Healthy people, healthy systems

A BLUEPRINT FOR OUTCOMES-FOCUSED, VALUE-BASED HEALTH CARE.

ahha
australian healthcare & hospitals association
the voice of public healthcare®

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australian healthcare & hospitals association

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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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background

As Australian, state and territory governments were preparing for a new national health funding agreement in 2017, AHHA launched the first iteration of *Healthy People, Healthy Systems: A Blueprint for a Post 2020 National Health Reform Agreement*. This edition of the Blueprint reflects contemporary governance and maps out how to transform our healthcare system, reorienting our healthcare system to focus on patient outcomes and value through a series of short-, medium- and long-term actions.

The Blueprint was developed through substantial consultation with, and input from, AHHA's Board, membership and stakeholders across the hospital, primary and community health sectors—including clinicians, academics, policymakers, administrators and consumers. There was a shared commitment across the system for the shift to outcomes-focused, value-based health care.

Since its release in 2017, all Australian governments have now signed on to the *Addendum to the National Health Reform Agreement 2020-25* which provides important opportunities for new thinking about the way health is delivered, including establishing the frameworks for system-wide attention to value-based health care (Council of Federal Financial Relations, 2020).The initial Blueprint laid out a comprehensive platform for reform, with many of the issues identified just as relevant today as they were in 2017. System sustainability is an ongoing concern, healthcare costs are continuing to rise, and issues of equity and access persist.

AHHA members and stakeholders have contributed to further development of the health policy reform agenda through the establishment of the Australian Centre for Value-Based Health Care in 2019, and publication of Blueprint supplements focused on virtual healthcare and team-based care.

New challenges have also emerged exacerbating existing systemic weaknesses while at the same time presenting new opportunities to innovate. Coronavirus disease 2019 (COVID-19) is a prime example, placing pressure on Australia's health system. COVID-19 stretched the limits and resources of the healthcare workforce; placed healthcare workforce safety at risk; disrupted global medical supply chains and disproportionally affected, both directly and indirectly, vulnerable members of the community. However, COVID-19 has also simultaneously stimulated rapid reform, particularly in areas of digital technology and virtual health. Climate change presents another pressing threat, with natural disasters and climate hazards becoming increasingly prevalent and impacting the health of Australians.

AHHA's refreshed Blueprint *Healthy People, Healthy Systems: A blueprint for outcomes focused, value-based health care* endeavours to reflect contemporary governance and funding arrangements and proposes strategies, including short, medium, and long-term actions, to strengthen the Australian health system. AHHA thanks all contributors who have collaborated on the 2021 edition of the Blueprint and identified areas of policy reform that are necessary to transform our healthcare system into a value-driven, sustainable, fit-for-purpose, 21st century system that will meet the needs of Australians.

executive summary

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

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

IN SUMMARY

SHORT TERM (within 2 years)	An independent national health leadership group is established, building on arrangements established during 2020 with the Australian Health Protection Principal Committee, and reporting directly to National Cabinet to provide stewardship for the health system, including primary and acute care, dental care, preventive health and public health. In addition to senior jurisdictional and public health representatives, it includes representatives of the Independent Hospital Pricing Authority (IHPA), the Australian Institute of Health and Welfare (AIHW), the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Healthcare (ACSQHC). Experts are co-opted to the leadership group as required.
	As foreshadowed in the Addendum to the National Health Agreement, agreements between Primary Health Networks (PHNs), and Local Hospital Networks (LHNs) or equivalent, are established to provide consistent governance arrangements for regional needs assessments, priority setting and funding; this coordinates and integrates approaches to reducing preventable hospital admissions and presentations.
	A National Climate and Health Strategy is developed and implemented that acknowledges environmental change, and the social and ecological determinants of health as key drivers of health system value, prevention, and improved outcomes.
MEDIUM TERM (within 5 years)	The independent national health leadership group supports efficient alignment of all agreements, strategies and plans established through the National Cabinet processes that impact on shared health objectives.
	The independent national health leadership group reports annually to the Australian Government, and state and territory parliaments on progress against the Addendum to the National Health Agreement and objectives outlined therein, including key performance indicators specified in the Australian Health Performance Framework, and supplemented with timely reporting on the implementation of national health strategies, e.g. in Prevention, Primary Health and the proposed Climate and Health Strategy.

2 Performance information and reporting that is fit for purpose

IN SUMMARY

DATA STANDARDS	
SHORT TERM (within 2 years)	All providers who receive government funding are required to supply data on patient outcomes and other service provision dimensions to better inform system performance.
	The Primary Health Care Data Asset, inclusive of a national minimum dataset and data dictionary for primary healthcare, is established and implemented as a priority.
	Standards for general practice and other primary healthcare electronic health records are developed and implemented.
	Interoperability standards to support better information sharing across the health system are developed and implemented as a priority.
	A whole-of-system framework is developed, enabling a nationally-consistent and coordinated approach to the collection and use of patient-reported experience and outcome measures (PREMs and PROMs) 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)	There is a shared commitment by general practices and primary care providers, and adequate resourcing, to enable the ICT architecture required to transform the way health care across the Australian healthcare system is delivered. This includes the infrastructure to support integration of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote monitoring systems and data sources outside the health system) and the sharing of information for team-based models of care.
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 that is reported at different levels of the healthcare sector, and to different audiences.
	The Choosing Wisely initiative and the ACSQHC mapping of variation in care include feedback loops to professionals. These initiatives are aligned to reduce duplicated effort and investment of public funds.
	Stakeholders receive financial and non-financial incentives to introduce standardised tracking of health outcomes and costs of care.
	My Health Record data, as agreed for secondary use, is available for public reporting purposes.
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 that empowers patients to make informed choices about treatment options and providers is made accessible to the 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.

