



Investing in healthier lives: *Pathways to healthcare financing reform in Australia*

A Health Policy Report - August 2015



THE GEORGE INSTITUTE
for Global Health

Level 13, 321 Kent St, Sydney NSW 2000 Australia
T +61 2 8238 2300

[@georgeinstitute](https://twitter.com/georgeinstitute)

www.georgeinstitute.org

[thegeorgeinstitute](https://www.facebook.com/thegeorgeinstitute)

A Health Policy Report - August 2015

About this report

On 6 August 2015 The George Institute Australia hosted a roundtable to deliberate on the future of healthcare funding in Australia, and to formulate policy recommendations in this area. The aim was to examine the financial reforms needed to ensure the Australian health system is sustainable, equitable and able to respond to the growing burden of chronic disease and injury.

Three broad questions were addressed during this roundtable:

- *What is the nature of the problem and what are the goals of reform?*
- *What are the best options for healthcare funding reform in Australia?*
- *How do we implement these reforms?*

The roundtable took place in Sydney with over 30 stakeholders from different parts of the health sector (participants listed at the end of this report) and was Co-Chaired by Professor Vlado Perkovic and Professor Stephen Jan from The George Institute for Global Health.

To encourage open discussion, the meeting was conducted under a version of 'Chatham House rules' where information provided and views expressed are not attributed to individuals or organisations in this report. This report is a summary of this discussion and the agreed recommendations that resulted from this specific group of participants.

While it is recognised that there are many other critical issues that need considering when examining the health system, the discussion was focused on assessing funding models in this instance. The George Institute will convene future forums to have targeted conversations addressing other issues critical to health system reform.

Acknowledgements

The George Institute thanks the participants in the roundtable and the organisations they represent for their contribution to this report. The views and recommendations in this report represent the outcome of the group discussion and do not necessarily reflect the specific views of the individuals at the roundtable or the organisations they represented (some of whom may have official positions that differ from that presented in this report). The George Institute would also like to make special mention of Dr Steve Hambleton, Professor Anthony Scott, Professor Tim Usherwood, Glenda Clementson, Professor Stephen Jan, and Dr Tracey Laba for their contribution to the roundtable program, and, Professor Jan, Dr Laba and Jan Muhunthan for their work on this report.

Foreword

What does a 21st century Australian health system look like? And, how do we make sure it can sustainably and effectively meet demand?

These are among the most important questions we face in Australia. Along with these, questions have been raised about how Medicare, a signature aspect of Australia's world class health system, will cope with the spiralling costs of chronic diseases and injury, our biggest killers and causes of disability.

We know life expectancy in Australia is high, our health expenditure is moderate by international standards, and comprehensive healthcare is available. Our researchers are continually excelling in scientific, technological and healthcare breakthroughs. We have a growing skilled workforce of doctors and other healthcare professionals. And, more and more Australians are actively looking for ways to live a healthy life and prevent disease.

But while our system has a lot of strengths, we face important challenges.

Health expenditure is likely to rise above the Organisation for Economic Co-operation and Development (OECD) average by 2023 – which may or may not be a bad thing - but if current trends continue, health spending per person is predicted to double by 2055.

Seven million people in Australia are living with a chronic disease, often requiring ongoing care. In many cases these people are faced with a multitude of challenges in negotiating a complex system that, in relation to such disease, is prone to duplication, inefficiency and gaps in service coverage. The cost of chronic disease to Medicare has more than doubled from about \$10 billion to almost \$20 billion over the past decade; and our ageing population and increasingly sedentary lives means the problem is likely to get worse.

The implications to our health as a nation are substantial. But solutions are within reach.

A health system that can deliver the best care to all Australians needs to be based on careful consideration of what we know works and what doesn't; and to consider and integrate views from across the health sector and the broader community. Reform must be determined first and foremost by models that will best serve the needs of patients and empower them to have maximum choice and control. The Government's review of the Medical Benefits Schedule, Primary Care arrangements, and the Federation structure have initiated an overdue process providing an opportunity to do just this, and to examine the efficiency of the health system.

