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A Vision for Australia

"The Australian Healthcare System as a Market"

GAP Workshop Report

Global Access Partners
Australian Centre for Health Research
Australian National Consultative Committee on Health
Capital Markets CRC
Cisco Systems

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Abstract

On 28 April 2015, Global Access Partners (GAP) and the Australian Centre for Health Research (ACHR), together with the Australian National Consultative Committee on Health, hosted a strategic workshop to discuss "The Australian Healthcare System as a Market".

The event brought together a select audience of health practitioners, industry leaders and consumer advocates to discuss the key issues affecting the Australian healthcare system's productivity, efficiency and performance and the drivers behind the rising costs of care.

The workshop featured David Jonas, Head of Health Market Quality Program at Capital Markets Cooperative Research Centre and Director of Lorica Health, as a keynote speaker.

This was the second meeting in a series of discussions on a sustainable healthcare system started by GAP and its partners in December 2013. The workshop was sponsored by GAP, ACHR, Capital Markets CRC and Cisco.

This paper summarises the proceedings of the day and outlines how the use of 'market quality frameworks' pioneered by Capital Markets CRC could improve the dissemination and understanding of health data across stakeholder silos, reduce waste and, in the longer term, improve clinical efficiency and consumer choice.

Disclaimer

This document represents a diverse range of views and interests of the individuals and organisations involved in the workshop. They are personal opinions that do not necessarily reflect those of the organisers and sponsors of the workshop. Given the different perspectives of participating individuals, it should not be assumed that every participant would agree with every argument or recommendation in full.

CONTENTS

EXECUTIVE SUMMARY

Key messages of the GAP Health Workshop

- The financial sustainability of the Australian healthcare system is an ever more pressing issue, given Australia's ageing population, increasing chronic disease and rising medical costs driven by new technology and procedures. A fresh approach to reform is required to limit the growth in costs and improve patient outcomes.
- The Australian Centre for Health Research (ACHR)[1] is renewing its mission to promote expert debate, commission evidence-based research and develop, implement and assess new healthcare solutions. Over the next eighteen months, it will campaign on 'the real costs of care', including health workforce costs and the cost differential in the last eighteen months of life.
- Healthcare is highly complex and demands continuous study and analysis. There are no simple solutions or easy answers. However, health is not a 'black hole' of current expenditure, but a vital investment in the nation's economic future. Given their myriad interrelationships, **welfare and health could be usefully considered together**, rather than as separate entities. While health costs always tend to rise due to improvement in techniques and demographic factors, the trend can be flattened by adopting long-term, holistic approaches to rational planning, provision and reform.
- Improving patient outcomes by identifying and eliminating low-value interventions, cutting waste and reducing adverse events could **save 20-30%** of the current health spend. Australia should **invest in scientific and medical research** to improve the efficacy of treatments and target them more effectively by identifying individual factors for success. The problem of excessive tests and 'defensive medicine' practised through clinician fear of legal action should also be addressed.
- Treating **healthcare as a dynamic market – or interrelated series of markets -** rather than an inflexible monolithic system offers new insights and levers to instigate change. However, such markets should remain **compassionate** in nature. The ethical element of care demands that treatment is not only offered to those in need, but is delivered in the most efficient way to maximise its benefits and availability.
- Market optimisation depends on **stakeholder access to transparent, reliable and digestible information** which is evidence-based. Investment in greater connectivity and modernised hospital IT systems, the relaxation of privacy legislation and the notion that patients, rather than clinicians, own their data would break down barriers between silos and **improve information flows**. Early and continued engagement with clinicians is needed to ensure their 'buy-in' to reform. The patient 'opt-out' policy for

Australia's ehealth records[2] will increase the number of records available to clinicians and so improve both administrative efficiency and treatment outcomes.

- Capital Markets CRC's Market Quality Research Programme identifies metrics for fairness and efficiency, gathers and synthesises data and develops and deploys solutions through the value chain. It can help the dissemination and understanding of health data across stakeholder silos, reduce waste and, in the longer term, improve clinical efficiency and consumer choice.
- The presentation of public health campaigns and best clinical practice should be tailored to match the differing learning styles of the public and health practitioners. The mere provision of information does not in itself guarantee rational decision making or the adoption of better techniques.
- Health reform should learn from the business, consumer service and workforce planning strategies adopted by leading firms in other sectors as well as encourage best practice by clinicians. **Inspirational leadership** is required, as well as facts and figures, to bring people and resources together to improve health outcomes. Examples can be drawn from successful Fortune 500 companies as well as other health systems.
- Instead of examining the healthcare system from the inside, it must be viewed from the consumer and client perspective. Consumers should be encouraged to become **co-managers of their own health**, and ways must be found to improve their skills, knowledge, responsibility and accountability to maximise their abilities to manage their own conditions. Empowering communities would improve the public's ability to manage their access to health services and improve consumer satisfaction and patient outcomes. **Self care** should be encouraged as an option where clinically appropriate.
- Whatever the terminology of market or system, **a new vision** is required to offer direction and maintain progress towards it. Reform should centre on improving outcomes for the public, rather than buttressing producer interests. A market approach underlines the centrality of consumer sovereignty in the same way that other approaches call for person-centric healthcare.
- All stakeholders favour reform for others, but oppose it for themselves as they protect their vested interests or cleave to traditional ways. Successful reform depends on addressing this **'human factor'** as new technology and business processes will not succeed without the support of those who will use them. Inspiring champions must be found and encouraged to lead health workforces and the public and get the job done.

Recommendations

1. The Australian National Consultative Committee on Health should establish a working group to follow up the workshop's debate and recommendations.
2. GAP should establish a health policy development strategy and organise a series of public forums to progress their objectives of a sustainable health system.
3. Projects to test the efficacy of proposals, such as payment for performance and offering information in different forms to suit particular audience learning styles, should be identified and undertaken.

REPORT OF PROCEEDINGS

Introduction

Workshop chairman Robert Lippiatt welcomed guests, sponsors and speakers. He stressed that the power of such gatherings lay in the discussions generated by the ideas presented and sharing the expertise of everyone in the room.

The sustainability of Australia's healthcare sector is a topical and widely discussed issue, given the rising costs of Australia's ageing population, an inexorable increase in chronic disease and the ever greater scope and complexity of medical technology and interventions. A single workshop cannot solve the complex problems faced by the sector, but it can mark the start of a journey towards their solution. A series of conversations will follow this event to offer insights, analyse policy options and generate action on the ground to foster positive change.

Mr Lippiatt then gave the floor to Rebecca Bartel, Executive Director of ACHR.

Australian Centre for Health Research

ACHR is a leading non-profit independent research institution specialising in performance, policy and productivity across the health and aged care sector. Its members are non-government funders and providers, and its partners include a number of leading universities and health institutions. ACHR is renewing its mission to promote expert debate and informed discussion, commission evidence-based research, develop policy programmes, model solutions, assess the impact of new measures and provide expert counselling and confidential advice.

ACHR argues that *'it's time to change the conversation'*. Health requires urgent reform, and the barriers between silos must be removed. ACHR will campaign over the next eighteen months on 'the real costs of care', including health workforce costs and the cost differential in the last eighteen months of life. It supports the use of predictive data analytics to suggest new evidence-based processes and improve patient outcomes.

