Healthy people, healthy systems

Strategies for outcomes-focused and value-based healthcare: A BLUEPRINT FOR A POST-2020 NATIONAL HEALTH AGREEMENT

DECEMBER 2017
## OUR VISION
A healthy Australia, supported by the best possible healthcare system.

## OUR MISSION
To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

## OUR GUIDING PRINCIPLES
Healthcare in Australia should be:
- Effective
- Accessible
- Equitable
- Sustainable
- Outcomes-focused.

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It’s with great pleasure and a sense of excitement that I present the Australian Healthcare and Hospitals Association’s blueprint for a post-2020 national health agreement.

 здоровые люди, здоровые системы были разработаны Австралийской ассоциацией здравоохранения, чтобы обеспечить здоровье лидеров Австралии.

Здравоохранения в продвинутых экономиках вокруг мира находятся на краю изменения, и это Австралия, их шанс преобразовать здравоохранение в систему, адаптированную к 21-му веку. Система будет отличаться от имеющегося 21-го века и будет обслуживать временные нужды общества.

Это будет требовать национальной едины и региональной интеграции здравоохранения, что обеспечивает возможность определить единую концепцию и обеспечить, что они могут работать вместе с выполнением целей и результатов.

В результате здравоохранение необходимо быть здоровым и влиятельным, не только между правительствами, но и между всеми, кто вносит вклад, включая профессионалов и финансовых стимулей.

Таким образом, интеграция и координация здравоохранения, чтобы достичь результатов, что меняет здоровьезащита и общества.

**DR DEBORAH COLE**

As such, coordination and integration of health services to meet the outcomes that matter to patients and communities needs a shared vision and coordinated effort, not just between governments but with all those who contribute to and influence the provision of healthcare.

Integrating local services commissioned and coordinated by Primary Health Networks and Local Hospital Networks (or equivalent) in addition to the wide range of services provided by the not-for-profit and private sectors will go a long way towards achieving this aim and providing a cohesive and more integrated health system to deliver improved outcomes.

If there is a genuine commitment to delivering patient-centred care that improves health outcomes, consumers must be genuinely engaged in co-designing services and how the entire health system functions across hospitals, primary healthcare and prevention activities.

There is a need to move away from siloed care delivery and transforming the vast amounts of data generated by our health system into intelligence that will facilitate continued improved system integration and a focus on outcomes.

This will require a health workforce that is flexible, competent, working to the top of their scope of practice, and actively participating in the design and delivery of health services.

We are thankful for their generous contributions.

In early 2017 Commonwealth Health Minister Greg Hunt asked AHHA to contribute ideas for a blueprint for a 10 year health agreement. A similar request was made by Leader of the Opposition Bill Shorten and Shadow Minister for Health and Medicare Catherine King.

These requests follow the reaffirmation by the Council of Australian Governments (COAG) that providing universal healthcare for Australians is a shared priority, with agreement on public hospitals funding to June 2020 (COAG 2016a).

COAG has begun considering longer-term public hospital funding arrangements for post-June 2020, and agreement is expected to be reached by COAG in 2018 (COAG 2016b).

This blueprint has been developed in response to these requests. It has been developed through substantial consultation with, and input from, AHHA’s Board, broad membership and stakeholders across the hospital, primary and community health sectors—including clinicians, academics, policy-makers, administrators and consumers. We are thankful for their generous contributions.
executive summary

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends that Australia reorientate the healthcare system over the next 10 years by enabling outcomes-focused and value-based healthcare. This requires:

A nationally unified and regionally controlled health system that puts patients at the centre

### SHORT TERM (within 2 years)
- An independent national health authority is established, distinct from the Commonwealth, and state and territory health departments, and reporting directly to COAG (or the COAG Health Council), to support integration of health services at a regional level.
- The authority assumes responsibility for stewardship of primary care and dental care, as well as functions currently led by the Independent Hospital Pricing Authority (IHPA), the Administrator of the National Health Funding Pool, the Australian Institute of Health and Welfare (AIHW), the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Healthcare (ACQHC).
- The authority becomes the single source of truth for national health data collection (performance and funding), bringing together and rationalising current disparate investments in data collection by the Commonwealth across the Australian Bureau of Statistics (including the National Health Survey), the AIHW, the Commonwealth Department of Health, Medicare and other smaller agencies.
- Agreements between the Commonwealth and Primary Health Networks (PHNs), and the states and territories with Local Hospital Networks (LHNs), establish consistent governance arrangements for regional needs assessments, priority setting and funding; this coordinates and integrates approaches to reducing preventable hospital admissions and presentations.

