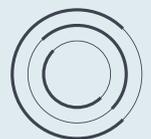


# A NEW GP MODEL



The case for investing in  
value-based primary care



OSANA®

## About the Author

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### DR KEVIN CHENG

Kevin is the Co-Founder of Osana and has a background in health policy and strategy consulting. He is a practicing GP with an interest in population health, lifestyle medicine, system reform and data analytics in healthcare. He has been an adviser to State and Federal Governments, the UK and Singapore health systems, and to the National Health and Hospital Reform Commission in Australia.

Kevin also worked for strategy consulting firms McKinsey & Company and Boston Consulting Group, leading business transformations in public sector and private industries such as retail banking, manufacturing, mining, education and technology. He has a medical degree from the University of WA, a fellowship with the Royal Australian College of General Practitioners and a MBA from INSEAD in France.

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# Foreword

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Australia's healthcare system is one of the best in the world. Our world-class doctors and nurses provide some of the best care available internationally. Every Australian has a vested interest in ensuring it continues to be at the forefront of delivering good outcomes for patients.

At Honeysuckle Health, we have a strong belief that data science will enable a transformation in healthcare. We provide a range of health programs and services to patients and health care providers all aimed at creating better pathways to better health. We use data to evaluate the impact of those programs and understand which patients are most likely to benefit from them.

Over the last few years, significant advances in big data, Artificial Intelligence (AI), cloud computing and health technology mean healthcare systems are better able to predict the risk of disease and illness, and consequently to prevent, manage and more precisely treat it.

We agree with Osana that advances in data science mean we can more effectively evaluate healthcare delivery and health programs relative to patient outcomes. This capability will play a critical role in ensuring our healthcare system is focused on the right models of care that can then be scaled to ensure system-wide improvement in patient outcomes.

Value based healthcare is a key component of the future and simply means linking the funding of healthcare to the quality of patient outcomes. This is what the data, new technology and science will allow us to do. It means Australians will be healthier.

Importantly the work of the GP will start to change. Instead of spending the majority of their time focused on looking after people when they are already sick, we should see a shift towards a focus on primary and secondary prevention. This shift will be enabled by data and technology that helps GPs focus their care on programs and interventions that are effective and on the patients that will benefit from it.

We believe strongly in the future of data science in health care and in building capability around technology and health service delivery to support this transformation. All developed economies share similar healthcare challenges. The leading healthcare systems of tomorrow will be those that successfully integrate new technology, alongside the best standards of clinical care to deliver new methods of prevention and treatment.

This white paper showcases the potential positive impact of healthcare transformation and the need to continually invest in new models of care. It aligns with our long-term vision for health care in Australia and we endorse its recommendations.

**RHOD MCKENSEY**  
**CHIEF EXECUTIVE OFFICER**  
**HONEYSUCKLE HEALTH**

## Introduction

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# 100%

of state revenues will be consumed by health care costs in 2046

Even prior to the shock of Covid-19, the Australian Department of the Treasury had forecasted that **healthcare costs would cannibalise State revenues** by 2046<sup>1</sup>, leaving no funding for other industries, including schools, roads, public transport, police, prisons and emergency services.

Australia's ageing population, increasing incidence of chronic disease, new technology and consumerism fuel greater demand for healthcare. Post Covid-19, there will be an even more **heightened focus on health and well-being**, coupled with an appetite for new models of care.

On the supply side, healthcare infrastructure, services and behaviours are slow to adapt. Despite our best efforts, our health care system remains hospital-centric, activity-focused and reactive. Only half of all common chronic health conditions are well managed<sup>2</sup>.



# 50%

of chronic conditions are well managed in Australia

**Value-based primary care** models demonstrate a better approach to patient care and a path to greater sustainability for health systems around the world. These models demonstrate a 20% to 30% reduction in hospital admissions, along with improvements in patient outcomes and experience<sup>3,4</sup>.

A pilot of value-based primary care called **Osana** has been implemented in Australia and is showing promising results. This pilot replicates successful case examples abroad that ensure clinicians have **accountability for improving health outcomes**.



# 30%

less hospital admissions through value-based primary care

This white paper analyses the key challenges of the current healthcare system and the opportunities that exist to improve outcomes. It highlights the benefits of a new GP model and makes a case for investing in value-based primary care.

# Australia's Health Care Challenges

## AN AGEING POPULATION WITH INCREASING CHRONIC DISEASE

Older Australians will more than double in size over a generation, with the number of those aged 65 and above expected to increase by 139% from 2000 to 2030<sup>5</sup>.

Older age is associated with higher susceptibility to chronic disease. As more people age, the cost of managing these conditions will increase exponentially. Over 30 years, the health care costs of diabetes will increase by 4.4 times, neurological conditions by 3.6 times and musculoskeletal conditions by 2.2 times<sup>6</sup>.