As recently outlined by The Minister for Health, The Hon. Sussan Ley, "There are three essential ingredients or elements in any effective, high quality modern health system – firstly, an efficient system structure with secure funding; secondly, clinical practice that is both accessible and evidence-based; and thirdly, well targeted research to underpin constant improvement."

This report examines one of these ingredients, Australia's health financing model, and considers how we pay for healthcare, what our payment model might aim to achieve, and what we need to do to create a truly 21st century health system.



Vlado Perkovic
Executive Director
The George Institute
for Global Health, Australia

7Million AUSTRALIANS
LIVE WITH
CHRONIC
DISEASE.
IN THE PAST TEN YEARS
CHRONIC DISEASE
MEDICARE COSTS
HAVE DOUBLED TO **\$20Billion**

Summary of key recommendations

1. There is an *urgent need to reform health funding*, to ensure that high-quality, effective and efficient healthcare is promoted and supported.
2. While the eventual goal of reform is whole-of-system improvements, *a priority for immediate reform needs to be people with chronic and complex conditions, and those who are significantly disadvantaged in access and/or outcomes.*
3. *A blended payment system is needed*, adding to current models a broader range of capitation-based payments promoting patient-centred care. In addition, *the role of performance-based payments as part of an overall funding model should be explored.*
4. *Change management is critical*, and reinvestment of savings from other areas, including areas from outside health, will be required.
5. *Linkages between healthcare providers should be strengthened.*
6. *Improvements in the quality of data available* from existing IT infrastructure investment is needed including data linkage.
7. *Moving from conversations to action needs careful planning, extensive discussion and consultation, and a staged approach.*

"...The five principles of Medicare – simplicity, affordability, universality, efficiency, and access..."

Introduction

Medicare is Australia's federally-funded, public health insurance scheme that pays for medical services, prescription pharmaceuticals and public hospital treatment; it has provided Australians with free access to public hospitals and subsidised primary and specialist care. The five principles of Medicare – simplicity, affordability, universality, efficiency, and access – reflect the very Australian notion that everyone deserves a 'fair-go'. Since Medicare was introduced, there have been significant advances in treatments and the way healthcare is delivered, and with these have come increasing costs. This was reflected in the recent Intergenerational Report that highlighted the growing challenges of maintaining a high quality and universally accessible health system in the face of increasing costs, an ageing population and growing burden of chronic diseases and injury. In addition, there has been evolution in the type of health services provided, with particular growth in the number of people requiring care for chronic and complex conditions, and in models of healthcare delivery. It is therefore timely to review whether the core funding model, primarily based on fee-for-service payments, is still the optimal approach to healthcare funding more than 30 years after Medicare was introduced.

There are many different funding models that could be used to pay for healthcare (see Box 1 on page 14). Fee-for-service payment, whereby services are unbundled and providers are paid for each item of service they provide, is the core funding model that pervades Australia's public and privately funded health system. For example, Medicare is essentially an uncapped, fee-for-service insurance system.

The fee-for-service model, with its strong historical roots, has been increasingly implicated as an important contributor to the system-wide problems of fragmented and inappropriate care resulting in unnecessary costs. By financially rewarding activity without considering effectiveness and quality, it has been argued that fee-for-service payments promote suboptimal care. Strong public debate over the past 18 months around patient co-payments in Australia have in large part been driven by fundamental concerns about these economic incentives and unnecessary costs created by fee-for-service payments, balanced against underlying concerns about equity of access to care.

Current initiatives

While there has been some ‘tinkering’ with Medicare, the experience of testing alternative payment models is very limited in Australia when compared to other international health systems such as the USA. However, initiatives such as chronic care plans and practice incentive payments represent shifts away from a pure fee-for-service funding model to one that incorporates financial incentives aimed at changing health professional practice to promote high-quality care. There have also been recent moves to pilot new payment models in the care of people with diabetes, as well as interest in blended payment systems that involve some element of salary or capitation payment for GPs (the latter has been the mainstay for the payment of providers in the UK for a number of decades). These alternatives may be better suited to the management of patients with chronic disease, can improve care co-ordination, and shift the focus away from individual episodes of care to one that considers all the needs of the patient.

