White Paper

Transitioning to Value-Based Healthcare: A Closer Look at Australia's Progress

BROOKE IPSEN, Consultant, Management Consulting, IQVIA
JACK SHEPPARD, Associate Principal, Management Consulting, IQVIA

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Executive Summary

Australia's high-performing healthcare system faces systemic pressures that threaten its sustainability. Healthcare expenditure is anticipated to increase from 4.1% of GDP in 2022-23 to 10.5% by 2062-63. An ageing population and rising life expectancy have led to a greater prevalence of complex health conditions and chronic diseases. Furthermore, the adoption and funding of a range of novel therapies (e.g. gene therapies, CAR T-cell therapies) and advanced diagnostic technologies is placing an increasing pressure on healthcare expenditure. Persistent health disparities remain within Australia, with the burden predominantly felt among socioeconomically disadvantaged individuals, First Nations peoples and rural communities.

Healthcare systems worldwide are undergoing a significant transformation toward value-based healthcare (VBHC), a concept which proposes care providers be paid based on health outcomes rather than models derived by how much activity (or care services) carers can provide.

This paradigm shift represents a departure from traditional management and funding models, emphasising patient outcomes, cost-effectiveness, and holistic care. Similarly, Australia has been gradually integrating elements of VBHC with the objective of improving the provision of care, lowering healthcare costs, and improving provider and patient satisfaction. However, this has been a stepwise process rather than a concerted, national level effort. This shift aligns with the broader healthcare aims of Australia which are focused on delivering more care in the community, shifting to preventive healthcare, and reducing system fragmentation by strengthening coordination and collaboration between primary care and hospital sectors, health providers and funders.

IQVIA, in its latest White Paper, delves into the purpose of VBHC, provides an overview of Australia's progress in this domain and shares examples of implementation barriers and recent initiatives. Specifically, the paper evaluates three **VBHC critical drivers** where Australia has experienced varying degrees of progress.

1. Integrated and patient-focused care

2. Defining and measuring value

3. VBHC funding mechanisms

1. Integrated and patient-focused care

Key strides have been taken to advance integrated and patient-focused care in Australia. The approach has primarily consisted of designing integrated models of care, typically at a state or regional level, to breakdown disciplinary and primary/tertiary care silos. Efforts have been spearheaded by New South Wales (NSW) and tend to focus on patients with complex or long-term care needs that will benefit the most from coordinated care delivery. Current models implemented across Australia operate within existing institutional structures and are dependent on temporary funding. As such, they face challenges including misaligned incentives with traditional funding models and barriers in information sharing between acute and primary services. Addressing these issues is necessary to advance integrated care in Australia.

2. Defining and measuring value in healthcare

Australia has begun to capture and measure health outcomes that are of value to patients, mainly through efforts to expand the use of Patient-Reported Measures (PRMs). However, the adoption of these measures is inconsistent across states, healthcare settings, and patient indications, with more frequent applications observed in acute care settings. Additionally, appraising value in healthcare requires the development of health data infrastructure that incorporates connected and interoperable electronic health records (EHR) and disease registries, and has the ability to link costing data to patient outcomes, which remains an unmet need for VBHC. Notable initiatives in interoperability of EHRs have been made by My Health Records and the NSW state-wide data linkage project Lumos. Another example is the use of the POLAR software which has improved GP practice data quality and ease of data extraction across Primary Health Networks (PHNs) in Victoria (VIC) and NSW. Despite these efforts, achieving a system that fully supports true interoperability still requires considerable progress.

3. VBHC funding mechanisms

Among the three drivers discussed in this paper, value-based funding models are where Australia has the least experience. Nonetheless, there is an appetite for reforming healthcare financing as the prevalent healthcare funding models in Australia such as fee-for-service/activity based funding incentivise a high volume of services or service efficiency rather than explicitly promoting higher value. Efforts to align provider incentives with VBHC in Australia include initiatives that enhance the efficient utilisation of resources by reducing 'low-value' interventions and small scale pilot programs experimenting with funding models closely aligned with VBHC (i.e. providers are rewarded for improving health outcomes). Although value-based funding is crucial for advancing healthcare in Australia, current endeavours to implement these models are limited in scale and conservative.

Australia's journey toward VBHC is a dynamic process, and this paper examines achievements and areas for further development. By embracing VBHC, Australian healthcare can become more sustainable and patient-centric.