### MEDIUM TERM (within 5 years)
- The independent national health authority reports annually to the Commonwealth, and state and territory parliaments on its key performance indicators, supporting regional needs assessments, priority setting and funding; this coordinates and integrates approaches to reducing preventable hospital admissions and presentations.
- The independent national health authority supports efficient alignment of all agreements established by the Commonwealth that impact on shared health objectives.
A national health workforce reform strategy is developed that goes beyond the adequacy, quality and distribution of the workforce as it currently exists, to pursue outcomes-focused and value-based changes in scopes of practice and models of care to meet public need, with coordination of education, regulation and funding (at the Commonwealth, state and territory, and regional service levels) for both regulated and unregulated practitioners, and across health service environments.

SHORT TERM (within 2 years)

Current Commonwealth funding levels for public hospitals, including the growth formula, are maintained for 7 years.

Health services are funded on a regional basis, with the architecture of agreements being centred on patient needs, not individual sector needs, while still recognising that models of care must be sustainable and attractive to health service providers as well as patients.

To support the movement to a value-based approach to healthcare funding, stakeholders are given financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care.

A mixed funding formula, with a 25% component for achieved health outcomes, is trialled relating to the top 4 chronic diseases, risk factors or determinants, and is expanded to cover all health conditions within 10 years.

MEDIUM TERM (within 5 years)

Funds are dedicated to prevention activities based on the regional needs assessments determining projected needs of the population 5–10 years in the future to inform investment in prevention.

LONG-TERM (within 7–10 years)

Outcomes data published that empower patients to make informed choices about treatment options and providers is made public, and includes data on the outcomes that matter most to each patient.

Stakeholders are given financial and non-financial incentives to improve healthcare value, based on standardised high quality outcomes data.

**IN SUMMARY**

**DATA STANDARDS**

**SHORT TERM** (within 2 years)

- All providers receiving government funding are required to supply data on patient outcomes and other service provision dimensions to better inform system performance.
- A national minimum dataset and data dictionary for primary healthcare are developed.
- A whole-of-system framework is developed for a nationally-consistent and coordinated approach to the collection and use of patient-reported experience and outcome measures (PREMs and PROMhs) across the health system.
- The matrix for identifying, measuring and monitoring institutional racism is validated in hospitals and health services.

**ICT ARCHITECTURE**

**SHORT TERM** (within 2 years)

- The development and implementation of interoperability standards to support better information sharing across the health system is fast-tracked.
- My Health Record data, as agreed for secondary use, is made available to the proposed independent national authority for public reporting purposes.

**MEDIUM TERM** (within 5 years)

- Standards for general practices electronic health records are developed and implemented.

**ANALYTICAL AND REPORTING CAPABILITY**

**SHORT TERM** (within 2 years)

- A strategy is developed for a standardised national approach to measuring value-based patient-centred outcomes, and is reported at different levels of the healthcare sector, and to different audiences.
- The Choosing Wisely initiative and the ACOs mapping of variation in care include feedback loops to professionals.
- These initiatives are aligned to reduce duplicated effort and investment of public funds.
- Stakeholders are given financial and non-financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care.

**MEDIUM TERM** (within 5 years)

- Benchmarking performance against standardised sets of value-based patient-centred outcomes is introduced.
- The matrix for identifying, measuring and monitoring institutional racism is incorporated into performance information and reporting requirements across the health system.
- Regional needs assessments determine projected needs of the population 5–10 years in the future to inform investment in prevention.