Health policy has long struggled to transfer evidence-based research into effective action. Data, communication platforms and clinical context must be combined to paint the full picture and encourage the adoption of better solutions. ACHR is compiling information to underline the credibility of its ideas and will 'pressure-test', socialise and communicate

them across the medical community and consumer groups. It will strive to *'get the politics right'* to create an environment for change. Health policy is often proposed without a plan for implementation, and therefore ACHR will concentrate on building strategic alliances with relevant stakeholders to secure their support. The Centre is open to discussions and partnership with any groups or individuals sharing these aims.

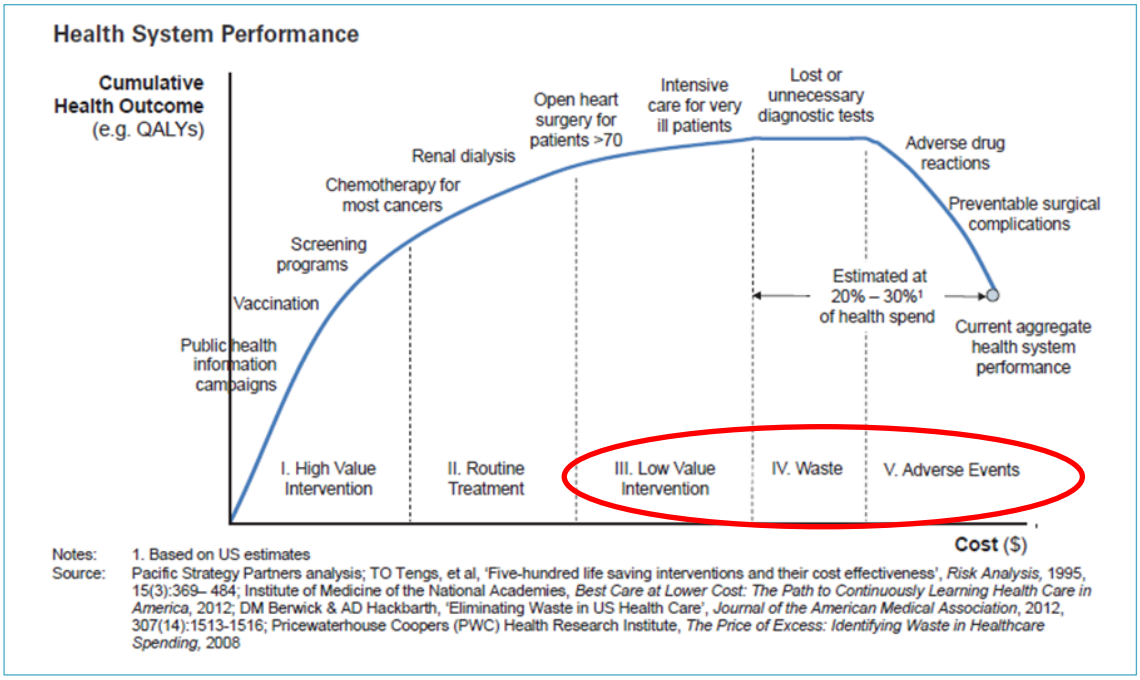
Mr Lippiatt then welcomed David Jonas to deliver the keynote address.

"The Australian Healthcare System as a Market"

Mr Jonas thanked GAP, ACHR and the Australian National Consultative Committee on Health for organising the workshop, and Cisco for hosting it. He outlined his intention to discuss healthcare as a market, the Health Market Quality Program's research and development plans and several promising developments in the sector.

Maximising value for money and patient outcomes

Mr Jonas argued the priority should be improving clinical quality, rather than reducing costs. Australia spends around the OECD average as a percentage of GDP on health, and the question is how best to spend it to improve people's quality of life.



Public health campaigns, vaccinations and screening programmes can be seen as cost-effective health spending. Most routine treatments are also efficacious; however, some other procedures have high costs but poor returns. Identifying and eliminating low-value interventions, reducing unnecessary diagnostic tests and limiting adverse events, such as preventable surgical complications, would reduce costs significantly.

Simon McKeon's Review of Health and Medical Research in Australia[3] found that

> *"…in the US 'up to one-third of the over $2,000bn spent annually on healthcare is lost on unnecessary hospitalizations, unneeded and often redundant tests, unproven treatments, over-priced, more expensive drugs, procedures and devices with no evidence of improved efficacy, and end-of-life care that brings neither comfort, care nor cure'. While an equivalent estimate has not been calculated for Australia, if it represents only 10% of health expenditure, savings of $13bn p.a. would accrue to the community".*

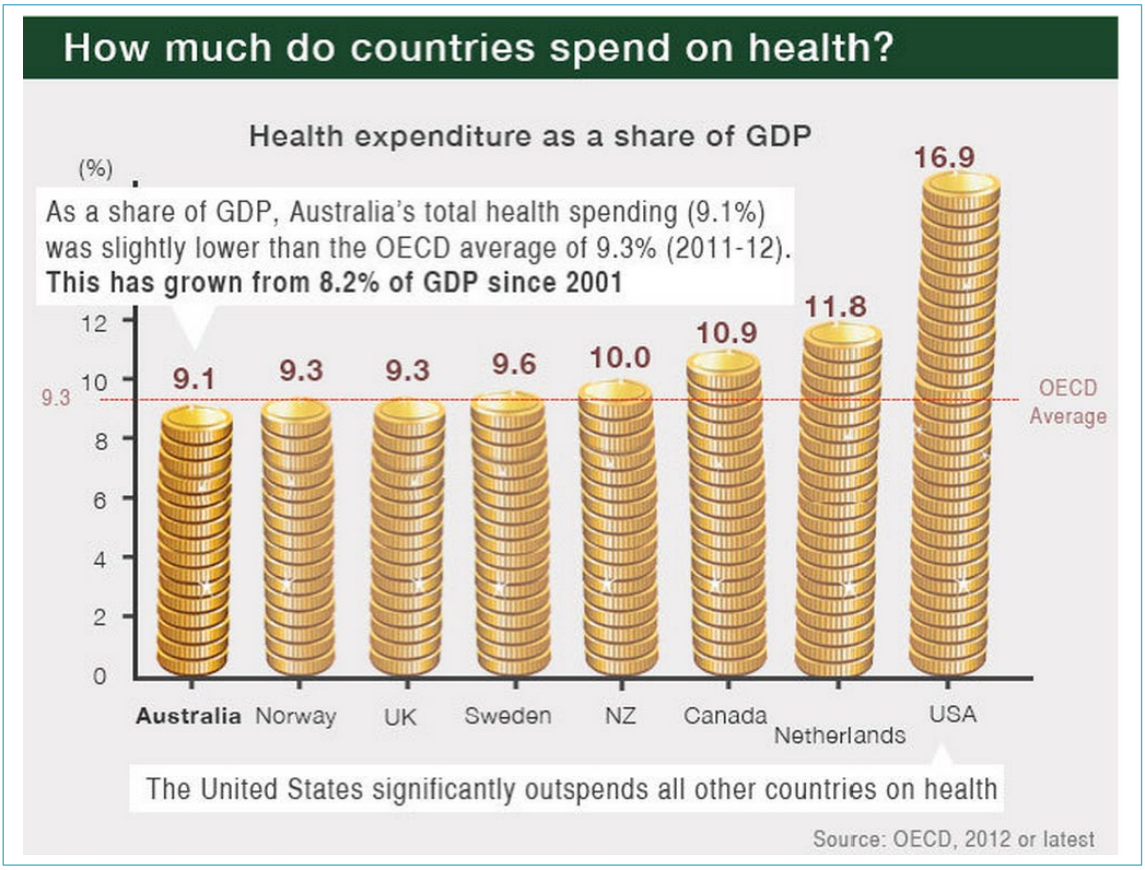
America's Institute of Medicine[4] estimates that US$765billion (30.6%) of the $2.5 trillion healthcare spend on health in the USA in 2009 was 'unnecessary'. This waste included fraud, unnecessary procedures, excessive pricing, missed prevention opportunities and other factors.

