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title Active disinvestment in low-value care in Australia will improve patient outcomes and reduce waste

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Key messages

- Australia is making good progress towards disinvesting in low-value care, but needs to start taking more active steps to ensure disinvestment continues.
- As a priority, the current activities of Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC) should be expanded to include regular ongoing review of publicly funded items.
- Processes need to be improved, allowing the recommendations of MSAC and the PBAC to be implemented efficiently.
- Funding mechanisms for health services should focus on outcomes not outputs.
- Outcomes-based funding will require enhanced collection and sharing of health outcomes data. The development, collection and sharing of health outcomes data should be prioritised.
- As a condition of receiving \$6 billion in the form of health insurance rebates from the Commonwealth, health insurance funds should be encouraged to assess the value of the care they fund and be excluded from covering non-evidence-based therapies, such as homeopathy.

Executive summary

This Issues Brief makes recommendations about the critical steps to be taken in Australia to promote disinvestment in low-value healthcare and encourage use of high-value care. These recommendations are not quick fixes, but essential if Australia wants to continue to have a world-class healthcare system; providing Australians with the best possible health outcomes in a sustainable manner into the future.

Major recommendations include:

1. The expansion of the work of MSAC and PBAC, to continue the work of the MBS Review Taskforce at the conclusion of its current review. Improvements to implementation processes for recommendations need to be made to enhance speed of implementation.
2. Aligning funding with the health outcomes achieved by services. This will require routine capture of health outcomes data.
3. Audit, feedback and reporting of outcomes to help providers track improvements in care provision over time and to assist patients in choosing high-value care and quality providers.
4. Encouraging private health insurers to contribute to the evidence base of what constitutes high and low-value care, through use of the rich datasets they collect, and, not to cover non-evidence-based treatments and services.

Crucial to the success of this work is continued strong leadership from Commonwealth and state and territory governments and wide stakeholder buy-in to ensure that the community understands disinvestment is about delivering high-value care, not cost-cutting.

All health system stakeholders, including industry, can be involved in the promotion of high-value care and in reducing use of low-value services. As part of this initiative, active participation of patients and consumers in decision-making about their healthcare should be encouraged. Overall, ongoing cooperation of all stakeholders will help to ensure disinvestment in low-value care continues so that the Australian healthcare system can provide high-value care and achieve the best possible health outcomes for all Australians.

Policy issue

Australian health policy-makers are faced with a dilemma; rising consumption of healthcare services, alongside concerns about increased costs. Choices about how we spend our healthcare dollars need to be evaluated to ensure that the system remains affordable in the future and to guarantee the best possible outcomes for patients. To create an affordable and sustainable system, investment in new cost-effective healthcare services needs to be balanced with disinvestment in low-value services.

Overuse of low-value care and underuse of high-value care is widespread and contributes to unnecessary costs and poor health outcomes.¹ A complex network of factors contributes to both overuse and underuse and can be categorised into three domains; money, knowledge, and power or relationships.² The doctor-patient interaction is at the centre of this complex interplay of factors, which drives the care a particular patient receives.²

Australia currently has good systems in place to ensure policy and decision-makers are presented with cost-effectiveness evidence to support investment in new medical services, products or technologies. However, many existing services, already funded, may not have been subject to thorough evaluation of their effectiveness or cost-effectiveness. Adding to this, where old services are superseded by new technology, in many cases employment of coordinated, active disinvestment in outdated services does not exist. This means that many patients are potentially receiving out of date or low-value care. Not only does this result in poorer health outcomes for the individual, it also means resources are being wasted, when they could have been spent on higher-value care.¹

Many activities are underway in Australia aimed at reducing use of low-value care or incentivising high-value care, but to date, only limited action has occurred, beyond reporting of ideas and potential strategies. Active investment and implementation of disinvestment strategies are needed in Australia to improve the quality of care provided to patients and also to ensure resources are not wasted.

What this paper is about

This paper is designed to aid policy-makers and other health system stakeholders to understand the concept of low-value healthcare and why disinvestment activities are important. It outlines why active disinvestment from low-value healthcare is critical for the ongoing sustainability of the Australian healthcare system and its potential effect on the health outcomes of Australian patients. It describes the current activities underway to promote disinvestment in Australia and makes recommendations about how best to capitalise on and improve these activities, to move towards effective and active disinvestment in low-value care.