**LONG-TERM** (within 7–10 years)

- Outcomes data published that empower patients to make informed choices about treatment options and providers is made public, and includes data on the outcomes that matter most to each patient.
- Stakeholders are given financial and non-financial incentives to improve healthcare value, based on standardised high quality outcomes data.
our vision for a healthy Australia supported by the best possible healthcare system

- **HEALTH SERVICES ARE TRULY INTEGRATED AND CONNECTED**
  - The health workforce is flexible, competent, and working to the top of their scope of practice, and participates actively in the design and delivery of health services.
  - Hospitals are effectively utilised beyond distinct episodes of care, to also be a resource for primary, home and community-based care providers throughout a patient’s health journey; active engagement and promotion of primary and alternative care arrangements; and public health initiatives.
  - Participation of individuals and communities in the design and evaluation of health services is mainstream.
  - Health service planning is robust, based on strong data across all sectors of the health system and innovates at the regional, state and territory, and national levels.
  - Health promotion, prevention and early intervention services are receiving a greater proportion of innovation or grant funding.
  - Planning includes responses to pandemics and the effects of climate change, and includes proactive interventions to prevent or detect major health events.

- **HEALTH LEADERSHIP IS INNOVATIVE, DEDICATED TO IMPROVING OUTCOMES FOR COMMUNITIES**
  - Governance of health services covers individuals, and primary, community and hospital services, and is regionally administered and monitored and provides a continuum of care.
  - The health system is more nimble and able to take up improvements in care quickly. New treatments and technologies are evaluated and adopted (where suitable and sustainable) in an accelerated manner. Low value and superseded treatments are assessed and de-funded in a timely manner.

- **INDIVIDUALS AND COMMUNITIES HAVE IMPROVED SELF-REPORTED RATES OF HEALTH AND WELLBEING**
  - Individuals have access to their own health information that they can share and use to optimise their health outcomes.
  - Individuals and communities have more informed choice about the care they receive.
  - Risk factors for chronic disease (such as smoking, risky drinking, obesity etc.) are decreasing.
  - Positive health outcomes are attainable for all individuals and communities.

- **REAL-TIME, LINKED DATA, INCLUDING SELFCARE, PRIMARY, COMMUNITY AND HOSPITAL CARE DATA IS UTILISED TO UNDERSTAND INDIVIDUAL AND POPULATION HEALTH NEEDS**
  - Positive health outcomes are attainable for all individuals and communities.
  - The use of technology and data to evaluate outcomes, including PREMS and PROMS, is mainstream, with sharing of data across all sectors of health, and with the community.
  - Patient-reported experience and outcome measures (PREMS and PROMS) are collected and reported.

- **Efficient models of care are used to meet the needs of individuals and result in desired outcomes**

- **Health outcomes are used to assess health sector performance and the quality of patient care**

- **Health literacy and self-care are on the rise**

- **Health outcomes are used to assess health sector performance and the quality of patient care**

- **Individuals have access to their own health information that they can share and use to optimise their health outcomes**

- **Individuals and communities have more informed choice about the care they receive**

- **Risk factors for chronic disease (such as smoking, risky drinking, obesity etc.) are decreasing**

- **Positive health outcomes are attainable for all individuals and communities**

- **The health system is more nimble and able to take up improvements in care quickly. New treatments and technologies are evaluated and adopted (where suitable and sustainable) in an accelerated manner. Low value and superseded treatments are assessed and de-funded in a timely manner**
Australia’s public healthcare system is being severely tested by uncoordinated reforms occurring at both the Commonwealth level and within individual jurisdictions, all in the absence of any agreed overarching healthcare strategy, along with mounting financial strain and increasing demand. Although Australians have had access to universal healthcare for more than 30 years, our system is not immune to pressures such as an ageing population, a growing burden of chronic and complex disease, rising individual and community expectations, and escalating healthcare costs associated with new technology and escalating healthcare costs. Strategic leadership is needed to address these challenges, in particular with associated new technology and escalating healthcare costs. The provision of effective and efficient universal healthcare, along with mounting financial strain, requires consideration of the social determinants of health, as well as a preventive approach to healthcare, supported by deliberate investment by government. ‘Health’ as a key decision-making factor in all areas of policy is widely supported (WHO 2014a), including recognition of the significance of the early years of life.