Best Doctors, an American group launched by a Harvard physician to provide second opinions for their customers, found that 29% of the cases referred to them had been misdiagnosed, 60% required a change in treatment and that 38% of surgeries had been unnecessary. This not only squanders large sums of money, but can affect the patient's medical outcomes and quality of life. Their findings were consistent with those of the American Journal of Medicine, indicating they were not the merely product of a self-selected and therefore unrepresentative sample of the overall patient population.

Economic Context

National health spending is often expressed as a percentage of GDP, and Australia appears comfortably placed compared to other developed nations. Australia's health spending of 9.1% of GDP was slightly lower than the OECD average of 9.3% in 2011-2012; however it has grown from 8.2% since 2001. The annual change from 2002-2003 to 2007-2008 was 4.9% in real terms and increased to 5.2% between 2007-2008 and 2012-2013.

If a future growth rate of 3% is assumed, health spending may increase by 7% per annum as a percentage of GDP over the next decade, boosting its share of GDP to 15%. However, if more realistic growth of 2.5% is assumed, health spending will increase by 10% and absorb 20% of GDP – a similar percentage to the USA. Such predictions suggest that action to limit the growth in health spending should be taken in good time.



The Australian Health Market

The goal of any health system or market should be affordable, high-quality, person-centric healthcare. Although a person-centric approach is extolled by all stakeholders, it not the hallmark of today's producer-dominated system.

The Australian health market comprises funders, providers and consumers. Funders include federal and state governments through the public health system, public insurers such as Medicare, Pharmaceutical Benefits Scheme (PBS) and the Department of Veterans' Affairs, 34 private insurers, accidence compensation insurers, National Disability Insurance Scheme and consumers through their taxes, out-of-pocket expenses and discretionary and over-the-counter purchases. Vendors include clinicians, public and private hospitals and clinics, allied health providers, pharmacies and prosthesis, pathology and imaging services.

Viewing Health as a Market

Mr Jonas argued that Australian healthcare should be viewed as a market as the term 'system' implies an entity which is 'hard wired' and 'inflexible'. Embracing a market mindset and helping consumers, providers and funders make more rational decisions allows a wider range of levers to be manipulated for change. Markets tend to evolve to handle new conditions and increase efficiency by their own volition, rather than rely on policy changes. A successful market maximises both fairness and efficiency. Poor quality, waste, inefficiency and under-delivery can therefore be seen as market failures which must be addressed. Capital Markets CRC (CMCRC) has found success with this definition and approach in capital markets, and its methodology is used by exchanges, regulators and brokers in 40 countries around the world.

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The Market Quality Research Program (MQRP) seeks to improve market quality by identifying metrics for fairness and efficiency, defining the data required to produce them and understanding how other factors affect them. Solutions to capture and analyse data and present the results in user-friendly ways can then be developed and shared with funders, providers and patients to empower their decision making.

A market is the product of diverse factors and stakeholders and the relationships between them. Changes in any part can therefore affect the whole. Information is the 'magic lubricant' which reduces market friction; however, information asymmetry is endemic – and often jealously guarded – in the current health sphere. There are nearly 60 different public and private funders of healthcare in Australia. The resultant fragmentation of information compromises patient outcomes and obfuscates costs, hinders the measurement and assessment of provider performance and complicates patient health journeys. Excessive administration costs affect funders, provides and patients alike. Improving information flows is therefore a vital prerequisite of progress.

A 'market quality framework' encompassing regulation and policy, empowered participants, improved information and new technology would increase efficiency, reduce costs and improve the 'discoverability' of price, quality and a full choice of treatments. 'Integrity measures' can reduce fraud (the stealing of money from within the system) and abuse (the over-prescribing of treatment). Levels of appropriate care could be improved by eliminating low-value treatments and improving access. The development of metrics and the collection of relevant data can highlight underperforming areas and focus efforts to improve them.

Issues affecting the market include the 'moral hazard' of what is effectively a 'no-fault' and 'no-pay' environment for health consumers. People, in other words, may be less careful with their health when others will bear the financial burden of resultant illness. Whether their healthcare costs are covered by the public health system, Medicare or private health insurers, people can indulge in poor lifestyle choices or risky behaviour without reducing their access to care or paying higher premiums. This 'free pass' given to their bodies does not apply to their houses or their cars. Most insurance markets give their customers a strong financial incentive to behave sensibly or risk higher premiums, but health has none – although the consequences of poor health decisions are literally life threatening. The reasons for this are debatable, although some stakeholders hold the view that service providers thrive on unhealthy patient behaviour.

Health spending always concentrates on treatment, rather than prevention, although research proves that lifestyle, nutrition, environment and genetics play important roles in the development of many medical conditions. People are only given attention once they 'fall off the cliff', rather than helped to avoid the cliff in the first place.

Mapping patient health journeys shows that patients tend to start in the primary sector before moving on to public or private hospitals and specialists. Patient information is not pooled between PBS and Medicare, hampering attempts to analyse and improve the patient experience, while vital details are poorly shared between other clinicians and stakeholders. Hospitals receive little data from the primary sector, for example, while BUPA is only informed that a client has received triple bypass surgery when it receives the $250,000 bill a fortnight later. This convoluted system creates problems for consumers, providers and funders, none of whom are allowed a full picture of the situation, and hamstrings market efficiency.

Legal barriers, technological incompatibility and issues of ownership all impede the free flow of information. Patient data is often locked within a general practitioner (GP) or specialist's office because clinicians claim they own patient data, rather than the patients owning their histories themselves. Legislation has been changed in Britain to underline that patients own their personal data and has made its disclosure mandatory in appropriate situations. The Australian patients are denied access to information they might need to make appropriate choices, have no way to assess the quality of physicians they visit or know the cost of procedures or out-of-pocket expenses until the last minute. An 83-year-old with numerous co-morbidities may suffer, rather than benefit, from a hip replacement, compared to managing their disability with painkillers, but older people are seldom offered that choice.

Incentives in Australian healthcare remain squarely centred on fees for service, rather than results. Remuneration is therefore driven by quantity, rather than outcomes or effectiveness. Many instances of excellent clinical practice occur in spite of the system, rather than because of it. There are also several intentional competitive restrictions and constraints of supply. Professor Nicholas Graves, a specialist in health economics at Queensland University of Technology, notes that no other industry allows its suppliers (e.g. clinicians and specialist) to determine both the quantity and price of the service they provide.[5] Private hospitals have greatly increased their use of rehabilitation without discussion with the insurers which have no option, but to pay for it. The health sector is rife with similar practices without due checks or balances.

The Market Quality Research Programme

MQRP is a technology and analytics CRC specialising in data management, analysis and visualisation for its clients. Its collaborative, multidisciplinary research receives input from private insurers and public institutions to produce market quality frameworks and generate technological solutions and commercial outcomes. It partners with 30 private health insurers through the Australian Private Health Care Alliance, Medibank and accident compensation insurers in Victoria. It works with the public health system through NSW Health, the National Health Performance Authority and the Health Roundtable - a collective of major public hospitals in Australia and New Zealand.