Key concepts

Disinvestment defined as ‘the processes of (partially or completely) withdrawing health resources from any existing health care practices, procedures, technologies or pharmaceuticals that are deemed to deliver little or no health gain for their cost, and thus are not efficient health resource allocations.’³

High-value care: use of an intervention which evidence suggests ‘confers benefit on patients, or probability of benefit exceeds probable harm, or, more broadly, the added costs of the intervention provide proportional added benefits relative to alternatives.’⁴

Low-value care: ‘use of an intervention where evidence suggests it confers no or very little benefit on patients, or risk of harm exceeds likely benefit, or, more broadly, the added costs of the intervention do not provide proportional added benefits.’⁵

Health Technology Assessment (HTA): a process of evaluating health services, technologies and treatments for cost-effectiveness and safety.⁶ HTA is undertaken to ensure publicly-funded healthcare is safe and that the health system is able to sustainably fund listed items.

Medical Services Advisory Committee (MSAC): an independent non-statutory committee, which evaluates medical services (using HTA) for public funding and provides advice to the Commonwealth Government about whether new medical services should receive public funding.⁷ It can also review currently funded services.⁷

MBS Review: a review currently being undertaken of the Commonwealth Medicare Benefits Schedule (MBS), in Australia. A high-level review of the whole MBS is being undertaken to identify priorities areas for detailed review. A comprehensive review of those priority areas is then being carried out, to bring the list into line with contemporary clinical practice in Australia. It involves several working groups assessing the quality and cost-effectiveness of items in different practice specialty areas, as well as examining the rules and regulations for claiming reimbursement under the schedule.⁸

Pharmaceutical Benefits Advisory Committee (PBAC): is an independent expert body whose primary role is to recommend new medicines for listing under the Pharmaceutical Benefits Scheme (PBS).⁹ New medicines can only be listed on the PBS with a positive recommendation from the PBAC, following appropriate HTA.⁹

Choosing Wisely Australia: a public awareness campaign led by the Australian Government funded NPS Medicine Wise, and designed to help ‘healthcare providers and consumers start important conversations about improving the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures.’¹⁰ Lists are created by clinical professional bodies in Australia and published on the Choosing Wisely webpage.¹⁰

Background

In January 2017, the OECD released a statement from the Health Ministerial Meeting regarding the next generation of health reforms.¹¹ This statement highlights the need for health systems to focus on delivering high-value care, moving towards more patient-centred care and being adaptable to new technology.¹¹ It also reported the need for a strong primary care sector and the establishment and implementation of national health data governance frameworks as key factors in achieving next generation reforms.¹¹

The discourse around disinvestment in low-value care has gained further momentum through the release of the Lancet's Right Care Series.¹² This series of papers and commentary provides a comprehensive overview of the drivers of overuse of low-value care and underuse of high-value care, and highlights these as global problems.¹²

In an increasingly globalised world, information about new medical treatments is widely available and the public demands affordable access to new technology.¹³ However, healthcare resources are not unlimited; supply cannot keep up with demand for healthcare or health services. At the same time, many current services have not been evaluated, leaving their cost-effectiveness or relative cost-effectiveness unknown. This has important implications for the quality of life of many Australians and the cost of their care. Australia is faced with a dilemma—an ever-increasing demand for and consumption of health services, and an increasing concern that healthcare costs are growing too fast.

To improve the efficiency of the system and guarantee its sustainability into the future, investment in new technology needs to be balanced with disinvestment in low-value and superseded care options. In seeking to improve the care they provide over time, clinicians have often engaged in disinvestment from low-value care, however, this process may be slow. Health policy can lag even further behind. An obvious example is the Medicare Benefits Schedule (MBS): until mid-2016 the MBS still contained *obsolete items*; defined as 'services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.'⁸ Prior to this, Elshaug et al identified 150 low-value practices in Australia, which should be considered for disinvestment, for example knee arthroscopy for osteoarthritis, yet little formal policy action has been taken to disinvest from these services.¹⁴ These delays in policy change unfortunately create financial incentives for clinicians who are not following or lag behind up-to-date best practice, in continuing to provide outdated care.

It is important to acknowledge the challenges of disinvestment are both political and social.⁴ Removal of funding for any program or policy can be politically challenging. This is accentuated in health as access to healthcare is recognised as a universal human right. Therefore disinvestment needs to be treated sensitively. Necessarily, the financial interests of some providers will be negatively affected by disinvestment in certain services; most healthcare costs represent a provider's income or profit. Similarly, some patients' expectations of health services available to them will also be affected. In a broader context, disinvestment requires cultural change.⁴

There are numerous stakeholders within the healthcare system, each with different interests and potential to improve the efficiency of health service delivery. Key health system stakeholders include: Commonwealth and state/territory governments, health service coordination groups (hospital and health services and primary health networks), service providers, clinicians and professional associations, researchers, industry and private health insurance funds, the public, patients and consumers. Each stakeholder group will have a different role to play in the successful disinvestment in low-value care in Australia.