3 An integrated health workforce that exists to serve and meet population health needs

IN SUMMARY

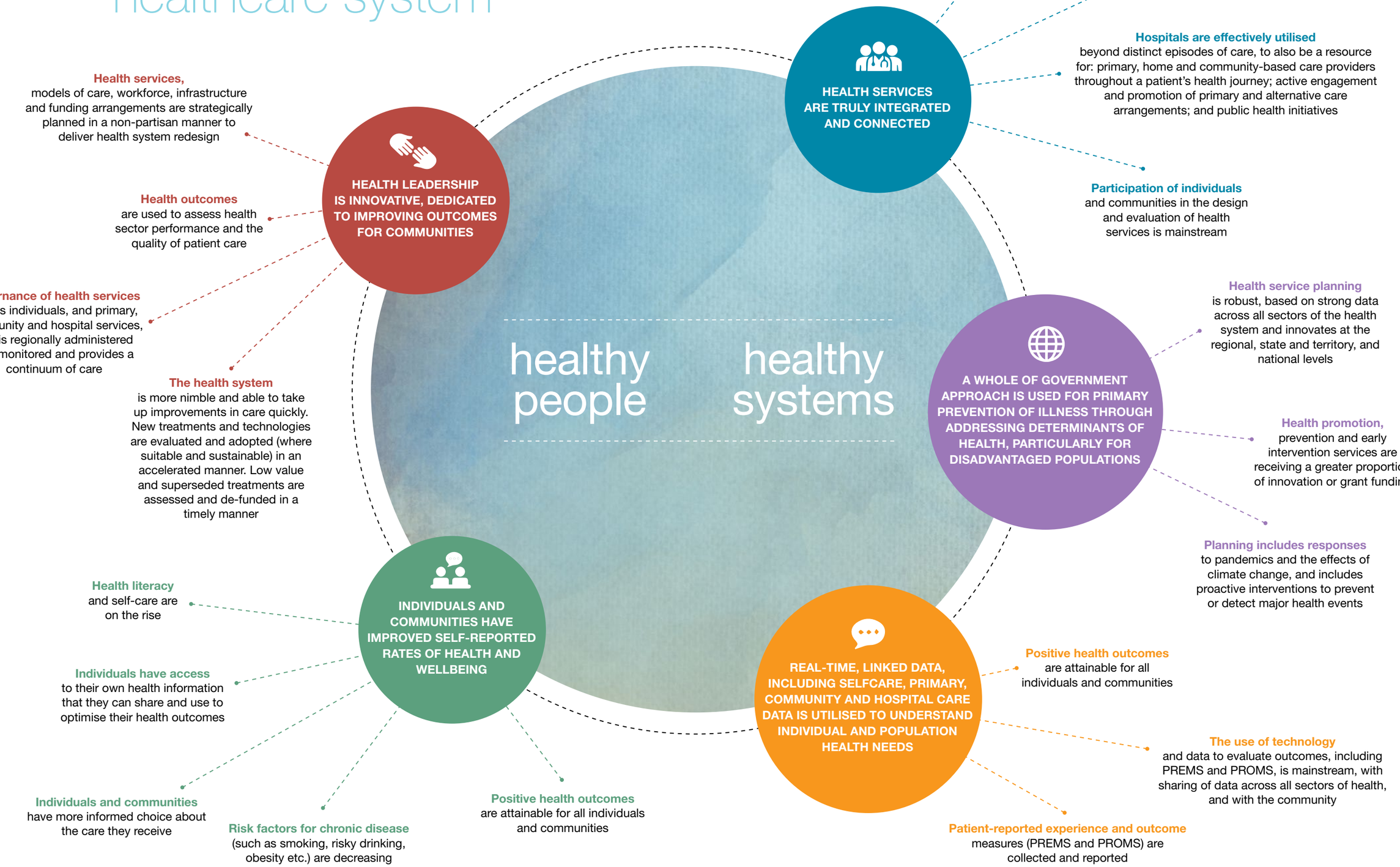
SHORT TERM (within 2 years)	A national health workforce reform strategy is developed that goes beyond the adequacy, quality and distribution of the workforce as it currently exists, to pursue outcomes-focused and value-based changes in scopes of practice and models of care to meet public need, with coordination of education, regulation and funding (at the Australian, state and territory, and regional service levels) for both regulated and unregulated practitioners, and across health service environments.
	Team-based models of care are enabled: • That are informed by regional needs assessments and collaborative population health planning • To practice shared care, coordinated around outcomes that matter to patients • Through joint funding at the local level • That are high-function and encourage the health workforce to work to the top of their scope of practice.

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

IN SUMMARY

SHORT TERM (within 2 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. Innovative funding models through pooled PHN/LHN regional funding for cross-sector care coordination and delivery are explored and evaluated by IHPA.
	Funding supports public health capacity at the regional level allowing for the implementation of national, regional and local prevention and health promotion agendas, adjusted to suit the specific needs of the local communities, e.g. the mass roll out of COVID-19 vaccination.
	To support the adoption of a value-based approach to healthcare funding models, financial incentives encourage stakeholders to introduce standardised tracking of health outcomes and costs of care.
	A national framework for health technology assessment is developed that provides a more consistent and transparent approach to assessing how new technologies are implemented in the Australian health system and how funding mechanisms are applied to these processes to ensure that value is achieved.
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.
	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.
LONG-TERM (within 7–10 years)	Following improvements in analytical and reporting capability, stakeholders are given financial incentives to improve healthcare value on the basis of outcomes data.

our vision for a healthy Australia supported by the best possible healthcare system



key concepts

UNIVERSAL HEALTHCARE

Australians have had access to universal healthcare for more than 30 years; however our system is increasingly being challenged by pressures including an ageing population, a growing burden of chronic disease, increasing life expectancy, climate threats, increasing individual and community expectations, and escalating healthcare costs associated with new technology and treatments. The COVID-19 pandemic has both highlighted the importance of universal healthcare to ensuring a healthy population, but also further challenged the capacity of our healthcare system to meet the healthcare needs of the nation. Strong and strategic leadership is needed from the Australian Government, in partnership with state and territory governments, to address these challenges and to preserve effective and efficient universal healthcare

QUALITY HEALTH OUTCOMES

Australia's healthcare system consistently outperforms many other Organisation for Economic Cooperation and Development (OECD) countries when comparing key health indicators and costs. But burdens such as an ageing population, increased rates of chronic and complex disease, progressively more frequent and destructive climate hazards and disaster, rising individual and community expectations, and new medical technologies and treatments are increasing the cost and complexity of healthcare. The provision of ineffective and futile care also persists (Blecher, Blashki & Judkins 2020).

Maintaining the status quo and tinkering around the edges of system reform will not provide the future-proofed health system that Australians expect and deserve. Traditional approaches of measuring outputs rather than outcomes do not capture elements of quality and safety, nor do they place the patient at the centre of the care provided. To ensure high quality, equitable and accessible healthcare, transparency and quality measures must be in place that demonstrate whether reforms are achieving intended outcomes. Robust, real-time, linked data, through national minimum data sets, are needed both within and across care systems to inform the development of performance measures focused on health outcomes, along with routine monitoring of those outcomes (Raymond 2019).

A HOLISTIC VIEW OF HEALTH AND WELLBEING

A person's healthcare should extend beyond immediate presenting concern(s) to take a broader view of their health and wellbeing. Such an approach requires consideration of the social, cultural and ecological determinants of health, as well as a preventive approach to healthcare, supported by deliberate investment by government (United Nations 2016: Langmaid et al 2020). Given the interconnected nature of mental, physical and social health, efforts to strengthen a cohesive cross-sector and cross portfolio collaborative approach to healthcare planning and decision making will be vital for improving health outcomes. '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. Further, people need to be seen as more than just their care needs, rather to be viewed first as experts and in charge of their own lives. Such an approach focuses on the strengths, skills and resources of individuals and communities, recognising their autonomy, and empowering choices and solutions right for them (Hunt, Bond, Brough 2004).

