Funding for value

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Overview

This paper discusses how Commonwealth and State governments can increase the financial sustainability and quality of healthcare by evolving funding models and making other complementary changes to focus more on value.

We recommend complementing traditional funding models used in Australia and worldwide, such as Activity Based Funding and global budgets, with new approaches. These new models include outcomes based funding, bundled payments, alliance contracting and a number of other variants.

These approaches are being implemented effectively in the United States, Germany and other countries. They are also being trialled to a limited extent in Australia. We believe it's time to accelerate their use in Australia, while making a range of other integration, education, policy and learning system changes.

Nothing short of system-wide transformation is required to secure the future sustainability of our health system, raise quality levels, and deliver outcomes that matter to patients.

No time for tinkering

Australians want a health system that is accessible, responsive, affordable and high quality. They also want a system that works for all members of our community, regardless of their location, background or personal circumstances. Beyond these basic and reasonable requirements, is a complex array of further needs and expectations. For instance, Australians want solutions that support wellness not just illness; seamless integration across multiple system touch points; precision medicine, not "one size fits all" solutions; care that's closer to homes and communities, at all stages of life; 24/7 access to services; a choice of clinicians and providers based on feedback from "people like me", and control over their own care.

While the stewards of our healthcare system want these things too, there are numerous challenges to overcome. There are the familiar challenges of increasing and changing demand, the changing nature of disease and care pathways, increasing budget pressures and system fragmentation. It could also be argued that Australia has a system where providers (rather than patients) control what, when and how services are delivered. Providers that have, in some cases, been slow to evolve their practices to be more customer-centric – particularly when compared to other industries.

In addition, our health system is unusual in being so federated, with different levels of government controlling and funding different parts of the system. This complicated intersection of policy and funding adds complexity and can slow the adoption of innovations that work well in other countries. It also creates obvious challenges in progressing towards a more fully integrated health system.

All of these challenges have been evident in different parts of the Australian health system in recent years. This paper is designed to support Commonwealth and state governments as they consider how to evolve their health systems to meet citizens' needs and expectations, while improving outcomes and maximising efficiencies. It particularly emphasises the importance of establishing the right funding models – built around appropriate incentives – as a central requirement to achieving sustainability of any health system.

Across Australia, system stewards have made incremental changes to funding models over many years. However, these minor changes have largely failed to deliver financially sustainable health systems with a consistently high quality of care. In addition, recent systemic and high-profile quality failures mean that many members of the public no longer believe that spending more on health automatically leads to a higher standard of care.

With all these factors in mind, we believe there is an urgent need to undertake more than modest review of existing funding models. Rather, we need a fundamental rethink of the way to incentivise the health system to operate in the way we want and need. This is about transformation, not tinkering at the edges, based on a consideration of what "value" means in the context of modern healthcare and how to attain it. In turn, governments need to pursue a value agenda, in the same way that NSW has begun to do.

Towards a value based approach

The meaning of value

As management professor Michael Porter has highlighted, "value" is about the outcomes that are achieved relative to the cost of achieving them. To improve value in the health system we can either improve outcomes while maintaining costs, or maintain outcomes while lowering costs.

The *Harvard Business Review* has also referred to the concept of a "value agenda"[1] in health, and said that moving to such an agenda requires a change in the way healthcare is organised, measured and funded. In practice, this equates to making the following transitions:

- moving away from a supply-driven health care system based on what physicians do and towards a patient-centred system based on what patients need
- moving away from a focus on the volume and profitability of services and towards a focus on the patient outcomes achieved
- moving away from fragmentation, in which every local provider offers a full range of services and towards a system in which services for conditions are concentrated in providers with the necessary volume, experience and locations to deliver high-value care.

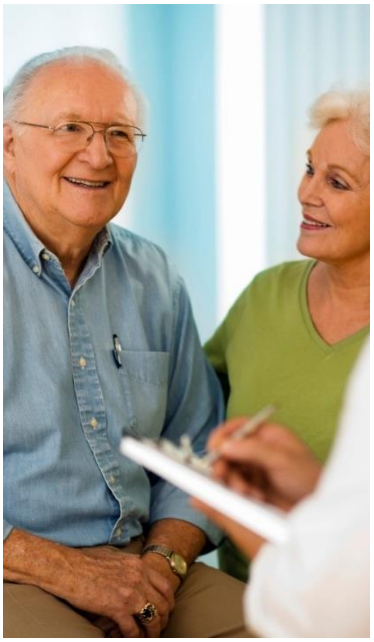
Funding-driven benefits

We believe that governments are on the right track in seeking to promote a value agenda. Further, we would argue that one of the most powerful levers government can pull is to change the way the health system is funded.