While these programs are currently modest in scope, and their impact is yet to be clearly determined, recent public discourse about health funding has catapulted discussion about what healthcare should look like and which funding models are best suited to support healthier lives in a 21st century health system into the political spotlight. The Australian Government is now seeking to build a ‘Healthier Medicare’ via reviews of the Medical Benefits Schedule and Primary Healthcare services exploring how we might align clinical care, especially for people with chronic and complex conditions, with best practice. This whole-of-system focus provides an unprecedented opportunity to examine financial reforms within the Australian health system.

In 2013, 14% of Australians reported they didn't get recommended care because of cost. Amongst those with chronic health problems, this proportion was 24%.

Challenges

High average life expectancy and other statistics can be used to appropriately highlight the successes of the Australian health system, yet these factors have arguably contributed to a sense of complacency about the need for health sector reform. Evidence about overall performance can mask failings of the health system for specific population groups such as Aboriginal and Torres Strait Islander people, culturally and linguistically diverse populations, the elderly and those with chronic illness, disabilities and mental illness. Furthermore they mask disadvantages in access to services that are often experienced by populations in rural and remote areas. The needs of each of these groups should be considered separately and prioritised in healthcare reform, with recognition that healthcare reform needs to be viewed in conjunction with wider policies that address the social determinants of health.

While Medicare was established to insure members against the financial risks associated with illness, it has evolved to address a broader range of health related issues, and also plays an important role in being a payment mechanism for providers. This creates challenges and opportunities since healthcare in Australia is to a large extent built on business structures that are continually evolving. For instance, general practice owners (who may not have a background in health) are increasingly becoming a part of the health system. Therefore payment reforms such as incentive payments for general practices may not be effective if they do not

ultimately feed through to the individual providers working within them. Reforms that are not cognisant of these organisational features and do not engage all stakeholders in a continually evolving system are thus unlikely to succeed.

Although research funders and governments are looking to the research community to develop stronger partnerships and collaborations with healthcare providers, there are currently very few links between primary and community care providers and the research community. One of the challenges is that the primary and community care sector is a vast network of service providers working as private practitioners who lack the time and resources to consider questions of research. Given the importance of primary and community care providers in delivering health services and maintaining healthy communities, increasing the emphasis on extending engagement beyond the acute sector with its strong focus on hospitals, to include primary and community care, is therefore an important element for reform.

Finally, consumers in the health system are facing a disintegrated, complex and increasingly unaffordable healthcare system with providers unable to co-ordinate with other health providers and services outside the health system. At the same time, healthcare expenditure per capita is growing. Reconfiguration of the system and its payment mechanisms is needed to address these many challenges.

10% OF AUSTRALIAN ADULTS
CITE COST AS THE REASON
THEY MISS OR DELAY
SPECIALIST APPOINTMENTS

AUSTRALIAN ADULTS WHO CITE
COST AS THE REASON THEY DELAY
OR DO NOT FILL THEIR ESSENTIAL
MEDICATION PRESCRIPTIONS **9%**

The Goals of Reform

The main goals of healthcare reform reflect the principles of Medicare, and should be:

- 1. Optimising health outcomes through high quality care,*
- 2. Optimising the patient and provider experience,*
- 3. Ensuring equity, and*
- 4. Achieving value for money for the whole system.*

Funding mechanisms, and the incentives they create, need to encourage the forms of behaviour that promote the achievement of these goals.

For patients with chronic disease and complex conditions, this means creating a system which is more integrated across providers and sectors than the existing approach. Whole-of-system stakeholder engagement is crucial in designing models of care which can be considered patient-centred. New systems need to be guided by what consumers believe will meet their needs.

To shift the management of patients away from hospitals, reforms to healthcare funding should focus on services delivered through primary care, as well as preventive care, since these are likely to drive and have a major impact on most of the downstream aspects of the health system. Suboptimal funding and inappropriate payment mechanisms in primary care ultimately impact on the sustainability and quality of care that can be delivered elsewhere in the system – in particular exerting pressures back onto the acute care setting (e.g. costs onto hospitals). In this sense all players in the health system have a stake in how we fund and support primary healthcare, including state government and private health insurers. In addition, many of the key considerations about funding of primary care are equally important to many specialist services, particularly those that relate to chronic conditions.