Heath should be seen as an investment, not just a cost. As reinforced in the Productivity Commission’s recent report, there is a strong rationale for a greater emphasis on public health and prevention in an integrated system (PC 2017), with expenditure on such measures contributing to budget repair by reducing future demand on the health system while simultaneously improving health outcomes and quality of life for all Australians.

Innovative initiatives that focus on prevention can create savings through reduced healthcare costs in the future and improve quality of life over the life course. With the fourth Intergenerational Report highlighting the pressure that health costs will place on the Commonwealth budget (Treasury 2015), it is vital that the Commonwealth and the state and territory governments collectively and cooperatively work in partnership to create a health system that is not constrained by Constitutional barriers or political positions. Similarly, vested professional and financial interests should be removed in order to foster innovation within the health sector.

A whole-of-system approach to reform is needed to ensure Australians with multiple care needs are able to seamlessly access services. As our population ages and rates of chronic disease continue to rise, Australians will increasingly find themselves in need of multiple types of care. Better coordination is required, both within the healthcare sector and with other sectors such as aged care and disability services. Greater coordination and integration of services across care sectors will ensure better service delivery, improved efficiency, better health outcomes and improved quality of life. The intersect between concurrent reforms across care sectors must be clearly understood and coordinated so as to prevent unintended consequences of bilateral government reforms.

Alternative models of care must also be matched with complementary payment models, as traditional payment mechanisms such as fee-for-service can create perverse incentives and encourage fragmented care. There should be mechanisms to support innovation where traditional funding frameworks can be challenged, and flexibility for different approaches to be trialed. For the health system to be meaningfully and sustainably re-orientated, it is vital that the Commonwealth and the state and territory governments collectively and cooperatively work in partnership to coordinate funding arrangements for the Commonwealth and the states and territories.

While Australia’s rate of growth in health spending has slowed in recent years (AHW 2016), there has also been a shift in the proportions different funders contribute. The proportion of total spending provided by governments has reduced in recent years, with relatively higher proportions now coming from private sources, e.g. private health insurers, compensation, individual out-of-pocket expenses and unpaid informal carers. Australians spend more on out-of-pocket healthcare costs than the OECD average (OECD 2015).

The overarching objective of the public healthcare system should be to ensure high quality care that is equitable, accessible and affordable. Health budget sustainability must include the concept of affordability for individuals and communities while acknowledging capacity to pay and individual/family/community health vulnerability. The concept of affordability is key to ensuring that the health system is stable and able to effectively respond to emerging and future needs. As Australia has a high quality health system delivering world-class population health outcomes, however, for some groups, health outcomes are poor. There is an increasing incidence of sexually transmissible infections and blood-borne viruses, as well as hospitalisation for injury and poisoning (AIHW 2016). As the population ages, rates of chronic disease increase and individual and community demand grows, resulting in increasing pressure on the health system. Innovative approaches to health service delivery, underpinned by a strong evidence base, are required to respond to these challenges.

The Australian Government, in partnership with all state and territory governments, must also provide leadership on proactively redefining traditional workforce models of healthcare delivery, recognising that vested professional and financial interests are an impediment to effective structural reforms in the way health services are designed, delivered and remunerated.
four steps towards outcomes-focused and value-based healthcare

‘Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs’ (Porter 2010).

Outcomes-focused and value-based healthcare can be better enabled through a whole-of-government approach to achieve:

1. a nationally unified and regionally controlled health system that puts patients at the centre

2. performance information and reporting that is fit for purpose

3. a health workforce that exists to serve and meet population health needs

4. funding that is sustainable and appropriate to support a high quality health system.

OBJECTIVE
The Commonwealth and the states and territories working in partnership to implement a nationally unified but regionally responsive health system, delivering integrated care and services centred on people’s needs.