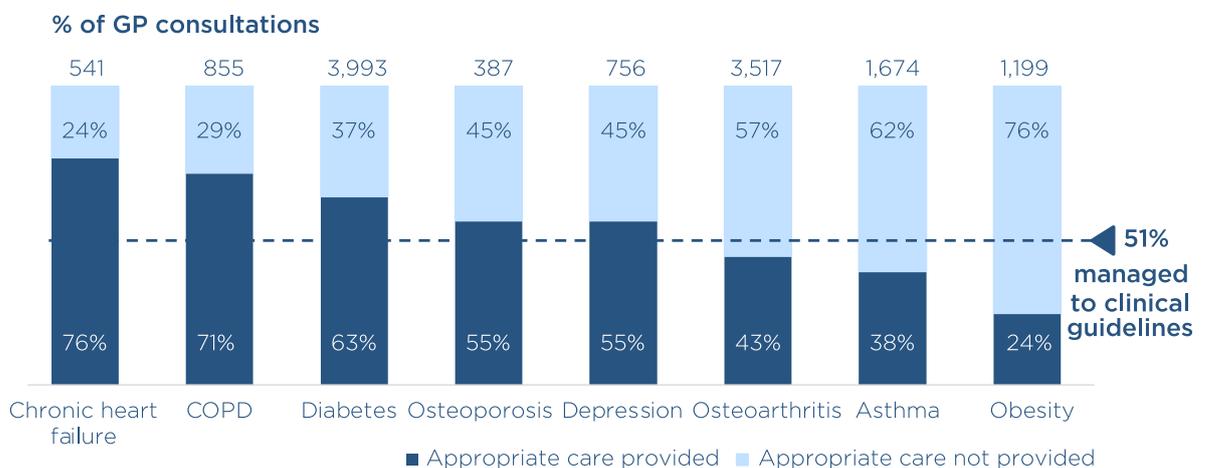
Many chronic diseases are preventable and can be better managed. 80% of cardiovascular conditions<sup>7,8</sup> and diabetes<sup>9</sup>, and 1 in 3 cancers<sup>10</sup> are avoidable.

However, only 51% of chronic diseases are managed according to clinical guidelines that are considered best practice - see Exhibit 1<sup>1</sup>. Suboptimal management leads to complications that necessitate specialist and hospital intervention later on in life, and increases healthcare costs.

A post-pandemic health system arguably cannot afford more chronic health conditions that end up in expensive hospital care.

**Exhibit 1**

### Chronic disease management according to clinical guidelines



Source: CareTrack: assessing the appropriateness of health care delivery in Australia (MJA 2012)

## A REACTIVE, ACTIVITY-BASED INDUSTRY FOCUSED ON SICKNESS

Australia's health system is reactive and works on demand. It kicks in when patients get sick, which misses an opportunity to address risk factors, prevent issues, manage symptoms at home, and avoid unnecessary tests, medications or hospital services. You don't wait until your car breaks down to service it, but our current health care system is like a breakdown service.

Only 1.3% of Australia's overall health expenditure goes towards prevention<sup>12</sup>. But prevention is cost-effective, especially in primary care. A GP consultation costs \$82<sup>13</sup>, versus an Emergency Department visit at \$561, or an admission to hospital at \$5,027<sup>14</sup>. The cost of healthcare escalates as you get further from a patient's home and engage later in a disease process.

Preventative primary care works. It leads to lower all-cause mortality, fewer acute admissions to hospital and improvements in self-reported health outcomes<sup>15</sup>. Increasing access to primary care leads to reductions in 5-year mortality rates, more preventative services performed and fewer acute flare-ups of chronic disease<sup>16</sup>.

A person with diabetes, for example, will require services that cost \$4,025 per annum if they are relatively well-controlled and do not have complications but will cost \$9,645 per annum if not well managed and experience complications<sup>17</sup>.

Our current health system is also activity-based, where 40% of total expenditure funds hospital care, linked to admissions and procedures, and 7% funds primary care GP services, linked to consultations<sup>18</sup>. The natural incentive is to increase throughput.

Public and private hospitals often contemplate how more activity can increase revenue. Do we want more admission to hospital, that is, more Australians to be sick? In essence, we have an industry for sickness rather than a system for wellness.

“  
**An industry for sickness rather than a system for wellness.**

”

# Improving outcomes through value-based primary care

## THE WINDS OF CHANGE – INCREASING FOCUS ON PREVENTION

Our health system is hard to change. Behaviours are hard fast, funding mechanisms are fixed, and infrastructure takes years to build or to update. Moreover, there are multiple governors, payers, providers and vested interests that result in competition, rather than collaboration.

Despite this, health systems worldwide are adopting a more proactive, outcome-based approach, with a greater focus on prevention.

There is strong evidence demonstrating benefits from early and better management of risk factors and chronic health conditions. Better sugar control in diabetes, for example, leads to a 33% reduction in heart attacks, a 24% reduction in eye and kidney disease, and a 27% reduction in premature death<sup>19</sup>.

Australian Government and health insurers have piloted different initiatives to be more proactive in health service delivery, including chronic disease and health coaching programs, care coordination and navigation services, transition care and discharge planning support\*.

