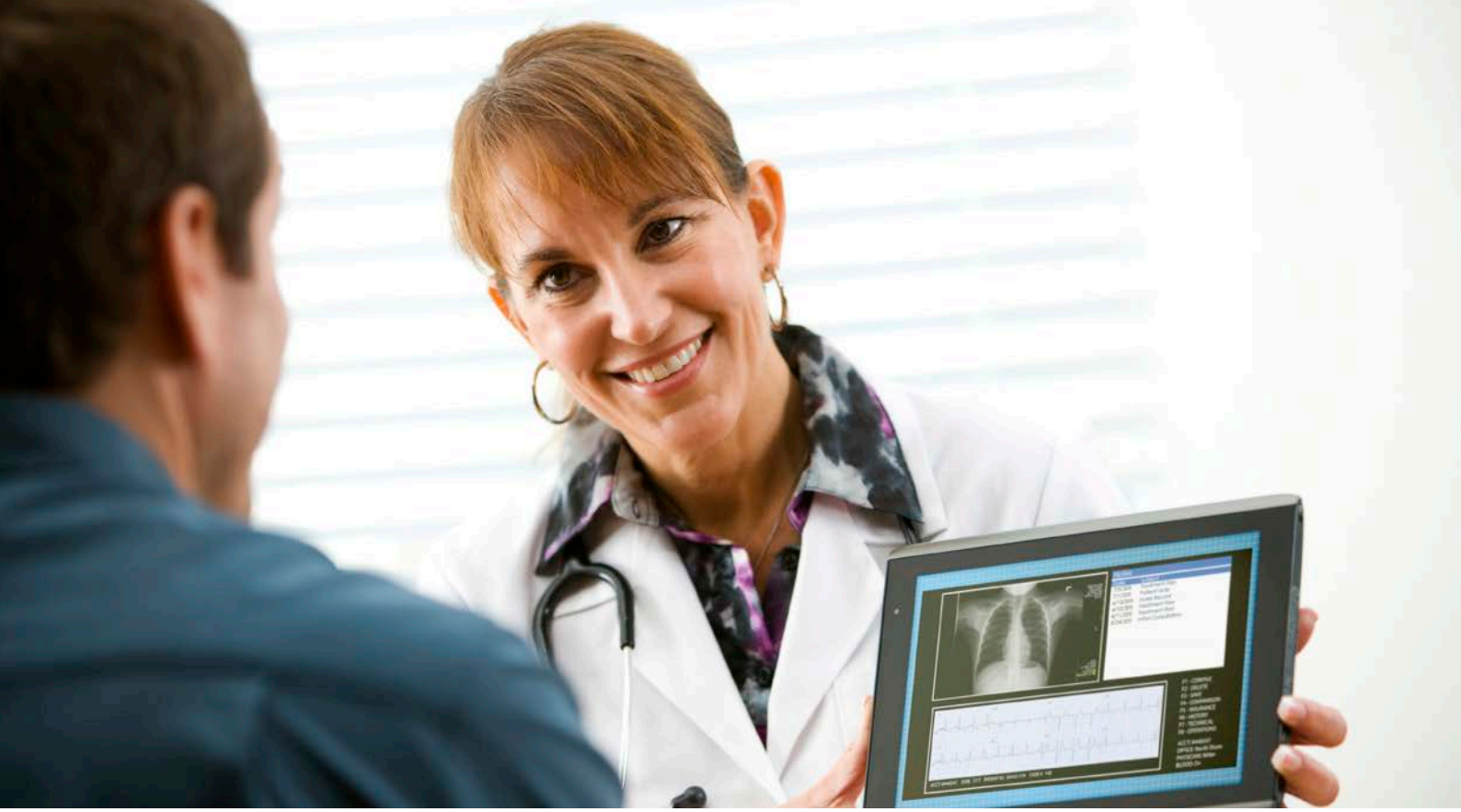
Supporting our Hospitals – this includes funding for public hospitals through Commonwealth funding to states and territories, as well as ensuring sustainability of private sector hospitals – which requires sustainable private health insurance. PHI reforms recently announced including measures to reduce premiums (e.g. savings in prostheses/medical devices), encourage take up in younger members, broaden services (e.g. mental health) and provide more transparency

3

Prioritising Mental Health, Preventive Health and Sport – increased investment in mental health, ongoing pilots for Health Care Homes, more screening, encouraging physical activity, better access in remote and rural communities, as well as engagement with food & beverage sector on voluntary improvements to nutrition

4

Investing in Medical Research – increased funding, in particular through the MRFF



In addition, there have been commitments to the NDIS to increasing funding to improve the sustainability of what is forecast to be a far more expensive initiative, as well as continued support for Aged Care. There is commitment to investment in My Health Record, with an "opt-out" model. We are also seeing actions being taken by many innovative players across the health ecosystem, for example, greater use of digital and analytics, as well as outcomes based commissioning by PHNs.