48% of potentially avoidable hospitalisations in 2013-2014 were for chronic conditions.

Key Recommendations

1. *There is an urgent need to reform health funding, to ensure that high-quality, effective and efficient healthcare is promoted and supported.*

Moving from a funding approach that encourages volume, to one that incorporates drivers that recognise and prioritise high-quality care provided in the most efficient manner possible, is clearly essential.

2. *While the eventual goal of reform is whole-of-system improvements, a priority for immediate reform needs to be people with chronic and complex conditions, and those who are significantly disadvantaged in access and/or outcomes.*

These include socioeconomically disadvantaged groups, Aboriginal and Torres Strait Islander populations, rural and remote communities, and those with mental illness.

Particular attention should be given to removing barriers in access to treatment, including costs, and to minimise the burden on patients in their management of long term illnesses and conditions through integrated models of care. It is likely that such improvements would have significant 'downstream' benefits such as reduced need for hospital care in addition to improved patient outcomes and experience of care.

Healthcare system reforms need to be part of a bigger program of policies that include measures to tackle the social determinants of health.

3. *A blended payment system is needed, adding to current models a broader range of capitation-based payments promoting patient-centred care. In addition, the role of performance-based payments as part of an overall funding model should be explored.*

Fee-for-service remuneration continues to work well in many circumstances. In particular, it is an appropriate means of remunerating providers for acute episodic care, for infrequent users of the health system, as well as for certain specialist procedures (e.g. endoscopy). A fee-for-service model could be maintained for these conditions and services.

For people with chronic and complex diseases and for disadvantaged groups, fee-for-service works less well and there is a need to consider alternative payment mechanisms. Common features of the preferred payment models involve moves towards risk-stratified and capitation-based funding, as well as performance-based models.

Capitation-based payments, weighted for risk, provide incentives that align with delivering long-term, patient-centred, integrated healthcare including tele-health, non-face to face interactions, involvement of non-medical team members and many preventative activities. These are not currently reimbursed and are thus not encouraged in the current system. Voluntary patient enrolment in practices (as well as risk weighting) minimises the risk of cream-skimming that is a potential adverse feature of capitation models. A fee-for-service element could be maintained in this model as a component of a broader funding package.

55.9 BILLION WAS SPENT ON HOSPITALS IN AUSTRALIA DURING 2012-13

52.9 BILLION IN THE SAME TIME SPAN PRIMARY HEALTHCARE IN AUSTRALIA COST

Key Recommendations continued

A good starting point for reform is to build on the innovations already in Medicare such as the Practice Incentive Payments (PIPs) that are currently relatively limited in scope, coverage and magnitude.

Strategies such as the establishment of funding pools for the purposes of funding patients with complex needs who are unable to afford intermediate services such as specialists and allied health professionals could also help to improve outcomes.

Performance-based payment systems that align with health system objectives should be explored but will need to be accompanied by investment in information systems and routine collection of data on appropriate process and outcome indicators in order to ensure that they are based on and can be evaluated using reliable information.

In line with international efforts, value-based healthcare should be central to any reform. However it is broadly accepted that substantial shifts in data availability and better linkage capability are needed, as are efforts to adequately define and measure outcomes that can indicate progress towards the goals of reform (i.e. equity, value, outcomes and experience).

4. Change management is critical, and reinvestment of savings from other areas, including areas outside of health, will be required.

Change management is crucial to the success of reforms. Key guiding principles for change are:

- For individual providers change needs to be at least revenue neutral wherever possible,

such that measures are available to address those disadvantaged by the creation of winners and losers.