OPPORTUNITY IN THE POST-2020 AGREEMENT
The following need was identified in the National Health Reform Agreement (CDAG 2012). ‘The Commonwealth and the States will work together on system-wide policy and state-wide planning for GP and primary health care given their impact on the efficient use of hospitals and other State-funded services, and because of the need for effective integration across Commonwealth and State-funded health care services’. For this to be realised, however, effective governance arrangements need to be formalised.

Leadership is needed to ensure the mechanisms to effect change at the regional level, at appropriate scale and pace, are established. For regional accountability and responsiveness, governance arrangements across the health sector need to ensure desired outcomes and value can be achieved. This will promote coordination of health service delivery, address unmet need and improve efficiency.

CURRENT CONTEXT
The National Health Reform Agreement (NHRA) identifies shared objectives and the division of roles and responsibilities between the Commonwealth, and the states and territories (CDAG 2012). However, governance arrangements for the provision of services at a regional level do not provide for coordinated care across the health sector as a whole. Public hospitals are governed by Hospital and Health Services or Local Health Districts/Networks (LHNs) accountable to state and territory governments. Private sector, general practice, pharmacy and allied health services are subsidised by, and accountable to, the Commonwealth. Some primary care services are commissioned by Primary Health Networks (PHNs), which rely on funding from, and are accountable to, the Commonwealth. Finally, the states and territories are responsible for community health services.

In the absence of an agreed primary healthcare strategy, it could be argued that reforms to reduce avoidable hospital admissions and presentations will not be effectively achieved. Clarity and coordination of roles and responsibilities is essential in strengthening the interface between hospitals and the primary care sector. By taking a more collaborative approach to the funding and delivery of care across these settings, savings and other efficiencies can be internalised to the joint benefit of all governments. Collective decision making through an independent agency with multi-jurisdictional representation has been effectively demonstrated with the Independent Hospital Pricing Authority (IHPA).

At a regional level, the formation of collaboratives and the pooling of funding to co-commission are occurring in some areas. However, governance arrangements can vary across and within jurisdictions, and often are not formalised. The value of establishing governance mechanisms to support a nationally unified and regionally controlled health system has been recognised internationally. For example, in the United Kingdom it has been argued that, ‘providers of services should establish place-based “systems of care” in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them’. Without effective governance and oversight, a “fortress mentality” can develop, with each service ‘acting on others’ at the expense of the population’.

In such circumstances ‘commissioning should be much more integrated and strategic in order to support the development of place-based systems of care’ (Ham & Alderwick 2015).
### RECOMMENDED ACTIONS

#### SHORT TERM (within 2 years)

A governance structure with funding responsibilities is created to support integration of health services at a regional level to achieve outcomes-focused and value-based healthcare. Given the shared roles and responsibilities between the Commonwealth and the states and territories, this would be achieved via the establishment of an independent national health authority, distinct from the Commonwealth, and state and territory health departments, guided by a skills-based Board with multi-jurisdictional representation and, consumer and professional expertise, reporting directly to COAG (or the COAG Health Council).

The authority assumes responsibility for stewardship of functions currently led by HPA, the Administrator of the National Health Funding Pool, AIHW, the Australian Digital Health Agency and ACSQHC.

The authority assumes responsibility for stewardship of coordinating improvements in primary and dental care and cross-sector integration, including:

- providing independent oversight of regional needs assessments, and identification of priorities in primary healthcare and prevention
- ensuring coordination and integration between states and territories, LHNs and PHNs (including processes for distribution of pooled funding at a regional level)
- distributing Commonwealth funding to PHNs
- financial management and audit of PHNs
- performance monitoring and reporting for PHNs
- providing advice on optimal use of existing capacity and evolving opportunities within general practice and primary healthcare services.

The authority becomes the single source of truth for national health data collection (performance and funding), bringing together and rationalising current disparate investments in data collection by the Commonwealth across the Australian Bureau of Statistics (including the National Health Survey), the AIHW, the Commonwealth Department of Health, Medicare and other smaller agencies.

Agreements between the Commonwealth and PHNs, and the states and territories with LHNs, establish consistent governance arrangements for regional needs assessments, priority setting and funding, aimed at a coordinated and integrated approach to reducing preventable hospital admissions and presentations.