MQRP collaborates with major universities around the country, including the University of New South Wales, University of Sydney, Macquarie University, University of Technology Sydney, University of Western Sydney, University of Wollongong, University of South Australia, Southern Cross University, Federation University Australia and Monash University. A third of its funding comes from industry, a matching third from government and a third from the university sector. The July 2014 spending round gave it $100 million to run its programmes for five years.

MQRP brings domain experts in health, including clinicians and experts in health economics and health informatics, together with data miners, statisticians, technologists and natural language processors. It is supported by a comprehensive database of health and financial market data. It has over 20 research streams, including the detection and management of administrative and management fraud, abuse, waste and errors. Building on these techniques, Lorica Health – another CMCRC company – has offered an 'advanced suite of leakage detection, clinical analytics and recoveries solutions and services' for the last six years and works with 90% of Australia's health insurers.

MQRP also works on ways to **empower consumer choice**. Providing up-to-date, dependable information to consumers in a user-friendly way has transformed markets in hotels, airlines and retail shopping. Applying these models to health and offering consumers more information about treatment quality, cost and alternatives could generate similarly disruptive change.

The group continues to develop methods to **improve data usage and management**. High-quality, well codified transactional and administrative data is widely collected throughout the health sector, but usually remains locked in a range of unconnected silos. Greater availability of data would allow similar analysis to Dr Frederico Girosi's modelling of 'Obamacare' in a RAND COMPARE Microsimulation[6] to be carried out in Australia. Girosi's model was based on publicly available sources and reliably predicted the social security impacts of improved health cover. This encouraged the Obama administration to move forward with confidence and sell its plan to the electorate and stakeholders. The predicted numbers of uninsured Americans tally closely with recent Gallup results.

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As previously noted, several studies highlight **'low-value care'** that offers little or no benefit to the patient. An investigation by the American Academy of Orthopaedic Surgeons on the management of full-thickness rotator cuff tears, for instance, found that while 16% of procedures were justified and 31% may have been appropriate, over half (53%) were not worthwhile[7]. Another study found that 25% of procedures for catheterising for cardiac diagnostics were inappropriate. Identifying, measuring and reducing low-value care would reduce wasteful spending, avoid unnecessary tests and end procedures which may cause harm without commensurate benefit. MQRP is working with private health insurers and NSW Health to target low-value procedures in Australia.

Other work streams include **the creation of user-centric health information systems** to help patients make more informed choices based on their personal circumstances and needs. Statistical studies can reveal the risks and benefits of particular procedures for different demographic profiles and apply these to individual cases.

The design of **better methods to pay hospitals** is also under consideration, given the interest of the Health Roundtable in the issue. A hospital's objectives are not always aligned with those of its patients, and payment systems directly and indirectly affect the quality and safety of care and resource allocation.

MQRP is also identifying and seeking **remedies for geographic variations in provision**. Such differences may point to an inefficient and inequitable distribution of resources, or reveal underlying factors driving regional health outcomes.

Finally, it is **using analytics to predict significant health events and outcomes** for both population clusters and individuals. This will allow health insurers to calculate the average hospital stay and costs of patients with particular characteristics and health problems. Outliers could then be identified and point to inappropriate care or hospital contacted infections.

Recent Developments

A range of recent government initiatives[8] offer cause for optimism. The Government's Medicare Benefits Schedule (MBS) Review Taskforce[9], led by Professor Bruce Robinson, Dean of the Sydney Medical School, will scrutinise the 5,500 services currently covered by the MBS and identify those out of step with best clinical practice. It will also recommend how new services can be aligned with contemporary clinical evidence in the future.

The Government is also establishing a Primary Health Care Advisory Group[10] led by former Australian Medical Association President, Dr Steve Hambleton. The Group will investigate options to provide better care for people with complex and chronic illness, explore innovative care and funding models, promote better recognition and treatment of mental health conditions, and improve connections between primary and hospital care.

The Government is also working with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks for practitioners. A small number of clinicians may misuse these services and generate superfluous costs.

The creation of 31 Primary Healthcare Networks (PHNs) [11]is another positive step and allows allied health providers, universities, private health insurers and some former Medicare Locals to create consortia. PHNs aim to improve the efficiency and effectiveness of provision for patients at risk of poor outcomes and ensure they receive the right treatment in the right place at the right time. PHNs will work directly with GPs, other primary and secondary care providers, hospitals and the broader community and begin operations on 1st July 2015.

Panel Perspectives

> *"There is much good will in the sector and many people are willing to make a difference, the task is to turn the good intentions of stakeholders into effective action for patients.*

One panellist confessed the presentation had both depressed him and offered him hope. Health is an incredibly complex entity, subject to a host of variables and issues, which mean unintended consequences are rife. Its issues are more difficult to analyse than three-body problems in quantum chemistry which still elude modern science. There will never be a simple 'single-line equation' to produce the perfect solution, but **there are plentiful opportunities to make progress on specific issues**. Although people will always disagree about priorities and ways to tackle them, a way forward must be found. Healthcare has so many components, with so many interactions, that while analysis can produce numerical approximations to improve the overall situation, specific interests may suffer as a result if only through the law of unintended consequences. **Continuing efforts to analyse and understand the system is the key to future improvements.**

Another panellist believed one of the best opportunities for cogent change had been the National Health and Hospitals Reform Commission (NHHRC) report[12] in 2009. The points made in that document remain pertinent and addressed many of the issues raised in the keynote speech. The H20 International Health Summit[13] hosted by the World Medical Association in November 2014 emphasised the importance of health for economic growth and argued that **health spending is a prudent investment in a nation's future prosperity**, rather than a 'black hole' of impoverishing current expenditure. The speaker called for continued investment and commitment to change from the Government, but recognised the need for a *quid pro quo* from health professionals and healthcare vendors to improve their performance as well. Doctors may appear defensive because critics are always 'throwing rocks at the profession', but the vast majority of doctors produce excellent outcomes, maintain proper ethics and recognise the importance of cost effectiveness. Medicare has recently tightened its scrutiny and has the power to strike miscreants off the medical register. Complicated though they undoubtedly are, the issues facing the health sector are less tangled than those afflicting community disability and welfare. A cross-agency, cross-department, cross-government approach is required to match individual needs with available services. Such efforts require skilled practitioners, better ways to coordinate effort and improved information systems. **Health and welfare should be considered together, rather than as separate entities**, and all stakeholders must work together to offer a contiguous patient journey, rather than maintain independent silos. There is much good will in the sector and many people willing to make a difference, the task is to turn the good intentions of stakeholders into effective action for patients.

Workshop Discussion

The debate was opened to questions from the floor, with the opening contributor backing the use of data analysis, but confessing the keynote had left him uneasy. He wondered if the term 'market' was right for health, given its implication of interest in the mere buying and selling of goods. He noted **a lack of focus on the patient who bears the risk and pays the cost of treatment** and wondered why so little attention had been paid to their concerns.

> *"Information can distort patient choices as well as improve them, if obtained from unreliable or fringe sources.*

He was assured that the keynote had not deliberately excluded consumers, and the need to improve Australia's 'lamentable' preventative health efforts and inform patients to enable and empower their choices was emphasised. MQRP has four research streams focused on the consumer and works closely with consumer advocate groups. It is working on a mobile app, for example, to offer patients more information on the consequences of treatment, with a view to encouraging less invasive – and less expensive - options.

