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Funding real health security: higher transparency of price and quality of care while transforming Medicare subsidies to governments and households

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Third Menzies Foundation Winter Series Lecture
Sydney, 27 July 2006

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1. INTRODUCTION

1.1 Progress to here

These three lectures were intended to raise the possibility that personal health security is not enhanced by the current payment systems that drive Medicare and private health insurance.

The first lecture identified four gaps in our prevention armour.

The second lecture used obesity to illustrate how we might enhance personal responsibility in changing unhealthy lifestyles that cause the burden of chronic illness to rage.

In this third lecture, I pull together some of the threads in addressing one issue: how should we retool Medicare and private health insurance to enhance health security?

1.2 Themes of this lecture

I ask four questions:

- How transparent to households are the true costs of healthcare and poor future health if some major risk factors are not reduced?
- Which inefficiencies in the current health system- and their related costs to society- are not transparent to payers or consumers?
- What new tools do payers and consumers need to become more informed purchasers of healthcare?
- How could Medicare be redeveloped as an integrated health security program that does more than bill paying?

2. TRANSPARENCY TO HOUSEHOLDS OF THE COSTS OF HEALTHCARE AND POOR HEALTH

2.1 Accountability in healthcare

The demand for healthcare is unlimited in a health financing system that

- offers open-ended subsidies;
- requires little effort by individuals to change unhealthy lifestyles, use health care appropriate to health needs or use providers of high quality care,.

Consider the following cycle of the creation and use of medical technology, associated with 60% of the growth in healthcare expenditures in the last twenty years.

- From the *research laboratories* of drug and medical device manufacturers, the medical technologies that save or prolong lives emerge and enter clinical

trials to establish safety and efficacy. The health-sector R&D corporations recognise the gaps that exist in today's technology and we should not expect them to cease innovative R&D. So new technology emerges and diffuses into medical practice.

- The safety and efficacy of medical technology is often defined by *regulatory authorities* (such as the Therapeutic Goods Administration) who pass judgement on the safety of new drugs and medical devices, and by health technology assessment organisations like Pharmaceutical Benefits Advisory Committee in Australia or the UK National Institute for Clinical Effectiveness (NICE).
- With few limits on demand, *providers of care* seek to offer this new technology, knowing that if they do not, consumers will move on to the next available provider, or, if their health suffers because care is withheld, they will become litigious.
- *Consumers of care* (*aka* "patients" in days of yore) seek the best care available. Regrettably, they have no tools to distinguish good or bad quality providers, and they cannot discern the differences between cost-effective and cost-ineffective technology. But they want the newest without knowing what it really costs.
- With budgets constrained by the premiums they are allowed to charge in Australia, the *health funds* do not necessarily accept the need to pay for all medical technologies, but they are also wary of offending providers or their members.

In this cycle, none of the listed entities perceives any reason to change the current mix of financing mechanisms and, with rising household incomes, health care expenditures rise inexorably (and often faster than the growth in GDP) because

- healthcare is what economists call a superior good;[1]
- the new technology may not replace existing treatments but is used alongside the old technology;
- both good and inappropriate use of the new technology are reimbursed at the same fee, and volumes of care rise.

2.2 Sustainability of healthcare financing with growth rates greater than GDP growth

With no incentives for frugality in this cycle, it is extremely difficult to discuss the sustainability of Medicare funding except by devices such as the Intergenerational Report in the 2002 Budget. The IRR was used to focus on the expenditure side of the Commonwealth Budget. The Commonwealth share is about 40% of total healthcare expenditures

With total national healthcare expenditures of $86 billion per year, the IGR merely tells us that when expenditures rise at about 8% per year, we will spend big slabs of GDO in 2042. Healthcare now consumes 10% of GDP, and my forecast is 13-14%

[1] A superior good is one for which the demand grows at a faster rate than the increase in personal income, and so the income elasticity of demand exceeds 1.0.

of GDP by 2011. I cannot think beyond five years, and any forecast to 2042 that assumes linearity is suspect.

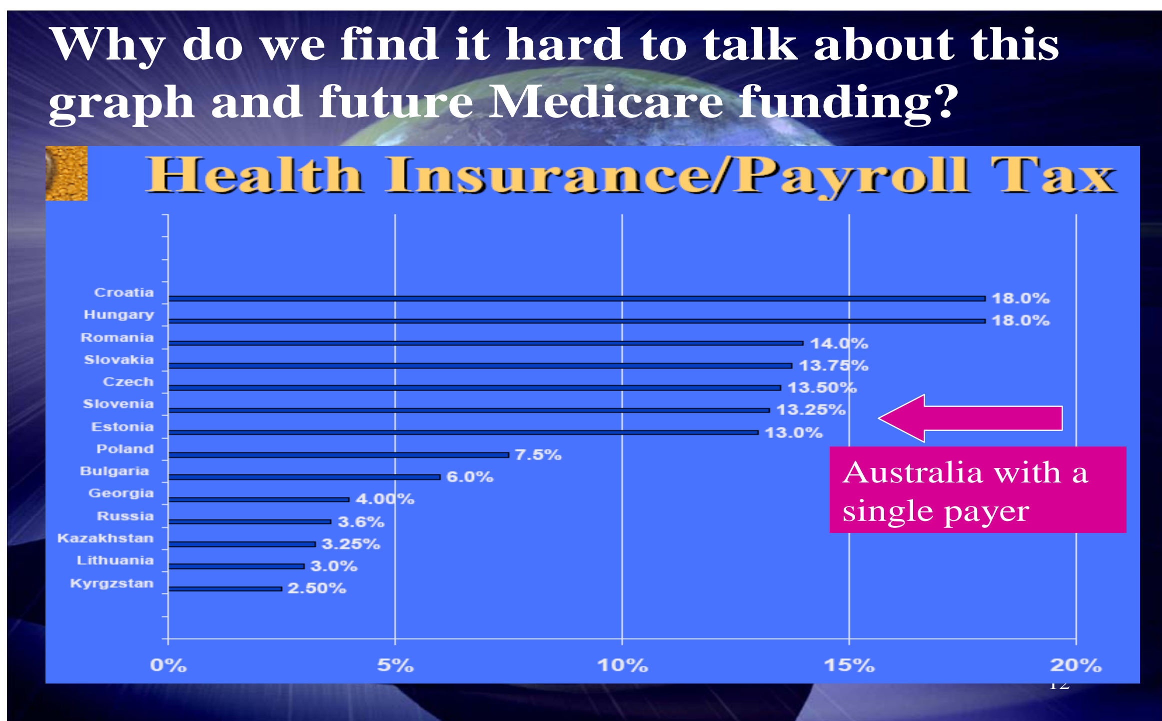
How many options do we have to sustain Medicare as a universal scheme offering subsidised access by all citizens to public hospitals, PBS drugs and medical services?