For a start, what gets measured (and paid for), gets done. Also, a funding model is about more than just paying enough money for providers to cover their costs – rather, it is a powerful tool for incentivising the responsible use of resources by the health system for the benefit of the patient and the taxpayer.

The right funding model can:

- reward providers for securing good outcomes that matter to the patient or consumer, therefore incentivising the exploration and deployment of new, better connected and integrated models of care that align providers and patients around shared goals
- increase market competition and depth, driving innovation and fresh investment
- encourage funding to be efficiently pooled around individuals and issues rather than incurring "leaks" as funds are spread across multiple agencies
- support patient choice and participation in shaping their healthcare experience
- encourage providers to continuously improve quality and safety
- lead providers to optimise resource allocation and reduce waste
- shift the focus from the "here and now" to longer term "invest to save" thinking
- reduce health inqualities between social groups.



Current funding models

Most health services around the world feature "fee for service" and "capitation based" funding models in primary care and "activity based funding" and "global budgets" models in secondary care.

All these models have been widely debated and there is a general consensus on the benefits and limitations of each. For example, Activity Based Funding (ABF) is the most common model for funding hospital based services. It is a mechanism for funding providers based on the type and volume of services they provide.

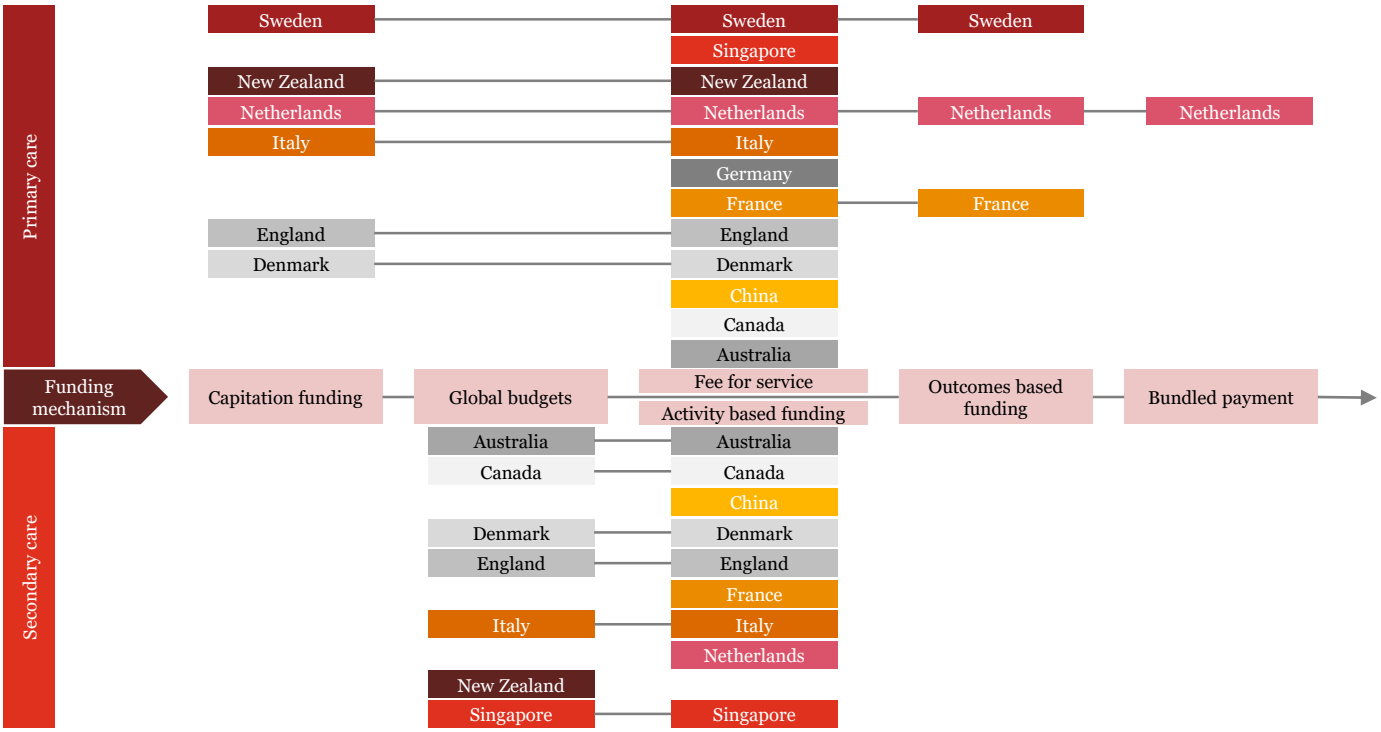
ABF remains highly regarded internationally and continues to play an important role in reliably funding acute health services in Australia. It is a good model for acute services when the patient's full episode of care is relatively easy to define and observe within the acute setting. In these circumstances, ABF can incentivise efficient and productive care throughout the care episode, and the provider's interests are aligned to the patient's outcome.