Figure 1: Summary of VBHC drivers assessed in this paper and evidence of advancements in Australia

	Definition	Evidence of progress in Australia
Integrated and patient-focused care	The delivery of seamless, effective, and efficient services that are tailored to and structured around an individual's health and social requirements	• Integrated care present in key policies, frameworks and plans at a national and state level • Generated experience through implementation of specific integrated models of care
Defining and measuring value in healthcare	Our ability to assess value based on health outcomes and costs to improve high-value care delivery	• Increased use and support for uptake of patient-reported measures (PRMs) • Strides to increase information sharing between providers
Value-based funding mechanisms	Evolving funding models beyond traditional fee structures to incentive the delivery of high 'value' care	• Slowly developing experience with pay-for-performance funding models through pilot programs • Appetite and 'push' for further value-based payment models seen in NHRA Mid-term Review

An overview of Australia's healthcare system and contextualising the shift to value-based healthcare

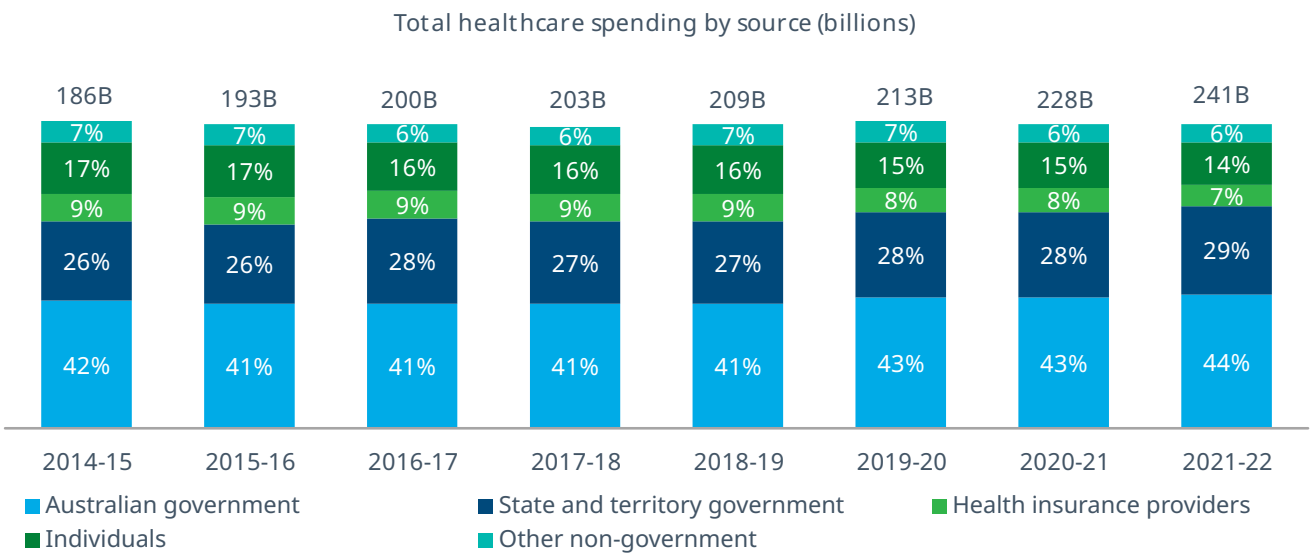
Australia has a high-performing healthcare system that, like other international healthcare systems, is grappling with numerous systemic pressures. It is anticipated that the nation's healthcare expenditure will rise from 4.2% of GDP in 2022-23 to 10.5% of GDP by 2062-63.[1] Australia's population is ageing with a rising life expectancy, which is leading to a greater prevalence of complex health conditions and chronic diseases such as Chronic Obstruction Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). This has resulted in a heightened demand for higher quality, accessible and long-term health services.[1] Acute services are also strained by workforce shortages and population growth, as well as an increased rate and complexity of cases. It has been projected that there will be a six-fold increase in total healthcare expenditure for individuals aged over 65 within the next three decades.[1] Moreover, the healthcare sector continues to evolve with the introduction of a range of new cell and gene therapies and advanced diagnostic technologies. The adoption and funding of such novel therapies coupled with our ageing population will heavily impact health expenditure and will increasingly become a challenge in Australia and around the world.

Australia's healthcare system is seen as fragmented, with sub-par coordination between service provision and funding due to the complex division of responsibilities among the Commonwealth, state governments, and the non-profit and private sectors.[2] The total amount of healthcare spend varies widely between these groups, as outlined by the Australian Institute of Health and Welfare (AIHW) (Figure.1), with Commonwealth and states bearing the majority of the costs and health insurance providers and non-government bodies spending the least.

In more recent years, the federal government has taken strides to transition from reactive hospital-based care to proactive community-based disease prevention and strengthen coordination and collaboration between the primary care and hospital sectors, and between health providers and funders. However, as per the National Health Reform Agreement (NHRA) Mid-term Review, current efforts 'fell short' in supporting intersectoral collaboration and enabling integrated patient care.