The benefits of evidence-based disinvestment need to be widely promoted so they are not overshadowed by claims of rationing or cost-cutting.⁴ Improved communication between clinicians and patients and shared decision-making have also been highlighted as key factors in reducing use of low-value care.² To prevent a negative political agenda, bipartisan support as well as backing across state, territory and Commonwealth governments and professional groups is required.³ While there will be winners and losers in any policy for change, it is crucial that the common goal of disinvestment be widely supported, because ultimately, all members of society will be negatively impacted if our healthcare system continues to be littered with low-value care and inefficiencies. Successful disinvestment in low-value care has the potential to generate less waste and greater health gains across the Australian health system.

Current disinvestment activities in Australia

There are several entities in Australia that use health technology assessment (HTA) to ensure that publicly available health services, treatments and interventions are safe and funding them is sustainable.⁶ This goes some way to ensuring publicly funded services are high-value, however, for the most part once approved for use or funding services, treatments and interventions are not routinely reviewed against the latest evidence. This means that while items may be high-value when first listed, if they are superseded, there is no formal disinvestment from them. Similarly, many older items have never been subject to economic evaluation and therefore their cost-effectiveness is unknown.

In Australia, steps towards disinvestment are under way. The Choosing Wisely and Evolve campaigns are promoting public awareness of low-value care.^{10,15} The current MBS Review is examining the value of more than 5,000 MBS items.¹⁶ In addition to these initiatives, the Australian Commission on Safety and Quality in Health Care (ACSQHC) is leading the development of standards, guidelines and indicators for safety and quality in Australian healthcare.¹⁷

These are significant steps towards changes which reduce the use of low-value care and incentivise use of high-value care. However, political support is important to create validity for engagement in processes for disinvestment in low-value care.^{4,18} Therefore national leadership and sound implementation strategies are needed, to coordinate efforts and encourage buy-in, collaboration and cooperation across the health sector.

Medical Services Advisory Committee (MSAC)

The Medical Services Advisory Committee is an independent non-statutory committee established in 1998 whose primary role is to evaluate medical services for public funding.⁷ It meets three times a year and provides advice to the Commonwealth Government about whether new medical services should receive public funding, primarily through the Medicare Benefits Scheme.⁷ While there is no formal ongoing review of services once listed, the Committee may also provide advice on matters related to the public funding of health services referred to it by the Minister for Health or under Australian Health Ministers' Advisory Council arrangements.¹⁹ As a non-statutory committee the Government is under no obligation to accept or act on the advice MSAC provides.²⁰ However, recommendations are publicly reported for transparency.

Applications involving new or emerging technologies and procedures are typically submitted by those with an interest in public funding for a new medical service such as the medical industry and medical professionals. The current process can take over 12 months, from application to creation of a new MBS item.^{21,22} Unlike applications for the PBS, there is no fee for applications to MSAC. However, the cost of preparing analyses and contributing to the process may present a barrier in itself.

Pharmaceutical Benefits Advisory Committee (PBAC)

The PBAC is a government-appointed, independent expert body, first established in 1953, whose primary role is to recommend new medicines for listing under the PBS.⁹ Like MSAC, the PBAC only meets three times per year. New medicines can only be listed on the PBS with a positive recommendation from the PBAC.⁹ The process is designed to ensure the sustainability of funding for pharmaceuticals and that low-value medicines are not publicly funded in Australia.

Submissions for listing new medicines must follow the guidance provided in the PBAC guidelines²³, to facilitate a clinical evaluation, economic evaluation, consideration of the likely extent of use and financial estimates. An economic evaluation has been a mandatory requirement for medicines listed since 1993.²⁴ This means any drugs listed between inception, in 1953, and 1993 are unlikely to have had a formal review of their cost-effectiveness.

Submissions are typically initiated by the sponsor or manufacturer of the new medicine, who holds the data needed and has the financial incentive for funding the preparation of the submission and the PBAC evaluation fee. PBAC evaluation fees are based on cost-recovery and range from \$500 for listing a new brand of an existing medicine to \$119,500 for innovative medicines.²⁵ While these fees can be waived where it is determined that the application involves the public interest and the fee would make the application financially unviable,²⁶ the costs of preparing submissions can still be a barrier to other stakeholders initiating PBAC reviews. The PBAC process typically takes 35 weeks from submission to recommendation for listing and further procedures follow prior to listing on the PBS.²⁷

There is no formal regular review of medicines once listed. However there are examples of ‘de-listing’ reviews being initiated by the Minister of Health. In 2015, the Minister requested that the PBAC provide advice as to specific drugs that are listed on the PBS which are also available for over the counter purchase, and to advise which of those items may be appropriate to remove from the PBS.²⁸

Despite no formal reviews by PBAC, there are other mechanisms utilised by the Australian Government to support disinvestment, improving cost-effectiveness once medicines are off-patent, for example, strategies to encourage generic prescribing and price disclosure to reduce reimbursement rates.