Health should be seen as an investment, not just a cost. As recognised by the Australian Government investment in the development of a National Preventative Health Strategy, there is a strong rationale for a greater emphasis on public health and prevention in an integrated system (Department of Health 2020a). Expenditure on prevention can contribute to budget repair by reducing future demand on the health system while simultaneously improving health outcomes and quality of life for all Australians.

The health of our planet is inextricably linked to human health (The Lancet 2020). With climate change set to disrupt the predictability of our environments, preventive action must consider the interconnected nature of inequality, health, and the ecological environment.

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 Australian Government budget (Treasury 2015), it is vital that there be a significant investment in preventive health strategies to lessen the individual, intergenerational and health system burden which will otherwise emerge in the future. This is consistent with Objective 1 of The National Strategic Framework for Chronic Conditions, which is 'to focus on prevention for a healthier Australia' (AHMAC 2017).

COORDINATED AND INTEGRATED CARE

A whole-of-system approach to reform is needed to ensure Australians with multiple care needs can 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. Given the rich evidence underpinning the interconnected relationship between mental, physical, social and planetary health, systems must be designed to support the integrated delivery of a suite of health, social, mental, and disability services, seamlessly connected and centred around the needs and preference of patients and their families (PC 2020).

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 to prevent any unintended consequences.

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 entrench fragmented care. There should be mechanisms to support innovation where traditional funding frameworks can be challenged, and flexibility for different approaches to be trialled.

For the health system to be meaningfully and sustainably re-orientated, it is vital that the Australian, 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 not be permitted to stifle innovation within the health sector.

LONG-TERM SUSTAINABLE FUNDING

The Australian healthcare system needs to be adequately funded in a sustainable and durable way, providing certainty for longer-term funding arrangements for the Australian Government and the states and territories.

Health spending in the last two decades has consistently grown at a faster rate than the rest of the economy, with an average yearly increase of 2.7% per person in real terms (AIHW 2020a). During this period there has also been a shift in the distribution of different funders' contributions, with an increasing proportion of the cost burden now coming from private sources, e.g., private health insurance, compensation, individual out-of-pocket expenses and unpaid/informal carers. Australians spend more on out-of-pocket healthcare costs than the global average of OECD countries ($846 USD per capita in 2017 compared to the OECD average $689 USD) (OECD 2020).

The overriding 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 inefficiencies of siloed approaches to funding should be acknowledged and addressed. Existing resources should be used effectively with all parts of the health system working together to eliminate waste, remove inefficiencies and discard low-value care.

Competition policy reform across the entire health system should not be used as a mechanism to drive health system efficiency. It risks perverse incentives to the system with the marginalised, at-risk, or individuals with poor health literacy being disadvantaged. It also does not work in all settings, e.g. rural and remote areas. In healthcare, equity of access, quality and a focus on outcomes, not just user choice, are critical

INNOVATION IN RESPONSE TO NEED

Australia has a high-quality health system delivering world-class population health outcomes. However, for some groups, health outcomes are poor. 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.

A strengths-based approach to healthcare delivery, where the self-determination and strengths of individuals and communities are emphasised, will be important to foster resilience and empower communities to improve health outcomes (Hunt, Bond, Brough 2004).

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

EQUITY IN HEALTH

Complementing Australia's universal health insurance (horizontal equity) is a requirement to tailor major reforms to regional challenges and develop targeted programs for vulnerable populations (vertical equity). Market-based consumer-driven programs, effective in major capital cities, may not work in rural/remote regions of Australia where there are few or no services (market failure). Service providers in rural and remote areas, informed by PHN-led needs assessments, need the flexibility to pool Commonwealth and state funding for programs such as drug and alcohol, and mental health programs, and in response to unforeseen health threats such as natural disasters and emergencies, to minimise duplication and fragmentation of care while assuring access. Targeted programs and services are also required to address issues specific to vulnerable populations in the Australian community including prisoners, refugees, LGBTIQ people, the homeless, the elderly, children, CALD communities, people in aged care, and Aboriginal and Torres Strait Islander Australians.

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. an integrated 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.

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

OBJECTIVE

The Australian Government 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 FOR REFORM

The National Health Reform Agreement (NHRA) and its 2020 Addendum (CFFR, 2020) marks a commitment by the Australian and state and territory governments to 'work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve local accountability and responsiveness to the needs of communities, through continued cooperation and collaboration between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs)'.

For this to be realised, 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.

CONTEXT

The The NHRA identifies shared objectives and the division of roles and responsibilities between the Australian Government, and the states and territories (CFFR, 2020). Public hospitals are governed by Hospital and Health Services, Local Health Districts/ Networks (LHNs), or their equivalent and are accountable to state and territory governments. Private sector, general practice, pharmacy, and allied health services are subsidised by, and accountable to, the Australian Government. Some primary care services are commissioned by PHNs, which rely on funding from, and are accountable to, the Australian Government. Finally, the states and territories are responsible for community health services.

Local governance

Internationally 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 to secure its own future regardless of the impact on others'*. This is particularly relevant in the Australian context where reducing avoidable hospital demand is a shared priority. 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).

The value of establishing governance mechanisms to support a nationally unified and regionally controlled health system has been recognised across numerous Australian Government reports and Royal Commissions, including most recently, the *Addendum to the National Health Reform Agreement 2020-2025*, the Royal Commission into National Natural Disaster Arrangements, and the *Productivity Commission Inquiry Report on Mental Health* (CFFR 2020; Commonwealth of Australia 2020; PC 2020).

National coordination

Intent expressed in the Addendum to National Health Reform Agreement 2020-25 highlights a national commitment to join planning and funding at the local level (CFFR 2020). This has facilitated at a regional level, the formation of collaboratives, and the pooling of funding to co-commission in some areas. Yet across the health sector as a whole, coordination remains fragmented.

By taking a more cooperative approach to the funding and delivery of care across jurisdictions and between sectors, savings and other efficiencies can be internalised to the joint benefit of all governments, as well as patients, providers and the broader community. Collective decision-making through an independent agency with multi-jurisdictional representation has been effectively demonstrated by the Independent Hospital Pricing Authority (IHPA 2019a) in its role determining a nationally efficient price for hospital services.

Ensuring there is coordination of critical areas of health will be crucial for reducing avoidable hospital admissions and presentations. The Australian Government has embarked on development of a number of national coordinating strategies and plans including the National Primary Care 10-year Plan, National 10-year Preventative Health Strategy, National Children's Mental Health Strategy, and separate National Women's and Men's Health Strategies (Hunt 2019: Department of Health 2019a: Department of Health 2020b). However, clarity and coordination of roles and responsibilities at the interface between hospitals and the primary care sector, as well as with disability, aged care, and social services require strengthening at the local level to achieve desired outcomes.