#### MEDIUM TERM (within 5 years)

The independent national health authority reports annually to the Commonwealth, and state and territory parliaments on its key performance indicators which align with our vision for a healthy Australia supported by the best possible healthcare system.

Reporting supports regional needs assessments.

Reporting replaces current (and often duplicated) reporting, e.g.:

- the biennial report by AIHW to the Australian Parliament on Australia’s Health
- the Report on Government Services
- National Health Performance Framework reports.

The independent national health authority supports efficient alignment of all agreements established by the Commonwealth and associated ‘independent’ entities such as NPS MedicineWise.

### OBJECTIVE

Whole-of-system health performance information and reporting is that focused on health outcomes, and facilitates achieving value in healthcare and transparency of performance.

### OPPORTUNITY IN THE POST-2020 AGREEMENT

Leadership is needed to establish a system where data accurately reflect care outcomes and are in the right format, timely and of sufficient quality to discern critical relationships between investment and results, as appropriate, for different audiences and purposes.

### CURRENT CONTEXT

Health performance information and reporting serves a number of purposes:

- For the public—patient-friendly and clinically-relevant statistical information to inform individuals and communities, promote transparency and support research.
- For the point of care—enabling comparisons in order to drive service improvements.
- For jurisdictions—informing policy and driving health system improvements.
- For regions—driving strategic directions and allocation of funding and resources

Publishing information on health system performance can improve clinical outcomes for patients and benefit the system as a whole. This occurs in two main ways:

- Increased consumer knowledge of healthcare provider performance can help consumers make informed choices (leth low-performing providers losing market share and making meaningful changes to improve performance in response); and
- Increased healthcare worker knowledge of their own performance can motivate them to provide better care.

### DATA STANDARDS

There are national standards for data on hospital services. Performance data for all public hospitals are largely provided to the AIHW by state and territory health authorities (AIHW 2017), while activity and cost data are provided to HPA. The provision of data by private hospitals is voluntary, although work being led by the Queensland Government Department of Health is exploring the extent to which mandatory reporting of healthcare quality and safety information should be extended to private healthcare service providers (Patient Safety and Quality Improvement Service 2017). As a fundamental requirement for receipt of funding by private hospitals is voluntary, although work being led by the Queensland Government Department of Health is exploring the extent to which mandatory reporting of healthcare quality and safety information should be extended to private healthcare service providers (Patient Safety and Quality Improvement Service 2017). As a fundamental requirement for receipt of funding by private hospitals is voluntary, although work being led by the Queensland Government Department of Health is exploring the extent to which mandatory reporting of healthcare quality and safety information should be extended to private healthcare service providers (Patient Safety and Quality Improvement Service 2017).
In the National Healthcare Agreement, ‘potentially preventable hospitalisations’ are a health system performance indicator of accessibility and effectiveness. This indicator has also become a headline performance indicator for PHNs given their key objective of improving coordination of care to reduce these hospitalisations. While the indicator may be calculated from routinely collected hospital data, it has significant limitations as an indicator of variation in the provision or quality of primary care. A key limitation is that not all of the hospitalisations captured by the indicator could have been prevented, at least in the short term. For example, there is often a long period between primary prevention initiatives and disease onset or complications. Further, it is influenced significantly by factors not easily influenced by health policy-makers (e.g. by socioeconomic status and prevalence of disease). The current specification also does not include all conditions which could potentially be used to measure the number of potentially preventable hospitalisations (Palmer & Jorm 2017).

There have been various efforts over the years to draw together primary health data, including the Bettering the Evaluation and Care of Health (BEACH) program, data extraction and analysis tools used by PHNs, and NPS MedicineWise. However none have been completely successful, with data collection being pursued in the absence of a national minimum dataset for primary healthcare, with the Commonwealth, and the states and territories having joint roles and responsibilities, and strong interest in reforms to reduce avoidable hospital admissions and presentations through primary care initiatives, coordinated performance information and reporting is critical. Much reform is currently occurring in the primary healthcare sector in the absence of a national minimum dataset, e.g. the development of a performance framework for PHNs and the implementation of Health Care Homes. There is also increasing interest across the health system in applying PREMs and PROMs to safety and quality improvement, but patterns of collection in Australia are highly variable (Centre for Health Service Development, AHRI 2016). These are used widely in clinical trials and other research settings; however their use is often limited to groups who have consented. This indicator also has also become a headline performance indicator for PHNs given their key objective of improving coordination of care to reduce these hospitalisations.