PwC has called out seven areas where we need to sustain focus in the reform journey:

1. ***Consumer empowerment:*** Identify and deliver on what consumers value most, putting the "patient at the centre". Use patient-reported outcomes to measure success and provide greater transparency to support better decisions.

2. ***Keeping people healthy:*** Shift focus from treatment of illness to wellness and prevention (including social determinants of health). Increase health literacy and encourage Australians to take greater responsibility for their health.

3. ***Right care, place and time:*** Implement new models of "integrated care" (e.g. prevention and care in the community). Increase quality and eliminate waste. Rethink business models, e.g. products to solutions, experience.

4. ***Digital and Analytics:*** Leverage technology and integrated data to deliver more convenient, affordable and personalised prevention and quality care. Build cyber security capabilities to manage increased risks as we digitise the health system

5. ***Reconfigure the workforce:*** build new capabilities for the future, e.g. digital and analytics, multi-disciplinary teams, leadership and change management. Consider how AI and robotics can complement human capital.

6. ***Outcomes-based funding:*** shift from volume to value to enable prevention, new care models and eliminate cost-shifting. Explore new models to drive innovation, e.g. social benefits bonds, PPPs. Integrate behavioural incentives into insurance.

7. ***Collaboration:*** Public and private organisations, Commonwealth and State, new entrants and established players, even competitors can benefit by partnering to deliver consumer-centred health services.

Further details are available here
https://www.pwc.com.au/publications/federal-budget-2017/health.html

Many of these areas resonate strongly with the Productivity Commission's analysis of the issues. But our point of view is not about the analysis of the issues but more **the derivation and delivery of practical solutions to overcome them.** Underpinning these practical solutions has to be a shift towards "**outcomes-based funding**", which we understand is where the next big wave for reform should and will be. The current fragmented funding models are incentivising the wrong behaviours and holding us back in Australia. This will require Commonwealth and State collaboration with permission to experiment with new models of care in partnerships across the sector. There are many examples of how this might help and we've set out some below.

Integrated Care: Our current federal/state model has different payors for prevention (typically in the primary sector) versus treatment, and care in a hospital versus the community. One manifestation of this would be the opportunity for "positive ageing" – an issue that will become even bigger in the future. From a consumer perspective, 70% of people would like to be in their home at the end of their life, yet only 10% of people are. This adds huge cost to our hospital system in treatment in the final years of life and will also put significant pressure on our social infrastructure needs. We know from PwC analysis that without changing the way we look after the elderly we will need significant additional investment and people, e.g. an additional $57 billion in capital costs for aged care and hospitals and 800,000 aged care workers by 2040. We all know that a solution based only on hospital based care for the elderly and those with chronic conditions produces sub-optimal outcomes, wouldn't be their choice and is more expensive.

An alternative blend, where some residential care is provided, and where this is augmented with a more **home and community based model of care** with step up models depending on need & circumstances must be a "win win" both for individuals and tax-payer dollars – and one where we could readily take a new approach.

Keeping people healthy: We also see challenges around funding interventions/investments today out of annual budgets which then pay off decades into the future. Our work in areas like Obesity/Diabetes and Mental Health makes a clear case for the need to shift focus to "keeping people healthy" rather than "treating them when they are sick". Reducing Obesity to WHO targets by 2025 would lead to an estimated economic benefit of **$10.3 billion**; however the pay-off from shifting the dial on childhood obesity will take years. Similarly, in Mental Health there is a cost of **$11 billion** in lost economic productivity in the workplace and **$14 billion** in health costs – with an RoI of 2.3 times for interventions. Even investments in digital hospitals (like EMR) typically take 7 years to pay off – which puts it beyond the reach of

Our funding

systems therefore need to allow an "invest to save" approach recognising that costs and benefits may fall in different cycles

$14 billion

in Mental Health costs – with a Return on Investment of 2.3 times for interventions that support wellbeing and improved productivity

Win-win

More home and community based model of care for the elderly must be a "win win" both for individuals and tax-payer dollars

many providers. Our funding systems therefore need to allow an **"invest to save"** approach – recognising that the benefits of investment may not fall in the same political cycle.

Pooled/integrated funding: As both PwC and the Commission have called out, the lack of outcomes-based funding incentivises the wrong thing and mitigates against a more person-centred and integrated approach to quality care. The King's Fund identified that one of the prerequisites of the best population based healthcare systems across the globe was **pooled funding.** Our practical solution here is about the establishment of **place based integrated care pilots** (underpinned by pooled/integrated funding) that derive and deliver the right solutions to address **locally determined priority outcomes** using information effectively. This is perhaps one of the biggest challenges facing the sector – migrating to **muti-disciplinary interventions that are derived from the outcomes** they are intended to achieve rather than provider-pushed traditional services. This should be done with consumers or patients employing techniques like **co-creation**. Our recent "master classes" in Melbourne and Sydney delivered with the CHF and AHHA focused on just this.