However, the main objective in implementing ABF was to improve efficiency in hospitals, rather than fostering the growth of integrated health systems. Also, ABF doesn't work as well where it is hard to define and observe a full episode of care within the acute setting – when care requirements are multi-faceted and important parts of the episode could (and should) occur outside an acute setting. In this situation, there is no one care provider responsible for delivering the patient outcome and the acute provider will tend to focus primarily on their specific activity in the pathway. Funders and patients can then be vulnerable to some of the disadvantages of the ABF model, such as:

- The incentive to keep activities in hospitals because funding is linked to activity. ABF models can offer protections against volume-focused behaviours, such as penalties for re-admissions and extended lengths of stay, but these are relatively immaterial in the context of hospital funding.
- The payments hospitals receive for services largely reflect the cost of delivering those services, not their cost-effectiveness. As a result, hospitals aren't incentivised to maximise the long-term outcomes of the patients. Instead, they have an incentive to pursue profitable activities.
- In many cases, ABF pays for output regardless of clinical outcome and regardless of whether a provider follows the optimal care pathway for a patient. There are some exceptions, in areas such as hospital-acquired complications and sentinel events, but generally speaking ABF does exactly as its name describes: it pays for activity rather than outcomes. This reduces providers' focus on quality of care, integrated care and innovating around new models of care.

It is notable that patients with chronic conditions – the very patients often cited as one of the main reasons for current pressures on public hospitals around the country – are often least well served by ABF-style models.

Figure 1: Dominant funding models – selected countries



Source: adapted from the Commonwealth Fund '2015 International Profiles of Health Care Systems'
http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf

Recommended funding models

The multi-billion-dollar question is, of course, what approach to funding would help to achieve the broad objective of creating a financially sustainable health system with a consistently high quality of care?

We believe the solution is to focus on the notion of value and incentivise care models that secure optimal outcomes for specific patient cohorts. This can be achieved by using a combination of the traditional funding models listed above (capitation, fee for service, ABF and global budgets) – which do still have a central role to play – while introducing innovative approaches. These new models include the following.

Shared savings

This approach involves incentivising providers to improve outcomes for a patient population by giving them a share of the resulting savings. This funding model is consistent with a value agenda where outcomes are patient-centred and apply to the full episode of care.

Example: a cohort of 5,000 patients with two or more chronic medical conditions is identified. The "expected" cost for these patients over the coming 12 months is determined – either though projection models based on historic service use for the cohort, or with the aid of a control group. Providers are rewarded with a proportion of the actual savings achieved throughout the year compared with the "expected" costs across the cohort.

Some important design features for the shared services model are:

- *A minimum cohort (often between 1,000 and 10,000 people) is required to make the model viable. The purpose of this is to reduce the inherent volatility in total costs across the group.*
- *Which services are considered in and out of scope is determined as part of the up-front contract negotiation. For example, pharmacy may or may not be included.*
- *Beyond the simple savings calculation, other performance benchmarks will be placed on providers such as clinical outcomes measures, quality indicators and patient satisfaction indicators. Protections will also exist for providers, such as clauses around the exclusion of high-cost patients.*
- *Payment amounts under the contract will typically have a cap and floor. For example, savings may need to be more than say 5% for a payment to be made to ensure the savings are likely to be "real" and may cap out at an appropriate threshold, for example 50%.*

Outcomes Based Funding, Performance Incentive Funding and Social Investment Bonds

There are a number of funding models where providers are only paid for services if they achieve certain pre-defined outcomes. For example:

- Outcomes Based Funding: where some, or all, of a contractual payment is conditional on certain outcomes being achieved. This is also known as Performance Based Funding if the performance targets for payment are outcomes-orientated.
- Performance Incentive Funding: where providers are awarded incentive or bonus payments for achieving certain outcomes.
- Social Investment Bonds: are an interesting variation of Outcomes Based Funding. Social Investment Bonds are a financial instrument that can be backed by either private funding, government funding or both. Bond "dividends" are paid if certain outcomes are achieved by the service provider. Social investment bonds are often used as the contractual mechanism for tackling particularly complex social problems.

Each of these funding models are consistent with a value agenda where outcomes are patient-centred and apply to the full episode of care.

Example: a cohort of 5,000 patients with two or more chronic medical conditions is identified. The provider is only paid for the services it provides for these patients if a pre-defined list of outcome measures are achieved. The provider receives a nil or only partial payment for the service if the measures aren't achieved. Or, less punitively, a bonus payment or some sort of "new money" may apply where the measure(s) are achieved. Similar design features to those listed under shared savings models will also apply.