Australian Commission on Safety and Quality in Health Care (ACSQHC)

The ACSQHC is jointly funded by all Australian governments and its work is developed by state and territory Health Ministers.¹⁷ Its role is to work with health system stakeholders “to achieve a sustainable, safe and high-quality health system”.¹⁷

It has developed the Atlas of Healthcare Variation and has put forward recommendations to tackle unwarranted variation in healthcare across Australia.²⁹ The ACSQHC recognises overuse of low-value care and underuse of high-value as factors in the variation of care across Australia and is now supporting the development of Clinical Care Standards.³⁰ Each standard is designed using the best evidence to help patients understand the care they should expect, regardless of where in Australia they are located, and to guide health professionals to provide high-value care.^{30,31}

The ACSQHC is also undertaking work on the use of patient-reported outcome measures (PROMs) as a more comprehensive and patient-centric method of assessing the quality of healthcare.³² As well as work on use of PROMs, as part of their joint working party with the Independent Hospital Pricing Authority (IHPA), the ACSQHC has undertaken comprehensive reviews of the literature on incorporating safety and quality measures into payment systems.^{33,34}

Medicare Benefits Schedule Review

The MBS Review is an ambitious undertaking, designed “to align MBS funded services with contemporary clinical evidence and improve health outcomes for patients.”³⁵ The terms of reference are wide-reaching, and if successful, will generate some improvements in the efficiency of healthcare delivery in Australia.

Various clinical committees and working groups exist within the MBS Review and its success will depend on the ability of the groups to identify low-value items and achieve effective policy action in disinvestment. To date, only those MBS items considered obsolete have been removed.³⁶ While this is an important step, it will not reduce waste in a meaningful way (i.e. it will not free up any resources) as the very nature of obsolescence means disinvestment has already occurred. The MBS Review presents an opportunity to go beyond ‘tinkering at the edges’ and make meaningful and lasting change to Australia’s healthcare

system. Success will be evidenced by the implementation of major recommendations, some of which have already been made.³⁷

Providing recommendations for a process of ongoing review has been included in the MBS Review Taskforce terms of reference.⁸ Embedding an ongoing process is essential to ensure continuous review of existing services. It is encouraging that the Commonwealth Government has committed funding for the MBS Review for a further 3 years, in the 2017-18 budget,³⁸ however it is important that the process be continued indefinitely.

Choosing Wisely Australia and Evolve campaigns

Choosing Wisely Australia is led by NPS Medicine Wise, an Australian government funded body, and is designed to enhance the conversation on reducing and eliminating low-value tests, treatments and procedures.¹⁰ It has a particular focus on improving patient-clinician communication and shared decision-making.¹⁰ Many of Australia's peak colleges, societies and professional associations have developed lists of healthcare practices and services to empower providers and consumers to question their use. The Royal Australasian College of Physicians (RACP) has set up its own Evolve campaign, with similar goals and outcomes to Choosing Wisely.¹⁵

These initiatives address important priorities for disinvestment, including active engagement of the public, clinicians, professional organisations and health service providers. However, evidence of their direct effectiveness in changing practice is mixed. Research from the USA Choosing Wisely campaign shows little change in the use of selected low-value services, suggesting that additional implementation strategies are needed for such initiatives to drive changes in practice.³⁹ Nevertheless, these campaigns are useful in raising awareness, an important step in achieving changes to practice and to engage patients and the public in the conversation. Evidence from surveys regarding the Australian campaign shows that members of the public who are aware of Choosing Wisely are more aware of the risks associated with unnecessary tests and treatments than the general population.⁴⁰ When asked if they "[a]gree that having a medical test when not needed can be harmful", 53% of consumers surveyed who knew about Choosing Wisely did agree, compared with only 33% of the general population.⁴⁰

International approaches

Disinvestment activities, including reviews of products and services, vary internationally. For example, when assessing funding for medicines, the approach in Canada is to identify candidates for disinvestment on an ad hoc basis, while in France, a systematic reassessment is undertaken on publicly funded pharmaceuticals five years after they are first listed.⁴¹

The National Institute for Health and Care Excellence (NICE), responsible for clinical guidance and recommendations to the National Health Service (NHS) in England⁴² is widely recognised as a world leader in its field.^{43,44} The NHS constitution requires that certain NICE recommendations be funded within three months of the recommendation being

published.⁴⁵ This helps to remove politics from the implementation of NICE recommendations. For other recommendations, implementation and adoption support is provided. As part of its work NICE also monitors and publishes the uptake of its guidance online.⁴⁶

Development of NICE guidelines includes wide involvement and consultation. Committees for the development of NICE guidelines are multidisciplinary and include clinicians or service providers as well as at least two members of the public, for example those who are using services or lay members with some experience of the services in question.⁴⁷ Registered stakeholders are also able to contribute to guideline development.⁴⁷

NICE guidance is frequently reviewed and changes are documented.⁴⁷ Guidelines and updates specify inappropriate treatments and/or conditions to be met before certain interventions are carried out. NICE also maintains a list of 'do not do' activities under their Savings and Productivity collection.⁴⁸ Unlike for recommendations to fund a new service, there is no legal requirement to discontinue doing activities on the 'do not do' list. However, many local NHS services have taken active steps to promote disinvestment or remove funding from 'do not do' activities.^{49,50} The requirement to fund additional services within three months of certain NICE recommendations potentially acts as a driver to free up resources through disinvestment from low-value 'do not do' activities.