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OBJECTIVE
A health workforce that supports service delivery models that are accessible and address population health needs more effectively and efficiently.

OPPORTUNITY IN THE POST-2020 AGREEMENT
Leadership is needed to proactively redefine traditional workforce models of healthcare delivery that better address population health needs. Leaders must recognize that vested professional and financial incentives are an impediment to effective structural reforms in the way health services are designed, delivered, and remunerated.

CURRENT CONTEXT
There are joint roles and responsibilities between the Commonwealth (Government and state and territory) governments relating to the health workforce and their education and training requirements. At both Commonwealth and state and territory levels, there is significant focus on the number and distribution of health professionals regulated under the Health Practitioner Regulation National Law 2009 (the National Law). In particular, medical professionals and nurses. However, the data does not currently capture information about accessibility, responsibility, acceptability, quality and appropriateness. Further, data on numbers and distribution need to be interpreted in terms of evolving and innovative changes in scopes of practice and models of care, particularly with growing evidence of the comparative cost-effectiveness of allied-health-led care and multidisciplinary involvement in models of care across the patient journey (Office for Professional Leadership 2015). Data related to scopes of practice and use of the non-registered workforce are also unavailable.

The development of a National Allied Health Dataset will be important for understanding the contribution and costs of this workforce, provided it is linked with outcomes (Stephens & Envin 2015). The Productivity Commission noted ‘labour costs comprise a large share of health expenditure, and so making better use of health workforce skills and competencies could lead to large efficiency gains’. There is evidence that some tasks that are currently the exclusive responsibility of particular professionals could be performed just as effectively by others, without compromising patient safety or the quality of care. Carefully relaxing some specific regulations affecting scopes of practice could allow workers to be better allocated to tasks where they can add the most value, and reduce the labour resources needed to effectively deliver specific health care services (freeing up workers to deliver more services and potentially improving patients’ access to health care) (PC 2016). The former Commonwealth entity Health Workforce Australia reported that a ‘business as usual’ approach to the health workforce is not sustainable, with a need for coordinated, long-term reforms by government, professions and the higher education and training sector for a sustainable and affordable health workforce. The main policy levers required for change include regulation and rethinking workforce training capacity and efficiency, and workforce distribution, with innovation and reform measures identified as the area of most promise (HWA 2015).

While the National Law has an objective ‘to enable the continuous development of a flexible, responsive and sustainable Australian health workforce’, there is no shared vision documented for what such a workforce would look like. Further, there are limited mechanisms to ensure a match between health professional education and training and which is controlled nationally, and the workforce needs of the largely state-controlled healthcare organisations (Jaggo 2014). The review of the National Registration and Accreditation Scheme (NRAS) identified that an improved mutual understanding about the future agenda in workforce reform was needed. Submissions to the review showed an almost universal agreement on the importance of developing national workforce policy guidance that can be acted upon by all entities and processes within, and interdependently with, NRAS—consumers, employers, professional associations, education providers, National Boards and government departments (Woods 2017). Clinical training and experience, particularly clinical placements, are a critical component in preparing health professionals for practice. The quality and time in pre-registration placements has been recognised as one of the main influencing factors in determining career destinations for health professionals (Universitas Australia 2017). Support and incentives for placements are critical in terms of rural and remote distribution, but should also be considered in terms of areas of public need and service models.

