AHHA Response to the Mid-term review of the National Health Reform Agreement

Submission

22 May 2023

OUR VISION

A for 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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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This submission has been prepared to provide input to the Mid-term review of the National Health Reform Agreement (NHRA) Addendum 2020-25. As an independent peak body focused on whole of system reform, the Australian Healthcare and Hospitals Association (AHHA) recommends governments pursue national health reform through an agreement that:

Enables health, rather than drives health care.

- This requires a fundamental paradigm shift that expands the focus beyond public hospital funding to focus on improving health and health inequities.

Supports place-based approaches to care.

- This requires recognition of the place-based nature of health and health care. Collaborative health system planning between key strategic partners (e.g., Local Hospital Networks (LHNs) and Primary Health Networks (PHNs)) must introduce enforceable obligations, with a single longer-term plan that guides investment and incentive decisions for the shared region, including physical infrastructure, digital infrastructure and workforce. It must ensure funding enables place-based models of care where universal policies are inadequate for improving health outcomes and equitable access to care.

Establishes a learning health system.

- This requires providing the digital infrastructure and enabling policy environment for a systematic approach to iterative, data-driven improvement in health care. A framework for national monitoring and evaluation of initiatives implemented by all levels of government will be important, capturing the outcomes achieved, as well as the processes and contextual factors on which those outcomes were dependent. It will require resourcing for health services and stewards to lead, interact and engage as learning health systems from a place-based perspective.

Implements integrated, place-based health workforce planning within a national framework.

- This must be needs-driven, not just demographically driven; be integrated with planning for health care services and health care funding; respond to, and inform, skill-mix innovation; and have the political commitment, governance and data to drive the necessary intersectoral support for a sustainable health workforce.

Drives de-implementation of low and no value care.

- This will require support for engaging and communicating with affected patient populations, ensuring an understanding of contextual and individual factors; implementation of transparent, data-driven approaches; and consistent price signals and financial incentives for high value care.

INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide input to the mid-term review of the National Health Reform Agreement (NHRA) Addendum 2020-25.

ABOUT AHHA

AHHA has been the national voice for public health care for more than 70 years, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and healthcare is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

ABOUT THIS SUBMISSION

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders as we contribute to the evolution of our health system.

In addition to numerous interviews with members, three dedicated virtual workshops were held with members in the preparation of this response to explore specific elements in health reform: the health workforce; equity; and primary and preventive care.

In preparing the submission, we acknowledge that the Review is limited to the operation of the National Health Reform Agreement Addendum 2020-25 and related factors, and not the operation of the entire health system.

1. ENABLING HEALTH, NOT DRIVING HEALTH CARE

- Agreements to date have focused on public hospital funding. Beyond hospital funding, the focus has largely been hospital performance, efficiency and transparency.
- Continuing a hospital centric approach to the Agreement will undermine the ability of the health system to provide universal, equitable, high-quality and sustainable care.

The Agreement requires:

- A fundamental paradigm shift that expands its focus beyond public hospital funding to focus on improving health and health inequities.

AGREEMENTS ARE CURRENTLY CENTRED AROUND HOSPITAL FUNDING

The Commonwealth and States and Territories have long shared many roles in policy, funding and regulation of the health system, with service delivery largely undertaken by the state and territory governments and the non-government sector.

Over time, intergovernmental agreements relating to health have evolved the roles and responsibilities of different tiers of government; from pre-Medicare Agreements, to Medicare Agreements (1984), Australian Health Care Agreements (1998), the Intergovernmental Agreement on Federal Financial Relations (2008) and the associated National Healthcare Agreement and Partnership Agreement, the National Health and Hospitals Network Agreement (2010) and the National Health Reform Agreements (2011).[1]

Successive reviews of these agreements have focused on issues of access, efficiency, quality and safety, sustainability, responsiveness, transparency and accountability. Such issues have not been ignored by governments, but responses have varied over time as Agreements have been developed.

Regardless, Agreements have centred on the funding of public hospitals first and foremost. While services beyond the hospital walls have previously been considered within Agreements (e.g., community health services in the Medicare agreement (1984), and Medicare Locals and then Primary Health Networks in the National Health Reform Agreements (2011)), cooperation beyond hospital funding has largely focused on hospital performance, efficiency and transparency.

HEALTH DOESN'T START AT HOSPITALS

Health is a fundamental human right. It is a right to the enjoyment of the highest attainable standard of physical and mental health, and is indispensable for the exercise of other human rights.[2] Australia has recognised the right to health through the International Covenant on Economic Social and Cultural Rights.

The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[3] It is well-recognised that factors such as where we live, our environment, education and income, and early life and social support

networks through life have a greater impact on our health, other than access and use of hospitals and health care services.