A panellist stressed the importance of evidence-based information. He noted the poor vaccination rates in wealthy suburbs where antivaccination groups such as the Vaccination Network[14] spread misleading information. He underlined that all information is not necessarily beneficial and can be actively destructive to health. The National Health and Medical Research Council (NHMRC) report on Homoeopathy[15] declared it ineffective, yet some health funds continue to fund it, and its popularity among its adherents still grows unabated. Numerous studies in authoritative medical journals show that iridology is also an absolute waste of time and money - and potentially misleads people from seeking appropriate care - yet some pharmacies still offer an iridologist service. Information can distort patient choices as well as improve them, if obtained from unreliable or fringe sources.

Rather than a single market, **health is a series of markets with imperfect interrelations.** Before his elevation to Archbishop, Anthony Fisher addressed doctors and nurses at a Royal Melbourne Hospital ethics seminar and emphasised **the value of compassion.**[16] Compassion cannot be ascribed a value in dollars, and yet is the reason why health professionals put in unrostered hours to help their patients. Such invisible benefits improve patient outcomes and community wellbeing, yet remain unaccounted for in market-based philosophy.

It was noted that the overall retail market is also the sum of innumerable specialised markets. Any market can be seen as a single entity, in which the consumer receives goods and services from vendors paid for by themselves or other purchasing bodies. Health consumers seek quality and length of life, and the sector should enable a logical and reasonable interplay of its constituent parts to achieve this end for those it serves. The intention of MQRP's market philosophy is not to increase private profit or reduce access for those less able to pay, but to create 'a transparent space' in which '*people can get what they need*'. Consumers should be well informed about services, and these should be funded in an appropriate way. The framing of health as a market is not a stalking horse for complete privatisation, and the compassionate nature of Australian healthcare is one of the reasons to reside here.

Another attendee viewed the issues from a consumer perspective. Although health consumers are usually viewed as patients currently using the health system, all members of the community are potential or future health service users. Their views must also be taken into account and, given their financial contributions through taxes and premiums, they also have an interest in improved efficiency. The NHHRC offered a range of ideas, including a market-based system called Medicare Select, which went 'over the heads' of the community because its benefits to them were not adequately explained. Australians rejected the proposal because they feared it would entrench privilege and further disadvantage marginalised individuals and groups. The attendee asked how MQRP would engage with the community to understand their needs and improve their access to services. The NHMRC Centre for the Social Determinants of Health Equity[17] was recently launched at Flinders University and may offer an opportunity for collaboration. A market approach must improve community knowledge, control and empowerment, rather than fixate on individuals' interaction with particular clinicians.

It was agreed the current system spends too much on treatment compared to prevention, and more efforts must be made to encourage the public to live healthier lives and avoid future health issues. Consumer interests can coincide with the efforts of funders to reduce costs, as wasteful expenditure benefits nobody. Funders support the inefficient use of prosthesis, for example, and reducing these costs would ease the immediate pressure on health insurance premiums.

A 2009 Productivity Commission report comparing public and private hospitals[18] quoted the Australian Health Service Alliance which found that private hospitals, on a case mix adjusted basis, paid 40% more than the public sector for similar goods. Suppliers tried to justify this differential by arguing the public sector bought higher volumes, although available figures did not substantiate this claim. Differences in the type of devices bought were also suggested, although could not be substantiated due to a dearth of available data.

Health economics are dominated by rising demand. Although reducing cost differentials in prosthesis may offer minor and short-term relief, it cannot address the major long-term dilemma. Cutting 5% from health premiums by such measures would only slow their increase for a year or two. **Health costs are driven by the ageing of Australia's population and the ever greater scope and complexity of medical care.** While a bad hip would have been treated with pain killers in the past, hip replacements – and re-replacements – are now commonplace even for the very elderly.

> *"A market approach offers interesting insights and new avenues for progress. It is not the only way to think about health, but is a useful additional perspective.*

However beneficial they may be from the afflicted individual's point of view, improvements in practice, capacity and technology drain the health budget. This raises the prospect of rationing services, charging more or 'fossilising' medicine by rejecting effective, but expensive modern procedures. Few clinicians or patients would feel comfortable with only adopting new treatments if they were cheaper than the ones they replaced.

It was agreed that these drivers are significant and well known. New drugs, techniques and technology are constantly developed, while older patients or those with co-morbidities receive expensive and intricate procedures which would not have been considered in the past. People in their 90s now undergo back surgery, for example, and diabetics receive renal transplants which would once have cost their lives. **The technological clock cannot be turned back, nor people rejected on the basis of age or infirmity.** The question is not whether we should improve our capacity, but how to do it most wisely. The ethical component of care demands not only that appropriate treatment is given to those in need, but also that they are delivered in the most efficient way to maximise their benefits and availability.

Another attendee explored the theory of markets in relation to health. Perfect competition, as envisioned by Adam Smith, requires conditions of perfect knowledge and choice which seldom pertain in the real world. Marx introduced an element of ideology, viewing the market as an instrument of class exploitation rather than consumer empowerment, and much of the entrenched opposition to health markets is born of the fear they will serve the interests of others. The speaker urged attendees not to dismiss the market concept out of hand. All markets are complex, interactive organisms. The health arena is highly complex, and clearly far from perfect, but **a market approach offers interesting insights and new avenues for progress**. It is not the only way to think about health, but is a useful additional perspective. People will always differ in the level of government intervention they wish to see, but all stakeholders have an interest in better services at less cost.

The following speaker strongly supported the concept of markets as they exist to provide consumers with the goods and services they demand. He was frustrated with consumers being handed expensive treatments with questionable impacts which fail to address their wants or needs. Regulation should support the market, rather than impede it. Health's complicated, multifaceted problems will never be easy to solve, but the system should be structured to help consumers get what they want from it. People routinely buy expensive and complicated products such as computers, houses and cars without being experts in these fields. Yet, through the mechanism of the market, they succeed in buying things which serve their purposes. The concept of health as a market underlines that healthy, happy consumer outcomes matter more than producer interests or traditional structures, and the greater the focus on consumer outcomes, the better healthcare will become.

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Another attendee underlined the need for compassion and consideration of 'the human factor' at every point in the debate. He agreed that information in itself is not a panacea or guarantor of rational decision making, as the obesity epidemic and billion dollar alternative and complementary health market clearly attest. He quipped that all models are wrong, but some are informative. People can learn something from the idea of markets in health, but not everything, just as calling it an ecosystem would offer insights, but not a complete template for reform. Perfect competition might require that comprehensive information exists and flows instantly to all parties who are in turn equally able to digest and understand it and empowered to act on it immediately, but the impossibility of this idea does not stop markets operating effectively in a host of other domains. The perfect should not be the enemy of the good. Rather than bemoan the size of the problems, people should take small steps towards solutions. The speaker offered a couple of areas which are small enough to measure and take action in, but could still offer significant gains. The first concerned better ways to teach new techniques to physicians. Experience in a mountain region of the USA had shown that doctors ignored reams of best practice material sent to their doors, but were willing to accept and implement it through discussions with their colleagues. Doctors are trained to think for themselves, and so allowing them to reach their own conclusions in consultation with their peers, rather than attempting to impose solutions upon them by the mere presentation of documents, proved highly effective. The presentation of information must therefore work with the learning style of its target audience, be it physicians or the general public.

Given the importance of this 'human factor', the mere provision of evidence-based information is a necessary, but not sufficient, element, and the speaker suggested organising A/B trials to find the best way to proceed. Changes in behaviour and outcomes could be measured and assessed to modify how information is presented, absorbed and applied by its intended audience. Big data analytics are valuable, but small experiments can also inform improvements and progress. The attendee noted that little attention had been given to payment by results and suggested this as another area which could benefit from trials. Few markets are amendable to organised experiments with control populations and variable inputs, but such projects could offer opportunities to make headway in health.