The three methods for funding a higher share of GDP in healthcare are a higher Medicare premium, higher health insurance premiums and higher copayments.

Single government payer, tax funding: Suppose we believed that a tax-funded Medicare system under the control of a single government was the preferred route, with all private health insurance abolished.

Other nations creating their health systems from scratch now know something about the percentage of income or wages needed to sustain a modern health system using a single tax- see **FIGURE 1** below:

FIGURE 1: Health insurance or payroll taxes in the new nations of Europe : tax rate -%



So if we went down the single payer track, we would now be paying about 13% of our income for all healthcare, a rather large jump from the 1.5% that most of us now pay.

I doubt that there is a government or opposition who could sell that proposition to the punters. So I move on to other theoretical possibilities

Reduce inefficiencies in Medicare and PHI: Suppose instead we believed we could fund future growth in health expenditures by removing some of the inefficiencies in today's funding, which I estimate further on to be $15 billion or 12% of national healthcare expenditures.

We cannot reduce these inefficiencies for as long as we rely on (1) the current reimbursement systems in Medicare and PHI; and (2) a poorly informed consumer of healthcare.

So this option looks infeasible as a sole solution. It might work in combination with other options.

Change the incentives for consumers and providers in Medicare and PHI funding: Suppose as a last resort[2] we paid providers more for high quality and provided incentives to consumers to reduce risk factors and seek quality care.

Why do I prefer this route of incremental change to wholesale uprooting of the Medicare system? I quote two recent opinions from other nations:

OPINION 1 (EU experts): "*This is not to say that the answer lies simply in introducing prospective global budgets. Both historical incremental budgets - widely employed in many NHS countries in Western Europe - and input-based budgets in the former Soviet Union countries were effective in containing costs, but did not offer any incentives for efficient or responsive provider behaviour. The challenge is … to build incentives for improved efficiency, quality and responsiveness while maintaining the prospective nature of payment in order to ensure financial sustainability*".

OPINION 2 (Chief Executive of the federal government CMS, USA): "*We can't solve Medicare's sustainability problems "by leaving Medicare's benefits out of date … (which) distorts the way health care should be delivered away from modern preventive treatments … (and) raises the costs of health care and sticks beneficiaries with these unnecessary costs " … or … "by imposing arbitrary government controls on prices and access to care …" …"We must solve our sustainability problems with a focus on increasing quality and avoiding unnecessary costs - that is, a focus on performance*".

What is blocking any[3] sustained focus on performance in Australia? One keen observer of the US health sector , Stu Altman, provides one obvious reason:

> "*Each interest group has its own preferred solution … and the status quo is everyone's second choice.*"

I think there is a second reason, viz., *when we do not measure performance, we do not have fully informed buyers of healthcare.*

Taking this assertion as my anchor, let me now build the case to obtain both efficiency gains AND higher quality care through higher transparency with both informed consumers and providers.

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[2] There are other options, including a larger role for PHI. I leave those options to another day.

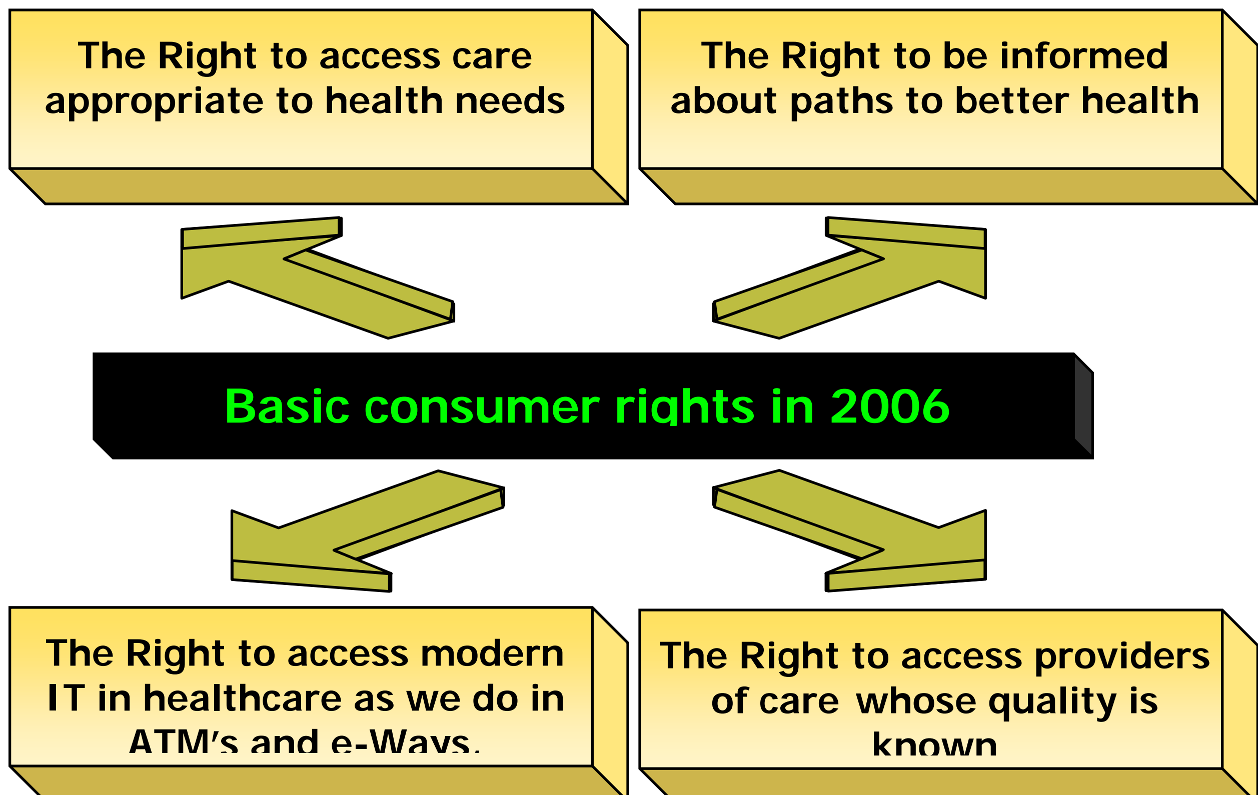
[3] DVA is not waiting, has studied the benchmark developments elsewhere, and is offering voluntary P4P payments in the next contract with private hospitals.