The effect of healthcare funding on disinvestment

Financial incentives are major drivers of behaviour, and healthcare provision is not immune to this. In Australia, outside of public hospitals, the health system operates on largely a fee-for-service payment basis, rewarding providers for each procedure or service delivered, in most cases, regardless of outcome. Clinicians are generally intrinsically motivated to improve patient care; studies have shown that clinicians' major motivation for taking part in paid quality improvement programs is patient improvement,⁵¹ however our current reimbursement systems do little to reward this. The unintended consequence of our fee-for-service funding arrangements is that providers have a strong financial incentive to provide a high volume of services, but limited financial incentive to provide high-value care.^{2,52} In their Conversation post, Hall et al.⁵³ outline some of the major issues facing the MBS Review, highlighting that incentives must be aligned, "making efficient choices easy choices for health service providers."

The Council of Australian Governments (COAG) has made a commitment to investigating options to reduce use of low-value healthcare, through funding mechanisms which take into account the quality and safety of hospital care.⁵⁴ On Ministerial Direction, the Independent Hospital Pricing Authority (IHPA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) are implementing changes to reimbursement aimed at removing payment for separations associated with sentinel events and imposing penalties or reducing payment for avoidable readmissions.⁵⁵ These are important steps, but do not extend beyond distinct avoidable safety-related events.

In addition to their work on sentinel events and rehospitalisations, the ACSQHC has conducted a comprehensive literature review on hospital funding mechanisms which integrate safety and quality of care.^{33,34} They have also undertaken a review of the literature on patient reported outcome measures (PROMs).³² The next steps should therefore be to implement strategies based on the conclusions and learnings from this research, both for hospital and MBS funded care.

Compounding problems with incentives for providers, is the fragmented funding arrangement for health services in Australia. While the majority of funding for health services comes from Commonwealth, state and territory governments, their respective health departments have competing priorities due to the division of responsibilities.⁵⁶ This can cause problems for implementing policies based on economic evidence, because there may be a reluctance to make changes when savings will not be realised in the same budget as proposed new expenditures.⁵⁷⁻⁵⁹ These divisions also mean there is often no incentive within funding mechanisms for continuity of care.

The Commonwealth government's contribution to private healthcare through private health insurance premium rebates further complicates matters by creating a shared responsibility for private healthcare. The Commonwealth private health insurance rebate amounts to more than \$6 billion annually.⁶⁰ This is not an insignificant amount and demonstrates the importance of the obligation of governments to regulate private health insurance products to discontinue coverage of low-value care.

The complexities of a fragmented funding system are largely avoided in countries with a single payer, such as the NHS in the United Kingdom. While an ideal situation would be a healthcare system with the ability to follow patients throughout their healthcare journey, rewarding providers for health outcomes, this is not a short-term possibility in Australia due to a broad range of factors. Acknowledging this, some groups within Australia have moved to undertake joint commissioning for some services, across state and federal funding boundaries. In Queensland, joint commissioning for mental health services is being investigated, with the view of avoiding duplication of effort and delivering better integrated care and improved outcomes for patients.⁶¹ In addition to this work, to complement integrated services, other groups are working on data integration possibilities.^{62,63} This demonstrates that governments are moving towards a focus on health outcomes as opposed to outputs.

Using data to improve healthcare

Some groups have suggested that the current state of data fragmentation in the Australian healthcare system means that we are 'flying blind'.⁶⁴ In July 2016, the Australian Digital Health Agency commenced operation as the government body tasked with producing a national digital health strategy.⁶⁵ Australia's National Digital Health Strategy was released in August 2017 after wide consultation, with involvement from consumers to healthcare providers and industry, about the future of digital health.^{66,67} The consultations showed that

Australians are supportive of greater use and sharing of health data to improve care and health outcomes, and to enable consumers to identify the cost, quality and availability of health services.^{68,69} The COAG Health Council approved the Strategy in August 2017.⁷⁰

The National Digital Health Strategy marks the way forward for the use of digital health information to improve the health of Australians and increase innovation in the field.⁶⁷ It outlines how data interoperability and sharing will be improved and used to reduce avoidable hospital admissions, medication errors and adverse events; all costly to the health budget and to the health of Australians.⁶⁷ However, while acknowledging that improved data analytics will contribute to improved outcomes for patients, there are few details about how this might be achieved more generally or how such improvements might be measured.