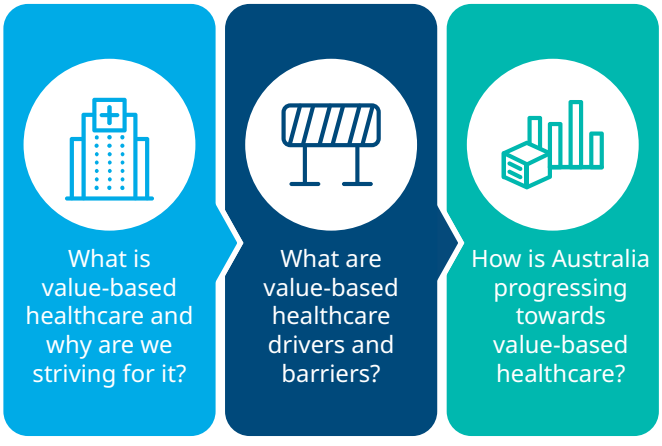
Moreover, there are persistent health outcome disparities, with a disproportionate burden on socioeconomically disadvantaged individuals and First Nations communities, as well as notable health disparities between rural and urban areas.[3]

Figure. 2: Total healthcare spending over time by funding source (AIHW)



Overview of value-based healthcare

Due to the challenges facing healthcare, systems globally are transitioning, at varying speeds, towards value-based healthcare. In this publication, we will provide an overview of VBHC, a view of key implementation drivers and hurdles, and then determine how Australia has progressed in adopting VBHC features in the context of 3 key drivers. **Below are the key questions this paper will address.**



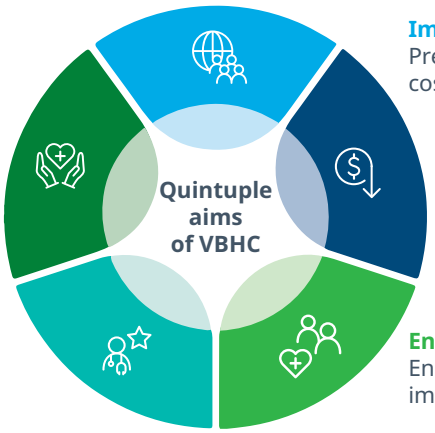
Value-based healthcare is a concept which proposes that care providers should be paid based on health outcomes, rather than models derived by how much activity (or care services) carers can provide.

VBHC was popularised by Michael Porter and Elizabeth Teisberg circa 2008, who coined the value equation (value = quality/cost) and has since taken hold within healthcare circles as an agreed-upon ideal that healthcare providers and systems can strive for. As opposed to fee-for-service approaches, value-based healthcare measures health outcomes that matter to patients against the cost of delivering the outcomes. Therefore, cost reduction occurs within the broader aim of delivering high value care and eliminating low value care.[4] Such models shift financial risk towards providers and incentivise the provision of high value care.

Inextricably tied to value-based healthcare are the core aims it is meant to facilitate, namely improving health outcomes that matter to patients, experiences of receiving care, experiences of providing care and effectiveness and the efficiency of care (Figure.2). More recently, **health equity** is also suggested as a key component to achieve improved care.

The ability to focus on patient outcomes, whilst generating cost savings and incentivising prevention and wellness is at the core of value-based care. Additionally, using data-driven decision making and improving coordination of care will allow for more customised and personalised care while also increasing transparency and accountability.

Figure 3: Quintuple aims of VBHC



Improving population health
Preventing and managing prevalent, costly and chronic diseases

Reducing cost of care
Reducing resource utilisation and readmission rates

Enhancing patient experience
Engage patients to play an active role in care to improve clinical outcomes and safety

Improving provider satisfaction
Access to tools and resources to address provider burden

Equity of health
Fair and just opportunity for all to attain optimal health

Key drivers of VBHC implementation and their barriers

Some of the most important drivers of VBHC implementation are explored below — these include prevention and early intervention, patient empowerment, stakeholder collaboration to allow integrated & coordinated care, and the definition and measurement of value and value-based funding.

These are non-exhaustive and we do not delve into the detailed aspects of implementation strategies and tools such as health information technology and the interoperability of solutions.

In addition, while the benefits of VBHC are often touted, it is important to note that due to the scale of the changes required, many barriers to implementation might arise. We explore some of these in this section also.

One key driver of VBHC models is to develop clinical care pathways or models of care focusing on **prevention and early intervention**, for a specific group of individuals that meet distinct, ideally measurable, clinical criteria. Often the therapy areas chosen for such programs are chronic as changes can be implemented before the patient worsens. This includes conditions such as COPD, CHF as well as obesity and mental health, although measurable outcomes are harder to quantify in the latter two. Identifying patients that are at the highest risk and most likely to benefit from care is also key. For this, having access to high quality data, ideally at different levels of granularity, is essential and ultimately allows effective tracking ofcohorts and evaluation of program outcomes.