Another participant said an investigation by the University of Wollongong for the Independent Hospital Pricing Authority had found little evidence to prove that paying hospitals for performance was effective.[19] Positive results could be the result of general trends or other factors, given the complications of measuring cause and effect. The Wollongong study was noted by every public sector jurisdiction and led to their conclusion that the introduction of payment for hospital performance would be premature. This is not to say that evidence will not emerge of its efficacy in hospitals or elsewhere, but, considering the emphasis given to evidence-based interventions, its failure to prove itself should be remembered, however counterintuitive it may appear.

The next contributor acknowledged the tangled nature of healthcare issues, but quoted Churchill's observation that '*out of intense complexities, intense simplicities emerge*'. Markets are an essentially simple concept built on the bedrock of consumer sovereignty. Once the primary of the consumer is agreed by all stakeholders, progress can be achieved. The massive purchasing power of the Government should be used to guide and stimulate desirable market changes and activity.

The same speaker lamented the failure of an earlier GAP initiative to help a state health department reduce costs by 4% by adopting Productivity Commission recommendations. Although its department heads agreed their organisation spent 80% of its budget on maintaining legacy systems and accepted the need for change, the project stalled because its administrators were 'too busy' running the legacy system to find time to adopt a more efficient one. The participant wondered why sensible people could not propose and embrace realistic solutions to solve practical problems and deliver efficient market outcomes. He criticised government purchasing procedures as 'inefficient and retrograde' and highlighted a new GAP project to discuss and drive the adoption of a 'Vision for Australia'[20]. He urged attendees to assess and pursue market opportunities to produce commercial outcomes for themselves and improve the current system through their own activities.

An academic raised his own concerns with the use of 'market' terminology. His business students understand the commercial reality that increasing a company's earnings demands the provision of more services or charging extra for existing ones. He argued that the commercialisation of the sector is already underway, with health companies being bought by non-sector firms because of their potential to make money from MBS items purchased by the Government.

> *"Accepting patients as co-managers of their own health prompts efforts to improve their skills, expertise, knowledge, responsibility and accountability.*

Obvious examples of waste are still being missed, and the speaker criticised the failure to tackle a 4,300% rise in pointless vitamin D deficiency tests for a decade. He called for better IT provision and legislative change to allow a greater sharing of data. Lord Kelvin once observed[21] that measurement is a prerequisite of improvement and, over and above administrative data sets, doctors need access to the deeper phenotypes of each patient to understand who will benefit or not from a particular treatment. The speaker commended the quest for evidence-based solutions and highlighted Britain's lead in integrating data to highlight areas of inefficiency. In addition to issues of safety and quality, he agreed that the wider appropriateness of health procedures must be considered. Engagement with clinicians to tackle overuse is vital as investigations are often used inappropriately and the cost per episode detected is high. Public hospitals spend $50 billion every year because a far greater range of treatment options are available for a host of conditions than a decade ago. Although consumers are central to markets, the private hospitals see doctors as the consumers of their services, rather than patients. Finally, the speaker urged the retention of the **'care in healthcare'** while organising the data and connectivity required to help stakeholders build a more appropriate, self-improving system.

The next speaker contrasted the ample lip service paid to 'person-centricity' with its absence on the ground. The term sounds '*lofty and noble and politically correct*', but that in itself is not enough to make it a reality. He reminded the workshop that market approaches in health have been tried for decades with varying degrees of success, and preferred an approach which emphasised the role that individuals can play as **'managers and co-managers'** of their own health and conditions. Accepting patients as co-managers of their own health prompts efforts to improve their skills, expertise, knowledge, responsibility and accountability. This would also move the focus to younger people and the prevention of disease. Steps should be taken to improve people's health and self-care skills throughout their lives, starting with the school curriculum. Everyone has a different capacity for managing their own health, as they will in their job or any facet of life, but this should not inhibit attempts to maximise everyone's potential.

Another attendee returned to the question of payment for performance. There is increasing recognition in the pharmaceutical industry that elements of both cooperation and competition can be advantageous to all. Paying for therapeutic performance should work, if robust outcome measures are employed. The point of considering health as a market is to find ways to drive improvement. Aspects of sociology and economics have been discussed to the exclusion of science, but biological science could hold the key to more effective outcomes. Science will increasingly pinpoint which procedures will work for which individuals and why, allowing the most effective treatments to be chosen. Investment 'at the front end' of scientific research will therefore bring greater dividends than spending more money on treatments without confidence in their results. The attendee raised the prospect of data analysis driving greater investment in science.

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The increased number of hospital tests is partly a product of defensive medicine, with doctors calling for tests they know are not necessary for fear of being sued for medical negligence if they do not. Legal firms prey on the medical profession, and a large number of cases are settled out of court before they gain media attention. Defensive medicine is clearly an inefficient use of resources, but doctors cannot be blamed for protecting themselves against unreasonable legal action.

The next speaker argued that while a classic market involves binary decision making on the part of both suppliers and purchasers – to supply or buy or not - healthcare remains highly probabilistic. Antibiotics might work 70% of the time, but 30% of the time they will not. A series of markets based on such probabilities is different from a single binary market, and so the health marketplace requires a different approach. Patients with co-morbidities such as cardiac and diabetic issues face a range of overlapping markets and treatments which may not always mesh well together. Big data analytics might offer some insights into handling such situations, and the speaker agreed that money should be invested 'up front' to help match individuals with appropriate and effective treatments. Developing systems to offer such guidance in real time might take 30 years to research and develop, a span which Australia's electoral cycle is ill equipped to support.

An experienced GP traced how medical practice had changed in the decades since he finished medical school. He underlined how defensive medicine has encouraged over-testing, while the costs of pathology have been driven higher by demographic factors and more chronic disease. 'Oodles' of best practice protocols are issued for every disease, but if doctors carry them out, they are warned they are doing too much, and if they do not, they are scolded for not doing enough. Medicine is in a 'difficult place', and while many people offer excellent advice, nobody can give definitive guidance. Clinicians must therefore do the best they can with the resources they have, commit themselves to ongoing improvement and plan for the future. The trajectory of health costs is always upwards. The gradient of growth can be flattened, but cannot be stopped or reversed. League tables 'frighten' clinicians until they know they can be approached in a collegiate way. The Bristol heart surgeon scheme in the UK, for example, proved that heart surgeons could cooperate effectively to raise standards. Many approaches can work, but each requires engagement with the professionals asked to implement them. Today's patients also differ from those in the past. GPs increasingly see patients suffering multiple co-morbidities, taking multiple medications and subject to multiple changes imposed by multiple health practitioners, which their GP knows nothing about without sifting through a large pile of letters. Improving IT platforms must form part of the solution, but merely suggesting reform is not enough.

A GAP taskforce on government procurement in health found that public hospitals tend to buy equipment over longer life cycles than their private counterparts. This means they tend to over-specify technical requirements in their initial tenders, rather than working with vendors on outcome-oriented solutions, and end up pushing obsolete equipment beyond its optimum working life. If purchasing processes are creating problems in health, then nothing will change until the purchasing processes themselves are reformed.

The next speaker observed that investment in new equipment is 'minuscule' in today's straightened economic environment. Capital budgets are not sufficient to buy the new IT systems which many attendees have called for, although a failure to invest today will stop better systems being created and operating in the future.

Attendees were urged to think of ways to cooperate and drive improvements themselves. People commanding purchasing power should use it to engender change, while organisations could run pilot schemes to test new approaches.