3. INEFFICIENCIES THAT REQUIRE MORE TRANSPARENCY AND PAYMENT METHODS THAT REWARD PERFORMANCE

3.1 Four consumer rights, two data gaps

In Lecture 2, I identified the four theoretical consumer rights summarised in **FIGURE 2** below.

FIGURE 2: Four theoretical consumer rights



I focus here on gaps affecting the top left and bottom right boxes, both due to defects in the health information systems that, in turn, diminish health security.

First, despite a long history of evolution through different governments of different political philosophies, the Health Insurance Commission, which should be a repository of all Medicare claims data that provides intelligence on trends in health status and health risks, is not capable of pulling together the data that other nations regularly process.

The Privacy Act and our inadequate investment in relevant health information systems are major barriers.[4]

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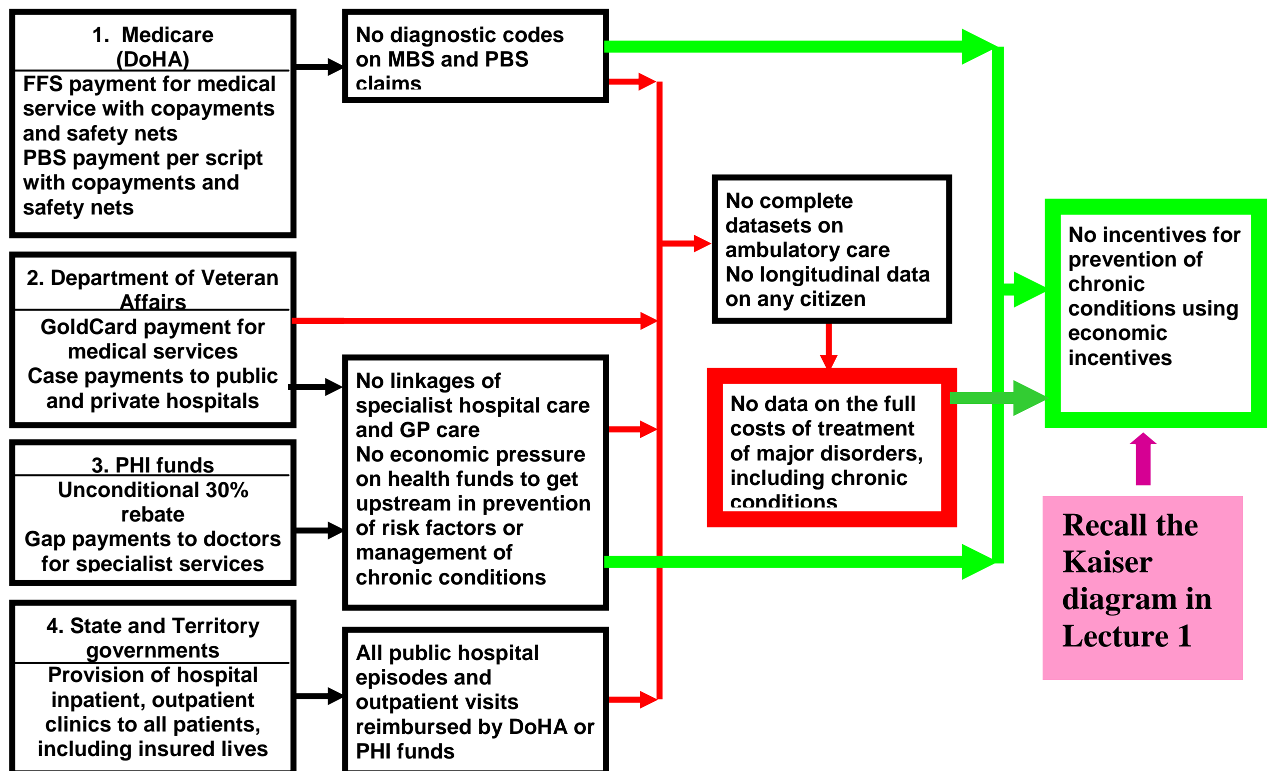
[4] The Privacy Commissioner believes that there are no barriers to stop the linkage of MBS and PBS data, and she will issue new guidelines-see: Newsbriefs." Privacy guidelines for MBS". *Medical Observer* 11 August 2006, 6.

FIGURE 3 below identifies some of our resulting gaps in data linkages.

FIGURE 3: Healthcare reform: filling the data gaps



The pink box at the right hand end asks you to recall the Kaiser Permanente spaghetti diagram from Lecture 1.

The Kaiser system suffers from none of the gaps in the right half of the picture.

3.2 Pay for (provider) performance

Second, despite our many disparate data collections on all providers of care, we do not embed the measures of the quality of provider care that other nations take for granted, and as such, we continue to pay equally for good and bad quality care.

When we pay equally for good and poor quality care, we waste scarce resources.

Consider just the following three sources of such waste:

- adverse events and hospital acquired infections;
- the preventable hospital admissions discussed in the first lecture; and
- excessive government regulations affecting the performance of health insurers, hospitals and doctors.