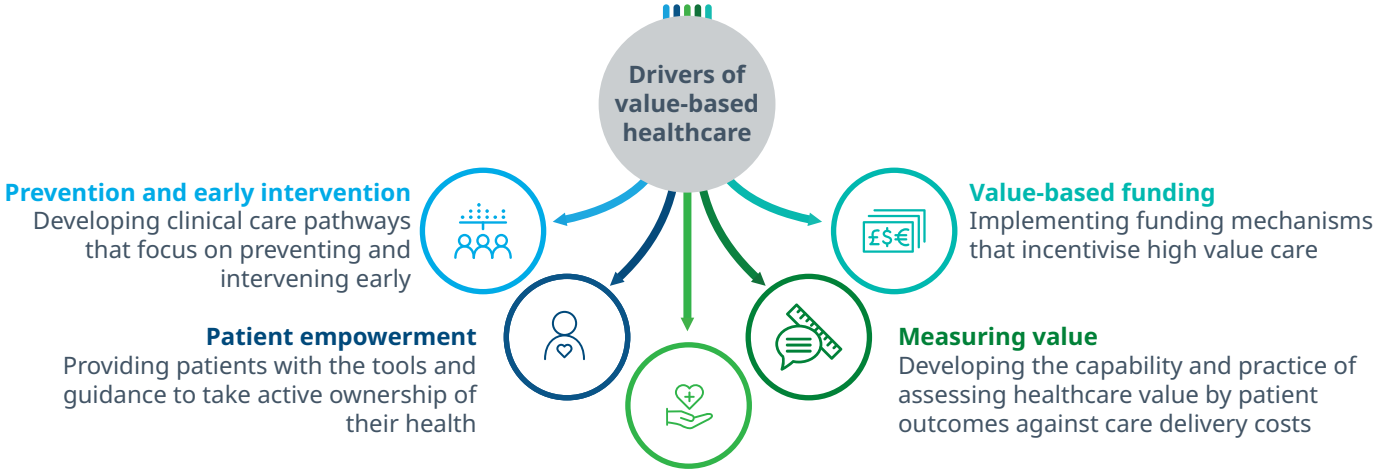
Linked to the development of new care pathways or models of care is **patient empowerment**. Within individual programs or as part of ad hoc GP touchpoints (pre or post discharge), providing patients with practical tools to take an active role in their care can help them recover from illness and injury faster and prevent future illnesses. This is especially important for chronic diseases such as heart disease, stroke, kidney disease, or lung disease where early action and prevention are strong indicators of long term patient health. Increasing patient literacy is also important as it allows patients to feel engaged and in charge of their care.

Collaboration between stakeholders is key to allow for the provision of **integrated and coordinated care**, including primary healthcare providers, acute and sub-acute healthcare providers, and post-acute community and aged care. Integrated and coordinated care aims to overcome fragmentation in care delivery and provide seamless care across a patient's journey. Further, it aims to address the individual experiences of care delivery and provide easy to navigate patient pathways. The greatest benefit has been seen in models of care developed for patients with complex or long-term care needs. Practically, this requires a greater capacity for information sharing and communication between acute and primary care settings as well as a multidisciplinary approach to care.

Next is the question of **how to measure value effectively**. To facilitate the VBHC transition, patient performance metrics and data need to be developed and analysed in a concerted fashion. This may be challenging partly due to disagreement as to what constitutes a favourable outcome, but also because of the plethora of health care technology providers and the lack a unified platform used across stakeholders along with interoperability issues. The choice of outcome to monitor might vary substantially across cohorts in an indication but also across indications and therefore requires careful attention. There is also debate as to whether the patient experience (linked to patient satisfaction) should be used as a measure value, as it may not directly link to medical outcomes. Once again, close coordination and collaboration is needed to develop tailored pilot programs as a proof of concept and ensure metrics allow relevant patient outcomes to be tracked, including patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs).

Finally, a crucial driver of a VBHC system is the implementation of **funding mechanisms** that disincentivise care that is not cost-effective, support the delivery of integrated care pathways, and encourage the provision of high-value healthcare. Value-based healthcare payment models incentivise the integration of care across primary and hospital care, and often transfer a portion of the financial risk associated with service delivery from the funders to the providers.

Multiple funding approaches and models have been developed based on VBHC principles to varying degree. Such models include bundled payments (covering end-to-end procedures, rather than paying for each intervention) and outcomes-based funding (linked to the quality of care and patient outcomes e.g. pay for performance). In most bundled payment and capitation models, providers assume a share of the financial risk related to the complexity of services and the heterogeneity of the patients, similar to activity-based funding (ABF).