Climate and health

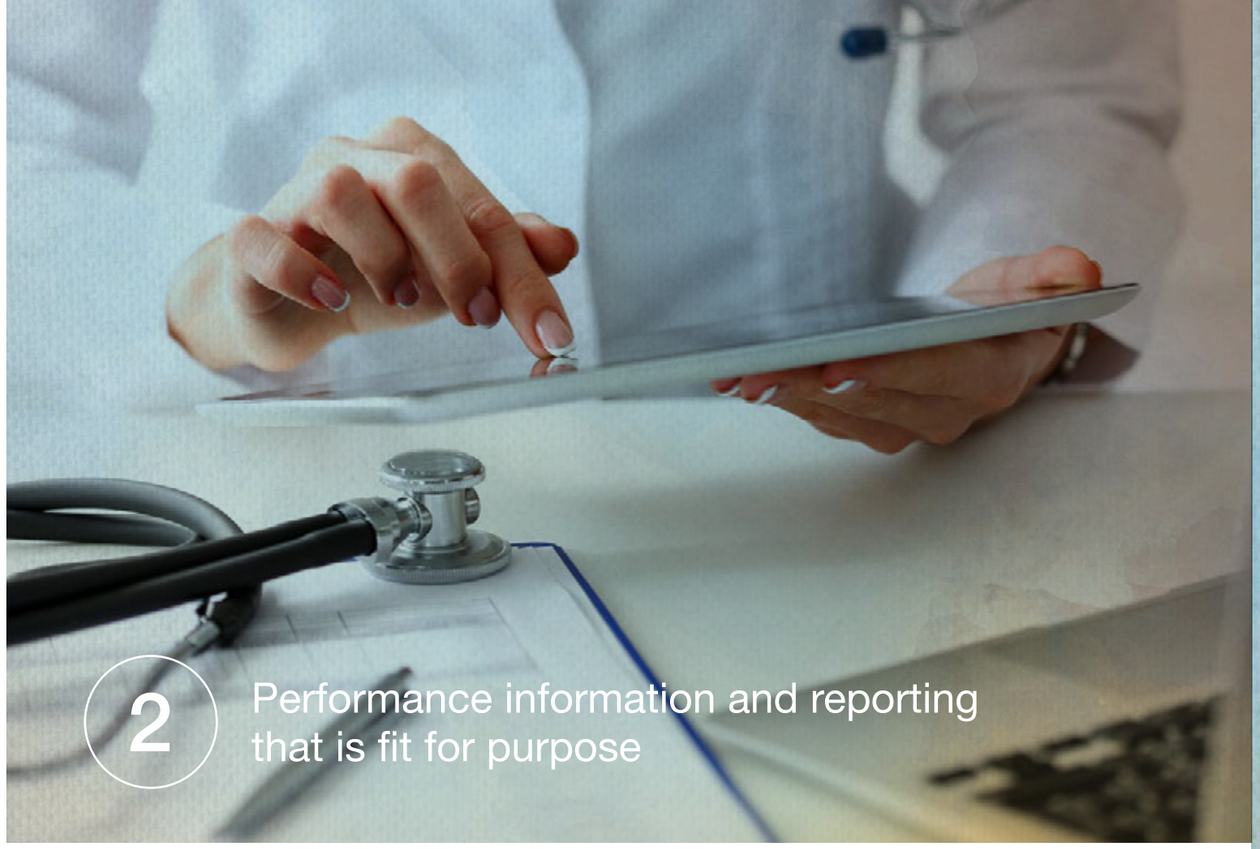
Australians are increasingly facing more intense and severe health impacts associated with a changing climate. This has both direct and indirect impacts on health outcomes and the economic and structural sustainability of the Australian health system (Duckett et al. 2020; Zhang et al. 2020). The World Health Organization has declared 'Climate Change the greatest threat to global health in the 21st century' (WHO 2020) and Australia's health community is calling for action (RACP 2019; ACN 2019; RACGP; AMA 2019).

In 2017 AHHA joined with other health peak health and professional organisations to endorse *The Framework for a National Strategy on Climate, Health and Well-being for Australians* (Climate and Health Alliance 2017). This framework highlights the need for coordinated state, territory, and national policy action, with demonstrated leadership from the Australian Government. While states, territories, private industry, and individual health organisations are demonstrating leadership and taking steps to implement sustainability initiatives, adaptation plans and climate strategies, a lack of a national leadership and coordination is contributing to fragmentation across the sector, leaving healthcare services and many Australians vulnerable to the threats of climate on health (Zhang et al. 2020).The reorientation of the health system to a value-based health care approach that recognises planetary health and ecological sustainability as key drivers of value and health outcomes will be crucial if Australia's health system is to withstand future challenges presented by climate change.

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

RECOMMENDED ACTIONS

SHORT TERM (within 2 years)	**An independent national health leadership group is established, building on arrangements established during 2020 with the Australian Health Protection Principal Committee, and reporting directly to National Cabinet to provide stewardship for the health system, including primary and acute care, dental care, preventive health and public health. In addition to senior jurisdictional and public health representatives, it includes representatives of the Independent Hospital Pricing Authority (IHPA), the Australian Institute of Health and Welfare (AIHW), the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Healthcare (ACSQHC). Experts are co-opted to the leadership group as required.**
	As foreshadowed in the Addendum to the National Health Agreement, agreements between Primary Health Networks (PHNs), and Local Hospital Networks (LHNs) or equivalent, are established to provide consistent governance arrangements for regional needs assessments, priority setting and funding; this coordinates and integrates approaches to reducing preventable hospital admissions and presentations.
	The Australian Government is undertaking long-term planning on the health risks and adaptation opportunities presented by climate change. **This includes the development and implementation of a National Strategy on Climate and Health that:** • **recognises planetary health, social and ecological determinants as key drivers of health system value and improved health outcomes** • **highlights the importance of preventive action, community capacity building and health promotion at the local level** • **recognises the interconnected nature of inequality, health and the environment; and** • **identifies the many physical, emotional and social health co-benefits of action to reduce the human impact on climate.**
MEDIUM TERM (within 5 years)	**The independent national health leadership group supports efficient alignment of all agreements, strategies and plans established through the National Cabinet processes that impact on shared health objectives.** **This includes reporting on their value to the overall health system. Examples include the National Indigenous Reform Agreement, the Community Pharmacy Agreement, the National Mental Health and Suicide Prevention Agreement and Australian government budget investment in associated independent entities such as NPS MedicineWise**
	The independent national health leadership group reports annually to the Australian Government, and state and territory parliaments on progress against the Addendum to the National Health Agreement and objectives outlined therein, including key performance indicators specified in the Australian Health Performance Framework, and supplemented with timely reporting on the implementation of national health strategies, e.g. the Preventive Health Strategy, Primary Health Care 10-year Plan and the proposed Climate and Health Strategy.