Pay for outcomes: Finally, and perhaps most critically, we have a model that rewards activity not outcomes: fee for service based models in primary care and activity-based funding in hospitals. This is holding us back from supporting new models of care with the "right care in the right place at the right time", eliminating waste (e.g. unnecessary face-to-face consultations or diagnostic tests) and fully capturing the opportunity from digital and analytics. **Funding for outcomes needs to extend into paying for outcomes.** There is some limited progress in this area with Health Care Homes and more significantly PHN outcomes based commissioning, but it's very early days. New practical solutions must reflect outcomes based payments and funding on a more substantive basis.

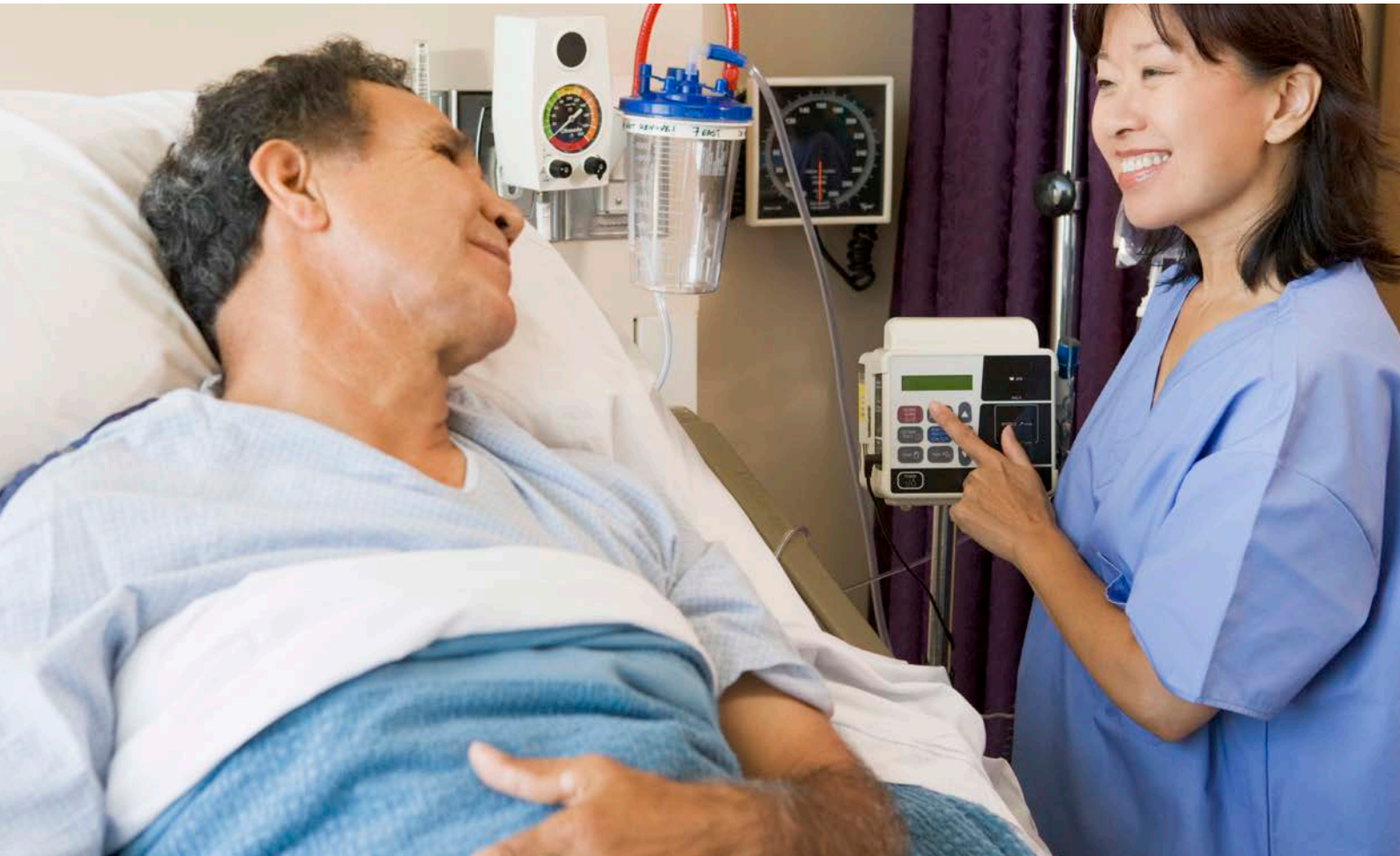
To conclude, we see this shift to "outcomes-based funding" and commissioning of services and interventions based on their ability to deliver outcomes as a critical enabler to support the changes needed and address current challenges; and we welcome the opportunity to work with the sector in this important topic.

Our practical solution

here is about the establishment of place based integrated care pilots (underpinned by pooled/integrated funding) that derive and deliver the right solutions to address locally determined priority outcomes

Most critically

we currently have a model that rewards activity not outcomes and this has to change



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