However, many of these initiatives have yet to significantly improve patient outcomes at scale or reduce health system costs for many reasons, including clinical inertia, change resistance, the predominance of activity-based funding, supply-induced demand, inadequate evaluation and data analysis, and lack of GP involvement.

Nonetheless, Australia's health system is ready for a more proactive approach to healthcare, and it is clear that there is an appetite for such change now. New models are paving the way to reimagine how we provide healthcare in this increasingly challenging context.

### BETTER SUGAR CONTROL IN DIABETES LEADS TO



**33%**

reduction in heart attacks



**24%**

reduction in eye & kidney disease



**27%**

reduction in premature death

\* Examples of current and past health initiatives include patient enrolment, healthcare homes, diabetes care project, whitecoat, care complete, NSW integrated care and the Australian primary care collaboratives program

## THE MERITS OF VALUE BASED PRIMARY CARE

Paying for health outcomes, rather than activity, is the premise underpinning value-based primary care. It aligns incentives with behaviours to deliver improved patient outcomes and promotes greater efficiency in our health system.

This concept originated from Harvard academics Michael Porter and Elizabeth Teizberg’s work on healthcare being a ‘zero-sum’ system<sup>20</sup>, which highlighted that healthcare markets tend to promote cost-shifting, capture patient volumes and extract profit from patients.

Instead of activity-based funding, commonly known as fee-for-service, linking payment to health outcomes can deliver better patient results and experience at a lower cost.

Value-based primary care increases accountability of GPs, allied health clinicians and service providers to deliver positive outcomes.

Under activity-based funding, the incentive is to provide more services, whereas value-based primary care encourages better results.

By sharing accountability and risk from payers (i.e. those that pay for healthcare) to providers (i.e. those that deliver healthcare services), improvements in patient outcomes and cost reductions are possible. Such mechanisms in US Health Maintenance Organisations have reduced patient mortality by 72% and health system costs by 25% (see Exhibits 2 & 3).

GPs are receptive to a value-based primary care approach. They seek professional satisfaction from doing a good job rather than doing more work. Their focus is to provide more preventative care and improve outcomes, which is better for both our patients; and our health system.

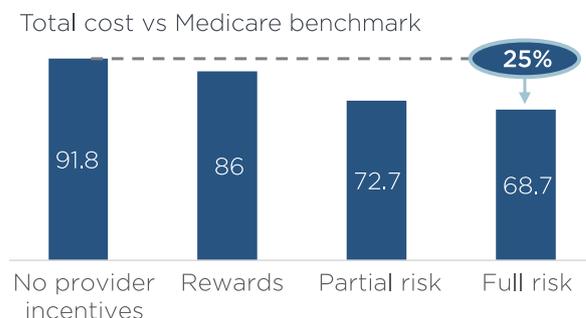
**Exhibit 2**  
Risk sharing improves mortality



FFS = Fee for service, PPO = Preferred provider organisation, HMO = Health maintenance organisation, CAP = Capitated health network

SOURCE: Alternate Payment Models Show Improved Health Care Value. Boston Consulting Group. 2013

**Exhibit 3**  
Risk sharing reduces costs



SOURCE: Alternate Payment Models Show Improved Health Care Value. Boston Consulting Group. 2013

Overseas examples of value-based primary care models have shown a capacity to deliver more preventative care through greater patient engagement, a population health approach and focusing on health outcomes.

These models highlight the opportunity for Australia to adopt value-based primary care models. Examples are shown in Exhibit 4 and are further described in the Appendix.

**Exhibit 4**

Value-based primary care models driving preventative care

 <b>PATIENT ENGAGEMENT</b>	 <b>POPULATION HEALTH APPROACH</b>	 <b>HEALTH OUTCOMES FOCUS</b>
 Health coaches to activate patients – 40% less admissions and 20% lower health costs	 Digital prevention with care managers – 30% less diabetes risk, 13% less cardiovascular risk	 Integrated primary and hospital care with enrolled population – 25% less health costs
 Community centres to engage patients proactively – 33% lower health costs	 Prevention health plans and coaching – 50% less medication costs	 Direct, personalised primary care – 20% less health costs
 Customer owners and community involvement – 36% less hospital bed days and 58% less specialist visits	 Team-base care with medical assistants and specialist input – 67% less readmissions	 Outcomes focused, more time with less patients – 34% less ED visits and 28% less admissions

SOURCE: Literature review, interviews & websites

## IMPROVING PATIENT OUTCOMES AND REDUCING HOSPITAL ADMISSIONS

The ultimate goal of value-based primary care is to keep patients healthy and reduce the risk of unnecessary hospital intervention. A range of hospital avoidance levers are available via GP-led preventative care, shown in Exhibit 5, which do not occur systematically in the Australian context.

Focusing on prevention should be central to the design of new primary care models. Before a disease develops, prevention involves risk detection assessments and early intervention strategies, such as patient education, coaching, behaviour change Apps, lifestyle modification and self-management. Success is reducing risk factors, the onset of symptoms and disease.