One member always hoped to be treated by a younger doctor, as they were more likely to be up to date on current medical practice, while another preferred his surgeon to be five years from retirement age.

Looking at the entire healthcare market as a single monolithic entity is problematic, but individual parts can be examined and improved. Improving consumer and clinician information flows in particular sectors can have a significant effect on patient outcomes.

> *"There has been no comprehensive and rigorous systems analysis of how information should flow through health communities to support the consumer or providers of care.*

While systems are by nature inflexible, **the capacity of markets to evolve in changing circumstances** was emphasised. The federal health department 'struggles to keep up' with the rapid pace of medical development, and the best practice of three years ago might not be appropriate now. The dynamism offered by markets might therefore be usefully engaged.

The potential of **improved connectivity** to address many of the issues raised was underlined by the next speaker. Healthcare, in common with many other sectors, is increasingly dominated by the connections between people and methods by which data is extracted, analysed, fed back and acted upon. The Internet of Things will see ever more smart devices adopted by individuals and hospitals to monitor and adjust the delivery of care. Unfortunately, hospital IT systems were often built on traditional administrative foundations, rather than an analysis of current needs and outcome-optimised solutions. Information is trapped in many different places in the same hospital, as well as between hospitals and the rest of the care system. There has been no comprehensive and rigorous systems analysis of how information should flow through health communities to support the consumer or providers of care. IT solutions have been developed in particular circumstances to fix specific problems, rather than to address the deficiencies of the system overall.

The next speaker worried that no definition of 'system' or 'market' had been agreed upon, despite the terms being discussed throughout the day. Given the elasticity of their concept and nature, he felt there was little sense in declaring either intrinsically good or bad. A systems-based approach should understand how different elements of the system interact with each other, regardless of the name given to the whole. Markets work well when actors in them make rational decisions, but this is not how healthcare works. Many people make irrational choices about their lifestyle every day, as evidenced by the high rates of obesity, continued incidence of smoking and poor levels of exercise in society. A large amount of money has been poured into encouraging wellness by the health industry over many years, with comparatively little improvement to show for it. People, even doctors, are skilled at rationalising their decisions to engage in risky or unhealthy behaviour, although they know its theoretical dangers. If health is seen as a market, and a market depends on rational decision making, then this irrationality must cause problems over time.

Stronger and widely accepted definitions of systems and markets are required before progress can be made on their improvement. [22]

> *Efforts must be made to better understand people's motivations and encourage behavioural change.*

This point of view was countered by the reiteration that consumers constantly make good decisions about complex purchases in other spheres of life they are far from expert in. The types of information they require to make better decisions about their health should be identified and offered in digestible forms. **Consumers should be approached through the way they actually think**, rather than the way in which health professionals wish they would think. Consumers do not care about the prominence of active ingredients on packaging, for example, but there is logic to their thought processes which can be engaged to encourage healthier choices in their lives.

Overweight individuals clearly do not make rational decisions about their food consumption, but most people find it very hard to accept they are overeating or improve their lifestyles and diet on a permanent basis. Everyone assumes that everyone is the same as everyone else, and indeed the same as themselves, but different people can have quite different thought processes. The participants in this workshop may well share and mutually reinforce an approach to situations which is at odds with that of the general population. Making further appeals to logic is in itself illogical when such appeals have consistently failed in the past.

Another member joked that he always made rational decisions, but just failed to carry them out. Any obese person can make a rational decision to lose weight, but many will lack the dedication or support required to transform initial motivation into long-term habit and success. He confessed that his attendance at the gym was driven more by the presence of his trainer waiting for him there, rather than any intrinsic motivation. He called for marketers and psychologists to be brought into the conversation to find more effective ways to encourage people to change.

The following attendee cautioned that many public health campaigns have been prepared in consultation with psychologists and marketers and yet have failed to encourage people to lose weight or exercise. Regardless of the approach attempted, it remains a Sisyphean task to encourage individuals to make and carry out rational decisions to improve their own health. Many people might even resent the influence of 'evil marketers' trying to persuade them to change their ways. Efforts must be made to better understand people's motivations and encourage behavioural change.

The next contributor raised the importance of **inspirational leadership to guide and motivate health workers to embrace reform**. Fortune 500 companies always stress the central role of their employees in their success and know the value of long-term workforce planning. He questioned whether anyone was focusing on the nature of the health market in 50 years' time. He appealed for **competency-based approaches** alongside the development of leadership to inspire change in the consumer-centric market that is emerging. Success will be a by-product of these factors, rather than something which can be pursued in isolation. The speaker reassured the group that they do not need to have every tool required to finish the job at hand to begin it. The label given to the market/system is less important than the development of forceful leaders to persuade those around them of the need for change and to progress it. The people in the room have a sphere of influence they can use to encourage change to ripple through the system. There is a need for champions to market the vision to professionals, as well as other stakeholders and the public.

The final contributor observed that everyone supports reform in theory as long as they do not have to change themselves. Eager reformers can hit 'brick walls' when people who have gone about their jobs in the same way for 40 years see no reason to reinvent themselves. He urged attendees not to underestimate how many entrenched vested interests will oppose change, and warned that granting concessions to 'special cases' will achieve nothing, as every interest sees itself as one.

Conclusion

Robert Lippiatt summed up the workshop's discussions. In his masterpiece 'The Prince', Niccolò Machiavelli observed that there is "*nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system. For the initiator has the enmity of all who would profit by the preservation of the old institution and merely lukewarm defenders in those who gain by the new.*" This remains as true today as it was in 1513[23]. Reform depends on successfully dealing with people, as well as inanimate systems, and dealing with this 'human factor' is paramount.

Health is a highly complex problem, and no silver bullet can change it or offer a complete solution. If the issues were that simple there would be no events held to discuss them. Demographic change and increasing costs create irresistible drivers for change, and so the health system has no choice but to evolve. As Winston Churchill is reputed to have once addressed his cabinet: "*Gentlemen, we have run out of money. Now we must think.*"[24]

Whether it is termed a market or a system, we must think and act differently to improve healthcare. A new vision must offer inspiring, uniting goals to save the debate from trudging in circles. **Reform is dependent on people and behaviours, rather than abstract systems**. While the importance of new technology and processes are often discussed, the most difficult and intractable element of reform is mastering this 'human factor'. Reformers must step outside the system and see it from the consumer and client's perspective, for they are the people it must be designed to serve. Let us ask what Australians want from the system they fund with their taxes, co-payments and premiums. How can processes be optimised, administration simplified and individuals empowered to do more and do it better?

Reformers should also study and adopt the strategies of successful firms in other spheres. Just as Australia's clinicians are encouraged to follow best practice in their treatment, so administrators, purchasers and decision makers should follow best business practice, too. Given the importance of mobilising the 'human factor', successful reform will ultimately depend on the development of inspiring leaders throughout the health sector to champion change and bring people together to get the job done.

Attendees, speakers and organisers were thanked for their contributions and invited to continue the conversation at forthcoming events, before the workshop was brought to a close.