I estimated in 2005 that these three sources of inefficiency cost us 3%, 5% and 6% of total national healthcare expenditures, or about $12 billion.

How might we reduce some of the economic waste arising out of the first two causes?

FIGURE 4 below summarises in the left column the current methods used to reimburse hospitals in Australia.[5]

FIGURE 4: Healthcare reform: new goals for provider payment

None of them offer incentives for quality care and improved patient safety. The three remaining columns summarise the newer reimbursement strategies being used in other nations to achieve those two goals.

There are some predictable early responses to proposals that Australia should introduce payment system in the second column: the pay-for-performance method.

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[5] I ignore the capitation payments being used by two health insurers in South Australia and the Alfred Hospital project in Victoria.

- Clinical quality cannot be measured - so how can we pay for "it"? **OR**
- My patients have more complex conditions and comorbidities than my peers, so how can you penalise me when I may have higher complications rate because of such differences? **OR**
- Patient safety is a cultural problem, and we need to change the culture before we offer higher payments for process measures of patient safety, **OR**
- Providers are being paid enough now, so don't pay the bad providers anything.

Notwithstanding these responses, all myopic or wrong, other nations (UK, USA) now have incentive payments for hospitals and doctors to encourage better quality care, higher efficiency, improved patient safety, higher patient satisfaction and improved care of the chronically ill patient following discharge.

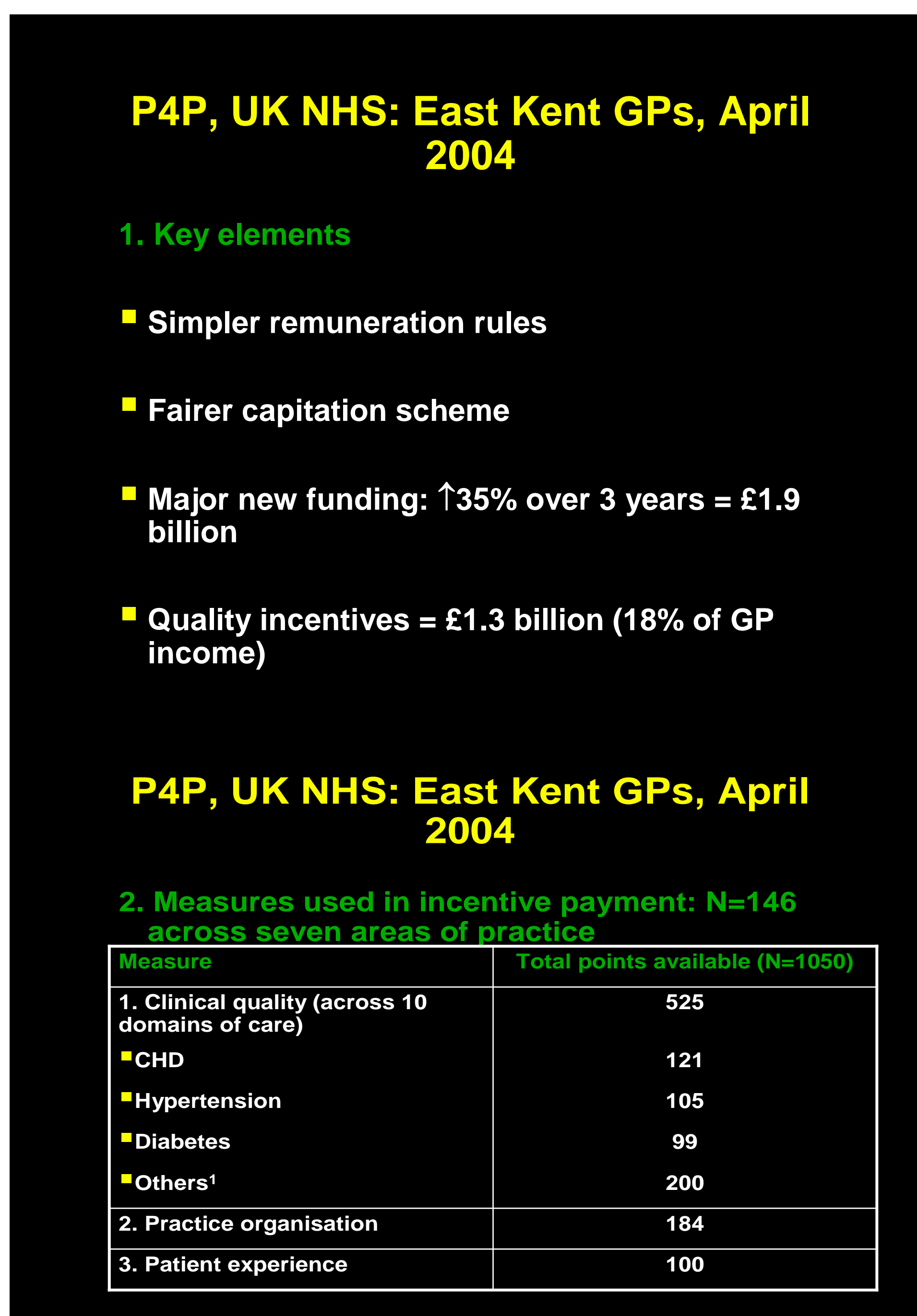
For example, the types of performance measures now being used in US hospitals are summarised in **FIGURE 5** and those used to reward UK doctors in **FIGURE 6** (UK).

FIGURE 5: Criteria used in P4P systems for US Hospitals from 2004

P4P criteria, two US payers, 2004

Category	BCBS-HI (hospital)	BCBS-MI (hospital)[1]
Quality	40	50
Patient satisfaction	30	
Connectivity	15	
Efficiency	15	
Clinical measures		15 (Rx safety)
IT investment		
Appropriate utilisation		25
Community health:CI		10

FIGURE 6: Performance criteria used to pay UK doctors:2004



Measure	Total points available (N=1050)
1. Clinical quality (across 10 domains of care)	525
▪CHD	121
▪Hypertension	105
▪Diabetes	99
▪Others[1]	200
2. Practice organisation	184
3. Patient experience	100

I stay with the UK P4P process and present some new data on the changed behaviour of UK GP's published in tonight's issue of the *New England Journal of Medicine* which arrived as I edited this lecture.