Bundled payments

The bundled payments model features a single payment for a "bundle" of activity that covers an end-to-end episode of care, and is strongly aligned to the value agenda.

For medical patients this might cover all admitted, non-admitted and community care activity for a given episode. Or, for chronic disease patients, it might cover all the care they receive for their disease over a specified period.

It is also possible to incorporate many of the attractive features of other funding models into the bundled payment mechanism. For example, system stewards could weave in an element of pay-for-performance, or shared savings, based on a pre-defined set of patient outcomes.

At a minimum, a bundled payment mechanism should:

- Cover all the care for the cohort for the specified condition, and exclude care for unrelated conditions.
- Be specific about the patient eligibility criteria, to manage some of the patient variability risk for combined sets of providers.
- Be contingent on achieving pre-specified patient-centred outcomes. These outcomes should have an element of flexibility to account for the differing risk/complexity of individual patients (for example, higher payments for older patients or patients with multiple co-morbidities).
- Have a "stop loss" measure in place to protect against unexpectedly complex patients or catastrophic events.
- Financially reward providers where high quality and high value care is delivered as planned.

There are particular benefits of this approach that lend well to the objectives of value based care. Bundled payments encourage team work. They also increase the coordination of care across a continuum of providers and settings. They therefore improve patient outcomes by reducing fragmented and siloed care, which in turn improves the quality of care. The inter-dependency created by bundled payments holds providers jointly accountable for the cost and quality of care they provide to patients.

Typically, under a bundled payment model, the actual payment amount would be negotiated with system stewards and providers based on the collective view of a fair and reasonable price for best practice value based care for that patient pathway.

There is obvious complexity, and a significant time investment required, to express the "value" of care in monetary terms. In Australia, this is further complicated by fragmentation across Commonwealth and state budgets. However, some methodologies for doing this in a structured and comprehensive way are emerging. In Germany, for example, authorities are making headway with an "efficiency frontier" approach. This uses real-world data on costs and outcomes to determine the best value treatment within each treatment area and then only pays the amount required to deliver that best value care.[2]

Alliance contracting

Another innovative approach is alliance contracting. Here, a group of care providers enters into a single, joint arrangement with a commissioner to deliver services under pre-agreed terms. The risks and responsibilities for delivering the agreed outcomes sits with all providers, creating an incentive to discover ways of delivering higher quality and more efficient care across the full care continuum rather than any one provider.

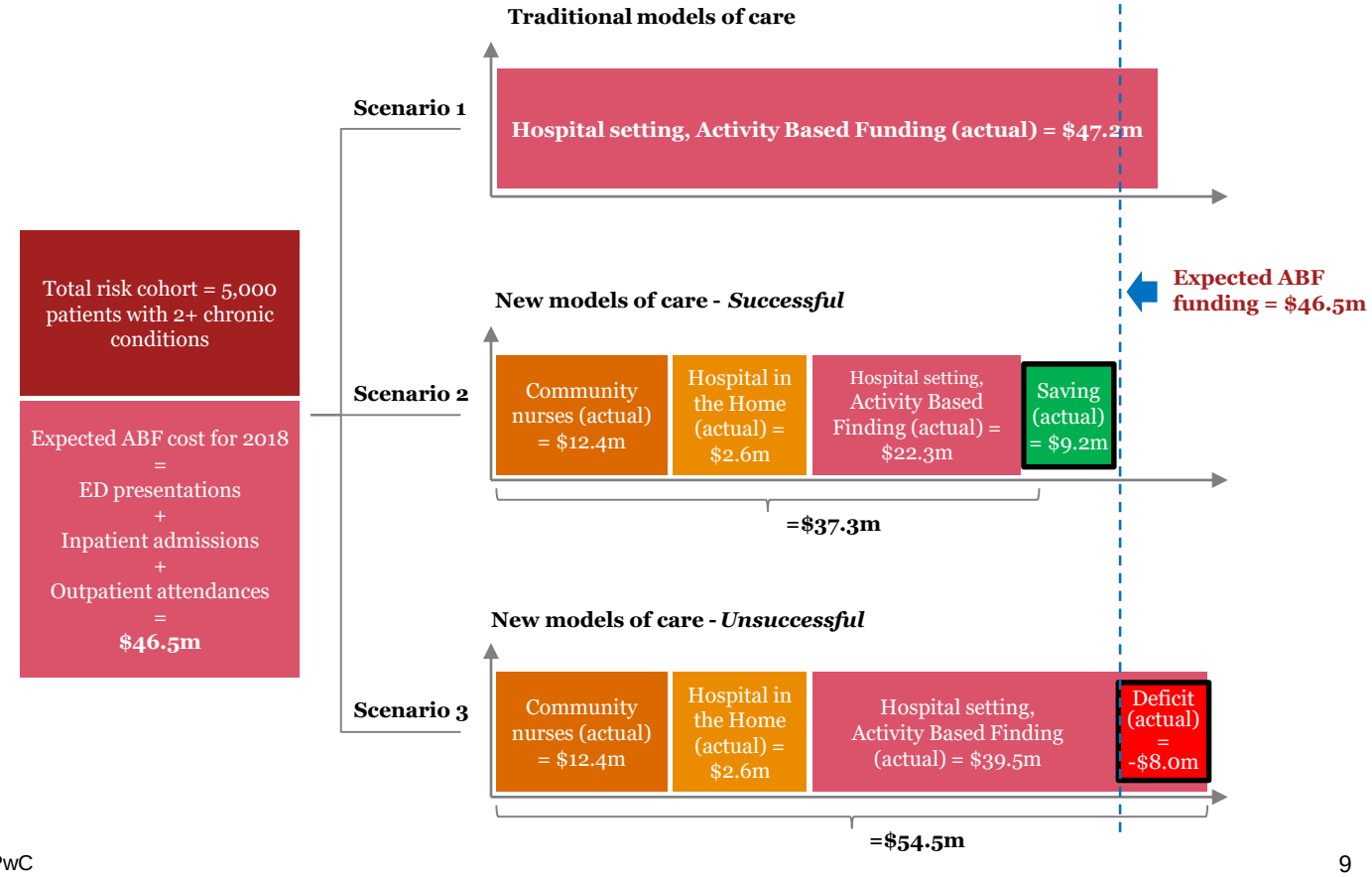
Example: a cohort of 5,000 patients with two or more chronic medical conditions is identified. A group of providers who deliver care for the cohort – for example, local GPs, hospitals and allied health providers – enter into an alliance and agree a single arrangement with the local commissioner. The alliance is only paid for the services it provides for these patients if a pre-defined list of performance or outcomes measures is achieved. Nil, or partial payment, applies if the measures aren't achieved, or alternatively, a bonus payment applies if the measures are achieved. Similar design features to those listed under shared savings models will also apply.