The WHO recognises that without the right incentives, health systems will naturally gravitate towards more specialised, hospital-centric care; arguing that hospital-centric approaches undermine the ability of health systems to provide universal, equitable, high-quality and financially sustainable care. As such, it advocates for hospitals to be part of an integrated person-centred health system.[4]

The Kings Fund (UK) further argues that the health system's focus must shift beyond integrating care for people with complex care needs, to being part of a system that focuses on promoting health and reducing health inequities.[5][6]

In Australia, the unsustainable demand on our hospitals will only begin to be addressed by shifting our focus from siloed investment approaches in vertical and priority programs, to 'upstream' social, economic, cultural, commercial and environmental factors that contribute to health.

THE HEALTH SYSTEM HAS A ROLE IN SHIFTING THE FOCUS UPSTREAM

The current National Health Reform Agreement (2020) defines its purpose as 'the shared intention of the Commonwealth, State and Territory governments (the States) to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system'.[7]

Accordingly, the Agreement must position the health system to have a more comprehensive role in shifting the care focus upstream and addressing the determinants of health. The WHO has outlined four intersectoral action categories that can guide the health system's contribution to addressing the social determinants of health (***Box 1***).

Box 1. Actions by which the health system can address social determinants of health

The WHO broadly categorises intersectoral actions that address social determinants of health by those that:[8]

- **Stratify** populations to reduce inequalities, mitigating effects of stratification
- Reduce **exposures** of disadvantaged people to health-damaging factors
- Reduce **vulnerabilities** of disadvantaged people
- Reduce **unequal consequences** of illness in social, economic and health terms.

The Agreement must define a more active role, for all facets of the health system, in reducing health inequalities. Obligations for health services and stewards in addressing inequity must include a focus on access to safe, high-quality care through:

- ensuring resources are distributed between areas in proportion to relative needs;
- responding appropriately to the needs of different population groups; and
- leading a more strategic approach to the development of public policies at both national and local levels to improve the health of disadvantaged communities.[9]

Globally, health systems are shifting towards value-based health care (VBHC) as a framework for bringing stakeholders together around a shared goal of improving health outcomes, sustainably and equitably. For example, the European Union, defines VBHC as comprehensively providing appropriate care to achieve patients' personal goals (personal value), achieving the best possible outcomes with available resources (technical value), equitably distributing resource across all patient groups (allocative value) and healthcare contributing to social participation and connectedness (societal value).[10]

VBHC provides a model on which the Agreement can operationalise its focus on improving health and health inequities.

WHAT THIS MEANS FOR THE NATIONAL HEALTH REFORM AGREEMENT

For the National Health Reform Agreement to achieve its purpose of sustainably improving health outcomes, there must be a paradigm shift. The Agreement must not only expand its focus beyond hospital funding; it must fundamentally change its focus to health.

Such a change would frame the shared intentions and the strategic priorities that underpins all health policy – how we define equitable access and universality, the way people and communities are engaged in service design, the way we invest in data and digital infrastructure, who our workforce is and the way they are engaged in care, and the way we introduce and fund innovation.

2. SUPPORTING PLACE-BASED APPROACHES

- Hospitals and health services are inextricably linked to the wellbeing of their communities, through the provision of health care, but also through influencing, for example, employment and investment decisions.
- Place-based approaches to health care recognise the variation in need between communities and ensure existing assets are leveraged in models of care to strengthen the system overall.

The Agreement must:

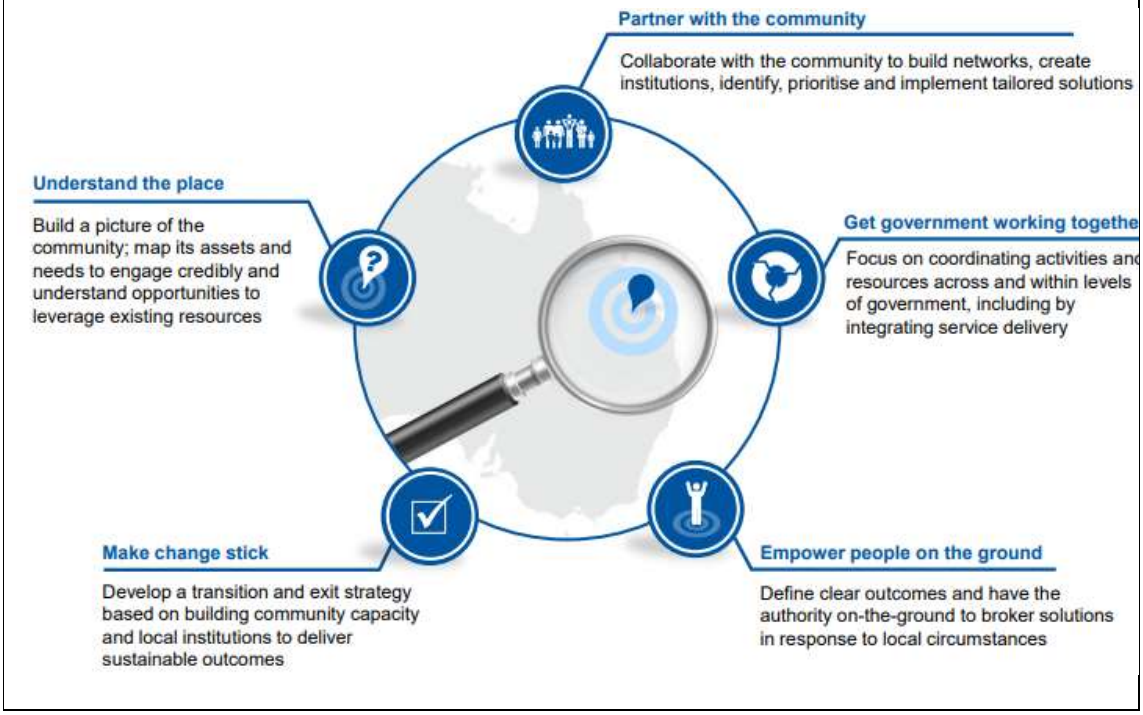
- Recognise the place-based nature of health and health care.
- Introduce enforceable obligations for collaborative health system planning between key strategic partners (e.g., LHDs and PHNs), with a single longer-term plan that guides investment and incentive decisions for their shared region, including physical infrastructure, digital infrastructure and workforce.
- Ensure funding enables place-based models of care where universal policies are inadequate for improving health outcomes and equitable access to care.