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A Vision for Australia

PROGRAMME

12:30pm	Registration & Lunch
1:00pm	WELCOME & INTRODUCTION **Mr Robert Lippiatt** Chair, Australian National Consultative Committee on Health
1:05pm	WELCOME FROM SPONSORS "ACHR: Time to change the conversation" **Ms Rebecca Bartel** Executive Director, Australian Centre for Health Centre
1:10pm	KEYNOTE PRESENTATION "The Australian Healthcare System as a Market" **Mr David Jonas** Chief Executive Officer, CMC Insurance Solutions
1:30pm	ROUNDTABLE DISCUSSION Informal Panel **Dr Mukesh Haikerwal AO** Chair of Council, World Medical Association **Dr Brian Hanning** Medical Director, Australian Health Service Alliance **Mr David Jonas** Chief Executive Officer, CMC Insurance Solutions Facilitator **Mr Robert Lippiatt**
3:00pm	Networking
3:30pm	Close

KEYNOTE SPEAKER

David Jonas
Head, Health Market Quality
Program, Capital Markets CRC
Director, Lorica Health

David Jonas is the Chief Operating Officer of the Capital Markets Cooperative Research Centre[25] and Head of its Health Market Quality (HMQ) research and development program, the creation and development of which he has driven over the past three years. CMCRC's HMQ program spans the private health insurance, accident compensation and public health sectors.

David was the founding CEO of Lorica Health[26] and remains a non-executive director of the company. Lorica Health's fraud detection and analytical solutions are used by over 90% of Australia's private health insurers. The company is currently developing solutions for all parts of the healthcare market as well as extending its solutions to overseas markets.

Formerly David was the founder and CEO of a leading electronic commerce consulting firm and prior to that Chief Technology Officer of a large multi-national group of industrial companies.

David has led over 500 assignments in the areas of private and public sector electronic trading and service delivery over the past 20 years, including over 50 large scale national (public and private sector) technology initiatives.

David's career has been distinguished by a commitment to and appetite for thought leadership and innovation. This has been recognised over the past fifteen years by appointments to the European Union's Global Business Dialogue on the Information Economy, the Australia-Singapore Joint IT Council, the Australian Government's National Authentication Expert Group, and IT Security Expert Advisory Group, and the National Electronic Health Transition Authority's Privacy Roundtable.

David has a deep interest in and commitment to public good and for many years targeted his consulting activities to the areas of health (including indigenous health), education, and social welfare. He is currently a non-executive director on the Board of Infoxchange Australia[27], a not-for-profit community organisation dedicated to overcoming digital disadvantage.

FACILITATOR

Robert Lippiatt
Chair, Australian National Consultative
Committee on Health

Robert Lippiatt is a strategic business advisor with over twenty four years experience in positioning and restructuring organisations in the public, private and not-for-profit (NFP) sectors across a number of industries.

For the past 12 years Robert has been working on a mix of projects concerned with the development of new service and delivery models in the health, aged and community care Sectors.

He is experienced in helping client's link future strategy, people, processes and technology. His special skill is in assisting organizations grappling with issues related to change and the development of more effective solutions to operating problems resulting from competition, strategic and market repositioning, managing change and development of business strategy.

Robert is currently leading projects in the areas of:

- Deregulation and change in the Health, Disability and Aged Care Sectors
- Person Centred Care in the Health and Care Sector
- Self Care and Self Management to support a sustainable Health and Care Sector
- Telecare as an enabler of service innovation in the provision of Community based Health and Care services, and
- Defence Community Health and Care

Since 1999, he has held a number of senior advisory roles and been on the boards of a number of health and care organisations including as Chairman of one of Australia's largest NFP aged and community care providers.

In addition to his current advisory roles, Robert is also:

- A Board Member of NFP community services provider YFS Ltd
- Chairman of the Australian National Consultative Committee on Health
- Chairman of the Australian Self Care Alliance
- Chairman of the Trans Tasman Veterans Mental Health Symposium, and
- A Member of the RSL's National Health and Aged Care Advisory Committee

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A Vision for Australia

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NOTES AND REFERENCES

1 Australian Centre for Health Research (ACHR), http://www.achr.org.au

2 On 10 May 2015, the Australian Government announced that it would deliver a rebooted personalised *myHealth Record* system for patients and doctors to trial an opt-out, rather than opt-in, option as part of its $485 million budget rescue package, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley050.htm

3 McKeon Review (2013, *Strategic Review of Health and Medical Research – Better Health through Research;* www.mckeonreview.org.au/downloads/Strategic_Review_of_Health_and_Medical_Research_Feb_2013-Final_Report.pdf

4 http://www.iom.edu/

5 As quoted by David Jonas during his presentation at the GAP Health Workshop on 28 April 2015

6 *How the RAND COMPARE Microsimulation Model Works*; RAND Health, http://www.rand.org/health/projects/compare/how-it-works.html

7 American Academy of Orthopaedic Surgeons (2013), Appropriate Use Criteria for Optimising the Management of full-thickness rotator cuff tears; http://www.aaos.org/research/Appropriate_Use/rotatorcuffaucfull.pdf

8 http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley045.htm

9 Medicare Benefits Schedule (MBS) Review Taskforce; http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce

10 Primary Health Care Advisory Group; http://www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryHealthCareAdvisoryGroup-1

11 Primary Healthcare Networks (PHNs); htttp://www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

12 NHHRC (2009), *A Healthier Future for All Australians*; http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report

13 H20 International Health Summit Report "*Healthy People - Successful Economy*"; http://www.wma.net/fr/50events/20otherevents/70g20melbourne/H20-Conference-Report-FINAL-for-distribution.pdf

14 The group changed its name to the Australian Vaccination-Skeptics Network in February 2014 after the Administrative Decisions Tribunal upheld an order issued in December 2012 by the New South Wales Office of Fair Trading. In 2010 the New South Wales Health Care Complaints Commission accused the group of disseminating 'misleading, inaccurate, and deceptive" information about vaccination.

15 NHMRC Statement on Homeopathy and NHMRC Information Paper - Evidence on the effectiveness of homeopathy for treating health conditions; https://www.nhmrc.gov.au/guidelines-publications/cam02

16 As quoted by a participant during the GAP Health Workshop on 28 April 2015

17 http://www.phcris.org.au/organisation/detail.php?id=6290

18 Productivity Commission (2009), *Performance of Public and Private Hospital Systems*, http://www.pc.gov.au/inquiries/completed/hospitals/report

19 Centre for Health Service Development (2013), *A Literature Review on Integrating Quality and Safety into Hospital Pricing Systems*, University of Wollongong, Wollongong; http://ro.uow.edu.au/cgi/viewcontent.cgi?article=1392&context=ahsri

20 http://openforum.com.au/content/what-your-vision-australia

21 "*In physical science the first essential step in the direction of learning any subject is to find principles of numerical reckoning and practicable methods for measuring some quality connected with it. I often say that when you can measure what you are speaking about, and express it in numbers, you know something about it; but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind; it may be the beginning of knowledge, but you have scarcely in your thoughts advanced to the state of Science, whatever the matter may be.*" [PLA, vol. 1, "Electrical Units of Measurement", 1883-05-03]

22 A later correspondent argued the system verses market debate might be usefully concluded by viewing health as both a system and a market. There are real markets operating within the overall health system but these are often driven more by political factors than market forces. From a systems thinking perspective, all markets are systems and some systems are markets, however such analysis will not end the controversy as it may confuse, rather clarify, people's thinking.

23 Although not printed until 1532, five years after his death, surviving correspondence suggests 'The Prince' was circulated under the Latin title De Principatibus (About Principalities) at least 19 years earlier.

24 The quote is also ascribed to Sir Ernest Rutherford, the great New Zealand physicist, but there's no solid evidence that either actually said it.

25 Capital Markets Cooperative Research Centre, http://www.cmcrc.com

26 Lorica Health, http://www.loricahealth.com

27 Infoxchange Australia, http://www.infoxchange.net.au