Some of the UK results in **FIGURE 7 AND 8** below are impressive, showing both the exceptional reporting achievements in GP reporting on chronic conditions, and the differences in median and inter-quartile range achievements with data collections.

FIGURE 7: UK P4P and chronic care management: percentages achieving benchmarks under P4P payments

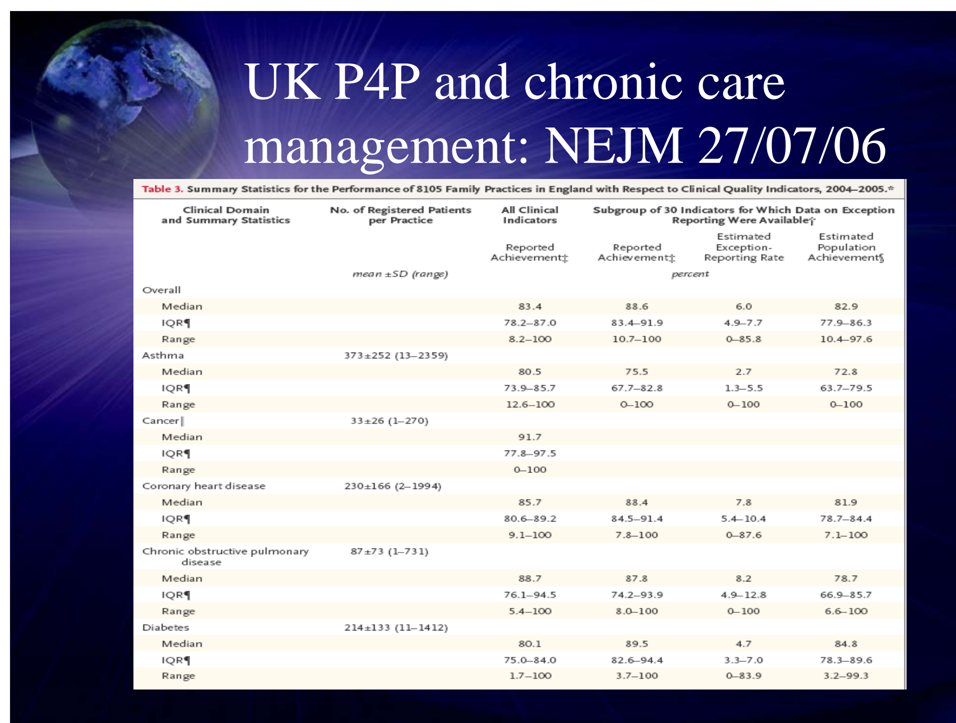


Table 3. Summary Statistics for the Performance of 8105 Family Practices in England with Respect to Clinical Quality Indicators, 2004–2005.*

Clinical Domain and Summary Statistics	No. of Registered Patients per Practice	All Clinical Indicators	Subgroup of 30 Indicators for Which Data on Exception Reporting Were Available†		
		Reported Achievement‡	Reported Achievement‡	Estimated Exception-Reporting Rate	Estimated Population Achievement§
	mean ±SD (range)	*percent*			
Overall					
Median		83.4	88.6	6.0	82.9
IQR¶		78.2–87.0	83.4–91.9	4.9–7.7	77.9–86.3
Range		8.2–100	10.7–100	0–85.8	10.4–97.6
Asthma	373±252 (13–2359)				
Median		80.5	75.5	2.7	72.8
IQR¶		73.9–85.7	67.7–82.8	1.3–5.5	63.7–79.5
Range		12.6–100	0–100	0–100	0–100
Cancer‖	33±26 (1–270)				
Median		91.7			
IQR¶		77.8–97.5			
Range		0–100			
Coronary heart disease	230±166 (2–1994)				
Median		85.7	88.4	7.8	81.9
IQR¶		80.6–89.2	84.5–91.4	5.4–10.4	78.7–84.4
Range		9.1–100	7.8–100	0–87.6	7.1–100
Chronic obstructive pulmonary disease	87±73 (1–731)				
Median		88.7	87.8	8.2	78.7
IQR¶		76.1–94.5	74.2–93.9	4.9–12.8	66.9–85.7
Range		5.4–100	8.0–100	0–100	6.6–100
Diabetes	214±133 (11–1412)				
Median		80.1	89.5	4.7	84.8
IQR¶		75.0–84.0	82.6–94.4	3.3–7.0	78.3–89.6
Range		1.7–100	3.7–100	0–83.9	3.2–99.3