2 Performance information and reporting that is fit for purpose

OBJECTIVE

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

OPPORTUNITY FOR REFORM

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.
- At 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 (Nous Group 2016).

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

- increased consumer knowledge of healthcare provider performance can help consumers make informed choices (with 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.

There is a danger that performance reporting will drive risk-avoidance behaviour by services; this will need to be properly managed to ensure an overall positive impact (Chen 2010; Campanella et al. 2016).

Despite the importance of health information and reporting, and the substantial data currently being collected, Australia has not implemented a long-term strategic plan to coordinate and direct national health information interests.

Recognising the need for a comprehensive national approach, the Australian Institute of Health and Welfare (AIHW) commenced development of a National Health Information Strategy (NHIS). Broadly, the NHIS aimed to overcome information gaps and barriers in the current system; drive investments in health information; and provide an enduring framework to achieve coordinated, integrated, efficient, effective and timely collection and development of health information. Its scope was expected to cover governance, infrastructure, national health data, analysis, and reporting (AIHW 2020b). However with the events of 2020, and COAG being replaced with the National Federal Reform Council, funding and governance is no longer assured, and development of the NHIS has been stalled.

Data standards, digital health architecture, and analytical and reporting capabilities are needed to support systematic tracking of health outcomes, relevant risk-adjustment factors, segment-specific interventions, corresponding costs of care and other relevant dimensions of health system performance (WEF 2016).

DATA STANDARDS

Data interoperability and cross-sector consistency

The Australian Digital Health Agency has identified interoperability of clinical data as one of its priority outcomes, with the first regions in Australia showcasing comprehensive interoperability across health service provision by 2022. This will support patient data being collected in standard ways for sharing in real-time with patients and their healthcare providers (ADHA 2017).

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 IHPA. The provision of data by private hospitals is voluntary and limited.

With private facilities regulated by states/territories, there is variation in quality and safety data reported both across the country and across public and private facilities. However, there is work underway to expand such reporting and achieve consistency within some jurisdictions (Queensland Health 2019).

As a large proportion of health care is being delivered by private health service providers in receipt of public funding, consideration is needed about how funding arrangements are structured to compel private providers to contribute data for the purposes of health system improvements.

Primary healthcare data

A large proportion of primary health care occurs in general practices, allied health practices and community health service providers, operating as private entities, not-for-profit or faith-based providers. This has implications for the mechanisms by which performance information and reporting can be achieved with accountability and responsiveness. Practitioners must firstly be engaged in focusing on outcomes and value. It must be easy for them to be involved in data collection, data must be interpreted appropriately, and practitioners must see real-time value in the care they provide to their own patients.

With general practice electronic health records currently unregulated, there are inconsistent structures, data elements and use of clinical terminologies and classifications. Addressing the lack of standards across electronic health records will facilitate transfer of clinical data between electronic health records for clinical purposes; linking individual health data for integration of care across different sectors of the healthcare system; and reliable extraction of patient data for practice improvement and research purposes (Gordon et al. 2016).

As noted above about private health service providers more generally, consideration is needed on the implementation of mechanisms to compel general practices to provide data for public reporting as part of their public funding arrangements.

Primary healthcare datasets

In the National Health Reform Agreement, 'potentially preventable hospitalisations' are a health system performance indicator of accessibility and effectiveness. They have 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 time-lag between primary prevention initiatives and disease onset or complications. Further, it is impacted significantly by factors not easily influenced by health policymakers (e.g. by socioeconomic status and prevalence of disease). The current specification also does not include all conditions that contribute to potentially preventable hospitalisations (e.g. stroke hospitalisations can sometimes be prevented if timely care in community is received) (Falster & 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 Medicine Insight. However, in the absence of a national minimum dataset for primary healthcare, none have been comprehensively successful. With the Australian Government, and the states and territories having joint roles and responsibilities, along with strong interest in reforms to reduce avoidable hospital admissions and presentations through primary care initiatives, coordinated performance information and reporting is critical. While much reform is currently occurring in the primary healthcare sector, it is occurring in the absence of a national minimum dataset and reliant on discrete evaluations to guide ongoing improvements. The development of the National Primary Care Data Asset will support this to some extent (AIHW 2020c). However, this may be limited without private health service providers being compelled to contribute data.

Patient experience data

There is 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, AHSRI 2016). These are used widely in clinical trials and other research settings; however, their use to improve the safety and quality of healthcare is still emerging. There is some activity in this sphere being led by government entities (e.g., through the NSW Agency for Clinical Innovation), by public health providers (e.g., Dental Health Services Victoria), and across public and private health providers (e.g. in the Continuous Improvement in Care cancer pilot trial in Western Australia). There is increasing implementation of approaches based on the relevant International Consortium for Health Outcomes Measurement (ICHOM) standardised sets of value-based patient-centred outcomes. The ACSQHC has been scoping an appropriate role for the measurement and reporting of patient-reported experiences and outcomes to support the health system to deliver patient-centred care.

For Aboriginal and Torres Strait Islander people, institutional racism in hospitals and health services fundamentally underpins racial inequalities in health. It forms a barrier to accessing healthcare and must be acknowledged and addressed to realise health equality. The National Safety and Quality Health Service (NSQHS) standards outline the responsibility of healthcare governing bodies to identify, prioritise and monitor the specific health needs of Aboriginal and Torres Strait Islander patients (ACSQHC 2019b). A matrix has been developed for identifying, measuring, and monitoring institutional racism. Simple and cost-effective to administer, research to date shows its value as both an internal and external assessment tool (Marrie & Marrie 2014: Bourke, Marrie & Marrie 2018).

ICT ARCHITECTURE

States and territories have digital health strategies that provide a shared direction for investment in the information and communication technology (ICT) architecture required for transforming the way health care is delivered. They are increasingly moving to single electronic health records for the hospitals and health services in their jurisdictions, recognising that capturing and effectively using clinical information is important in ensuring quality, safe and sustainable healthcare services. The records of general practices and other primary care providers are typically not incorporated, although some jurisdictions have developed systems to allow GPs to view patient's hospital records to support continuity of care (Queensland Health 2020).

The ICT architecture within the states and territories has also been planning for integrating the increasing amounts of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote monitoring systems and data sources outside the health system) and how these can be used to inform care (e.g. NSW Health 2016).