THE PLACE-BASED NATURE OF HEALTH AND HEALTH CARE MUST BE RECOGNISED

Hospital and health services are inextricably linked to the wellbeing of their communities. Their impact is more than just the provision of health care. They also have influence, for example, on employment, investment and purchasing decisions within the local community. The decisions that are made about the way health care is provided thereby impacts the safety, vibrancy, and stability of those communities.

The Agreements between the Commonwealth and States and Territories have, over time, included initiatives to drive local responsiveness to community need (e.g., community health services (1984); Medicare Locals and then Primary Health Networks (2011)). These inclusions to the Agreements provided a platform for place-based approaches, which are designed and delivered with the intention of targeting a specific geographical location and particular population group to respond to complex problems. They focus simultaneously on place *and* people.[11] As such, place-based approaches not only recognise that needs vary between communities, but also how assets and resources vary. The resulting healthcare responses are thereby designed to build community capacity so the system is strengthened overall (see ***Figure 1***[12]).

Figure 1. Effective place-based initiatives



GREATER ACCOUNTABILITY IS NEEDED FOR COLLABORATION

Within the current National Health Reform Agreement, joint planning and funding at a local level is identified as one of the priorities for long-term health reform (clause C1.). Here it refers to the Local Hospital Districts (LHDs) or equivalent and Primary Health Networks (PHNs) collaborating in place-based planning and investment decisions. However, the collaboration is only 'encouraged' (clause C26.a.), and as such there is variability in the commitment and investment from different entities. It has been reported anecdotally that too much collaboration is achieved based on interpersonal relationships between the individuals in key roles, rather than systematically embedded in structures that can persist when individuals leave those roles.

Relationships for successful collaboration are also resource-intensive to maintain. When funding drives transactional care, rather than relational care, the structures that enable collaboration are consequently under-resourced. This is a particular risk in the primary care sector where a large number of small businesses operate outside a formal governance structure.

Therefore, greater accountability is needed within Agreements to systematise collaboration, supported by adequate resourcing. There should be accountability for key strategic partners (e.g., LHDs and PHNs) collaborating in a single place-based plan for a region's health system. Investments, regardless of the funding mechanism or source, should be required to respond to the needs that have been identified and prioritised in that plan. This would cover the capital infrastructure, digital infrastructure and the health workforce.

Such an approach would also help to mitigate against political and vested commercial interests driving investments that are inconsistent with the allocative and societal value of investments.

THE MODEL OF CARE MUST INFORM THE FUNDING MODEL, NOT VICE VERSA

Current funding streams can be a barrier to sustainable care models that would better meet people's needs.

The flexibility to redistribute Commonwealth funds allocated for services within hospitals to other sectors has restrictions. These restrictions can apply even when evidence supports the shift. For example, moving from the hospital to models of care outside of the hospital or to care models that leverage technological advances. Innovation, when it has occurred, has typically occurred as a result of the states redistributing their own funding contributions, rather than innovation being incentivised by the Commonwealth. However, the ability for States to sustain these innovations is challenged if the model results in a reduced funding contribution from the Commonwealth.

Outside of Agreements, the Commonwealth provides funding for primary care through a range of mechanisms, including the Medicare Benefits Schedule (MBS), general practice incentive payments, the Community Pharmacy Agreement, Primary Health Network commissioning, direct funding of initiatives and Partnership Agreements with states and territories, as well as through the National Disability Insurance Scheme (NDIS) and aged care funding. States, in addition to contributing to hospital funding, also fund primary and community care through a range of programs.