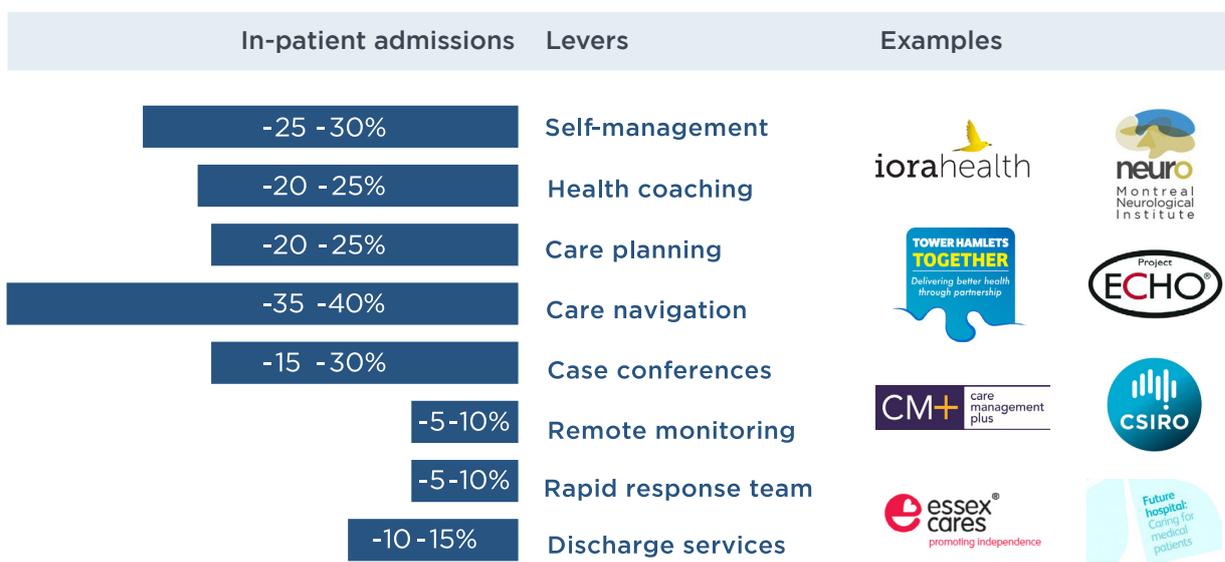
Once diagnosed with a disease, prevention consists of patient mentors, team-based care, goal setting, health planning, chronic disease checklists, regular check-ups and deployment of Medical assistants to coordinate care.

Success is reducing complications and the need for medications and specialist interventions.

When disease progresses, prevention then involves medication reviews, multi-disciplinary case conferences, home assessments, remote monitoring, and quality improvement activities. Success is keeping patients at home rather than progressive admission towards hospital-based services.

Improving patient outcomes and reducing hospital admissions require investment across all prevention areas, and actively engaged GPs to achieve the best results. Prevention is better than cure—for both patients and the health system.

**Exhibit 5**  
Initiatives to reduce hospital utilisation



SOURCE: Literature review; Case studies

# A New GP Model

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## BUILDING A NEW MODEL OF PRIMARY CARE

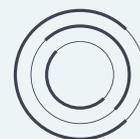
In 2018, \$13 million in social investment was raised to build and test a new value-based primary care model in Australia – Osana. Three pilot sites launched in Sydney and approximately 6,000 patients enrolled into an ethics-approved research study to examine the impact on patient outcomes and health system costs.

Osana is a Spanish name that means “health and well-being”. Osana is a purpose-driven social impact organisation, certified globally as a B-corporation, with a dedicated focus to design and deliver a new GP model for Australia.

Over the past three years, medical and wellness services have been provided at an operating cost of approximately \$2,000 per person per annum. Besides social investment funding, income derives from Medicare, membership fees, private health insurance and block payments by corporate partners and Primary Health Networks (PHNs).

The George Institute of Global Public Health was engaged to independently evaluate Osana’s success by linking Osana data to the NSW hospital dataset and comparing it to a control group. The primary research hypothesis is that GP-based preventative care improves patient outcomes and is cost-effective for the health system, based on reducing hospital admissions.

“A purpose-driven social impact organisation, certified globally as a b-corporation”



O S A N A®

Osana is a value-based primary care model designed, built and tested in Sydney. It draws upon evidence-based interventions that deliver improved patient outcomes and reduced hospital admissions.

At its core, the Osana model reinvents the role of being a GP. The design principles behind Osana include preventative care, patient activation, and population health management:

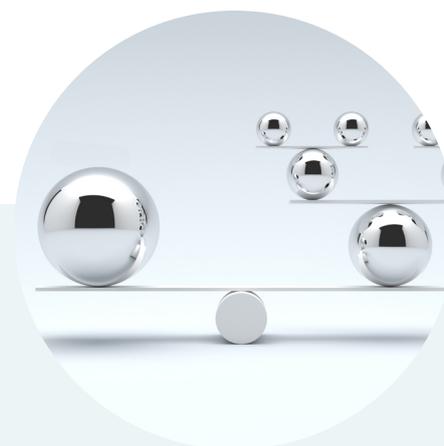
- **Preventative care:** Longer consultations, salaried GPs, risk stratification, proactive health assessments and health plans, multi-disciplinary teams and regular follow-up when people are well. All clinical care is evidence-based and checklist-driven to reflect up-to-date best practices;
- **Patient activation:** Membership subscription, Health Assistant support, goal setting, health coaching, lifestyle modifications such as nutrition, exercise and meditation classes, and shared medical appointments and community groups for peer support; and
- **Population health management:** Quality improvement focus enabled by regular data collection, clinical dashboards, scrubbing of clinical records, team huddles, KPIs linked to staff incentives, member gamification and rewards.

