ABOUT THE SYMPOSIUM

The **NHMRC Partnership Centre for Health System Sustainability** is a new and unique research entity led by Professor Jeffrey Braithwaite, Director of the Australian Institute of Health Innovation at Macquarie University in Sydney. It will commence in mid-2017 and will take a co-production approach to research design and implementation. This research collaborative comprises thirteen outstanding academic and health system investigators, and a range of health service providers, system managers, policy-makers, consumers, professional bodies and insurers from across Australia.

An Inaugural Symposium was held in Sydney on 16 March 2017 to showcase the proposed research to be conducted and stimulate critical discussion and involvement in formulating the vision and future work of the Centre.

Over 120 people attended the Symposium, representing a broad range of sectors: health departments and government health agencies, research institutions, health insurers, private health services, professional and peak bodies, Local Health Districts and Primary Health Networks, hospitals, consumers and industry experts. Feedback was both constructive and positive, particularly from consumers who also attended a separate Symposium the following day designed to better harness consumer input into AIHI's research agenda.

The Symposium explored key themes around better use of analytics, data and technology; reducing low-value care and waste; and financial reforms to promote better value for each health dollar spent. Feedback received from the audience reinforced the critical importance of utilising existing knowledge and the Centre's implementation research strengths to upscale successful local innovations into system-wide, sustainable change. Getting clarity on what a 'sustainable health system' looks like, how it might be measured and what levers, tools and goals will catalyse and hasten system sustainability were all considered important early tasks for the new Centre.

A summary of the feedback received from the audience is summarised below and should be read in conjunction with the presentations given by all Lead Investigators available at:
http://www.healthsystemsustainability.com.au/news-events-and-participation/event-outcomes/

SESSION 1: USING ANALYTICS, TECHNOLOGY AND SHARED DATA

- Use of big data and predictive analytics to help avoid chronically ill/aged patients being unnecessarily admitted to hospital (rather than as a tool to predict recovery/death trajectory). How generalisable is the model from hospital to hospital? Perception management important – attention to clinical ethics, consumer engagement and marketing.
- Important to link with the two other Partnership Centres in relation to using analytics and shared data to improve value-based care for chronically ill and aged populations.
- Value of feedback to the frontline – analytics (e.g. STARS analytics system at Sydney LHD) – in positively influencing clinician behaviour (more valuable than financial incentives) particularly

where clinical governance structures conducive to change. How to replicate this initiative from SLHD?

- Increased specialisation and growing number of doctors considered significant in driving up costs of care per patient – need to consider research focussed on best ways of containing this as will worsen with increasing size and specialisation of medical workforce.
- Re-orientation of 'System' towards a prevention and wellness focus will make the most difference to sustainability; rest may be tinkering around the edges. Nonetheless, for this PC, acute care is where the largest expenditure is, and will be ripe for savings.
- Beware of spending too much time further establishing proof about what we know works; focus effort on how we get evidence into operations and then roll-out and scale-up what has shown promise. For example, e-medication management tools.
- Importance of shared decision-making tools but also of better informing and educating both consumers and clinicians about risk in common areas of over-testing and over-diagnosis. Clinicians, particularly GPs, need tools/training to explain properly why non-referral/non-testing etc. appropriate as many - but not all - consumers may not be equipped to make informed choices due to complexity and fear of not knowing.
- On-line triage tools, e-bed boards, HealthDirect - all useful digital health tools/services - large scale roll-out would help better manage appropriateness of ED use and right hospitalisation nationally. Don't test the tools, test the rollout. Opportunities for 'natural experiments' by having a number of health services participating in interventions.
- Consider importance of leadership and clinical governance structures and supports on mediating cultural/behavioural change.
- For telehealth - focus on disruptive strategies that don't require government funding.
- Determine where on-line care more effective than direct contact e.g. geriatric assessments where contextual information about living environment afforded by telehealth.
- Must resolve payment methodology for telehealth to enable roll-out; consider moral hazard implicit in telehealth, vested interests and gaming – smart purchasing required.

SESSION 2: REDUCING WASTE AND LOW-VALUE CARE

- Clearly establish root cause(s) of the known increase in volume of care per patient.
- Over-use of diagnostics, over-detection and subsequent unnecessary interventions are all important areas to conduct research, however the 'how' of changing those behaviours will be the real challenge. Do outcome payments address these behaviours and reduce waste?
- Need to deal with the difficulty of replacing current testing and therapy regimes with alternate strategies as it will affect the livelihoods of manufacturers, providers of testing and/or treatment services; vested interests are powerful and difficult to address from research standpoint. How do we handle this?
- Cost-shifting via unnecessary referral of care to specialists and conversion of public patient to private inflates cost. Agreement that greater medical 'generalisation' (e.g. general physicians) is likely to reduce cost and the volume of waste contributed by low-value care – can this be proven? Will require informing and re-educating both clinicians and patients.
- Potential to investigate costs/waste involved in rework and error in hospital administration systems that support clinicians?
- Carers/patients views of 'alternate settings/providers' - capture early in design process.
- Is there value in investigating areas that generate particularly high costs of service e.g. ICU cost per service/day or high volumes of service?
- How much do we know about web/social media driving increased/decreased demand for testing and treatment?
- Consider operational waste (e.g. cannula insertion) as well as clinically defined waste.