Successful implementation of electronic health records and other technological solutions is dependent on a broad range of organisational, human and technological factors and significant challenges are typically faced (Fennelly, et al., 2020). General practices and other primary care providers are typically distinct small business entities, and while there are companies supporting the technological developments available, there is not a shared commitment to the ICT architecture needed for transforming the way health care is delivered.

Primary healthcare is also provided by a network of community health service providers. ICT architecture and data standards can vary significantly across these providers, bringing similar inconsistencies and interoperability challenges as with private providers.

ANALYTIC AND REPORTING CAPABILITY

Performance information must be analysed and reported in a manner that is fit for purpose and timely, meeting the needs of different levels of the health system, as well as different audiences.

The AIHW is primarily responsible for national reporting on key health and health services issues in Australia. They release more than 180 print, web, and data products every year that draw on national major health and welfare data collections, including their own.

Attempting to overcome the fragmentation of health system performance reporting, the Australian Health Performance Framework provides a single mechanism for system wide performance reporting to assess the health of the Australian population and overall health system. It allows comparison across population groups and different levels of geography, and supports the monitoring and evaluation of value and sustainability to inform future health system priorities (NHIPPC 2017).

The AIHW reports local level data via its MyHospitals and MyHealthyCommunities web pages. Data are presented on how different areas, disaggregated to hospital and PHN levels respectively, perform against a range of indicators.

The ACSQHC is also responsible for national reporting on safety and quality issues, including through the Australian Atlas of Healthcare Variation, a web-based platform that demonstrates variation by mapping use of healthcare according to where people live, providing key findings and recommendations for exploring the variation.

IHPA maintains a National Benchmarking Portal to allow hospital managers to compare differences in activity, costs, and efficiency at similar hospitals across the country. This simplifies performance benchmarking and highlights clinical variation. Access to the portal is controlled by the jurisdictions.

States and territories also collect data and report across the breadth of the areas covered by these national bodies. And at a regional level, each PHN is required to undertake a needs assessment process that will identify and analyse health and service needs within their regions. While the reports are published, regionally collected data that underpins the health needs analyses, collected in the absence of data standards, are not consistently available for broader use.

The private sector also holds significant collections of data. Private hospitals, private health insurers, corporate and individual service providers, and other organisations have information they collect, use and report in varying ways and for varying purposes, e.g., NPS MedicineWise collects data related to medicines use.

Clinical quality registries are used to systematically monitor the quality (appropriateness and effectiveness) of healthcare, within specific clinical domains, by routinely collecting, analysing and reporting health-related information. This information is fed back to clinicians to inform clinical practice and decision-making. Reports may also be provided to jurisdictions, healthcare providers, funders, clinical colleges and researchers (ACSQHC 2017b). Sweden has been the international pacesetter in clinical quality registries, where they have been effectively used in an integrated and active way for continuous improvement, research and management to contribute to the best possible care for patients (Larsson et al. 2012).

In Australia, the ACSQHC has led work to inform the national policy context for national clinical quality registries (ACSQHC 2019c), and the Australian Government Department of Health has proposed a strategy for maximising their potential (Department of Health, 2019b)

From the perspective of individual professions, the Royal Australasian College of Surgeons showed leadership in analysing and reporting data for quality improvement, partnering with Medibank to publish Surgical Variance Reports (RACS 2019). These analyse a number of clinical and other indicators for common procedures within surgical specialties. By highlighting variation in practice, surgeons can consider reasons for the variations in order to improve clinical outcomes and patient care.

RECOMMENDED ACTIONS

DATA STANDARDS 'It is well accepted in the world of statistics and large databases that metadata leads to better data. This is because they enable all people collecting, using and exchanging data to share the same understanding of its meaning and representation' (AIHW 2017	
SHORT TERM (within 2 years)	All providers who receive government funding are required to supply data on patient outcomes and other service provision dimensions in a consistent, coordinated, and transparent way to better inform system performance. Relevant data from the private sector (hospitals, general practitioners, allied health, private health insurers, etc.) are captured, with requirements for public reporting of healthcare quality and safety also applied to private facilities and service providers.
	The Primary Health Care Data Asset, inclusive of a national minimum dataset and data dictionary for primary healthcare, is established and implemented as a priority, featuring: • metadata aligned with acute care national minimum datasets to support data linkage and development of outcomes data reporting • data submission requirements for those receiving a Medicare provider number, practice incentive payments, or other government funding.
	A whole-of-system framework is developed, enabling a nationally-consistent and coordinated approach to the collection and use of PREMs and PROMs across the health system, with standardised national definitions and descriptors.
	The matrix for identifying, measuring and monitoring institutional racism is validated in hospitals and health services.
	Business plans for the Australian Digital Health Agency include the development and implementation of interoperability standards to support better information sharing across the health system, with the work fast-tracked for achievement within 2 years.
	The *Framework to guide the secondary use of My Health Record system* data is being implemented, with outcomes data to support better stewardship and governance of the health sector being made available for public reporting purposes.
MEDIUM TERM (within 5 years)	Standards for general practices electronic health records are developed and implemented. Elements addressed include: • a defined electronic health record data model that links related data elements • consistent data element labels and definitions • use of standardised clinical terminologies and classifications • accreditation of general practices in terms of electronic health record capability and processes
ICT ARCHITECTURE 'All these innovations are rapidly expanding the "art of the possible" when it comes to integrating health data around the patient'. [They must] become integral components of the comprehensive informatics infrastructure for value-based healthcare' (World Economic Forum 2017).	
SHORT TERM (within 2 years)	There is a shared commitment by general practices and primary care providers, and adequate resourcing, to enable the ICT architecture required to transform the way health care across the Australian healthcare system is delivered. This includes the infrastructure to support integration of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote monitoring systems and data sources outside the health system) and the sharing of information for team-based models of care.

ANALYTICAL AND REPORTING CAPABILITY 'Once health systems begin to routinely track and share health outcomes data and other relevant information by condition and population segment, the resulting accumulation of data will become a powerful asset for driving research and innovation in healthcare' (World Economic Forum 2017).	
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. This includes setting clear objectives, defining target audiences, developing transparent principles and methodology through broad consultation, and timely monitoring and evaluation of unintended consequences.
	The Choosing Wisely initiative facilitated by NPS MedicineWise, that identifies tests, treatments, and procedures where evidence shows they provide no benefit or, and in some cases, lead to harm (NPS MedicineWise 2020), is extended to provide individualised feedback to professionals who continue to provide such services. Similarly, the work being led by the ACSQHC mapping variation in care includes a feedback loop to professionals where significant variation is identified. Ideally the Choosing Wisely initiative is integrated with the work being undertaken by the ACSQHC to ensure alignment of activity, and to reduce duplicated effort and investment of public funds.
	Stakeholders receive financial and non-financial incentives to introduce 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 with: • anonymous public reporting across and within health systems • reporting back to providers of their relative performance, with a focus on learning and continuous improvement • validated methodologies for outcomes tracking and risk-adjustment
	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 that empowers patients to make informed choices about treatment options and providers is made accessible to the 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.