Local service providers may be recipients of multiple funding streams, particularly those providing services to priority populations. These services then use this mixed funding to develop a service offering that not only meets the contractual obligations of each funding stream, but meets community need and provides a coherent employment model for their workforce. The viability of the service offering as a whole is often then dependent on maintaining all of the funding streams.

This can be a particular concern in thin markets. While these have been the subject of many reviews, debates about thin markets use terminology variably and there is limited evidence to guide policy.[13] What we observe though, in Australia, is governments applying their stewardship of such markets in silos (between health, aged care and disability sectors; between levels of government; and between programs within each level of government). Instead, we need collaborative, place-based approaches to longer-term planning, investing in and evaluating of healthcare models.

WHAT THIS MEANS FOR THE NATIONAL HEALTH REFORM AGREEMENT

The current National Health Reform Agreement (clause C24.e.) acknowledges that mixed funding and accountability arrangements do not incentivise providers to plan, work and coordinate care together.

The next Agreement should enable the health system to respond with place-based approaches where:[14]

- universal policy approaches have not been effective in resolving entrenched complex problems in particular places;
- an understanding of the local context is essential to addressing the problem; and

- there is community appetite to invest in a new approach.

The Agreement should ensure Governments provide the time, resources and commitment for place-based approaches through a single, longer-term plan for a region's health system. Collaboration between LHDs and PHNs, and more broadly with service providers and other stakeholders, must be routine and resourced. Together, commonly identified risks for place-based initiative can be addressed; with evidence and experience shared at all points of the policy and implementation cycle as part of a learning health system (as described further in Recommendation 3).

3. ESTABLISHING A LEARNING HEALTH SYSTEM

- In the health sector, where government funding and regulation have a heavy influence, it will be the diffusion of ideas and embedding of adaptive business models that will allow innovation to flourish.

The Agreement must:

- Provide the digital infrastructure and enabling policy environment for a systematic approach to iterative, data-driven improvement in health care.
- Resource health services and stewards to lead, interact and engage as learning health systems from a place-based perspective.
- Provide a framework for national monitoring and evaluation of initiatives, capturing the outcomes achieved, as well as the processes and contextual factors on which those outcomes were dependent.

DIFFUSION AND ADAPTIVE BUSINESS MODELS NEEDED FOR SUSTAINABILITY

In the health sector, where government funding and regulation have a heavy influence, it is not simply scientific breakthroughs that will drive innovative, high quality and sustainable health care. More significantly, it will be the diffusion of ideas and embedding of adaptive business models that will allow innovation to flourish.[15]

This innovation must occur across a complex mix of health professionals and service providers; delivering services in various ways and in numerous settings and who are funded, operated, managed and regulated from all levels of government and the non-government setting (AIHW, 2022). For the effective and efficient use of health professionals and service providers, we must challenge the current organisation of roles which have developed in the absence of evidence and over-specialisation of professions being misaligned with the current needs of the population.[16]

It has long been recognised, globally and in Australia, that more generalist doctors are required to manage multimorbidity.[17] However, the numbers of non-GP specialists are growing faster than the number of GPs.[18] (Workforce reform is discussed further under Recommendation 4.)

These are not new issues but require changes that involve a coordinated approach to legislation, government policy and funding, and which politically may require confrontation with vested interests.[19]

The Australian healthcare system is a complex ecosystem that must respond to relentless demands and shifting internal and external pressures. As such, top down and linear models of change will be insufficient for improving performance. Instead, network models that draw from complexity science, that maintain pace with exponentially increasing volumes of evidence, and induce collaboration that transcends specialties and individual services will be needed.[20]

SYSTEMATIC APPROACH TO DATA-DRIVEN IMPROVEMENT NEEDED

Learning health systems have been identified globally as 'the next stage in quality improvement' and 'what is required to find a sustainable way out of the current crisis' for health systems. They are defined as 'a systematic approach to iterative, data-driven improvement', where a learning community is 'formed around a common ambition of improving services and outcomes'. [21]

While there are many examples of learning health systems, all with variation in their approaches, four common areas for achieving progress have been identified:[22]

- Learning from data
- Harnessing technology
- Nurturing learning communities
- Implementing improvements to services.

1. LEARNING FROM DATA

Data is a key component of achieving high-quality, high-value, safe and equitable care and is a foundational component of a learning health system. Bringing together information from different sources in a way that is easy to understand and act on is important, particularly for supporting care decisions for people with chronic and complex health needs.[23] It must also be brought together in a way that facilitates an understanding of both outcomes and costs.

A substantial volume of data is collected across the health system. The work of the Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Healthcare, as well as state-based agencies, continues to provide important population level insights and ongoing improvements in our understanding of variation.