Australian GPs usually see patients for 14 minutes, during consultations that are normally initiated by patients when they are unwell. GPs are usually remunerated by a percentage payment that is linked to the volume of services they provide<sup>24</sup>.

Under the Osana model, GPs lead a team to manage patients over time, working proactively with them on health goals to improve their health status and reduce hospital admission risk. The orientation is towards health outcomes rather than throughput activity.

***Being a GP at Osana is fundamentally different by:***

- Practicing slow medicine with a focus on outcomes rather than activity;
- Managing a population of enrolled patients, not just those who book an appointment;
- Providing team-based care and delegating tasks to Health Assistants and Allied Health;
- Focusing on education, coaching and behaviour change as much as diagnosis and treatment;
- Adopting a culture of data science, research and quality improvement;
- Embracing feedback – examining what’s working vs what’s not, to target services to need;
- Applying problem-solving techniques to address social determinants and the whole person; and
- Being rewarded for improving patient outcomes and reducing hospital visits.



## SUCCESSFUL RESULTS OVER THREE YEARS

Regular data collection is part of the Osana model. The following outcomes are observed:

### Fewer hospital visits

# -51%

Less hospital bed days before vs. after Osana (70% of Osana members have a chronic disease).

### Improved patient activation

# +18%

More activated patients are validated internationally to have improved self-reported health, better clinical outcomes and less hospital admissions.

Osana uses the UK-13 Patient Activation Measure, and has improved this result by 18%.

### Positive Net Promoter Score

# +82%

A reflection of advocacy and satisfaction with the service model.

### Lower lifestyle risk factors

# -21%

Reduction in smoking or in moderate to heavy alcohol consumption.

# -11%

Reduction in obesity (BMI>30).

# -21%

Reduction in psychological distress (K10 score).

# +45%

Increase in patients meeting national exercise guidelines.

### Improved chronic disease management

# 81%

Diabetes meeting a HbA1c target (industry average is 49%).

# 81%

Heart disease meeting a blood pressure and cholesterol target (industry average is 42%).

# 69%

Hypertension meeting a blood pressure target (industry average is 32%).

# +21%

Improvement in osteoarthritis function (industry average is +19% after surgery).

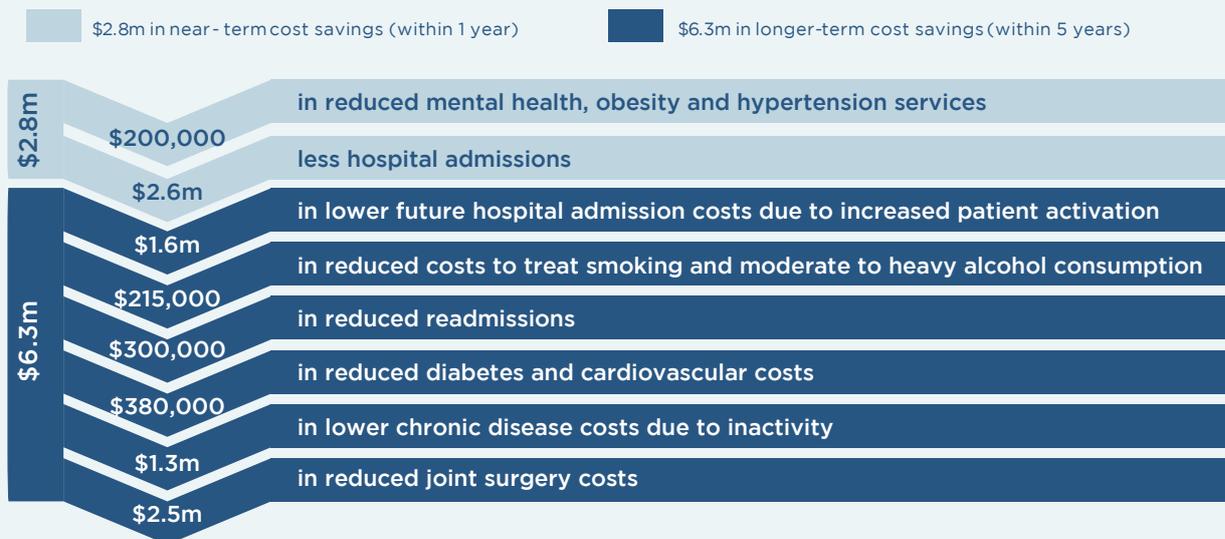
There are many considerations in creating a new model of primary care. The relatively easy parts of the Osana model to implement have been slow medicine, risk stratification, data collection, team huddles and case conferences. Clinicians have demonstrated a strong appetite for practising in a proactive way to support their patients.