Are there any limitations to value-based healthcare?

While broadly referred to and accepted within healthcare circles, some question why the value-based healthcare concept is used almost dogmatically, and posit that it may oversimplify what modern healthcare should strive for. There might also be unintended consequences that stem from trying to implement VBHC. For instance, there might be a push to focus on somewhat healthier patients or easier to treat indications to showcase successful outcomes for relevant programs. This might lead to more complex, high-cost patients to be neglected or deprioritised. Another argument is that better care may actually be provided within hospitals, and by shortening hospital stays, patients may end up receiving suboptimal care and feeling concerned or rushed.

Evaluation of Australia's value-based healthcare efforts against select drivers

Australia, cognisant of global trends, is seeking to transition to a value-based healthcare system with the objective of improving the provision of care, lowering healthcare costs and improving provider and patient satisfaction.

Currently, Australia lacks a national level strategic framework for VBHC. However, VBHC objectives are present within various national policies, strategic frameworks and agreements including the Addendum to the NHRA 2020-25 and Australia's Primary Health Care 10 Year Plan 2022.[5] At the state-level, there exist varying degrees of VBHC policy and implementation.

IQVIA has selected three internationally recognised VBHC drivers to evaluate Australia's progress towards value-based care. Our paper will provide an initial assessment of Australia's healthcare system against these three drivers: **a) Integrated and patient focused care; b) Defining and measuring value in relation to health outcomes and costs** and **c) Funding mechanisms to incentivise improved patient outcomes.**

Integrated and patient-focused care

The provision of patient-centred care and integrated approaches to care are fundamental components of VBHC. Shifting from the provision of fractured, difficult to navigate care towards co-ordinated team-based care pathways under a VBHC framework is evidenced to produce efficiencies, reduce duplication, and improve patient outcomes.[6]

Significant steps have been taken to advance this in Australia, where the approach has primarily consisted of designing integrated models of care at a state or regional level, to breakdown disciplinary and primary/tertiary care silos. The Addendum to the NHRA 2020-2025 showcases the commitment of states and territories to provide stronger incentives for local health organisations, particularly PHNs, to coordinate care, pool funding and integrate health services. It also encourages collaboration when planning health services and making investment decisions. It promotes engagement and collaboration between PHNs and local acute health services, identifying joint planning as a strategic priority.[2] However, it is important to note that the NHRA primarily delivers funding through ABF, which focuses on inpatient settings rather than supporting coordinated and integrated care across various health settings.

NSW has demonstrated leadership in implementing integrated care in Australia. One advanced initiative in NSW is Collaborative Commissioning, which overcomes primary and acute care fragmentation and incentivises locally developed integration of care through the creation of a joint body with members from the respective Primary Health Networks and Local Health Districts.[17] In NSW, six Collaborative Commissioning partnerships have been implemented for chronic diseases driven by a need reduce costs and pressures of community and hospital services.[8]

Furthermore, in Queensland and Victoria, additional integrated care initiatives have been undertaken. Some notable examples include:

- The Commissioning Collaborative for Mental Health, Alcohol and other Drug and Suicide Prevention (MHAODSP) services, where a governance group with members from the respective PHN, Hospital and Health Service (HHS), QLD Health, and Children's Health QLD was created to consult and plan the co-commissioning of MHAODSP services.
- The Victoria Integrated Care Model (VICM), which was developed to support care providers to implement high quality integrated care and provide a patient centred approach across primary secondary and tertiary care. Initiatives that draw on the VICM include HealthLinks, the Hospitals Admission Risk Program (HARP) and the Patient Centred Medical Home (PCMH) model of care.

Australia has been learning about the implementation of integrated care for over 10 years, generating experience at a regional and state level. Efforts have focused on specific programs primarily for patients with complex or long-term care needs where fragmented care can have the greatest impact.

These initiatives have been implemented within existing institutional structures and are dependent on temporary funding programs, not reflective of national wide systemic changes. Initiatives have often benefited from traditional financing, which in some instances may be incompatible with VBHC due to misaligned incentives between stakeholders. This is one factor that currently presents a major barrier to making integrated care a sustainable reality in Australia and value-based payments should be explored instead (see later section). Additionally, **barriers in information sharing between acute and primary services affect implementation of integrated care programs and continuity of care of patients.** Finally, the creation of additional roles such as care coordinators to support patients in navigating care pathways, as well as providing additional roles to existing providers (e.g. allowing pharmacists to conduct spirometry tests) has been effective at a local level and a framework for rolling such changes out nationally could be considered.