However, while Australia's data linkage capability has grown substantially over the past 50 years, healthcare data remains steadfastly siloed. There are also still many challenges to real-time access to information in Australia.[24,25,26] These are due to challenges in stakeholder and community support, complex legal and ethical environments, cross-jurisdictional collaborations and a lack of continuous financial support.[27]

An example of a critically-needed enabler is a national, cohesive approach to standards for electronic health records. To contribute to a learning health system, electronic health records in primary care, for example, will require:

- A defined data model that links related data elements
- Consistent data element labels and definitions
- Use of standardised clinical terminologies and classifications.[28]

Such standards are important to harness technology in a way that is person-centred and across full care pathways. However, learning from data requires more than just the data. It requires teams to be supported to understand and interpret the data, for individual patients, as well as around communities and populations.

2. HARNESSING TECHNOLOGY

Interoperability among Australia's digital health technologies is immature. This issue, recognised by the Australian Digital Health Agency,[29] hinders continuous learning and improvement for teams across full care pathways.

While the technology itself may have been available for decades, its effective and sustainable implementation requires sector wide collaboration that blends the necessary national policies (e.g., standards for digital interoperability, education accreditation standards, an evaluation framework) with a place-based approach (e.g., implementation and evaluation for person-centredness and equity), as discussed under Recommendation 2 above.

3. NURTURING LEARNING COMMUNITIES

For a learning health system to be effective, a community of people with different roles and backgrounds must be committed to participating (a 'learning community'), with an ability to reconcile differing views and progress decisions. [30] Nurturing learning communities requires:

- Systematic approaches and iterative, continuous learning with implementation contributing to new best-practice care
- Broad stakeholder, clinician and academic engagement and co-design with a culture of learning and improvement
- Skilled workforce, capability and capacity building
- Resources with sustained investment over time
- Data access, systems and processes.[31, 32]

Although they might not be formally recognised as such, there are numerous examples of learning health systems being established in Australia). Most are condition-focused or thematic-based, for example, End of Life Directions for Aged Care (ELDAC) and Health Justice Partnerships. Others, such as the PHNs, drive significant activity through communities of practice and collaborations. While the NSW Statewide Initiative for Diabetes Management provides an example of a cross-sector service-led collaboration with focus areas aligning with those of a learning health system, i.e., capability building, shared information and data, identified governance and leadership with a focus on partnerships.

This small number of examples illustrates variation in how health services and stewards lead, interact and engage within such learning health systems from a place-based perspective. Available resources, workforce engagement and data availability continue to present challenges.

As such, there is significant opportunity for governments to resource place-based learning health systems more explicitly. Such support aligns with the long-term health reforms identified in the current Agreement (e.g., joint planning and funding at a local level) and should be a fundamental element of support in policy reforms that are currently being pursued (e.g., the introduction of voluntary patient enrolment in primary care (MyMedicare) and the exploration of value-based payments (see ***Box 2***[33]).

Governments should provide resourcing to initiate and sustain learning communities at the local level to build the evidence base for place-based solutions.

4. IMPLEMENTING IMPROVEMENTS TO SERVICES

Translating these solutions into practice must also be supported whereby existing local capability is enhanced to use the data to improve care.

With worldwide interest in implementation research, a growth in research literature has produced an increasing number of implementation frameworks. However, the terminology is inconsistently used to define constructs, measures, processes and activities. This has created a major problem in evaluating implementation of different models of care for the purpose of adoption, diffusion and spread.[34]

Place-based flexibility is important in designing innovative models of care, with flexibility needed both in the way funding is used as a policy lever and in how skill-mix changes and workforce reform can support new models of care. An evaluation model that is outcomes-focused will be important to support the necessary cultural shift for innovation. Agility will be important to continue to adapt and improve, with innovation being supported by the best available evidence and real-time engagement with data.

There is also a need to facilitate the diffusion of ideas between learning communities through the development of standardised frameworks for evaluating implementation. A framework is needed that not only identifies the outcomes achieved, but reflects the processes and contextual factors on which those outcomes were dependent. This will also be valuable when looking to evidence from other countries as health systems globally face similar challenges to Australia.

WHAT THIS MEANS FOR THE NATIONAL HEALTH REFORM AGREEMENT

The Agreement must support a learning health system by resourcing the digital infrastructure and enabling policy environment for a systematic approach to iterative, data-driven improvement in health care. It must commit to a framework for national monitoring and evaluation of initiatives that are pursued by all levels of government, capturing the outcomes achieved, as well as the processes and contextual factors on which those outcomes were dependent.

It must also resource health services and stewards to lead, interact and engage as learning health systems from a place-based perspective.

Box 2. Progressing value-based funding reform within a learning health system

The implementation of value-based payments through a learning health system approach was recently explored in a brief published by the Deeble Institute for Health Policy Research. The following is adapted from that brief.

Value-based payment models are a necessary step towards securing Australia's healthcare system sustainability. However, developing a value-based payment model is complex.

Policy direction suggests PHNs and LHNs will also be tasked with developing outcomes-based funding models, premised on the suggestion that local level planning will deliver better outcomes. To do this, PHNs and LHNs require the necessary skills and experience, policy levers, supporting infrastructure and workforce to appropriately implement a value-based payment model. Such a decentralised approach is unlikely to be efficient.