FIGURE 8: UK P4P impact on exceptional reporting for chronic care management

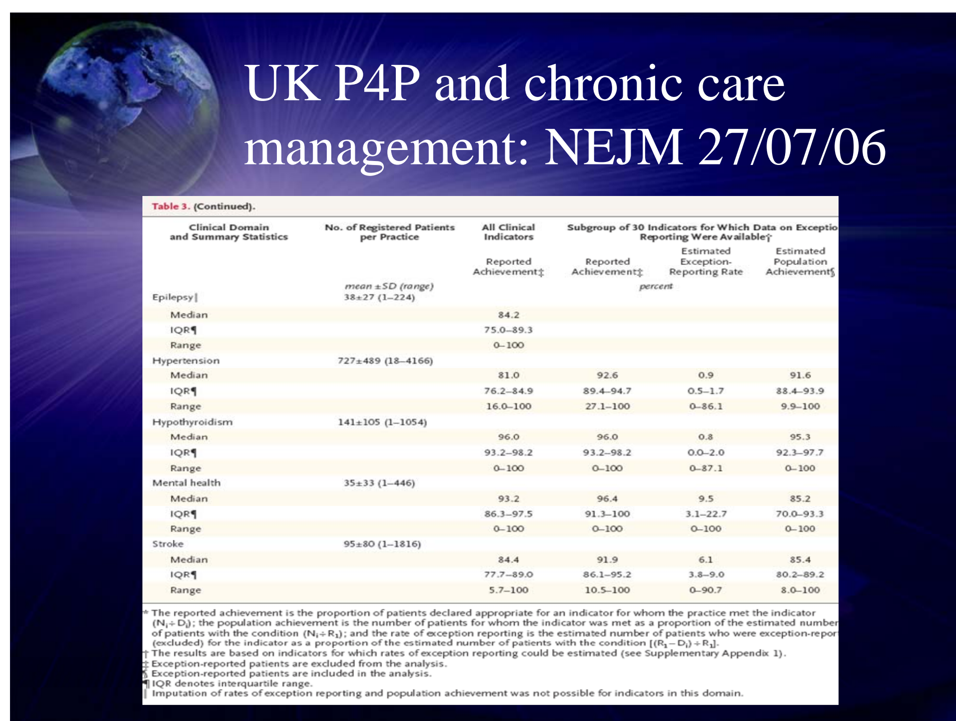


Table 3. (Continued).

Clinical Domain and Summary Statistics	No. of Registered Patients per Practice	All Clinical Indicators	Subgroup of 30 Indicators for Which Data on Exceptio[n] Reporting Were Available†		
		Reported Achievement‡	Reported Achievement‡	Estimated Exception-Reporting Rate	Estimated Population Achievement§
	mean ±SD (range)	*percent*			
Epilepsy‖	38±27 (1–224)				
Median		84.2			
IQR¶		75.0–89.3			
Range		0–100			
Hypertension	727±489 (18–4166)				
Median		81.0	92.6	0.9	91.6
IQR¶		76.2–84.9	89.4–94.7	0.5–1.7	88.4–93.9
Range		16.0–100	27.1–100	0–86.1	9.9–100
Hypothyroidism	141±105 (1–1054)				
Median		96.0	96.0	0.8	95.3
IQR¶		93.2–98.2	93.2–98.2	0.0–2.0	92.3–97.7
Range		0–100	0–100	0–87.1	0–100
Mental health	35±33 (1–446)				
Median		93.2	96.4	9.5	85.2
IQR¶		86.3–97.5	91.3–100	3.1–22.7	70.0–93.3
Range		0–100	0–100	0–100	0–100
Stroke	95±80 (1–1816)				
Median		84.4	91.9	6.1	85.4
IQR¶		77.7–89.0	86.1–95.2	3.8–9.0	80.2–89.2
Range		5.7–100	10.5–100	0–90.7	8.0–100

* The reported achievement is the proportion of patients declared appropriate for an indicator for whom the practice met the indicator ($N_i \div D_i$); the population achievement is the number of patients for whom the indicator was met as a proportion of the estimated number of patients with the condition ($N_i \div R_1$); and the rate of exception reporting is the estimated number of patients who were exception-repor[ted] (excluded) for the indicator as a proportion of the estimated number of patients with the condition $[(R_1 - D_i) \div R_1]$.
† The results are based on indicators for which rates of exception reporting could be estimated (see Supplementary Appendix 1).
‡ Exception-reported patients are excluded from the analysis.
§ Exception-reported patients are included in the analysis.
¶ IQR denotes interquartile range.
‖ Imputation of rates of exception reporting and population achievement was not possible for indicators in this domain.

In P4P, a core component is data collection and analysis, activities both rendered much easier by investment in healthcare information systems.

3.3 Low investment in health information technology

FIGURE 9 below provides one clue why we do not measure in Australia, and why, unlike the UK National Health Service in its reporting on chronic conditions, we will be limited in the types of P4P systems that we should be using to empower doctors.

FIGURE 9: Australia's health IT investment and world benchmarks, 2005

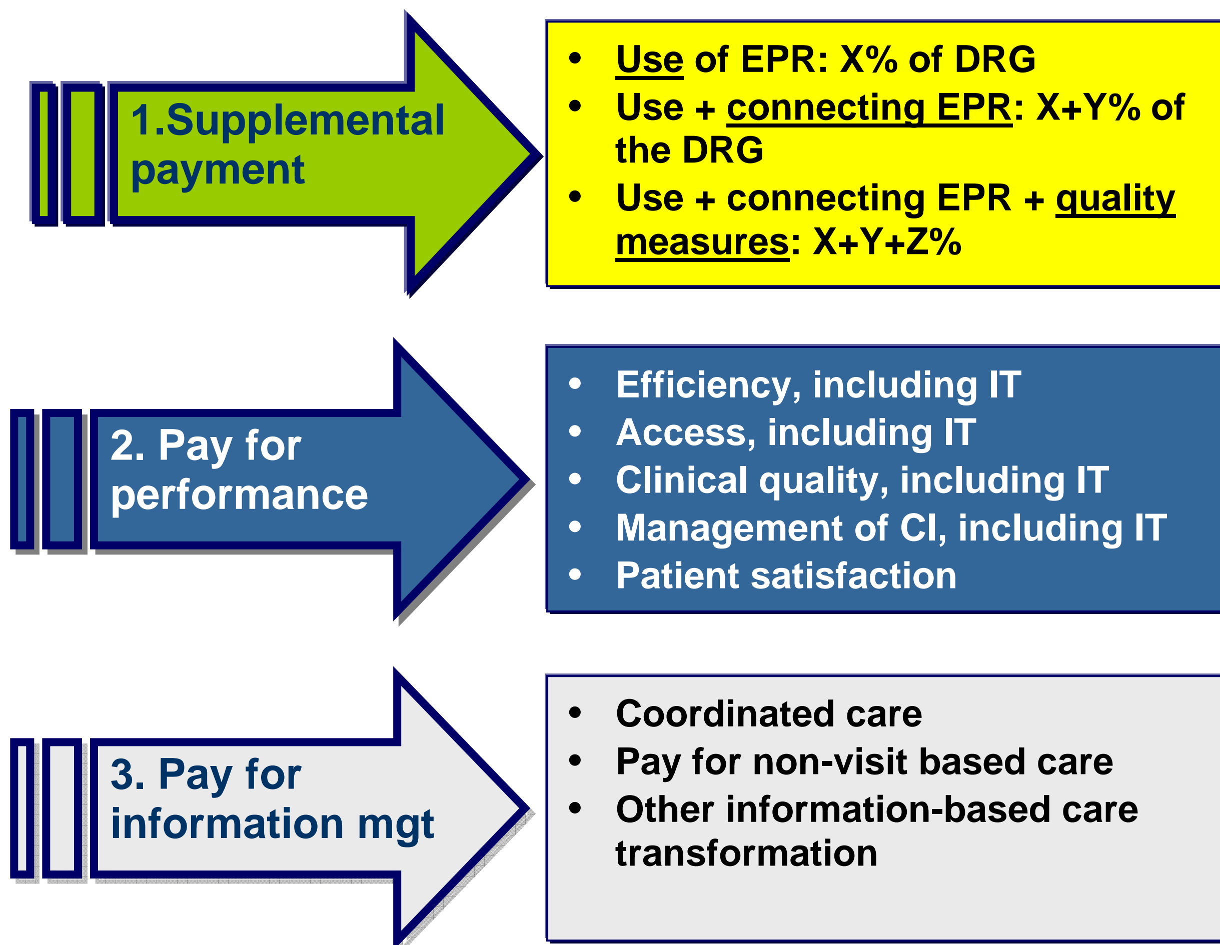
NATION	Per capita investment in national health IT system (US$ 2005)
Australia	5
Canada	32
Germany	21
Norway	11
UK	193
USA	0.43
Kaiser Permanente USA	**140**