There is also opportunity to build on the localised learnings to date to implement Commonwealth and/or state driven, systemic reform to support integrated and coordinated care, such as the implementation of system wide enablers. In QLD, NSW, VIC and South Australia state-wide initiatives have begun to systematically improve the measurement of patient reported measures. However, this is typically in acute hospital-based care, rather than general practice.[10]

Defining and measuring value

A pivotal factor in advancing value-based healthcare and facilitating the transition to a high-value healthcare system lies in our ability to define and assess value based on health outcomes and costs. There is a need in Australia to reduce 'low-value' healthcare provisions with the NHRA Mid-term Review estimating that "only 60% of health care is consistent with guidelines, with 30% considered wasteful or low-value and 10% harmful."[11]

Innovation in assessing value in healthcare provision is challenging because it is difficult to define and measure appropriate outcomes attached to financial

value accurately and subsequently attribute them to relevant healthcare providers. Additionally, the development of health data infrastructure, including connected and interoperable EHR, disease registries, and the ability to link to costing data, remains a key challenge critical to the adoption of VBHC.

In Australia, there has been a notable increase in the standardised use of PRMs and the collection of clinical outcomes data, primarily in acute-hospital based care. However, consistent use varies widely across Australia and between indications.

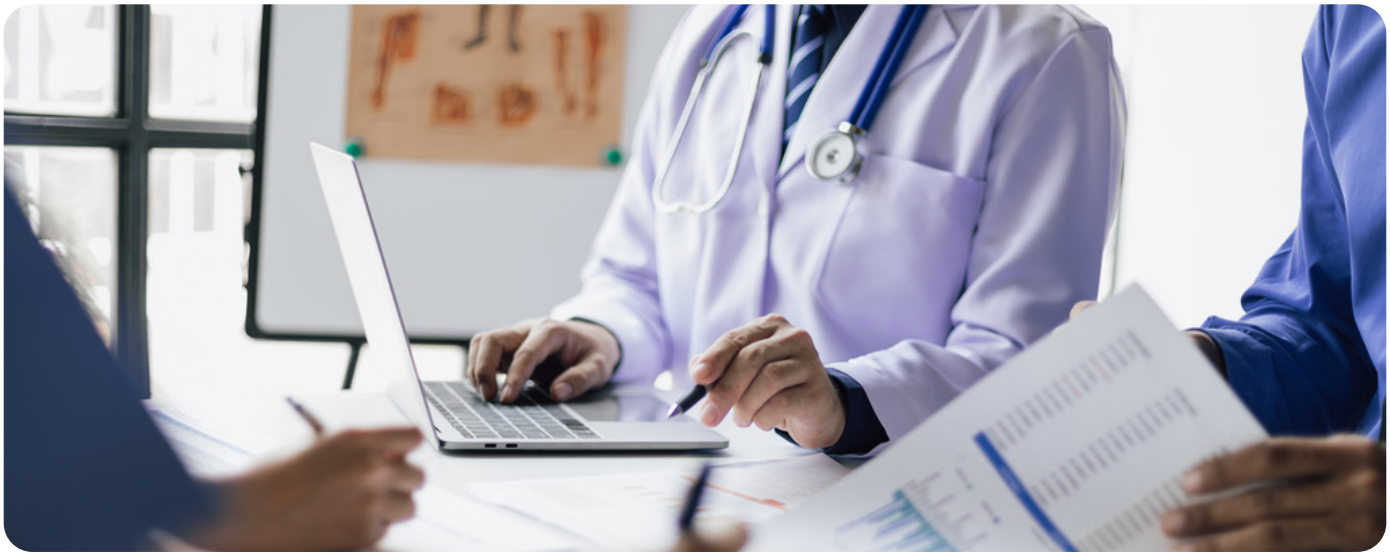
The Australian Commission on Safety and Quality in Healthcare (ACSQH) is a national government body that supports the uptake of PRMs for quality improvement and person-centred care and has made important progress in capturing learnings from early adopters. Further, efforts are emerging to advance the discourse at a national level and apply a VBHC approach to the measurement of healthcare outcomes. For example, the Australian Centre for Value-Based Health Care hosted a forum in 2022 "Measuring What Matters" to discuss the need to improvement PRMs use across Australia.[7] In QLD, NSW, SA, and VIC state-wide initiatives have begun to systematically improve the measurement of patient reported.[10]

Australia has a healthcare system whose complexity and fragmentation has led to compartmentalised health information systems, along with inconsistent data formats, standards, and terminologies across different information systems. Such examples are detailed in table 1. The Australia Digital Health Agency acknowledged these challenges when it reported "The healthcare sector lags behind other industries in adopting digital technologies that deliver seamless connectivity."[12]