How can these funding models be implemented in an Activity Based Funding environment?

Each of these funding models sounds good in theory, but how can they be supported and piloted by Commonwealth and state governments in an environment that is dominated by Activity Based Funding or Fee For Service type arrangements? We believe there is a way to pilot these new models within the current environment.

Example: Let's take our cohort of 5,000 patients with two or more chronic conditions:

- *"Scenario 1" depicts the status quo – in 2018 the "expected" Activity Based Funding cost of this cohort of 5,000 patients is $46.5m. At the end of 2018, due to normal variations, the actual Activity Based Funding cost for this cohort is $47.2m.*
- *In "Scenario 2", new models of care and a new funding model are piloted. Here, the Local Health District equivalent seeks agreement from the State to fund the cohort at the expected level – $46.5m – on the condition that it achieves certain pre-defined patient outcomes. The Local Health District is then free to design and fund new models of care to support the cohort, which may include, for example, additional community nursing or additional Hospital in the Home support, as well as the traditional hospital-based model of care. Due to more pro-active management in community/home settings, the patient outcome measures are met, and the total cost of caring for the cohort reduces to $37.3m, resulting in a $9.2m overall saving. This saving may be shared between the Local Health District (as an incentive and to re-invest in services) and the State in various proportions, with flow through savings to the Commonwealth Government given their annual contribution to State health services.*
- *In "Scenario 3", the new models of care and a new funding model are also piloted. Again, the Local Health District equivalent seeks agreement from the State to fund the cohort at the expected level – $46.5m – and the Local Health District is then free to design new models of care to support the cohort. However, in this scenario while additional community nursing and Hospital in the Home support is deployed, due to poor implementation the pilot fails to achieve the pre-defined patient outcomes or adequately reduce the flow of activity into the hospital setting. The total cost of caring for the cohort increases to $54.5m resulting in a deficit in the cost of care for the cohort of $8.0m. The risk of the deficit sits with the Local Health District in the first instance (followed by the State, to the extent that the State underwrites the Local Health District) – which is appropriate given that the Local Health District ultimately has control over the design and implementation of the new models of care.*



Lessons from the United States

While the US has a fundamentally different health system to Australia, it is leading the way in implementing value based care models. The winners emerging in the US experience include those that:

- develop clinically integrated health systems from primary care through to acute care and long-term hospice care.
- collect and use data to continually improve the value they are delivering to patients – both the breadth of data (longitudinal patient datasets over multiple episodes) and the depth of data (detailed snapshots of each patient encounter).
- are willing to take on risk based pricing models (both upside and downside).