The more challenging parts of the Osana model have been supporting patients in behaviour change and building innovative solutions to drive clinical improvements and a better experience. Osana has integrated lifestyle prescriptions and health coaching with medical care, built dedicated IT applications and dashboards to enable quality improvement, and trained GPs to deliver population health management in a proactive way.

## COST SAVING BENEFITS AND RETURN ON INVESTMENT FOR OUR HEALTH SYSTEM

### OSANA TOTAL ANNUAL COST SAVINGS \$9.1m

(with 6000 members over 36 months)



The Osana pilots incur an operating deficit of approximately \$1.5m each year, which, when considered with annual cost savings of \$9.1m, equates to an approximate **6x return on investment** for the health system.

Further efficiencies in pilot Osana clinics can be achieved by increasing utilisation (currently only two-thirds full), allowing more time for quality improvement and behaviour change, and digitising manual workflows.

These estimates represent direct health care cost savings only and exclude indirect benefits from a better quality of life, increased longevity and productivity gains. Independent health economists from the George Institute will evaluate cost-effectiveness of the Osana model in order to validate these preliminary findings.

Extrapolating these cost savings for all Australians with chronic disease and risk factors equates to a significant opportunity:

- \$15.6 billion in recurrent annual savings over the near-term, through lower hospital admissions, improved mental health and better management of conditions such as hypertension and obesity, plus
- \$17.6 billion in recurrent annual savings over the longer-term, through less joint surgery, improvements in lifestyle risk factors such as smoking, higher patient activation, and better management of conditions such as heart disease and diabetes.

Combined, the **\$33.2 billion preventative care opportunity** for Australia represents 18% of the total healthcare budget<sup>25</sup> and is the equivalent healthcare cost of managing two global pandemics in Australia every year (i.e. testing, respiratory clinics, PPE, contact tracing, vaccination etc.).

Capturing this opportunity for better patient outcomes and health system cost savings requires coordination and collaboration across our health system. Prevention levers are “upstream” or early on when patients initially visit their GP; benefits accrue downstream through reduced medications, specialist and hospital interventions.

For value-based primary care to be successful in Australia, the following pre-requisites are required:

- A degree of vertical integration between hospital payers (i.e. state Government and health insurers) and GPs, achieved through co-ownership, partnership or value-based contracts where accountability and risks are shared;
- A system-wide view that overcomes the fragmentation and siloed nature of health care, plus a willingness to invest in innovative approaches that reflect best practices overseas and go against current pressures of activity-growth; and
- Strong leadership that can orchestrate a long term vision and transformation, including addressing the natural tendency of our system to be short-term focused, reactive and risk-adverse.

Australia is behind other developed nations in implementing value-based primary care. Our health system is not sustainable based on current course and speed - we have successful pilots like Osana that can be scaled up.

“**Prevention levers are upstream;  
Benefits accrue downstream**”



# Taking action to invest in our primary care system

## CREATING A MARKET PLACE FOR VALUE-BASED PRIMARY CARE

To realise the opportunity for value-based primary care, we need a willing coalition of public and private-sector, and partnership between payers and providers. Health reform is not easy and much is invested in the status quo of how we configure, fund and deliver healthcare today.

The prize of innovation, however, is delivering better health outcomes for Australians in a post-Covid world, and strengthening our health system for years to come. In essence, it would mean a healthier population at lower healthcare costs, proven possible by successful examples around the world (see Appendix) and the Osana pilot.

A potential way forward is to create a contestable market place for value-based primary care. Payers can define target objectives they wish to achieve, provide a fee for these outcomes, and encourage providers to compete for and achieve those results.

Payers such as Local Health Districts and Health insurers could offer a payment for outcomes and conduct data matching to track results. Providers such as Primary health networks, Osana and other GPs could offer to provide preventative care based on the Osana model and other examples. Government and peak bodies could oversee programs to ensure they are evidence-based and consistent with policy directions.

Such a market place could offer fees for specific outcomes, such as:

- **Managing a complex patient:** A case payment per annum plus an additional top-up if hospital admissions are lower than the previous year;
- **Providing transition care to a patient being discharged from hospital:** A service payment for 3 months of home visits and medical care, plus an additional top-up if no readmissions occur during this period;
- **Caring for seniors at home or in aged care facilities:** A case payment per annum plus an additional top-up if hospital admissions are lower than the previous year;
- **Providing preventative care to chronic disease patients:** A results-based payment for 6 months, dependent upon HbA1c (for diabetes), blood pressure & cholesterol (for cardiovascular disease), K10 (mental health), and hip & knee surveys (for osteoarthritis) meeting agreed clinical targets; and
- **Delivering wellness programs to reduce long-term risks,** such as losing weight, reducing dependence on nicotine & alcohol, and supporting new parents or those without social support to avoid unnecessary emergency department visits. A results-based payment for 6 months based on agreed outcomes such as BMI reduction, smoking cessation or reduced A&E presentation.