Table 1. Australian health information system integration initiatives

CASE STUDY	DETAILS
My Health Record	• My Health Records is centralised repository of healthcare records for Australians which was intended to support EMR information sharing between providers and overcome siloed data structures • Despite significant investment there remain issues with data gaps and poor visibility which restrain the use for clinicians
Practice incentives program quality improvement (PIP QI)	• PIP QI was introduced in 2019 to incentivise quality improvement through a payment to general practices • Nationally, the implementation of a quality improvement incentive program for general practice (PIP QI) has led to ~5,000 general practices sharing data across 31 PHNs
Lumos	• Lumos is a NSW state-wide data linkage project supported by the NSW Government and the Commonwealth under the NHRA • Lumos integrates primary care and acute care data to provides a system-wide view of patient healthcare needs and service gaps, overcoming fragmentation of healthcare data collected separately across public, private, acute, and primary health care providers

Australia has taken initial steps to create systems to identify health outcomes that are of value to patients, primarily via a push to increase use of PRMs. However, use varies across jurisdictions, indications, and healthcare settings (greater use in acute settings) and further national-level consultation and coordinated approaches are needed. Initial steps towards integrating healthcare data have been observed. What remains necessary is the systematic capability to accurately capture patient outcomes across their care pathway. This will require a dedication to enhance data gathering on health outcomes and costing data across the care continuum.



VBHC funding mechanisms

Australia's current healthcare funding arrangements sit within a complex health system, with multiple funders across a public-private system with shared governance at national, state and regional levels. Different funding models are used, based on where care is delivered and the type of organisation. Tertiary care is funded through a mix of activity-based funding/ fee-for-service for clinical services whilst primary care relies upon fee-for-service payments mainly funded through the Medicare Benefits Schedule and out-of-pocket payments. This presents a landscape where navigating complex care pathways and integrating care is difficult, as it is challenging to allocate funds across the health system in an efficient way. Furthermore, the most prevalent healthcare payment model, fee-for-service, incentivises the provision of a high volume of services rather than explicitly promoting higher value.

Out of the three drivers analysed in this paper, value-based funding is likely where Australia has the least experience and further commitment to researching and trialling innovative payment types is needed. Current efforts encompass initiatives that enhance the efficient utilisation of resources by reducing 'low-value' interventions and small scale pilot programs experimenting with various funding models more closely aligned with VBHC (i.e. providers are rewarded for improving health outcomes).

The efforts to reduce low-value interventions include national initiatives such as the Medicare Benefit Schedule (MBS) review, which aimed to improve value and efficiency by amending or removing MBS items. However, recent analysis suggests there were no significant effects on medical expenditure, the volume of care or average fees charged (except in the case for GP fee for spirometry diagnosis) and the net overall effect was cost neutral.[13]

Further, initial efforts in Australia to implement outcomes-based funding have included pay-for-performance schemes that either reward providers based on process standards or intermediate health outcomes, or penalise providers for poor performance or outcomes.[14] Examples of such policies that have been implemented at varying levels across Australia include:

1. In 2017, IHACPA reduced or provided no funding for episodes of care with poor performance (e.g., hospital acquired complication or avoidable hospital admission).[15]
2. The Practice Incentive Program QI (administered by the Department of Health) provides financial payments to GPs based on process outcomes (collection and provision of data) and on select domains (e.g., diagnosis and effective management of diabetes, provision of data to PHN's).[16]
3. NSW Leading Better Value Care program is a pay for performance-best practice tariff model where providers are rewarded for delivering care that aligns with clinical best practice.[14]

There remain various barriers to the implementation of outcomes-based payments in Australia including lack of consensus over which metrics can be used to evaluate health outcomes across different settings and conditions, the measurement of and access to health outcomes data, and importantly, accurately attributing provider actions to patient outcomes measures. Further, value-based payment models shift financial risk onto providers and there exists a hesitancy from providers.

Capitation models, where a provider is given a fixed amount to cover some or all the needs of an enrolled population for a specified period, have also been used globally to pay for VBHC programs. In Australia, there is limited use of capitation model, however it is used to pay aged care providers to deliver care within residential care homes under the Australian National Aged Care Classification model.

There is appetite for healthcare funding reform in Australia, and Australia continues to make efforts to pilot and implement outcomes-based payment models to incentivise innovative service delivery and improve outcomes, however more is required. Notably, in the 2023-23 Federal Budget a commitment of $24.6 million over four years from 2023-24 was announced to trial blended payment models in the National Disability Insurance Scheme (NDIS).[18] Furthermore, the NHRA Mid-Term Review includes recommendations regarding the development and implementation of pricing approaches that reward high-value care and penalise low-value care. Additionally it recommends the implementation of innovative payment models: 1) to develop and implement bundled payments within the NHRA with an initial focus on maternity care, 2) the development of a 10 year National Health Funding and Payments Framework informed by national bodies and agreed by Council of Australian Governments (COAG) that incorporates blended models of care, bundled payments, an agreed value and outcomes road map and agreed milestones and accountabilities.[11] Value-based funding represents a key enabler for value-based healthcare to progress in Australia, however, currently efforts remain small scaled and reserved.