On the other hand, small providers that operate in an isolated and independent way, and may not have the volume to deliver care efficiently, are more likely to struggle. So too will those that fail to collect or secure access to integrated datasets and so continue to have a limited view of their patient population.

Technology companies are enabling networks to be created, to the benefit of the whole system, but are also offering competing on-line alternatives. At the same time, pharmacies and large retailers such as Walmart are providing primary care services. These new entrants can sustain operations at a much lower price point than traditional health service providers, ensuring traditional providers will need to find a way to integrate with those operations if they wish to deliver truly value based care.

Conditions for success

In addition to exploring new funding models, other environmental and cultural changes will be required for a value agenda to succeed in Australia.

Public education for prevention, responsibility and empowerment

The health system should be unwaivering in its commitment to education programs that embed healthy behaviours from birth. Prevention has a long pay-off cycle, but is the most potent way to make the health system sustainable and to bend the long-term cost curve.

It is also important to empower people with the data, information and tools they need to understand and engage in the management of their own health. For example, this might mean giving patients (and with consent, their family and friends) easy access to their health records and making this information accessible on smart device apps.

A renewed focus on measuring outcomes by providers

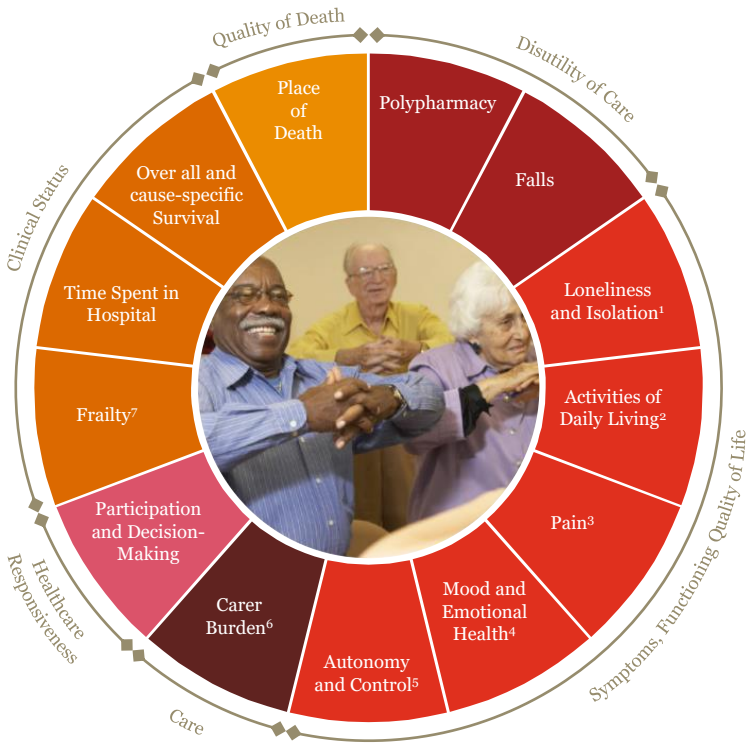
Providers need to measure "outcomes", but what do we mean by the term? The outcomes that matter are those that matter to the person being treated, as opposed to the profitability of the provider or some target length of stay in a treatment facility.

In many cases, these outcomes will be things such as feeling respected, informed and consulted on the care they receive; being able to resume normal life in a reasonable amount of time; not having to sit in a hospital bed just because someone hasn't processed the paperwork yet; and not having to re-tell the same story about their health every time they engage with a new care provider. Things that matter to patients may also be items that regularly show up in patient satisfaction surveys, such as the quality of food in hospital cafeterias and the availability of close and affordable parking.

The International Consortium of Health Outcomes Measurement (ICHOM) has developed the following "wheel" of factors that matter to the frail elderly. These factors contrast sharply with the outcomes and performance measures tracked by most Australian providers.

However, in placing patients at the centre of their own care, we should acknowledge that we don't always know or do what is best for our own long-term health. Therefore there is also a role for clinicians, carers, family and friends in defining what is good value care, and Australian taxpayers have a right to influence the debate on what is and isn't good value care too.

Figure 1: Dominant funding models – selected countries



Empowerment, co-operation and trust between players

It's impossible to over-emphasise the importance of strong relationships between organisations, including Primary Health Networks (PHNs), Local Health Districts (LHDs), Allied Health providers, GPs, private health providers, pharmacists and non-government organisations (NGOs).

Value based care models flourish in an environment where there is a high level of trust between system participants.

All participants in the system have a role to play in allowing new and innovative funding models to thrive. However, for this to happen, the role of each participant needs to be clearly defined and they should feel empowered to deliver on the responsibilities of that role.