MORNING WRAP-UP (Annette Schmiede):

Australia doesn't have just ONE health system in reality – we need to put effort into better understanding how we can connect the many disconnected parts/systems better. Work on the behaviour changes we want and payment incentives to make it happen. Message is transforming local innovation to large scale; collaboration across industry, system and funders. Sit down with other PCs and get synergy going across the 3 research areas.

SESSION 3: PROMOTING BETTER VALUE FOR THE HEALTH DOLLAR

- Evidence that everything improves if consumers involved in decision-making about their own care. Don't discount value of systematically analysed patient stories – "add a heartbeat to research". Need a more deliberative approach and inclusion of consumers in design.
- PHNs may be an important lever to influence sustainability – do 'live' research on what basis do/should they make decisions on what they purchase and be accountable back to communities about what they spend?
- Over-supply of doctors and competition could lead to unintended upward pressure to over test/treat – *if I don't DO something, I may lose my patient to the new Dr down the road?* Possible multiplier effect on low-value care. Don't know enough about the effects of competition on quality of care.
- Do we need incentives for hospitals and clinicians to actually acquire/accumulate/analyse data or is it just a matter of making data entry/analytics easier? What does the research tell us?
- Health Homes – need more evidence about the 'how' than the 'what': structure, staffing (e.g. inclusion of a general physician); payment models that reduce cost and improve outcomes?
- Does the alignment of PHNs and LHDs present an opportunity to test pooled funding / alliance commissioning (including of Aged Care) for a common set of outcomes – joint stewardship?
- Priority-setting frameworks for system managers need to be co-designed with clinicians and consumers/community. Experience suggests that priority-setting rarely based on cost and quality considerations.
- Does the 70 (Govt):20 (PHI):10 (Personal) split in expenditure still hold true as the ideal?

GROUP WORK REPORT BACK: What are the priority areas for attention?

- Overarching definition of sustainability and affordability: conduct initial, strategic research on what we spend on health in Australia–is it right in total (too much or too little) and in the right proportions (ratio of government: health insurance: personal out-of-pocket)?
- Future role of private health insurance (PHI) - as currently provided, or something different; what is the opportunity cost of $ invested in PHI government rebate; how do we ensure affordable consumer choice but avoid junk policies?
- Do patient reported outcomes, if measured accurately, improve sustainability (effectiveness and/or affordability)?
- How do we ensure more appropriate referral to specialists to better contain unnecessary intervention, particularly where driven by over-testing?
- Many health services overwhelmed already with implementing new ideas to improve quality, safety, affordability. Change fatigue is real issue. Focus on doing a few things well.
- Bundled payments for the chronically ill; is there practical evidence of ↑ value?
- How can better data linkage release greater value to the system?

- Which new models of care will release most value - Healthcare homes, Headspace, telehealth etc.? How do they have to be structured to release that value?
- Getting proven reforms to stick – implementation science is key to success of the PC.
- Sharing data beyond the 'walls', including primary care, socioeconomic and geospatial data may be critical.
- Has priority-setting and decision-making improved consequent to devolution (LHNs/PHNs)?
- Unlock innovation occurring at smaller systems level/front-line by using PC as a repository for sharing research and innovation that has already released value to the 'system'.
- How do we ensure new models/therapies/tests/procedures 'replace' rather than 'add' to the compendium of care? How do we more quickly remove/decommission those that are proven not to have value?
- Incorporate consideration of current reforms in research planning – e.g. NDIS, Aged Care reforms; trials of fundholding, healthcare homes, Productivity Commission's work on competition and choice.
- Towards end of life care – co-design of approach to minimise unnecessary/unwanted testing/intervention; use predictive analytics to prevent hospitalisation; value of improved consumer awareness of low-value care; concerns about ethics of testing then withholding of treatment.
- Focus on knowledge sharing strategies and large-scale system uptake and implementation; use system partners as 'laboratories'.
- Proposed research agenda is sound - focus on some early wins where evidence known but implementation lacking and a longer term 'big' platform of work where testing and refinement required before large-scale roll-out can be justified.