- Detailed consultation with the groups most affected by these changes will be required as part of the planning and implementation processes.
- Some degree of investment is likely to be needed in the short-term to achieve long term gain. It is noted that the current MBS review, the existing freeze on Medicare payment increases and other initiatives are expected to generate significant health funding savings thereby providing an opportunity for reinvestment.
- It should be recognised that Australian government healthcare funding costs are modest by international standards. In addition, previous surveys have found broad public support for increasing levies or taxes directed to health funding. As such, the possibility of increasing government revenue or reallocating from other areas outside health to support greater investment in high quality healthcare should be considered.

5. Linkages between healthcare providers should be strengthened

Payment systems need to support team-based care. Such care involves not only linking healthcare providers within an organisation, but across the system – potentially spanning preventive and acute care services. This could naturally include allied health professionals and non-physician providers. Any funding reforms need to account for the

23% of people who visited an emergency department in 2012-13 felt their care could have been provided by a GP.

Key Recommendations continued

infrastructure requirements and upfront costs of transitioning to team-based care.

Capitation-based payment models may better incentivise for such linkages but reform of payment systems alone is not enough. They need to be developed alongside adequate support for structural reform as well as relevant education and training packages. The new Primary Health Networks may provide an opportunity to look at regionally relevant commissioning models, potentially pooling funding from several sources (e.g. Commonwealth, State, Private insurer and other funds) for an agreed common aim.

6. Improvements in the quality of data available from existing IT infrastructure investment is needed including data linkage

Further development of IT infrastructure is required to generate the required information to support reforms e.g. performance-based payment systems require identification of and the routine monitoring of appropriate indicators.

Better understanding of the 'at-risk' population who frequently visits emergency departments yet are much less visible to primary care is desperately needed. To this end, evidence from private health insurers could be utilised and, if tied to a funding model, could drive change.

In the long term, improved use of data should drive further efficiency gains that can facilitate further investment.

7. Moving from conversations to action needs careful planning, extensive discussion and consultation, and a staged approach

Increasing broader public awareness that there is scope for improving our healthcare system through modifying funding approaches is an immediate priority. The concept of patients as partners in care must be also acknowledged in this context. Political buy-in and commitment to reform is also essential. A broad constituency is needed to reach agreement and drive change that outlasts the political cycle. Community and non-health agencies should be given a voice in health pathways and in the bundling of services.

An important opportunity exists to learn from other schemes within and outside the health sector and from overseas. For example, the NDIS is a useful case study for patient-driven service delivery policy reform.

Live evaluation and staged implementation of programs are needed to generate the evidence base to ensure effective roll-out of reforms. Consideration should be given to forming a reform 'statutory body' with a permanent secretariat to continue the reform process and monitor progress.

The way forward

A system based on a blend of funding models is needed to enable better integrated management of chronic conditions, encourage prevention and promote the long term financial sustainability of the Australian health system. The features of such blended funding will be:

- *Fee-for-service payments for the treatment of acute, episodic conditions.*
- *Capitated payments to providers managing complex conditions with weightings to ensure that payments are adjusted according to risk, and a voluntary patient enrolment system that ensures that patients have freedom to choose their providers.*
- *In addition these might be augmented by performance-based payments that align with broader health system objectives of optimising outcomes, optimising patient experience, ensuring equity and value for money.*

The process of implementing reforms needs to be broad-based and take into account the views of all stakeholders and in particular, avoid dividing the community into clear winners and losers. Key features of this change process will be:

- *Measures to ensure that reforms do not significantly financially disadvantage individual providers, recognising that there is a general need to invest in primary care.*
- *Significant investment in the change management process to cover in particular the infrastructure costs incurred by individual practices/providers. The recent freezes in Medicare rebates for instance have potentially created some fiscal capacity to enable, and simultaneously intensified the need for, such investment.*

- *An initial focus on programs of reform targeting populations of greatest need such as individuals with chronic conditions and disability including socioeconomically disadvantaged groups, Aboriginal and Torres Strait Islander populations, rural and remote communities, and those with mental illness. Detailed involvement by these groups in planning and implementation is required.*
- *Staged implementation of individual programs of reform, building on existing programs such as PIPS, accompanied from the outset by rigorous evaluation and routine collection of appropriate data, which is likely to entail expansion of existing IT capacities.*
- *In the longer term, the roll out of such reforms across the wider community.*

Ultimately reforms to payment models represent one lever that needs to be considered in making structural changes to the health system. To ensure we achieve an integrated and sustainable health system that can meet the current and future needs of all Australians we need to address the four objectives highlighted earlier in this report: optimising health outcomes, optimising the patient and provider experience, ensuring equity, and achieving value for money for the whole system.