Figure. 3: Summary of VBHC progress and barriers in Australia

	Evidence of progress in Australia	Persistent barriers
Integrated and patient- focused care	• Integrated care present in key policies, frameworks and plans at a national and state-level • Generated experience through implementation of specific integrated models of care	• EMR information sharing • Fragmented funding across care continuum
Defining and measuring value in healthcare	• Increased use and support for uptake of patient-reported measures (PRMs) • Strides to increase information sharing between providers	• Access to timely and high-quality cost and outcome data for government and providers that can be easily shared in a safe and secure manner
Value-based funding mechanisms	• Slowly developing experience with pay-for-performance funding models through pilot programs • Appetite and 'push' for further value-based payment models seen in NHRA Mid-term Review	• Complexity in defining and implementing outcomes-based payment models • Accurate and accessible data to support payment-model • Engaging providers

Conclusion

While Australia lacks a national strategic framework for the implementation of value-based healthcare, several initiatives at the state and PHN/HHS level have been effective in addressing the fragmentation of healthcare provision on a small scale. These initiatives, alongside other global examples, suggest that a coordinated, Commonwealth driven shift to value-based care could help address larger care fragmentation issues the system is experiencing and deliver outcomes that are truly patient-centred.

As highlighted in this paper, a number of barriers still exist to the effective implementation of VBHC. These include data management challenges, with significant hurdles in collecting accurate and comprehensive data from multiple sources, integrating it, and analysing it. This problem is also linked to the lack of consensus on which metrics are the most useful to evaluate health outcomes across different settings and conditions. Inadequate reimbursement models are also an issue and understanding how to leverage MBS and ABF funding effectively will be crucial to navigate the development of VBHC systems.

Even if the above considerations were addressed, a strong level of alignment will be needed between all health stakeholders to ensure there is a common goal and that current mindsets are changed. One could argue this needs to be the first step in the establishment of an effective national VBHC system.

As ideal as a coordinated, national level push to VBHC sounds, it is likely that this will not become a reality for many years to come. This presents an opportunity for all PHNs and HHSs to take a leading role and think creatively about the issues impacting their jurisdictions and explore innovative solutions, looking to leading PHNs/HHSs for inspiration about new models of care to implement for example. Additionally, understanding how stakeholders - such as pharmacists with prescribing authority - can be leveraged in novel ways is essential for PHNs/HHSs to address the pressures faced by the primary and secondary care workforce today.

About IQVIA

Who we are

IQVIA is a global provider of advanced analytics, commercial strategy advisory services, and clinical research services to the life sciences industry. With a footprint in over 100 countries, we have unparalleled expertise in understanding issues faced by the life sciences industry and governments to respond to the challenges as novel therapies and technologies come to market. Leveraging our global expertise, IQVIA provides services based on best-practice case studies to help adapt to a rapidly evolving healthcare landscape.

Our capabilities

IQVIA's team in Australia supports PHNs and HHSs in developing, costing, implementing and evaluating relevant Value-Based Healthcare programs.
This includes:

- Developing target cohorts by indication for local care pathways
- Co-designing with local stakeholder the future care pathways using VBHC principles
- Evaluating existing VBHC programs
- Costing new care pathways
- Proving the sustainability of new models of care

Further, IQVIA has its pulse on the evolving role of stakeholders withing the primary healthcare space, such as pharmacists and their increasing role in aiding patients - notably via the ability to prescribe some medications and conduct health evaluations. By leveraging longitudinal data we can also effectively measure prescribing trends at the pharmacy level and use this in the context of evaluating specific VBHC program successes.

Globally, IQVIA is supporting NHS England in the implementation of their federated data platform, to provide software to effectively link patient data between NHS trusts and regional system.[19]

Our global capabilities expand into a range of solutions, including our modular Connected Healthcare Platform which is aimed at improving healthcare and research to help drive improved care delivery, operational efficiencies and cohort centred initiatives. Capabilities include telehealth, ePROs, population health, patient costing, capacity management, data analytics and benchmarking, patient finder, and more.

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About the authors

BROOKE IPSEN
Consultant, Management Consulting,
IQVIA Australia and New Zealand

brooke.ipsen@iqvia.com
+61 482 531 369

JACK SHEPPARD
Associate Principal, Management Consulting, IQVIA Australia and New Zealand

jack.sheppard@iqvia.com
+61 420 741 935

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CONTACT US

iqvia.com