3 An integrated health workforce that exists to serve and meet population health needs

OBJECTIVE

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

OPPORTUNITY FOR REFORM

Leadership is needed to proactively redefine traditional workforce models of healthcare delivery to prioritise person-centred care that is respectful of, and responsive to, the preferences, needs and values of individuals, their carers and families (ACSQHC 2011). Leaders must recognise that vested professional and financial incentives are an impediment to effective structural reforms in the way health services are designed, delivered and remunerated.

CONTEXT

Workforce need

The geographic spread of the health workforce in Australia does not reflect the distribution of the population, nor the level of healthcare need. Workforce shortages exist across many professions, particularly in outer metropolitan, regional and remote areas and in disadvantaged populations. This presents significant challenges with health services increasingly exposed to a diverse range of multifaceted and complex physical, social, emotional, cultural and ecological threats (e.g., climate change, pandemics, chronic disease, ageing population) (AIHW 2016: Langmaid et al 2020).

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 (HWA 2013).

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 2015).

National coordination

The Health Practitioner Regulation National Law Act (the National Law) has an objective 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce'(Health Practitioner Regulation National Law Act 2009), yet 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 which is controlled nationally, and the workforce needs of the regions and communities. 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 interdependent with, NRAS—consumers, employers, professional associations, education providers, National Boards and government departments (Woods 2017).

Workforce data

Joint roles and responsibilities exist between the Australian Government and state and territory governments relating to the health workforce and their education and training requirements (CFFR 2020). At both national, and state and territory levels, there is significant focus on the number and distribution of health professionals regulated under the National Law, specifically medical professionals and nurses. However, data do not currently capture information about accessibility, responsiveness, 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; Legatt 2004). Data related to scopes of practice and use of the non-registered workforce are also unavailable.

The Primary Health Care Data Asset (AIHW 2019) must be established as a priority to inform population health planning and identify service delivery gaps, to better enable the development of person centred, team- based models of care that are supported by fit-for-purpose multidisciplinary workforce training and education programs.

A National Allied Health Dataset has been developed by AIHW. However, a focus on hospital data limits its effectiveness as an overall measure of the allied health workforce as it does not reflect the care contribution of the broader community and primary care allied health workforce (AIHW 2018). Inclusion of allied health data in the National Primary Care Data Assert will be important for understanding the contribution and costs of the allied health workforce, providing an opportunity to collect standardised outcomes data to inform workforce planning (Stephens & Erven 2015; Allied Health Professionals Australia, 2020).

Education and training

Clinical training and experience, particularly clinical placements, are a critical component in preparing health professionals for practice. The quality of, and time in pre-registration placements has been recognised as one of the main influencing factors in determining career destinations for health professionals (Universities 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 similar drivers supporting clinical training/ placements in the latter settings, including primary healthcare, disability care, aged care, and mental health. Without sufficient exposure to healthcare settings outside of public hospitals, the choice to practise in other settings (and 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 (2019b) has developed the Australian Teaching and Training Classification, 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.

Workforce sustainability and resilience

The COVID-19 pandemic has highlighted the need for a flexible, responsive healthcare workforce, exposing structural and systemic weaknesses in the way Australia's health workforce is organised. Border restrictions have temporarily halted the immigration of overseas trained health professionals, and social distancing protocols have disrupted student clinical placement schedules. These pipeline disruptions, if not addressed, will likely have significant future workforce sustainability implications.

Additionally, the safety risk associated with an increasingly casualised workforce have been demonstrated by the COVID-19 pandemic, as has the need for enhanced infrastructure and continuing professional development to foster virtual care and digital health competencies. In situations of increased system wide pressure, the health and safety of the health workforce must be a critical priority with sufficient structures and protections in place to allow health professionals to perform their roles safely and effectively (e.g., adequate staffing, skills distribution, resources, and training) (The Lancet, 2020; Work Health and Safety Act 2011).

However, the COVID -19 pandemic has also demonstrated the ability of the healthcare workforce to adapt and implement rapid widescale innovation and reform in the face of seemingly insurmountable challenges. Critical lessons must be learned from this experience to facilitate a transition of the workforce to new and different ways of working on a permanent basis (AHHA, 2020). A focus on community and patients, clarity of roles, communication, education, and training; as well as strong clinical governance and mechanisms that support coordination and integration will be critical to maintaining an agile, responsive and safe workforce for the future (AHHA, 2020).

RECOMMENDED ACTIONS

SHORT TERM (within 2 years)	**A national health workforce reform strategy is developed, including action plans for medium term (within 5 years) and longer term (within 7–10 years) reforms.** **This strategy 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 Australian Government, state and territory, and regional service levels) for both regulated and unregulated practitioners, and across health service environments.** **This strategy is linked with regional needs assessments and strategies.**
	Team-based models of care are enabled: • **that are informed by regional needs assessments and collaborative population health planning** • **to practice shared care, coordinated around outcomes that matter to patients** • **through joint funding at the local level** • **that are high-function and encourage the health workforce to work to the top of their scope of practice.**

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

OBJECTIVE

The Australian, state and territory governments work in partnership to ensure health funding achieves high quality health outcomes for Australians.

OPPORTUNITY FOR REFORM

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; IHPA 2019a). Payment mechanisms can be used to drive sustainable transformations in healthcare that will improve individual and population health outcomes.

CONTEXT

Public hospital funding

Public hospital funding occurs within a context of agreed strategic priorities for health system reform, defined in the *Addendum to the National Health Reform Agreement 2020-25* to include: improving efficiency and ensuring financial sustainability; delivering safe, high quality care in the right place at the right time; prioritising prevention and helping people manage health across their lifetime; and driving best practice and performance using data and research (CFFR, 2020).

ABF is the system currently used for funding public hospital services where providers are paid based on the number and mix of services provided to patients. The Australian Government's contribution to the funding of hospital-based activity is specified in the Addendum to the National Health Reform Agreement and is based on a National Efficient Price (NEP), independently determined by IHPA. States and territories are responsible for the distribution of public hospital funding, with their contribution to the funding of hospital-based activity based on a price per service, determined by the state, for services agreed to be provided (Administrator National Health Funding Pool 2017).

The Australian Government funding contribution is currently set at 45% of efficient growth of activity-based services, subject to the growth in funding capped at 6.5% per year. Bilateral agreements with each state and territory articulate specific health care reforms (CFFR, 2020).