For example, the levers, funding and systemic influence of PHNs in NSW remains somewhat unclear two years after their creation. If PHNs are to be able to flex their muscle in supporting GPs, nurses and allied health practitioners to improve patient care, they may need to be handed greater powers – or at least greater clarity on role, and additional capacity to better connect with LHDs regarding place-based, joined up commissioning.

Cross-sector co-operation

The vast majority of factors that affect people's health sit outside the health system. They include:

- behavioural factors such as exercise, diet, smoking, and drug and alcohol consumption
- social factors, such as community connections and personal relationships
- self-sufficiency factors, such as education, employment and the ability to seek out other social services as needed
- environmental factors, such as pollution, housing and transport.

The health system – and health workforce – doesn't have the resources to become involved in all aspects of a person's life, nor should it. But it must work more closely with other human services agencies, local councils and NGOs to play a greater role in influencing determinants of health and to better understand patient needs, desires and expectations.

Better learning systems

We need to recognise the process of maturity and design learning systems that can capture new information and evidence "in flight" then adjust accordingly.

Without these systems, it is likely we will develop new models of care or interventions that are fixed and contracted through hard, inflexible mechanisms.

Case study: Becoming outcome focused at Martini-Klinik

The Martini-Klinik in Germany specialises in prostate surgery. For more than 25 years it has been surveying patients before and after their surgery to continually improve patient outcomes. Patients are asked about 70 questions about their quality of life and sexual and urinary function, with some aspects being re-surveyed post-surgery at one week, three months and then annually thereafter for up to 20 years. The results of these surveys are evaluated by an independent statistician to understand what sort of variability in outcomes patients experience. Following this, the surgeons jointly reflect on the statisticians' analysis to try and understand why patients experience this variance in outcomes, and work together to achieve improvements.

One striking result has been a reduction in incontinence rates for their patient population following surgery to less than 5% (down from 10%), compared to an average of 20% elsewhere in Germany. This is an excellent example of better value care where the targeted outcome – a reduction in post-surgery incontinence – was drawn from a survey of what matters to patients. This information was used to focus efforts on improving outcomes for these patients and the resulting solution, which was a small adjustment to the surgical method, added no additional cost to the treatment.[3]

How to evolve to a value based model

While transitioning to a more value based approach offers significant benefits, it would also represent a substantial change for all parties involved in the health system. To ensure success in any jurisdiction, we believe it will be important to pursue transformation in a staged manner.

Stage 1: Establish the case for change

System stewards must set out and actively promote the case for change with all stakeholder groups, especially providers and commissioners. To achieve a cultural shift inside organisations "supplying" care to patients the message will need to be driven from the highest levels of leadership.

Stage 2: Build integrated datasets

Data is a fundamental enabler of transformation. Any organisation looking to shift to a value based care approach will need access to a single, integrated, data feed to support the transformation across clinical, operational and financial aspects. This will also require a fit-for-purpose underlying IT infrastructure.

Many states have launched data and analytics frameworks in recent years. Despite this, we continue to observe commissioners and providers undertaking retrospective analysis on siloed datasets, often with limited engagement with front line staff. There are very few examples of organisations that are centralising clinical, operational and financial data to proactively identify and deliver better outcomes and better value care for patients.

Stage 3: Understand patient concerns

Better value care is ultimately about better outcomes for patients and better value for the taxpayer. Patients will need to play their part in achieving this change by articulating the outcomes that matter to them. They will also need to share their experiences through surveys and by consenting that their data is used to allow clinicians to learn and improve outcomes for future patients. Gaining this engagement from patients will depend on ensuring they understand the case for moving towards value based care.

Patients will instinctively know if they've had a good or bad experience in the same way they might judge any other service they receive. Many states have a process for collecting information from patients on their experience. The extent to which this is comprehensively and systematically used to improve patient care is questionable. If "the system" wants patients to dedicate time to giving feedback and sharing their health data to improve future care, then it needs to demonstrate the benefits to the patient of doing so and close the feedback loop. Further, while some patients might be aware that their feedback is desired, we believe that few understand what "better value care" might mean for them as a patient or taxpayer. This means that there is a need to do more to raise awareness and engage patients in the state's value agenda.

Stage 4: Select pilot cohorts

Global research and citations can only go so far in demonstrating the benefits of value based models in the local environment, so there is a need to conduct pilots in Australia. In acknowledging the person-centric nature of value based care, these pilots should treat the whole person not just a single aspect of their health needs. They should also include primary care, pharmacists, NGOs and private health providers, in addition to state health providers.