In facilitating this process of reform there needs to be broad consultation and consideration of all perspectives – the private and public sectors, providers and consumers. This recent roundtable meeting represents one step in that process and is particularly relevant given its timing alongside major Government reviews currently underway around the Medicare Benefits Schedule, Primary Healthcare and the Federation.

Thank you

The George Institute Australia is grateful for the participation of the following representatives in the roundtable discussion that is the basis of this report:

- Alison Verhoeven, Chief Executive Officer, Australian Healthcare & Hospitals Association
- Andrew Cottrill, Medical Director, HCF
- Annette Schmiede, Executive Lead, Bupa Health Foundation
- Anthony Brown, Executive Director, Health Consumers NSW
- Anthony Scott, Professorial Research Fellow and NHMRC Principal Research Fellow, Melbourne Institute
- Brian Morton, GP & Chair, Australian Medical Association Council of General Practice
- Bronwen Ross, Deputy CEO, Royal College of Pathologists Australasia
- Chris Dalton, Medical Director, Bupa
- David Cook, Deputy Dean, Sydney Medical School & Member of the Board, Westmead Millennium Institute
- David Peiris, Program Head, Primary Healthcare Research, The George Institute for Global Health
- Dion Forstner, Dean Faculty of Radiation Oncology, Royal Australian and New Zealand College of Radiologists
- Glenda Clementson, Board Member, Health Consumers NSW
- Glenn Salkeld, Head of School and Associate Dean, Sydney Medical School, University of Sydney
- Ian Hickie Co-Director, Health and Policy, Brain & Mind Centre, University of Sydney
- James Gillespie, Deputy Director Menzies Centre for Health Policy; Director of Health Policy, Sydney School of Public Health, Sydney Medical School, University of Sydney
- Jeff Richardson, Foundation Director, Centre for Health Economics, Monash Business School, Monash University
- Kees van Gool, Health Economist, CHERE
- Leanne Wells, CEO, Consumer Health Forum of Australia
- Nathan Pinski, Chair, NSC-eHealth, Royal Australian College of General Practitioners
- Nick Buckmaster, FRACP, Royal College of Physicians
- Paul Bates, Chief Medical Officer, Bupa
- Rebecca Bell, General Manager, Utilisation Management, Medibank Private
- Robert Wells, Deputy, CEO, Sax Institute
- Stephen Jan, Head of Health Economics, The George Institute for Global Health
- Steve Hambleton, Chair, Primary Care Advisory Group
- Tessa Boyd-Caine, Deputy CEO, Australian Council of Social Service
- Tim Usherwood, Professor of General Practice, University of Sydney; Associate, Menzies Centre for Health Policy
- Tracey Laba, Research Fellow, Health Economics The George Institute for Global Health
- Vlado Perkovic, Executive Director, The George Institute, Australia
- Walter Kmet CEO, WentWest, University of Western Sydney

Box 1: Categories of Healthcare Payment Models

Type	Description	Potential Benefits	Potential Challenges
Fee-for-Service	Providers paid a fee for each unit of care they deliver according to a fixed price schedule	Greater access to care, service provision and productivity IF affordable for patients	Financial risk is borne by the payer. Payment linked to output rather than quality so incentive for over-provision of treatment and under-provision of preventive activities
Fixed Payments per unit of Time (salaries)	Salaries negotiated centrally with individual-based adjustments to allow for experience, location and other considerations	Funders greater control over costs	Incentive for under-provision of services and excessive referrals to secondary providers. Disincentive to attract new patients
Capitated Funding	Providers paid by each patient enrolled.	Incentivise cost containment. Funders control the overall level of expenditure. May incentivise preventive services. Upfront payment can reduce financial barriers to treatment if this offsets payment needed at the point of delivery	Incentives for: under-provision of services. Patient selectivity (if payments are not risk-adjusted). No incentive to improve performance, efficiency or more appropriate service provision.
Pay-for-Performance	Payments to providers or practices based on type/number of services provided of a specific standard/type.	Additional payments for beneficial services not otherwise remunerated. May improve processes and access. Encourages collection of data on performance.	Rewards activity. Does not encourage improvement beyond targeted threshold. Discourages participation if processes and access low at baseline. Monitoring costs.
Activity-based funding	Providers funded on activity	Promotes technical efficiency. Encourages collection of data on activity.	Reduced flexibility if funds cannot be moved across items. Relies on episode-based classifications. Monitoring costs