The strategy also recognises that Australian governments want greater focus on preventive healthcare and maintenance of wellbeing; essential for reducing avoidable use of expensive hospital care.⁶⁷ Bold statements are made about how the My Health Record will improve medication adherence through digital prescriptions (resulting in reduced disease progression) and allow better clinician-patient communication and health management through access to high-quality health information.⁶⁷ While in theory improved communication and medication adherence should lead to improved health outcomes, there is no detail about how this will be measured or how evidence will be generated of what works and what does not.

As part of this initiative, work on the National Minimum Data Set for primary care should be expedited, particularly since the discontinuation of funding for the BEACH program.^{71,72} Now is the opportune time to carry out this work, to piggyback on current efforts in this sphere. However, to be able to assess the effect of improvements in accessibility of health data, those same data sets should include quality of life information in the form of patient-reported outcome measures (PROMs). Capture of outcomes data, extending beyond traditional clinical markers of disease, is essential in the drive towards consumer-centric care, acknowledging that measures of quality should include the consumer's perspective.

Australian health services currently do not routinely collect PROMs data from patients⁷³ and yet they provide important information about the value of health services to patients. Including the capture of quality of life data from patients in a way which allows outcomes to be linked to treatments and services patients receive will provide valuable information for researchers assessing the cost-effectiveness of different services and interventions. In turn cost-effectiveness evidence based on quality of life data provides a rich source of information for those making resource allocation decisions designed to get the best health outcomes for their communities.

Private health insurers are another important source of information about value in healthcare. They collect and have access to large data sets related to their members' use of services, and are in a position to be able to follow members relatively easily over time,

which may provide insights into the quality of services members receive. Being partially funded through the Commonwealth rebate, private health insurers should be encouraged to use the data they collect to assess the value of services they fund, and to publish findings.

With increased focus on patient choices and shared decision-making, it is important that information about the quality and cost of healthcare services be made publicly available. A Queensland Government discussion paper outlines many of the pros and cons of public reporting in healthcare.⁷⁴ Possible effects of mandatory reporting include perversely incentivising providers to take only low-risk patients for fear of appearing to perform poorly if outcomes are not properly risk-adjusted, or to focus efforts on services being monitored to the detriment of other areas.⁷⁴ However, the discussion paper also notes that there is evidence that public reporting of performance data can alone act as a motivator for quality improvement activities in individual hospitals, due to concerns about reputation.⁷⁴ Other researchers have also found evidence that providing audit and feedback to healthcare providers is effective in changing practices in healthcare, and that public reporting can drive improvements in the quality of care.^{75,76} Performance indicators can also act as a tool for health service decision-making where room for performance improvement is highlighted.⁷⁴ Therefore it is likely that many of the potential problems related to public reporting of health service performance data are largely outweighed by the benefits of good public reporting and can be minimised if monitoring and reporting are well thought out.

In addition to ensuring performance indicators are appropriate for driving improvements in performance and service output for providers, public reporting needs to be useful for consumers. Publicly-reported health service performance data should enable consumers to choose high-quality services and providers. While there is some publicly available information on the My Hospitals website about the performance of public hospitals and some private hospitals who voluntarily contribute, it only reports on bloodstream infections, hand hygiene, waiting times, lengths of stay and some costing measures.⁷⁷ These are important measures of patient safety and quality of care, but they are of limited use for patients wanting to make informed choices about the quality of care they can expect to receive. Other patient feedback websites exist, such as Whitecoat and Patient Opinion, but again these do not provide consistent information about the quality of care and outcomes across all providers.^{78,79} Probably the most useful reporting website is the Healthcare Observer, run by the Bureau of Health Information in NSW.⁸⁰ It provides interactive data about public hospital performance across a number of different measures, including health outcomes, but again it is difficult to navigate, partly due to the quantity of information it tries to display.⁸⁰ The summary version of these data, the local hospital performance page, presents the data more clearly, but does not include health outcomes.⁸¹ Patients need better and more relevant information that is published in an accessible and meaningful way to enable them to make better healthcare decisions.

As we improve use and sharing of health data in Australia, there are many opportunities not to be missed that will help to drive improvements in health services and enhance consumer choice and empowerment. Alongside allowing patients to better assess and choose the care

they receive, collection, sharing and reporting of patient-relevant quality and cost of care data will help drive disinvestment independently. Reporting on health outcomes should be included as part of our national health data collections (for example, by the Australian Institute for Health and Welfare). This is a critical aspect in the enhanced use and sharing of health data in Australia, which if done well, will contribute greatly to our ability to identify and disinvest from low-value care.