While the Long-Term Health Reforms Roadmap for the current National Health Reform Agreement identifies some of the enablers and approach, they are not adequately aligned, e.g., the trial of funding and payment reforms is planned prior to having a national approach to data governance arrangements, structures and process.

Implementing a value-based payment model in isolation will lead to duplication and missed opportunities to share learnings and iteratively improve value-based payment models.

The likelihood of developing a program of successful value-based payment models will be substantially greater if state, territory and federal governments develop a structured and supportive policy and institutional framework around the intent to trial and evaluate ongoing value-based payment models nationally.

4. A SUSTAINABLE HEALTH WORKFORCE

- The health system can only function with a strong and effective health workforce.
- A sustainable supply and appropriate skill-mix for the health workforce will require effective cooperation and governance across multiple sectors, including health, education, labour, trade, finance, gender and social welfare, as well as the engagement of the private sector, and across all levels of government – from the local to the national.

The Agreement must enable more sophisticated, place-based health workforce planning, within a national framework, that:

- Is needs-driven, not just demographically driven.
- Is integrated with planning for healthcare services and healthcare funding.
- Can transparently respond to, and inform, skill-mix innovation.
- Has the political commitment, governance and data to drive the necessary intersectoral support for a sustainable health workforce.

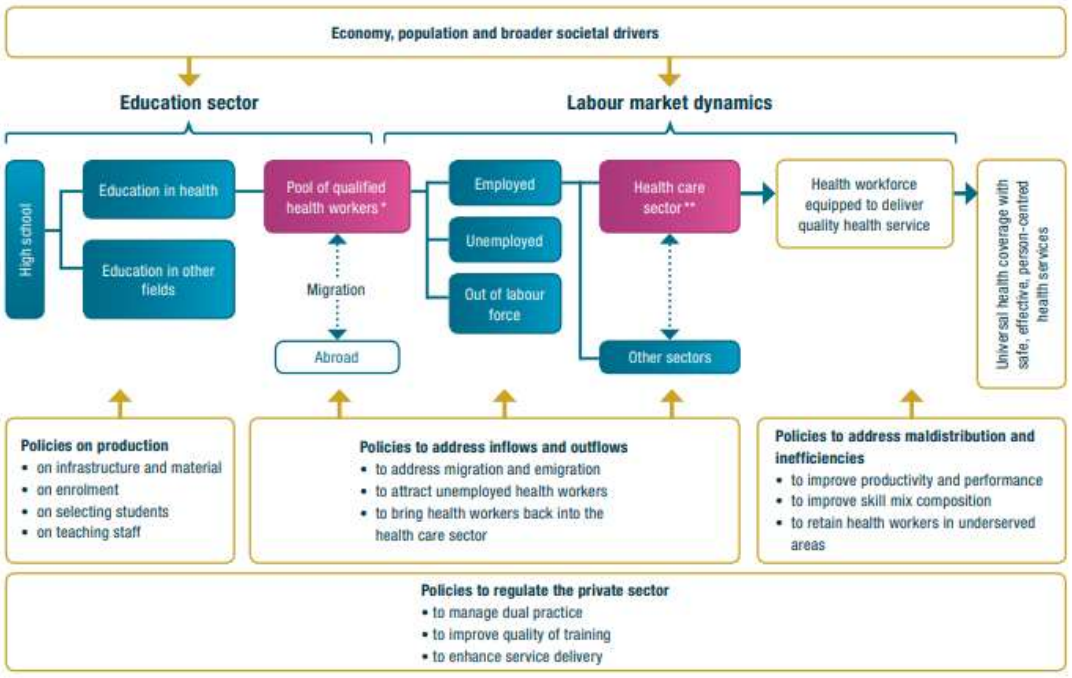
PERSISTENT WORKFORCE CHALLENGES REQUIRE COLLABORATIVE ACTION

A strong and effective health workforce is essential to a functioning health system. However, our members and stakeholders continue to identify workforce challenges as one of the most critical issues limiting universal access to health care. The challenges are diverse, and not unique to Australia:[35] workforce shortages, skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, a skewed gender distribution, limited availability of health workforce data, persist, often within an ageing workforce.

Matching and forecasting the needs, demands and supply of the health workforce is complex in any context. With epidemiological profiles and population structures evolving, the burden of non-communicable diseases and chronic conditions is increasing. Together with a progressive shift for person-centred, community-based and personalised long-term care, global demand for the health workforce is growing substantially. Over the next five years, in Australia alone, the National Skills Commission estimates that the health and social sector will require an increase of 301,000 skilled workers nationally. This is against a backdrop of a pandemic that has exacerbated the impact and pervasiveness of workforce burnout.