With drivers to shift care from hospital to primary and community care sectors, there needs to be a similar drivers supporting clinical training placements in the latter settings, including primary healthcare, disability care, aged care and mental health. Without sufficient access to healthcare settings outside of public hospitals, the choice to practice in other settings (and their readiness to do so) is reduced. Promoting efficient and sustainable use of limited clinical training resources is of value and benefits all stakeholders. While IHPA is designing a nationally consistent method of classifying teaching and training activities and the associated costs to inform activity-based funding (ABF) in public hospitals, consideration of, and responsibility for placements beyond the hospital environment needs attention.
**Funding that is sustainable and appropriate to support a high quality health system**

**OBJECTIVE**

The Commonwealth and the states and territories work in partnership to ensure health funding achieves high quality health outcomes for Australians.

**OPPORTUNITY IN THE POST-2020 AGREEMENT**

Outcomes are the ultimate measure of success in healthcare. Leadership is needed to ensure funding is directed to health sector priorities and used effectively and efficiently to deliver high-value services.

While payment mechanisms are just one of the policy levers to address quality in healthcare, they are recognised as a powerful instrument in altering health provider behaviour in terms of the volume and quality of health services delivered (European Observatory on Health Systems and Policies 2014). Payment mechanisms can be used to drive sustainable transformations in healthcare that will improve individual and population health outcomes.

**CURRENT CONTEXT**

ABF and FFS can be effective mechanisms to achieve consistency and transparency in health service funding, although this can create inappropriate incentives to provide treatment and favour volume at the expense of effectiveness and quality of care. Equity and access can also be compromised. A value-based approach to funding aligns payment incentives with health system objectives. These objectives may be related to such things as quality, care coordination, health improvement and efficiency, with the achievement of targeted performance measures rewarded. They typically blend or augment base payment systems (European Observatory on Health Systems and Policies 2014).

In Step 2 of this paper, recommendations relating to performance information and reporting have been identified. However, there are still challenges in applying funding and financing models to performance measures. The literature is growing, as are examples locally and internationally, from which we can learn. Factors that have been identified for the success of a value-based approach include:

- defining performance broadly rather than narrowly
- attention to limiting patient selection and health-reducing substitution
- including risk adjustment for outcome and resource measures

**RECOMMENDED ACTIONS**

**SHORT TERM**

Within 2 years

- Current Commonwealth funding levels for public hospitals, including the growth formula, are maintained for 7 years with a review commencing at year 5, to determine funding which could be quarantined as pooled PHN/LHN regional funding for cross-sector care coordination and delivery.

**MEDIUM TERM**

Within 5 years

- Funds are dedicated to prevention activities based on the regional needs assessments determining projected needs of the population over 5–10 years. These funds should initially target a return to funding levels commensurate with the average in recent years of around 23% of recurrent expenditure on health, with the increase in funding being incremental over 5 years.

**LONG-TERM**

Within 7–10 years

- Follow-up improvements in analytical and reporting capability, stakeholders are given financial incentives to improve healthcare value on the basis of outcomes data.
Abbreviations and acronyms

**ABF** Activity-based funding  
**ACSOHC** Australian Commission on Safety and Quality in Healthcare  
**AHHA** Australian Healthcare and Hospitals Association  
**AHMAC** Australian Healthcare Ministers Advisory Council  
**AIHW** Australian Institute of Health and Welfare  
**BEACH** Bettering the Evaluation and Care of Health program  
**COAG** Council of Australian Governments  
**FFS** Fee-for-service  
**ICHOM** International Consortium for Health Outcomes Measurement  
**ICT** Information and communications technology  
**IHPA** Independent Hospital Pricing Authority  
**LGBTIQ** Lesbian, Gay, Bisexual, Transexual, Intersex, Queer  
**LHN** Local Health Network (also known as Hospital and Health Service or Local Health District)  
**MBS** Medicare Benefits Schedule  
**NDIS** National Disability Insurance Scheme  
**NEAT** National Emergency Access Target  
**NEP** National Efficient Price  
**NHRA** National Health Reform Agreement  
**NRAS** National Registration and Accreditation Scheme  
**OECD** Organisation for Economic Cooperation and Development  
**PHN** Primary Health Network  
**PREM** Patient-reported experience measure  
**PROM** Patient-reported outcome measure  

References


Enough? How Much Does Australia Spend and Is It Enough? Canberra: Foundation for Alcohol Research and Education. 