Recommendations for disinvestment in Australia

The following section outlines the key recommendations critical to successful and sustained disinvestment in low-value care in Australia.

Recommendation 1. Improving the disinvestment potential of MSAC and PBAC

The current health technology assessment systems in Australia have a good international reputation.⁴⁴ As a result of the work of MSAC and PBAC, investment in new health products and services in Australia is subject to thorough economic evaluation. However, we are currently 'stuck with the old and overwhelmed with the new', because their scope does not extend to formal ongoing review of treatments and services once listed.³ Both committees only meet three times per year and the process for implementing funding for recommended new services can be slow.

Two recommendations therefore follow:

- 1) Expand the scope of MSAC and PBAC to include formal ongoing review of currently listed items, in addition to evaluating new items.
- 2) Improve implementation processes for recommendations – both to invest and to disinvest.

It is recommended that the functions of MSAC and the PBAC be expanded to allow more rapid changes to be made on the basis of their recommendations. This must include a system of ongoing evaluation of healthcare products and services, aimed at the iterative removal of items when they are superseded by higher-value options or technologies, or indeed if new evidence shows that a service is low-value. This will involve both concurrent assessment of associated services, when new service is evaluated, and ongoing review of items over time. The current MBS Review terms of reference foresees the relevance of such ongoing review and it is recommended that this is prioritised to ensure the efforts of the current review continue.⁸

The Productivity Commission and other groups have previously highlighted the importance of more efficient disinvestment from low-value care, alongside assessment of new services.^{3,44} The current MSAC and PBAC processes take more than six months, not including the time for a recommendation to be implemented by the Minister for Health. While it is important that evaluations be carried out thoroughly, in a time of rapidly-changing technology it is important that changes can be implemented quickly. The NHS currently

operates on a three month implementation timeline, meaning NICE recommendations must be funded within that time.⁴⁵ If Australia is to keep up with advances in medical technology, rather than waiting for a budget cycle, a similar timeframe for implementation of recommendations is essential.

The same should apply to disinvestment; where there is a positive recommendation to fund a new service, which supersedes an existing service in cost-effectiveness or safety, delisting should occur concurrently. It is acknowledged that disinvestment is more challenging and so a longer timeframe for disinvestment is appropriate to allow patients and providers to adjust. This would take Australia a step beyond NICE's 'do not do' list and expedite processes of investment in high-value and disinvestment from low-value products and services.

To improve transparency of decision-making processes, greater consumer involvement in MSAC and PBAC functions is also recommended. Currently, their processes are not easily accessible to the average consumer and greater involvement would help to reassure the public that disinvestment is not simply an exercise in cost-cutting.

Recommendation 2. Collection of health outcomes data

The World Economic Forum has identified the systematic measurement of health outcomes relevant to patients as a key factor in achieving value in healthcare.⁸² Patient reported outcome measures related to quality of life are essential if we want to be able to fully assess the value of health services in Australia. Such data are also needed to provide audit and feedback to health providers about their performance and to report outcomes to the public. Similarly, data can feed into resources designed to enable patients to make better-informed decisions about their healthcare.

It is therefore recommended that development, collection and sharing of patient relevant outcomes, including health-related quality of life data, be prioritised. Quality of life outcomes data will strengthen our ability to fully assess the value of different healthcare services, will allow improved reporting and feedback to healthcare providers, and reporting will assist patients in making good healthcare choices.

Recommendation 3. Data sharing and reporting to support disinvestment

Carefully thought-out public reporting of health outcomes will help to drive disinvestment from low-value care in Australia. Additionally, there is evidence that audit, feedback and reporting independently help to drive improvements from providers.^{75,76} Reporting will help providers to assess the value of the different services they provide and compare their performance against their peers.

The Australian Institute of Health and Welfare should be charged with reporting on the data collected alongside their other reporting on the health and wellbeing of Australians. Data and reports should also be fed back to bodies such as MSAC and the PBAC for their updated and ongoing analyses of the value of publicly-funded healthcare products and services.

Recommendation 4. Better information for consumer decision-making

Consumer buy-in is a critical part of disinvestment and therefore needs to be addressed carefully. Current platforms for patient choice do not provide information in a way that enables patients to make informed decisions about the care they receive. Performance metrics are often related to safety, which is important, but not the only factor affecting patient outcomes.

Patient reported health-related outcomes data are key to helping patients make informed decisions. It is important that patient reported metrics focus on health outcomes, rather than satisfaction in more general terms, which may inadvertently create a focus on “hotel-like” qualities of services. Such metrics do not assist patients in choosing a service that will improve their health. Similarly, safety and quality measures such as infection rates and waiting times, while important and easier to measure, tend to provide information about the likelihood of things not going to plan. They do not provide insight into expected health improvement when things do go to plan and yet this is vital for consumers wanting to make informed decisions about their care.