There are three ways we can reduce our health IT investment deficiencies in public and private health care:

- supplementing existing case-mix payments to hospitals to incentivise hospitals to invest in IT;
- embedding IT incentives in the new P4P payment currencies (the US Department of Veterans Affairs is the forerunner but our DVA is capable of emulating its US cousin), or
- paying doctors more for their role in information management.

FIGURE 10 shows how these three routes might develop.

FIGURE 10: Healthcare reform: increasing the incentives for investment in health IT



- The first option for hospitals would mean that the DRG weight for the whole hospital would be increased by x% if the hospital used an electronic patient record (EPR), an extra y% would be added if the hospital used the EPR and connected all its affiliated medical clinics into the hospital IT system, and an extra z% if the hospital installed, connected and then measured the quality of its care with its IT system.
- The second option is to use a P4P payment system that uses the five domains of performance shown and adds another set of bonus points for hospitals that use IT to measure the performance on all five domains.
- The third option would pay more to medical practices that offered all three processes of care, and which used IT as the vehicle, as in the Kaiser Permanente system.

To this point, I have flagged some of the tools that might be used with minor adjustments to Medicare and PHI rebates.

I now want to propose systematic reforms to both to render Medicare and PHI relevant to the care of a population that is fatter, older and sicker.

4. RETOOLING MEDICARE AS AN INTEGRATED HEALTH SECURITY PROGRAM

4.1 COAG excludes the growing private health sector

As I inferred in the first two lectures, if we have a crisis in healthcare, it is a crisis of complacency about the gaps in our health system, not a crisis in the health system as a whole.

The Chinese word for "crisis" has two symbols, one indicating "threat" and the other indicating "opportunity".

An older, fatter, and more disabled Australia requires policies that are appropriate to these threats. We need:

- Vision and leadership at the federal level (READ: chronic illness needs new funding)
- Collegial entrepreneurism at all levels of government and the private health sector (READ: public/private partnerships)
- Adaptation to policy turbulence (READ: collective recognition by the public and private health sectors of the policy gaps that MUST be filled to avoid a crisis)

The opportunity facing policymakers is to balance the dangers of

- *complacent utopianism* ("a touched-up Medicare is all we need") and
- *minimal opportunism* ("the major problems in private health insurance have been fixed, and everything else is a second-order issue").

In the course of these three lectures, COAG met on 14 July. When we rely on COAG for collective action, consider the following actions that eventuated within one week:

- **COAG 14 July 2006**: "this is the most cooperative arrangement that we've reached" (Premier Beattie), and a National Reform Council was created to oversee collaborative reforms envisaged by COAG.
- **State/Territory Premiers 21 July 200**6: "…we are creating the Council of the Federation as a block against centralisation", with the CoF Secretariat located in …….Canberra!!

A week is indeed a very short period in political memories, and the third and fourth tiers of government generated as solutions by COAG are the latest manifestations of utopianism and zero opportunism.

The track record of COAG as a reform agent in healthcare is poor. I do not have high hopes that COAG alone can solve anything quickly, a view I expressed in the first lecture.

If COAG was fully tuned to the need to confront chronic disease now rather than 15 years hence, and actively involving the private health sector that is now the

dominant supplier of medical, hospital and aged care services, the following three not-so-radical reforms might have been implemented:

- More appropriate care of chronic conditions and risk reduction incentives to consumers (see Lecture 2).
- Incentives for efficiency gains in institutional care, based on new pay-for-performance incentives to providers.
- National funding vehicles for retirement and long-term care would be on the agenda for public debate, or we would be creating new savings incentives for all citizens.

4.2 Other nations have lifted the bar in federal-state relationships by changing irrelevant health financing methods

Germany: Other nations do not move at such glacial speed. Their governments act rather than talk. I mentioned Germany in the first lecture as an example of a nation that is changing its economic policies and healthcare financing policies.

Two years ago, Germany introduced disease management strategies to reduce chronic disease and associated risk factors.

- It created a national health promotion foundation at the federal level, funded at the level of 200 million Euros.
- It allocated 20% of the funding to the federal level to define targets and assure quality.
- It allocated the remaining 80% as 40% to the state governments to create the vehicles, and 40% to the sickness funds (health insurance funds) for individual projects.

Its relevance to Australia is that it is national, integrated and adequately funded to bring about change through both the States and the health insurance funds, exactly the problem we face here with out public and private health systems.