Primary and specialist care funding

In general and specialist practice, services are typically provided by fee-for-service (FFS), with Medicare reimbursing patients for 100% of the Medicare Benefits Schedule (MBS) fee for a GP and 85% of the MBS fee for a specialist. However out-of-pocket costs associated with this model have become more and more inconsistent, 'undermining the universality of Medicare, widening health inequalities and arguably leading to increased hospital costs' (Russell & Doggett 2015). FFS is also the most common mechanism by which allied health and dental services are funded, and typically through patient out-of-pocket contributions, sometimes supported by private health insurance or MBS rebates.

Value-based funding

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.

The World Health Organization (WHO) and the OECD estimate that around 30% of resources spent on health care are wasted on avoidable complications, unnecessary treatments, or administrative inefficiencies (EIT Health 2020). A value-based approach to funding aligns payment incentives with health system objectives to achieve better value by driving improvements in quality and slowing growth in spending (IHPA 2019a). Objectives may be related to such things as quality, care coordination, sustainability, 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).

Recommendations relating to performance information and reporting have been identified in this Blueprint. 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
- involving providers in program design
- favouring group incentives over individual incentives
- using rewards or penalties, depending on the context
- more frequent, lower powered incentives
- absolute targets preferred over relative targets
- multiple targets preferred over single targets
- Value being a permanent element of overall provider payment systems (European Observatory on Health Systems and Policies 2014).

In Australia, lessons can be learned from programs such as the adoption of the National Emergency Access Target (NEAT) across Australia (Silk 2016), the ACSQHC development and application of Clinical Care Standards (ACSQHC 2017a) for quality improvement, and the Practice Incentives Program in general practice (European Observatory on Health Systems and Policies 2014).

Funding models being tested in other jurisdictions, e.g. in the Hospital Value-Based Purchasing Program in the Centers for Medicare and Medicaid Services in the United States (CMS 2017), and in public hospitals in Australia via IHPA, include a combination of activity, block and performance-related funding measures. Mixed, flexible funding models, incorporating these measures, are likely to be required in order to adequately compensate for activity, to protect equity (particularly in rural and regional areas and for vulnerable population groups), and to reward and incentivise agreed performance standards and outcomes (Verhoeven et al, 2020). The Voluntary Patient Enrolment initiative anticipated for implementation in general practice in 2021 provides opportunities to focus investment in primary care through funding models that reward high value care, particularly for conditions where continuity of care is important.

The successful implementation of alternate and mixed funding models will require prioritisation of support across all areas of healthcare delivery. To avoid siloed areas of reform support must be provided across the entire change journey, recognising the breadth of structural and process reform needed to embed new funding models in practice. Support must be provided to facilitate change management processes, allowing organisations to restructure processes and procedures (EIT Health, 2020).

Funding new technology

As our healthcare system increasingly becomes reliant on new technologies, an emerging issue noted in the *Addendum to National Health Reform Agreement 2020-2025*, is the fragmented, uncoordinated approach to health technology assessment informing investment and disinvestment decisions across Australian (Appendix) (CFFR, 2020).

The Addendum foreshadows the development of a national framework that would provide a more consistent and transparent approach to assessing how new technologies are implemented in the Australian health system, and how funding mechanisms are applied to these processes to ensure that value is achieved (Flynn & Verhoeven 2020).

Prevention

Australia spends less on public health and preventive care than most other OECD countries (Gmeinder, Morgan and Mueller, 2017; OECD 2017). The increasing burden of chronic disease within Australia intensifies the need for investment in evidence based preventive health strategies. This is reinforced by Australia's commitment to the 2025 WHO global targets to reduce premature mortality from the four major non-communicable diseases: cardiovascular disease, cancer, chronic lung diseases and diabetes (WHO 2013: Moodle, Tolhurst & Martin 2016).

An effective way to address government fiscal pressures is to take earlier steps to prevent health conditions from occurring, delaying the onset, and reducing the severity of any conditions. Preventive health is therefore an important means of reducing future demand on the health system while simultaneously improving quality of life. Preventive health measures should be directed to activities that have been demonstrated to be cost effective (Jackson & Shiell 2017; WHO 2014b; Vos et al 2010) and which interpret lifestyle choices in the context of the opportunity costs and other incentives faced by individuals (Sassi & Hurst 2008).

The Voluntary Patient Enrolment initiative in general practice, anticipated for implementation in 2021, provides an opportunity for exploring funding models for preventative health initiatives in primary care that focus on value for individuals and the population.

4 Funding that is sustainable and appropriate to support a high-quality health system

RECOMMENDED ACTIONS

SHORT TERM (within 2 years)	Health services are funded on a regional basis, with: • shared needs assessments between primary and hospital sectors, and regional planning, informing the distribution of funding • shared needs assessments at a regional level informing investment in prevention • continued investment in mechanisms to integrate healthcare across sectors (e.g. through HealthPathways) • the architecture of agreements being centred on outcomes that matter to patients, not individual sector needs, while still recognising that models of care must be sustainable and attractive to health service providers as well as patients.
	Innovative funding models through pooled PHN/LHN regional funding for cross-sector care coordination and delivery are explored and evaluated by IHPA.
	Funding supports public health capacity at the regional level allowing for the implementation of national, regional and local prevention and health promotion agendas measures adjusted to suit the specific needs of the local communities, e.g. the mass roll out of COVID-19 vaccination.
	The anticipated Voluntary Patient Enrolment initiative introduces funding models that prioritise high-value care with a focus on outcomes for patients where continuity of care is of particular importance.
	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. This expands to cover the top 10 chronic diseases, risk factors or determinants within 5 years, and all health conditions within 10 years. Conditions are agreed, based on available data.
	A national framework for health technology assessment is developed that provides a more consistent and transparent approach to assessing how new technologies are implemented in the Australian health system and how funding mechanisms are applied to these processes to ensure that value is achieved.
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 2.3% of recurrent expenditure on health, with the increase in funding being incremental over 5 years to reach at least 4% of recurrent expenditure. Preventive health measures should be directed to activities that have been demonstrated to be cost-effective and which interpret lifestyle choices in the context of the opportunity costs and other incentives faced by individuals.
LONG-TERM (within 7–10 years)	Following 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
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AHHA	Australian Healthcare and Hospitals Association
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
BEACH	Bettering the Evaluation and Care of Health program
CALD	culturally and linguistically diverse
CFFR	Council of Federal Financial Relations
COAG	Council of Australian Governments
COVID-19	Coronavirus disease 2019
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
NHIS	National Health Information Strategy
NHRA	National Health Reform Agreement
NRAS	National Registration and Accreditation Scheme
NSQHS	The National Safety and Quality Health Service
OECD	Organisation for Economic Cooperation and Development
PHN	Primary Health Network
PREM	Patient-reported experience measure
PROM	Patient-reported outcome measure
WHO	World Health Organization

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