There are many policy levers that shape the health workforce. ***Figure 2***[36] provides a high-level summary. In Australia, policies shaping the health workforce are developed by a broad number of entities, including the federal government, state and territory governments, independent government agencies, professional bodies, unions and service providers.

Figure 2. Policy levers that shape the health workforce



* Supply of health workers= pool of qualified health workers willing to work in the health-care sector.
** Demand of health workers= public and private institutions that constitute the health-care sector.
Source: Sousa A, Scheffler M R, Nyoni J, Boerma T "A comprehensive health labour market framework for universal health coverage" Bull World Health Organ 2013;91:892– 894

However, policy levers are too often applied inconsistently across different sectors, our federated system and in relation to the global workforce market. For example:

- Incentives introduced to attract and retain a workforce in a particular setting, when applied in isolation of a place-based approach, can just shift shortages between sectors or geographical regions. This can result in a workforce misaligned with both community need and cost-effective resource allocation.
- The introduction of new models of care can be driven more by the vested interests of individual professions or services, rather than strategic investments based on evidence of quality, safety and demonstrated models of clinical governance. Even when rigorous health technology assessment processes are in place, the application process is resource-intensive and so likely to be pursued by those with potential for a commercial gain.
- Slow response to initiatives in the global market diminishes Australia's attractiveness as a country to which to migrate. This has been seen when visa processing times were significantly greater, or migration policies more restrictive, than competing countries.
- An over-reliance on internationally trained health professionals to meet population need.

- Recruitment of foreign-trained health professionals can raise ethical concerns when it increases vulnerabilities within countries already suffering from low health workforce densities.[37]
- Limited and sporadic policies and projects to support health workers to access affordable housing in reasonable proximity to work require long commutes and further impact on shortages.[38]

Policies can also be restrictive, inflexible and unsupportive of rural and remote or other contexts where there is high community need, e.g., some supervision and mentoring requirements applied by professional bodies, accrediting authorities or training providers.

SKILL-MIX INNOVATION MUST BE INTEGRATED WITH SERVICE AND FUNDING PLANNING

Achieving universal access to health care is closely linked to having the workforce with the right skills and knowledge to provide high quality care. Globally, debates have typically focused on achieving the required density and distribution of health professionals. However, this has occurred in professional silos, with limited attention to the team composition and skill-mix requirements,[39] and without consideration of the impact on productivity.[40] Further, planning for the health workforce is typically not integrated with planning for health care services and health care funding, despite any one of these functions having implications for the other.[41]

Skill-mix changes can occur through re-allocating tasks (e.g., non-medical prescribing; screening performed by nurses), adding new tasks and roles that did not previously exist (e.g., navigator and coordination roles) or introducing or changing teamwork (e.g., shared care). Importantly, the changes are not limited to health professionals, but can also include patients, peers, carers, vocationally trained health workers and 'machines' (through digital innovations).[42]

While there is limited guidance and evidence for what an appropriate skill-mix entails, the WHO recommends a community-based strategy that includes a variety of different health professions, educational levels and backgrounds as important for meeting population health needs sustainably and equitably.[43]

A scope of practice review to examine current models of primary care was recently announced in the 2023-24 Federal Budget, but to have impact, workforce planning must become more sophisticated.

INTERSECTORAL SOLUTIONS TO HEALTH WORKFORCE CHALLENGES

A sustainable supply and appropriate skill-mix for the health workforce will require effective cooperation and governance across multiple sectors, including health, education, labour, trade, finance, gender and social welfare, as well as the engagement of the private sector, and across all levels of government – from the local to the national.[44] The benefits are not one-directional – for example, with the health sector a significant employer across a wide range of education and skill levels; a large employer of women, migrants and other minorities; and providing employment across a dispersed geography, it can support broader aims around social development.[45]

As such, there has been global recognition that intersectoral collaboration is essential to developing and strengthening the health and care workforce, and this requires political leadership from the top to set the agenda.[46]

Governance will be critical in influencing the availability, accessibility and quality of the health workforce, 'requiring:

- Transparency of decisions
- Accountability of decision-makers
- Participation of stakeholders
- Integrity derived from fair and transparent procedures and management of the health workforce
- Capacity among decision-makers and other stakeholders to generate evidence-informed policies.'[47]

Reliable data and forecasting will be crucial. It must be timely and reliable, with planning tools that are place-based and context-specific. The evidence must be sufficiently granular that it extends beyond numbers and distribution of the workforce as it currently exists, and express supply and demand in terms of skill-mix and aims.[48]

WHAT THIS MEANS FOR THE NATIONAL HEALTH REFORM AGREEMENT

References to workforce in the current National Health Reform Agreement are largely limited to isolated capability requirements (e.g., in data, health literacy), rather than a strategic approach to Australia's health workforce.

Successful reform for a sustainable health system will require health workforce planning that extends beyond the numbers and distribution of professions in silos. Through the National Health Reform Agreement, a national strategy for the workforce is needed that drives skill-mix innovation that is integrated with health service and health funding planning. This will also require intersectoral political commitment that recognises a sustainable health workforce has benefits broader than just the health system.