USA: The US government, seemingly powerless in the international sector, was on the front foot domestically in June 2006 when it announced subsidies for lifestyle changes in its very obese Medicare (federal program for the elderly) population:

- Its target is heart disease, a problem that is also the highest cost disease here.
- The new subsidy is for intensive cardiac rehabilitation programs, and we have program funding gaps here in rehabilitation=tertiary prevention. The subsidy will cover programs of cardiac rehabilitation such as
    - the Ornish Program for Reversing Heart Disease
    - the Benson Cardiac wellness program
- The subsidy will pay for comprehensive lifestyle changes via
    - support groups
    - good nutrition, low-fat diets
    - stress management: yoga, mediation, deep breathing

4.3 Medicare reform: an incremental strategy for chronic disease

We can and must do better than leave COAG spinning its wheels on how to restructure Medicare for the 21st Century.

My vision for transforming Medicare in incremental fashion is simple: allow it to pay for quality in chronic care management.

Goals: My goals are to reduce the health risks of at-risk target populations, and improve the quality and safety of chronic care management.

Incremental changes: The components of this new Medicare would be:

1. Evidence-based decision-support for doctors and patients.

2. A new business model that pays providers more for specific population-based health outcomes.

3. A new administrative role for the Department of Health and Ageing in

   (a) setting goals;
   (b) contracting with public and private patients; and
   (c) managing and analysing HIC and health fund data in ways that improve the outcomes of care via techniques used by Kaiser Permanente as outlined in the first lecture.

Public-private partnerships under Medicare for better chronic care: The proposal has six simple steps to transform some of the limitations noted in this lecture.

1. The Minister of Health[6] would be empowered to enter into contracts with

   - State health regions (maybe States?)
   - Private health insurers
   - Disease management companies with a track record in population-based health management (e.g., McKesson, United Healthcare)
   - Large GP Divisions
   - Royal College of Physicians

2. The prime targets would patients with the following chronic conditions or risk factors: heart disease, diabetes, chronic kidney disease, chronic pain, depression, asthma, chronic obstructive pulmonary disease, high blood pressure, raised lipids, overweight and obese person of all ages, dementia and falls.

3. The funding from the federal government would be performance-based for all funding sources (MBS, PBS, health fund benefits, and the Health Care

[6] The Minister of Veterans' Affairs could allow the same contracts for veterans. In many senses, the Minister is will be doing this with the proposed P4P contract options from late 2007.

Agreements for public hospital, as follows:

- All funding would embed additional payments for measured quality and patient safety
- All future Health Financial Agreements with the states would be rewritten to embed new performance payments
- The initial focus in Stage 1 would be on care in public and private hospitals, focusing on medical errors, hospital acquired infections and IT deficiencies, followed by MBS payment incentives in Stage 2 to reduce the preventable admissions noted in the first lecture
- The criteria for performance-based funding would include: effectiveness, efficiency, access, patient safety, patient satisfaction, educating patients with chronic conditions

4. New annual upfront payments to GPs for integrated care would occur in the Stage 1 reforms of the MBS:

- $400 per patient per year would be paid to GP's who took on performance-based payments in which the GPs (and practice nurses) agree to take on added responsibilities for patients with 3+ chronic conditions or designated risk factors
- To receive this payment, the GP would agree to coordinate all care for the 8-10 chronic conditions listed above, and to maintain simple longitudinal patient records
- Additional quality bonus payment (related to patient satisfaction, health and functional outcomes, and investment in health IT) would be paid in Stage 2

5. The eligible management programs for the chronic conditions listed as prime targets in point 2 above would have to:

- Offer voluntary patient enrolment to a care management program
- Develop and use care plans and Clinical Practice Guidelines
- Coordinate the care of all enrollees
- Participate in clinical trials of the coordinate care vs non-enrollees ($20 million in new funding would be provided for evaluation)
- Provide patient information, education and outreach to all enrollees

6. Each eligible organisation contracting with the Minister in point 1 above would have to provide minimum data on:

- Monitoring of health and functional status
- Reductions in hospital and medical treatment errors
- Hospital readmission rates
- Patient satisfaction
- The direct and indirect cost impacts of the care provided

These reforms would transform Medicare to allow it to fund integrated care of the types already accessible in benchmark organisations.

4.4 Priority for the National Reform Council of COAG

As noted above, in July COAG created a fourth tier of government called the National Reform Council. I think it is a knee-jerk response by COAG that lacks any *raison d'etre*.

But I would gladly apologise for this slur if the NRC took on a role the promoter of some needed reform in public and private health care. Here is a relevance test of its *bona fides*:

- **GOAL**: It must sketch within twelve months the path to a healthcare system that encourages risk factor reduction, achieves better access, improves quality and achieves greater efficiency
- **TASKS**: It should be judged by its ability to provide a costed strategy to change the current financing and delivery of healthcare; identify the public AND private policies/practices that would achieve the above four goals by 2011; propose specific path to retool Medicare, PHI, WCI; and cost the potential efficiency gains from P4P and MBS reforms
- **MECHANISM**: It must involve both public and private health sectors in a goal-directed, time-limited attack on chronic conditions.

5. CONCLUSIONS

I conclude these three lectures with four uncontestable assertions.

- Consumers do not see the full cost of care. Without price and quality signals, they are blind buyers of care of unmeasured quality.
- Some inefficiencies can be removed by a real investment in information technology and by a P4P reimbursement strategy for providers of care.
- Economic incentives for providers of care AND for personal responsibility of most of the the population are feasible in both Medicare and PHI.
- COAG, the National Reform Council or the Council of the Federation represent the worst form of benign neglect of the chronic illness burden until they push us to the world best practice care and prevention represented in organisations such as Kaiser Permanente.

After 44 years of watching every other alternative fail, and still today seeing governments that embraced more private initiative being ejected (Slovakia) or assailed by the punters (UK), why am I still optimistic about the value of a mixed public and private health system that responds to the incentives outlined in these three lectures?

GB Shaw is one of my two crutches:

"Reformers have the idea that change can be achieved by brute sanity."

My other crutch is evidence-based. For 60 years, Kaiser Permanente has been the pioneer and the exemplar for any nation seeking to prevent illness and disability at

an affordable cost. As I have illustrated in these three lectures, it is a health system that offers enviable levels of health security that we lack.