There are already pilots underway nationally that are aligned to the value agenda. For example:

- The Federal Government's Healthcare Homes trials for patients with chronic conditions gives PHNs access to pooled funding arrangements with state and community based service providers. GPs are paid on an upfront monthly or quarterly basis for co-ordinating care for chronically ill patients. These bundled payments also support more widespread telehealth provision as part of a new approach to flexible funding. The existing fee for service model remains in place for the rest of the population who do not meet the patient eligibility criteria.
- In Victoria, the Health Links Chronic Care program aims to improve care for patients at high risk of multiple unplanned hospital admissions, many of whom have chronic and complex conditions. This program includes a flexible new funding model.
- Numerous High Value Care initiatives are underway in Queensland, including a Kidney Supportive Care Program in Metro North Hospital and Health Service, and a Palliative Care Program in Sunshine Coast Hospital and Health Service[4].
- A large workers' compensation insurer is currently developing a new model of care for musculoskeletal patients backed by a bundled payment model.

Stage 5: Evaluate, evaluate, evaluate

A comprehensive evaluation framework should be agreed prior to starting any pilot. This should allow for ongoing monitoring and feedback while the pilot is "in flight", to support the aforementioned flexible learning systems. Ideally, the final evaluation can be made public as a tool for global health community learning about key features such as setting patient eligibility requirements, selecting patient-centred outcome measures and choosing appropriate funding models.

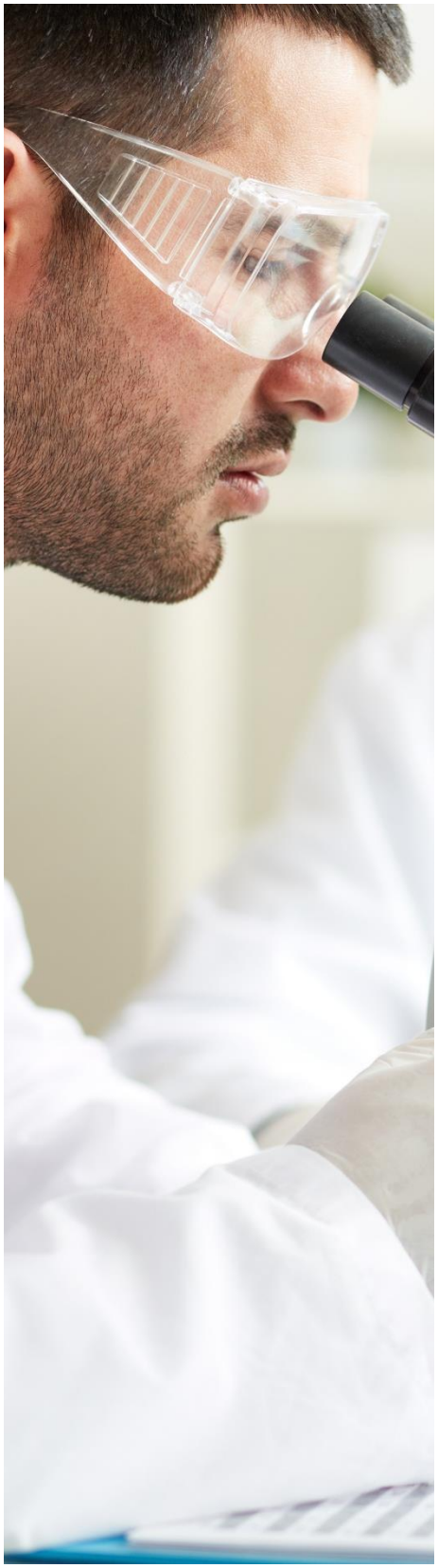
One valuable source of program learning is the Center for Value-Based Care Research at the Cleveland Clinic in the US[5]. The Center undertakes observational studies of variations in care among numerous providers and assesses comparative effectiveness of interventions to identify best practice. It has also focused specifically on value based care[6].

Stage 6: Scale successful pilots

Once successful pilots have been identified, the next challenge is to scale these pilots to larger geographical areas or adapt them for adjacent patient cohorts. This process should include sponsorship from senior leaders to help remove siloed behaviours, eliminate complexity, and listen and respond to concerns raised by system stakeholders.

There will also be a need for additional funding and resources to help scaling-up programs succeed; leadership and clinical champions in each new organisation or treatment area; and the establishment of comprehensive change management programs and well-resourced central project management offices.

Other useful steps are to create networks and alliances at all levels to support horizontal scaling (expansion and replication). It is also essential to continuously monitor progress and complete evaluations to ensure there is a positive feedback cycle as programs grow.



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Endnotes

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[3] Source: 'Value-based Healthcare in Germany From free price-setting to a regulated market', A report from The Economist Intelligence Unit, 2015, https://www.eiuperspectives.economist.com/sites/default/files/Value-based%20Healthcare%20in%20Germany_0.pdmaturif

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