Sources

- Commonwealth of Australia. The 2015 Intergenerational Report: Australia in 2055, The Commonwealth of Australia
- Speech by the Minister for Health Sussan Ley at George Institute World Health Day health policy event on Medicare Reform 22 April 2015
- Oliver-Baxter J and Brown L. Primary Healthcare Funding Models. PHCRIS Research Roundup. 2013
- Australian Institute of Health and Wellbeing, 'Analysis of the 2004-05 National Health Survey', Australian Federal Government, 2015
- Speech by the Minister for Health Sussan Ley at George Institute World Health Day health policy event on Medicare Reform 22 April 2015
- National Commission of Audit, 'A pathway to reforming healthcare', Australian Government, 2013
- Commonwealth of Australia. The 2015 Intergenerational Report: Australia in 2055, The Commonwealth of Australia
- The George Institute for Global Health, 'Health Policy, Administration and Expenditure: Submission', The George Institute for Global Health, 2015
- The George Institute for Global Health, 'Health Policy, Administration and Expenditure: Submission', The George Institute for Global Health, 2015
- Primary Care Advisory Group, 'Better Outcomes for People with Chronic and Complex Health Conditions through Primary Healthcare: Discussion Paper, 2015
- NHPA 2015, 'Healthy Communities: Frequent GP attenders and tear use of health services in 2012-13
- Australian Institute of Health and Welfare, 'Health expenditure Australia 2012-13: analysis by sector', Australian Federal Government, 2014

The George Institute for Global Health

About The George Institute for Global Health

The George Institute conducts targeted, innovative health research aimed at reducing the burden of leading causes of death and disability in Australia and around the world, to ensure all Australians have efficient access to safe and effective healthcare.

For the past 16 years our research has influenced medical guidelines and practice, and changed thinking about some of the most common prevention strategies and medical treatments around the world. Since the establishment of its Australian headquarters, The George Institute has developed a global research program with additional offices in China, India and the United Kingdom. The George Institute employs over 500 staff and has more than 50 ongoing research projects. It has raised over \$500 million in funding for global health research, and is affiliated with the University of Sydney, Peking University Health Science Centre, and the University of Oxford. The George Institute is listed in the SCImago Institutions Rankings as one of the world's top 10 research organisations for impact, and has done so for each of the last 4 years. In addition, the National Health and Medical Research Council's (NHMRC) 'Measuring Up Australia 2013' report ranked the George Institute first among Australian research organisations for research impact.

Investing in healthier lives

The roundtable and report was a production of The George Institute for Global Health.

Vlado Perkovic, Executive Director, The George Institute Australia.

Stephen Jan, Head, Health Economics and Process Evaluation Program.

Dr Tracey Laba, Research Fellow, Health Economics.

Janani Muhunthan PhD Candidate, Research Assistant.

E. Richard Mills, Director, Global Communications and Advocacy.

Maya Kay, Communications Manager Australia.

Aaron Wakeley, Senior Media Advisor, Communications Australia.

Alexander Baldock, Design Manager, Global Communications.

Kevin Truong, Digital Engagement Manager, Global Communications.

Chelsea Hunnisett, Communications Assistant.



Ranked among the top 10 research institutions in the world for scientific impact by the **SCImago Institutions Rankings (SIR)** *World Reports* in 2011, 2012, 2013 & 2014.

The George Institute for Global Health

 @georgeinstitute

www.georgeinstitute.org

 thegeorgeinstitute