## ROLLING OUT THE OSANA PILOT TO OTHER LOCATIONS

To implement a market place for value-based primary care, we could consider a staged process over 18 months, shown in Exhibit 6 below.

### Exhibit 6 Roll out stages

JUL - DEC 2021	JAN - JUN 2022	JUL - DEC 2022
<ul style="list-style-type: none"> <li>• Syndicate Osana pilot &amp; case examples with stakeholders</li> <li>• Conduct data matching &amp; validation of results</li> <li>• Discuss marketplace &amp; outcomes that could be funded</li> <li>• Select additional locations for potential roll out</li> </ul>	<ul style="list-style-type: none"> <li>• Build Osana pop-up clinics in additional locations</li> <li>• Recruit &amp; train 3-4 surrounding medical centres for each region</li> <li>• Contract for specific health outcomes</li> <li>• Enrol patients &amp; collect baseline data</li> </ul>	<ul style="list-style-type: none"> <li>• Provide an Osana-type model of care to improve outcomes</li> <li>• Track results &amp; feedback along the way</li> <li>• Validate with researchers &amp; conduct control matching</li> <li>• Make payments &amp; inform policy directions</li> </ul>

Initially, we propose syndicating this white paper with payers, peak bodies and providers to align on the primary care opportunity, including validation of Osana pilot results.

Then, we propose defining desired health outcomes and potential locations to achieve those outcomes. This would allow further testing of the Osana model, recruitment of interested non-Osana clinicians and forming integrated partnerships with local hospitals and specialists. Osana would invest in training and supporting new GPs to provide preventative care.

Once specific outcomes are agreed, based on what payers are willing to fund and what GP providers are able to deliver, we could invite appropriate patients to participate. Along the way, data collection, tracking of results and payment for outcomes would enable a “scale-up as we go” approach.

## Conclusion

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There is a clear opportunity to re-wire our health system towards prevention and pay for good clinical outcomes for patients. A reactive, activity-funded industry focused on sickness is not sustainable nor affordable.

Value-based care and investment in new primary care models enables a “triple-win” scenario. Australians become healthier, GPs receive incentives for working in a way they enjoy (by focusing on value, not volume), and our health system can limit future cost growth.

Design of value-based primary care can include either “gain share” rewards (i.e. upside), or “pain share” penalties (i.e. downside), or both. Sharing accountability and risk between payers and primary care providers engages GPs proactively. As gateways to the health system, they can typically access more levers than other providers to improve patient outcomes and reduce hospital admissions. Doing so allows us to better accommodate our ageing population and the increasing prevalence of chronic disease.

Osana is scaling up its model to support more Australians to achieve better health outcomes and lower healthcare costs. It is focusing on working with hospital payers to deliver mutually beneficial outcomes as quickly as possible.

Innovation is not easy for a risk-adverse health care system characterised by rules, regulations, clinical inertia and a short-term focus. However, the long-term prize is enormous, and it is time to act now to ensure the sustainability and affordability of Australia’s future health system.

“ **It’s time for a fundamentally new strategy...**

**At its core is maximising value for patients; that is, achieving the best outcome at the lowest cost...**

**The most powerful way to drive costs down is to improve outcomes.** ”

**MICHAEL PORTER, HARVARD**

## Appendix Case examples

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### Oak St Health

Myers, G. et al, Caring for Older Adults in a Value-Based Model. New England Journal of Medicine. 2016

Oak St Health are a Chicago-based primary care service that looks after elderly patients with chronic health conditions. They operate on a fully capitated, at-risk basis and are responsible for all the medical costs of their patients. Their model involves risk stratification, long appointments, care managers, patient transport, team-based planning and data analytics. Oak St Health have reduced hospital admissions by 40% for their patients and have a five star HEDIS rating (Healthcare Effectiveness Data and Information Set - National rating system for American health plans).



### Iora Health

Govindarajan, V. & Ramamurti, R. Transforming Health Care from the Ground Up. Harvard Business Review. 2018

Iora Health was founded in 2010 to tackle the fee for service culture in the US, invest more in primary care and create IT systems that support patient care delivery and track outcomes. Its model centres around empowering patients to take control of their own health, and employs health coaches to work with GPs and focus on well being and behaviour change. Iora Health has reduced hospital admissions by 40%, reduced total health care costs by 20% and achieves a Net Promoter Score in the 90s.



### Nuka System of Care

Gottlieb, K. The Nuka System of Care: improving health through ownership and relationships. International Journal of Circumpolar Health. 2013

The Nuka System of Care was developed to encourage greater participation and control by the Alaskan Native people in health service delivery. The model involves a broader focus on family, community and wellness, "customer owners", multi-disciplinary teams, modern medicine combined with traditional healing, behavioural health and education. It has reduced hospital admissions by 36%, emergency department visits by 42% and specialist interventions by 58%.