5. DE-IMPLEMENTATION OF LOW AND NO VALUE CARE

- There is significant waste within healthcare systems, with one component being low or no value care.

The Agreement must drive a collective focus on de-implementation of low value care through:

- Engaging and communicating with affected patient populations, ensuring an understanding of contextual and individual factors
- Transparent, data-driven approaches
- Consistent price signals and financial incentives for high value care.

SIGNIFICANT WASTE WITHIN HEALTHCARE SYSTEMS CONTINUES

It has been estimated that only 60% of health care is consistent with guidelines, with 30% considered wasteful or low value and 10% harmful.[49] Wasteful health care was also identified in the landmark CareTrack Australia study. In studying 22 conditions, it was reported that Australians received appropriate care in 57% of consultations, ranging from 13% of consultations for alcohol dependence to 90% of consultations for coronary artery disease.[50] Large variations in low value services has also been reported in Australian public hospitals.[51]

Removing low and no value care has broad ranging benefits – for patient outcomes and experience, for financial sustainability of the health system, for environmental impact, and for the health workforce providing meaningful care.

There has been significant investment in identifying low or no value care in Australia. This includes:

- Wiser healthcare is a research collaboration for reducing overdiagnosis and overtreatment.
- The Australian Atlas of Healthcare Variation maps variation in care, derived from information routinely gathered by the health system, to show how healthcare use differs across the country and raise important questions about why this variation might be occurring. The aim is to prompt further investigation into whether the observed variation reflects differences in people's healthcare needs, in the informed choices they make about their treatment options, or in other factors.
- Evolve is a physician-led initiative to drive high value, high quality care.
- Choosing wisely is part of a global, health profession-led initiative to promote dialogue on unnecessary tests, treatments and procedures, and support people to choose health care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm and truly necessary.
- The MBS Review ran from 2015 to 2020 to consider how MBS items could be better aligned with contemporary clinical evidence and practice. Subsequently in 2021, the MBS Continuous Review was established to ensure the MBS continues to support high-quality care, remains flexible, and stays up to date. This is done through a process of ongoing expert reviews.

- Prostheses List reforms – The Australian Prostheses list has been under review since 2017. A taskforce was established in 2021 to implement an agreed set of reforms.
- The use of clinical quality registries and data analyses undertaken at the individual, organisation, state and agency levels.

Criteria to facilitate systematic and transparent prioritisation of existing, potentially cost-ineffective practices for detailed assessment have also been proposed.[52]

COLLECTIVE EFFORT NEEDED FOR DE-IMPLEMENTATION

Despite enthusiasm for initiatives to identify low or no value care, there have been few large-scale changes in the rates of low or no value reported.

De-implementation is an emerging area of research. Around the world, there has been a focus on de-implementation frameworks, e.g.

- Choosing Wisely De-implementation Framework in Canada, with five stages after identifying low value care:
  Phase 0, identification of potential areas of low-value healthcare;
  Phase 1, identification of local priorities for implementation of CW recommendations;
  Phase 2, identification of barriers to implementing CW recommendations and potential interventions to overcome these;
  Phase 3, rigorous evaluations of CW implementation programs;
  Phase 4, spread of effective CW implementation programs.
- Research in the Netherlands identified the most important barriers to reducing the overuse of care were a lack of time, an inability to reassure the patient, a desire to meet the patient's wishes, financial considerations and a discomfort with uncertainty. The most important facilitators were support among clinicians, knowledge of the harms of low-value care and a growing consciousness that more is not always better. Repeated education and feedback for clinicians, patient information material and organisational changes were valued components of the strategy.
- Research from Canada aimed to identify and characterise the use of theoretical approaches used to understand and/or explain efforts to reduce low-value care. The authors reinforce both the individual and contextual determinants to de-implementation efforts, and make particular reference to a novel perspective on the role of habit, and the need to address repeated behaviours that do not require decision-making processes, i.e., guided by habit more than attention. They also highlight passive interventions (education, guidelines, do not do lists) do not appear to be effective, with effectiveness increased with active interventions (financial incentives, data feedback and system level interventions).
- The Research Consortium for Health Care Value Assessment in the US propose a framework that first emphasises low hanging fruit to help demonstrate the potential for larger, systematic efforts to reduce low value care.

Given the cultural, structural, commercial and political barriers to successful de-implementation, collective action across all jurisdictions and sectors, public and private, is needed with clear governance and accountability through data feedback and price signals.

WHAT THIS MEANS FOR THE NATIONAL HEALTH REFORM AGREEMENT

For health system sustainability, reform needs to not only focus on incentivising high value care, but also on removing low and no value care.

The current National Health Reform Agreement included health technology assessments as an important enabling factor requiring collective action. This needs to be extended in the next Agreement to ensure price signals are applied consistently to remove incentives for low and no value care.

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