Therefore, it is recommended that health-related quality of life data feed into reporting systems designed to aid consumer choice. This should build on the efforts of Choosing Wisely Australia and other consumer empowerment initiatives to improve health literacy, helping patients better understand the choices available to them.

Recommendation 5. Private health insurers should promote use of high-value care only

The Commonwealth currently contributes \$6 billion annually to private health insurance in the form of rebates.⁶⁰ That contribution should come with a responsibility to spend it wisely and health insurers can play a role in ensuring their customers receive high-value care, wherever possible. Private health insurers should be involved in driving disinvestment, through promotion of and in investment in high-value care.

Restrictions should exist to stop the promotion of cover that reimburses low-value care, such as homeopathy and other non-evidence-based treatments. Such promotions do nothing to improve public health literacy and are likely to result in wasted health resources that could otherwise be invested in high-value, evidence-based care. It is well-known that patients respond to price signals and therefore reducing the price of services (in this case by inclusion in a health insurance policy) will affect demand for them.^{2,83,84}

On the other hand, private health insurance funds collect large amounts of data, providing them with the potential to assess the value and effectiveness of care they fund. Insurers should play an active role in ensuring that disinvestment in low-value care occurs in the private health sector, particularly with such a large contribution from the Commonwealth. However, it is important to ensure the public understands that such involvement is not purely an exercise in cost-cutting.

It is therefore recommended that private health insurers use the data they collect to evaluate the services they fund and publicly report on the value of services assessed. This will add to the information available to consumers contributing, alongside other efforts to publish content on the value of healthcare services, to their ability to make good healthcare choices.

Recommendation 6. Outcomes based funding

In order to promote the provision of high-value care, over low-value alternatives, providers need to be reimbursed for the **quality** of outcomes, not only the **quantity** of outputs. Financial incentives are important drivers of any activity, including healthcare. Linking reimbursement rates to health outcomes will aid in incentivising uptake of high-value care and improve disinvestment in low-value care.⁴

Therefore it is recommended that funding for care provided under the MBS be aligned to the health outcomes achieved through payment mechanisms and incentives that focus on health outcomes, not just activity. The MBS Review Taskforce sees aligning of funding with value (in health outcomes) as an important factor, however, it does not fall directly within the scope of its terms of reference.⁸ This could be done with reference to the conclusions drawn from the work the ASCQHC on funding mechanisms and PROMs.³²⁻³⁴

This has the potential to drive both provider and patient behaviour through price signals. However, this will only be achievable alongside the collection of health outcomes data from patients receiving healthcare services.

Conclusions

The recommendations made in this Issues Brief are not easy fixes, but will require ongoing commitment and work as healthcare continues to evolve. Ever-increasing strain on health budgets means this work is essential if Australia wants to continue to have a world-class healthcare system. We need to adapt to advances in practice, so that we are no longer 'stuck with the old and overwhelmed by the new.'³

Because it is a sensitive topic, wide stakeholder buy-in and involvement will be essential to ensure the community understands that disinvestment is not an exercise in cost-cutting, but is aimed at providing Australians with the highest-value care possible. There is a role for all health system stakeholders in ensuring high-value care is promoted and use of low-value care is discouraged. Patients and consumers should be encouraged to share in healthcare decision-making and play an active role in their care choices.

The roles of MSAC and PBAC need to be expanded to allow ongoing review of publicly-funded healthcare products and services. This should continue and build on the work being undertaken by the MBS Review Taskforce, at the conclusion of its current review. This is necessary to ensure that as new technology or services are assessed and funded, superseded services can be actively de-funded.

It is also imperative that the process for implementation of recommendations be made more efficient. The current process takes far too long for a rapidly-changing environment. Processes need to be in place to delist and disinvest at the same time as investments in new services or products are being made. To contain growth in health budgets, new investments need to be countered with disinvestment from low-value care. Including wide consultation in processes and transparency in analyses will help to instil public confidence in decisions and when changes are being made.

In addition to reviewing and actively removing superseded services, funding needs to be aligned to health outcomes. This will require routine capture of outcomes data to feed into funding assessment and review processes. Greater audit, feedback and reporting of outcomes will help providers track their improvements in care provision over time and benchmark themselves against others. It will also provide useful information to assist patients in choosing high-value care and quality providers.

Ultimately, continued strong leadership from the Commonwealth and state and territory governments and close partnership with clinicians and consumers will be essential to drive disinvestment in low-value care. The ongoing cooperation of all stakeholders is needed to hold the healthcare system accountable for providing high-value care and achieving the best possible health outcomes for Australians.

Key readings

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Elshaug AG, Rosenthal MB, Lavis JN, et al. Levers for addressing medical underuse and overuse: achieving high-value health care. The Lancet. 2017.

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