### ChenMed

Klein, S. & Hostetter, M. In Focus: Redesigning Primary Care for Those Who Need It Most. The Commonwealth Fund. 2016

ChenMed is based in Miami and focuses on serving low to moderate income seniors - 70% of their patients have five or more chronic health conditions. Their model focuses on spending more time with less patients, team-based reviews and taking global capitated risk for health care costs. Their results are 38% fewer hospital admissions, 90% improvement in patient education and a 90% Net Promoter Score.

## Appendix Case examples

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### Intermountain

Harrison, M. A 5-Point Model for Value-Based Health Care. Harvard Business Review. 2019

Intermountain has created a re-imagined primary care model that focuses on continuous improvement, lower acuity care settings, social determinants, telehealth and evidence-based practices. Its results include 60% less hospital admissions, 35% less emergency department presentations, and 20% lower overall health care costs.



**Australian Government**  
**Department of Health**

### Diabetes Care Project

Fountaine, T. & Bennett, C. Health care homes: lessons from the Diabetes Care Project. Medical Journal of Australia. 2016

This federal Government funded pilot tested a risk-based model of primary care. It involved 23 organisations, including 3 State Governments and 180 general practices over 3 years. The model involved care coordination, patient education, risk-based funding and data tracking to measure health outcomes. The results showed a significant improvement in clinical outcomes such as HbA1c (sugar control), blood pressure, cholesterol, waist circumference and depression.



### Care Complete

Tinning, R. A before and after evaluation of a complex “real world” chronic disease management intervention. Faculty of Medicine, University of NSW. 2018

Care Complete is a suite of programs developed by Australian health Insurers and State Health Departments. The programs include evidence-based interventions such as health coaching, care coordination, care planning, transition care, patient education, and payment for outcomes. Evaluations are ongoing, but pilot studies have achieved significant improvements in blood pressure, waist circumference, physical activity levels, hospital risk scores and patient mortality.



### Australian Primary Care Collaboratives

Knight, A. et al, The Australian Primary Care Collaboratives Program: improving diabetes care. British Medical Journal. 2012

The Australian Primary Care Collaboratives were large-scale, multi-year, quality improvement initiatives that were implemented across general practices. The model included training workshops for clinicians, quality improvement strategies, data measurement and inter-practice collaboration. In diabetes and cardiovascular disease, there were 50% improvements in HbA1c and cholesterol levels meeting clinically recommended targets.

# References

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1. Altman, L. et al, One in Four Lives: The Future of Telehealth in Australia. Australian Disease Management Association. 2014
2. Runciman, W. et al, CareTrack: assessing the appropriateness of health care delivery in Australia. Medical Journal of Australia. 2012
3. Horner, B. et al, How Hospitals Can Work Together to Improve Value in Health Care. Boston Consulting Group. 2020
4. Dorling, G. et al, The evidence for integrated care. McKinsey & Company. 2015
5. Trends in Population Ageing. Department of Health. 2008
6. Goss, J. Projection of Australian health care expenditure by disease, 2003 to 2033. Australian Institute of Health and Welfare. 2008
7. Stampfer M. et al, Primary prevention of coronary heart disease in women through diet and lifestyle. New England Journal of Medicine. 2000
8. Chiuve S. et al, Healthy lifestyle factors in the primary prevention of coronary heart disease among men: benefits among users and nonusers of lipid-lowering and antihypertensive medications. Circulation. 2006
9. Steinbrecher, A. The preventable proportion of type 2 diabetes by ethnicity: The Multiethnic Cohort. Annals of Epidemiology. 2011
10. Wilson et al. How many cancer cases and deaths are potentially preventable? International Journal of Cancer. 2018
11. Runciman, W. et al, CareTrack: assessing the appropriateness of health care delivery in Australia. Medical Journal of Australia. 2012
12. Jackson, H. & Shiell, A. Preventive health: How much does Australia spend and is it enough? La Trobe University. 2017
13. Australian Medical Association recommended guidelines on GP consultations
14. Independent Hospital Pricing Authority, Round 23 National Hospital Cost Data Collection Report. 2021
15. Starfield, B et al, Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005
16. Starfield, B et al, Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005
17. Shaw, J. & Tanamas, S. diabetes: the silent pandemic and its impact on Australia. Baker IDI Heart & Diabetes Institute. 2012
18. Health expenditure Australia 2017-18. Australian Institute of Health and Welfare. 2019
19. Homan, R. et al, 10-Year Follow-up of Intensive Glucose Control in Type 2 Diabetes. New England Journal of Medicine. 2008
20. Porter, M. & Teisberg, E. Redefining Health Care: Creating Value-Based Competition on Results. Harvard Business Review. 2006
21. Kecmanovic, M. & Hall, J. The use of financial incentives in Australian general practice. Medical Journal of Australia. 2015
22. Pricing and funding for safety and quality: Risk adjustment model for Hospital Acquired Complications. Independent Hospital Pricing Authority. 2019
23. Kaplan, J. et al, Alternative Payer Models Show Improved Health-Care Value. Boston Consulting Group. 2013
24. Britt, H. et al, Time for care. Length of general practice consultations in Australia. Australian Family Physician. 2002
25. Prime Minister Press Release 14 March 2021



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